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

Roberto Rodriguez,

Petitioner,

vs. NO: 15 WC 16678

The Lombard Company,

Respondent.

18IWCC0668

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 2018, is hereby affirmed and adopted.

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

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

18IWCC0668

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 1 - 2018
o102518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

RODRIGUEZ, ROBERTO
Employee/Petitioner

Case# **15WC016678**

THE LOMBARD COMPANY
Employer/Respondent

18IWCC0668

On 3/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 CASTANEDA LAW OFFICE
JOHN J CASTANEDA
514 W STATE ST SUITE 210
GENEVA, IL 60134

0560 WIEDNER & McAULIFFE LTD
CANDICE E DREW
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

R. Rodriguez v. The Lombard Co., 15 WC 016678

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)

Roberto Rodriguez
Employee/Petitioner

v.

The Lombard Company
Employer/Respondent

Case # **15 WC 016678**

18IWCC0668

An *Application for Adjustment 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 **December 14, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0668

FINDINGS

On the date of accident, **4/13/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,025.80**; the average weekly wage was **$1,096.65**.

On the date of accident, Petitioner was 45 years of age, *married* with 3 dependent children.

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

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

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

ORDER

Petitioner reached MMI for the April 13, 2015 injuries as of July 15, 2015 and, therefore, no medical bills are awarded for treatment rendered after July 15, 2015.

Respondent shall pay Petitioner medical expenses of $793.00, in accordance with Sections 8(a) and 8.2 of the Act, as is set forth below.

Petitioner's claim for prospective medical care and TTD benefits is denied.

Petitioner's claim for penalties and fees is denied.

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

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

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

Signature of Arbitrator

March 15, 2018
Date

MAR 16 2018

FINDINGS OF FACT

Petitioner testified via a Spanish/English interpreter.

Petitioner was employed by Respondent as a foreman/laborer. He has been so employed since 1995. Petitioner was 45 years old on the claimed date of accident.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 13, 2015. Petitioner testified he was picking up a heavy form (weighing 70 to 80 pounds), pulled it two feet, and then felt pain in his back and knees. Petitioner continued working for the remainder of his shift. At the end of his shift, his lower back was hurting.

The following day, Petitioner returned to work. He worked the entire day, although he noticed that he could not walk properly. He had low back pain. He was bent forward. He had decreased ability to do work. It was hard to bend forward. Petitioner's supervisor sent him to the work clinic, WorkRight Occupational Health. On April 14, 2015, the physical examination revealed full range of motion of the lumbar spine, and Petitioner was diagnosed with a lumbar strain. He was advised to take over-the-counter medication and apply heat. Petitioner was released to return to work at full duty. (PX 1) Petitioner testified that he did indeed return to his full duty position. Petitioner returned to WorkRight Occupational Health on April 17, 2015. He complained of low back and right leg pain when walking. He stated he was working regular duty. On April 24, 2015, Petitioner stated he was doing better and was still working regular duty. He continued to be diagnosed with a lumbar strain and the treatment protocol remained the same. (PX 1)

Petitioner continued working regular duty. Petitioner felt that the WorkRight treatment was not helping him.

On June 3, 2015, Petitioner presented to Dr. Kern Singh, an orthopedic surgeon at Midwest Orthopaedics at Rush. Petitioner testified that an interpreter was present at his appointments with Dr. Singh. Petitioner complained of back pain on the left side. The physical examination was normal and revealed a negative straight leg raise bilaterally. Dr. Singh diagnosed a lumbar muscular strain and ordered four weeks of physical therapy. Petitioner was released to return to work at full duty. (PX 2)

Petitioner returned to Dr. Singh on July 13, 2015, with persistent low back pain, this time greater on the right than the left side. Physical examination was normal, and Dr. Singh's diagnosis remained lumbar muscular strain. Dr. Singh referred Petitioner for a lumbar spine MRI. Petitioner was prescribed Flexeril and released to full duty work. (PX 2)

A lumbar spine MRI was completed on July 13, 2015. The impression was degenerative disc changes at L3-L4 and L4-L5, causing mild spinal canal and mild bilateral foraminal narrowing. There was no significant spinal canal or foraminal stenosis at other levels. The body of the MRI report indicates there was a mild disc bulge at L3-L4 causing bilateral foraminal stenosis and a small left foraminal annular tear. At L4-L5, no annular tear was noted. At L5-S1, a minimal disc bulge was noted with no significant spinal canal or foraminal stenosis. No annular tear was noted. (PX 2)

Petitioner followed up with Dr. Singh on July 15, 2015 to review the lumbar spine MRI. Petitioner advised he was working full duty without restrictions. Dr. Singh opined the lumbar spine MRI showed mild spondylosis

and no stenosis., Dr. Singh diagnosed a lumbar muscular strain and lumbar spondylosis. Dr. Singh opined Petitioner was at maximum medical improvement ("MMI") and was able to return to work full duty with no restrictions. Dr. Singh's hand-written ROS document of July 15, 2015 shows that he saw the patient with the MRI. Dr. Singh thought that the MRI was without stenosis and showed mild spondylosis. The diagnosis was LMS (lumbar muscular strain). TX: (treatment) was 1.) RTW w/o restrictions and 2.) At MMI. The following is lined out: 1. 2 – 4 weeks W/C (work conditioning); 2. off?. The Arbitrator declines to find an evil motive in this line out. The inference to be taken is that Dr. Singh perhaps considered the lined out options, but after reviewing the benign MRI and considering the patient's complaints and the benign physical and neurologic exams, released the Petitioner from care. (PX 2)

Respondent referred Petitioner for a §12 exam with Dr. Steven Mash, an orthopedic surgeon, on July 15, 2015. An interpreter was present. Petitioner reported he was working without restrictions and had no radicular symptoms. Petitioner testified that he did not recall telling Dr. Mash that he had no leg symptoms. Upon physical examination, Petitioner reported discomfort at the lumbosacral level. The remainder of the physical examination was normal and consistent with the results of the examination by Dr. Singh on the same day. Dr. Mash diagnosed recovering low back syndrome. Dr. Mash opined Petitioner was able to continue working full duty. Dr. Mash wanted to review the recent lumbar spine MRI as well as additional medical records prior to commenting on MMI. Dr. Mash noted that Petitioner appeared to have subjective complaints without further objective findings. (RX 1)

Dr. Mash authored a Section 12 addendum on August 20, 2015. Dr. Mash reviewed the report of the lumbar spine MRI of July 13, 2015. He opined the findings were consistent with Petitioner's age of 45 years, with some degenerative changes in the lumbar spine. Dr. Mash opined Petitioner was at MMI and needed no further treatment. Dr. Mash opined Petitioner was able to continue working full duty without restrictions. (RX 2)

On direct examination, Petitioner testified that following the IME with Dr. Mash and his release from care by Dr. Singh, he continued to work and was performing all of his job duties. He testified that he did not seek treatment again until December 2015. He testified that he continued to have pain in his back. He was taking 5 Advils every 4 hours, every day. His symptoms were getting worse.

Petitioner presented to a chiropractor at La Clinica for treatment on December 1, 2015. Petitioner noticed this entity when driving by and saw that they spoke Spanish there. Because of this, Petitioner thought that he could express himself well. Petitioner advised that his back pain improved with the prior therapy, but that he had ongoing back pain. It was recommended that he continue with chiropractic care, which he did throughout the remainder of December 2015. Treatment at La Clinica continued through June 16, 2017 (averaging 10 sessions a month from December of 2015 through January of 2017 and 2 sessions per month from February 2017 through June 2017). (PX 3)

Petitioner testified that his treatment at La Clinica consisted of him laying down and moving his legs to each side with his knees towards his stomach. He also underwent ultrasound therapy, electrical stimulation and used hot and cold packs. Petitioner testified that his pain would return two to three hours after his therapy sessions. Petitioner was given work restrictions from Dr. Zaragoza of 15 pounds lifting and to rest when appropriate. Per Petitioner, he remained on the same job and was able to work within these restrictions.

Petitioner presented to Dr. Allen Kao of the Pain Center of Illinois on December 16, 2015. Petitioner complained of low back pain with pain into his bilateral legs. Physical examination revealed tenderness to

palpation over the left lower lumbar facet joint areas with limited range of motion. Petitioner had positive straight leg raise testing on the left side. The assessment was low back pain and bilateral leg pain, greater on the left side. Dr. Kao recommended an updated lumbar spine MRI, EMG/NCV testing, and physical therapy. Petitioner was released to return to work light duty and was prescribed medication. (PX 6)

A lumbar spine MRI of December 26, 2015 showed spondylotic changes with disc bulging and annular tearing from L3-L4 through L5-S1. There was no stenosis. The body of the MRI report provides there was a broad based disc bulge at L3-L4, with a focal annular tear on the left. At L4-L5, there was broad based disc bulge with a focal annular tear on the right side. At L5-S1, there was a broad based disc bulge with bilateral paracentral annular tears. (PX 9)

An EMG/NCV study was completed on January 7, 2016. There was possible evidence of nondenervative left S1 radiculopathy, and clinical correlation was recommended. Otherwise, the study was normal. (PX 9)

Petitioner continued with chiropractic care at La Clinica through January 2016. (PX 3)

On January 20, 2016, Petitioner saw Dr. Intessar Hussain of the Pain Center of Illinois. Petitioner complained of persistent pain in his low back, radiating to his bilateral buttocks and down the left greater than right thigh to his foot. He had nominal improvement with therapy. Dr. Hussain noted the findings of the recent lumbar MRI and EMG/NCV study. The EMG finding of mildly attenuated left S1 reflex may indicate early S1 radicular involvement. The assessment was lumbar radiculopathy and intervertebral disc displacement in the lumbar region. Dr. Hussain recommended a lumbar epidural steroid injection on the left at the L4-L5 and L5-S1 levels. (PX 6)

Petitioner's chiropractic treatment continued at La Clinica through February 2016. (PX 3) Petitioner testified that he stopped working on February 17, 2016, as he was laid off.

Petitioner came under the care of Dr. Kevin Koutsky of Elmhurst Orthopaedics on February 29, 2016. Petitioner testified that an interpreter was present at his appointments with Dr. Koutsky. Petitioner reported low back pain radiating down both lower extremities, left greater than right, with some numbness and tingling. Dr. Koutsky reviewed the lumbar spine MRI, noting a central to left paracentral disc protrusion/annular tear at L3-L4, a right central to paracentral disc protrusion/annular tear at L4-L5, and bilateral protrusions/annular tears at L5-S1. Dr. Koutsky recommended additional therapy, an epidural steroid injection, and prescription medication. Dr. Koutsky also administered trigger point injections to the bilateral paralumbar muscles. Petitioner was given a 10 pound work restriction. (PX 4)

Petitioner continued to receive treatment at La Clinica and saw Dr. Koutsky again on April 4, 2016. Petitioner presented with disabling back pain. The assessment was bilateral L4-L5 and L5-S1 radiculopathy. They were awaiting authorization of an epidural injection and Petitioner was authorized off of work. Dr. Koutsky prescribed medication and recommended therapy. (PX 3, 4)

Respondent set up another §12 examination by Dr. Mash on April 11, 2016. Dr. Mash noted that he previously reviewed an MRI study of July 13, 2015, which was consistent with some degenerative disk disease at L3-L4 and L4-L5, causing mild spinal canal and mild bilateral foraminal narrowing. Dr. Mash believed the findings were age-appropriate. Dr. Mash noted that Petitioner was subsequently released to return to work by Dr. Singh. Petitioner reported to Dr. Mash that his condition had worsened and he had begun treating with Dr. Koutsky and underwent another lumbar MRI. He was currently off of work. Dr. Mash noted that the EMG/NCS

study was equivocal. Dr. Mash reviewed several medical records and completed a physical examination of Petitioner. Dr. Mash's assessment was degenerative low back syndrome. He opined that Petitioner's treatment was reasonable, but was not related to the work accident of April 13, 2015. Dr. Mash noted that based on the medical records, Petitioner's condition improved through mid-summer 2015. Dr. Mash opined that Petitioner's current condition was the result of chronology of aging and degenerative disc disease. Petitioner had reached MMI for the work accident. Dr. Mash explained that although Petitioner may require further treatment, this was for an underlying degenerative condition and not the work accident of April 13, 2015. (RX 3)

Petitioner next saw Dr. Koutsky on May 9 and June 13, 2016. Petitioner was still awaiting approval of the epidural steroid injection. The assessment was bilateral L4-L5 and L5-S1 radiculopathy. Petitioner was to continue his treatment at La Clinica and take pain medication. He underwent trigger point injections on June 13, 2016 and was released to work with a 15 pound lifting restriction. (PX 4)

Petitioner testified that he returned to work for Respondent in a light duty capacity on June 15, 2016. He testified that he continued to work light duty until July 28, 2017, when he was laid off. Petitioner seeks TTD from 2/18/2016 through 6/14/2016 and 7/29/2017 to the date of trial.

Dr. Hussain reexamined Petitioner on June 15, 2016. Petitioner continued to report low back and bilateral leg pain. Dr. Hussain noted Petitioner had undergone extensive therapy and was now being recommended for an epidural steroid injection. The assessment was lumbar radiculopathy with intervertebral disc displacement in the lumbar region. Dr. Hussain recommended a lumbar epidural steroid injection at the L4-L5 and L5-S1 levels. (PX 6)

On July 8, 2016, Dr. Neema Bayran administered an epidural steroid injection at L4-L5 and L5-S1. (PX 7) In the interim, Petitioner continued to receive therapy at La Clinica, with little improvement. (PX 3)

Petitioner returned to Dr. Koutsky on July 18, 2016. He reported an increase in nerve pain on the left side. Petitioner related minimal improvement with the epidural steroid injection. A second injection was pending. Petitioner was working light duty, and Dr. Koutsky recommended additional therapy and pain medication. Dr. Koutsky administered trigger point injections. (PX 4)

Dr. Koutsky authored a narrative report on July 18, 2016, at the request of Petitioner's attorney. The report states that Petitioner had been a patient since February of 2016. Petitioner's primary complaint was low back pain radiating down both legs, greater on the left side, with some numbness and tingling. Petitioner advised that his symptoms began after the April 13, 2015 work injury. Dr. Koutsky noted that Petitioner had positive left-sided straight leg raise testing. He further noted that the lumbar spine MRI of February 26, 2015 showed disc herniations/annular tears from L3-L4 through L5-S1. Petitioner had undergone an EMG, which was consistent with S1 radiculopathy, and consistent with the MRI pathology and disc herniation. Petitioner had limited improvement with an injection and was still undergoing physical therapy. (PX 4)

Dr. Koutsky opined that Petitioner was a reasonable candidate for a lumbar decompression and possible stabilization with instrumentation. Dr. Koutsky opined Petitioner was currently released to light duty work. Dr. Koutsky opined that, to a reasonable degree of medical and surgical certainty, Petitioner's lumbar radiculopathy and low back pain were related to the work injury of April 13, 2015. (PX 4)

Dr. Hussain reexamined Petitioner on July 25, 2016. Petitioner related 50% improvement with the first steroid injection. (PX 6) However, his symptoms persisted. On August 8, 2016, Dr. Hussain administered a

second epidural steroid injection on the left side at L4-L5 and L5-S1. (PX 7) In the interim, Petitioner's therapy at La Clinica continued with minimal improvement. (PX 3)

At Petitioner's appointment with Dr. Koutsky on August 22, 2016, he related minimal long term relief with the steroid injections. He was working with a 15 pound lifting restriction. The assessment was bilateral L4-L5 and L5-S1 radiculopathy. Dr. Koutsky recommended pain management and additional therapy. If Petitioner's pain continued, they would discuss surgery at the next visit. Dr. Koutsky administered trigger point injections. (PX 4)

On August 29, 2016, Petitioner advised Dr. Hussain he had no relief with the second steroid injection. (PX 6) Petitioner next saw Dr. Koutsky on September 26, 2016, and reported continued pain despite the injection and therapy. Dr. Koutsky noted Petitioner had exhausted physical therapy and would not be recommended for an additional injection. Dr. Koutsky opined Petitioner had disc protrusions/annular tears at L4-L5 and L5-S1, contributing to lateral recess stenosis. Dr. Koutsky discussed the possibility of a decompression and fusion. Petitioner was released with a 15 pound lifting restriction. Petitioner was referred to Dr. Geoffrey Dixon for a neurosurgical opinion. Dr. Koutsky administered trigger point injections. (PX 4)

Dr. Dixon evaluated Petitioner on October 6, 2016. The work accident was noted. Dr. Dixon opined Petitioner's pain was refractory to therapy, injections and medication. Dr. Dixon noted the MRI of December 26, 2015 showed diffuse spondylosis with a broad based disc herniation at L4-L5 and L5-S1, with annular tears causing bilateral lateral recess stenosis and foraminal nerve root compression. Dr. Dixon discussed surgery, to include a fusion at L5-S1. Petitioner wanted to proceed. (PX 5)

Petitioner returned to Dr. Koutsky on November 7, 2016. He was still undergoing treatment at La Clinica with pain complaints at 7-9/10. Petitioner had seen Dr. Dixon, who agreed he was a candidate for a lumbar fusion. Petitioner was released to work with a 10 pound lifting restriction and a 10 hour workday. Petitioner saw Dr. Koutsky on December 12, 2016 and January 16, 2017. He continued to be symptomatic and they were awaiting approval of surgery. (PX 4)

Dr. Koutsky's deposition was completed on February 2, 2017. (PX 9) On direct examination, Dr. Koutsky provided testimony based on his treating medical records. Dr. Koutsky clarified that the lumbar spine MRI he reviewed was from December 26, 2015, and not February 26, 2015. Dr. Koutsky testified that the lumbar MRI of December 26, 2015 showed a left sided disc protrusion at L3-L4, a right paracentral protrusion with annular tear at L4-L5 and a central protrusion with annular tear at L5-S1. Dr. Koutsky testified that it was his opinion the findings on the MRI were related to the work accident. (PX 9)

On direct examination, Dr. Koutsky testified that he initially recommended epidural injections to treat Petitioner's back pain. Dr. Koutsky testified that physical therapy was not improving Petitioner's condition, but it was the only treatment that was being authorized. Dr. Koutsky testified that he authored a report on July 18, 2016, wherein he opined that Petitioner's condition in his back was related to the work accident. Dr. Koutsky testified that although he knew Petitioner had been sent for a Section 12 examination, he never reviewed the reports. Dr. Koutsky testified that Petitioner needed a fusion at L5-S1, but also had stenosis at L4-L5. (PX 9)

On cross-examination, Dr. Koutsky admitted that he did not see Petitioner until February 29, 2016 (10 ½ months after the work accident). He testified that he did not review any medical records prior to February 29, 2016, with the exception of the December 26, 2015 lumbar MRI. He testified that he did not review any of the medical records from Petitioner's prior treating physicians, and had not reviewed any of the Section 12 reports

prepared by Dr. Mash. Dr. Koutsky testified that although it would be helpful to review the complete medical records in rendering his opinions to a reasonable degree of medical and surgical certainty, he was comfortable doing so with the information he had been provided. Dr. Koutsky testified that it was possible his opinions could change if he reviewed prior medical records. It was possible that an MRI completed in July 2015 would provide a more accurate depiction of Petitioner's work injuries than an MRI taken eight months after the work incident. Finally, Dr. Koutsky testified that the findings on the lumbar MRI could be degenerative in nature. (PX 9)

Petitioner continued to see Dr. Koutsky monthly, on February 22, March 23, and April 24, 2017. Petitioner was still undergoing therapy at La Clinica and working with restrictions. Dr. Koutsky continued to believe Petitioner was a surgical candidate. On April 24, 2017, Dr. Koutsky recommended an updated lumbar spine MRI. (PX 4)

Petitioner was seen by Dr. Mash for a third §12 examination on May 11, 2017. Dr. Mash noted he had seen Petitioner on several prior occasions, and that an interpreter was present. Dr. Mash noted that since his prior examination, Petitioner had been working light duty, and was still treating with Dr. Koutsky and at La Clinica. Petitioner complained of pain in the low back with occasional radicular symptomatology. Physical examination was unchanged from the prior appointment on April 11, 2016. After reviewing several medical records, Dr. Mash diagnosed degenerative low back syndrome. Dr. Mash noted there was a significant discrepancy in straight leg raising between the seated and supine position, which would suggest Petitioner may be exaggerating his complaints. Nevertheless, Dr. Mash opined that while Petitioner may be a candidate for a lumbar fusion, this treatment was not related to the work accident. Dr. Mash explained that Petitioner improved after his release from care by Dr. Singh, and only later developed ongoing difficulty. This suggested that Petitioner's condition was degenerative in nature. Dr. Mash opined Petitioner attained MMI for the work accident as of July 15, 2015, and that any ongoing work restrictions or treatment was related to his degenerative back condition. (RX 4)

A third lumbar spine MRI was completed on May 13, 2017, and showed mild foraminal stenosis with left foraminal fissure at L3-4, mild foraminal and central canal stenosis at L4-L5, and mild foraminal stenosis at L5-S1 with stable spondylitic changes. The body of the report provides there was a disc bulge and focal annular tear on the left at L3-L4. There was a disc bulge and annular tear on the right at L4-L5 with mild stenosis. There was a disc bulge and bilateral annular tears at L5-S1 with no stenosis. (PX 4)

Dr. Koutsky reviewed the recent lumbar MRI on May 25, 2017. Petitioner was still undergoing therapy at La Clinica. Dr. Koutsky's assessment was L4-L5 and L5-S1 radiculopathy. Dr. Koutsky continued to recommend a decompression and fusion, and Petitioner was released with work restrictions. Petitioner was to continue with therapy. (PX 4)

Petitioner saw Dr. Koutsky on June 29, August 3, September 7, and October 12, 2017. Petitioner was still undergoing therapy at La Clinica and complaining of pain. Dr. Koutsky's treatment recommendations remained the same. (P x 4)

Petitioner's last visit at La Clinica was on November 8, 2017 (PX 3), and his last appointment with Dr. Koutsky was on November 16, 2017. Petitioner still had back pain into his lower extremities. He was taking medication as needed and Dr. Koutsky released Petitioner with a 10 pound lifting restriction. Dr. Koutsky continued to recommend surgery. (PX 4)

At trial, Petitioner testified that he still has low back pain, which he rated 7/10. He was taking over-the-counter anti-inflammatory medication. He was performing home exercises, which he described as laying on the

floor, bending his knees, and bringing them to his chest. Petitioner testified that he had difficulty sleeping and pain with bending. He testified that during the five month gap in treatment in 2015, he continued working for Respondent but was not performing his full job due to pain. Petitioner wants to continue with therapy. He wants to undergo the surgery that Dr. Koutsky recommends, because Dr. Koutsky says that the pain will get better. He wants to get back to work. Petitioner takes 800 mg of Ibuprofen every 4 hours. He uses a cane that Dr. Zaragoza had recommended (Petitioner answered the question about the cane with a "yah" response). He does exercises at home. He has difficulty sleeping. He wears a back belt all day. He has difficulty putting his shoes and socks on. He has difficulty bending.

Petitioner testified that he had not felt the same back pain prior to the lifting event on April 13, 2015. He had not received medical treatment for his back before this incident. Petitioner did not suffer any subsequent injuries to his low back.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Company v. Industrial Commission, 129 Ill.2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003)

Decisions of the Arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1 (e)

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding his low back is not causally related to the work injury of April 13, 2015. The Arbitrator finds the opinions of Dr. Singh and Dr. Mash more persuasive than those of Dr. Koutsky in this case and finds that Petitioner reached MMI from the work accident on July 15, 2015, when he was released from care by Dr. Singh.

When Petitioner began treating with Dr. Singh on June 3, 2015, the physical examination revealed negative straight leg raise testing bilaterally and was mostly benign with 5/5 strength and equal and brisk reflexes. After Petitioner underwent therapy and having viewed the lumbar spine MRI, Dr. Singh deemed Petitioner at MMI and discharged him to full duty on July 15, 2015, with no recommended further treatment. Dr. Singh is a back surgeon and if Petitioner had symptoms consistent with a surgical lesion, Dr. Singh would have offered further treatment.

Dr. Mash's examination of Petitioner on July 15, 2015 was consistent with Dr. Singh's exam of the same day. While Dr. Mash only reviewed the report regarding the July 13, 2015 MRI that Dr. Singh reviewed, he concurred that it was unremarkable. Importantly, Dr. Koutsky did not review the July 13, 2015 MRI and did not review the prior medical records. Dr. Koutsky's causal connection opinion is, therefore, found to be not persuasive.

It is also noted that Petitioner did not seek additional treatment for approximately five months after he was released from care by Dr. Singh. He continued to work at his regular job during this time (indeed Petitioner continued to work at his regular job until February of 2016, some 10 months after the accident). This persuades the Arbitrator that Dr. Singh's diagnosis of resolved lumbar muscular strain is correct.

A causal connection between the accident and Petitioner's condition of ill-being regarding his low back as of July 15, 2015 (resolved lumbar muscular strain, with no work restrictions and no further recommendations for medical care, as opined by Dr. Singh) has been established.

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

Given the Arbitrator's finding above regarding causation, the Arbitrator finds that Respondent is liable for medical bills for treatment rendered to Petitioner from April 13, 2015 through July 15, 2015, pursuant to §8(a) and the Fee Schedule/Section 8.2 of the Act. The awarded bills are:

- Midwest Orthopaedics at Rush - $748.00
- WorkRight Occupational Health - $245.00

TOTAL: $793.00

Respondent is entitled to a credit for all awarded bills that it has paid.

The Arbitrator finds that all other claimed bills are not causally related to the accident and that Respondent is not liable for same.

K. Is Petitioner entitled to any prospective medical care?

Given the Arbitrator's finding above regarding causation, the Arbitrator finds that Petitioner is not entitled to prospective medical care.

L. What temporary benefits are in dispute?

As the Arbitrator has found that Petitioner was at MMI for his injuries as of July 15, 2015, the Arbitrator finds that Petitioner is not entitled to any TTD benefits.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator finds that penalties and fees should not be imposed on Respondent and denies Petitioner's Petition for Penalties and Fees. The Arbitrator finds that Respondent did not act unreasonably or in a vexatious manner in disputing Petitioner's treatment after July 15, 2015.

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

Hugo Gonzalez,
Petitioner,

vs.

NO: 16 WC 22702

A & D Logistics Inc,
Respondent.

18IWCC0669

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 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 21, 2018, is hereby affirmed and adopted.

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

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

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

NOV 1 - 2018

DATED:
o122518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

GONZALEZ, HUGO
Employee/Petitioner

Case# **16WC022702**

A & D LOGISTICS INC
Employer/Respondent

18IWCC0669

On 3/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0533 ROSS TYRRELL LTD
JAMES E TYRRELL
111 W WASHINGTON ST SUITE 1120
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
AMY L TURNBAUGH
120 N LASALLE ST SUITE 1750
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)

HUGO GONZALEZ
Employee/Petitioner

v.

A & D LOGISTICS, INC.
Employer/Respondent

Case # **16** WC **22702**

Consolidated cases: **n/a**

18IWCC0669

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JANUARY 23, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 18IWCC0669

On the date of accident, **MARCH 17, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$34,612.39**; the average weekly wage was **$665.62**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$0.00** 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

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

> The Petitioner failed both to prove that he sustained accidental injuries that arose out of and in the course of his employment with the Respondent and that he provided timely notice of his alleged accident to the Respondent. As such, the remaining issues are moot and the Petitioner's request benefits under 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

MARCH 21, 2018
Date

MAR 21 2018

ICArbDec19(b)

HUGO GONZALEZ v. A & D LOGISTICS, INC.

16 WC 22702

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on the Petitioner's Section 19(b)/8(a) Petition on January 23, 2018. The issues in dispute were accident, notice, causal connection, TTD, and prospective medical care. (*Arbitrator's Exhibit* 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b). (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

The Petitioner testified he worked for the Respondent five years before the claimed date of accident of 3/17/16. His job was a truck driver, delivering Chinese restaurant food supplies to different locations in Illinois and surrounding states. The Petitioner testified his job required him to report to the Respondent's location in the morning and obtain his route instructions for the day from the dispatcher. After checking the truck, which was already loaded with his assigned delivery product, the Petitioner would proceed to the designated routes. He reported some days the loads were lighter and some were heavier, depending on the locations and orders. Once he arrived at a location, the Petitioner would remove a ramp stored under the truck and then use a two-wheel dolly to unload product to the customer's location. He stated the trucks also came equipped with two (2) dollies for use.

The Petitioner testified his delivery route on March 17, 2016 consisted of twelve different locations, several in Michigan. (*Petitioner's Exhibit* 3). He reported one of these locations was at Asian Gourmet, the third delivery spot of the day. The Petitioner stated he had set the ramp and had begun unloading product. As he was on the ramp with a load of product, a wheel came off the dolly and, the next thing he knew, he was flying in the air, falling approximately four feet off the side of the ramp, landing on asphalt on his left knee before coming to rest on the ground on his side. The Petitioner testified he had complained about the dolly to his boss on March 9, 2016, that the Respondent's mechanics had put a new wheel on it, and he was certain it was the same dolly that had previously been repaired.

After Petitioner fell, he testified he got up and noticed pain in his left knee, which he characterized as a nine (9) on a 10-point pain scale. He stated he requested help from "friends" at subsequent delivery locations on the rest of his route to unload product from his truck. He admitted he completed the rest of his scheduled deliveries before returning to the Respondent's location. The Petitioner testified, upon his return to the Respondent's location, he told the dispatcher, Mr. Chen, of his injury. He reported he showed Mr. Chen his knee and was told to get out. He then departed the Respondent's location and went home, where he showed his then girlfriend his knee.

The Petitioner testified he was scheduled and did work the next day with complaints he could not bend his leg. He stated he thought the pain would go away, but it did not get better and he then told "Mr. Ming" when Mr. Ming came to work on March 23, 2016. The Petitioner reported Mr. Ming told him to take some Tylenol and a few days off. He testified he told Mr. Ming the mechanics did not fix the dolly properly. The Petitioner then testified he continued to work until deciding to seek treatment in the emergency room on March 29, 2016. He reported he went to Good Samaritan Hospital and told the doctors he hurt himself on March 17, 2016.

The medical records from Good Samaritan Hospital indicate the Petitioner presented to the Hospital's Emergency Department on March 29, 2016, with complaints of bilateral knee pain. The Petitioner provided a history of falling onto both knees three weeks earlier while delivering Chinese food. He also noted he took a few days off, went back to work, and had persistent pain for the past three weeks. (*Petitioner's Exhibit* (hereinafter, *PX*) 5 at 13). X-rays were taken of both knees which documented degenerative changes of both knees and bilateral mild loss of the medial tibiofemoral joint spaces. (*PX* 5 at 15). The Petitioner then was discharged with a diagnosis of a contusion, a recommendation of Tylenol for pain, and a directive to use ice every four hours over following two days. (*PX* 5 at 16).

The Petitioner testified he tried several times to obtain a "work comp number" from the Respondent so he could schedule a follow-up appointment, but was unsuccessful in doing so. The Petitioner noted he took some time off in April because he did not feel good and the Respondent did not give him more work because he could not make deliveries. He stated this time off work amounted to 20 to 28 days. The Petitioner testified he could not complete his scheduled deliveries on April 30, 2016, and discontinued his delivery route before returning the Respondent's location. He "guessed" Respondent fired him because he was not put on any additional work schedules, but claimed they never stated he had been fired. (*Transcript* at 71). The Petitioner further testified he continued to see Dr. Hussain and Dr. Bayran for an unrelated cervical issue in April and May of 2016, before deciding to seek additional treatment for his left knee on June 14, 2016.

The Petitioner met with Dr. Hussain on April 20, 2016, to follow-up on unrelated neck symptoms. In addition to examining the Petitioner's cervical spine and the range of motion in his neck, Dr. Hussain also performed and recorded his findings of his physical examination of the Petitioner's bilateral lower extremities. The examination revealed the Petitioner had 5/5 findings for hip flexion, knee flexion, knee extension, inversion and eversion, bilaterally. His deep tendon reflexes were found to be 2+, bilaterally. Furthermore, all straight leg raise testing was negative, bilaterally. (*PX* 6 at 20-21).

The Petitioner also saw Dr. Bayran on June 14, 2016, and reported to Dr. Bayran both his left pain symptoms and the nature of his fall onto his left knee when the dolly lost a wheel. He reported he was not sure if he told Dr. Bayran the exact date of his accident, and could not remember specifically telling Dr. Bayran it occurred on February 1, 2016. However, he did state Dr. Bayran prescribed therapy and an MRI study, and kept him off work.

The June 21, 2016, MRI study revealed mild intrasubstance signal alteration of medial meniscus without surface tear, slight lateral patellar tilt, tiny osteochondral defect along the articular surface of medial femoral condyle and minimal effusion. (*PX* 6 at 27-28). The Petitioner then appeared for initial physical therapy evaluation at ATI on June 27, and participated in thirteen therapy sessions between June 27 and July 28. (*PX* 7). Notably, the ATI intake form references a February 1, 2016, accident date and lists the Petitioner's attorney as his legal counsel. (*PX* 7 at 41-43).

The Petitioner returned to Dr. Bayran on July 1, 2016, where Dr. Bayran then referred the Petitioner for orthopedic evaluation of the left knee. (*PX* 6). The Petitioner subsequently met with Dr. Markarian on July 9, 2016. During that appointment, the Petitioner provided a history of an accident occurring on March 17, 2016, the first reference in his medical records to this alleged accident date. He reported to Dr. Markarian his accident occurred when the dolly's wheel fell off, and he "landed and twisted his left knee." Dr. Markarian's records make no mention of falling onto the knee itself as he had previously described to other medical providers. (*PX* 8 at 3). Dr. Markarian reviewed the MRI, diagnosed the Petitioner with an osteochondral defect, prescribed conservative management and x-rays, and continued to restrict the Petitioner from working. (*PX* 8).

On July 30, 2016, the Petitioner returned to Dr. Markarian, who reviewed the x-rays and opined they indicated no arthritis. Dr. Markarian recommended a repeat of the skier's view x-ray, but also recommended surgery for possible removal of loose body and nano/microfracture of the defect, while continuing to restrict the Petitioner's work status. Subsequently, the

Petitioner returned to Dr. Markarian on a consistent basis with the same complaints where his work status remained unchanged and Dr. Markarian noted he would not perform the recommended surgery without authorization. (*PX* 8). This course of medical care and work restrictions continued up to the Petitioner's most recent appointment with Dr. Markarian on January 10, 2018. (*PX* 8).

Dr. Markarian opined the Petitioner had an osteochondral defect that was causally related to a mechanism described as falling and ***landing on his left knee*** while making a delivery. (*PX* 9 at 21). Dr. Markarian stated he refuses to be distracted when dictating his office notes from a patient visit, and dictates the history and mechanism of injury immediately after seeing the patient. He then reported the Petitioner's history from the July 9, 2016, appointment was that the Petitioner fell, but landed and ***twisted his left knee***. (*PX* 9 at 7-8).

Pursuant to the Respondent's Section 12 request, Dr. Lieber examined the Petitioner on 9/7/16.[1] The Petitioner advised Dr. Lieber that a wheel on a dolly fell off and he fell over onto the left knee onto the ground. He complained of pain with ambulation and going up and down stairs. He complained of swelling and popping, weakness and giving away with stiffness. Dr. Lieber appreciated positive joint line tenderness medially and laterally, positive McMurray and Steinmann, and positive with patellar apprehension, patellofemoral pain and tenderness to palpation. He also reviewed the MRI films and records from the Emergency Department, Drs. Bayran and Markarian, and ATI. Dr. Lieber then diagnosed the Petitioner with internal derangement and chondromalacia left knee. (*Respondent's Exhibit* 1).

Dr. Lieber opined the Petitioner's objective findings were consistent with chondromalacia of the patellofemoral joint area. He further opined that objective finding did not correlate with the Petitioner's subjective complaints, which he believed were out of proportion to the minor underlying abnormalities within the Petitioner's left knee. He reported the MRI showed a small pre-existing degenerative osteochondral lesion with no evidence of any acute abnormality that could be related to a March of 2016 event. Dr. Lieber opined the Petitioner did not need any additional testing or treatment (including surgery), was capable of full duty work, and had reached MMI based on the records reviewed as of July 1, 2016, after the MRI was obtained. He further opined the Petitioner's knee condition showed no causal relationship to the alleged work event in March of 2016. (*Respondent's Exhibit* (hereinafter, *RX*) 1).

[1] The Petitioner confirmed an interpreter was present during his examination with Dr. Lieber. (*Transcript* (hereinafter, *T.*) at 110).

The Petitioner testified that, because of the alleged work injury and his inability to work, he lost the residence he lived in with his girlfriend and moved in with his parents in Chicago. The Arbitrator notes medical records indicate the Petitioner's address at the time of his Emergency Department visit on March 29, 2016, was on South Trumbull in Chicago, contrary to his testimony and that of Ms. Nava. The medical records of Drs. Hussain and Bayran from 2015 indicate the Petitioner's address was on West 24th Place in Cicero. (*PX* 6). The Petitioner's driving records that were printed on February 23, 2016, listed an address in Schaumburg, Illinois. (*RX* 3). The Petitioner's 2014 and 2015 W-2 forms also listed an address in Schaumburg. (*RX* 4[2]).

Ms. Antoinette Nava testified pursuant to a subpoena from the Petitioner. Ms. Nava reported she lived with the Petitioner in March of 2016 as his girlfriend. She stated she specifically remembered March 17, 2016, as she is part Irish and had plans to go out and celebrate St. Patrick's Day that year. She reported the Petitioner called her from the road and informed her that he hurt his knee, so she stayed home and waited for him to return. Upon his return, Ms. Nava observed him limping and asked him to show her his leg. She testified she observed a lot of bruising on his left leg in the knee area. She stated she later convinced the Petitioner to seek treatment at the emergency room, and, on several occasions, she observed that his left knee was swollen and larger than his right knee.

Ms. Nava also admitted the Petitioner never stated to her that he had any issue with respect to his right leg or knee, nor did she herself observe any issue with respect to the right knee. She also agreed she lived with the Petitioner from 2013 to September of 2016 on West 24th Place in Cicero, Illinois. However, she acknowledged she moved out from that residence in September of 2016.

Ming Yee Kwok testified on behalf of the Respondent. Mr. Kwok testified he began working for Respondent in February of 2017 and confirmed he did not know the Petitioner. Mr. Kwok testified he is the Manager for the Respondent and the company is a trucking business used by Midwest Food Service to deliver food products to restaurants. Mr. Kwok's duties as Manager include anything from ordering new trucks, managing the repairs to trucks, dealing with English speaking drivers, and overseeing all general record keeping for employees and the

[2] *Respondent's Exhibit* 4 was identified as the claim file for the Petitioner. This file includes copies of the medical records and bills for the Petitioner's 2014 work accident. However, that file does not contain any Emergency Department records from the Petitioner's initial treatment on March 29, 2016.

company. These documents include driving records, prior employment information, medical certificates for CDL licensing, and accident reports.

Mr. Kwok identified both the Petitioner's employment file and separate claim file for his workers' compensation claims. (*RX* 3 and *RX* 4). Mr. Kwok described a typical day for a driver to begin in the morning when they arrived for work at the Respondent's facility. Typically, a daily delivery route already is set. Drivers have a list of restaurants for deliveries and accompanying invoices for the deliveries. They also have two dollies in the truck to use while performing deliveries. Mr. Kwok confirmed the invoice typically lists the restaurants in the order of the deliveries to be made, as well.

Mr. Kwok identified a January of 2016 to April of 2016 payroll sheet the Respondent's dispatcher completed for all drivers, noting it allows the Respondent to monitor employee attendance. (*RX* 5). He identified the Respondent's entries for the Petitioner on the payroll sheet as "Hugo." He then described the coding used on the payroll sheet, including a zero (0) that means the employee did not work that day, and a one (1) that denotes the employee covered a light route. He further testified higher numbers indicate heavier routes, where the employee is paid time and a half or double pay. He also confirmed the Respondent does not operate on Sundays.

Ming Kit Ngai testified on behalf of the Respondent. Mr. Ngai testified he worked as the Manager for the Respondent from July of 2009 until the end of December of 2016. Mr. Ngai also testified as to the duties of Manager for Respondent, confirming Mr. Kwok's prior testimony.[3] Mr. Ngai identified the Petitioner and acknowledged he had worked with the

[3] Mr. Ngai also explained the coding utilized on the Respondent's payroll sheets and how these entries reflected the types of routes and loads handled by the Respondent's drivers. (*RX* 5). These payroll sheets indicate the Petitioner worked March 18 and 19, and then was off, per his normal schedule, from March 20 to March 22. He then worked March 23 to March 26, and then was off, again per his normal schedule, from March 27 to March 29. The Petitioner worked March 30 with a slightly larger delivery before being off on March 31 and April 1.

During April of 2016, the Petitioner worked April 2, was off on April 3 and 4, and then worked from April 5 through April 9. He was off from April 10 to April 12 before working from April 13 to April 16. His subsequent work schedule included off days on April 17 and 18, a work day on April 19, and another off day on April 20. During the last portion of April of 2016, the Petitioner worked from April 21 to April 23, was off on April 24, and then worked April 25 to April 28. He concluded the month of April with an off day on April 29 and working on April 30. (*RX* 5).

These sheets indicate the Petitioner was off 18 days during the period from March 17 through April 30, 2016. They also indicate he was off 14 days in January of 2016, 12 days in February of 2016, 11 days in March, and 11 days in April.

Petitioner during his time with the Respondent. Mr. Ngai reported he communicated with all employees, including the Petitioner, most often through texts via cell phone, as he found it to be the most convenient and clear means of communication.

Mr. Ngai acknowledged his cell phone number in 2016 was the same as the cell phone number cited in *Petitioner's Exhibit* 1. He also testified *Respondent's Exhibit* 6 consisted of copies of text messages between himself and the Petitioner from March 8, 2016 until July 19, 2016. Mr. Ngai reported the Petitioner always called him "Boss" and would routinely communicate with him regarding any work issues, including equipment, money collection, and delivery routes. He stated he never had a conversation or text exchange with the Petitioner during March or April or 2016 concerning any injury to the Petitioner's left knee. Mr. Ngai also denied having any conversation with the Petitioner on or about March 23, 2017, at which time the Petitioner alleged he gave notice of the accident to Mr. Ngai.

Mr. Ngai testified he took a personal vacation to Japan in late April of 2016. During that trip, he received word that one of the Respondent's customers had reported to the Respondent's dispatcher the Petitioner had failed to make a scheduled delivery and the dispatcher could not locate the Petitioner. Upon his return from Japan, Mr. Ngai was informed the Petitioner had been fired. Subsequently, on June 30, 2016, Mr. Ngai sent a text message to the Petitioner requesting information about the Petitioner's injury for an accident report. However, Mr. Ngai could not recall what prompted him to send that text message. (*RX* 6).

CONCLUSIONS OF LAW

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

Issues C & E: *Accident and Notice*

The Arbitrator finds the Petitioner's testimony not credible considering the evidence in the record. Specifically, the Petitioner asserts an accident on March 17, 2016. (*AX* 1). However, he worked regular shifts on March 18 and 19, and from March 23 through March 26. He took his regular scheduled days off on March 20 and 21, and then from March 27 to Marcgh 29. The Petitioner sought medical care at the Good Samaritan Hospital Emergency Department on March 29 and gave a history of the accident occurring three (3) weeks earlier, which would have been on or about March 8. During this Emergency Department visit, he gave a vague

history of having fallen and landing on both knees. However, there is no mention of the mechanism of a wheel falling off a dolly at the time of the fall.

The medical records document the Petitioner had complaints concerning his bilateral knees during that visit. However, at no time, whether it be in subsequent medical reports, his testimony or that of his witness, does the Petitioner ever reference any claimed injury to his right knee, despite seeking treatment for the same. Ms. Nava admitted she appreciated no issues with the Petitioner's right knee when she viewed his legs upon his return home after work on March 17.

The medical records indicate the Petitioner waited until twelve (12) days after his alleged March 17 accident date to seek medical care on March 29. That March 29 date also is recorded as the last day of a regularly scheduled three days off work period. (*RX* 5). Despite Emergency Department discharge instructions to ice his knees every four hours for the next two days, the Respondent's payroll sheets indicate he went back to work the next day and worked a slightly heavier route. (Compare *PX* 5 and *RX* 5).

The medical records admitted into evidence show the Petitioner did not seek any additional medical treatment for his knee complaints until well after his April 30 termination from the Respondent. However, during the period from March 29 to April 30, he did return to Dr. Hussain on April 20 where a full physical examination was performed, including the Petitioner's bilateral knees, and the findings were reported to be normal. (*PX* 6 at 19-21).

On June 14, 2016, the Petitioner did seek further medical care for his knee, some one-and-a-half months after his April 30 termination date, and ten days after his unrelated June 4 cervical radiofrequency ablation procedure. (*PX* 6 at 23-25). During that June 14 appointment, the Petitioner informed Dr. Bayran his left knee injury occurred in February of 2016. (*PX* 6 at 25).[4] The Petitioner confirmed he had no short-term memory problems or head injuries in March of 2016, and he and Ms. Nava both stated they remembered the alleged accident date as March 17, 2016, because it was St. Patrick's Day and they had plans that evening. However, this testimony is contradicted by the credible medical records that indicate the Petitioner could not identify a specific accident date during his initial medical visits.

The Arbitrator also finds Ms. Nava was not a credible witness. Ms. Nava testified she and the Petitioner lived together at an address on West 24th Place in Cicero, Illinois, from 2013

[4] Therapy records from ATI Physical therapy indicate the Petitioner reported a February 1, 2016 injury date when he began a course of physical therapy on June 27, 2016, as ordered by Dr. Bayran. (*PX* 7 at 3).

until 2016. However, the record demonstrates the Petitioner has had multiple addresses in 2014, 2015 and 2016. The Arbitrator notes, while these discrepancies are not germane to the issues of accident and notice, they do highlight additional inconsistencies by the Petitioner and Ms. Nava that further establish their lack of credibility.

Furthermore, after the Petitioner sought medical care on March 29, 2016, his subsequent actions do not support the claimed level of injury to which he testified. Despite Emergency Department discharge instructions that urged him to his knees every four hours, the Petitioner returned to work the next day (March 30) and worked a heavier than normal route. (*RX* 5). Thereafter, and for the entire month of April of 2016, the Petitioner worked his same average schedule and days as he did during the preceding months of January and February of 2016. (*RX* 5). These payroll sheets also call into question the credibility of the Petitioner's Driver's Daily Log entries that only indicate he participated in a thirty minute "pre-trip" on March 30, 2016. (*PX* 2). Additionally, the Driver's Daily Log entry that follows the March 30 entry indicates the was "off duty" from March 27 to April 24, 2016, and again is refuted by the Respondent's credible payroll sheets that itemized the Petitioner's work days through his termination on April 30, 2016. (Compare *PX* 2 and *RX* 5).

Additionally, the text communications between the Petitioner and Mr. Ngai raise further questions as to the Petitioner's credibility. A complete reading of these text exchanges between the Petitioner and Mr. Ngai reveals the Petitioner's texts routinely were brief and used "broken" English or incorrect grammar. However, the July 7, 2016, two-part text message allegedly from the Petitioner is very detailed, uses grammatically correct English, and is the first written notification to the Respondent alleging a March 17, 2016, accident date. However, this message is not even supported by the Petitioner's trial testimony as both the Petitioner and Mr. Ngai confirmed the Petitioner's dolly was repaired prior to his alleged March 17 accident date. Also, the text is "signed" by "Hugo" at the end and, at no time in any of the prior texts, did the Petitioner ever sign his name to texts.

Furthermore, the Arbitrator finds the Petitioner failed to provide timely notice to the Respondent within 45 days of his alleged March 17, 2016, accident. The Respondent's employment files for the Petitioner contain no documentation of any medical care the Petitioner had received within 45 days of his alleged accident. Furthermore, the June 14 chart note from Dr. Bayran specifies a February 1, 2016 accident date. The first history in the medical records alleging a March 17, 2016, accident date did not occur until his July 9, 2016, appointment with Dr. Markarian, well after the 45-day notice period expired on or about May 1, 2016. Similarly, the July 7, 2016 text message to Mr. Ngai alleging a March 17 accident date is beyond the 45-day notice period under the Act. Prior to that text, the Petitioner testified he

notified Mr. Ngai on March 23 of his March 17 accident, six days after that alleged episode. However, the Petitioner, whose credibility is lacking as noted above, also failed to specify a March 17 accident date when he reported to the Emergency Department on March 29, 2016. Based upon the documentary evidence and Petitioner's lack of credibility, the Arbitrator finds the Petitioner did not give timely notice of any alleged accident to the Respondent until well after 45 days expired, even assuming an accident date of March 17, 2016.

For the reasons stated above, the Arbitrator finds the Petitioner failed to prove he suffered an accident while working for the Respondent on March 17, 2016, and failed to provide the Respondent timely notice of any alleged accident. Accordingly, his claim for benefits under the Act is denied.

Issue F: *Causal connection*

Based upon the findings regarding **Issues C & E** above, the issue of causal connection is moot.

Issue J: *Medical bills*[5]

Based upon the findings regarding **Issues C & E** above, the issue of medical bills is moot.

Issue K: *Prospective medical care*

Based upon the findings regarding **Issues C & E** above, the issue of prospective medical care is moot.

Issue L: *TTD*

Based upon the findings regarding **Issues C & E** above, the issue of TTD is moot.

Signature of Arbitrator

MARCH 21, 2018
Date

[5] The parties stipulated the Petitioner "is not submitting bills" at the time of the January 23, 2018 hearing. (*AX* 1 and *T.* at 6). However, as this was marked as a disputed issue by the Respondent ("no liability for medical expenses"), it will be addressed in this Arbitration Decision. (*AX* 1).

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GREG A. HURLEY,

Petitioner,

vs.

NO: 13 WC 35226

18IWCC0670

DOMINION REALTY, INC., d/b/a
LINCOLN SQUARE APARTMENTS,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts the Arbitrator's Decision with respect to all issues except the permanent partial disability award. The Commission concurs with the Arbitrator's permanency analysis under the strictures of §8.1(b) except the Commission affords even greater weight to the facts under §8.1(b)(v), the level of disability corroborated by the treating records. The Commission agrees with the Arbitrator finding the opinions of Dr. VanFleet to be more persuasive than those of Dr. Jhee, specifically Dr. VanFleet's opinion that Petitioner has no functional impairment as a result of his injury. The Commission notes that Dr. VanFleet testified that Petitioner has a mild deformity, cement in the bone and even if he has a subjective complaint of pain and tenderness, that is no reason for restrictions. The Commission finds, however, that the Arbitrator's Decision failed to appreciate the significance of Petitioner's permanent partial disability described by Dr. VanFleet, specifically, Petitioner's mild deformity and residual cement in the bone after the kyphoplasty procedure. Therefore, the Commission modifies the permanent partial disability award from 10% loss of use of the person as a whole to 17-1/2% loss of use of

the person as a whole under section 8(d)2.

Finally, the Commission modifies the Arbitrator's Order regarding the medical services award. In the second line of the Arbitrator's Order, and the second paragraph under the Arbitrator's Conclusions of Law on page five (5) of the Decision, the Arbitrator references the medical expenses "identified in Petitioner's Exhibit 22." The Commission notes the medical expenses are identified in both Petitioner's Exhibit 22 and Petitioner's Exhibit 23. Therefore, the Commission modifies the Arbitrator's Order and the second paragraph under the Arbitrator's Conclusions of Law on page five of the Decision to include the medical expenses "identified in Petitioner's Exhibit 22 and Petitioner's Exhibit 23."

The Commission also notes the Arbitrator's comments regarding the fact that many of the medical bills tendered by Petitioner are for medical services provided to Petitioner subsequent to September 11, 2013, and the Arbitrator also noted that many medical bills in Petitioner's exhibits are for conditions not related to Petitioner's T7 compression fracture. The Commission finds the Respondent is not liable for medical bills unrelated to the subject T7 compression fracture injury including but not limited to the Petitioner's cervical, lumbar, right shoulder and left thigh complaints.

Therefore, based on the fact that the Arbitrator found, and the Commission agrees, there are unrelated medical bills in Petitioner's Exhibits 22 and 23, the Commission modifies the first paragraph of the Arbitrator's Order, and the second paragraph under the Arbitrator's Conclusions of Law on page five (5) of the Decision, as follows: "Respondent shall pay to Petitioner the reasonable and necessary medical services provided to Petitioner from March 16, 2012 through September 11, 2013 related to the treatment for the T7 compression fracture and kyphoplasty as identified in Petitioner's Exhibits 22 and 23, as provided in Sections 8(a) and 8.2 of the Act, subject to fee schedule."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 7, 2018 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of 10% loss of use of the person as a whole under §8(d)2 for permanent partial disability is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $386.67 per week for a period of 79-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $348.00 per week for a period of 87.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 17-1/2% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical services provided to Petitioner from March 16, 2012 through

September 11, 2013 related to the treatment for the T7 compression fracture and kyphoplasty as identified in Petitioner's Exhibits 22 and 23, as provided in Sections 8(a) and 8.2 of the Act, subject to fee schedule.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,861.00. 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 - 2018
KWL/bsd
O: 9/11/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HURLEY, GREG
Employee/Petitioner

Case# **13WC035226**

DOMINION REALTY INC D/B/A LINCOLN SQUARE APARTMENTS
Employer/Respondent

18IWCC0670

On 2/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2593 GANAN & SHAPIRO PC
SARAH ANTRIM
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Greg Hurley
Employee/Petitioner

v.

Dominion Realty, Inc. d/b/a Lincoln Square Apartments
Employer/Respondent

Case # 13 WC 35226

Consolidated cases: n/a

18IWCC0670

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on December 28 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On March 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $30,160.00; the average weekly wage was $580.00.

On the date of accident, Petitioner was 48 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $38,456.53 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $38,456.53. At trial, the parties stipulated Respondent paid Petitioner statutory permanent partial disability for a fractured vertebra.

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

ORDER

Respondent shall pay reasonable and necessary medical services for treatment provided to Petitioner from March 16, 2012, through September 11, 2013, as identified in Petitioner's Exhibit 22, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $386.67 per week for 79 4/7 weeks commencing March 3, 2012, to September 11, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $348.00 per week for 50 weeks because the injury sustained caused the 10% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

February 2, 2018
Date

ICArbDec p 2

FEB 7 - 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on March 2, 2012. According to the Application, Petitioner was "injured at work" and sustained an injury to the "back and other parts of the body" (Arbitrator's Exhibit 2). Respondent stipulated that Petitioner sustained a work-related injury, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Respondent also disputed liability in regard to medical expenses and the period of time for which Petitioner claimed he was entitled to temporary total disability benefits. In regard to medical bills, Respondent claimed it had no liability after an IME/MMI date of September 11, 2013, as well as there being no foundation or causal connection. In regard to temporary total disability benefits, Petitioner claimed he was entitled to payment of temporary total disability benefits of 80 weeks, commencing March 3, 2012, to September 20, 2013 (the number of weeks computed by the Arbitrator was 80 6/7). Respondent disputed its liability for the period of time claimed by Petitioner and stipulated that Petitioner was entitled to payment of temporary total disability benefits for 77 4/7 weeks, commencing March 3, 2012, to September 11, 2013 (the number of weeks computed by the Arbitrator was 79 4/7). Accordingly, the period of disputed temporary total disability benefits was one and two-sevenths (1 2/7) weeks (Arbitrator's Exhibit 1).

In addition to the preceding, the nature and extent of Petitioner's disability was a disputed issue. Specifically, Petitioner claimed he was entitled to a wage differential award pursuant to Section 8(d)1 of the Act (Arbitrator's Exhibit 1). Petitioner and Respondent also disputed what Petitioner's current average weekly wage would have been had he continued to work for Respondent. Petitioner claimed it would have been $807.06. Respondent claimed it would have been $646.62. The primary basis of this average weekly wage dispute was whether overtime earnings were to be included.

Petitioner worked for Respondent as a maintenance worker/supervisor in an apartment complex owned by Respondent. Petitioner's job duties included moving furniture, cleaning apartments, painting, maintaining the grounds, performing various repairs, etc. On March 2, 2012, Petitioner attempted to move a mattress that was stuck under a trash dumpster. When Petitioner "rocked" the dumpster, he felt what he described as three "pops" in the middle portion of his back.

Petitioner went to the ER of OSF on March 16, 2012. At that time, Petitioner gave a history of the accident and complained of worsening pain in the thoracic spine. An x-ray was taken of the thoracic spine which revealed degenerative changes (Petitioner's Exhibit 4 and 11).

Petitioner was subsequently seen by Dr. Jack Spaniol, on March 20, 2012. Petitioner continued to complain of mid back pain. Dr. Spaniol noted that the x-ray of the thoracic spine was negative, but he ordered an MRI of the thoracic spine which was performed on March 30, 2012. The MRI revealed a compression fracture of T7 (Petitioner's Exhibits 4 and 5).

Petitioner was subsequently treated by Dr. Jason Seibly who initially saw Petitioner on April 5, 2012. Dr. Seibly agreed Petitioner had sustained a compression fracture of T7 and recommended Petitioner undergo a kyphoplasty. Dr. Seibly performed that surgical procedure on June 19, 2012 (Petitioner's Exhibits 4, 7 and 13).

Following surgery, Dr. Seibly ordered physical therapy which Petitioner received between August and November, 2012. Dr. Seibly subsequently ordered work hardening which Petitioner received between December, 2012, and January, 2013 (Petitioner's Exhibits 12 and 13).

Petitioner was then treated by Dr. Won Jhee, a physical medicine and rehabilitation specialist, who initially saw Petitioner on January 24, 2013. When seen by Dr. Jhee, Petitioner continued to complain of mid back pain; however, Dr. Jhee also treated Petitioner for right shoulder and neck pain. Dr. Jhee agreed Petitioner had sustained a T7 fracture and noted tenderness in the mid back on examination. He authorized Petitioner to remain off work (Petitioner's Exhibit 9).

When Dr. Jhee saw Petitioner on February 28, 2013, he authorized Petitioner to return to work on March 1, 2013; however, it was subject to a number of restrictions. Dr. Jhee imposed restrictions of no frequent lifting, lifting over 40/50 pounds, no static pushing/pulling over 40/80 pounds, no overhead lifting over 20/30 pounds and no frequent bending or twisting at the waistline (Petitioner's Exhibit 9).

Dr. Jhee continued to periodically see Petitioner from March, 2013, through January, 2017. He has continued to impose the same work restrictions he noted on February 28, 2013 (Petitioner's Exhibit 9).

At the direction of Respondent, Petitioner was examined by Dr. Timothy VanFleet, an orthopedic surgeon, on September 11, 2013. In connection with his examination of Petitioner, Dr. VanFleet reviewed medical records provided to him by Respondent. Dr. VanFleet noted the work restrictions imposed by Dr. Jhee and that Petitioner had undergone prior cervical and lumbar fusions as well as shoulder surgery in 2002. Petitioner advised he was not working and had pain in the middle thoracic spine which radiated toward the right shoulder and right flank areas (Respondent's Exhibit 2).

Dr. VanFleet reviewed the MRI and agreed it revealed a T7 compression fracture. Other than some superficial tenderness to palpation across the thoracic spine, Dr. VanFleet's examination of Petitioner was normal. He opined Petitioner was at MMI, could return to work without restrictions and no further medical treatment was indicated (Respondent's Exhibit 2).

From March 20, 2014, through August 3, 2016, Petitioner was treated by Dr. Terry Hunt, a pain management specialist. Dr. Hunt administered epidural steroid and right rhomboid trigger point injections as well as nerve blocks (Petitioner's Exhibit 15).

Petitioner also sought treatment from Dr. Nenita Tudtud for neck and trapezius pain from December 13, 2012, through December 20, 2013. Petitioner was also treated by Dr. Paul Naour for cervical spine symptoms from September 30, 2016, through October 24, 2016 (Petitioner's Exhibit 24).

Petitioner was again seen by Dr. Spaniol on October 24, 2016. At that time, Petitioner advised that he had sustained another injury to his thoracic spine when he was performing some maintenance work on his wife's car (Respondent's Exhibit 8).

At the direction of Petitioner's counsel, Petitioner was evaluated by Dennis Gustafson, a vocational rehabilitation expert, on January 10, 2014. When Gustafson met with Petitioner, he reviewed Petitioner's education and employment history as well as medical records provided to him by Petitioner's counsel. The medical records included a list of the various work restrictions that were previously imposed by Dr. Jhee on February 28, 2013. Gustafson opined that Petitioner would not be able to return to the building maintenance job he had with Respondent. He opined Petitioner was employable and listed a number of jobs with hourly earnings that ranged from $8.74 to $10.91 (Petitioner's Exhibit 2).

At the direction of Respondent, Mary Andrews, a vocational rehabilitation expert, performed a labor market survey to determine if Petitioner was employable. Andrews did not meet with Petitioner, but reviewed his education and work history as well as medical records provided to her by Respondent. The medical records included the opinions of both Dr. Jhee and Dr. VanFleet regarding what work restrictions were appropriate for Petitioner. At the direction of Respondent, Andrews used the restrictions imposed by Dr. Jhee when performing her labor market survey. Andrews' report of December 16, 2016, was received into evidence at trial (Respondent's Exhibit 3).

Andrews found 10 prospective employers that either had openings or potential openings for jobs for which Petitioner was qualified. As aforestated, the jobs Andrews found conformed to the restrictions imposed by Dr. Jhee. The various jobs Andrews found that hourly earnings from $9.70 to $15.51 (Respondent's Exhibit 3).

Dr. VanFleet was deposed on April 9, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. VanFleet's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. VanFleet testified that while Petitioner had some muscular tenderness in the area of the mid spine, were no positive objective findings and the tenderness he noted on examination was not consistent with any known pathology. He specifically noted that the injury had occurred 18 months prior and that there was a compression fracture of a vertebra, a condition that usually takes six to eight weeks to heal. He also stated that chronic pain symptoms after one sustained a compression fracture of a vertebra are rare. He stated Petitioner was at MMI and no further treatment was indicated. Further, Dr. VanFleet stated that Petitioner would have, in fact, been at MMI and when he completed work hardening on May 20, 2013 [The Arbitrator notes this date is inconsistent with the record] (Respondent's Exhibit 1; pp 9-14, 19).

Dr. Jhee was deposed on December 15, 2014, and his deposition testimony was received into evidence at trial. Dr. Jhee's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. When questioned about Petitioner's work restrictions, Dr. Jhee was not able to state with any certainty whether the restrictions he imposed were permanent (Petitioner's Exhibit 1; p 21).

On cross-examination, Dr. Jhee conceded that Petitioner's cervical, lumbar and left thigh complaints were not related to the accident. Further, he agreed that the first time Petitioner complained of right shoulder and low back pain was on September 30, 2013 (Petitioner's Exhibit 1; pp 22-24, 32).

Mary Andrews was deposed on September 20, 2017, and her deposition testimony was received into evidence at trial. On direct examination, Andrews reaffirmed the opinions contained in her report of the labor market survey she conducted. Andrews also specifically stated that, at the request of the adjuster, she used the restrictions imposed by Dr. Jhee when she conducted the labor market survey (Respondent's Exhibit 7; pp 9).

Petitioner tendered into evidence wage data from his current employer, Randstad Inhouse Services. Petitioner's current average weekly wage was $246.70 (Petitioner's Exhibit 20). Petitioner also tendered into evidence earnings of another employee of Respondent in a job similar to the one Petitioner had at the time he sustained the accident. Petitioner computed the average weekly wage including overtime to be $807.06. Respondent computed the average weekly wage excluding overtime to be $646.62 (Petitioner's Exhibit 25).

At trial, Petitioner testified that he was still under the restrictions imposed by Dr. Jhee. Petitioner's present job for Randstad consisted of data removal from laptops for which he was paid $10.50 an hour, 37.5 hours per week. In regard to the fractured T7 vertebrae, Petitioner and Respondent stipulated that Respondent paid Petitioner the statutory permanent partial disability for a fractured vertebra.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to the fracture of the T7 vertebrae is causally related to the accident of March 2, 2012. In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a work-related accident on March 2, 2012, to his mid back. A compression fracture of T7 was diagnosed shortly thereafter. There was no issue regarding the relationship of the T7 fracture to the accident.

Subsequent to the accident, Petitioner was treated for other conditions involving the cervical and lumbar spines, right shoulder and left thigh. None of these conditions were related to the accident of March 2, 2012.

Respondent's Section 12 examiner, Dr. VanFleet, an orthopedic surgeon, opined Petitioner was at MMI when he saw him on September 11, 2013, and no further medical treatment was indicated.

Further, Petitioner apparently sustained what may have been a new injury to his mid back in October, 2016, while performing some maintenance on his wife's car.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the medical treatment provided to Petitioner for his mid back condition from March 16, 2012, through September 11, 2013, was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services for treatment provided to Petitioner from March 16, 2012, through September 11, 2013, as identified in Petitioner's Exhibit 22 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes following:

Respondent's Section 12 examiner, Dr. VanFleet, an orthopedic surgeon, opined Petitioner was at MMI when he examined him on September 11, 2013, and no further medical treatment was indicated.

Petitioner continued to be seen and treated primarily by Dr. Jhee, a physical medicine and rehabilitation specialist, and Dr. Hunt, a pain management specialist, but with little or no resolution of his symptoms.

The Arbitrator finds the opinion of Dr. VanFleet to be more persuasive than that of Dr. Jhee and Dr. Hunt.

In addition to the fact that many of the medical bills tendered by Petitioner are for medical services provided to Petitioner subsequent to September 11, 2013, the Arbitrator notes that many are for conditions not related to Petitioner's T7 compression fracture. Specifically, there are bills for an EMG/nerve conduction study, MRI of the cervical spine, treatment for lumbosacral neuritis and other conditions.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits of 79 4/7 weeks, commencing March 3, 2012, to September 11, 2013.

In support of this conclusion the Arbitrator notes the following:

As aforestated, when Dr. VanFleet examined Petitioner on September 11, 2013, he opined Petitioner was at MMI. The Arbitrator is not persuaded by Dr. VanFleet's testimony that Petitioner would have been at MMI when he completed work hardening on May 20, 2013 [The Arbitrator notes this date is inconsistent with the record], several months before Dr. VanFleet examined Petitioner.

At trial, Respondent stipulated Petitioner was temporarily totally disabled from March 3, 2012, to September 11, 2013.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 10% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

At the time of the accident, Petitioner worked as a maintenance worker/supervisor, a job that was physically demanding. As noted herein, Dr. VanFleet opined Petitioner could return to work without restrictions. The Arbitrator gives this factor minimal weight.

Petitioner was 48 years old at the time of the accident. There was no evidence that Petitioner's age had any effect on the nature and extent of disability. The Arbitrator gives this factor no weight.

At the time of the accident, Petitioner had an average weekly wage of $580.00. If the work restrictions imposed by Dr. Jhee had been found to be appropriate and permanent, there would be no question that the accident had a negative impact on Petitioner's future earning capacity. However, as noted herein, the Arbitrator found the opinion of Dr. VanFleet as to Petitioner's work restrictions to be more persuasive than that of Dr. Jhee. Because Dr. VanFleet opined Petitioner could return to work without restrictions, the Arbitrator gives this factor no weight.

Respondent's Section 12 examiner, Dr. VanFleet, opined Petitioner could return to work without restrictions. He noted no positive objective findings on examination and that vertebral fractures usually heal in six to eight weeks and that chronic pain symptoms following a fractured vertebra are rare.

While Petitioner's primary treating physician, Dr. Jhee, imposed significant work restrictions on Petitioner, when he was deposed, Dr. Jhee stated he was not certain if these restrictions were, in fact, permanent.

The Arbitrator finds the opinion of Dr. VanFleet as to Petitioner's work restrictions to be more persuasive than that of Dr. Jhee. The Arbitrator gives this factor significant weight.

Petitioner sustained an injury to the thoracic spine which caused a compression fracture of T7. Respondent has paid Petitioner the statutory permanent partial disability for a fractured vertebra.

Given the fact that Petitioner has been released return to work without restrictions, the Arbitrator concludes Petitioner has not proven that he is entitled to a Section 8(d)1 award.

Petitioner still has persistent subjective complaints referable to the thoracic spine.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RASHIED DAVIS,

Petitioner,

vs.

NO: 08 WC 2862
10 WC 13601
10 WC 13602

CHICAGO BEARS FOOTBALL CLUB,

Respondent.

18IWCC0671

DECISION AND OPINION ON REVIEW PURSUANT TO §8(a) OF THE ACT

Timely Petition pursuant to Section 8(a) of the Act having been filed by Petitioner, and due notice provided to all parties, the Commission, after considering the issues of causal relationship, medical expenses, and prospective medical care, and being advised of the facts and the law, grants Petitioner's Section 8(a) Petition and awards the recommended C4-6 anterior cervical discectomy and fusion (ACDF), as well as all reasonable medical expenses related to Petitioner's neck and cervical spine. The Commission, however, denies Petitioner's request for attorney's fees.

Procedural History

This matter had been settled by the parties with a lump sum settlement contract, approved by Arbitrator Deborah Simpson on July 13, 2013. As part of the settlement agreement, Respondent agreed to maintain open medical rights under Section 8(a) of the Act "for any reasonable and related medical expenses relating specifically to neck or cervical spine, subject to review per provisions of the Act." (T.21; PX2).

On August 15, 2016, Petitioner filed a Section 8(a) Petition; Section 8(a) of the Act provides for a review by the Commission if additional medical expenses are incurred.

On July 28, 2017, Petitioner filed an amended Section 8(a) Petition requesting approval of a C4-6 ACDF, and that Respondent pay all reasonable medical expenses related to Petitioner's neck and cervical spine.

The matter proceeded to hearing on April 12, 2018 before Commissioner Michael J. Brennan; proofs were closed on May 17, 2018. The parties timely filed briefs, and oral arguments were made before the Commission on October 23, 2018.

Findings of Fact

Petitioner is a retired football player; he had played for the Chicago Bears for seven years as a wide receiver and defensive back. (T.10). Petitioner has not played football since he retired from the sport in 2013. (T.11).

Petitioner had filed three workers' compensation claims, which were consolidated; the first accident date was August 1, 2007 [10 WC 13601]. Petitioner explained how he was injured: "I remember getting a stinger, what we would call a stinger, which is like hitting someone and it shoots this numbing pain down either side of your body. And in this case, I believe it was the left side." (T.16; PX1). Petitioner testified that as of the date of hearing, he continued to feel tingling sensations in his pinky, ring finger, and middle finger. (T.17).

The next date of accident was August 25, 2007 [08 WC 2862]. (PX1). Petitioner was playing for the Bears against the Texans in Houston, Texas. "I can't tell you specifically, but I do remember making a tackle and being – and falling to the ground and being fallen on top of. That is where I believe the injuries started." (T.15). Petitioner further testified, "I can't remember if it was a fumble recovery or interception or whatever, I made a tackle, fell to the ground. Defensive lineman fell on top of me, fell basically on my neck between my shoulders and head, and sort of pressed me into the ground." (T.16).

The third accident date was August 15, 2009 [10 WC 13602]; Petitioner was playing for Respondent against the Buffalo Bills in Buffalo, New York. (T.19; PX1). Again, Petitioner could not recall whether he hit someone during this game or if another player hit him, "but I had the same stinger effect happen." (T.20).

Following the 2007 and 2009 accidents, Petitioner continued to play football for some time afterwards. (T.25). He did not recall sustaining any further injury to his neck from 2009 until his retirement from professional football in 2013. (T.26). From 2009 through 2012, Petitioner received treatment in the form of ice, stimulation, heat, massage, and chiropractic care. (T.26). Despite the

treatment, Petitioner stated that his condition worsened; the pain and stiffness on both sides of his neck increased. (T.27).

Petitioner testified that in June 2013, he agreed to settle all three workers' compensation claims. (T.20; PX2). As part of the settlement agreement, Respondent agreed to maintain open medical rights under Section 8(a) of the Act "for any reasonable and related medical expenses relating specifically to neck or cervical spine, subject to review per provisions of the Act." (T.21; PX2). Petitioner stated that in June 2013, he continued to have issues with his neck, "Stiffness, pain down both sides, tingling in my fingers and hands. I mean, a lot of the same issues that I deal with today." (T.24). Specifically, Petitioner had pain across the top part of his neck, closest to his head, as well as pain deep down on the right and left sides. (T.24). He also had burning and tingling on the left side, down the left side of his neck, through his left arm, elbow, and down to his hand. (T.24). Petitioner also had tingling on the right side, but not as severe as the left side. The constant pain caused "cluster headaches on the right side of my neck." (T.25).

At the time Petitioner signed the settlement agreement in July 2013, he was still seeking treatment for the neck pain and tingling and numbness. (T.25). Petitioner underwent physical therapy, massage, acupuncture, chiropractic care, epidural injections, and cortisone injections. (T.27-30). Petitioner had received three epidural injections to his neck in 2016 and 2017; this was the last treatment he undertook for his neck. (T.30-31).

Petitioner testified that in 2013, he sought treatment from a group called Advanced Physicians. (T.31; PX5). Petitioner had completed an MRI on May 20, 2013 at Advanced Physicians MRI & Imaging Center. The impression revealed cervical spondylosis with multi-level annular and neural foraminal bulging in conjunction with endplate spurring contributing to neural foraminal narrowing at multiple levels, as well as broad-based left paracentral herniation at C4-5 and right paracentral herniation at C5-6. An EMG/NCV study completed on May 23, 2013 suggested chronic left radiculopathy. (PX5).

Petitioner returned on February 15, 2016 for another MRI of the cervical spine at Advanced Physicians MRI & Imaging Center. At C2-3, C3-4, C6-7, and C7-T1, there was evidence of small disc bulges. At C3-4, there was mild spinal stenosis and mild right foraminal stenosis; at C6-7, there was moderate right and severe left foraminal stenosis, with effacement of the C7 nerve roots; and, at C7-T1, there was mild left foraminal stenosis. The MRI also revealed that Petitioner had spondylosis. At C4-5, Petitioner had a 2-3 mm broad-based disc bulge with moderate spinal stenosis and mild left anterior spinal cord flattening; there was also mild to moderate bilateral foraminal stenosis. At C5-6, the MRI indicated a 5-6 mm broad right paracentral disc protrusion, severe spinal stenosis and mild to moderate spinal cord effacement, as well as moderately severe bilateral foraminal stenosis with effacement of the C6 nerve roots in the foramina. (PX5).

On February 19, 2016, Petitioner consulted with Dr. Salman Chaudri at Advanced Physicians. Dr. Chaudri noted that Petitioner had a seven-year career in the NFL. Petitioner was currently treating with a chiropractor. Petitioner reported pain down his left side and numbness. Dr. Chaudri reviewed the February 15, 2016 MRI of the cervical spine, and found that Petitioner had a 5-6 mm protrusion at the C5-6 level with severe spinal stenosis, as well as multiple protrusions at the other cervical levels. Dr. Chaudri diagnosed Petitioner with a C5-6 herniated disc with spinal stenosis and radiculopathy. Dr. Chaudri ordered an EMG to evaluate the cervical radiculopathy. (PX5).

Petitioner reviewed the results of the EMG with Dr. Chaudri on February 29, 2016. Dr. Chaudri stated that the study revealed some radiculopathy on the left side related to C5-6. Dr. Chaudri recommended conservative treatment, including a Medrol Dosepak and physical therapy; Dr. Chaudri indicated that Petitioner may need epidural injections in the future if the radiculopathy did not resolve. (PX5).

On April 4, 2016, Petitioner consulted with Dr. Rajesh Patel at Advanced Physicians. Despite ongoing conservative therapy, Petitioner reported pain in the upper, mid, and lower cervical spine; the pain radiated to the left upper arm, left forearm, and left hand. Dr. Patel noted that the event which precipitated this pain was sports injury. Petitioner also reported stiffness, paravertebral muscle spasm, radicular arm pain, and numbness in the left upper arm. Dr. Patel reviewed the recent MRI and EMG, and found left C4-5 radiculopathy, C5-6 disc protrusion with severe spinal stenosis, moderate cord effacement, moderate to severe bilateral neuroforaminal stenosis, disc bulge at C4-5 with moderate CCS [central cord syndrome], and multi-level degenerative disc disease. Dr. Patel recommended and proceeded with an epidural steroid injection at the C7-T1 level. (PX5).

Petitioner followed-up with Dr. Patel on April 18, 2016. The medical record stated that Petitioner's symptoms had initially improved, then worsened; the procedure provided a 40% improvement in pain. Dr. Patel administered a second epidural steroid injection at the C7-T1 level, which provided up to 60% improvement in pain. On June 27, 2016, Petitioner received his third epidural steroid injection at the same level; the procedure provided a 20% relief in pain. (PX5).

On April 19, 2016, Petitioner consulted with Dr. Sean Salehi to discuss other treatment options for his neck. (T.36; PX6). Petitioner testified that his neck was getting progressively worse. "I needed to figure out what my options were in terms of should I continue to treat like I had been treating since I left the NFL, or is it time to start looking for something more serious." (T.37). Dr. Salehi noted Petitioner's complaints of neck pain that radiated to both shoulders, primarily the left, with further pain going into the left upper arm and numbness and tingling into the hand and fingers. Dr. Salehi indicated that Petitioner played football. (PX6).

Dr. Salehi reviewed the February 15, 2016 MRI of the cervical spine and the February 29, 2016 EMG report; he diagnosed Petitioner with cervical spondylosis and herniated cervical disc. Dr. Salehi discussed three treatment options with Petitioner: Continue to treat conservatively, undergo artificial disc replacement at C4-5 and C5-6, or undergo C4-6 ACDF. Dr. Salehi wrote: "Patient understands if intra-operatively the artificial disc appears not to be a good fit inside the interbody space, a fusion will be performed." (PX6).

Petitioner chose to treat conservatively, but his condition did not improve. (T.41-42). "Physical therapy made the situation worse. It increased my pain. So I didn't like that at all. Chiropractic care helped for moments, you know, for a day, two days, whatever. But never any lasting effects. When it came to the epidural injections, minimal benefits but no real change." (T.41-42).

On May 5, 2017, Petitioner consulted with Dr. Lawrence Chan at Advanced Physicians. Petitioner reported worsening neck pain with associated numbness and tingling, and pain going down his left arm. "Patient has taken prescription medication, steroid injections and therapy in the past with various success. Patient also has a history of disc herniations in the neck shown by MRI. Patient states lately that his neck pain is disrupting his daily activities and sleep." Dr. Chan diagnosed Petitioner with brachial neuritis or radiculitis. He ordered another MRI, which Petitioner completed on May 5, 2017. The impression indicated little to no change from the February 15, 2016 MRI, except the disc herniation at C5-6 was less severe than previous; it was 3 mm. More physical therapy was prescribed. (PX5).

Petitioner testified that his neck condition was affecting his daily life activities. "The raising of my kids, picking up my son and daughter, that was increasingly more difficult. I had young kids and they like to horse around and play around, so that was affecting my daily life with them." (T.43). Petitioner also had difficulty with driving, especially looking over his shoulder and checking his blind spots on the right and left sides. (T.44). Overhead movements became more difficult. Petitioner had trouble putting on a jacket. (T.44). Petitioner's neck condition also affected his current work; he testified that he was presently a self-employed, part-time personal trainer. (T.9-10).

> To do it on a long-term basis because it's very hard to reach over my head and demonstrate exercises. As a personal trainer part of your job is teaching someone how to do a specific exercise. They may be able to do the exercise, but I can't. So whenever I have to demonstrate anything overhead, if I – if the weight is too heavy or I do it too frequently, I end up in a lot of pain the next day. (T.45-46).

Petitioner also began treating with Dr. Kim Williams in May 2017. (T.47). The evidence deposition of Dr. Williams was completed on January 29, 2018. (PX7). Dr. Williams was board-

eligible in neurological surgery. (PX7, pg. 5). Dr. Williams first saw Petitioner on May 11, 2017, and noted that Petitioner was a former wide receiver in the NFL. Dr. Williams indicated that Petitioner reported neck pain with significant left arm pain. (PX7, pgs. 10-12; Deposition Exhibit 2).

At the May 2017 appointment, Dr. Williams reviewed the cervical spine MRI with Petitioner and found degenerative disc disease at C5-6 and C6-7 pressing on the nerve root at C7. (PX7, pg. 16). Dr. Williams recommended either an ACDF, a laminectomy, or a foraminotomy. (PX7, pg. 17). Dr. Williams explained that a disc replacement would not be an option, because Petitioner had significant degenerative changes in the disc spaces at C5-6 and C6-7; a disc replacement would not prevent further degeneration. (PX7, pgs. 17-18).

Although Dr. Williams was not aware of any specific trauma to Petitioner, he knew that Petitioner had been a former football player. (PX7, pg. 19; 29). With that, Dr. Williams opined that Petitioner's need for an ACDF could be related to injuries he sustained playing football for Respondent. (PX7, pg. 26). The basis for Dr. Williams' opinion was, "[I]t is rare for me to see people in their 30s with degenerative spondylosis to that degree. Unless they are laborers doing hard labor or having multiple traumas, like in professional sports." (PX7, pg. 26).

Dr. Williams further testified that degenerative spondylosis alone would not merit undergoing an ACDF. "[I]t has to be coupled with the symptoms. If I scan 10 people, 10 people are going to have degenerative change. But if you have neck pain, arm pain, in the distribution of that degenerative change, then those patients will benefit from surgery." (PX7, pgs. 26-27). Dr. Williams testified on cross-examination that Petitioner could not go on without surgery; he would not get better without surgery. (PX7, pg. 34; 41). Petitioner wanted to pursue surgical treatment. (T.49). As of the date of the April 12, 2018 hearing, Petitioner testified that he was still treating conservatively. (T.49).

Petitioner's Exhibit 4 was the evidence deposition of Dr. Richard Sherman, a board-certified orthopedic surgeon, which was taken on April 23, 2013. (PX4, pg. 3). Dr. Sherman had evaluated Petitioner for a Section 12 examination, at the request of Petitioner's attorney, on June 12, 2012. (PX4, pg. 38). Petitioner reported a history of stingers, "which are brachial plexus traction injuries associated with neck pain. He reported to me that he had some stiffness in his neck and tingling in his left hand . . ." (PX4, pgs. 5-7). Dr. Sherman referred to Petitioner's MRIs of the cervical spine, dated August 25, 2009 and November 9, 2009, that revealed an annular tear as well as multiple bulging discs, bone spurs. (PX3; PX4, pg. 10; 13).

Dr. Sherman had testified that Petitioner's cervical disc and brachial plexus injuries were causally related to the August 1, 2007 and August 15, 2009 accidents. (PX4, pg. 32). Dr. Sherman stated that Petitioner could have a progression of nerve dysfunction and disc deterioration, and that

those types of events could lead to further medical treatment or surgical intervention. (PX4, pgs. 33-34).

Respondent had sent Petitioner for a Section 12 examination with Dr. Alexander Ghanayem, a board-certified orthopedic spine surgeon, on May 7, 2012 and April 17, 2017; Dr. Ghanayem's evidence deposition was taken on February 7, 2018. (RX1; pgs. 4-5; Deposition Exhibit 2 and 6). Dr. Ghanayem noted that Petitioner was a professional football player who had a couple of stinger-type accidents between 2007 and 2009. (RX1, pg. 8). When Petitioner saw Dr. Ghanayem on May 7, 2012, he had no complaints of neck pain, arm pain, or neurological symptoms. (RX1, pg. 8).

Dr. Ghanayem's examination on May 7, 2012 revealed full, unrestricted range of motion of the neck, foraminal compression and Lhermitte sign were both negative, no tenderness in the neck, and Petitioner's neurological exam of the arms was normal. (RX1, pg. 8). Motor, sensory, and reflex function were also normal. (RX1, pgs. 8-9). Dr. Ghanayem reviewed three MRI reports, and not the actual scans, dated August 3, 2007, September 14, 2007, and August 25, 2009. (RX1, pgs. 9-10).

Dr. Ghanayem noted that the August 3, 2007 report indicated that Petitioner had a minimal bulge at C5-6 and C6-7, which was not uncommon. (RX1, pg. 11, Deposition Exhibit 3). Dr. Ghanayem read the September 14, 2007 MRI report, which stated, "MRI examination of the cervical spine fails to demonstrate disc herniation, significant central or neural foraminal stenosis. Evaluation of the cervical cord is unremarkable as well." (RX1, pg. 12, Deposition Exhibit 4). With these findings, Dr. Ghanayem opined, "Once again, when I saw Mr. Davis, he was neurologically normal, consistent with the MRI report, no compression. And he had no symptoms." (RX1, pg. 12). As to the August 25, 2009 MRI report, Dr. Ghanayem read the report: "There are no disc bulges or herniations, neural foraminal narrowing, or central spinal stenosis. There is a tiny focus of high signal within the posterior aspect of the C5-C6 intervertebral disc on T2-weighted images raising the possibility of the central annular tear." (RX1, pg. 13, Deposition Exhibit 5). Dr. Ghanayem found no inconsistencies between the August 3, 2007 MRI findings and the August 25, 2009 MRI findings. "[T]he August 2007 MRI scan talks about some disc bulges. The central annular tear, the possibility of one is consistent with that." (RX1, pg. 13).

Dr. Ghanayem's opinion as to Petitioner's diagnosis was, "Relative to the two events he related to me, he did have what appears to be stingers, or burners as otherwise people call them. It appears that there may be some cervical spondylosis, which is the disc bulging, if you will. From a clinical standpoint, he was asymptomatic." (RX1, pg. 16). Dr. Ghanayem did not have or make any further treatment recommendations and opined that Petitioner could return to physical activity without restriction. (RX1, pgs. 16-17).

During Dr. Ghanayem's deposition, Petitioner's attorney objected to the entire line of questioning related to Dr. Ghanayem's May 2012 report stating that they were there to question the doctor on his second Section 12 report dated April 17, 2017. (RX1, pgs. 14-15). However, during cross-examination, Dr. Ghanayem testified that he had reviewed his May 2012 Section 12 report in drafting the April 2017 report. (RX1, pg. 29).

Dr. Ghanayem re-evaluated Petitioner on April 17, 2017. By this time, Dr. Ghanayem noted that Petitioner had retired from professional football in 2013, and Petitioner was working as a personal trainer. Petitioner's complaints on this date were neck pain; he had numbness in his left arm, in the small and ring finger of the left hand, and the left triceps and forearm region; Petitioner also had numbness in the small and ring finger of the right hand. (RX1, pg. 18).

During his physical examination of Petitioner, Dr. Ghanayem found that Petitioner stood and walked normally, he had good cervical range of motion, and foraminal compression sign was negative. Neurologically, Petitioner had no motor deficits, sensation was intact except for the ulnar side of his left hand, reflexes were normal, and Hoffman sign was negative. Petitioner also had some tenderness in his neck muscles, "more on the upper cervical, as well as the cervical base regions." (RX1, pg. 19).

Dr. Ghanayem reviewed the actual films of the February 15, 2016 MRI of the cervical spine, and found multiple levels of spondylosis, a disc protrusion at C5-6 on the right side, and there was some narrowing on the left side, but nothing compressive. (RX1, pgs. 19-20). Dr. Ghanayem opined that there was no correlation between the MRI and Petitioner's clinical symptoms of the arm, but that it correlated with Petitioner's neck pain. (RX1, pg. 21). Although Dr. Ghanayem did not testify in detail as to the EMG completed by Petitioner, his April 17, 2017 Section 12 report stated that the EMG results did not correlate with his left arm and hand symptoms; there is no further explanation in the report or during Dr. Ghanayem's testimony. (RX1, pg. 25; RX1, Deposition Ex. 6).

In reviewing all the cervical MRIs from 2007 to 2016, Dr. Ghanayem testified,

> He had some radiographic disc bulges, at least on one of the reports at C5-6 and C6-7. That can progress based on time and aging. So that's not uncommon. C4-5 shows something that was not mentioned on either prior MRI scans. So the origin of that at this point is unknown. (RX1, pg. 22).

Dr. Ghanayem diagnosed Petitioner with cervical spondylosis and neck pain. (RX1, pg. 22). He did not believe Petitioner was a candidate for an ACDF at C5-6, but did recommend that Petitioner undergo non-surgical treatment to strengthen his neck. (RX1, pgs. 22-23). The basis for his opinion was, "You don't do anterior cervical discectomies and fusions for neck pain. And he

did not have subjective complaints or physical exam findings consistent with cervical radiculopathy." (RX1, pg. 23). Dr. Ghanayem further stated, "I don't believe he sustained an injury as a professional football player which puts him at higher risk for having cervical spine surgery." (RX1, pg. 44).

During cross-examination, Dr. Ghanayem testified that his opinion was based on Petitioner's subjective complaints, his objective physical exam findings, Dr. Ghanayem's actual reading of the MRI scan, and not the medical records. (RX1, pg. 25).

Conclusions of Law

Under Section 8(a) of the Act (820 ILCS 305/8(a)), 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' Comp. Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011).

Following the July 2013 settlement agreement between the parties, Petitioner continued to have issues with his neck, with pain radiating down both arms, with the pain worse in his left arm. (T.24-25). Since his initial injury on August 1, 2007, Petitioner had undergone a significant regimen of continuous conservative treatment, including physical therapy, massage, acupuncture, chiropractic care, epidural injections, and cortisone injections; the treatment did not alleviate Petitioner's symptoms. (T.26-31; T.41-42).

Each physician on Petitioner's behalf, Dr. Salman Chaudri, Dr. Rajesh Patel, Dr. Sean Salehi, Dr. Lawrence Chan, and Dr. Kim Williams, noted abnormal findings consistent with cervical spondylosis, stenosis, protrusions/herniations at C4-5 and C5-6, and cervical left radiculopathy; these conditions were supported by various MRIs and EMG studies. (PX5; PX6). Both Dr. Salehi and Dr. Williams had recommended a C4-6 anterior cervical discectomy and fusion (ACDF). (PX6; PX7, pg. 17). Each doctor noted Petitioner's history as a professional football player and that Petitioner's pain was precipitated by sports injury. (PX5). Dr. Williams opined that Petitioner's need for an ACDF could be related to injuries he sustained playing football for Respondent. (PX7, pg. 26). The basis for Dr. Williams' opinion was, "[I]t is rare for me to see people in their 30s with degenerative spondylosis to that degree. Unless they are laborers doing hard labor or having multiple traumas, like in professional sports." (PX7, pg. 26).

Prior to Petitioner's settlement agreement with Respondent in July 2013, the parties had taken the evidence deposition of Dr. Richard Sherman, a board-certified orthopedic surgeon. (PX4, pg. 3). Dr. Sherman testified that Petitioner's cervical disc and brachial plexus injuries were causally related to the August 1, 2007 and August 15, 2009 accidents. (PX4, pg. 32). Dr. Sherman stated that Petitioner could have a progression of nerve dysfunction and disc deterioration, and that

those types of events could lead to further medical treatment or surgical intervention. (PX4, pgs. 33-34).

In contrast to the findings and opinions of Petitioner's physicians, Respondent relies on the sole opinion of Dr. Alexander Ghanayem, its Section 12 examiner. By Respondent's Brief, Respondent disputes Petitioner's need for the recommended C4-6 ACDF based on Dr. Ghanayem's opinion that Petitioner was not a candidate for an ACDF. The basis for his opinion was, "You don't do anterior cervical discectomies and fusions for neck pain. And he did not have subjective complaints or physical exam findings consistent with cervical radiculopathy." Dr. Ghanayem further testified that while the February 15, 2016 MRI films of the cervical spine correlated with Petitioner's neck pain, it did not correlate with Petitioner's left arm pain. (RX1, pg. 21).

Based on the evidence, the Commission finds the opinions of Petitioner's physicians more persuasive than Dr. Ghanayem's opinion. The physicians, Petitioner's physicians and Respondent's Section 12 examiner, reviewed the same February 15, 2016 MRI of the cervical spine in diagnosing Petitioner's condition but arrived at different conclusions. Dr. Ghanayem did not opine that an ACDF was unreasonable, but testified that an ACDF was not indicated for patients with neck pain alone. Despite Petitioner's longstanding history of radiating pain into his arms, a positive EMG study, and the findings of Petitioner's physicians, Dr. Ghanayem found no evidence of neck pain and cervical radiculopathy. In fact, his testimony as to Petitioner's EMG studies was limited; Dr. Ghanayem offered no detailed testimony or explanation as to the test results or which EMG study he had reviewed. Dr. Ghanayem's April 17, 2017 Section 12 report also did not elaborate on the EMG results, and simply stated that the findings did not correlate with Petitioner's left arm and hand symptoms. (RX1, pg. 25; RX1, Deposition Ex. 6). More importantly, Dr. Ghanayem testified that his opinion was based on Petitioner's subjective complaints, his objective physical exam findings, his actual reading of the MRI scan, and not the medical records. (RX1, pg. 25).

The Commission finds that Dr. Ghanayem's failure to reference the multiple positive EMG findings, and the fact that Petitioner's medical records consistently documented left-sided and right-sided symptoms of pain, tingling, burning, and numbness undermines his opinion in this regard. The Commission therefore affords greater weight to the opinions of Petitioner's physicians, and finds that Petitioner's need for an ACDF is reasonable, necessary, and causally related to his work injuries.

The Commission further takes notice of Petitioner's prayer for relief, as contained in Petitioner's Petition and supporting Brief, requesting attorney's fees and costs in bringing this Section 8(a) Petition. The Commission notes that Petitioner made no argument on this issue. The Commission hereby denies Petitioner's request for attorney's fees, finding that a legitimate dispute existed as to Petitioner's need for additional treatment.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition pursuant to Section 8(a) of the Act is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the recommended C4-6 anterior cervical discectomy and fusion and associated medical expenses prospectively.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall make payments for reasonable, necessary and related medical expenses pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for attorney's fees is hereby denied.

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

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

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

DATED: NOV 2 - 2018

MJB/pm
O: 10-23-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

Donald Fort,

Petitioner,

vs.

NO: 16 WC 32671

City of West Frankfort,

Respondent.

18IWCC0672

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 issue(s) 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 January 26, 2018 is hereby affirmed and adopted.

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

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

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

DATED: NOV 5 - 2018
SJM/sj
o-10/10/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

FORT, DONALD
Employee/Petitioner

Case# **16WC032671**

16WC032670

CITY OF WEST FRANKFORT POLICE
Employer/Respondent

18IWCC0672

On 1/26/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

1433 McANANY VAN CLEVE & PHILLIPS
AJ SHEEHAN
505 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

18IWCC0672

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

DONALD FORT
Employee/Petitioner

v.

CITY OF WEST FRANKFORT POLICE
Employer/Respondent

Case # 16 WC 32671

Consolidated cases: 16 WC 32670

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **June 14, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **September 10, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,332.80**; the average weekly wage was **$1,006.40**.

On the date of accident, Petitioner was **46** years of age, *married* with **1** dependent child.

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

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

ORDER

The Arbitrator finds that the Petitioner has failed to prove that his lumbar spine condition is causally related to the September 10, 2016 accident.

No benefits are awarded.

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

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

Signature of Arbitrator

January 25, 2018
Date

JAN 26 2018

STATEMENT OF FACTS

The Petitioner, a 22-year patrolman for the Respondent, testified that on 1/26/16 he was rolling up a heavy downed telephone wire and felt a pop in his upper neck and shoulder area. He believed he'd had a prior cervical work injury in 2000. As to his lumbar spine, Petitioner testified to prior injuries in 2006 following a foot chase,

in approximately 2010 when he stepped on a rolling PVC pipe and fell onto a wall, and in 2013 due to an altercation. He testified that he'd had no cervical or lumbar surgeries or surgical recommendations prior to 2016. He returned to unrestricted work duties after the 2013 incident. As a small police department, the Petitioner testified that he would handle all manner of police calls.

With regard to the 11/8/10 injury where he rolled off a PVC pipe, Petitioner testified he landed onto his buttocks on the wall and rolled off of it, and he did recall having some numbness in his right leg to the heel. The 4/15/13 altercation he had with an arrestee involved a workers' compensation claim. The Petitioner did not recall having numbness down the right leg with that incident, but wouldn't disagree if this is indicated in his medical records. He did recall having lumbar injections in 2013, but testified he continued to work after the 4/15/13 altercation.

The Petitioner agreed that he reviewed his medical records to date which were being submitted into evidence and verified they accurately reflect what he reported to the providers.

Petitioner saw Dr. Muniz on 1/29/16. He reported a history of back problems, noting he would see a chiropractor when he had problems, and that he had undergone L3/4 injections in 2013. The doctor recorded: "Ongoing [history] of cervical neck pain fell a year ago ongoing neck pain was pulling something on Wednesday felt a pop." A cervical MRI was prescribed. (Px3; Rx4).

The Petitioner also sought treatment with chiropractor Dr. Kathalynas on 1/29/16. His intake form there, as well as a 1/27/16 "Ergo Insight WC Employee Injury Report" intake form included within the records of Dr. Kathalynas lists prior workers' compensation claims including the neck and back. The incident involved rolling cable that was found abandoned on the roadway. With the current incident, Petitioner reported pain and numbness into the bilateral upper extremities with numbness in the middle and ring fingers. It specifies that he had similar symptoms when he slipped and fell on ice and hit his head about a year prior. (Px4; Px14; Px15; Rx5).

Dr. Kathalynas' 1/29/16 report noted the Petitioner reported rolling up downed wire lying in the road on 1/26/16, it got hung up on something and he jerked it very hard, injuring his upper back and neck. He noted sharp discomfort in the cervical and bilateral dorsal areas, as well as numbness and tingling in the bilateral hands. The diagnoses included cervical radiculopathy and cervical/thoracic strains. Chiropractic care was initiated from 1/29/16 through 10/17/16. (Px4; Rx5).

At a 2/12/16 follow-up with Dr. Muniz, the Petitioner reported an April 2015 injury when he stepped out of his squad car, slipped on the ground under the car and hit his head. He reportedly had sharp upper back neck area pain radiating down both arms, and had relief with a couple of months of chiropractic treatment. He would have occasional aggravation of his pain and some occasional bilateral hand numbness at night. The report states: "most recently 1/26/16 was rolling up two blocks of wire while working felt something pop upper back neck region since then ongoing numbness in bilateral hands. Gets some relief with chiropractor but still there [sic] occasional muscle spasm. Denies loss of muscle strength painly [sic] sensation." He noted he had been treating with a chiropractor, but still had numbness in the right hand. Dr. Muniz diagnosed cervical pain and radiculopathy. Cervical x-rays and EMG/NCV testing were prescribed, noting that an MRI would likely be needed. (Px3; Rx4).

Cervical x-rays showed degenerative changes, particularly in the lower cervical spine and greatest at C5/6. 3/3/16 MRI films showed Generally well-maintained disc height and alignment for his age with the exception of mild disc desiccation and spondylitis at C5/6 and C6/7. The spinal cord appeared normal with a borderline congenitally small canal, with some osteophytes stenosis at C5/6 and C6/7. Minimal left and moderate to

moderately severe right foraminal stenosis from C5 to C7. Disc bulges were noted at all cervical levels from C3 down, with disc osteophytes complexes from C5 to C7. (Px3).

On 3/11/16, Dr. Kathalynas noted Petitioner continued to have pain that radiated into his hands, but his pain level was down to 5/10 from 7/10. On 3/23/16, Petitioner reported ongoing pain but good improvement, and that he was waiting for a neurosurgical consult. On 4/11/16, Petitioner reported that he had a neurosurgical consult pending in June 2016. On 4/13/16, it appears that Dr. Kathalynas started to treat the low back as well, with no indication as to how this pain began. Subsequent visits note complaints of low back pain/tightness. Petitioner reported increased soreness on 5/4/16 after having to run and chase someone down. However, by his next visit he was reporting only 4/10 pain, and that it was only 60% of the time instead of constant. By mid-May, this was down to 2/10 pain. On 5/27/16, Petitioner reported an increase to a 7/10 pain level, noting he didn't recall doing anything to make it worse, and that he just woke up in pain. On 6/3/16, Petitioner reported his entire spine, including his low back, was bothering him, again with an indication that there was no inciting event. (Px4; Rx5).

The Petitioner initially saw orthopedic surgeon Dr. Gornet on 6/9/16, which he indicated was on referral from Dr. Muniz. The Petitioner reported neck pain and headaches at the base of his neck, bilateral trapezius, both shoulders down both arms into his hands with numbness in tingling, with the right shoulder and arm being most significant. Dr. Gornet reported that Petitioner's current problems began, "at least in its level of severity", on or about 1/26/16, when he began to reach and pull a telephone wire off the road over and over again. Petitioner reported a history of neck pain going back to April 2015, when he slipped on ice at work, landing hard on his left side and injuring his low back and neck. He did not recall undergoing prior MRI testing. The Petitioner was working full duty, but would have increased symptoms with certain activities. He noted numbness and tingling in his hands, particularly his fingertips. Sensation was decreased in right C6/7 and left C7 dermatomal patterns on exam. Dr. Gornet indicated cervical x-rays showed loss of disk height and spurring at C5/6 and C6/7, with more significant foraminal stenosis on the right. His review of the 3/3/16 MRI films suggested a C6/7 disc herniation and a smaller herniation at C5/6, noting films were of moderate to poor quality. Dr. Gornet opined that the Petitioner's symptoms were causally related to his work accident and that he could continue to work. A repeat MRI and medication were prescribed. (Px6).

The radiology report from the 6/9/16 cervical MRI indicated a central and right C5/6 herniation with degenerative changes likely affecting the exiting right C6 nerve root, a broad-based and smaller herniation at C6/7 with a right foraminal component though small than at C5/6, and small central herniations at C4/5 without definite nerve root impingement. (Px8).

Following the MRI, Dr. Gornet reviewed the films and found what he opined to be more significant disc pathology with acute-on-chronic disc herniations at C5/6 and C6/7, as well as a central C4/5 herniation/annular tear. He also noted severe right foraminal stenosis from C5 to C7, moderate at left C5/6. Petitioner was referred to Dr. Boutwell for epidural injections. (Px6). She performed an epidural at C6/7 on 6/9/16 with a post-procedure pain score of 4 to 5/10 noted, and at C5/6 on 6/30/16, with a post-procedure pain score of 4/10. (Px7).

On 6/10/16, Petitioner told Dr. Kathalynas that Dr. Gornet was recommending cervical surgery. It was at approximately this point that Kathalynas' treatment begins to focus more significantly on the lower back, per the treatments indicated in his reports. On 6/17/16, Petitioner specifically indicated lumbar and sacroiliac (SI) discomfort of 6/10 for 80% of the time, mainly noticing this after prolonged sitting and standing. On 6/20/16, he reported numbness in his right hand and tingling in his right foot, noting he did a lot of walking that he felt irritated his low back. On 6/27/16, Petitioner reported his right leg had been irritated the past couple of days, and he continued to have numbness into both arms depending on his activities. On 7/1/16, the Petitioner reported

that he was improved following a cervical injection. On 7/8/16, the Petitioner reported discomfort in the low back and SI areas at 5/10 level. On 7/15/16, the Petitioner reported that his surgeon had recommended surgery for two or three cervical discs, and that he had low back pain into the right leg. On 7/20/16, Petitioner reported an increase in spinal pain after having to get an uncooperative person into his squad car. On 7/22/16, he reported that he felt like the cervical injection was wearing off. On 7/25/16, Petitioner reported increased neck, mid and low back pain after stepping in a rut on the highway. (Px4; Rx5).

On 7/14/16, Petitioner reported to Dr. Gornet that the injections gave him some relief, at C6/7 more than C5/6, but that the improvement wore off. Dr. Gornet recommended disc replacement surgeries at C5/6 and C6/7. A pre-surgical cervical CT myelogram was performed on 8/4/16, while the Petitioner was allowed to continue full duty work pending surgery. The myelogram report indicated right lateral recess C5/6 effacement, and extradural defects at C5/6 and C6/7 without significant central or foraminal stenosis. The CT showed: 1) right lateral recess protrusion with spurring at C6/7, resulting in right cord flattening, mild central canal stenosis and right greater than left foraminal stenosis, and 2) circumferential bulging with right foraminal superimposed protrusion with associated spurring at C5/6, with mild central and severe right greater than left foraminal stenosis. (Px9). Dr. Gornet's review of the CT myelogram revealed disc pathology at both noted levels with particularly right sided foraminal stenosis. (Px6).

- Prior to the cervical surgery, the Petitioner testified he had another work accident on 9/10/16. He was called to a scene where a woman acting psychotically ran into traffic. He and another officer pulled her out of the street, an altercation ensued, and he injured his low back.

  The 9/12 and 9/14/16 reports of Dr. Kathalynas do not reference anything about the alleged 9/10/16 work injury. The next report of 9/19/16 report states that Petitioner "is still hurting from his last fight at work. He did go up to his surgeon on Saturday and they did another MRI on his neck and he is waiting for his surgery to be scheduled." It was noted that the surgeon prescribed 6 weeks of chiropractic treatment for the neck and low back.

  A 9/19/16 intake form for Dr. Kathalynas, as well as a 9/13/16 "Ergo Insight WC Employee Injury Report" intake form, reference the 9/10/16 injury involving an altercation with an arrested suspect who was resisting arrest. The listed injuries include neck and low back pain, with radiation to the right groin. They also note prior workers' compensation claims involving similar symptoms and complaints as nerve damage in the neck in 2015 and 2016 and the low back in 2013 and 2015. (Px4; Px15; Px16; Px17; Rx5).

- On 9/15/16 he underwent an abdominal CT scan due to complaints of sudden onset right flank pain. He previously had undergone the same test a year prior. Petitioner indicated he stopped to see his chiropractor, who did not feel it was related to the back condition. (Px5). Petitioner told Dr. Kathalynas on 9/21/16 that he felt improved after being off work due to a lack of light duty availability, as he hadn't had to do anything to irritate his neck and upper back. (Px4; Rx5).

- On 9/17/16, Dr. Gornet noted that cervical surgery had been approved, but that Petitioner had developed new symptoms in his low back and neck again on 9/10/16 in an altercation with a citizen. He noted Petitioner had a prior history of low back pain, with chiropractic care, but that Petitioner's initial 6/9/16 visit pain diagram did not reflect low back complaints. He had undergone a prior 2013 lumbar MRI after an altercation at work and had seen Dr. deGrange. The records of Dr. deGrange were not submitted into evidence. Petitioner reported he recovered with a low level of tolerable symptoms. His current low back symptoms reportedly were now constant bilaterally, particularly into the right buttock and leg to the heel, with tingling in his left foot. Motor exam showed decreased EHL function on the right and decreased sensation in an S1 dermatome on the left. Dr.

Gornet stated: "I have discussed with Mr. Fort that he may have aggravated his underlying condition in his lumbar spine that was quiescent as well as potentially producing a new injury in the disk. The same is true in his cervical spine." Cervical examination was unchanged. A repeat cervical MRI was obtained and Dr. Gornet verified no change in the films, particularly at C4/5. The Petitioner was restricted to light duty for two weeks and referred for chiropractic treatment. Lumbar MRI was planned. Dr. Gornet opined that the increase in the Petitioner's symptoms was directly attributable to the 9/10/16 accident. (Px6). The cervical MRI report indicated circumferential disc bulges at C5/6 and C6/7 with superimposed right foraminal epicenter broad-based protrusions resulting in severe right greater than left foraminal stenosis at both levels but mild central canal stenosis at the C6/7 level, as well as central annular tears at C3/4 and C4/5 resulting in mild right foraminal stenosis at both levels. (Px8).

At this point in the Arbitrator's review of Px4, it appears that Dr. Kathalynas started to prepare two separate reports from the same dates, one focused on the cervical and thoracic spine, and the other on the low back. A separate 9/19/16 report notes the Petitioner was seen for injuries he sustained "at work on ." [Arb note: there is no date indicated]. Petitioner reported struggling with someone he was trying to arrest and ended up on the ground trying to pick up the assailant, resulting in lower back pain and sharp discomfort in the right lumbar and SI regions. Petitioner reported the symptoms had been present for several days. This report goes on to describe the examination in much more significant detail than the general records of Dr. Kathalynas indicate. Multiple lumbar diagnoses are indicated, including sprains/strains and radiculopathy. On 9/21/16, Petitioner was awaiting a lumbar MRI. On 9/23/16, he noted that sitting at ball games really made his legs hurt. On 9/26/16, Petitioner had ongoing 4/10 lumbar and SI pain, most noticeable in the morning. The 10/10/16 note indicates pain with sitting on the ground deer hunting. The last note of 10/17/16 indicates Petitioner was overall doing the same since his last treatment. (Px4; Rx5).

The 10/18/16 surgery involved C5/6 and C6/7 disc replacements with Dr. Gornet. The report notes that herniations were found at central and right, and smaller left, at C5/6 with significant right-sided stenosis. At C6/7, he noted central and right-sided herniations and right foraminal stenosis. Both levels were decompressed. (Px11).

Petitioner testified that his neck pain with numbness and tingling into his arms and fingers did impact his work to some degree, but he was able to perform his duties prior to surgery. Petitioner testified he underwent surgery on 10/18/16 based on the Respondent authorizing same. (Px2). He was held off work afterwards.

Petitioner reported on 11/7/16 that his neck was doing "wonderfully well", but that he still had low back pain. (Px6). Lumbar MRI was obtained on 11/28/16 reportedly showing: 1) a central, broad-based L4/5 disc protrusion, slightly increased in thickness versus 5/13/13 films, with a likely left paracentral annular tear, mild central canal stenosis and bilateral foraminal stenosis that was worsened since 5/13/13; 2) an L2/3 annular disc bulge with superimposed right foraminal protrusion with increasing thickness, moderate right greater than left foraminal stenosis and borderline central canal stenosis; and, 3) annular disc bulge with right foraminal protrusion at L3/4 and L5/S1, with moderate right greater than left foraminal stenosis and mild central canal stenosis, all stable since the prior 5/13/13 films. (Px8).

On 11/28/16, Dr. Gornet noted Petitioner's neck was doing very well. His review of the lumbar MRI indicated multilevel disc degeneration with a central herniation/annular tear at L4/5 and mild left L5/S1 foraminal stenosis. Comparing it to 5/13/13 films, Dr. Gornet opined there was a new more right-sided L3/4 herniation and new L4/5 annular tear. He stated that the low back "will be difficult to solve", and recommended initial right L3/4 and L4/5 injections based on the symptoms being mainly right-sided. Petitioner remained temporarily disabled. (Px6). On 12/22/16, Dr. Boutwell performed bilateral L3/4 epidural injection, indicating a post-

procedure pain score of 4/10. On 1/19/17, she performed a right L4/5 epidural injection, again indicating a post-procedure 4/10 pain score. (Px7).

On 2/16/17, Petitioner noted mild neck pain he felt was weather related, but for the most part felt a dramatic cervical improvement. Lumbar injections provided only temporary relief. Noting the multilevel problems, Dr. Gornet's first recommended option was right microdecompression at L2/3 and L3/4 for the large herniations. He noted there was "no perfect scenario", and that any surgery had the potential to destabilize the spine with increased back pain, but that Petitioner was "miserable" and had failed conservative care. He opined that the Petitioner had already had nerve injury and that this often can't be fixed with surgery. (Px6).

A2/16/17 cervical CT scanning noted the disc replacements were in satisfactory position with mild C6/7 and borderline C5/6 central canal stenosis due to spurring that was unchanged. Otherwise, previously seen stenosis were significantly improved bilaterally by the decompression. (Px9).

A 5/15/17 pre-surgical lumbar CT impression was annular disc bulges with posterior element hypertrophy at all lumbar levels, including facet arthropathy and ligamentum flavum hypertrophy. At L2/3 there was a superimposed right foraminal protrusion, at L3/4 there was mild central canal stenosis, and at all lumbar levels there was bilateral foraminal stenosis. (Px9).

At the last visit with Dr. Gornet on 5/15/17, the Petitioner's cervical spine looked good. He opined that the lumbar CT scan showed no evidence of a major facet arthropathy with the exception of L5/S1, where it was fairly significant. Based on these findings, Dr. Gornet recommended facet rhizotomies (RFA), medial branch blocks and L5/S1 epidural before attempting microdecompression surgery. He reviewed the report of Dr. Stiehl, noting he personally found no evidence of symptom magnification with the Petitioner, supported by a good cervical outcome. (Px6).

The Petitioner testified that he experienced dramatic improvement with the cervical surgery - "it was just crazy. It was unbelievable" – and continues to improve. As to the lumbar spine, the Petitioner testified that he did not indicate any lumbar symptoms at the initial 6/9/16 visit with Dr. Gornet, with no indication of low back pain in the pain diagram, and that while he had been able to continue to work, his low back pain has not resolved since the 9/10/16 incident. Currently, the Petitioner stated he has a fist-sized knot in his low back with pain radiating into the right buttocks and numbness down the leg to the foot. He gets some spasms in the left leg. Prolonged sitting or standing increases the symptoms. As to the lumbar epidurals and RFA that Dr. Gornet has recommended, the Petitioner testified he would prefer to try this as he would like to avoid surgery. He testified that he is being paid salary while off work, and that he did not feel he is currently able to work full duty.

On cross examination, the Petitioner was asked about his prior 2/16/15 slip and fall accident, and he acknowledged that he struck his left posterior head when he slipped on ice getting out of his squad car, reporting symptoms going down his arms with tingling in the hands and fingers. He didn't recall having radiating pain down his legs into his heels, but testified he wouldn't disagree with the medical records if they indicated he reported this.

The Respondent submitted a number of pre-accident records from the office of Nolen Clinic, which appears to be a chiropractic facility. These documents appear to show treatment for low back and right leg pain from November 2010 to April 2011, and from April to June of 2013. One intake form indicates on 11/8/10 the Petitioner stepped over a short brick wall, stepped on a PVC pipe, which rolled out and he fell back. An 11/15/10 note states that he had a prior work-related back injury in 2006, when he lifted and turned an intoxicated person away from the roadway. A separate intake form notes that on 4/15/13, the Petitioner injured

his low back and right hip escorting someone who was under arrest. The Petitioner indicated he had been injured twice before, and that he went home after the incident to apply a heating pad and TENS unit. There were also some thoracic and cervical complaints in 2011. A 5/13/13 lumbar MRI showed mild-to-moderate posterior bilateral paracentral disc bulging at multiple levels from L1 to S1, with mild-to-moderate central canal and mild bilateral neuroforaminal stenosis noted from L2 to S1. (Rx3).

Petitioner saw Dr. Davis on 5/21/15 for right shoulder, neck and low back injuries. The injury itself was not described in detail, but it was noted that Petitioner was getting chiropractic treatment, that his left shoulder was not 100%, and that he no longer had tingling in his fingers but still had right trapezius spasm. His back pain was worse with extended use, and would get radiating pain into the right leg down to his heel ("He said after about 5 hrs of pittling around he starts getting the pain in his leg."). Diagnoses were cervical strain, low back pain and spasm. He was to continue chiropractic care and back exercises. (Rx2).

On 1/26/16, his injury was more neck/shoulder than low back. He was treating with Dr. Kathalynas for the low back prior to the 9/10/16 accident.

Orthopedic surgeon Dr. Gornet testified for hearing via evidence deposition on 5/18/17. The Petitioner believed that his cervical and upper extremity problems began with the 1/26/16 work incident with the telephone wire, though Dr. Gornet noted he had neck pain going back to at least April 2015, when he had slipped on ice and injured his neck and low back. When he initially saw Petitioner on 6/9/16, he had no complaints of low back pain, and while his neck and upper extremity tingling improved somewhat with chiropractic treatment, his constant pain did not. He was working full duty. Examination abnormalities included decreased sensation in a C6/7 pattern on the right and C7 on the left. The repeat MRI was obtained due to the relatively poor quality of the prior MRI, and Dr. Gornet opined it showed acute-on-chronic C5/6 and C6/7 herniations and a central annular tear at C4/5. Diagnosis was discogenic pain from C5/6 and C6/7 secondary to disc injury and herniations as well as irritation of foraminal stenosis at those levels, and a C4/5 annular tear. Dr. Gornet opined that the cervical conditions were causally related to the work accident, as a reaching/pulling injury can mechanically load the cervical spine and cause disc injury. Petitioner's symptoms correlated with this objective pathology. Dr. Gornet testified: "Clearly he had some preexisting symptoms, and that's well noted and was seen in the medical records. But there was a change in his symptoms, and that was consistent with the acute-on-chronic change that we saw on the MRI." Surgery was recommended as the only real option for relieving his symptoms, given mild but temporary improvement with injections. CT myelogram indicated no significant facet pathology and some bony foraminal right stenosis at C5 to C7. The stenosis would have been preexisting, but could easily be aggravated by his work activities. (Px12).

At Petitioner's 9/10/16 visit, he reported injuring his low back and aggravating his neck in an altercation with a citizen at work a week prior. The Petitioner did report a history of low back pain with chiropractic care. He had bilateral low back pain, but the symptoms were mainly into the right hip and leg to the heel with tingling in the left foot. Exam noted decreased EHL function on the right and decreased S1 dermatome sensation on the left. These findings would involve the L5/S1 and L4/5 levels. X-rays showed some multilevel degeneration, but were relatively benign. Dr. Gornet opined that the altercation could have aggravated the underlying lumbar condition. The cervical exam was unchanged after this incident, but he was taken off work as to the low back. Lumbar MRI was delayed due to cervical surgery, but conservative care was prescribed for the low back. Dr. Gornet's lumbar diagnosis was aggravation of preexisting condition or potentially new injury at L4/5 or L5/S1, and even at L3/4 "because of translation." There was "no question" in Gornet's mind that the lumbar condition is causally related to the 9/10/16 accident, as the Petitioner didn't complain of his low back and it was not an issue when he first saw him on 6/9/16. (Px12).

The Petitioner underwent cervical surgery on 10/18/16, and did wonderfully well, but he continued to have low back pain. The lumbar MRI was obtained on 11/28/16, and was compared to 5/13/13 films. There was a new right-sided L3/4 herniation, and Dr. Gornet felt there was a new L4/5 annular tear. He clearly had preexisting disc degeneration and L5/S1 foraminal stenosis in the 2013 films, but "I think he may have aggravated his underlying degeneration and foraminal stenosis at L5/S1." He advised Petitioner his low back would be "more difficult to solve" and harder to get him back to full duty given multilevel problems. Petitioner was held off work. Recommended right L3/4 and bilateral L4/5 epidurals provided only temporary relief. In Dr. Gornet's opinion, the only real option to return Petitioner to baseline, would be L2/3 and L3/4 microdecompression on the right where the herniation is. Petitioner was told this could help the right hip and leg pain, but no surgery was going to make him perfect. The lumbar CT showed no major facet arthropathy except at L5/S1, which could have been a source of Petitioner's buttocks pain. Based on this, "I changed my thinking there", and Dr. Gornet recommended right facet rhizotomies at L5/S1, as he felt that avoiding surgery would be Petitioner's best option to get back to full duty work. If that doesn't work, the previously recommended decompression surgery would be the fallback recommendation. (Px12).

With regard to the reports of Dr. Stiehl, Dr. Gornet testified his experience with the Petitioner indicated no evidence of functional overlay, and he has objective pathology consistent with the subjective complaints. He did agree with Dr. Stiehl that there was L2/3 and L3/4 foraminal encroachment, and that Petitioner had an excellent cervical result. He disagreed that Petitioner had reached MMI as to the neck, as that would not be until a year after surgery. Again, Petitioner was candid in noting he'd had back pain for years, but "There's a difference between tolerable back pain that he doesn't even put on his pain diagram and intolerable back pain that affects his quality of life." His goal would be to get Petitioner back to his baseline tolerable lumbar condition with ongoing chiropractic maintenance. (Px12).

As to the records of Dr. Kathalynas noting reports of low back pain prior to the 9/10/16 accident going back to 6/8/16, on cross exam Dr. Gornet essentially testified that chiropractic records tend to show every possible diagnosis, and that he was "comfortable" that Petitioner did not have any significant back complaints when he was treating him prior to the accident. He acknowledged that Petitioner had prior lumbar problems in 2013, when he underwent MRI, and 2015. Dr. Gornet did not recall if Dr. Muniz' records reflected radicular lumbar symptoms after the 2015 slip and fall. He did not review any records of Logan Primary Care from 5/15 indicating radicular symptoms into the right heel, but wouldn't dispute if Petitioner had preexisting radicular symptoms. He indicated it was important to his causation opinion that Petitioner had no symptoms, then an altercation, and then increased symptoms, as his condition thus changed as a result. Dr. Gornet also did not recall reviewing any records of Dr. Nolen. (Px12).

Dr. Gornet agreed the Petitioner's degenerative spinal findings were generally age-appropriate. He was asked if the records showed Petitioner reported numbness and tingling in the right side/lower extremity after his 2013 injury, whether this would be similar to what he has now, and Dr. Gornet testified that the numbness and tingling is similar, but he currently has more of a right buttock/hip/groin pain. As to the 2013 MRI showing disc bulges at 5 lumbar levels, Dr. Gornet testified that "bulging is sort of insignificant", but agreed Petitioner clearly had preexisting multilevel lumbar degeneration, which does occur over time. As to whether the L3/4 herniation could have developed over time since 2013, Dr. Gornet indicated this was "pure speculation", and changes since 2013 were noted from L2 to L5. He testified that: "generally I don't believe that those changes occur in the long-term. I think that they occur usually with an acute event." He questioned how the degeneration would have developed over time but only progressed in the areas to which Petitioner's symptoms correlated. In his opinion, there was no other plausible explanation than to associate the changes to the accident / altercation. (Px12).

Respondent's Section 12 examining orthopedic surgeon Dr. Stiehl testified via evidence deposition on 5/17/17. (Rx1). At the initial examination of 11/10/16, the Petitioner reported a history of neck and upper back problems, but that he developed symptoms after rolling up long portions of wire on 1/26/16 and felt a pop in his upper back. He opined that x-rays showed degeneration that was age-appropriate. Regarding Petitioner's neck condition, Dr. Stiehl opined that Petitioner sustained a cervical sprain as a result of the 1/26/16 incident. He testified the Petitioner's exam was normal and showed no objective signs of neurologic changes, and there were no acute injuries to the cervical bones or ligaments. He did have degenerative findings at C5/6 and C6/7 that included moderate to severe right foraminal stenosis. As to the 6/9/16 repeat MRI, Dr. Stiehl didn't disagree with the radiologist's findings, but opined that there were no acute herniations depicted. Based on a strain injury, he opined that the Petitioner would have reached MMI within two months. Regardless of causation, he should have reached MMI three to four months post-surgically. Dr. Stiehl testified that given the Petitioner did not have cervical neuropathy, he would not have recommended the disc replacement surgery and would have allowed the Petitioner to return to work. (Rx1).

Dr. Stiehl re-examined the Petitioner on 4/10/17. He opined that the principal target of lumbar treatment today is radiculopathy, testifying: "if you don't have a neuropathy, you don't have much of an injury." A 5/13/13 Lumbar MRI showed significant bulging at all levels, which would be normal for the Petitioner's age. Compared with the 11/28/13 films, Dr. Stiehl acknowledged that while the 2016 MRI report noted slight increases in an L4/5 protrusion and L2/3 annular bulge, there was not really much change, testifying the findings are degenerative, and: "They just don't change over time." On lumbar exam, Dr. Stiehl testified that the Petitioner had 5 out of 8 Waddell signs, and three of the five were suspicious for symptom magnification. Dr. Stiehl's diagnosis was a minor low back strain that caused him to have neck pain, and opined that he should have reached MMI within 4 to 6 weeks. He opined that Petitioner did not need lumbar surgery and was able to return to work as to the lumbar spine. (Rx1).

On cross examination, Dr. Stiehl testified that he hasn't performed surgery since 1982, and estimated that only 15% to 20% of his practice consists of treatment for spinal disorders. He agreed the Petitioner acknowledged prior neck and low back complaints. As to the cervical spine, Dr. Stiehl agreed that the Petitioner was working full duty at the time of his accident, and that there was no evidence the Petitioner had undergone a cervical MRI prior to 1/26/16. He did not review the cervical MRI films, but did review the lumbar MRI films, and that his cervical diagnosis would not have changed if he had reviewed the films. He acknowledged that the mechanism of the pulling wires to remove them from the roadway would be competent to cause or aggravate a cervical spine injury. As to his report indicating that the Petitioner was not evaluated for nearly two weeks following the accident, he was not aware the Petitioner had seen Dr. Muniz and Dr. Kathalynas on 1/29/16, three days post-accident. As to his opinion that Petitioner was not a surgical candidate, in part, because he had no chronic radiculopathy, Dr. Stiehl agreed that complaints of numbness and tingling down both of his arms at his initial 6/9/16 visit with Dr. Gornet on 6/9/16, as well as Gornet's exam findings of decreased sensation in the C6/7 dermatome, could be consistent with cervical radiculopathy. Dr. Stiehl testified he knew of Dr. Gornet as a "very skilled doctor" with top flight training, and in seeing a few of his cases, he noted that he'd "never seen the slightest problem or complication", and he acknowledged that the Petitioner had an excellent outcome. He testified that he has been "amazed at how well these necks do after that particular operation." (Rx1).

Dr. Stiehl testified that he considered the injury resulting from the 9/10/16 altercation as a "minor back injury" because Petitioner hadn't gone to the ER or sought other emergency treatment. While he agreed his findings were consistent with Dr. Gornet's during his lumbar examination, he pointed out that chiropractic records from 2016 prior to 9/10/16 reflected complaints of low back pain, though he agreed the main complaint in the records was the cervical spine. The Arbitrator notes that Dr. Stiehl acknowledged multiple discrepancies in his reports, which he testified generally were typos. (Rx1).

Dr. Stiehl conceded that no other physician who examined Petitioner documented positive Waddell signs, and that he made no such findings at the initial 11/10/16 exam. He agreed that his 4/10/17 report didn't document the specific tests he performed to elicit those signs in his report. When asked why he would believe that Petitioner was malingering or exaggerating when Petitioner was working full duty up until his neck surgery, Dr. Stiehl indicated he didn't necessarily believe the Petitioner was a malingerer and that he "basically made those – that call of the Waddell signs on the day that [he] saw him." As to the comparison of the 2013 and 2016 lumbar MRIs, he agreed there were some differences, but "I'm looking for findings that are consistent with what I would believe to be pathological changes that cause surgery or other treatments to be rendered, and I can't tell you that I saw those changes." He did not see the large disc herniation described by Dr. Gornet, opining that what he saw was age-related degenerative changes. He admitted that a patient can have a permanent increase in symptoms without evidence of changes showing on an MRI. Dr. Stiehl conceded that Petitioner's lumbar treatment was based on his complaints of back pain, and "so I would say that he was treated for a condition that I attribute to a claim. Does that make sense?" He was unable to comment on any of Dr. Gornet's post-9/17/16 recommendations because he had not reviewed those medical records, but he testified that given there were no lumbar abnormalities of any kind when he saw him for examination, he still would have placed him at MMI. (Rx1).

The Petitioner testified that he brought diagnostic film CDs for Dr. Stiehl to review, but was never asked for them. He told Stiehl's nurse he brought all the films per a letter from Respondent, and the nurse said the doctor had everything he needed, so the Petitioner took them back.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner has failed to prove that his lumbar condition is causally related to the 9/10/16 accident.

The Petitioner in this case has a long-standing lumbar spine problem. There are multiple references in his current and past medical records to low back injuries and low back pain that radiates to the right leg, including down to the heel, as well as symptoms of numbness or tingling. While this in and of itself doesn't rule out the compensability of an accident which aggravates or accelerates that condition, the greater weight of the evidence does not support such finding in this case.

The biggest factor in the Arbitrator's determination in this case, unlike in the companion case 16 WC 32670, is that the Petitioner's lumbar symptoms were occurring and being treated for several months prior to the accident date of 9/10/16.

On 4/13/16, Dr. Kathalynas started to treat the low back, with no explanation regarding the reason for onset. indication as to how this pain began. His pain improved for a while and then on 5/27/16, Petitioner reported an increase in low back pain to a 7 out of 10 pain level, and Dr. Kathalynas specifically noted that he didn't recall doing anything to make it worse, and that he just woke up in pain. On 6/3/16, his entire spine including his low back was bothering him, again with an indication that there was no inciting event. On 6/10/16, the doctor's records start to specifically note treatment to the lower lumbar spine. On 6/17/16, Petitioner specifically indicated lumbar and sacroiliac (SI) discomfort at a 6/10 level, and on 6/20/16 he reported tingling in his right

foot, noting he did a lot of walking that he felt irritated his low back. On 6/27/16, Petitioner reported his right leg had been irritated the past couple of days. On 7/8/16, the Petitioner reported discomfort in the low back and SI areas at a 5/10 level. On 7/15/16, the Petitioner complained of low back pain into the right leg. On 7/25/16, Petitioner reported increased neck, mid and low back pain after stepping in a rut on the highway. After visits on 9/12 and 9/14/16 without any report of a work accident, on 9/19/16 Dr. Kathalynas references that Petitioner "is still hurting from his last fight at work."

Dr. Gornet's causation opinion is most significantly based on a chain of events analysis: the Petitioner had no low back pain when he initially saw him, he then had a work accident and developed low back and leg symptoms which have continued, and therefore there is a causal relationship. While this theory of causation is valid, it is flawed in this case because it ignores the lumbar and right leg complaints that the Petitioner made to Dr. Kathalynas for several months prior to the 9/10/16 accident, as noted above, and the fact that treatment had been undertaken. His explanation that chiropractic records contain "every possible diagnosis" is not a satisfactory explanation when the records specifically note treatment to the low back. While Dr. Stiehl's testimony in this case was not very persuasive in many ways, the greater weight of the evidence also does not support the causation opinion of Dr. Gornet. The Arbitrator believes that the greater weight of the evidence indicates the Petitioner has had on and off lumbar pain and radicular symptoms for years, and there is a much clearer delineation of onset occurring months prior to the accident date than there is at the time of the accident. The change that appears to have occurred at that point was the reporting of the symptoms to Dr. Gornet and his subsequent lumbar work-up.

The Petitioner testified that he reviewed his medical records and they were accurate in terms of what he reported. Thus, the fact that Dr. Gornet did not indicate any report from Petitioner of low back pain, the records of Dr. Kathalynas clearly indicate low back and right leg complaints had been ongoing for several months prior to the accident. Additionally, while Dr. Gornet testified that there was a difference in the Petitioner's current and prior complaints, the Arbitrator's review of the prior records over many years, as well as the months prior to the accident, reflects very similar if not identical complaints. Dr. Gornet testifies that the new lumbar MRI findings he visualized could be causing the right sided symptoms, but this determination is not persuasive to the Arbitrator when the Petitioner had virtually the same complaints in 2013 when he underwent an MRI.

The greater weight of the evidence indicates that the Petitioner developed low back and right leg complaints in the months prior to 9/10/16 and was actively treating for them when he had the accident on that date. The Arbitrator sees no significant change in his condition at that time versus the months prior, particularly in the context of the longstanding nature of these complaints going back to 2010.

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

Based on the Arbitrator's findings with regard to causation, the Respondent is not liable for the Petitioner's lumbar-related treatment. As indicated in the Arbitrator's decision in the companion case, 16 WC 32670, the expenses of Dr. Kathalynas were awarded in that case despite the fact that some of the treatment involved the lumbar condition as well as the cervical condition.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to causation, this issue is moot.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that while the parties have not indicated that TTD is an issue in this case, they have stipulated that the Petitioner has had lost time from work, but that he has received a salary continuation during such time, and thus that TTD benefits are not applicable to the current hearing.

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

Donald Fort,

Petitioner,

vs. NO: 16 WC 32670

City of West Frankfort,

Respondent.

18IWCC0673

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 issue(s) 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 January 26, 2018 is hereby affirmed and adopted.

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

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

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

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

NOV 5 - 2018

DATED:
SJM/sj
o-10/10/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

FORT, DONALD
Employee/Petitioner

Case# **16WC032670**

16WC032671

CITY OF WEST FRANKFORT POLICE
Employer/Respondent

18IWCC0673

On 1/26/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

1433 McANANY VAN CLEVE & PHILLIPS
AJ SHEEHAN
505 N7TH ST SUITE 2100
ST LOUIS, MO 63101

18IWCC0673

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

DONALD FORT
Employee/Petitioner

v.

CITY OF WEST FRANKFORT POLICE
Employer/Respondent

Case # 16 WC 32670

Consolidated cases: 16 WC 32671

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **June 14, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 26, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,332.80**; the average weekly wage was **$1,006.40**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **1** dependent child.

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

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

Respondent is entitled to a credit for any awarded medical expenses paid prior to hearing pursuant to Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner's cervical condition of ill-being is causally related to the January 26, 2016 accident.

Respondent shall pay reasonable and necessary medical services which are causally related to treatment of the cervical spine, as contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

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

The Petitioner's request for the award of prospective medical treatment is denied, as there are no specific current treatment recommendations. However, the ongoing post-surgical cervical condition remains causally related to the January 26, 2016 accident.

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.

18IWCC0673

Signature of Arbitrator

January 25, 2018
Date

JAN 26 2018

STATEMENT OF FACTS

The Petitioner, a 22-year patrolman for the Respondent, testified that on 1/26/16 he was rolling up a heavy downed telephone wire and felt a pop in his upper neck and shoulder area. He believed he'd had a prior cervical work injury in 2000. As to his lumbar spine, Petitioner testified to prior injuries in 2006 following a foot chase, in approximately 2010 when he stepped on a rolling PVC pipe and fell onto a wall, and in 2013 due to an altercation. He testified that he'd had no cervical or lumbar surgeries or surgical recommendations prior to 2016. He returned to unrestricted work duties after the 2013 incident. As a small police department, the Petitioner testified that he would handle all manner of police calls.

With regard to the 11/8/10 injury where he rolled off a PVC pipe, Petitioner testified he landed onto his buttocks on the wall and rolled off of it, and he did recall having some numbness in his right leg to the heel. The 4/15/13 altercation he had with an arrestee involved a workers' compensation claim. The Petitioner did not recall having numbness down the right leg with that incident, but wouldn't disagree if this is indicated in his medical records. He did recall having lumbar injections in 2013, but testified he continued to work after the 4/15/13 altercation.

The Petitioner agreed that he reviewed his medical records to date which were being submitted into evidence and verified they accurately reflect what he reported to the providers.

Petitioner saw Dr. Muniz on 1/29/16. He reported a history of back problems, noting he would see a chiropractor when he had problems, and that he had undergone L3/4 injections in 2013. The doctor recorded: "Ongoing [history] of cervical neck pain fell a year ago ongoing neck pain was pulling something on Wednesday felt a pop." A cervical MRI was prescribed. (Px3; Rx4).

The Petitioner also sought treatment with chiropractor Dr. Kathalynas on 1/29/16. His intake form there, as well as a 1/27/16 "Ergo Insight WC Employee Injury Report" intake form included within the records of Dr. Kathalynas lists prior workers' compensation claims including the neck and back. The incident involved rolling cable that was found abandoned on the roadway. With the current incident, Petitioner reported pain and numbness into the bilateral upper extremities with numbness in the middle and ring fingers. It specifies that he had similar symptoms when he slipped and fell on ice and hit his head about a year prior. (Px4; Px14; Px15; Rx5).

Dr. Kathalynas' 1/29/16 report noted the Petitioner reported rolling up downed wire lying in the road on 1/26/16, it got hung up on something and he jerked it very hard, injuring his upper back and neck. He noted sharp discomfort in the cervical and bilateral dorsal areas, as well as numbness and tingling in the bilateral hands. The diagnoses included cervical radiculopathy and cervical/thoracic strains. Chiropractic care was initiated from 1/29/16 through 10/17/16. (Px4; Rx5).

At a 2/12/16 follow-up with Dr. Muniz, the Petitioner reported an April 2015 injury when he stepped out of his squad car, slipped on the ground under the car and hit his head. He reportedly had sharp upper back neck area pain radiating down both arms, and had relief with a couple of months of chiropractic treatment. He would have occasional aggravation of his pain and some occasional bilateral hand numbness at night. The report states: "most recently 1/26/16 was rolling up two blocks of wire while working felt something pop upper back neck region since then ongoing numbness in bilateral hands. Gets some relief with chiropractor but still there [sic] occasional muscle spasm. Denies loss of muscle strength painly [sic] sensation." He noted he had been treating with a chiropractor, but still had numbness in the right hand. Dr. Muniz diagnosed cervical pain and radiculopathy. Cervical x-rays and EMG/NCV testing were prescribed, noting that an MRI would likely be needed. (Px3; Rx4).

Cervical x-rays showed degenerative changes, particularly in the lower cervical spine and greatest at C5/6. 3/3/16 MRI films showed Generally well-maintained disc height and alignment for his age with the exception of mild disc desiccation and spondylitis at C5/6 and C6/7. The spinal cord appeared normal with a borderline congenitally small canal, with some osteophytes stenosis at C5/6 and C6/7. Minimal left and moderate to moderately severe right foraminal stenosis from C5 to C7. Disc bulges were noted at all cervical levels from C3 down, with disc osteophytes complexes from C5 to C7. (Px3).

On 3/11/16, Dr. Kathalynas noted Petitioner continued to have pain that radiated into his hands, but his pain level was down to 5/10 from 7/10. On 3/23/16, Petitioner reported ongoing pain but good improvement, and that he was waiting for a neurosurgical consult. On 4/11/16, Petitioner reported that he had a neurosurgical consult pending in June 2016. On 4/13/16, it appears that Dr. Kathalynas started to treat the low back as well, with no indication as to how this pain began. Subsequent visits note complaints of low back pain/tightness. Petitioner reported increased soreness on 5/4/16 after having to run and chase someone down. However, by his next visit he was reporting only 4/10 pain, and that it was only 60% of the time instead of constant. By mid-May, this was down to 2/10 pain. On 5/27/16, Petitioner reported an increase to a 7/10 pain level, noting he didn't recall doing anything to make it worse, and that he just woke up in pain. On 6/3/16, Petitioner reported his entire spine, including his low back, was bothering him, again with an indication that there was no inciting event. (Px4; Rx5).

The Petitioner initially saw orthopedic surgeon Dr. Gornet on 6/9/16, which he indicated was on referral from Dr. Muniz. The Petitioner reported neck pain and headaches at the base of his neck, bilateral trapezius, both shoulders down both arms into his hands with numbness in tingling, with the right shoulder and arm being most significant. Dr. Gornet reported that Petitioner's current problems began, "at least in its level of severity", on or about 1/26/16, when he began to reach and pull a telephone wire off the road over and over again. Petitioner reported a history of neck pain going back to April 2015, when he slipped on ice at work, landing hard on his left side and injuring his low back and neck. He did not recall undergoing prior MRI testing. The Petitioner was working full duty, but would have increased symptoms with certain activities. He noted numbness and tingling in his hands, particularly his fingertips. Sensation was decreased in right C6/7 and left C7 dermatomal patterns on exam. Dr. Gornet indicated cervical x-rays showed loss of disk height and spurring at C5/6 and C6/7, with more significant foraminal stenosis on the right. His review of the 3/3/16 MRI films suggested a C6/7 disc herniation and a smaller herniation at C5/6, noting films were of moderate to poor quality. Dr. Gornet opined that the Petitioner's symptoms were causally related to his work accident and that he could continue to work. A repeat MRI and medication were prescribed. (Px6).

The radiology report from the 6/9/16 cervical MRI indicated a central and right C5/6 herniation with degenerative changes likely affecting the exiting right C6 nerve root, a broad-based and smaller herniation at

C6/7 with a right foraminal component though small than at C5/6, and small central herniations at C4/5 without definite nerve root impingement. (Px8).

Following the MRI, Dr. Gornet reviewed the films and found what he opined to be more significant disc pathology with acute-on-chronic disc herniations at C5/6 and C6/7, as well as a central C4/5 herniation/annular tear. He also noted severe right foraminal stenosis from C5 to C7, moderate at left C5/6. Petitioner was referred to Dr. Boutwell for epidural injections. (Px6). She performed an epidural at C6/7 on 6/9/16 with a post-procedure pain score of 4 to 5/10 noted, and at C5/6 on 6/30/16, with a post-procedure pain score of 4/10. (Px7).

On 6/10/16, Petitioner told Dr. Kathalynas that Dr. Gornet was recommending cervical surgery. It was at approximately this point that Kathalynas' treatment begins to focus more significantly on the lower back, per the treatments indicated in his reports. On 6/17/16, Petitioner specifically indicated lumbar and sacroiliac (SI) discomfort of 6/10 for 80% of the time, mainly noticing this after prolonged sitting and standing. On 6/20/16, he reported numbness in his right hand and tingling in his right foot, noting he did a lot of walking that he felt irritated his low back. On 6/27/16, Petitioner reported his right leg had been irritated the past couple of days, and he continued to have numbness into both arms depending on his activities. On 7/1/16, the Petitioner reported that he was improved following a cervical injection. On 7/8/16, the Petitioner reported discomfort in the low back and SI areas at 5/10 level. On 7/15/16, the Petitioner reported that his surgeon had recommended surgery for two or three cervical discs, and that he had low back pain into the right leg. On 7/20/16, Petitioner reported an increase in spinal pain after having to get an uncooperative person into his squad car. On 7/22/16, he reported that he felt like the cervical injection was wearing off. On 7/25/16, Petitioner reported increased neck, mid and low back pain after stepping in a rut on the highway. (Px4; Rx5).

On 7/14/16, Petitioner reported to Dr. Gornet that the injections gave him some relief, at C6/7 more than C5/6, but that the improvement wore off. Dr. Gornet recommended disc replacement surgeries at C5/6 and C6/7. A pre-surgical cervical CT myelogram was performed on 8/4/16, while the Petitioner was allowed to continue full duty work pending surgery. The myelogram report indicated right lateral recess C5/6 effacement, and extradural defects at C5/6 and C6/7 without significant central or foraminal stenosis. The CT showed: 1) right lateral recess protrusion with spurring at C6/7, resulting in right cord flattening, mild central canal stenosis and right greater than left foraminal stenosis, and 2) circumferential bulging with right foraminal superimposed protrusion with associated spurring at C5/6, with mild central and severe right greater than left foraminal stenosis. (Px9). Dr. Gornet's review of the CT myelogram revealed disc pathology at both noted levels with particularly right sided foraminal stenosis. (Px6).

Prior to the cervical surgery, the Petitioner testified he had another work accident on 9/10/16. He was called to a scene where a woman acting psychotically ran into traffic. He and another officer pulled her out of the street, an altercation ensured, and he injured his low back.

The 9/12 and 9/14/16 reports of Dr. Kathalynas do not reference anything about the alleged 9/10/16 work injury. The next report of 9/19/16 report states that Petitioner "is still hurting from his last fight at work. He did go up to his surgeon on Saturday and they did another MRI on his neck and he is waiting for his surgery to be scheduled." It was noted that the surgeon prescribed 6 weeks of chiropractic treatment for the neck and low back.

A 9/19/16 intake form for Dr. Kathalynas, as well as a 9/13/16 "Ergo Insight WC Employee Injury Report" intake form references the 9/10/16 injury involving an altercation with an arrested suspect who was resisting arrest. The listed injuries include neck and low back pain, with radiation to the right groin. They also note prior

workers' compensation claims involving similar symptoms and complaints as nerve damage in the neck in 2015 and 2016 and the low back in 2013 and 2015. (Px4; Px15; Px16; Px17; Rx5).

On 9/15/16 he underwent an abdominal CT scan due to complaints of sudden onset right flank pain. He previously had undergone the same test a year prior. Petitioner indicated he stopped to see his chiropractor, who did not feel it was related to the back condition. (Px5). Petitioner told Dr. Kathalynas on 9/21/16 that he felt improved after being off work due to a lack of light duty availability, as he hadn't had to do anything to irritate his neck and upper back. (Px4; Rx5).

On 9/17/16, Dr. Gornet noted that cervical surgery had been approved, but that Petitioner had developed new symptoms in his low back and neck again on 9/10/16 in an altercation with a citizen. He noted Petitioner had a prior history of low back pain, with chiropractic care, but that Petitioner's initial 6/9/16 visit pain diagram did not reflect low back complaints. He had undergone a prior 2013 lumbar MRI after an altercation at work and had seen Dr. deGrange. The records of Dr. deGrange were not submitted into evidence. Petitioner reported he recovered with a low level of tolerable symptoms. His current low back symptoms reportedly were now constant bilaterally, particularly into the right buttock and leg to the heel, with tingling in his left foot. Motor exam showed decreased EHL function on the right and decreased sensation in an S1 dermatome on the left. Dr. Gornet stated: "I have discussed with Mr. Fort that he may have aggravated his underlying condition in his lumbar spine that was quiescent as well as potentially producing a new injury in the disk. The same is true in his cervical spine." Cervical examination was unchanged. A repeat cervical MRI was obtained and Dr. Gornet verified no change in the films, particularly at C4/5. The Petitioner was restricted to light duty for two weeks and referred for chiropractic treatment. Lumbar MRI was planned. Dr. Gornet opined that the increase in the Petitioner's symptoms was directly attributable to the 9/10/16 accident. (Px6). The cervical MRI report indicated circumferential disc bulges at C5/6 and C6/7 with superimposed right foraminal epicenter broad-based protrusions resulting in severe right greater than left foraminal stenosis at both levels but mild central canal stenosis at the C6/7 level, as well as central annular tears at C3/4 and C4/5 resulting in mild right foraminal stenosis at both levels. (Px8).

At this point in the Arbitrator's review of Px4, it appears that Dr. Kathalynas started to prepare two separate reports from the same dates, one focused on the cervical and thoracic spine, and the other on the low back. A separate 9/19/16 report notes the Petitioner was seen for injuries he sustained "at work on ." [Arb note: there is no date indicated]. Petitioner reported struggling with someone he was trying to arrest and ended up on the ground trying to pick up the assailant, resulting in lower back pain and sharp discomfort in the right lumbar and SI regions. Petitioner reported the symptoms had been present for several days. This report goes on to describe the examination in much more significant detail than the general records of Dr. Kathalynas indicate. Multiple lumbar diagnoses are indicated, including sprains/strains and radiculopathy. On 9/21/16, Petitioner was awaiting a lumbar MRI. On 9/23/16, he noted that sitting at ball games really made his legs hurt. On 9/26/16, Petitioner had ongoing 4/10 lumbar and SI pain, most noticeable in the morning. The 10/10/16 note indicates pain with sitting on the ground deer hunting. The last note of 10/17/16 indicates Petitioner was overall doing the same since his last treatment. (Px4; Rx5).

The 10/18/16 surgery involved C5/6 and C6/7 disc replacements with Dr. Gornet. The report notes that herniations were found at central and right, and smaller left, at C5/6 with significant right-sided stenosis. At C6/7, he noted central and right-sided herniations and right foraminal stenosis. Both levels were decompressed. (Px11).

Petitioner testified that his neck pain with numbness and tingling into his arms and fingers did impact his work to some degree, but he was able to perform his duties prior to surgery. Petitioner testified he underwent surgery on 10/18/16 based on the Respondent authorizing same. (Px2). He was held off work afterwards.

Petitioner reported on 11/7/16 that his neck was doing "wonderfully well", but that he still had low back pain. (Px6). Lumbar MRI was obtained on 11/28/16 reportedly showing: 1) a central, broad-based L4/5 disc protrusion, slightly increased in thickness versus 5/13/13 films, with a likely left paracentral annular tear, mild central canal stenosis and bilateral foraminal stenosis that was worsened since 5/13/13; 2) an L2/3 annular disc bulge with superimposed right foraminal protrusion with increasing thickness, moderate right greater than left foraminal stenosis and borderline central canal stenosis; and, 3) annular disc bulge with right foraminal protrusion at L3/4 and L5/S1, with moderate right greater than left foraminal stenosis and mild central canal stenosis, all stable since the prior 5/13/13 films. (Px8).

On 11/28/16, Dr. Gornet noted Petitioner's neck was doing very well. His review of the lumbar MRI indicated multilevel disc degeneration with a central herniation/annular tear at L4/5 and mild left L5/S1 foraminal stenosis. Comparing it to 5/13/13 films, Dr. Gornet opined there was a new more right-sided L3/4 herniation and new L4/5 annular tear. He stated that the low back "will be difficult to solve", and recommended initial right L3/4 and L4/5 injections based on the symptoms being mainly right-sided. Petitioner remained temporarily disabled. (Px6). On 12/22/16, Dr. Boutwell performed bilateral L3/4 epidural injection, indicating a post-procedure pain score of 4/10. On 1/19/17, she performed a right L4/5 epidural injection, again indicating a post-procedure 4/10 pain score. (Px7).

On 2/16/17, Petitioner noted mild neck pain he felt was weather related, but for the most part felt a dramatic cervical improvement. Lumbar injections provided only temporary relief. Noting the multilevel problems, Dr. Gornet's first recommended option was right microdecompression at L2/3 and L3/4 for the large herniations. He noted there was "no perfect scenario", and that any surgery had the potential to destabilize the spine with increased back pain, but that Petitioner was "miserable" and had failed conservative care. He opined that the Petitioner had already had nerve injury and that this often can't be fixed with surgery. (Px6).

A2/16/17 cervical CT scanning noted the disc replacements were in satisfactory position with mild C6/7 and borderline C5/6 central canal stenosis due to spurring that was unchanged. Otherwise, previously seen stenosis were significantly improved bilaterally by the decompression. (Px9).

A 5/15/17 pre-surgical lumbar CT impression was annular disc bulges with posterior element hypertrophy at all lumbar levels, including facet arthropathy and ligamentum flavum hypertrophy. At L2/3 there was a superimposed right foraminal protrusion, at L3/4 there was mild central canal stenosis, and at all lumbar levels there was bilateral foraminal stenosis. (Px9).

At the last visit with Dr. Gornet on 5/15/17, the Petitioner's cervical spine looked good. He opined that the lumbar CT scan showed no evidence of a major facet arthropathy with the exception of L5/S1, where it was fairly significant. Based on these findings, Dr. Gornet recommended facet rhizotomies (RFA), medial branch blocks and L5/S1 epidural before attempting microdecompression surgery. He reviewed the report of Dr. Stiehl, noting he personally found no evidence of symptom magnification with the Petitioner, supported by a good cervical outcome. (Px6).

The Petitioner testified that he experienced dramatic improvement with the cervical surgery - "it was just crazy. It was unbelievable" – and continues to improve. As to the lumbar spine, the Petitioner testified that he did not indicate any lumbar symptoms at the initial 6/9/16 visit with Dr. Gornet, with no indication of low back pain in

the pain diagram, and that while he had been able to continue to work, his low back pain has not resolved since the 9/10/16 incident. Currently, the Petitioner stated he has a fist-sized knot in his low back with pain radiating into the right buttocks and numbness down the leg to the foot. He gets some spasms in the left leg. Prolonged sitting or standing increases the symptoms. As to the lumbar epidurals and RFA that Dr. Gornet has recommended, the Petitioner testified he would prefer to try this as he would like to avoid surgery. He testified that he is being paid salary while off work, and that he did not feel he is currently able to work full duty.

On cross examination, the Petitioner was asked about his prior 2/16/15 slip and fall accident, and he acknowledged that he struck his left posterior head when he slipped on ice getting out of his squad car, reporting symptoms going down his arms with tingling in the hands and fingers. He didn't recall having radiating pain down his legs into his heels, but testified he wouldn't disagree with the medical records if they indicated he reported this.

The Respondent submitted a number of pre-accident records from the office of Nolen Clinic, which appears to be a chiropractic facility. These documents appear to show treatment for low back and right leg pain from November 2010 to April 2011, and from April to June of 2013. One intake form indicates on 11/8/10 the Petitioner stepped over a short brick wall, stepped on a PVC pipe, which rolled out and he fell back. An 11/15/10 note states that he had a prior work-related back injury in 2006, when he lifted and turned an intoxicated person away from the roadway. A separate intake form notes that on 4/15/13, the Petitioner injured his low back and right hip escorting someone who was under arrest. The Petitioner indicated he had been injured twice before, and that he went home after the incident to apply a heating pad and TENS unit. There were also some thoracic and cervical complaints in 2011. A 5/13/13 lumbar MRI showed mild-to-moderate posterior bilateral paracentral disc bulging at multiple levels from L1 to S1, with mild-to-moderate central canal and mild bilateral neuroforaminal stenosis noted from L2 to S1. (Rx3).

Petitioner saw Dr. Davis on 5/21/15 for right shoulder, neck and low back injuries. The injury itself was not described in detail, but it was noted that Petitioner was getting chiropractic treatment, that his left shoulder was not 100%, and that he no longer had tingling in his fingers but still had right trapezius spasm. His back pain was worse with extended use, and would get radiating pain into the right leg down to his heel ("He said after about 5 hrs of pittling around he starts getting the pain in his leg."). Diagnoses were cervical strain, low back pain and spasm. He was to continue chiropractic care and back exercises. (Rx2).

On 1/26/16, his injury was more neck/shoulder than low back. He was treating with Dr. Kathalynas for the low back prior to the 9/10/16 accident.

Orthopedic surgeon Dr. Gornet testified for hearing via evidence deposition on 5/18/17. The Petitioner believed that his cervical and upper extremity problems began with the 1/26/16 work incident with the telephone wire, though Dr. Gornet noted he had neck pain going back to at least April 2015, when he had slipped on ice and injured his neck and low back. When he initially saw Petitioner on 6/9/16, he had no complaints of low back pain, and while his neck and upper extremity tingling improved somewhat with chiropractic treatment, his constant pain did not. He was working full duty. Examination abnormalities included decreased sensation in a C6/7 pattern on the right and C7 on the left. The repeat MRI was obtained due to the relatively poor quality of the prior MRI, and Dr. Gornet opined it showed acute-on-chronic C5/6 and C6/7 herniations and a central annular tear at C4/5. Diagnosis was discogenic pain from C5/6 and C6/7 secondary to disc injury and herniations as well as irritation of foraminal stenosis at those levels, and a C4/5 annular tear. Dr. Gornet opined that the cervical conditions were causally related to the work accident, as a reaching/pulling injury can mechanically load the cervical spine and cause disc injury. Petitioner's symptoms correlated with this objective pathology. Dr. Gornet testified: "Clearly he had some preexisting symptoms, and that's well noted and was seen

in the medical records. But there was a change in his symptoms, and that was consistent with the acute-on-chronic change that we saw on the MRI." Surgery was recommended as the only real option for relieving his symptoms, given mild but temporary improvement with injections. CT myelogram indicated no significant facet pathology and some bony foraminal right stenosis at C5 to C7. The stenosis would have been preexisting, but could easily be aggravated by his work activities. (Px12).

At Petitioner's 9/10/16 visit, he reported injuring his low back and aggravating his neck in an altercation with a citizen at work a week prior. The Petitioner did report a history of low back pain with chiropractic care. He had bilateral low back pain, but the symptoms were mainly into the right hip and leg to the heel with tingling in the left foot. Exam noted decreased EHL function on the right and decreased S1 dermatome sensation on the left. These findings would involve the L5/S1 and L4/5 levels. X-rays showed some multilevel degeneration, but were relatively benign. Dr. Gornet opined that the altercation could have aggravated the underlying lumbar condition. The cervical exam was unchanged after this incident, but he was taken off work as to the low back. Lumbar MRI was delayed due to cervical surgery, but conservative care was prescribed for the low back. Dr. Gornet's lumbar diagnosis was aggravation of preexisting condition or potentially new injury at L4/5 or L5/S1, and even at L3/4 "because of translation." There was "no question" in Gornet's mind that the lumbar condition is causally related to the 9/10/16 accident, as the Petitioner didn't complain of his low back and it was not an issue when he first saw him on 6/9/16. (Px12).

The Petitioner underwent cervical surgery on 10/18/16, and did wonderfully well, but he continued to have low back pain. The lumbar MRI was obtained on 11/28/16, and was compared to 5/13/13 films. There was a new right-sided L3/4 herniation, and Dr. Gornet felt there was a new L4/5 annular tear. He clearly had preexisting disc degeneration and L5/S1 foraminal stenosis in the 2013 films, but "I think he may have aggravated his underlying degeneration and foraminal stenosis at L5/S1." He advised Petitioner his low back would be "more difficult to solve" and harder to get him back to full duty given multilevel problems. Petitioner was held off work. Recommended right L3/4 and bilateral L4/5 epidurals provided only temporary relief. In Dr. Gornet's opinion, the only real option to return Petitioner to baseline, would be L2/3 and L3/4 microdecompression on the right where the herniation is. Petitioner was told this could help the right hip and leg pain, but no surgery was going to make him perfect. The lumbar CT showed no major facet arthropathy except at L5/S1, which could have been a source of Petitioner's buttocks pain. Based on this, "I changed my thinking there", and Dr. Gornet recommended right facet rhizotomies at L5/S1, as he felt that avoiding surgery would be Petitioner's best option to get back to full duty work. If that doesn't work, the previously recommended decompression surgery would be the fallback recommendation. (Px12).

Regarding the reports of Dr. Stiehl, Dr. Gornet testified his experience with the Petitioner indicated no evidence of functional overlay, and he has objective pathology consistent with the subjective complaints. He did agree with Dr. Stiehl that there was L2/3 and L3/4 foraminal encroachment, and that Petitioner had an excellent cervical result. He disagreed that Petitioner had reached MMI as to the neck, as that would not be until a year after surgery. Again, Petitioner was candid in noting he'd had back pain for years, but "There's a difference between tolerable back pain that he doesn't even put on his pain diagram and intolerable back pain that affects his quality of life." His goal would be to get Petitioner back to his baseline tolerable lumbar condition with ongoing chiropractic maintenance. (Px12).

As to the records of Dr. Kathalynas noting reports of low back pain prior to the 9/10/16 accident going back to 6/8/16, on cross exam Dr. Gornet essentially testified that chiropractic records tend to show every possible diagnosis, and that he was "comfortable" that Petitioner did not have any significant back complaints when he was treating him prior to the accident. He acknowledged that Petitioner had prior lumbar problems in 2013, when he underwent MRI, and 2015. Dr. Gornet did not recall if Dr. Muniz' records reflected radicular lumbar

symptoms after the 2015 slip and fall. He did not review any records of Logan Primary Care from 5/15 indicating radicular symptoms into the right heel, but wouldn't dispute if Petitioner had preexisting radicular symptoms. He indicated it was important to his causation opinion that Petitioner had no symptoms, then an altercation, and then increased symptoms, as his condition thus changed as a result. Dr. Gornet also did not recall reviewing any records of Dr. Nolen. (Px12).

Dr. Gornet agreed the Petitioner's degenerative spinal findings were generally age-appropriate. He was asked if the records showed Petitioner reported numbness and tingling in the right side/lower extremity after his 2013 injury, whether this would be similar to what he has now, and Dr. Gornet testified that the numbness and tingling is similar, but he currently has more of a right buttock/hip/groin pain. As to the 2013 MRI showing disc bulges at 5 lumbar levels, Dr. Gornet testified that "bulging is sort of insignificant", but agreed Petitioner clearly had preexisting multilevel lumbar degeneration, which does occur over time. As to whether the L3/4 herniation could have developed over time since 2013. Dr. Gornet indicated this was "pure speculation", and changes since 2013 were noted from L2 to L5. He testified that: "generally I don't believe that those changes occur in the long-term. I think that they occur usually with an acute event." He questioned how the degeneration would have developed over time but only progressed in the areas to which Petitioner's symptoms correlated. In his opinion, there was no other plausible explanation than to associate the changes to the accident / altercation. (Px12).

Respondent's Section 12 examining orthopedic surgeon Dr. Stiehl testified via evidence deposition on 5/17/17. (Rx1). At the initial examination of 11/10/16, the Petitioner reported a history of neck and upper back problems, but that he developed symptoms after rolling up long portions of wire on 1/26/16 and felt a pop in his upper back. He opined that x-rays showed degeneration that was age-appropriate. Regarding Petitioner's neck condition, Dr. Stiehl opined that Petitioner sustained a cervical sprain as a result of the 1/26/16 incident. He testified the Petitioner's exam was normal and showed no objective signs of neurologic changes, and there were no acute injuries to the cervical bones or ligaments. He did have degenerative findings at C5/6 and C6/7 that included moderate to severe right foraminal stenosis. As to the 6/9/16 repeat MRI, Dr. Stiehl didn't disagree with the radiologist's findings, but opined that there were no acute herniations depicted. Based on a strain injury, he opined that the Petitioner would have reached MMI within two months. Regardless of causation, he should have reached MMI three to four months post-surgically. Dr. Stiehl testified that given the Petitioner did not have cervical neuropathy, he would not have recommended the disc replacement surgery and would have allowed the Petitioner to return to work. (Rx1).

Dr. Stiehl re-examined the Petitioner on 4/10/17. He opined that the principal target of lumbar treatment today is radiculopathy, testifying: "if you don't have a neuropathy, you don't have much of an injury." A 5/13/13 Lumbar MRI showed significant bulging at all levels, which would be normal for the Petitioner's age. Compared with the 11/28/13 films, Dr. Stiehl acknowledged that while the 2016 MRI report noted slight increases in an L4/5 protrusion and L2/3 annular bulge, there was not really much change, testifying the findings are degenerative, and: "They just don't change over time." On lumbar exam, Dr. Stiehl testified that the Petitioner had 5 out of 8 Waddell signs, and three of the five were suspicious for symptom magnification. Dr. Stiehl's diagnosis was a minor low back strain that caused him to have neck pain, and opined that he should have reached MMI within 4 to 6 weeks. He opined that Petitioner did not need lumbar surgery and was able to return to work as to the lumbar spine. (Rx1).

On cross examination, Dr. Stiehl testified that he hasn't performed surgery since 1982, and estimated that only 15% to 20% of his practice consists of treatment for spinal disorders. He agreed the Petitioner acknowledged prior neck and low back complaints. As to the cervical spine, Dr. Stiehl agreed that the Petitioner was working full duty at the time of his accident, and that there was no evidence the Petitioner had undergone a cervical MRI prior to 1/26/16. He did not review the cervical MRI films, but did review the lumbar MRI films, and that his

cervical diagnosis would not have changed if he had reviewed the films. He acknowledged that the mechanism of the pulling wires to remove them from the roadway would be competent to cause or aggravate a cervical spine injury. As to his report indicating that the Petitioner was not evaluated for nearly two weeks following the accident, he was not aware the Petitioner had seen Dr. Muniz and Dr. Kathalynas on 1/29/16, three days post-accident. As to his opinion that Petitioner was not a surgical candidate, in part, because he had no chronic radiculopathy, Dr. Stiehl agreed that complaints of numbness and tingling down both of his arms at his initial 6/9/16 visit with Dr. Gornet on 6/9/16, as well as Gornet's exam findings of decreased sensation in the C6/7 dermatome, could be consistent with cervical radiculopathy. Dr. Stiehl testified he knew of Dr. Gornet as a "very skilled doctor" with top flight training, and in seeing a few of his cases, he noted that he'd "never seen the slightest problem or complication", and he acknowledged that the Petitioner had an excellent outcome. He testified that he has been "amazed at how well these necks do after that particular operation." (Rx1).

Dr. Stiehl testified that he considered the injury resulting from the 9/10/16 altercation as a "minor back injury" because Petitioner hadn't gone to the ER or sought other emergency treatment. While he agreed his findings were consistent with Dr. Gornet's during his lumbar examination, he pointed out that chiropractic records from 2016 prior to 9/10/16 reflected complaints of low back pain, though he agreed the main complaint in the records was the cervical spine. The Arbitrator notes that Dr. Stiehl acknowledged multiple discrepancies in his reports, which he testified generally were typos. (Rx1).

Dr. Stiehl conceded that no other physician who examined Petitioner documented positive Waddell signs, and that he made no such findings at the initial 11/10/16 exam. He agreed that his 4/10/17 report didn't document the specific tests he performed to elicit those signs in his report. When asked why he would believe that Petitioner was malingering or exaggerating when Petitioner was working full duty up until his neck surgery, Dr. Stiehl indicated he didn't necessarily believe the Petitioner was a malingerer and that he "basically made those – that call of the Waddell signs on the day that [he] saw him." As to the comparison of the 2013 and 2016 lumbar MRIs, he agreed there were some differences, but "I'm looking for findings that are consistent with what I would believe to be pathological changes that cause surgery or other treatments to be rendered, and I can't tell you that I saw those changes." He did not see the large disc herniation described by Dr. Gornet, opining that what he saw was age-related degenerative changes. He admitted that a patient can have a permanent increase in symptoms without evidence of changes showing on an MRI. Dr. Stiehl conceded that Petitioner's lumbar treatment was based on his complaints of back pain, and "so I would say that he was treated for a condition that I attribute to a claim. Does that make sense?" He was unable to comment on any of Dr. Gornet's post-9/17/16 recommendations because he had not reviewed those medical records, but he testified that given there were no lumbar abnormalities of any kind when he saw him for examination, he still would have placed him at MMI. (Rx1).

The Petitioner testified that he brought diagnostic film CDs for Dr. Stiehl to review, but was never asked for them. He told Stiehl's nurse he brought all the films per a letter from Respondent, and the nurse said the doctor had everything he needed, so the Petitioner took them back.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's cervical condition is causally related to the 1/26/16 accident. While the Petitioner clearly had preexisting cervical symptoms, there is no evidence he was undergoing ongoing treatment

as of 1/26/16. He did see Dr. Davis on 5/21/15, and indicated he had two additional chiropractic visits to attend, but there are no other records in evidence that the Arbitrator was able to locate which reflect 2015 cervical treatment. There was no evidence of prior cervical MRI scanning.

It appears he was then able to continue working full duty through 2015, as again there was no evidence presented which would indicate otherwise, and sought no further treatment until after the 1/26/16 accident. The evidence indicates that he promptly reported the 1/26/16 accident and provided a consistent history of what occurred.

Ultimately, under Illinois law, an accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665 (2003). Here, the greater weight of the evidence supports that the 1/26/16 accident was a causative factor in the Petitioner's cervical condition after that date, and that the Petitioner's symptoms which led to surgery are causally related to the accident.

The Arbitrator also finds that the opinions of Dr. Gornet in this regard were significantly more persuasive than those of Section 12 examiner Dr. Stiehl. The examination findings of Dr. Gornet reflected evidence of neurological deficits, and these were supported by the diagnostic testing, as he testified to. Additionally, the Petitioner testified that he had an excellent result from the disc replacement surgery. While he testified that the Petitioner's cervical degeneration preexisted the accident date, he acknowledged that the findings included moderate to severe right foraminal stenosis.

Taking the entirety of the evidence into account, the greater weight of that evidence supports the finding that the Petitioner's cervical condition of ill-being and surgical decompression and disc replacements at C5/6 and C6/7 are causally related to the 1/26/16 accident.

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

The Arbitrator finds that the Respondent is liable for the cervical treatment administered to the Petitioner from 1/29/16 through the 6/14/17 hearing date. Therefore, the Petitioner is awarded all cervical-related treatment expenses contained in Petitioner's Exhibit 1. The Arbitrator notes that this specifically includes the treatment rendered by Dr. Kathalynas, as this treatment included the cervical spine prior to the date of cervical surgery.

The Respondent is entitled to credit for any of these awarded expenses which were paid by Respondent prior to hearing pursuant to Sections 8(a), 8(j) and 8.2 of the Act. With regard to any such credits, the Respondent shall hold the Petitioner safe and harmless from any claims for reimbursement.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes there is currently no specific treatment recommendations as to the cervical spine, and as such no award is made of prospective cervical treatment. Dr. Gornet testified that he would reach MMI approximately a year after his surgery, which would be October 2017, subsequent to the date of hearing.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that while the parties have not indicated that TTD is an issue in this case, they have stipulated that the Petitioner has had lost time from work, but that he has received a salary continuation during such time, and thus that TTD benefits are not applicable to the current hearing.

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

Linda K. Dickerson

Petitioner,

vs. NO: 13WC042688

City of Springfield,

Respondent.

18IWCC0674

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(s) of accident, permanent 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 December 29, 2017 is hereby affirmed and adopted.

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

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 5 - 2018
SJM/sj
o-10/11/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DICKERSON, LINDA K
Employee/Petitioner

Case# **13WC042688**

CITY OF SPRINGFIELD
Employer/Respondent

18IWCC0674

On 12/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% 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:

1590 SGRO HANRAHAN DURR RABIN ET AL
ELLEN C BRUCE
1119 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
DENNIS S O'BRIEN
620 E EDWARD ST PO BOX 335
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)SS.

COUNTY OF SANGAMON)

18IWCC0674

- [ ] 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

LINDA K. DICKERSON
Employee/Petitioner

v.

CITY OF SPRINGFIELD
Employer/Respondent

Case # 13 WC 42688

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **September 26, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On October 25, 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 $52,286.87; the average weekly wage was $1,005.52.

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 $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 failed to prove that she suffered an accident which arose out of and in the course of her employment by Respondent, and because she further failed to prove a causal connection between said alleged accident and her conditions of right carpal tunnel syndrome and left lateral epicondylitis, 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.

Edward Lee 12/17/17

Signature of Arbitrator Date

ICArbDec p. 2

DEC 29 2017

Findings of Fact and Conclusions of Law:

Testimony at arbitration:

Petitioner testified that as of the date of arbitration she was retired, having done so in May of 2015 after working for Respondent since January of 1978. She was initially employed as a data input operator, later being promoted to Clerk Typist 3, Buyer 1 and finally, Buyer 2, the position she held at the time of her retirement. As a Buyer 2 she said she entered purchasing documents on the computer, and she was on the computer pricing items requested by other city departments. She said she used a computer in her job the entire time she worked for Respondent. She said her job involved typing, estimating she would spend 75 percent of her day doing data entry during the last five years she was working. She felt that would have been true the entire time she worked for Respondent. She said she worked from 8 a.m. to 4:30 p.m., with two 15 minute breaks and an hour lunch break. Petitioner described her work station as having a computer and a keyboard on top of the desk as well as a telephone on her left.

Petitioner said she reported her injury to her supervisor, Mike Lesko, on October 25, 2013 as she had been having trouble with her hand and elbow and had constant tingling and numbness in her right hand and wrist as well as sharp pain in her wrist area. She said she had sharp pain in her left elbow which traveled up her arm. She noted that Mr. Lesko was present at the arbitration hearing.

Petitioner said the City talked to her and they took steps to correct her work area, purchasing a new chair and hand rest and adjusted her computer and keyboard. Prior to that change she said she typed down onto the desk, and they then made adjustments to the keyboard. She said she would rest her elbows on her desk while working if she was on the phone, it was just a habit she had.

When asked if she had previously experienced similar pain she said she had, a few years earlier, seen a doctor and was told it could be carpal tunnel. He had her take Ibuprofen and rest her hands when possible as well as gave her a wrist band which she used for a while. She said she wore it basically at night so she wouldn't reinjure it while sleeping. She said the pain occasionally woke her up.

Petitioner said she received medical treatment from Dr. Berry who tested her and told her she had carpal tunnel. She said she attended an independent medical examination in St. Louis.

Petitioner said that as of the date of arbitration she occasionally had pain in her wrist and elbow, but as for medical treatment she basically took Ibuprofen and wore the band to bed.

On cross examination Petitioner said that in 2006 her primary care physician was Dr. Hingle, and at the time she made complaints and she had her hands and elbows undergo electrodiagnostic testing.

Petitioner said she did not remember complaining to Dr. Hingle in June of 2014 of right elbow pain of a month duration on the posterior of her right elbow and shooting up and down, though if the doctor's records reflected that they could be accurate. She said that in August of 2013 she again complained to Dr. Hingle of wrist pain, worse on the left than the right. She said she had pain in both her hand and elbow. She agreed that when she saw Dr. Hingle on August 28, 2013 her complaints were primarily in the left wrist.

After seeing Dr. Berry she was referred to Dr. Mueed for another EMG test. She said when she then returned to see Dr. Berry the next day, October 25, 2013, she was told by that doctor the results of the testing. She said she did not shift her primary complaints from the left hand to the right hand after being told that there was no problem in the left but possibly in the right, saying her problem was always in her right hand and wrist.

She said she did not know who requested the work station inspection, she just knew the safety department made some adjustments. She said it was possible that the adjustments included a new chair for her back, and other adjustments for her neck, hips, legs, but she didn't know for sure. She said they ordered a key tray and a wrist rest.

Petitioner said she did not see Dr. Berry for fourteen months after seeing her on October 25, 2013, and that when she did see her on December 19, 2014 her complaints were in her right hand. She said she eventually had surgery on her right carpal tunnel on July 2, 2015. At that time the doctor also injected her left elbow. By July

17, 2015 she said she was telling Dr. Berry that she was doing very well from a carpal tunnel standpoint, but she did not think the injection to her left elbow helped. She said she stopped receiving any treatment for her carpal tunnel about a month after the surgery, and had not received any treatment to the right carpal tunnel since August of 2015.

Petitioner said she had surgery on her left elbow on December 3, 2015, but she did not know if it was for cubital tunnel syndrome or epicondylitis, all she knew is that it was for nerve damage. She said when seen on December 18, 2015 she had tenderness during her examination, even if the doctor said she did not. She denied telling Dr. Berry that all of her symptoms had resolved, saying it felt a little better than it had been.

Petitioner said she was released from Dr. Berry's care and told to return if she had problems and had not returned to see her in one and three quarter years, since December 18, 2015.

Petitioner said Dr. Berry did not request a job description from her. She said her job did involve some heavy lifting, with supplies that might be delivered on a weekly basis. When asked if that might be five to seven minutes of work she said she did not know. She said the only other tools she might use would be a dolly used to get items on a weekly or monthly basis.

In regards to the actual work she performed she said different divisions of CWLP would send purchase requests to her or her boss, sometimes with a filled out purchase request, sometimes with documentation of what they wanted her to do, sometimes on a purchase request form which could just be converted. Some departments would do their own purchasing documentation. Some orders came over the phone. Repeated orders would involve her pulling up a template and only filling in certain portions of the purchase order, while others could just be converted from what was sent to her. She did not make every document from scratch. Whether she entered just a few keystrokes of information or numerous keystrokes varied.

Other work she performed involved getting prices for items, which was through phone enquiries and checking the computer for the best deals. She said some of her work was therefore reading.

She said it might be fair to say that approximately 25 percent of her time was spent actually inputting data on the computer.

On redirect examination Petitioner testified she was right handed. She said the supplies she transported were office supplies, paper, boxes of shoes. When asked how many purchase orders she would complete, on average, she said sometimes she did ten to twenty, it varied, as her boss would keep some and do them himself.

She said that Dr. Hingle did not order a work station evaluation in 2007.

Medical evidence:

Petitioner was seen by her primary care provider, Dr. Hingle, on June 7, 2006, complaining of a three month history of wrist pain. Dr. Hingle felt it was likely caused by tendonitis but ordered an EMG/NCV to check for carpal tunnel syndrome, even though Petitioner had negative Tinel and Phalen's tests. That testing was performed by Dr. Acharya on June 29, 2007. He found moderate left ulnar neuropathy but no evidence of carpal tunnel syndrome. (RX #3; RX #4)

Petitioner saw Dr. Hingle on June 14, 2014 complaining of right elbow pain of a month duration with no numbness or tingling. She did tell the doctor that she did computer work most of the day and was advised to modify her work environment. When next seen by Dr. Hingle on August 28, 2013 Petitioner was complaining of wrist pain which was worse on the left, which had been going on for a month. She told the doctor she did quite a bit of computer work but did not rest her hands on the keyboard or her elbows on the desk. (RX #2) Petitioner testified, however, that she did in fact rest her elbows on the desk.

Dr. Berry testified via deposition. She is a board certified plastic surgeon. She first saw Petitioner on October 9, 2013 when Petitioner had tenderness in the left ulnar nerve. She said Petitioner had a lot of pain throughout multiple areas, that it was hard to localize the source of the pain. She ordered an EMG as well as an ergonomic study of Petitioner's work station, saying she did that when people spend a lot of time on the computer. She said she did not recall Petitioner telling her how much time she was spending on the computer, nor did she recall speaking to Petitioner about her job duties at all at that appointment, saying "It was more of a

let's make sure your work environment is well-positioned so you don't have extra compression on your nerves." (PX #4 p.6,8,9,10,12,13)

Dr. Berry said the EMG was performed by Dr. Mueed on October 24, 2013and it was positive for moderate right carpal tunnel syndrome and ulnar nerve bilaterally, mild in the right and moderate on the left. She said Petitioner's symptoms on October 9, 2013 were consistent with somebody who had carpal tunnel and cubital tunnel syndrome. She testified she did not feel Petitioner was exaggerating her symptoms while she was treating her, though she had more diffuse symptoms than she would expect. She said when she saw Petitioner on October 25, 2013 she explained the EMG findings, telling her she had right carpal tunnel and left cubital tunnel. She recommended surgery but it was not performed immediately as Petitioner wanted to check with her employer to see if she could get approval. (PX #4 p.17-19)

Dr. Berry reviewed the ergonomic study she had requested and said the one thing they did for her hands was to add a tray for her keyboard, saying that she may have been hyperextending and a tray would put her hands in a more neutral position. (PX #4 p.20,21)

When next seen eleven months later, on September 19, 2014, Petitioner continued to have diffuse pain which was difficult to pinpoint, and she said she did not like to do surgeries that will not help people. She therefore did a steroid injection of the carpal tunnel to see if she could pinpoint the pain. Petitioner said it relieved symptoms for about three weeks. She said relief could last for years or for three weeks, it was very unpredictable. (PX #4 p.23,26,27)

Right carpal tunnel surgery was performed on July 2, 2015. Dr. Berry said she also injected the right cubital tunnel at that time. She said it was the typical carpal tunnel with no complications. She saw Petitioner in followup on August 12, 2015 and the carpal tunnel was improving but she was then complaining of epicondyle pain, so she suggested a denervation of the left epicondyle, which was performed on December 3, 2015. She saw Petitioner next on December 18, 2015 at which time Petitioner reported no symptoms from the right carpal tunnel or the left cubital. (PX #4 p. 27-31)

Dr. Berry was asked a hypothetical question of whether Petitioner's working doing data entry for approximately 37 years could cause or aggravate the symptoms of carpal and cubital tunnel. Respondent objected to this question as not having sufficient information with which an opinion could be given within a reasonable degree of medical certainty. Dr. Berry felt the work could aggravate the symptoms of carpal tunnel depending on the positioning of the wrist keyboarding . In regards to the cubital tunnel she said that was less predictable as to what could cause the compression of the nerve, it was hard to say because of the multiple areas of compression. She said she could not tell it what its causation was, and that as to aggravation it was a "maybe, just maybe." (PX #4 p.32-35)

Dr. Berry noted that she actually never treated Petitioner's cubital tunnel and was not sure where that would lead in the future. (PX #4 p.36)

On cross-examination Dr. Berry agreed that aggravations could be temporary or permanent, and she did not know if typing changed Petitioner's condition or just caused it to be temporarily symptomatic. (PX #4 p.37,38)

Dr. Berry said she never decompressed Petitioner's ulnar nerve at the cubital tunnel, she never looked at it, in fact, as she treated a different problem in the elbow, which had been diagnosed much later in her treatment, epicondylitis, tennis elbow. Dr. Berry further testified that she had no knowledge as to whether or not Petitioner's work caused her epicondylitis. (PX #4 p.38)

Dr. Berry agreed that Petitioner's hand complaints were initially worse on the left than the right, that the EMG showed there was very little going on in the left hand, but that the right had mild carpal tunnel, and that Petitioner's complaints on the left reduced following the EMG while the right hand, which had been less symptomatic, had increased complaints after she was told the EMG showed more involvement on that side. (PX #4 p.40,41)

Dr. Berry agreed pain was subjective, that tenderness was the voicing of pain on palpation and that during her first exam on October 9, 2013 Petitioner had complained of subjective tenderness of the left ulnar nerve and left hand and wrist which was not focal, which made it difficult to tell which nerve it might be coming from. That generalized tenderness made other tests for carpal tunnel difficult to assess, as "even minor pressure of her wrist was causing pain," that she would wince in pain when even touched lightly. Initially Dr. Berry stated that

Petitioner's subjective manifestations were not in excess of her objective findings, but when reminded that EMG testing was then done which showed very minimal problems over the left wrist, she again noted that she could hardly touch Petitioner without her wincing in pain, she admitted that was excessive. She admitted that Petitioner's wincing was on the side with normal test results. (PX #4 p.41-44)

Dr. Berry agreed that while she had testified that Petitioner had bilateral cubital tunnel per EMG testing, a review of the testing numbers showed her to have a velocity of 52 and that anything greater than a 51 was normal, so Petitioner did not in fact have right cubital tunnel syndrome. She agreed that the only abnormalities seen on the EMG were highlighted on the test were right carpal tunnel and left cubital tunnel. She also agreed that her own records for October 25, 2013 indicate that she changed her diagnosis to only cubital tunnel on the left and carpal tunnel on the right. (PX #4 p.44,46)

Dr. Berry agreed that no medical study in the preceding ten years had linked keyboarding to the development or aggravation of carpal tunnel syndrome, that keyboarding had not been linked to that condition in the last ten to fifteen years, that studies during that period of time had all repudiated prior studies to the contrary. (PX #4 p.48,49)

Dr. Berry said that the ergonomic report of January 16, 2014 made recommendations for her back and how to sit, how far away her monitor should be, keeping her feet flat, spine straight, shoulders back and head and shoulders aligned as well as recommendations for the alignment of her hips and knees. The only recommendation in regards to the keyboard was having a keyboard tray installed. She agreed the report did not talk about whether or not the workstation was horrific, bad or mediocre, or that would indicate hyperflexion or hyperextension of over 20 degrees. She said she could not say whether the recommendation meant it was in excess of 20 degrees, and while she would bet that it was, that would absolutely be just guessing or speculation on her part. (PX #4 p.51-54)

Dr. Berry said that when she saw Petitioner on December 19, 2014, after a fourteen month absence, Petitioner was complaining of non-specific symptoms in her left arm which were not consistent with cubital tunnel, and her symptoms did not match the EMG/NCV or her objective physical examination findings. In regards to the left hand complaints on that date Dr. Berry said, "I think they were so vague and so diffuse that we didn't really record exactly what she was complaining about." (PX #4 p. 54,55)

Dr. Berry said her next office notes, for May 13, 2015, state, "continued non-specific complaints of pain over her right volar wrist as well as numbness in her long finger." She also had negative Tinel and Phalen tests on that date meaning the median nerve was not irritated with palpation. Petitioner was also making a new type of left elbow pain complaint on that date, which was not one of a nerve distribution but more of an elbow pain issue. (PX #4 p.56-59)

In regards to the carpal tunnel surgery she performed on Petitioner, Dr. Berry agreed there was no description of an actual constriction of the nerve by the ligament or of an hourglass appearance. She said if she had seen such a constriction she would have noted that in her operative report. She agreed that there was no actual physical evidence of a constriction of the nerve when she actually looked at it. (PX #4 p.59,60)

In regards to the injection of the left elbow performed during the right carpal tunnel surgery, Dr. Berry said Petitioner told her during an office visit following the injection that the left elbow was doing worse since the injection, which Dr. Berry agreed did not make a lot of sense, as she would have expected either no reaction to it or improvement, as the injection contained a steroid and a painkiller which should have dulled the area causing the person's pain to improve. She said Petitioner did not have a normal response. She also noted that this injection was not for a nerve, but to a different location where a tendon inserts into the bone, as it was not for cubital tunnel but instead was for the epicondylitis. She said Petitioner's numbness and tingling in the elbow was from the epicondylitis. (PX #4 p.60-62)

She said the surgery she did on December 3, 2015 for the epicondylitis involved taking a small nerve and disconnecting it so it did not get the pain sensation. She said it was not the ulnar nerve they did this to, and that the disconnection of the nerve did not cause any functional problem. (PX #4 p.62-64)

Dr. Berry said that post-operatively Petitioner's left elbow physical examination was basically normal with a full range of motion and no tenderness on compression, and Petitioner told her she was doing great, she was a happy patient. Dr. Berry did not anticipate any functional disability caused by either of her surgeries. She noted

that she had never performed grip testing on Petitioner's hands and did not know if she had any abnormality in that regard. She said carpal tunnel syndrome which is serious or of long duration will cause demyelination with atrophying of the intrinsic muscles of the hand, and Petitioner had no such atrophy. She agreed her records did not include any description of Petitioner's work, she had never reviewed a job description for Petitioner and she had no idea how much time Petitioner did of any task. (PX #3 p.64-66)

Dr. Berry said the cause of most carpal tunnel syndromes is idiopathic, of unknown origin, that the vast majority of the eight to ten she sees every day are idiopathic. She agreed there were other risk factors for carpal tunnel syndrome including Vitamin D deficiency, being overweight, being a female and being a smoker. She said Petitioner was a long time smoker and that could cause or aggravate her carpal tunnel. She said leaning on tables could cause or aggravate some carpal and cubital tunnels. She did not know how long Petitioner typed during her workday, how long she looked at things on computer screens, how long she was on the phone or talking to fellow employees, how long she was standing or walking, how long her breaks were, etc.. She said Petitioner did not describe any heavy gripping activities at work to her, any tools she had to use, any heavy objects she was required to move or any repetitive actions such as on an assembly line. Dr. Berry agreed that all of those things have an effect upon the development or non-development and aggravation or non-aggravation of carpal and cubital tunnel. (PX #4 p.66-71)

Dr. Berry said she could not within a reasonable degree of medical certainty say what caused or aggravated Petitioner's carpal tunnel. (PX #4 p. 70)

Dr. Rotman also testified by deposition. He testified he is a board certified orthopedic surgeon with added certification of qualifications in hand surgery. He examined Petitioner at the request of Respondent on March 10, 2014 after first reviewing all of the medical records supplied. He said the examination itself would usually take no more than 15 minutes, which is about twice as long as a patient who is being treated as he has to go over work activities with more detail. He said a history from Petitioner which included her hand and elbow complaints and her work as a Buyer 2 for Respondent, as well as what treatment she had undergone so far. He went over the ergonomic report and recommendations with her and found that the changes had already been made two to three months earlier, but had not had any effect in her condition. He said that was significant as it meant her workstation had nothing to do with her complaints. He said Petitioner advised him she did data entry at least five hours per day. (RX #1 p.5-12)

He found several medical records significant, including the October 2013 EMG which showed the left carpal tunnel and the right cubital tunnel to be normal, minor slowing at the left cubital tunnel and mild changes at the right carpal tunnel. (RX #1 p.12,13)

During his physical examination he had difficulty because Petitioner said she woke up with her fingers on fire, so it was difficult to determine what he could do to make her fingers worse since she already felt they were on fire. He said that and most of her complaints were quite unusual. He said she had magnified complaints of pain when he examined her elbows, when he just touched her skin she had significant discomfort, which suggests magnification as there was nothing wrong with her skin, no swelling, no rashes, no fractures. He said the very minor abnormalities on the left (and normal on the right) would have no effect on the skin, you would have to compress the nerve pretty hard to get any discomfort. (RX #1 p.14,15)

Dr. Rotman said he could evaluate the left nerve despite the fact that she would not allow him to touch the nerves, but he could tell there was no subluxation of the nerves, elbow flexion and extension of the elbow did not cause the nerves to pop out of their grooves. His said the elbow flexion test was the best exam for cubital tunnel, it was negative on the right but on the left it caused her entire hand to become numb and painful. He said that was not an expected response for cubital tunnel, pain would generally just go into the small finger and a bit into the ring finger, it would not cause pain in the hand. (RX #1 p.15-17)

Dr. Rotman said there was no physiologic reason for her thumb CMC joint test results. that she had such discomfort he ordered x-rays which were normal. (RX #1 p.17)

Dr. Rotman said wrist extension and flexion testing was performed to test for epicondylitis. He said resisted wrist flexion on the left caused Petitioner to have pain on the top of the wrist, and that there was no physiologic reason for that finding. He said he tested her grip and she gave absolutely no effort. He said on the right she got

a 5 on the first setting and a 0 on every other setting. Even with the worst looking hands you would get more than a zero, and she had normal looking hands with no atrophy, and full motion. With full musculature and the full ability to make a fist Petitioner should have been able to generate more than zero on grip strength testing. (RX #1 p.17-20)

Dr. Rotman said he reviewed a job description for Petitioner's job, saying it involved no heavy gripping, heavy tool use and vibration, it was desk duty. He said it might be repetitive in that it had grasping and fingering 80 percent of the time, but it was all computer work. (RX #1 p.21)

After reviewing all of the above information Dr. Rotman said that based on Petitioner's objective physical examination findings and test results, her lack of effort, nonphysiological responses and magnified pain complaints, Petitioner had a diagnosis of mild left cubital tunnel and mild right carpal tunnel. (RX #1 p.22)

As for treatment, he felt she should avoid hyperflexion of the left elbow as well as avoiding leaning on the inner elbows, possible use of a Heelbo pad and/or elbow brace at night to keep the arm straight. As for the right carpal tunnel he recommended splinting or a steroid injection, specifically not recommending surgery, which could be done later, as he was very hesitant to recommend a surgical procedure on someone like this. (RX #1 p.23)

Dr. Rotman did not think Petitioner's work as a Buyer 2 caused or aggravated either of the two diagnosed conditions, saying her work had no risk factors for carpal tunnel as there was no heavy grip forces involved, no vibratory tool use, and while the work was repetitive, the forces involved were light, and that repetition without heavy forces is not a risk factor for an aggravation of an idiopathic carpal tunnel condition. He noted that keyboard use is not a risk factor for carpal tunnel, that there was no higher incidence of carpal tunnel in keyboard users than non-keyboard users. He said that while earlier studies thought there was such a link, since 2000 medical opinion had changed based on better studies which showed no higher incidence in keyboard users than the general population. He knew of no study since 2000 indicating a link between keyboarding and carpal or cubital tunnel. (RX #1 p.23-25)

Dr. Rotman stated that the cause of carpal tunnel is unknown, idiopathic, and that cubital tunnel is aggravated by leaning on the inner elbows, a direct blow to the inner elbows, an elbow fracture, repetitive elbow flexion or holding the elbows past 90 degrees for a prolonged period of time or sleeping in a fetal position with the elbows hyperflexed. (RX #1 p.27)

On cross-examination Dr. Rotman said his exam was from the neck to the fingertips, describing what was done during that exam. He said that the test he normally performed but was unable to perform on Petitioner was palpation of the inner elbows, because of pain to palpation and complaint of fingers being on fire. He said he was otherwise able to complete a full exam.(RX #1 p.29)

Dr. Rotman said he would expect improvement in an individual right away after ergonomic changes, within days. (RX #1 p.30)

Dr. Rotman testified that Petitioner showed him how she held her hands at her workstation. When asked if Petitioner's holding her hands at 10 to 20 degrees of flexion would aggravate carpal tunnel, Dr. Rotman said it would not, that 10 to 20 degrees of flexion is good, that it would require 70 to 80 degrees of hyperflexion. (RX #1 p.33)

Dr. Rotman agreed that from her job description Petitioner could spend over 50 percent of her day typing, but said that level of typing would not cause or aggravate carpal or cubital tunnel, unless, in the case of cubital tunnel, she was typing with her elbows resting on a firm surface or hyperflexed past 90 degrees. (RX #1 p.34,35)

On re-direct examination Dr. Rotman said that as described to him by Petitioner, she was not putting pressure on her elbow at an armrest, and that keyboarding is not normally done with hyperflexion of the elbows past 90 degrees or on hard surfaces. (RX #1 p.37,38)

Accident and Causal Connection:

Petitioner alleges that her job is repetitive and caused her right hand and left elbow injuries. Petitioner's description of her job varied somewhat from direct examination to cross-examination and when speaking with Dr. Berry and Dr. Rotman.

- On direct examination she estimated she would spend 75 percent of her seven working hours each day doing data entry, using a keyboard on top of her desk. On re-direct examination Petitioner said that on average she would sometimes do ten to twenty purchase orders in a day.
- On cross-examination she said some of the people who sent her purchase requests would have filled out the form and she would just have to convert it, that some departments would do their own purchasing documentation, while repeated orders would require her to simply pull up a template and fill in certain portions of the purchase order. She agreed that she did not have to make every document from scratch and might just enter a few keystrokes. She testified that it might be fair to say that approximately 25 percent of her time was spent actually inputting data on the computer, that the rest of her time was spent getting prices on items, making phone enquiries and checking the computer for the best deals.
- Petitioner did not describe her work in any detail to Dr. Berry, who said she did not recall speaking to Petitioner about her job duties at all. The hypothetical question asked of Dr. Berry described Petitioner's work simply as doing data entry for approximately 37 years, with no detail as to amount of time actually using the keyboard doing that data entry.
- Dr. Rotman said he took a history from Petitioner of her work and that she just attributed her complaints to repetitive work. Dr. Rotman was the only witness who examined a job description for Petitioner's job. He said the work involved no heavy gripping, no heavy tool use and no vibratory tools, it was desk work. He said it might be repetitive with fingering 80 percent of the time, but it was all computer work. Petitioner told him she did data input at least five hours per day.

Regardless of which witness's testimony is considered, none of the testimony describes a repetitive job. While Petitioner initially testified to doing data entry 75 percent of the time, on cross-examination she agreed that it would be fair to characterize her work as actually doing data input 25 percent of the time, and performing other non-hand intensive work such as getting prices, making phone enquiries and checking the computer for the best deals as the remainder of her work. The number of purchase orders she normally processed in a day is also not high, between ten and twenty, and on cross-examination she agreed that some were sent to her already prepared and only needed to be converted and that others were repeat orders which only required her to pull up a template and make changes with only a few keystrokes.

Petitioner's complaints have changed over time and, seemingly, based upon her being advised where tests indicate there is and is not an indication of injury. When seen by Dr. Hingle on June 14, 2013, Petitioner was complaining of right elbow pain on a month duration with no numbness or tingling. No mention was made of hand or wrist pain.

When seen by Dr. Hingle on August 28, 2013 Petitioner was complaining of wrist pain which was worse on the left, which had been going on for a month. She also testified that she did not rest her hands on the keyboard or her elbows on the desk, but she testified at arbitration that she in fact did rest her elbows on the desk.

When she first saw Dr. Berry on October 9, 2013, Petitioner complained of hand complaints intitially which were worse on the left than the right.

An EMG ws performed by Dr. Mueed on October 24, 2013. It did not indicate anything being wrong in the left wrist, the side Petitioner had initially claimed was worse, or in the right elbow, but did find mild carpal tunnel in the right wrist. Dr. Berry advised Petitioner that the test did not indicate carpal tunnel on the left but instead found it on the right, and showed mild cubital tunnel on the left.

Dr. Berry testified that after advising Petitioner of the results of the testing Petitioner had increased complaints in the right hand. No left carpal tunnel complaints are contained in the medical records following the negative EMG testing for that condition.

On cross-examination Petitioner agreed that she told Dr. Hingle in August of 2013 of wrist pain which was worse on the left than the right, that her complaints on August 28, 2013 were primarily in her left wrist. She said she did meet with Dr. Berry the day after Dr. Mueed's testing and was told of the tests. She denied her primary complaints then shifted from the left hand to the right hand, saying her problem had always been in her right hand and wrist. That statement is contradicted by Dr. Hingle's records, Dr. Berry's testimony, and even earlier portions of Petitioner's testimony.

In regards to Petitioner's left elbow, Petitioner's statements to Dr. Hingle that she did not rest her elbows on her desk is contradicted by Petitioner's testimony at arbitration that she indeed did rest her elbows on her desk.

Dr. Berry testified that she did not receive a description of her work from Petitioner. On cross-examination she admitted she did not know how long Petitioner typed during her workday, how long she looked at things on computer screens, how long she was on the phone or talking to fell employees, etc.. She was asked a hypothetical question as to whether Petitioner's doing data entry for approximately 37 years could cause or aggravate carpal or cubital tunnel. Her opinion that it could aggravate the symptoms of carpal tunnel was dependent on the position of the wrist while keyboarding. She acknowledged that the report from the ergonomic study she ordered did not indicate whether the workstation was horrific, bad or mediocre, or whether it indicated hyperflexion of hyperextension of over 20 degrees. While she said she would "bet" that it was, she said that would be just guessing or speculation. A claimant has the burden of proving all the elements of his case in order to recover benefits. Liability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence. A.M.T.C. of Illinois, Inc. v. Industrial Commission, 77 Ill. 2d 482, 488, 34 Ill. Dec. 132, 397 N.E.2d 804 (1979).

While Dr. Berry did eventually perform surgery on the right carpal tunnel, during that surgery she did not see any evidence of compression, noting that there was no mention of it in the operative report, and that if she had seen compression she would have included it in her report.

Dr. Berry's testimony in regards to the cubital tunnel was even less persuasive. She testified that compression of the nerve there was less predictable as to what could cause the compression of the nerve because of the multiple areas of compression. She said she could not determine what the causation was, and that in regards to aggravation it was a "maybe, just maybe." She also testified that she never actually treated the cubital tunnel. The surgery she performed to the left elbow on December 3, 2015 was actually for epicondylitis, which she said was the cause of Petitioner's numbness and tingling in the elbow, and that she had no knowledge as to whether or not Petitioner's work caused her epicondylitis.

Dr. Berry at the very end of her testimony clearly stated that she could not within a reasonable degree of medical certainty say what caused or aggravated Petitioner's carpal tunnel.

The testimony of Dr. Rotman also found no causal connection to either carpal tunnel or cubital tunnel. He noted that while Petitioner's work was repetitive, the forces involved were light, and that repetition without heavy forces is not a risk factor for an aggravation of an idiopathic carpal tunnel condition. He noted that keyboard use is not a risk factor for carpal tunnel, that there was no higher incidence of carpal tunnel in keyboard users than non-keyboard users. He said that while earlier studies thought there was such a link, since 2000 medical opinion had changed based on better studies which showed no higher incidence in keyboard users than the general population. He knew of no study since 2000 indicating a link between keyboarding and carpal or cubital tunnel. Dr. Berry on cross-examination agreed that no study in the past ten to fifteen years had shown a link between keyboarding and carpal tunnel syndrome.

Both Dr. Berry and Dr. Rotman described unusual, nonphysiologic findings of Petitioner during physical examinations. Both found her to wince and complain of extreme pain when the physicians would merely touch the skin, a finding with no known physiologic cause. Dr. Rotman also found her grip test results nonphysiologic, while Dr. Berry did not perform such testing. Dr. Rotman described Petitioner's complaints as being quite unusual, that she had magnified complaints of pain when he examined her elbows, suggesting magnification.

The Arbitrator finds that Petitioner has failed to prove that she suffered an accident which arose out of or in the course of her work for Respondent on October 25, 2013 and has failed to prove a causal connection between any hand or arm injury as a result of said alleged accident based on the testimony of Petitioner, Dr. Berry and Dr. Rotman, the limited history of job duties to Dr. Berry, the changing description of job duties at arbitration, the changing complaints following the explanation of EMG testing performed by Dr. Mueed, the unusual, nonphysiologic complaints during physicians' examinations, the non-treatment of left cubital tunnel syndrome by Dr. Berry as well as Dr. Berry's testimony that Petitioner's elbow numbness and tingling were instead caused by epicondylitis as opposed to cubital tunnel syndrome, Dr. Berry's testimony that she could not testify within a reasonable degree of medical certainty what caused or aggravated Petitioner's carpal tunnel and did not know the cause of Petitioner's epicondylitis, and Dr. Rotman's testimony that Petitioner's work did not cause or aggravate Petitioner's carpal or cubital tunnel syndromes.

Compensation is therefore denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Misek, Jr.

Petitioner,

vs.

NO: 12WC010861

Illinois Tollway Authority,

18IWCC0675

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(s) of accident, occupational disease, permanent disability, causal connection, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 2018 is hereby affirmed and adopted.

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

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

18IWCC0675

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 5 - 2018
SJM/sj
o-10/25/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MISEK JR, JOHN
Employee/Petitioner

Case# **12WC010861**

ILLINOIS TOLLWAY AUTHORITY
Employer/Respondent

18IWCC0675

On 3/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

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

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

John Misek, Jr.
Employee/Petitioner

v.

Illinois Tollway Authority
Employer/Respondent

Case # 12 WC 10861

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Waukegan**, on **1/26/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **03/07/2012**, 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 **$71,000**; the average weekly wage was **$1,365.38**.

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

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

ORDER

Medical benefits

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related condition as provided in Sections 8 and 8.2 of the Act.

Permanent Partial Disability: Schedule Hearing Loss

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 79 weeks, because the injuries sustained caused the 33% loss of hearing in the right ear and 46% loss of hearing in the left ear, as provided in Section 7 of the Occupational Disease Act.

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

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

Carolyn M. Wheeby

Signature of Arbitrator

3/14/18

Date

MAR 16 2018

FINDINGS OF FACT

By way of procedural history, the Arbitrator initially notes that the instant matter of Misek v Illinois Tollway Authority 12 WC 10861 and the separate matter of Hayden v Illinois Tollway Authority 12 WC 7522 were initially treated in tandem without formal consolidation by a prior Arbitrator. This procedure explains the multiple references on the trial exhibits to both Petitioners. However, only the matter of Misek v. Illinois Tollway Authority 12 WC 10861 was presented for trial before this Arbitrator on January 26, 2018 to which the following Decision applies. The matter of Hayden v Illinois Tollway Authority 12 WC 7522 was voluntarily dismissed before this Arbitrator on January 26, 2018 and did not proceed to trial. The Arbitrator further notes that the instant matter of Misek v. Illinois Tollway Authority 12 WC 10861 was filed under the Illinois Occupational Disease Act per the Application for Adjustment of Claim at ARB EX 2.

Petitioner, John Misek, testified before the Arbitrator at trial on 1/26/18 as well as by evidence deposition taken on 9/17/14. PX 5. At his evidence deposition, Petitioner testified that he was employed by Respondent for 32 years and that his job title was "equipment operator/laborer." P. 5. On March 7, 2012, Petitioner presented to the Aurora Burlington clinic to have his hearing examined due to his perceived loss of hearing ability. P. 5. Petitioner was asked when he started to perceive hearing loss prior to March 7, 2012 and he answered, "an easy ten years." P. 5. He stated that he did not "go for" a hearing test prior to March 2012. On March 20, 2012, Petitioner reported to his supervisor that he believed that his hearing loss was related to his job at the tollway. Petitioner completed a report indicating that his hearing loss was due to the years spent working with equipment at the tollway. P. 6-7.

Specifically, Petitioner testified that he worked 17 years in Garage M4 and 15 years at Garage M5 and was exposed to the same equipment and noises as described in the deposition of Mr. Hayden at PX 6. Namely, Petitioner Misek was exposed to "noisy" equipment including older snow plow trucks with hydraulics inside the cab which caused a constant "whine", plow blade noise, loud radio, constant and chronic traffic noise heard through open truck windows and while performing roadway repair or lawn maintenance with weed wackers, chain saws and air hammers. PX 5, 6. Petitioner testified that he was also required to perform sand blasting inside of a salt dome increasing the associated noise due to working inside. While working inside the garages, Petitioner was exposed to air compressors and loud speakers without volume control. PX 5.

Petitioner further testified that ear protection was "not routinely made available until more recently at the tollway" and that "in the earlier years, they were available but not always left out. I had to compensate. A lot of times I would forget them, if they did have them. I would forget them, but I was a smoker. I would take cigarette butts and jam them in my ears so I could keep working. It sounds crazy but it worked and the earplugs that you did get back then they were so hard and brittle you'd put them in your ears and they would fall out. ..." PX 5. P. 14. He further testified that the available plugs were many times locked in the parts cage and not accessible. During his first 20 years of employment he used hearing protection "more often than not" but they kept falling out and would work but "not for long." PX 5, p. 15. Petitioner testified that he did not wear ear protection while driving a snow plow truck so that he could hear the radio dispatch. PX 5, p. 16-17.

Petitioner testified that he had a hearing exam approximately 10 years prior to March 7, 2012 but could not remember where he had the test or the results. PX 5, p. 19. Petitioner agreed with the job description contained in the Noise Study report at RX 1 and the description of the equipment he used as a tollway maintenance worker. He further agreed that his 8 hour work day included one 30 minute and two 15 minute breaks and that he was not always operating equipment during the remaining 7 hours of his shift. He further agreed that Respondent provides ear protection to maintenance workers including disposable ear plugs and ear muffs. However, Petitioner testified that the ear muffs were hard to get but that ear plugs were available. He testified

that in the "early days" the ear protection had to be requested from parts but now the ear protection is "left out" and he routinely uses the available ear protection. Lastly, Petitioner testified that the equipment he used during his first 20 years of employment when ear protection was harder to procure was much louder than the equipment he used over the last 10 years he worked for Respondent. PX 5, p. 32-33.

Scott Kapton testified via evidence deposition that he has been employed by the Tollway for 29 years and is currently the Roadway Maintenance Manager. He testified that before that, he worked as a Roadway Maintenance Equipment Operator Laborer – commonly referred to as a Maintenance Workers – same position that Petitioner held (Pet. Ex. 7, Res. Ex. 3, p. 5, 6). He testified Petitioner's job title on February 15, 2012, was Roadway Maintenance Equipment Operator – commonly referred to as Maintenance Workers. He testified he was familiar with the job duties of this position as it existed in March of 2012 (Pet. Ex. 7, Res. Ex. 3, p. 7). Mr. Kapton identified Respondent's Exhibit 2 as a true and accurate copy of the job description of Equipment Operator/Laborer for Illinois Tollway. He testified it accurately depicted the job duties of a Maintenance Worker when he became Supervisor, when he first became District Supervisor, when he first became Assistant Supervisor, and when he worked as a Maintenance Worker from 1985 to 1992. He testified the job description has not changed. (Pet. Ex. 7 and Res. Ex. 3, p. 8, 9).

Mr. Kapton testified that the foam earplugs have always been available by request in the same way as hard hats, safety glasses, gloves and rain gear. He agreed with Petitioner that the foam ear plugs were not just "left out" and had to be requested. PX 7, p. 14. He testified that Petitioner never complained to him about any alleged hearing loss and that prior to the alleged manifestation date in 2012, he was not aware of complaints made by Petitioner to anyone else in the work force pertaining to alleged hearing problems (Pet. Ex. 7, Res. Ex. 3, p. 18).

Mr. Kapton reviewed Table 7 on page 10 of the Noise Study (Res. Ex. 1) and testified that the left-hand column listed equipment and that the next two columns listed 20 NRR and 33 NRR respectively. He explained that NRR refers to Noise Reduction Ratings (Pet. Ex. 7, Res. Ex. 3, p. 18, 19). On page 8 of the Noise Study (Res. Ex. 1) and testified that of the six different types of possible hearing protection types that were listed only the first two disposable foam ear plugs were made available to Maintenance Workers for the last 29 years. Pet. Ex. 7, Res. Ex. 3, p. 19). He then testified that the high end exposure for disposable ear plugs on Table 6 is 33 NRR (Pet. Ex. 7, Res. Ex. 3, p. 19, 20). He also testified that ear muffs have always been available "intermittently" and to some degree depending on the job and that the high end exposure for ear muffs on the chart was 30 NRR (Pet. Ex. 7, Res. Ex. 3, p. 19, 20).

Referring back to Table 7, Mr. Kapton was asked "So taking, for instance, the top one, loader, what is your understanding of the allowable time someone could work without damage using an ear plug that has a 32 noise reduction rating?" He testified, "They can operate that loader safely for 24 hours plus continuously" (Res. Ex. 3, p. 20). Mr. Kapton then testified that he agreed with the statement that all of the equipment listed on page 10 of Respondent's Exhibit 1 shows a 24+ hour allowable time quotient for the 33 Noise Reduction type of hearing protection device (Pet. Ex. 7, Res. Ex. 3, p. 20, 21). In other words, Petitioner could operate that equipment safely for more than 24 hours plus continuously while wearing disposable ear plug hearing protection.

As noted above, Mr. Kapton also identified Respondent's Exhibit 1 as the Tollway Noise Study Report that was completed by Huff & Huff. This report presents the methods used, associated testing details, and resultant findings from four days of screening Illinois State Toll Highway Authority workers and equipment for noise exposure and noise levels. This study estimated the typical noise exposure for maintenance workers during a typical day. It also analyzed the noise exposure associated with various pieces of equipment potentially used during a maintenance worker day (Res. Ex., p. 1).

The Noise Study report indicates that Huff & Huff, Inc. conducted noise dosimeter monitoring to evaluate noise level exposure during the typical 8-hour work day of maintenance workers over a four-day period. According to the study, two approaches were used to measure the potential noise exposure of maintenance workers, "as they have highly variable work days, comprised of activities that change season-by-season and even day-to-day." One methodology was to fix a maintenance worker with a dosimeter, while he completed work as regularly scheduled. The second methodology monitored maintenance workers using various pieces of equipment that may be used during any typical day, but not usually all utilized in a single day. Noise levels were monitored for each pieces of equipment until stead state noise levels were reached to estimate the typical noise exposure form each piece of equipment. The data were then used to determine workers' exposure levels and establish acceptable time limits for various activities, if applicable (Res. Ex. 1, p. 1).

On page 5 of the Huff & Huff report under Section 3.2 Maintenance Worker Monitoring Methodology, the report explains that for this monitoring study, the dosimeter was placed in the employee's hearing zone. Specifically, because of time spent driving with the driver's window open, the dosimeter was placed on the worker's left shoulder, near the ear. The maintenance worker wore the dosimeter throughout the work day while completing activities as normally scheduled. Eleven different activities are listed on page 5 of the report (Res. Ex. 1). Both Petitioner (Pet. Ex. 5, p. 25) and Scott Kapton (Res. Ex. 3, p. 9-11) agreed that this list accurately reflects job tasks that Petitioner would have done as a maintenance worker at the Tollway. However, Petitioner testified that other tasks he performed were not listed such as snowplowing, tollway drain and guardrail/fence repair, weed scraping. He further testified that when using the jackhammer and post-pounder he did so for more than one half hour per day. He testified that at times he would use the sandblaster for hours and saw concrete using a quick saw for several hours per day. Lastly, he confirmed that he used cigarette butts in his ears because the ear protection was not available to him. PX 5, pp. 30-32.

Page 5, table 4 of the Noise Study report indicates that the dosimeter placed on the maintenance worker did not record measurements that "exceeded a 50% dosing of 8 hour 80 dBA threshold for hearing conservation or the 100% dosage for the 8-hour 90 dBA threshold for engineering controls/personal protective equipment" (Res. Ex. 1).

Page 6 and 7 of RX 1 summarizes equipment noise measurements for various pieces of equipment that are potentially used by a maintenance worker during a typical work day. Both Petitioner and Mr. Kapton testified that the name of the equipment on the bottom axis of Chart 1 or Chart 2 (p. 7, 8) accurately reflected the type of equipment that the Petitioner would have come in contact with potentially as a maintenance worker at the Tollway (Pet. Ex. 3, p. 27; Pet. Ex. 7; Res. Ex. 3, p. 13).

Mr. Kapton also testified that Petitioner was paid for eight hours a day including a half hour lunch and two 15-minute breaks. He testified that out of an eight-hour day, seven hours were spent away from lunch and breaks. He testified that Petitioner's job required travel to certain areas of the Tollway and that this travel time would be included in that seven hour part of the work day. (Pet. Ex. 7, Res. Ex. 3, p. 10, 11).

Petitioner's retained expert is Thomas Thunder, an audiologist and acoustical specialist. PX 11. He reviewed Petitioner's audiograms from 2/27/14 and 3/7/12. He also reviewed Petitioner's deposition and the noise study completed in November 2013. Mr. Thunder assessed Petitioner with hearing loss stating that he "has a moderately severe loss in the high frequencies that is a bilateral loss, meaning it affects both ears. Test results show that it's a sensorineural loss meaning it's in the inner ear consistent with exposures due to noise, and it has a pattern and configuration that would be classically related to noise." Petitioner did not have a problem with

the middle ear. PX 11, p. 10. He opined that Petitioner's hearing loss was caused by noise exposure based upon the audiogram results as well as his review of the noise level date in the study.

He understood that in Illinois, the hearing loss must be on average above 30 db to be compensable under the Act. He calculated Petitioner's hearing loss using the mandated parameters under the Act using the 2/27/14 audiogram. PX 3. He determined Petitioner sustained 33% loss of hearing in the right ear and 46% loss in the left ear. After reviewing the noise study, he opined that the report shows numerous pieces of equipment that workers are expected to use that "would all be considered hazardous to hearing." PX 11, p. 15. He points to the report chart 4 page 11 in RX 1 to state that over half of the equipment Petitioner used generated noise levels above 90 db. With regard to excessive exposure he further opined, "... As I mentioned that table, if you're at a source that generates 95 db of noise, you're allowed to be out there for 4 hours; but if you work in the morning on one piece of equipment that generating 95 db of noise where you're allowed to be there for four hours, then the afternoon you work on another piece of equipment that's 95 db for four hours, you have exceeded that 90 db time-weighted average. It's an addition of both of them.... It's cumulative." PX 11, p. 17. In short, increasing the time in that noise increases the exposure. Accordingly, he opined that the "evidence points" to Petitioner being overexposed to permissible state noise levels based on cumulative noise exposure at work. PX 11, p. 18,22.

On cross-exam, Mr. Thunder testified that he did not interview or examine Petitioner and that he did not have a formal job description for Petitioner. He did not review Petitioner's referenced audiogram from 10 years prior to the audiogram of March 2012. He reviewed the noise study from November 2013 but did not reference noise reduction ratings or NRR in his report. He testified that NRR is not applicable in this case. The noise study does reference NRR which the witness dismissed as "a laboratory-devised method under strict laboratory control that has no bearing on the real world performance of hearing protection." He bases his opinion on numerous studies and on his lab experience. He agreed that foam ear plugs had a NRR of 33 on the high end but stated the NRR was misapplied. He also agreed that table 7 on page 10 of the report lists 33 NRR would allow for 24 hours of 100% dosage while wearing hearing protection for all of the equipment listed on the page. Lastly, he testified that the "gold standard" for determining work related hearing loss is to be able to compare multiple hearing loss evaluations done over time, which were not available in this case. PX 11, p. 51.

Respondent's expert Dr. Horwitz, board certified in Otolaryngology, drafted an initial report dated May 23, 2017. He examined Petitioner and reviewed the medical records. He stated that Petitioner advised him that he had bilateral hearing loss for about 10 years and had an audiogram in 2008 and in 2012. Petitioner advised that he worked 33 years for Respondent and retired in 2015. His job involved using a variety of equipment including air hammers, weed whips, hydraulic equipment, and snow plows. He noted "however he did wear ear protection when using air hammers or weed whips." Petitioner also advised he turned up the radio volume while snow plowing and that he wears ear protection while shooting rifles.

In his opinion, Petitioner showed hearing loss of 28.1% in the right ear and 35.6% in the left ear "using the AMA Guide to the Evaluation of Permanent Disability (6th edition)." He opined the loss was not work related in that Petitioner's exposure did not rise to significant levels and was not in violation of OSHA, Petitioner wore ear protection, and his audiogram was not consistent with noise induced hearing loss in his opinion. RX 4. He concluded Petitioner's hearing loss was idiopathic.

Dr. Horwitz reviewed additional records including the noise study dosimeter results and Mr. Thunder's report. He reiterated his opinions above and added that the documents reviewed confirm that Petitioner's noise exposure was kept below the OSHA limitation with ear protection "which he admitted to using with the noisiest pieces of equipment." RX 5. He also again concluded that his hearing at 2000 Hz actually improved slightly

from the 2012 audiogram as evidenced by audiograms done in 2014 and 2017, including the one done in his office.

Mr. Thunder responded to Dr. Horwitz' reports in an email dated 7/1/17. PX 14. He states that OSHA limitations/violations are not the standard but whether the noise exposure exceeded the 90 db time weighted average limit. He stated, "... 14 of the 19 pieces of equipment in the ...report exceeded 90 db. That means working with any one of them in a day would have contributed to their total daily dose. An accumulated does of 100% would be in excess of the State's criterion. For example, working with a jackhammer alone for only ½ hour would have been a dose of 100% all by itself. ... Working with any of the other 13 items for ANY amount of time would have put the total accumulated does above the 100% dose limit."

Mr. Thunder further states that Petitioner's use of hearing protection was not current and that in the 1980s and 1990s he had to request protection which was not readily available or provided. He further stated that the 2012 audiogram is consistent with noise inducted hearing loss. Lastly, he stated that Petitioner's hearing loss due to noise increased most rapidly during the first 10 to 15 years of exposure and the rate of hearing loss then decelerates as the hearing threshold increases. This is in contrast to age related hearing loss which accelerates over time.

CONCLUSIONS OF LAW

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

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "C"(ACCIDENT), AND REGARDING "F"(CAUSAL CONNECTION.) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Based upon the record in its entirety, the Arbitrator finds that Petitioner was exposed to harmful noise levels on a continuous basis over his 32 years of employment for Respondent and that his bilateral hearing loss is causally related to that exposure. In so finding, the Arbitrator notes that the noise study completed November of 2013 identifies numerous pieces of equipment to which Petitioner was frequently exposed that generated noise exposure in excess of 90 decibels. Petitioner confirmed the use of this equipment as did Mr. Kapton. After reviewing the noise study, Thomas Thunder credibly opined that the report shows numerous pieces of equipment that maintenance workers are expected to use that "would all be considered hazardous to hearing." PX 11, p. 15. He points to the report chart 4 page 11 in RX 1 to state that over half of the equipment Petitioner used generated noise levels above 90 db. He specifically notes that some 14 of the 19 pieces of equipment analyzed in Respondent's noise study exceeded the 90 decibel cutoff and that working with any one of them would have contributed to Misek's total 100% daily dose. The Arbitrator concludes that the preponderance of the evidence establishes that Petitioner was exposed to noise levels in excess of 90 decibels during his 32 year career with the Illinois Tollway as an equipment operator/laborer.

The Arbitrator also finds persuasive Mr. Thunder's opinion that Petitioner's exposure to noise levels above 90 db was cumulative and that his hearing loss was causally related to the cumulative exposure. Mr. Thunder testified, "... As I mentioned that table, if you're at a source that generates 95 db of noise, you're allowed to be out there for 4 hours; but if you work in the morning on one piece of equipment that is generating 95 db of noise where you're allowed to be there for four hours, then the afternoon you work on another piece of equipment that's 95 db for four hours, you have exceeded that 90 db time-weighted average. It's an addition of both of them.... It's cumulative." PX 11, p. 17-22.

The Arbitrator is not persuaded by Dr. Horwitz' opinion that Petitioner's exposure was limited because of use of hearing protection as well as by the short time he would likely have been exposed to each particular piece of equipment. As previously stated, based upon the record in its entirety, the Arbitrator finds that Petitioner's exposure was sufficiently cumulative. In addition, the Arbitrator is not persuaded by the argument that Petitioner's use of ear protection brought sound levels to which the claimant was exposed below the statutory threshold for compensability. Specifically, the Arbitrator places greater weight on Petitioner's testimony regarding the unavailability and/or difficulty in obtaining ear protection earlier in his career as illustrated by his further testimony that he used the readily available and more effective cigarette butt for ear protection.

Based on the above, the Arbitrator finds that Petitioner was exposed to harmful and excessive noise levels throughout his 32 year career with Respondent sufficient to cause his bilateral hearing loss under the Act.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "J" (MEDICAL SERVICES), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Based on the Arbitrator's findings on the issues of exposure and causation, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall have credit for amounts paid, if any.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (NATURE AND EXTENT OF THE INJURY), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner sustained bilateral hearing loss as exhibited by audiograms. Using the mandated hearing loss parameters, Mr. Thorton calculated, and the Arbitrator finds, that Petitioner sustained hearing loss of 33% in the right ear and 46% in the left ear per the Illinois Occupational Disease Act. Respondent shall pay Petitioner the maximum ppd rate of $695.78 per week for a total period of 79 weeks as provided in Section 7 of the Occupational Disease 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

Carman Golf,

Petitioner,

vs.

NO: 17WC 14321

City of Chicago,

Respondent.

18IWCC0676

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, 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 19, 2018 is hereby affirmed and adopted.

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

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

18IWCC0676

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 5 - 2018
SJM/sj
o-10/25/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOLF, CARMAN
Employee/Petitioner

Case# **17WC014321**

CITY OF CHICAGO
Employer/Respondent

18IWCC0676

On 4/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
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0113 CITY OF CHICAGO CORP COUNSEL
STEPHANIE LIPMAN
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CHICAGO, IL 60602

18IWCC0676

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

Carman Golf
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # 17 WC 014321

An *Application for Adjustment 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 **January 12, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0676

FINDINGS

On **February 2, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$101,269.86**; the average weekly wage was **$1,947.50**.

On the date of accident, Petitioner was **61** 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 **$32,087.03** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$32,087.03**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,298.33 per week for 29-3/7 weeks, commencing February 13, 2017 through September 7, 2017, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $5,747.74, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner permanent partial disability benefits of $775.18 per week for 55 weeks, because the injuries sustained caused the 11% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from 2/2/2017 through 1/12/2018, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

April 19, 2018
Date

APR 19 2018

FINDINGS OF FACT

Petitioner was employed by Respondent as a hoisting engineer in CDOT (Chicago Department of Transportation), primarily operating an asphalt roller. He has been so employed since April 1, 2014. Petitioner is right handed. In order to operate the asphalt roller, He has to climb up 4 steps and grab bars with both hands to climb onto the roller. He has to fill the roller with water, which requires him to climb down and open a fire hydrant. The steering mechanism on a roller is different than the steering mechanism of a car. Turning a roller requires more steering wheel revolutions than does turning a car. Forward and backward movement of the roller is controlled by a joy stick that requires movement of the entire arm.

Petitioner testified that, on February 2, 2017, he was present at Respondent's yard known as "Bosworth". Bosworth is located under the Kennedy Expressway and is where all the equipment is stored. Only employees of Respondent are allowed in the Bosworth lot. He reports to a trailer at Bosworth each morning, in order to clock in before his work shift. On that date, he arrived at approximately 6:00 a.m. and punched in. The weather was very cold and he was wearing heavy clothes (long underwear and a Carhart). As he exited the trailer, he walked down the stairs with his hands in his pockets. Petitioner identified the stairs as depicted in the photographs entered as Petitioner's Exhibit 3(a), (b) and (c). After descending the steps, he walked a couple of feet and he tripped and fell straight onto his face and was knocked out. Petitioner identified the location of the fall on the pavement, approximately two to three feet from the steps, where there was an indentation in the pavement. He described the condition of the asphalt in that entire area as being damaged, uneven, cracked and out of proportion with a flat surface. The Arbitrator notes that the photographs depict previous attempts to remedy defects in the pavement as shown on Petitioner's Exhibit 3(a), (b) and (c).

After regaining consciousness, Petitioner was examined by ambulance personnel, but declined to be transported to the hospital. The accident was reported to Petitioner's foreman on the date of occurrence. Petitioner continued to work following the accident but the symptoms failed to resolve. He was having difficulty

performing his job duties including climbing up on his machine and the pain in his right shoulder increased over time. He so notified his supervisor on February 9, 2017 and an accident report was completed. (RX 1) Respondent then directed Petitioner to Physician's Immediate Care (PIC) and his supervisor took him there for examination and treatment. (PX 1)

The records from PIC reflect that Petitioner gave a history of having fallen at work on February 2, 2017 and presented with reports of neck pain, chest pain and right shoulder pain. He was diagnosed with a contusion of the thorax, spondylosis of the cervical region and a sprain of the right shoulder joint. Restrictions were imposed and he was instructed to return to the clinic in one week. In a follow up appointment an MRI was prescribed in response to Petitioner's increasing complaints of pain in the right shoulder. In the interim, he underwent physical therapy, was given pain medication and took a course of steroids. The shoulder MRI showed a torn rotator cuff tear and the Petitioner was referred for orthopedic treatment. (PX 1)

Petitioner chose to exercise his choice of physicians and was next examined by Dr. Brian Forsythe at Midwest Orthopedics at Rush on March 16, 2017. Dr. Forsythe suspected a full thickness tear of the anterior distal suprastanatus tendon and offered surgery. On March 22, 2017 Petitioner underwent surgical intervention consisting of arthroscopic rotator cuff repair, subacromial decompression, subpectoral biceps tenodesis and arthroscopic glenohumeral joint debridement. Petitioner was excused from work. Physical therapy was initiated on April 11, 2017. (PX 2)

As of July 11, 2017, Petitioner continued in therapy and was making steady but slow progress. He was noted to be compliant and it was recommended that he remain in therapy, as the potential for rehabilitation was good. (PX 2)

Respondent accepted the claim and paid all medical and indemnity benefits through this period. On July 31, 2017, Petitioner received correspondence from Respondent advising him that all further treatment for the injury was denied as non-compensable. (PX 5) No explanation was given to Petitioner as to the basis for the termination of benefits and no UR review was obtained regarding appropriateness of treatment in accordance

with the Act. At the time the benefits were suspended, Petitioner was still restricted from working by Dr. Forsythe, with additional therapy being recommended. (PX 2)

Petitioner testified that because the benefits were terminated, he was unable to continue with prescribed physical therapy. On August 17, 2017 the work restrictions were modified to allow for light duty work. (PX 2) Petitioner testified Respondent would not allow him to return to work in the absence of a full duty release. Petitioner could no longer afford to be off work, given his financial situation. Petitioner testified that in September of 2017, he advised Dr. Forsythe that he was "just fine" and needed to return to work full duty, even though he had not fully recovered. (PX 2)

Petitioner returned to his regular job duties with the Respondent on September 8, 2017.

During the course of the claim, Respondent placed Petitioner under surveillance and RX 3 consists of 239 minutes and 43 seconds of surveillance generated from June 14th through June 19th of 2017. RX 2 contains selected highlights of the surveillance which was viewed by the Arbitrator and both Parties at the arbitration hearing. The activities depicted in the surveillance include Petitioner's operation of a bobcat and the lifting and carrying of various items around his home. He is seen tossing some tree branches that he cut in a neighbor's yard. He uses both hands to move bricks and lift patio slabs. He reaches up with his right arm to close a car trunk. When he operates the bobcat, Petitioner is seen to use his right hand and he does use his right arm to reach up and pull down the safety bar on the bobcat. Petitioner is seen smoking a cigar at one point. (RX 2, 3)

Petitioner testified that the operation of the bobcat was entirely distinct from the physical actions required in order to operate the asphalt roller that he runs in his job. The asphalt roller requires climbing up a ladder to access the driver's seat and then utilizing a steering wheel much like a bus. Operation of the bobcat merely requires movement of the hands below shoulder height to pull the joysticks.

Petitioner testified that since his return to work in September of 2017, he has been performing his regular job duties with difficulty. He takes medication at night when the pain is severe.

Petitioner denied any subsequent injuries to his shoulder. It was noted that he received further treatment at Rush regarding his hand (knuckle replacement) that was not related to the February 2 accident.

Prior to February 2, 2017, Petitioner had injured his neck and right shoulder working for Respondent. This injury occurred in November of 2016. Petitioner had to "muscle open" a fire hydrant and hurt his neck and right arm. He had an injection at PIC, lost no time from work and continued to perform his regular job duties. (PX 1)

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

The Arbitrator observed Petitioner's testimony and his demeanor under examination by 2 skilled lawyers and his testimony is found to be credible, even in light of the minor inconsistencies in the histories given to PIC and Dr. Forsythe as to the exact mechanics of the trip and fall on February 2, 2017 and Petitioner's testimony that he lied to Dr. Forsythe and his later testimony that he does not lie or smoke (he is seen smoking a cigar on 6/17/2017).

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

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on February 2, 2017. He was on Respondent's premises, in an area not accessible to the public at large, having just punched in. Clearly, he is in the course of his employment by Respondent at that time. He trips on an uneven (and deteriorated) pavement, wearing his work Carharts and with his hands in his pockets due to cold weather (not all members of the public at large are dressed to work outside on a cold Chicago day in February), sustaining injury. The risk of a fall and injury such as Petitioner sustained under these circumstances is greater than the risk of same to the public at large. The injury arose out of Petitioner's employment by Respondent.

The minor inconsistencies in the histories given by Petitioner to PIC and Dr. Forsythe regarding the exact mechanics of the trip and fall have been considered and do not persuade the Arbitrator to make a finding against Petitioner on the issue of accident/arising out of/in the course of.

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

Petitioner's current condition of ill-being regarding his right shoulder is causally related to the injury, based upon Petitioner's testimony and the medical records.

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

Petitioner's claimed medical bills were submitted as PX 4. The bills are from Midwest Orthopaedics at Rush and they include charges for the 3/22/17 surgery, pre-op and follow-up visits and some charges from Dr. Robert Wysocki, who treated Petitioner for the unrelated knuckle condition. Respondent claimed a credit for all bills that it had paid. The bills associated with the treatment provided by Dr. Forsythe are found to be reasonable and necessary and causally related to the injury.

The said bills are awarded as follows: DOS 3/22/2017 (Surgery charges less refunds/adjustments): $5,006.54; DOS 3/30/2017 (Post Op radiology): $142.60; DOS 3/16/2017 (Outpatient visit and radiology): $390.60; DOS 3/22/2017 (Shoulder orthotic): $208.00; **TOTAL: $5,747.74**

The award of medical expenses is made in accordance with §§8(a) and 8.2 of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was first excused from work on February 13, 2017 and he was released to return to work by Dr. Forsyth effective September 8, 2017. Based upon the Arbitrator's findings above regarding accident and causation, Petitioner is entitled to TTD from February 13, 2017 to September 7, 2017, a period of 29-3/7 weeks.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);

(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of the injury;

(iv) the employee's future earning capacity; and

(v) evidence of disability corroborated by the treating medical records.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. This factor is, therefore, given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a hoisting engineer/asphalt roller operator at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. This factor is given much weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 61 years old at the time of the accident. This factor is given some weight in determining PPD because Petitioner still has some years left in the workforce and the residuals of the injury/surgery may affect Petitioner's ability to perform some of his job functions.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was adduced regarding future earning capacity other than the effects that may occur due to residuals of the injury/surgery. This factor is given little 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 has complaints of pain after work for which he takes medication. These mild residual complaints are given moderate weight in determining PPD.

Based on the above factors, and the Record taken as a whole, the Arbitrator finds that as a result of the injuries sustained, Petitioner suffered permanent partial disability to the extent of 11 % loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chad Carson,

Petitioner,

vs. NO: 17WC020775

State of Illinois Department of Transportation,

18IWCC0677

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses, causal connection, prospective medical care, Petitioner engagement in injurious practices under Section 19(d), 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 February 23, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

18IWCC0677

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 5 - 2018
SJM/sj
o-10/11/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

CARSON, CHAD
Employee/Petitioner

Case# **17WC020775**

SOI/DEPARTMENT OF TRANSPORTATION
Employer/Respondent

18IWCC0677

On 2/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS'COMPENSATION MANGER
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0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

FEB 23 2018

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

STATE OF ILLINOIS

18IWCC0677

COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHAD CARSON
Employee/Petitioner

Case # 17 WC 20775

v.

Consolidated cases: _____

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION
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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **October 12, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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 **Did Petitioner engage in injurious practices under Section 19(d)?**

18IWCC0677

FINDINGS

On the date of accident, **June 19, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,108.00**; the average weekly wage was **$1,213.62**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent on June 19, 2017. His current condition of ill-being with regard to his right ankle is causally related to the accident. Petitioner has not reached maximum medical improvement and Respondent is liable for ongoing medical care.

Respondent shall pay reasonable and necessary medical services totaling **$21,973.31**, as set forth in Petitioner's Exhibit 1 and itemized in the Arbitration Decision, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers for which Respondent is receiving credit under Section 8(j).

Respondent shall pay temporary total disability benefits of **$809.09/week for 13 weeks**, for the period of July 13, 2017, through October 12, 2017, as provided in Section 8(b) of the Act, for a total of **$10,518.17**.

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

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

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

Signature of Arbitrator

February 22, 2018
Date

ICArbDec19(b)

FEB 23 2018

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

18IWCC0677

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHAD CARSON
Employee/Petitioner

v.

Case #: 17 WC 20775

STATE OF ILLINOI/DEPARTMENT OF TRANSPORTATION
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This cause came before the Arbitrator on Petitioner's Section 19(b) Petition with disputed issues of accident, causal connection, liability for past and prospective medical expenses and treatment, and liability for temporary total disability benefits. Respondent agreed to the claimed period of disability representing 13 weeks, but disputed liability for same. Respondent also disputed liability for prospective medical care on the basis that Petitioner was engaged in injurious practices under Section 19(d). Respondent agreed that the issues regarding causal connection, liability for past medical expenses, and liability for temporary total disability all stemmed from its dispute of accident, and that these issues would be moot in the event the Arbitrator found that Petitioner met his burden of proof on the issue of accident.

On June 19, 2017, Petitioner was 39 years old, married, and had two dependent children. He was employed as a Highway Maintainer for Respondent and had been so employed for four years. He previously served in the U.S. Army for about four years. He testified that on June 19, 2017, he was transporting "flaggers ahead" construction signs to a construction site. The signs were in a large box, which was loaded onto a flatbed truck with a forklift. Petitioner testified that he then got up on the flatbed to strap down the box. The flatbed was about four to six feet high and did not have a ladder on the side by which to climb on top. Petitioner pulled himself up and then rolled his body onto the flatbed. He proceeded to strap down the box without incident, and then dismounted the truck. He testified, "I leaned down and just hopped off the vehicle backwards, onto the ground." When he hit the ground he felt a tweak in his foot. He continued working, but as the day went on he noticed that his foot was swollen and he had a knot on the back of his foot, which was rubbing the back of his shoe. Petitioner testified that he had no prior injuries to his right foot, ankle, heel, or Achilles tendon, even while serving in the U.S. Army.

Petitioner testified he continued working from June 20, 2017, through July 12, 2017, but was on light duty and sat in an office. Petitioner originally treated at Work Care, then began to

see Dr. Golz. He had an MRI of his right ankle which showed a partially torn Achilles tendon. He testified he had never previously been diagnosed with an Achilles tendon problem. Dr. Golz recommended Petitioner wear a boot and undergo physical therapy. Petitioner testified the boot helped, but the physical therapy did not. He testified he did not follow up with Dr. Golz after the physical therapy because he wanted a second opinion, so he saw Dr. Bradley upon referral of his attorney. He first saw Dr. Bradley on August 17, 2017. Petitioner testified that Dr. Golz prescribed a boot and assistive walking device immediately, but had taken him out of the boot and off of the cane on either July 23 or July 26, 2017.

Petitioner testified he had seen the surveillance reports submitted by Respondent and identified himself as the person to which those investigative reports refer. He admitted performing all of the activities that are listed in the investigative report.

Petitioner testified that he ultimately underwent surgery, which has helped him. He is continuing to improve and the knot has gone away. He currently has restrictions of no running and no jumping. He was scheduled to see Dr. Bradley again on December 11, 2017, and his projected return to work date is January 1, 2018.

On cross-examination, Petitioner testified he was given an air cast boot on June 20, 2017, in the emergency room and was told to wear that boot. He was shown Respondent's Exhibit 9, which he identified as a photograph of himself posted on Facebook by his wife. The photograph was taken on July 3, 2017. Petitioner admitted he was not wearing his boot in that photograph. He testified he did not have to wear the boot at that time because he already had his MRI and had been released from wearing the boot. He then admitted that his MRI was not until July 6, 2017, and he did not see Dr. Golz until July 13, 2017. Petitioner did not respond when asked who released him from wearing his boot on July 3, 2017.

Petitioner acknowledged he was given a driving restriction by Dr. Golz on July 13, 2017, which was in place until July 26, 2017. At that time, Dr. Golz took him out of the boot, off the cane, and off the driving restriction. Petitioner testified he went to Dr. Bradley because he wanted a second opinion, as he did not believe that a partially torn Achilles tendon would heal on its own and that it was something that had to be surgically addressed. He acknowledged he did not have a medical degree.

On re-direct, Petitioner testified he did not have to wear the boot between June 19, 2017, and July 12, 2017 when he was working light duty because he was not told to do so. He testified that he would not be allowed to wear a boot in the facility because he has to wear steel-toed boots in the work area. He testified there was never a time that he was operating outside of the restrictions given to him by his doctors.

On re-cross, Petitioner admitted that steel-toed boots are not required in the office and that he in fact was wearing Crocs while working light duty in the office.

Mr. Brad Myers was present on behalf of Respondent and was called to testify by Petitioner. Mr. Meyers testified he has been employed by Respondent for almost two years. He confirmed that the flatbed truck from which Petitioner jumped was four to six feet high. He was

shown Respondent's Exhibit 8, the IDOT Employee Accident/Incident Report. He testified that, to his knowledge, there was nothing inaccurate in the report.

Mr. Sean Haney was present on behalf of Respondent and was called to testify by Petitioner. Mr. Haney testified he has been employed by Respondent since March 2002 and works with Petitioner. He testified that he and Petitioner were moving signs on a flatbed truck, which was four to six feet off the ground. He testified there were no ladders or steps on the flatbed, by which to climb up and down. He explained that getting on and off the truck is "difficult because the way it's set up" and that one could use the tire or the hitch on the back to do so.

On cross-examination, Mr. Haney testified that he did not see Petitioner get on or off of the truck, though indicated in his Witness Report (RX4) that Petitioner had jumped off. Petitioner did not indicate that he had hurt himself at that time. Mr. Haney testified he did not hear Petitioner say "ouch", or see him stumble or begin limping.

On redirect, Mr. Haney testified that he became aware that Petitioner was hurt either later in the same day or the following day, when Petitioner took his boot off and showed him that his foot was swollen. He testified that he had no knowledge of any other incident that could have caused Petitioner's injury.

Mr. Scott Wright was present on behalf of Respondent and was called to testify by Petitioner. Mr. Wright testified he has been employed by Respondent for more than 25 years and is currently the Operations Supervisor I. He is Petitioner's supervisor. He testified he was not present at the accident site when Petitioner jumped off the truck, and became aware of his injury the following day. He had no knowledge of any account of the incident other than the one Petitioner reported to him the next day and no knowledge of any facts that would rebut the occurrence of Petitioner's injury.

On cross-examination, Mr. Wright reviewed Respondent's Exhibit 8, the IDOT Employee Accident/Incident Report, and confirmed that he completed the bottom portion labeled as "Supervisor's Review". Mr. Wright testified that a "three-point contact" is the protocol for getting off trucks that have hand grips and ladders, which involves always having three parts of your body in contact with the truck while getting up or down. However, with regard to the flatbed, he testified, "On the flatbed, we don't have that. It's just a regular pickup, so nothing to grab ahold of or grab onto. So usually, you sit down and slide off. You try to minimize the impact." He testified that Petitioner reported he had used this (sit and slide) method, rather than the three-point contact, to dismount the truck.

Respondent called Mr. Keith Miley as a witness. Mr. Miley testified he has been employed by Respondent for more than 34 years and is the Operations Engineer. He is familiar with Petitioner. He testified that on July 19, 2017, he was working, and specifically was out looking at work being performed to repair flood damage in rural Jackson County along Route 2, down by the Mississippi River. On that date, while heading back to the Carbondale Headquarters after checking on the repair work, he happened to drive by Petitioner's residence and saw Petitioner out in front of his home. Mr. Miley testified that Petitioner was not wearing any kind of protective boot and was not holding a cane. He did not see a boot or cane at all. Mr. Miley testified Petitioner was not walking around, but was standing and talking on the telephone.

On cross-examination, Mr. Miley testified that he signed Respondent's Exhibit 8. He explained that he only reads such a report and signs it to verify that he has read it. He does not make a judgment about whether or not someone is telling the truth. Rather, the purpose of the form is to advise him there has been an incident. He testified that in this case he had no reason to dispute Petitioner's report of the accident.

Respondent called Jason Taylor as a witness. Mr. Taylor testified he has been employed by Respondent for two years and is the Administrative Manager. He testified that on July 29, 2017, he and Keith Miley drove around looking at flood damage. On their way back to the office they drove by Petitioner's home, at which time he observed Petitioner "walking in front of his house on the phone, wearing a pair of shorts, flip flops, and a t-shirt". He testified Petitioner was not wearing any kind of boot, was not using a cane, and was not walking with a limp.

On cross-examination, Mr. Taylor conceded he was unaware that Petitioner had been working eight hours a day on light duty from June 20, 2017, until July 15, 2017, and that he was not taken off work until mid-July. Mr. Taylor further conceded he was unaware that during that period of time on light duty, Petitioner worked inside Respondent's facility without a boot and wearing Crocs.

Respondent called Ronald Elkins as a witness. Mr. Elkins testified he is employed as a private investigator by Frasco Investigative Services. He has been a private investigator for eleven years. He testified that he performed surveillance on Petitioner on July 29, 2017. He identified Petitioner from his social medial profile and witnessed him load something into his vehicle. Petitioner was not wearing a brace or other protective device, and was not using a cane. Mr. Elkins testified he followed Petitioner and his family to Murphysboro State Park. He then set up surveillance and witnessed Petitioner lifting his child, picking up firewood, building a fire, and moving a plastic table. He testified that Petitioner was carrying the plastic table and walking backwards with it. Mr. Elkins opined that Petitioner did not seem injured to him.

Respondent called Tommy Fenton as a witness. Mr. Fenton testified he is employed as a surveillance investigator at Frasco Investigative Services. He has been a surveillance investigator for eleven years. He testified that he performed surveillance on Petitioner on August 23, 2017. He testified he observed Petitioner arrive home in his pickup truck, then later carry two fishing poles to his truck and leave home. Petitioner drove to a bait shop, entering and exiting the shop multiple times. On the final trip Petitioner was carrying a five-gallon minnow bucket. He was not wearing any kind of boot or protective device and was not using a cane. Mr. Fenton testified that Petitioner did not appear to be walking with any kind of difficulty or a limp.

Petitioner testified in rebuttal. He testified he did not do anything outside of his doctor's restrictions. He further testified that he had not sustained any intervening accidents between June 19, 2017, and the time of trial to his foot, heel, or Achilles tendon.

On June 20, 2017, Petitioner completed an Employee's Notice of Injury and an IDOT Employee Accident/Incident Report. On both reports he indicated he was strapping down a sign box on a flatbed truck and when he hopped down he felt his foot pop. RX2, RX8. The IDOT Employee Report also contained a bottom section, "Supervisor's Review", which was completed

by Scott Wright. In the comments section, Mr. Wright wrote, "When Chad dismounted the flatbed he used hands to help dismount. Stated he did not jump." RX8. Petitioner testified that this account was accurate, and that he did use his hands to help him down.

On June 20, 2017, a Supervisor's Report of Injury was completed by Walter Gibbs, which indicated that Petitioner felt a pop in his foot. The report further indicated that Petitioner had continued working but the next day (June 20) he could barely walk. RX3.

On June 20, 2017, a Witness Report was completed by Sean Haney, who stated that Petitioner jumped down from a flatbed truck after strapping down a sign box. RX4.

Following the accident, Petitioner presented to the emergency room at Memorial Hospital on June 20, 2017, with complaints of pain and swelling in the right heel/Achilles tendon area. He reported he had jumped off the back of a flatbed truck the day before. On examination, there was swelling and redness to Petitioner's right heel and he was unable to bear full weight without pain. He was noted to be ambulating with a limp. X-rays negative for any fracture or other abnormality. An ultrasound was performed, which showed mild subcutaneous edema of the right Achilles tendon, but no other abnormality. PX3.

On July 6, 2017, Petitioner underwent a right ankle MRI at Cedar Court Imaging, as ordered by Dr. Mindy Dudenbostel. It revealed: (1) mild to moderate Achilles tendinopathy in the distal six centimeters; (2) acute moderate tendinopathy at its insertion laterally and a focal subtle tear; (3) associated adjacent soft tissue edema and mild underlying marrow edema; (4) no high-grade tear; (5) mild to moderate tibialis posterior tenosynovitis distally; and (6) mild peroneus brevis tendinopathy. PX5.

Respondent's Exhibit 9 is a photograph of Petitioner dated July 3, 3017, standing on a beach in the sand. He is not wearing a boot or any footwear and is not using a cane.

On July 12, 2017, Petitioner presented to Dr. Robert Golz at The Orthopaedic Institute of Southern Illinois, upon referral by Dr. Mark Smith. He reported that he had jumped off the back of a flatbed truck onto asphalt and had a sharp, painful pop in his ankle with some initial difficulty bearing weight. It was noted that he continued to work that day, but by the next day "could hardly walk". He reported that he had gone to the emergency room, followed up with urgent care, had undergone an MRI, and had been placed on light duty. He noted he was better, but still had localized soreness in his Achilles, where he had a knot which was very tender. PX4.

On examination, Dr. Golz noted that Petitioner was wearing "Croc type footwear" and was ambulating independently but with a slightly antalgic gait. He had markedly restricted dorsiflexion, was markedly tender over his right Achilles tendon insertion, and had some localized soft tissue swelling. Dr. Golz reviewed the MRI and agreed it showed a partial-thickness tear of the Achilles near its insertion with mild swelling. Dr. Golz noted concerns for the potential of a complete Achilles tendon rupture. He advised Petitioner to wear a 3D boot and noted he "probably needs a cane for assisted ambulation", but indicated he could be weightbearing as tolerated. He ordered physical therapy and prescribed Mobic for inflammation. Petitioner was to remain on light duty work, with no climbing, driving, or heavy lifting. He was asked to attempt to try on his

steel-toed work boots to see if he could tolerate them, with the goal being to progress him back into his boots for full duty work. PX4.

On July 19, 2017, Petitioner presented to physical therapy at The Orthopaedic Institute and gave a consistent history of the accident. It was noted he was "now off work no driving". He participated in therapy on July 19, 21, 24, and 26, 2017. On July 26, it was noted that his pain was 0-4/10 after wearing the boot all day yesterday. He reported his main issue was friction or pressure at the lateral Achilles bump area. PX4.

Petitioner returned to Dr. Golz on July 26, 2017, and reported continued tenderness over the area of swelling at the Achilles insertion. It was noted he was continuing with physical therapy and had been on light duty. He had been using his 3D boot, but was no longer using any walking aids. On examination, there was an enlarged area of firm tissue over the insertion site of the Achilles tendon, which was tender to palpation. There was no erythema or ecchymosis. Strength and motion were well maintained. Dr. Golz noted bilateral deformities in the back of Petitioner's ankles; however, the prominence over the right ankle was swollen. Petitioner was instructed to continue physical therapy and continue with light duty. There were no instructions noted for him to continue with the boot. PX4. The Arbitrator notes that Petitioner testified that his only restrictions or instructions at that time were to avoid footwear that enclosed the back of his ankle, and to wear shoes with no backs. He testified that he worked a light duty office position until he was taken off work.

On July 29, 2017, surveillance was undertaken of Petitioner. Video of the surveillance was admitted as Respondent's Exhibit 7, and a report summarizing the activities on the video was admitted as Respondent's Exhibit 5. The investigator was Ronald Elkins, whose testimony is detailed above. The Arbitrator viewed the surveillance video in its entirety and notes that the report of August 1 and the testimony of Mr. Elkins accurately reflect the activities contained within the video. The Arbitrator notes that throughout the video, Petitioner is seen wearing sandals or open-back footwear, which was within the boundaries of his restrictions. Petitioner testified that he was wearing similar open-back footwear when working light duty. He further testified that none of the activities shown in the video were outside of his restrictions. The Arbitrator further notes that at the time of the surveillance, Petitioner was under no instructions from Dr. Golz to wear a boot or use a cane. He was to continue therapy and continue light duty. Dr. Golz did not specify as to what light duty would consist of, and he did not complete a "Work Status and Restrictions" form, as he had on July 12. The restrictions on July 12 included no climbing, heavy lifting, or driving. Assuming *arguendo* that those were the same restrictions Dr. Golz intended on July 26, the video does not depict Petitioner involved in any climbing or heavy lifting, but does show that he was driving his truck. In viewing the surveillance video, it is apparent that Petitioner's Achilles injury is untouched by his footwear. Further, the "knot" which Petitioner described is readily visible when the investigator zoomed in at about 49:49. Overall, the Arbitrator did not view anything that would raise concern that Petitioner did not have an injury or that he was somehow making his injury worse by his actions.

Petitioner participated in physical therapy on August 1, 3, and 9, 2017. On August 9, he returned to Dr. Golz and reported he was continuing to improve, but still had swelling over the back of his ankle. He reported that he still could not wear shoes or work boots without discomfort, and had to wear sandals to a funeral the day before, due to discomfort. On examination, he

ambulated with a very slightly antalgic gait. He continued to have swelling and a firm palpable nodule over the back of the ankle. There was mild tenderness to palpation over the Achilles insertion. He had improved range of motion and strength. He was able to stand on his toes bilaterally, but had difficulty doing so on just one foot. Dr. Golz instructed him to continue therapy for two weeks and to rest and use ice for discomfort. He was to continue with work restrictions but did not have to use the boot or cane. Petitioner was to return in two weeks, at which point he would "likely be released to return to regular duty".

On August 17, 2017, Petitioner presented to Dr. Matthew Bradley of Orthopedic Sports Medicine & Spine Care Institute for a second opinion. He reported a consistent history of the accident and his treatment to date. He reported he had not received improvement with therapy and continued to have a significant amount of pain and difficulty with prolonged standing and walking, particularly going up hills. Dr. Bradley reviewed the MRI and agreed it showed an acute partial thickness tear to the insertion of the Achilles tendon over the lateral aspect. On examination, there was pain to palpation over the insertion of the Achilles tendon, as well as swelling and a small bump to the insertion of the Achilles. Dorsiflexion caused pain. Standing on tip toes on the right foot only created a significant amount of pain at the insertion of the Achilles tendon. Dr. Bradley noted that Petitioner had bilateral prominences on the back of his ankles, which he identified as Haglund's deformity, but further noted that these defects were not palpable. Dr. Bradley opined that Petitioner's acute partial thickness tear of the right Achilles tendon was causally related to his work accident on June 19, 2017. He noted that Petitioner had undergone a significant amount of non-operative treatment but continued to have pain and dysfunction. As such, he recommended surgery consisting of debridement and repair of the Achilles tear, as well as removal of the Haglund's deformity. PX6.

On August 18, 19, and 23, 2017, surveillance was undertaken of Petitioner. Video of the surveillance was admitted as Respondent's Exhibit 7, and a report summarizing the activities on the video was admitted as Respondent's Exhibit 6. The investigator was Tommy Fenton, whose testimony is detailed above. The Arbitrator viewed the surveillance video in its entirety and notes that the report of August 1 and the testimony of Mr. Fenton accurately reflect the activities contained within the video.

On September 15, 2017, Petitioner underwent surgery by Dr. Bradley consisting of repair of the Achilles tendon of the right ankle and excision of the Haglund's deformity. Intraoperative findings demonstrated that 20% of Petitioner's Achilles tendon was avulsed from its insertion to the calcaneus. The tearing was noted to be acute, given that there was no significant retraction or chronic inflammatory tissue about the Achilles tendon. PX7. Petitioner followed up with Dr. Brandley on October 9, 2017. The office note was not available at the time of hearing, however a handwritten referral to physical therapy was admitted. PX6. Petitioner testified that surgery improved his condition and that his knot is gone.

The Arbitrator notes that Respondent did not have Petitioner examined.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

It is clear and undisputed that Petitioner was *in the course of* his employment as a highway maintainer at the time of his injury, as he was preparing to transport construction signs to a construction site from Respondent's facility at "Carbondale Yard". The issue then is whether the accident *arose out of* his employment.

An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 204 (2003).

The Arbitrator finds that Petitioner met his burden of proof in establishing that an accident occurred which arose out of and in the course of his employment. In so concluding, the Arbitrator finds significant that the flatbed truck in question had no ladders, steps, or other assistive devices to help Petitioner get up onto or down from the flatbed. This fact is uncontroverted and was corroborated by all of Respondent's employees, including Petitioner's supervisor, Scott Wright. He specifically testified that it was not possible to use a "three-point contact" to get up or down, as there were no ladders or handgrips on the flatbed. Sean Haney also testified that getting on and off the flatbed was "difficult because the way it's set up". It is also undisputed that the truck bed from which Petitioner had to descend was at least four feet high.

The Arbitrator finds that the facts above clearly constitute a work-related hazard that was distinctly associated with Petitioner's employment and an increased risk of injury. Further, it was reasonably foreseeable to Respondent that an employee would be injured in such a fashion, given that the truck provided no ability to use three-point contact to ascend or descend the flatbed.

Respondent attempted to show that Petitioner gave differing accounts to as to how he injured his ankle. The Arbitrator disagrees and finds that the accounts were very consistent, both in his reporting to Respondent and in his reporting to various medical providers. Respondent further attempted to show that Petitioner sought a second opinion from Dr. Bradley only when he

believed that treatment with Dr. Golz was concluding and he would be returned to work. The Arbitrator again disagrees and notes that during his last visit with Dr. Golz on August 9, 2017, physical examination continued to show "swelling and a firm palpable nodule over the posterolateral aspect of the ankle". Petitioner continued to have tenderness to palpation over the Achilles insertion and he had difficulty standing on his toes with just his right foot. All of these objective findings remained and were noted by Dr. Bradley on August 17, 2017. Finally, the Arbitrator viewed the surveillance videos in their entirety and did not find any of Petitioner's activities therein to be outside the restrictions placed by Dr. Golz or Dr. Bradley, or inconsistent with Petitioner's subjective complaints to either doctor or his testimony. The Arbitrator found Petitioner to be credible and forthright in his testimony

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st. Dist. 1994).

Respondent agreed that the issues regarding causal connection, liability for past medical expenses, and liability for temporary total disability all stemmed from its dispute of accident, and that these issues would be moot in the event the Arbitrator found that Petitioner met his burden of proof on the issue of accident. Given the aforementioned findings as to accident, the Arbitrator notes that there is an unbroken chain of causal connection from the accident leading directly to Petitioner's current condition of ill-being. Petitioner testified to no prior or subsequent right ankle injuries, and there is otherwise no evidence of any intervening accident in the record. Respondent did not have Petitioner examined; therefore, there is no contrary medical opinion in the record.

The Arbitrator finds Petitioner's current condition of ill-being with regard to his right ankle is causally related to his work accident of June 19, 2017, and that he has not reached maximum medical improvement.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issues (C) and (F), and in light of Respondent's position that the issue of liability for past medical expenses stemmed from its dispute of accident, the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to his accident of June 19, 2017. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for all payments previously made to providers, including those made pursuant to Section 8(j), for which a credit is allowed. The Arbitrator finds that Respondent is liable for the following outstanding medical bills as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act and subject to prior payments.

1. Memorial Hospital of Carbondale	$ 2,740.31
2. Cape Radiology	$ 111.00
3. Orthopaedic Institute of Southern Illinois	$ 1,715.00
4. Cedar Court Imaging	$ 500.00
5. Dr. Matthew Bradley	$ 1,035.00
6. Chesterfield Surgery Center	$15,872.00
TOTAL	**$21,973.31**

The Arbitrator notes that not all of the bills for services rendered had been invoiced as of the date of arbitration (i.e., Dr. Bradley, Western Anesthesia). Given the Arbitrator's findings on all issues, Respondent is liable for those bills, though they were not available at the time of arbitration.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatment that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Comm'n*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that Petitioner is not currently at maximum medical improvement and is in need of further care. He is currently participating in post-operative care and continues to treat with Dr. Bradley. The Arbitrator finds that Respondent is liable for prospective medical care for Petitioner's right ankle.

In support of the Arbitrator's decision relating to issue (L), Petitoner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

Respondent agreed with Petitioner's claimed period of temporary total disability of July 13, 2017, through October 12, 2017, that being the date of arbitration, for a total of 13 weeks. Respondent disputed liability for benefits, based on its dispute of accident. In light of the Arbitrator's decision relating to the issue of accident, the Arbitrator finds that Petitioner was temporarily and totally disabled from July 13, 2017, through October 12, 2017, for a total of 13 weeks. Having previously found that Petitioner has not yet reached maximum medical improvement, the Arbitrator finds that Petitioner is entitled to ongoing temporary total disability benefits until such time as his condition allows him to return to work or until he reaches maximum medical improvement.

The parties stipulated that Petitioner's average weekly wage was $1,213.62. The Arbitrator finds that his temporary total disability rate is $809.09. The Arbitrator finds that Respondent is liable for 13 weeks of temporary total disability benefits of $10,518.17.

In support of the Arbitrator's decision relating to issue (O), whether Petitioner was engaged in injurious practice that imperiled his recovery pursuant to Section 19(d) of the Act, the Arbitrator finds the following:

If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee. 820 ILCS 305/19(d).

Respondent claims that Petitioner's actively ambulating outside of a boot, as testified to by Respondent's witnesses and shown in the surveillance videos, constituted an injurious practice. Petitioner testified, however, that he was not required to be in a boot at the time the surveillance was taken, and further testified without rebuttal that there was never a time when he operated outside of his restrictions. The records corroborate Petitioner's testimony.

Dr. Golz placed Petitioner in a boot temporarily on July 12, 2017, but did not confine him to it at all times. He instructed Petitioner to "be up weightbearing as tolerated," instructed him to try using his steel toed boots, and encouraged him to try to progress to full activity prior to the scheduled follow-up in two weeks. When Petitioner returned to Dr. Golz on July 26, 2017, he reported that he did make use of his boot, and Dr. Golz noted that Petitioner was working light duty without the use of any walking aids. At the conclusion of that visit, there were no instructions for Petitioner to continue using his cast or boot. Petitioner's only instructions per his therapy order were to continue therapy consisting of range of motion strengthening and exercises. Therefore, Petitioner was completely released from his boot at the time the surveillance videos were taken.

Notwithstanding the aforementioned, given the fact that Petitioner reported to his therapists that his main problem was "friction or pressure at the lateral Achilles bump area," stated that he was not able to wear shoes or boots without discomfort, lamented that he was forced to wear open sandals to a funeral for comfort, and was encouraged to be weightbearing as tolerated, the Arbitrator does not find his conduct of taking the opportunity to move about without his boot so unreasonable as to warrant reduction or suspension of his benefits. There was absolutely no evidence in the medical records to suggest that Petitioner's actions materially worsened his condition. Dr. Golz did not find increased swelling because of Petitioner's behavior or continue to recommend that Petitioner wear his boot to further improve his condition. Consequently, the Arbitrator finds that Petitioner was not engaged in an injurious practice within the meaning of Section 19(d) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dave Schreiber,

Petitioner,

vs. NO: 14 WC008339

Allan Brown Chevrolet,

18IWCC0678

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(s) of accident, medical expenses, causal connection, notice, 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 February 5, 2018 is hereby affirmed and adopted.

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

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

18IWCC0678

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,500.00. 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.

NOV 5 - 2018

DATED:
SJM/sj
o-10/25/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHREIBER, DAVE
Employee/Petitioner

Case# **14WC008339**

ALLAN BROWN CHEVROLET
Employer/Respondent

18IWCC0678

On 2/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4262 ROMANEK & ROMANEK
ONE NORTH LASALLEDARON ROMANEK
ONE N LASALLE ST SUITE 425
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
AMY L TURNBAUGH
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602

18IWCC0678

STATE OF ILLINOIS)
)SS.
COUNTY OF McHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dave Schreiber
Employee/Petitioner

v.

Allan Browne Chevrolet
Employer/Respondent

Case # **14** WC **008339**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Woodstock**, on **November 3, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 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 **$7,071.75**; the average weekly wage was **$359.15.**

On the date of accident, Petitioner was **43** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$0.00** 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 **$4,500.65** under Section 8(j) of the Act for medical benefits paid.

ORDER

*Respondent shall reimburse the Illinois Department of Healthcare and Family Services in the amount of: **$555.87** for reasonable and necessary medical services paid by the Illinois Department of Healthcare and Family Services on Petitioner's behalf, and hold Petitioner harmless.*

*Respondent shall be given a **credit of $4,500.65** for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.*

*Respondent shall pay Petitioner temporary total disability benefits of **253.00/week** for **13 3/7** weeks, commencing **November 24, 2014** through **February 25, 2015**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner temporary total disability benefits that have accrued from **November 24, 2014** through **February 25, 2015**, and shall pay the remainder of the award, if any, in weekly payments.*

*Respondent shall pay Petitioner permanent partial disability benefits of **$253.00/week** for **75 weeks**, because the injuries sustained caused the **15%** loss of the person as a whole, as provided in Section 8(d)(2) of the Act.*

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

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

Signature of Arbitrator

2/2/18
Date

FEB 5 - 2018

BEFORE THE
ILLINOIS WORKERS COMPENSATION COMMISSION

State of Illinois)
)
County of Lake)

DAVE SHREIBER,)
)
Petitioner,) No. 14 WC 8339
)
v.)
)
ALLAN BROWNE CHEVROLET,)
)
Respondent.)

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

Dave Schreiber ("Petitioner") testified he was hired by Allan Browne Chevrolet ("Respondent") on October 2, 2012 as an auto mechanic (Px.7, pp. 6 and 52). He further testified that on the alleged accident date, February 4, 2014, he was working for Respondent as a service administrator. Petitioner began his workday on that date between 7:30 and 8:00 a.m. Sometime after his return from lunch, sales manager Brad Finnan, asked Petitioner's supervisor, Gary Walley, for permission to "borrow" Petitioner to assist with a truck that had gotten stuck on Respondent's premises. Petitioner testified he then walked outside to assist in extricating the stuck vehicle, holding a chain in his right hand to aid in this maneuver. He further testified he slipped while walking going down into a ditch, falling onto his right, extended arm. Petitioner then got up, finished towing the truck and returned to Respondent's office.

Petitioner testified he did not feel well once he returned to Respondent's service office because his stomach hurt and his right shoulder had become painful. Petitioner also testified that shortly after he returned to Respondent's service office, he told Gary Walley that he had fallen outside while attempting to tow the truck Brad Finnan had gotten stuck.

Gary Walley testified he does not recall Petitioner informing him that he had been involved in a work accident on February 4, 2014.

Since he did not feel well, Petitioner asked Gary Walley for permission to leave work early during the afternoon of February 4, 2014. Mr. Walley testified that he allowed Petitioner to leave work early on February 4, 2014 but did not recall why. Mr. Walley testified that Petitioner's workday should have ended at 5:00 p.m. on February 4, 2014.

According to Respondent's time card for Petitioner for February 4, 2014, Petitioner punched in on February 4, 2014 at 8:01 a.m., punched out for lunch at 12:28 p.m., punched back in after lunch at 1:38 p.m. and punched out for the final time on February 4, 2014 at 3:26 p.m. (Rx.2, p. 2).

Petitioner testified after punching out of work, he presented to his primary care physician, Dr. Syed Hassan with complaints of "right arm pain for a couple hours now after falling at work today." (Px.1, pp. 54-67; Rx.2, p. 2). Petitioner also reported having stomach pain at a 10/10, predominantly on his left side. (Id., p. 61). Dr. Hassan referred Petitioner to the emergency department at St. Anthony Medical Center (Id., p. 63).

Petitioner was admitted to St. Anthony Medical Center emergency room at 5:15 p.m. on February 4, 2014 (Px.2). The attending doctor noted Petitioner had suffered "a mechanical-sounding fall when he slipped on ice". Petitioner reported his abdominal pain began to resolve on its own while he drove to the hospital (Id., p. 15). X-rays of Petitioner's right shoulder were negative for a fracture and Petitioner's abdominal x-ray was not suggestive of free air (Id., p. 18). Petitioner was prescribed Naprosyn for his shoulder pain and discharged with a note for two (2) days off work (Id., pp. 21, 26; Px.7, p. 9).

On February 6, 2014, Dr. Hassan noted Petitioner's continuing complaints of mild shoulder pain with movement. Petitioner requested pain medication and a note for light duty work (Px.1, p. 70). Petitioner was prescribed Norco for pain, cyclobenzaprine for muscle spasms, and issued off work restrictions until February 10, 2014. (Id.).

Petitioner testified he returned to work for Respondent on February 10, 2014 and presented his off-work note to his supervisor, Gary Walley. Petitioner further testified that on February 10, 2014, Respondent's owner/general manager, Phil Harris, made some heated comments in a raised voice which offended Petitioner. Deciding that he had enough and could no longer work for Respondent, Petitioner quit (Px.7, p. 7).

On February 27, 2014, MRI of Petitioner's right shoulder, performed at St. Anthony Medical Center documented a sizable tear of the posterior interior labrum with cyst and mild tendinopathy and bursitis. Following the MRI, Petitioner was referred to orthopedic evaluation by Dr. Hassan (Px.2, p. 46; Px.1, p. 88).

Petitioner did not treat for a period of time after February 27, 2014. Petitioner testified after he left his job with Respondent, he could not afford to pay for his health insurance (Px.7, p. 42 – health insurance letter Respondent sent Petitioner with respect to Petitioner first work injury of January 9, 2013).

Petitioner testified he applied for Medicaid through the Illinois Department of Healthcare and Family Services and also applied for charity and financial assistance from OSF St. Anthony Hospital.

On July 28, 2014, Petitioner presented to family practitioner, Dr. Kashif Zaheer at OSF Medical Group with a history of right shoulder complaints since February of 2014, following a work-related slip and fall in which he landed on his right, outstretched arm. Dr. Zaheer instructed Petitioner to begin a physical therapy program (PX 3, p. 5, 8).

Petitioner participated in nine (9) physical therapy sessions for his right shoulder from July 28, 2014 through August 25, 2014 when he was discharged with instructions to continue with his home exercise program (Px.3, pp. 4-68).

Petitioner testified the physical therapy improved the motion in his right shoulder, but not his symptoms (Px.4, p. 1).

Petitioner presented to Dr. Ruchi Prabhakar Parikh, a family doctor with OSF Medical Group on September 30, 2014. Dr. Parikh recommended a second right shoulder MRI.

On October 2, 2014, MRI of Petitioner's right shoulder noted "abnormal signal again noted in the posterior inferior labrum with interval increase in the multiloculated para labral cystic changes. Findings suggestive of [a] labral tear with associated para labral cyst."

On November 11, 2014, Petitioner presented to OSF Medical Group, orthopedic surgeon, Dr. Andreas Fischer for evaluation of his right shoulder. (PX4, p. 6) Petitioner reported a history of falling at work in early February of 2014. Petitioner denied previous right shoulder problems. Dr. Fisher questioned Petitioner regarding right shoulder x-rays from January 2013. Petitioner replied he could not recall the circumstances of such (Id.). Regarding Dr. Fisher's recommendations and treatment pursuant to Petitioner's history, examination and MRI findings, Dr. Fisher stated: "I have some concerns in that typically a cyst does not develop within such a short period of time after injury in my opinion and I am unable to provide a reasonable degree of medical certainty that this is related to any injury at work event" (PX4, p. 7).

After some discussion, Petitioner agreed to Dr. Fischer's recommendation of surgical diagnostic arthroscopy and debridement of the right shoulder (Px.4, pp. 7-8).

On November 24, 2014, Dr. Fischer performed the above-mentioned surgery at St. Anthony Medical Center (Px.2, pp. 8-9). Dr. Fischer's post-operative diagnosis noted a right shoulder labral tear with cyst (Px.2, p. 8).

On December 4, 2014, Petitioner followed up with Dr. Fischer who recommended Petitioner continue with his right arm in a sling for another four (4) weeks or so prior to beginning physical therapy (Px.4, p. 8).

Petitioner began post-surgical physical therapy on January 9, 2015 which continued until March 12, 2015 (Px.3, pp. 69-201).

Petitioner saw Dr. Fischer for the last time on February 25, 2015 at which time Petitioner reported his continued improvement in his right shoulder. Dr. Fischer did not place any restrictions on the use of Petitioner's right shoulder (Px.4, p. 4).

- Petitioner testified he never tore the labrum in his right shoulder or had a right shoulder MRI before February 4, 2014. Petitioner further testified he did not injure his right shoulder in any way after the February 4, 2014 work accident.

- Petitioner testified regarding a prior work accident while working for Respondent on January 9, 2013 (Px.9). On that date, Petitioner lifted school bus tires when he developed neck pain and right-sided arm pain. Petitioner further testified that during this work accident on January 9, 2013, he did not actually injure his right shoulder joint.

Petitioner testified he presented for initial consult with Dr. Alexander Ghanayem on April 1, 2013 with complaints of persistent neck pain and much improved right arm pain. Petitioner testified Dr. Ghanayem diagnosed a herniated neck disk. Petitioner further testified he last saw Dr. Ghanayem on November 12, 2013, at which time he felt much better with no right arm complaints. According to Petitioner, Dr. Ghanayem released Petitioner back to work on that date without any restrictions.

Petitioner testified he has since moved to Florida and has been working at a Chevrolet dealership since May of 2015 as a "PDI" performing new car inspections and test drives.

Petitioner testified he continues to experience right shoulder pain. He does not take any prescription medication for this right shoulder pain, but does occasionally use Ibuprofen. At his current job, he has right shoulder pain when he twists his arm or needs to turn a bolt. Petitioner testified that he never had any of these problems prior to February 4, 2014.

Petitioner testified when he attempts to throw a ball today, his right shoulder becomes painful and bothersome. He further testified he can no longer sleep on his right shoulder due to pain. He now performs certain tasks with his left arm such as lifting a gallon of milk.

Brad Finnan, on behalf of Respondent, testified he was hired by Respondent approximately 4-1/2 years ago as a sales manager of the used car inventory and its sales staff. His responsibilities include moving vehicles on or around the lot. He confirmed that in February 2014, he was the only "Brad" working in the sales department. He has known Petitioner for 3-4 years and last saw him in February, 2014. Mr. Finnan was not a direct supervisor of Petitioner. Mr. Finnan denied that anything out of the ordinary occurred on or about February 4, 2014, where he would have enlisted Petitioner to assist in extricating a stuck vehicle. He further denied witnessing Petitioner fall in the parking lot. On cross-examination, Mr. Finnan conceded it is within his purview to plow Respondent's lot and it is possible in February 2014 he would have been using a truck to plow snow if the weather required it.

On behalf of Respondent, Gary Walley, testified he has worked for Respondent since December 1, 2013. On the alleged accident date, he the service manager and Petitioner's direct supervisor. His duties include overseeing the productivity of repairs and the technicians in the shop. Mr. Walley testified he knew Petitioner prior to working at Respondent's location as they both previously worked at Wolf Chevrolet. Mr. Walley testified he was the only "Gary" working at Respondent's location at that time of the alleged accident. He further testified that Petitioner never reported any accident or injury involving his shoulder on or about February 4, 2014. He further denied that Brad Finnan asked to "borrow" Petitioner to assist with a stuck vehicle. Mr. Walley explained that if an employee under his supervision was hurt at work, barring in injury severe enough to warrant an ambulance called, Respondent's directive was to take the injured employee to the immediate care clinic in DeKalb for treatment.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator observed Petitioner's demeanor noting he presented as sincere and honest whose testimony is corroborated by the treating medical records in evidence. The Arbitrator notes that Brad Finnan, Respondent's pre-owned sales manager, and Gary Walley, Respondent's service manager, both testified that Petitioner was a good, reliable and honest employee. Gary Walley further testified that he knew and worked elsewhere with Petitioner twelve (12) years prior to Respondent employing Mr. Walley; and, Gary Walley testified that during the time he supervised Petitioner while they both worked for Respondent, Petitioner was not reprimanded by Respondent in any way. Needless to say, the Arbitrator found Petitioner to be a credible witness.

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

Petitioner testified he was asked to help Brad Finnan extricate a vehicle that had become stuck outside of Respondent's premises. Petitioner, armed with tools, walked outside of Respondent's premises and while attempting to traverse a ditch, slipped and fell, landing on his right, outstretched arm. Petitioner testified he then got up, finished towing the truck and returned to Respondent's office where he later requested to leave work early to seek medical treatment for his right shoulder and aching stomach.

The Arbitrator notes the contemporaneous medical records from Petitioner's primary care provider, the contemporaneous medical records from St. Anthony's emergency room, Petitioner's time card for February 4, 2014 and to some degree, Respondent's witnesses corroborate Petitioner's testimony on this issue.

Brad Finnan testified on cross-examination, it is within the purview of his job duties, to plow Respondent's lot and it is possible in February 2014 he would have been using a truck to plow snow if the weather required it. Mr. Finnan further testified he was the only "Brad" working for Respondent on February 4, 2014.

Gary Walley testified he allowed Petitioner to leave work early on February 4, 2014 but did not recall why. Mr. Walley testified that Petitioner's workday should have ended at 5:00 p.m. on February 4, 2014.

Petitioner's February 4, 2014 time card shows he punched out at 3:26 p.m. (Rx.2, p. 2). Gary Walley testified that Petitioner's workday should have ended at 5:00 p.m. Gary Walley did not recall why he allowed Petitioner to leave work early on February 4, 2014.

Petitioner testified after punching out of work, he presented to his primary care physician. The February 4, 2014 records from Dr. Syed Hassan note Petitioner's complaints of "right arm pain for a couple hours now after falling at work today." (Px.1, pp. 54-67). Petitioner had his vitals taken at 4:08 p.m. (Px.1, p. 64). Dr. Hassan referred Petitioner to the emergency department at St. Anthony Medical Center (Id., p. 63). The Arbitrator notes Dr. Hassan dictated his office note regarding Petitioner's visit at 4:39 p.m.

Medical records from St. Anthony Medical Center emergency room note Petitioner was admitted at 5:15 p.m. on February 4, 2014 (Px.2). The attending doctor noted Petitioner had suffered "a mechanical-sounding fall when he slipped on ice". Petitioner was prescribed Naprosyn for his shoulder pain and discharged with a note for two (2) days off work (Id., pp. 21, 26; Px.7, p. 9).

Based on a careful review of the evidence contained in the record, the Arbitrator finds that on February 4, 2014, Petitioner sustained accidental injuries that arose out of and in the course of his employment by Respondent.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes by a preponderance of the evidence, including Petitioner's credible testimony, that timely notice of the accident was given to Respondent.

Petitioner testified that shortly after he injured his right shoulder on February 4, 2014, he notified his supervisor Gary Walley, in Respondent's service office, that he fell and injured himself while trying to extricate the truck that Brad Finnan had gotten stuck while plowing Respondent's premises.

Petitioner filed and mailed via certified and regular mail an application for adjustment of claim to Respondent on March 11, 2014, thirty-five (35) days after Petitioner's work accident (Px.8, pp. 1-2). Since the Carol Stream, IL post office processed the certified mail that contained Petitioner's application for adjustment of claim on March 13, 2014, even though Respondent's representative (Allan Browne) did not write the date of delivery on the back of the certified mail green card, the Arbitrator concludes that Respondent received Petitioner's application for adjustment of claim on or before March 17, 2014, forty-one (41) days after Petitioner's work accident (Px.8, pp. 3-4).

On March 14, 2017, Respondent's office manager, Elaine Aller, wrote and placed a note in Respondent's employment file for Petitioner which stated that on February 10, 2014, Petitioner "...did not say anything regarding an injury or not being able to work because of any injury." (Px.7, p. 7) Then, on March 17, 2014, Elaine Aller partially filled out an "Illinois Form 45: Employer's First Report of Injury or Illness" although pertinent information such as date and time of the accident, address of accident, etc. were left blank. (Px.7, p. 6)

In light of the foregoing, the Arbitrator concludes that on February 4, 2014 timely notice of the accident was given to Respondent.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein.

The Arbitrator notes Dr. Fischer's November 11, 2014, note indicating he had "...some concerns in that typically a cyst does not develop within such a short period of time after [the] injury in my opinion and I am unable to provide a reasonable degree of medical certainty that this is related to any injury [or] work event." (Px.4, p. 7) Following surgery, Dr. Fischer noted a post-operative diagnosis on November 24, 2014 of a "Right shoulder labral tear with cyst." (Px.2, p. 8) Despite Dr. Fisher's November 11, 2014, note, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being is causally related to Petitioner's February 4, 2014 work accident. In so finding, the Arbitrator has carefully reviewed the evidence contained in the record including Petitioner's testimony along with the medical records.

A medical, causation opinion is not essential in supporting the conclusion of the Commission that an industrial accident caused the claimant's disability. *Corn Belt Energy Corporation Corp. v. The Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, 56 N.E.3d 1101, 1108 (2016) citing *International Harvester v. Industrial Commission*, 93 Ill. 2d 59, 63, 442 N.E.2d 908, 911 (1982).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester*, 93 Ill. 2d at 63-64, 442 N.E.2d at 911.

Petitioner's unrebutted testimony was that he began experiencing right shoulder pain on February 4, 2014 after his work-related slip and fall accident. (Px.4, p. 6). The contemporaneous medical records from Dr. Syed Hassan and St. Anthony Medical Center corroborate Petitioner's testimony that his right shoulder complaints began after his work-related accident.

Approximately three weeks following Petitioner's accident a right shoulder MRI noted a sizeable tear in the posterior inferior labrum of Petitioner's right shoulder (Px.2, p. 46).

The Arbitrator concludes that Petitioner has proven by a preponderance of evidence that the accident at issue caused Petitioner's right labral tear. With respect to the cyst in Petitioner's right shoulder, the Respondent took Petitioner as it found Petitioner on February 4, 2014. *See O'Fallon School District No. 90 v. Industrial Commission*, 313 Ill. App. 3d 413, 729 N.E.2d 523, 526 (2000), citing *General Refractories v. Industrial Commission*, 255 Ill. App. 3d 925, 930, 627 N.E.2d 1270, 1274 (1994).

In light of the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his February 4, 2014 work accident.

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?

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same in concluding that Petitioner has proven by a preponderance of the evidence that the medical services that were provided to Petitioner were reasonable and necessary.

Petitioner testified he applied for and received Medicaid through the Illinois Department of Healthcare and Family Services (see Px.11); and, Petitioner also testified that he received charity and financial assistance from St. Anthony Medical Center.

The Arbitrator has reviewed:

Petitioner's Exhibit No. 10 (Blue Cross Blue Shield letter and "Consolidated Statement of Benefits" dated October 4, 2017);
Exhibit No. 12 (February 4, 2014 bill from St. Anthony Medical Center);
Exhibit No. 13 (February 4, 2014 and February 6, 2014 bills from OSF Medical Group);
Exhibit No. 14 (February 4, 2014 bill from Illinois Pathologist Services, LLC); Exhibit No. 15 (February 4, 2014 bill from Rockford Pathology Associates, P.C.); Exhibit No. 16 (February 4, 2014 bill from OSF Healthcare, pp. 1-2);
Exhibit No. 18 (February 4, 2014 bill from OSF Saint Anthony Medical Center).

The Arbitrator finds the aforementioned charges are related to reasonable and otherwise necessary care and treatment for Petitioner's right shoulder condition. Respondent shall be given a credit in the amount of: **$4,500.65** for these particular medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any of the aforesaid providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

The Arbitrator has reviewed Petitioner's Exhibit No. 11 (Illinois Department of Healthcare and Family Services letter and spread sheet of payments made on Petitioner's behalf dated October 26, 2017) and the bills contained within Exhibit No. 11. The Arbitrator notes that the charges for medical services and prescription medication contained in Exhibit No. 11 are related to reasonable and otherwise necessary care for Petitioner's related condition. Based upon this finding, Respondent is to reimburse the Illinois Department of Healthcare and Family Services in the amount of: **$555.87.**

The Arbitrator further notes that the following bills have been paid in full by charity and financial assistance from OSF Healthcare and St. Anthony Medical Center and have zero ($0.00) balances:

Exhibit No. 15, p. 3 (February 27, 2014 bill from St. Anthony Medical Center), Exhibit No. 15, p. 4 (October 2, 2014 bill from St. Anthony Medical Center), Exhibit No. 15, pp. 5-7 (November 24, 2014 bill from St. Anthony Medical Center) Exhibit No. 17, pp. 1-8 (July 28, 2014 – August 25, 2014 bills from St. Anthony Medical Center)

After Arbitrator finds these charges are related to reasonable and otherwise necessary care and treatment for Petitioner's related condition. Respondent shall hold Petitioner harmless from any claims by any of the aforesaid providers for these particular bills set forth in this paragraph in the event that any of these providers seek reimbursement.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same in concluding that Petitioner has proven by a preponderance of the evidence that he should be awarded temporary total disability benefits.

The Arbitrator notes that Dr. Fischer's records do not contain any off-work notes. Moreover, there are not any additional notes within Dr. Fischer's chart that comment on Petitioner's ability or inability to work between November 11, 2014 and February 25, 2015 (See Px.4). Nevertheless, the Arbitrator relies on the treating medical records in support of this finding.

Petitioner had surgery on November 24, 2014 and his right arm placed in a sling immediately after his surgery (Px.2, pp. 8-9; Px.4, p. 9). Petitioner saw Dr. Fischer for the first time after his surgery on December 4, 2014 (Px.4, p. 8). Dr. Fischer noted Petitioner was to keep his right arm in a sling for another four (4) weeks before beginning physical therapy or a home exercise program (Px.4, p. 8).

Petitioner testified that he was incapable of working on December 4, 2014.

Petitioner returned to Dr. Fischer on December 31, 2014. Petitioner was still taking Norco for pain and his right arm remained in a sling (Px.4, p. 9). Dr. Fischer wanted Petitioner to begin physical therapy December 31, 2014, working on progressive, active and passive range of motion, along with organizing a home exercise program (Px.4, p. 9). Petitioner testified that he was incapable of working on December 31, 2014.

Petitioner next saw Dr. Fischer on January 28, 2015 (Px.4, p. 10). Petitioner continued with physical therapy as of January 28, 2015, but his physical therapy had been reduced from three (3) times a week to two (2) times a week (Px.4, p. 10). Petitioner still had pain as of January 28, 2015, with mornings being the worst for his pain (Px.4, p. 10). Petitioner continued his physical therapy subsequent to January 28, 2015 (Px.3, pp. 124-201). Petitioner testified that he was incapable of working on January 28, 2015.

Petitioner saw Dr. Fischer for the final time on February 25, 2015 (Px.4, p. 3). Petitioner had three (3) physical therapy sessions remaining on February 25, 2015 (Px.4, p. 3). Dr. Fischer determined on February 25, 2015 that Petitioner had sufficient motion so that he could complete his remaining physical therapy sessions and then continue on with his own home exercise program (Px.4, p. 4). Petitioner testified he was capable of returning to work as of February 25, 2015.

Petitioner testified that he remained unemployed after he left his employment with Respondent on February 10, 2014 (Px.3, p. 1). Petitioner further testified that he never applied for unemployment during the entire time he missed work because of his right shoulder injury.

The treating medical records support a finding the Petitioner was incapable of returning to work from the date of Petitioner's right shoulder surgery, November 24, 2014, through the last date he saw Dr. Fischer, February 25, 2015, for a total of 13 3/7 weeks.

Petitioner is hereby awarded temporary total disability for that time period.

ISSUE (L) What is the nature and extent of the injury?

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same in addressing the nature and extent of Petitioner's causally related injuries.

In determining permanent partial disability, Section 8.1(b) provides that permanent partial disability shall be established using the following criteria: (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.

Regarding (i), the Arbitrator notes that the parties did not submit an American Medical Association (AMA) impairment rating; therefore, in light of the foregoing, the Arbitrator assigns no weight to the AMA impairment rating.

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

JOHN THOMPSON,

Petitioner,

vs.

NO: 15 WC 29162

AMERICAN STEEL FOUNDRIES,

18IWCC0679

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 causation, temporary total disability, and medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but adds additional reasoning as outlined below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

We find Petitioner's credibility lacking regarding his continued low back pain between the date of the stipulated accident on August 1, 2015 and his emergency room visit on August 26th. Petitioner testified that, after his shift ended around 7 a.m. on August 1, 2015, he texted his supervisor, Chad Everett, saying he would not be able to work that evening because he didn't have a babysitter. *T.79*. Petitioner admitted that his text message said nothing about being unable to work because of a work injury. *T.80-81*. Petitioner testified that he continued working his regular job, between 45 and 50 hours per week, until August 26th. There are no records of any treatment during that period.

Petitioner testified that he requested August 15th off work and a shift change on August 22nd because he needed to move items from his house in Granite City, Illinois to his new house in St. Peters, Missouri, which is about a 45-minute drive, barring traffic. *T.30, 82-89.* At 2:29 p.m. on August 26, 2015, Petitioner sent a text message to Chad Everett stating:

> I need to see the work doctor about my back, the last two nights driving to and from work my back really hurt and now this morning my right lower leg is going numb and my right foot and toes are numb and tingling and it hurts like hell to walk. I need to take off tonite [. sic] *Rx9*

Mr. Everett testified that, at the time he received this text message, he was not aware that Petitioner was claiming a work injury on August 1, 2015. *T.124.* Mr. Everett sent an e-mail to his superiors indicating that Petitioner had been moving the past week and had been granted off work on Saturday August 15th and changed his shift on August 22nd so he could continue to move. *T.125, Rx14.* Mr. Everett testified he did this because the text message from Petitioner confused him because he never knew of Petitioner's injury or any pain or any limitations "so when he was texting me about personal stuff, then all of a sudden he jumps in and says that he needs to see a work doctor about his back… I started getting concerned and confused about why now all of a sudden he wants to see the work doctor when I didn't even know he had a work injury." *T.126.*

A triage note from August 26, 2015 at 9:11 p.m., contained in the Progress West Hospital records, states that Petitioner had right low back pain that started around 7 a.m. that morning, with burning, shooting pain and numbness and tingling down the right leg. *Px1.* A nursing note at 10:31 p.m., indicates an onset of 2-3 days but the symptoms "have worsened in last 1 day." *Id.* We find it significant that this record does not relate Petitioner's back pain to any accident at work on August 1, 2015, but rather to something in the last two or three days. This would be consistent with Petitioner's text message on August 26th, indicating that "the last two nights driving to and from work my back really hurt." The history in this record also indicates the onset of low back pain was that morning around 7 a.m. with pain down his right leg and numbness and tingling in his toes. We note that this record also states that Petitioner "reports that today at work his symptoms worsened and he was forced to lay down. He then managed to get home and has been lying down all day." *Id.* However, Petitioner never testified at hearing that his pain worsened at work that morning or that he was forced to lay down. Petitioner testified:

Q: Did anything happen that day?
A: No, just when I got out of the car. When I got home from work I could barely get out. Wife seen me hobbling in, she's like what's wrong and I said it really, really hurts, you know. I said, I feel like somebody's trying to yank my leg off. It hurt. At that particular time, I mean, just everything just – I could hardly think straight it hurt so bad.
Q: Were you in pain at work?

A: Again, I was in a whole lot of discomfort at work, you know. I don't know how else to put it. I mean, everybody knew I was in discomfort.
Q: Did anything happen between [8/1] and [8/26] that increased or caused different pain?
A: I wouldn't say anything that – you know, I just did my daily work stuff, you know.
Q: So you weren't injured driving a car, moving, anything that caused injury?
...
A: No. *T.28-29.*

We note that Petitioner did not call any witnesses to support his claim that "everybody" at work knew he was in pain. To the contrary, Chad Everett testified that both he and Petitioner worked the first shift during the week of Monday, August 3rd through Friday, August 7th. *T.116.* Mr. Everett testified that he would see, work, and talk with Petitioner "very often" and many times they worked on jobs together. *T.116-17.* He testified that, during that week, Petitioner did not complain to him about any low back pain, leg pain, leg numbness or difficulty walking. *T.117.* Mr. Everett also did not observe Petitioner limping or exhibiting any facial grimacing or any other signs that he might be in pain, and he was not aware of any difficulty Petitioner might have been having performing his job duties. *Id.* He worked with Petitioner on nine shifts between August 1st and August 26th. *T.129.* Mr. Everett testified that up to and including August 25, 2015, he had not noticed any change in Petitioner's physical condition. *T.151.*

We find the causation opinion of Dr. Matthew Gornet to be unpersuasive because it is based on his belief that Petitioner continued to have low back pain from August 1st until August 26th. *Px7 at 7.* Dr. Gornet testified that Petitioner told him three weeks later his pain progressed without any other trauma, slips, falls, or other injuries. *Id. at 8.* Petitioner developed severe pain down his right leg, so he went to the emergency room. *Id.* Dr. Gornet opined Petitioner injured his disc on August 1, 2015 and "then it blew three weeks later." *Id. at 26, 46.* Dr. Gornet testified:

Q: And can you get an L4-5 extruded fragment such as you saw in the September 2015 MRI from putting a load on the spine as a result of bending over?
A: Again, anything that for whatever reason causes the disc to fail could cause that fragment to extrude out more. It's just the amount of activities are infinite, so you'd have to relate that to the patient's history. That's the only way you can associate it with a particular history.
Q: And so bending over is a type of activity that could produce an extruded fragment such as you saw during surgery, correct?
A: Bending over, twisting, we know – and I'm sure everyone involved in this knows that bending and lifting can cause an injury to the disc, and so you'd have to relate that to the patient's history to determine whether or not that is associated or not. *Id. at 57.*

Regarding the gap in treatment between August 1st and August 26th, Dr. Gornet testified:

> the gap between those two times is indicative of a disc injury that ultimately blew. I believe the allegations in this case are maybe that it blew for different reasons. I can't refute or deny that. The only thing I can state is that the only medical history provided is one of an injury at work, which is consistent with that disc injury. There is no other medical history supporting that; therefore, my opinions are that they are causally connected to the disc injury at work. *Id. at 67.*

However, Petitioner did not inform him that he had been moving his family and household during the week before he developed the sudden onset of right leg pain. *Id. at 26, 58.* It also does not appear that Dr. Gornet was aware Petitioner's right leg pain and numbness developed during his drive home on August 26th, which caused Petitioner difficulty getting out of his car. *T.28.*

Respondent's Section 12 examiner, Dr. Frank Petkovich, testified that, based on a June 16, 2011, Petitioner had a pre-existing herniation at L4-5. *Rx1 at 18-22.* He opined that Petitioner sustained a lumbar strain on August 1, 2015, which can happen without affecting the underlying L4-5 disc herniation that was already present. *Id. at 49-50.* Dr. Petkovich testified that "something happened" around August 26th, which caused a flare up of the pre-existing L4-5 condition. *Id. at 51.* He opined that Petitioner's driving long distances to and from work or moving during the previous weekends could have caused it. *Id.* Dr. Petkovich testified that activities of daily living could cause the pre-existing herniation to become worse or more symptomatic because "it was definitely a ticking time bomb waiting to go off" from at least June 2011. *Id. at 52.* He testified, "Any very minor things can cause a disc to explode...such as going down the steps wrong or tying your shoes" but the driving back and forth and the moving were two very important factors. *Id.* He explained that driving long distances affects the L4-5 disc because "you're loading your lumbar spine to where you're putting increased pressure there" and it's "a known fact that prolonged sitting or driving can stir it up." *Id. at 53.*

We agree with the Arbitrator that Petitioner sustained a lumbar strain on August 1, 2015, which resolved. We find it more likely than not that his pre-existing L4-5 herniated disc worsened while driving long distances in the days leading up to August 26th, and Petitioner became suddenly more symptomatic with new right leg complaints that morning while driving. We find this consistent with Dr. Petkovich's opinion, which is more persuasive than that of Dr. Gornet. We find Petitioner failed to prove that his condition on August 26, 2015 and the subsequent treatment was causally related to his lumbar strain on August 1, 2015.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed is hereby affirmed and adopted with the above additions.

18IWCC0679

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 7 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 9/12/18
49

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

THOMPSON, JOHN
Employee/Petitioner

Case# **15WC029162**

AMERICAN STEEL FOUNDRIES
Employer/Respondent

18IWCC0679

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

If the Commission reviews this award, interest of 1.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
GIAMBATTISTA PATTI
PO BOX 99
E ALTON, IL 62024

0385 BONALDI CLINTON & DAVIS LTD
DAVID C DAVIS
2900 FRANK SCOTT PKWY WEST
BELLEVILLE, IL 62223

18IWCC0679

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOHN THOMPSON
Employee/Petitioner

v.

AMERICAN STEEL FOUNDRIES
Employer/Respondent

Case # **15** WC **29162**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **November 22, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 1, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$80,393.84**; the average weekly wage was **$1,546.04**.

On the date of accident, Petitioner was **47** years of age, *married* 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 **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's request for payment of medical services is denied because the accident of August 1, 2015, did not necessitate any such services.

Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being is causally related to his accident at work on August 1, 2015. Petitoner's request for prospective medical care is denied.

Petitioner's request for temporary total disability is denied because he did not require any work restrictions related to the accident of August 1, 2015.

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

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

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

Signature of Arbitrator

June 1, 2017
Date

JUN 6 - 2017

ICArbDec19(b)

18IWCC0679

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOHN THOMPSON
Employee/Petitioner

v.

Case #: 15 WC 29162

AMERICAN STEEL FOUNDRIES
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On August 1, 2015, Petitioner was 47 years old, married, and had three dependent children. He was employed by Respondent as an electrician and had been so employed since July 5, 2011. On July 31, 2015, Petitioner was working the third shift, which ran from 11 p.m. to 7 a.m. He testified that in the early morning hours of August 1, 2015, he was in the process of helping to replace old resister cabinets with new ones. He had ground off the bottom of the old cabinets to free them up so they could be moved. Various estimates put the weight of the resister between 300 and 500 pounds. He got the resister free and started to rock it when it began to fall over. He tried to hold it but could not and in the process he felt a pain shoot down his right leg. He reported the incident to his then supervisor Bo, and went to the plant dispensary where he was seen by an EMT.

The dispensary note of August 1, 2015, indicates he was complaining of low back pain rated at 6/10 which he described as being sharp, going down the spine and buttocks and into the right leg. He was treated with an ice pack and heating pad and given Ibuprofen after which his pain was rated as 2/10. He left the dispensary a little over an hour later to return to work. RX7.

While in the dispensary, Petitioner completed an accident report entitled "Statement of Injured Party" indicating that the accident occurred at 3:45 a.m., and that the body part injured was his "left lower back". The form asked whether he had ever "experienced any pain, discomfort, numbness, or any other symptoms to these injured body parts" and he answered "no". RX6, TR51, 54-55. He signed the form, thereby certifying that he understood all the questions and had answered them truthfully and accurately. RX6.

Petitioner finished his shift at 7:10 a.m. At 7:43 a.m. he sent a text to his supervisor, Chad Everett, stating that he would not be able to work that night because he did not have a babysitter. RX11, RX9. There was no mention of the work injury or any back pain. TR79-81.

Petitioner resumed working his regular shift on August 3, 2015, and continued working approximately 45 to 50 hours a week until August 26, 2015. TR81. Between August 1 and August 26, 2015, Petitioner did not seek any treatment from a physician, although there is a dispensary on site for such a purpose. TR123. Petitioner testified that during those 25 days he had constant, but not always strong, pain, and that he would go to the dispensary on a daily basis for Ibuprofen because his back was sore. TR22, 25-26. He did not experience any leg pain during those 25 days. TR91-92, PX7.

Petitioner testified that he purchased a new home in St. Peters, Missouri around August 1, 2015, and that he was moving out of his home in Granite City, Illinois during the month of August. TR13, 24. On Saturday, August 15, 2015, he requested and received permission from Mr. Everett to take off work to help with his move. On Saturday, August 22, 2015, he switched his hours to the third shift so that he could again help with the move. TR82, 88. Petitioner testified that only the bedding and clothes were moved over in August, and that the larger items such as furniture and the refrigerator were not moved until much later. TR14, 85, 86-87. He testified that he only lifted some bags of clothes and let his son and his son's friend move everything else, including the beds. TR24-25, 88, 89, 105. They were living in the St. Peters home by the end of August. It was a 45 minute drive one way between the old and new houses. TR87. Petitioner testified that between August 1, 2015, and August 26, 2015, he did not sustain any accidents. TR25.

Chad Everett testified for Respondent. He has worked for Respondent for 19 years, the last 16 as the Chief Electrician over all electricians. TR109, 114. He hired Petitioner and has remained his supervisor since then. TR111. Petitioner's time card for the month of August 2015 was admitted into evidence. RX11. Mr. Everett testified that he was working Monday through Friday that month from 6:30 a.m. to 4:00 p.m. and that he and Petitioner worked the same shift 9 times between August 1 and August 25, 2015. TR114-115, 129. When on the same shift, he would see Petitioner "very often" and they would work together many times. TR116-117. Mr. Everett's office was approximately 50 yards from where Petitioner normally worked. TR113. During the nine shifts they worked together, Petitioner never complained to Mr. Everett of having any pain, never asked to be placed on lighter duties, never grimaced or showed other signs of being in pain, never limped, and never had any difficulty performing his job duties. TR115-117, 120-121. On the days between August 1 and August 26, 2015, when they were not working the same shift, there would be an overlap of 1.5 to 2 hours in the morning where Mr. Everett would talk, observe, and work with Petitioner. During those times, there were again never any complaints of low back pain, leg pain, numbness, or difficulty walking. Mr. Everett never saw Petitioner grimace, limp, or otherwise indicate that he might be in pain. Petitioner never requested that he be assigned lighter duties and he never had any difficulty performing his job. TR118-119.

Mr. Everett testified that injured employees are supposed to come to him if they have a work injury, but that Petitioner never told him about the August 1, 2015, accident. TR36, 138,

142. One of Mr. Everett's duties is to investigate any work injury involving the electricians but he did not do that for Petitioner because he was not aware of it until several months later. TR142-143, 146. He testified that Petitioner's physical condition, presentation, and ability to work was no different between August 1 and August 25, 2015, than it was in the 12 months before. TR151.

On August 25, 2015, Petitioner was working the third shift, which ended at 8:37 a.m. on August 26. TR122. The start of Mr. Everett's shift overlapped the last couple of Petitioner's hours that day but the two never spoke that day. TR122-123. Petitioner testified that when he got home from work on August 26 he could barely get out of the car. He hobbled inside and felt like someone was trying to yank his leg off. TR28-29. He testified he had shooting pain down his right leg along with back pain. TR29-30. At 2:29 p.m. that day, Petitioner sent Mr. Everett a text that stated:

"I need to see the work doctor about my back, the last two nights driving to and from work my back really hurt and now this morning my right lower leg is going numb and my right foot and toes are numb and tingling and it hurts like hell to walk. I need to take off tonight. I just talked to work infirmary and they said to see my doctor and my wife said I'm going to the hospital tonite no matter what. If I have too (sic) take a vacation day for tonite that's okay. With all the hospital and things happening to me and the wife this year I'm still sitting around 7 points so I can't afford anymore points against me." RX9.

Mr. Everett replied that he would give Petitioner a vacation day. Petitioner's text does not mention the August 1, 2015, work accident as the cause of his various complaints.

At approximately 9:00 p.m. on August 26, 2015, Petitioner presented to the emergency room at Progress West Hospital in O'Fallon, Missouri with a chief complaint of right lower back pain that started that morning around 7:00, along with burning and shooting pain going down the right leg with numbness and tingling in his toes. When standing, his leg went numb. He reported that his symptoms worsened at work that day and he was forced to lie down. Petitioner said he managed to get home and had been lying down all day, and that his pain was exacerbated with ambulating. There was no history relating the onset of these complaints to the incident on August 1, 2015, which was not mentioned in these records. Petitioner was diagnosed with sciatica, given medications, and taken off work for two days. RX8.

On August 27, 2015, at 2:34 p.m., Petitioner sent Mr. Everett another text advising that he would not be in to work that night or the next night because he had severe sciatica and could not be out of bed as a result of a herniated or bulging disc. Again, there was no mention of the August 1 work accident as being causative. Petitioner sent Mr. Everett another text on Sunday, August 30, 2015, calling off work and describing his symptoms, but again not relating them to the August 1 accident. RX9.

Petitioner testified that he followed up with a Dr. Bell who referred him to Dr. Mark Eavenson, a chiropractor with Multi-Care Specialists. TR37-38, PX2. On August 31, 2015, Petitioner saw Dr. Eavenson, who recorded a history of the work injury three weeks earlier when he twisted and pulled his lower back. Petitioner said he had episodes of low back injuries previously. Namely, ten years earlier he initially hurt his back and went to a company doctor

and was sent for rehabilitation; he also hurt his back playing soccer in his backyard; and had an MRI six years earlier and was told he had a disc bulge. Petitioner reported he had recently moved to O'Fallon, Missouri and that the drive over and back caused excruciating low back pain. He stated he then developed numbness in the right leg and foot and went to the emergency room. Dr. Eavenson diagnosed a lumbar disc protrusion with right lower extremity radiculitis, prescribed an MRI and physical therapy, and took Petitioner off work. PX2.

On September 2, 2015, Petitioner underwent a lumbar MRI, which the radiologist read as showing (1) a central and right paracentral disc herniation with a prominent right paracentral inferiorly extruded disc fragment at L4-5, resulting in severe stenosis of the right lateral recess and displacement of the right traversing L5 nerve root; and (2) a disc bulge and milder left paracentral disc herniation at L5-S1 with facet arthropathy contributing to left moderate foraminal stenosis. PX3.

Dr. Eavenson referred Petitioner to Dr. Matthew Gornet. Dr. Gornet testified for Petitioner by deposition. He is a Board Certified Orthopedic Surgeon who devotes his practice to treating only the spine. Petitioner first saw Dr. Gornet on September 9, 2015. He gave a history of the August 1 work accident and reported that it caused immediate sharp pain to his right side and buttock but did not go down the leg. Petitioner further said that he continued to work but also continued to have low back pain. He reported that three weeks later the pain progressed without any other trauma, slips, falls or other injuries causing severe right pain down the leg and prompting the ER visit. He advised he had had prior episodes of low back pain and most recently had an MRI five years earlier. Dr. Gornet took lumbar x-rays, which showed some retrolisthesis and loss of disc height at L4-5 and some loss of disc height at L5-S1 with some narrowing on the left side. He reviewed the MRI and noted it revealed a massive herniation at L4-5 on the right with a free fragment migrating into the foramen, correlating with Petitioner's symptoms. He noted the MRI also showed a central annular tear at L5-S1. Dr. Gornet's diagnosis was lumbar radiculopathy secondary to the L4-5 disc herniation, along with a possible structural injury to the discs at L4-5 and L5-S1. He took Petitioner off work and recommended an emergency epidural steroid injection at L4-5, which was performed but provided no benefit. Dr. Gornet then recommended "emergent" surgery, which he performed on September 15, 2015. Specifically, he performed a microdiscectomy at L4-5 with removal of the free fragment and an L5 nerve root decompression. Testing during surgery showed the L5 nerve function to be severely impaired. Dr. Gornet testified he has operated on three other patients having comparable massive herniations. PX7. On November 19, 2015, Dr. Gornet prescribed physical therapy three times a week for six to eight weeks.PX4. Petitioner testified he did not attend due to transportation issues. TR93.

On December 14, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Frank Petkovich. Dr. Petkovich testified for Respondent by way of deposition. He is a Board Certified Orthopedic Surgeon who has been in private practice since 1980. The focus of his practice had been spine surgery until three to four years ago when he stopped doing it due to an eye injury and resulting surgeries. He testified he had performed 40 to 50 surgeries for massive herniations like the one noted on the MRI of September 2, 2015. Petitioner described the August 1, 2015, work accident and stated it caused low back pain with some discomfort into the right gluteal area. He further stated that he was able to return to work without restrictions

after the accident, until he developed a sudden onset of severe low back and right leg pain on August 26, 2015. He also reported that he was moving from one house to another on a couple of weekends in mid-August, but that his sons did most of the lifting. Dr. Petkovich reviewed the MRI report and films along with Dr. Gornet's records, including his operative report. RX1.

Petitioner reported to Dr. Petkovich that his leg pain had improved dramatically with the surgery and that he had some residual low back pain and right leg discomfort. He also complained of numbness on the lateral aspect of the right foot. On examination, there was a mildly limited range of motion in the lumbar spine consistent with the surgery; mild tenderness to palpation in the right paraspinous area without spasm; decreased sensation on the right foot and calf; and mild radicular symptoms on the right-sided straight leg raising test. Dr. Petkovich diagnosed a disc herniation at L4-5 with an extruded fragment, a disc herniation at L5-S1 on the left which was asymptomatic, and degenerative disc disease at L4-5 and L5-S1. He did not believe Petitioner required any further treatment, noting that he does not order physical therapy for micro-discectomies. He recommended a home exercise program only, including walking a mile a day. He opined that Petitioner was at maximum medical improvement from the surgery and could return to his electrician job without any restrictions based on his experience in treating similar conditions. RX1.

On January 25, 2016, Petitioner returned to Dr. Gornet, who released him to return to work with a 25 pound restriction. Dr. Gornet did not believe Petitioner was at maximum medical improvement, noting that the clinical course following massive herniations was unpredictable in his experience. PX7.

On February 16, 2016, Petitioner presented to Chiropractor Mark Eavenson for therapy. He reported low back pain rated at 3/10, and reported that he had no lower extremity complaints other than some mild numbness in the middle three toes of the right foot. Dr. Eavenson prescribed concurrent chiropractic and physical therapy three times a week. On March 16, 2016, Petitioner reported that his pain was only a 2/10 and that he felt 75% improved. On March 23, 2016, he told his physical therapist that he had ridden his motorcycle for the first time the day before and was having increased pain at a level of 5/10. PX2. The Arbitrator notes that Petitioner testified that he owned a Harley Davidson motorcycle weighing over 500 pounds but denied riding it after the surgery. TR97-98. The Multi-Care Specialists notes indicate that Petitioner's pain was generally in the 1-3/10 range from April 12, 2016, through his final visit on April 25, 2016. PX2.

On April 28, 2016, Dr. Gornet believed Petitioner was suffering from significant back and buttock pain to the right hip and right great toe. He noted that if Petitioner's symptoms persisted he would recommend a disc replacement surgery at L4-5 and a fusion at L5-S1. PX4. On June 30, 2016, Petitioner underwent a repeat lumbar MRI, upon referral by Dr. Gornet. The radiologist interpreted it to show a recurrent protrusion in the right paracentral-lateral recess position with minimal extrusion of disc material, and a possible small sequestered fragment resulting in a right-sided stenosis. The radiologist also noted a protrusion with a right annular tear and bilateral stenosis at L5-S1. PX3. Dr. Gornet reviewed the scan on June 30, 2016, compared it to the one taken on September 2, 2015, and recommended the previously discussed surgery. PX4.

On August 15, 2016, Petitioner returned to Dr. Petkovich for a second Section 12 exam. He reported that he had no right leg pain, had some low back discomfort, and had some residual numbness in the right foot. On examination, Dr. Petkovich found (1) mildly restrictive range of motion, consistent with mild degenerative disc disease; (2) subjective tenderness to palpation in the right lumbar region with no muscle spasms; (3) intact neurologic exam except for mild decreased sensation along the L5 nerve distribution, consistent with chronic irritation of that nerve root; and (4) positive straight leg raise on the right, consistent with longstanding irritation of that nerve root dating back to at least 2011. RX13.

Dr. Petkovich reviewed all the medical records to that point in time, along with the June 30, 2016, lumbar MRI report and films, which he did not believe showed any findings. He opined that Petitioner had some chronic low back pain without evidence of herniation or nerve root compression. He took flexion and extensive x-rays to look for any instability, but found none. He continued to believe Petitioner was at maximum medical improvement and did not need any additional testing or treatment. He noted Petitioner had done quite well, his low back pain was under control, there were no radicular symptoms, there was no nerve root irritation, and although he had some chronic decreased sensation along the L5 nerve root, it was not affecting his walking. Dr. Petkovich did not recommend any further surgery based on the absence of any radicular symptoms, Petitioner's great physical shape, and only mild numbness in the right leg which some chronic low back pain. He explained that Dr. Gornet's proposed disc replacement surgery at L4-5 and fusion at L5-S1 was indicated for intractable back pain, leg pain, and/or an unstable spine, none of which were present in Petitioner's case. He continued to believe that Petitioner was capable of returning to work as an electrician without restrictions, and had been capable of working in that capacity since his initial exam on December 14, 2015. PX13.

On September 29, 2016, Dr. Gornet continued to recommend surgery and continued Petitioner on light duty restrictions. PX4.

Petitioner has an extensive history of back problems prior to the August 1, 2015, work accident. On August 27, 20015, he presented to Dr. Donald Bassman, an orthopedic surgeon, complaining of low back pain. TR55-56. He gave a history of injuring his back four years prior, for which he underwent physical therapy, which helped. He reported he was now hurting again as a result of lifting weights while exercising. It was noted he was working regular duty. Dr. Bassman prescribed physical therapy. On November 2, 2005, he returned to Dr. Bassman and advised he went to two PT sessions, felt better and stopped, then moved a DVD and developed severe right-sided pain and went back to therapy. He reported his pain ranged from 3/10 to 8/10, that he was weak, and that he had a difficult time walking. Dr. Bassman diagnosed a lumbar strain and ordered an MRI. RX2. The MRI was performed on November 4, 2005, and revealed mild diffuse annular disc bulges at L4-5 and L5-S1 with mild anterior impressions upon the thecal sac. RX3. On November 30, 2005, Petitioner returned to Dr. Bassman and reported that therapy had helped a lot, he was exercising, and he had obtained 100% pain relief. Petitioner was diagnosed with degenerative disc disease, instructed to continue with a home exercise program, and told to return as needed. RX2.

On March 10, 2010, Petitioner saw his primary care physician, Dr. Delores Dotson. He gave a history of being unemployed, having issues with anxiety for 20 years, of drinking heavily for the past six years, being in treatment since he was 22, and having a history of marijuana use. He was diagnosed with a mood disorder and alcohol abuse, and was encouraged to seek treatment for both. On May 25, 2010, he followed up with Dr. Dotson and indicated that he was receiving treatment for the mood disorder and alcohol abuse and was doing better. RX5.

On June 13, 2011, Petitioner returned to Dr. Dotson with a history of developing right-sided low back pain from picking up a dog one week earlier. His pain radiated to the right leg and was 6-9/10. His pain was exacerbated by coughing, bowel movements and sitting. He had tried six Motrin a day which provided only mild relief. He reported that week before this pain began, he had moved furniture. He said since last seeing Dr. Dotson, he had checked himself into a hospital for psychological reasons and had done well since his discharge without any alcohol or drugs for several months. He did not want any pain medications for his back, but wanted to get whatever was wrong fixed. On examination, he had a positive straight leg raise on the right. A lumbar x-ray was reported as normal. Petitioner was diagnosed with lumbago with sciatica and a herniated lumbar disc. Dr. Dotson prescribed Motrin and physical therapy and ordered an MRI. He was to return in four weeks. RX5.

The MRI was performed on June 16, 2011, which revealed: (1) L4-5 bulging disc with a large right paracentral disc extrusion extending down into the right lateral recess with severe compression of the traversing right L5 nerve root with mild central spinal canal stenosis and mild bilateral facet arthropathy; and (2) L5-S1 bulging disc with a large superimposed broad-based left foraminal zone protrusion causing mild mass effect and posterior displacement of the traversing left S1 nerve root with an annular tear and mild bilateral facet arthropathy. RX5.

Dr. Dotson reviewed the lumbar MRI report on July 1, 2011, determined that Petitioner needed to follow up with neurosurgery, and stopped any further physical therapy. On July 4, 2011, Petitioner was notified of Dr. Dotson's recommendations by telephone. RX5. Petitioner testified that he did not see a neurosurgeon and that his pain went away "in a couple of weeks". TR61-62.

In late June of 2011, Petitioner sought employment with Respondent which required him to fill out various forms. TR63-64. One of the forms was a "Pre-placement Disclosure Statement", wherein the applicant was warned that failing to provide accurate information could result in withdrawal of an employment offer or discharge. Petitioner completed and signed the form on June 27, 2011. TR. 64. That disclosure statement inquired about Petitioner's medical history. Question 15 asked whether he had ever had back pain and he answered "no". Question 60 asked whether he had ever had medical treatment for his back and he answered "no". Question 83 asked whether he was currently under the care of a doctor and he answered "no". RX10. At trial, Petitioner admitted that these were false statements. TR70-72. Petitioner was also required to complete a "Medical Evaluation Questionnaire", which he completed and signed on June 27, 2011. He answered question 14 indicating that he had never had a back injury and question 15 indicating that he did not currently have any back pain. RX10. Petitioner testified that these were not false statements, because his back pain had resolved by then. TR71-72. At

trial, Petitioner testified that he passed his pre-employment physical with Respondent, which required him to pick up large weights and climb ladders, among other things. TR19-20.

Petitioner also testified that when he completed his "Statement of Injured Party" on August 1, 2015, (RX6) he falsely stated that he had never injured his back before. At trial, he said he did not see a doctor for his back between 2011 and August 26, 2015, and stated that he does not like going to doctors. TR73, 102. He also testified that his back pain has not gone away and that he wants to proceed with Dr. Gornet's recommended surgery. Petitioner also testified that he has not worked since August 26, 2015. TR91.

Dr. Gornet and Dr. Petkovich offered opinions on issue of causation. Dr. Gornet testified that he wanted "to be very clear" that he cannot date when the massive disc herniation appeared in August of 2015. Nevertheless, he believes the accident of August 1, 2015, caused an injury to the L4-5 disc which then progressed to a massive herniation 25 days later. On cross-examination, Dr. Gornet conceded that Petitioner's symptoms changed between August 1, 2015, and August 26, 2015, and that he cannot refute or deny that the disc "blew" for reasons other than the original injury. He also acknowledged that lumbar strains usually cause severe back pain, muscular pain, and spasm which can cause pain to radiate to the buttocks and hips, that some people can work with lumbar strains, and that 90% of the people with strains have a resolution of their symptoms within 6 weeks to 3 months. He testified that 99.9% of muscular strains improve spontaneously without any operative treatment. He reviewed the MRI of June 16, 2011, and agreed that it showed a large herniation on the right at L4-5 compressing the L5 nerve root, along with stenosis and arthritis. He testified those conditions are capable of causing low back and right leg pain. He conceded that the L5 nerve root remained compressed from June 16, 2011, until the time of Petitioner's surgery, and that such compression could cause ongoing weakness and motor changes as a result of damage to the nerve. He testified there was a new fragment found at the time of his surgery which was also compressing the L5 nerve root. He did not remove the old extruded fragment which was calcified. PX7.

Dr. Gornet conceded that the pathology shown on the June 16, 2011, MRI could become symptomatic through "mechanic loading", which is a force that exceeds what the annulus can handle, noting that over time the disc will lose its ability to resist mechanic loading stresses. He noted that moving a sofa is an example of mechanic loading. He testified that bending over and twisting are other examples of activities which can cause the kind of massive herniation he found during surgery. He agreed that Petitioner's residual leg numbness noted on October 21, 2015, could be a symptom of the long-standing nerve root compression dating back to at least 2011. Regarding the L5-S1 disc, Dr. Gornet testified that the MRI's of June 16, 2011, and September 2, 2015, showed the same pathology. Although he is now recommending a fusion at L5-S1, he did not express any opinion at his deposition or in his office notes relating the necessary for that procedure to the work accident of August 1, 2015. Lastly, Dr. Gornet agreed that Petitioner was capable of sustaining a lumbar strain superimposed on the pre-existing pathology without causing a new injury to the L4-5 disc. He testified that it was "very clear" that the disc blew three weeks after the work accident of August 1, 2015. PX7.

Respondent's examining physician, Dr. Petkovich, testified that the work accident of August 1, 2015, caused a muscular lumbar strain. He based his opinion on Petitioner having

symptoms consistent with that condition per the August 1, 2015, dispensary note, on Petitioner's subsequent history of having low back pain but no leg pain until August 26, 2015, and on Petitioner's ability to continue working without restrictions until August 26, 2015. Like Dr. Gornet, Dr. Petkovich testified that Petitioner could suffer a lumbar strain without affecting the underlying disc herniation at L4-5. Dr. Petkovich agreed with the medical literature indicating that most back strains resolve within 12 weeks. He further testified that the work-related strain either had resolved by August 26, 2015, or would have resolved on its own without any need for any treatment. Dr. Petkovich did not believe Petitioner sustained an injury to the L4-5 disc on August 1, 2015, because if he had, he would have had a different set of symptoms. Namely, he would have developed severe radiating leg pain within two to three days and would not have gotten better such that he could have continued working without restrictions. PX1.

Dr. Petkovich testified that "something happened" shortly before August 26, 2015, when Petitioner developed his severe right leg pain. He described Petitioner's pre-existing pathology at L4-5, noted on the June 16, 2011, MRI as a "ticking time bomb" waiting to go off, and that very minor things could have caused that to happen, including activities of daily living, going down steps, tying shoes, driving his vehicle long distances between his old and new homes, light lifting such as he described doing during the move, coughing, sneezing, or any one of another thousand things. RX1.

Dr. Petkovich testified he did not believe Dr. Gornet's proposed surgery was necessary, as previously noted, and further testified that such a procedure would not be related to the August 1, 2015, work accident. He explained that if Petitioner were to have surgery, it would be for the degenerative changes that were present before August 1, 2015, including the long-standing nerve root compression at L5, which had caused some permanent nerve damage manifesting in right calf and foot numbness and occasional right leg discomfort. RX13.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his current condition with regard to his lumbar spine is causally related to his accident of August 1, 2015, and further finds that the accident resulted in a lumbar strain only.

Following the accident, Petitioner experienced immediate pain in his low back and buttock, but did not experience leg pain for the next 25 days. Within an hour of ending his shift on August 1, 2015, Petitioner texted his supervisor, Mr. Everett, to request that he be taken off his shift later that evening. The reason for needing off was not because of the work injury or back pain, but because he could not get a babysitter. He was able to return to work in his physically demanding job, working 45 to 50 hours a week, without missing a shift and without needing accommodations or restrictions. With the exception of the visit to the dispensary on August 1, he did not seek any medical treatment over the next 25 days, despite having the dispensary onsite. No one recommended that he get an x-ray or an MRI during that time. Petitioner's supervisor, Chad Everett, credibly testified that Petitioner's condition, physical appearance, and ability to work was no different between August 1 and August 25, 2015, than it had been in the prior year. Mr. Everett worked with Petitioner on nine shifts of those 25 days after the accident and saw and talked with Petitioner for up to two hours on all other shifts during that period. Petitioner never mentioned the work accident, never complained of any low back or leg pain, never asked for lighter work, never limped, grimaced, or showed any signs of being in pain, and never had any difficulty performing his duties.

Dr. Gornet and Dr. Petkovich agreed that a person such as Petitioner could sustain a lumbar strain without setting off or injuring the underlying L4-5 disc pathology. They also agreed that on August 26, 2015, Petitioner's L4-5 disc "exploded", causing severe radiating right leg pain and severe back pain, necessitating the emergency room visit, an MRI, an injection, and surgery all within three weeks. Dr. Gornet failed to offer a cogent explanation for how the August 1, 2015, accident led to this explosion 25 days later. Significantly, he admitted that he could not refute or deny that the disc blew for reasons other than the August 1 accident.

The Arbitrator finds significant that when Petitioner presented to the emergency room on August 26, 2015, he did not relate the onset of his symptoms to the accident on August 1. In fact, he made no mention of the accident, but rather reported the onset of his symptoms was 2-3 days prior. In addition, when he texted Mr. Everett several hours after the end of his shift on August 26 to let him know he would be going to the hospital, he did not relate his problems to the accident on August 1.

Dr. Petkovich described the L4-5 disc pathology as of August 26, 2015, as a ticking time bomb waiting to explode, and clearly did that day. He explained that almost anything could have caused the explosion, from activities of daily living, to moving his household from Granite City to St. Peters, to the long drives between those two residences. The Arbitrator finds this case to be very similar to *Greater Peoria Mass Transit Dist. V. Industrial Commission*, 88 Ill.2d 38 (1980). In that case, Petitioner was alleging a work related shoulder injury, but her surgeon indicated that any episode of minor trauma could have caused her shoulder to dislocate because it was a "time bomb" which could go off at an unpredictable time. The Supreme Court reversed the circuit court and Commission, and found Petitioner's condition was not related to her employment. In the case at bar, the evidence shows that Petitoner's pathology at L4-5 had so deteriorated that any normal daily activity could have caused the disc to explode.

The Arbitrator finds Dr. Petkovich to be persuasive in his opinion that Petitioner's accident of August 1, 2015, caused only a lumbar strain. In addition, the Arbitrator finds

significant that Petitioner sought no medical treatment following the incident on August 1, save for the trip that morning to the dispensary, that he never complained to his supervisor about pain from the accident in his several text messages to Mr. Everett, that he continued to work without limitation 45-50 hours a week, and that he admittedly moved his household contents between August 1 and August 26, 2015.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to meet his burden of proof in establishing that his current condition of ill-being is causally related to his work accident of August 1, 2015.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

In light of the Arbitrator's findings above with respect to issue (F), the Arbitrator finds that Petitioner did not require any medical services for the work-related lumbar strain. Petitioner's request for medical services is denied.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

In light of the Arbitrator's findings above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care.

In support of the Arbitrator's decision relating to issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In light of the Arbitrator's findings above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits. He missed no time from work that is attributable to his accident of August 1, 2015.

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

James Coffman,

Petitioner,

vs.

NO: 14 WC 39712

Hanson Material Services,

18IWCC0680

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2018, is hereby affirmed and adopted.

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

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

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

NOV 8 - 2018

DATED:
TJT:yl
11/5/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COFFMAN, JAMES
Employee/Petitioner

Case# **14WC039712**

HANSON MATERIAL SERVICE
Employer/Respondent

18IWCC0680

On 5/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0445 RODDY LAW LTD
CHRISTOPHER A TOMCZYK
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

18IWCC0680

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Coffman
Employee/Petitioner

v.

Case # **14** WC **39712**

Consolidated cases: **N/A**

Hanson Material Service
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **April 16, 2018**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On October 20, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was not* given to Respondent as explained *infra*.

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

In the year preceding the injury, Petitioner earned $64,295.92; the average weekly wage was $1,236.46 as explained *infra*.

On the date of accident, Petitioner was 50 years of age, *married* with 1 dependent child.

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

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

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

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable accident at work on October 20, 2014 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits including temporary total disability benefits, payment of medical bills, and permanent partial disability benefits are denied.

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

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

Signature of Arbitrator

May 15, 2018
Date

MAY 16 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

James Coffman
Employee/Petitioner

v.

Hanson Material Service
Employer/Respondent

Case # **14** WC **39712**

Consolidated cases: **N/A**

FINDINGS OF FACT

A hearing was held in Petitioner's above-captioned case. Arbitrator's Exhibit[1] ("AX") 1. The issues in dispute include accident, notice, causal connection, Petitioner's entitlement to temporary total disability benefits from October 25, 2014 through February 28, 2015, and the nature and extent of Petitioner's injury. AX1. The parties have stipulated to all other issues. AX1.

Background

James Coffman (Petitioner) testified that he was employed by Hanson Material Service (Respondent) for 18 years as a Mechanic. On October 20, 2014, Petitioner testified that he hit his head on an exhaust pipe while working on a boat at approximately 10 a.m. Petitioner explained that he stood up and hit his head while working on the engine. He testified that his right eye went black such that he could only see a little bit peripherally. Petitioner explained that he also felt dizzy and experienced a bad headache, so he sat down. He testified that a couple of days before this incident, he hit his head on a furnace on another boat. Petitioner felt a headache after that incident, but was otherwise ok. He did not experience any loss of vision then.

Notice

Petitioner testified that there was another worker with him that saw the accident. Petitioner testified that he spoke with Brian, the lead man, approximately an hour or two after the accident at the company. Petitioner testified that Juan, a welder and co-worker, was present. Petitioner explained that he reported that he hit his head.

Medical Treatment

Petitioner testified that he first received medical treatment on October 27, 2014. He explained that he experienced an immediate loss of vision in his right eye.

The medical records reflect that Petitioner presented at Adventist Bolingbrook Hospital on October 27, 2014 and discharged on October 31, 2014. PX1. The history on discharge reflects the following in pertinent part:

[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 deposition transcripts are further denominated with "(Dep Ex. _)."

> This is a 50-year-old while male who was admitted to Adventist Bolingbrook Hospital secondary to experiencing an acute stroke. It appears that patient was having symptoms, possibly even last week, when he has some disorientation and fell and since then has noted that his right eye vision is very poor and this has been of great concern to him. His wife also noted that he had some speech slurring or just speaking sort of incomprehensible type of speech pattern, which then eventually cleared. He was then found to have thrombus in the RCA and the internal carotid on the right side. Dr. Kannan was placed on consult when patient was in the emergency room, and the patient was judged to be stable and was brought to the medical floor. … The patient was placed on CIWA score and Ativan was used as well as beta blocker. The patient's agitation resolved nicely over a few days, but we were still unable to obtain MRI secondary to patient's inability to state still in the machine. The patient states the pounding caused him to have such terrible headache he could not tolerate it . He was extremely agitated, and this was tried several times when finally a repeat CT of the head was done. The patient also had speech evaluation which cleared him for p.o. feedings, thickened fluids and okay for solids. The patient was also seen by Dr. Subhash Shah, the physiatrist, who felt that he could be transferred to inpatient rehabilitation at Hinsdale when medically stable. The patient was then transferred on 10/31/2014 to Hinsdale inpatient rehab with the goal of aggressive rehabilitation and to have Dr. Walsh, the vascular surgeon, evaluate him regarding thrombus in the ICU and RCA, right side. I also had Dr. Prakash Selvaraj see the patient secondary to his complaints of loss of central vision in the right eye, and Dr. Selvaraj felt it was consistent with the retinal thrombus and it may be a more permanent type of a defect, which may not clear even after intervention is performed. ….

PX1. Regarding the head condition, Petitioner was diagnosed with an acute right-sided stroke with left hemiplegia. *Id.* While hospitalized, Petitioner was also examined by Dr. Kannan from the Center for Brain and Nerve Disorders on October 28, 2014. *Id.* He noted a history that Petitioner "woke up with symptoms, had right eye problem yesterday." *Id.* Dr. Kannan diagnosed Petitioner with acute CVA without any mention of trauma. *Id.* On discharge from the hospital, Petitioner was instructed to follow up with Dr. Walsh, a vascular surgeon. *Id.*

Petitioner testified that his symptoms continued with a worsening headache and inability to see out of his right eye. He then felt numbness and weakness down his side. Petitioner went to the emergency room and was an inpatient through October 31, 2014 and was then transferred to Hinsdale for inpatient rehabilitation through November 5, 2014.

Petitioner then presented to Christine Shih, M.D. (Dr. Shih) on November 12, 2014. PX3. She noted that he had a history of stroke with symptoms that began about two weeks ago. *Id.* Petitioner reported that he saw Dr. Salvaraj the day prior and was able to see more and had a field of vision after dilation. *Id.* He also reported poor vision in his left eye and reduced dexterity in the left hand, which he was working to improve. *Id.* Dr. Shih noted that Petitioner's left eye vision might not return and that Petitioner continued to experience a headache in the right side of his head. *Id.* Dr. Shih diagnosed Petitioner with a thrombotic stroke and indicated that he could return to work with restrictions to be evaluated by the employer to see if they could be accommodated. *Id.*

On November 13, 2014, Petitioner presented to Anuraj Gupta, M.D. (Dr. Gupta), an ophthalmologist, on referral from Dr. Shih. PX4. Dr. Gupta noted Petitioner's report that he hit his head on a pipe three weeks earlier after which he had a sudden loss of center vision with only peripheral vision now. *Id.* He also noted that Petitioner had a stroke on October 27, 2014. *Id.* Dr. Gupta diagnosed Petitioner with central retinal artery occlusion. *Id.*

Petitioner testified that he returned to work March 1, 2015. The medical records reflect that he continued to follow up with Dr. Gupta or Dr. Shih. PX3-PX4.

Petitioner eventually presented to Mark Benjamin, M.D. (Dr. Benjamin) of Benjamin Eye Care Center on July 23, 2015. PX6. Dr. Benjamin noted Petitioner's report that he fell and hit his head at work then a couple of days later had a stroke on October 27, 2014 and loss of right eye vision. *Id.* He diagnosed Petitioner with blunt head trauma and subsequent carotid plaque occlusion. *Id.*

Dr. Benjamin – Narrative Letter

In a letter dated October 6, 2015, Dr. Benjamin indicated that Petitioner's examination correlates with his historic recollection of blunt head trauma on October 27, 2014 and subsequent carotid plaque occlusion that caused anterior ischemic optic neuropathy in the right eye. PX7.

Dr. Gupta – Narrative Letter

In a letter dated January 11, 2016, Dr. Gupta indicated that Petitioner suffered a central retinal artery occlusion in the right eye, which led to permanent and dramatic decrease in his vision in the right eye. PX5. Dr. Gupta stated that Petitioner had lost approximately 99% of his vision in the right eye due to damage from the central retinal artery occlusion, which is often immediate and permanent. *Id.*

Petitioner's Section 12 Report & Deposition Testimony – Dr. Eidt

Petitioner called Steven Eidt, M.D. (Dr. Eidt), a board-certified ophthalmologist, as a witness and he gave testimony at an evidence deposition on April 28, 2017. PX8. Dr. Eidt did not examine Petitioner, but rendered a report at Petitioner's attorney's request regarding the relatedness, if any, of Petitioner's physical condition to the alleged injury at work. PX8 (Dep Ex. 2-5). Dr. Eidt reviewed Petitioner's medical records from Benjamin Eye Care Center, Dr. Benjamin's narrative letter, and the medical records from Dr. Gupta at DuPage Medical Group. PX8 (Dep. Ex. 3-5).

In his report dated January 27, 2016, Dr. Eidt noted that, based on the records that he reviewed, Petitioner sustained an ischemic insult to the neurosensory pathway of the right eye causing significant and extensive vision loss in the eye approximately two days following a head trauma on October 27, 2014. PX8 (Dep. Ex. 2). He opined that, due to the nature of the ischemic insult, any vision loss is usually permanent. *Id.*

Dr. Eidt testified that a carotid plaque occlusion as diagnosed by Dr. Benjamin means that a plaque from his carotid artery caused an embolus which caused lack of blood flow to his neurologic tissue. PX8 at 7. He testified that Petitioner suffered a central retinal artery occlusion to the right eye. *Id.*, at 10. Dr. Eidt testified that it was impossible for him to know for certain whether Petitioner's history of a pipe hitting Petitioner, falling, and striking his head either caused or aggravated his condition resulting in the stroke that resulted in the central artery occlusion. *Id.*, at 11. However, Dr. Eidt testified that "it appears to me that the striking of the head likely caused a plaque to break loose from his carotid artery which subsequently lodged into his either ophthalmic artery or central retinal artery, causing him to have a central retinal artery occlusion." *Id.*

Respondent's Section 12 Report & Deposition Testimony – Dr. Carroll

Respondent called Richard Carroll, M.D. (Dr. Carroll), board-certified in cardiology and internal medicine, as a witness and he gave testimony at an evidence deposition on January 19, 2018. RX1. Dr. Carroll did not examine Petitioner, but rendered a report at Respondent's attorney's request regarding the relatedness, if any, of

Petitioner's physical condition to the alleged injury at work. RX1 (Dep. Ex. 2). Dr. Carroll reviewed Petitioner's medical records from Adventist Bolingbrook Hospital and Dr. Shah from Petitioner's rehabilitation care. *Id.* He noted that, while Petitioner reported sustaining head trauma, there was no objective medical documentation of such an injury. *Id.* Regardless, Dr. Carroll opined that he did not feel that a blow to the head could have caused an occlusion of the right carotid artery as seen on Petitioner's CT scan. *Id.* He explained that "the right carotid artery occluded because a thrombus (of blood clot) developed with in the lumen of the artery, secondary to the advanced atherosclerosis." *Id.* Dr. Carroll further stated as follows:

> First of all, I would not expect to see the types of symptoms and findings the petitioner presented with on October 27, 2014 as a result of head trauma. The type of stroke he sustained was a function of decreased blood flow to the right middle cerebral artery. Head trauma does not cause that. Trauma can cause vascular disruption resulting in a stroke, for example by causing a dissection of an artery, but that was not the case here. There was no dissection of the artery. There was thrombus within the artery, a result of advanced atherosclerotic disease. This was a garden-variety stroke secondary to the thrombotic occlusion of the right carotid artery, not as a result of external trauma. Additionally, there were no signs on CT of trauma, i.e. a skull fracture, a subdural, or subarachnoid bleed.

RX1 (Dep. Ex. 2). Dr. Carroll maintained that a blow to the head would not cause Petitioner's current complaints resulting from an acute stroke that resulted from a blow to the head. *Id.* He explained that "[h]ead trauma causes skull fractures, subdural hematomas, and occasionally subarachnoid bleeds. They do not cause carotid atherosclerotic disease with resultant thrombus and subsequent stroke. These are two very different conditions." *Id.* Ultimately, Dr. Carroll opined that Petitioner's condition was not causally related to any alleged head injury. *Id.*

Dr. Carroll testified that he specifically noted the neurology notes of Dr. Kannan from the records because, in a stroke case, the timing of the treatment is particularly important. RX1 at 9-11. According to Dr. Kannan, Petitioner mentioned that he was having some right eye problems the night before he was admitted to the hospital when he started to notice a strange feeling in his vision. *Id.* Dr. Carroll also noted that the etiology of Petitioner's stroke was identified via CT scan and there was no medical evidence of trauma to the head like a skull fracture, subdural bleed or subarachnoid bleed. *Id.*, at 11-15. Dr. Carroll maintained that a trauma to Petitioner's head "like this" could not cause his condition. *Id.*, at 15. He explained that

> ... [Petitioner] had a garden variety atherosclerotic plaque in his carotid artery. So if we think of heart disease and we think of atherosclerosis developing within the wall of the artery, that atherosclerosis builds up to the point where it can either cause a thrombus to form sending a blood clot downstream or it can get so tight that it narrows significantly. That's down in the neck. That's a very flexible part of the body. You can move your head around, neck around and it's designed for movement. He got hit or allegedly got hit on the top of his head.
>
> As I mentioned earlier, those are two different zip codes. They are A, two different areas of the body and B, two very different processes in terms of what develops. So this is garden variety atherosclerosis. Typically you have two risk factors like hypertension and smoking [both comorbidities that Petitioner had].

Id., at 15-17. Dr. Carroll further explained that Petitioner's atherosclerosis could not have been caused by a head injury because of the timing; the disruption of the artery takes a couple of years to develop and would have not developed within a short period. *Id.* at 17-18.

Additional Information

Regarding his current condition of ill-being, Petitioner testified that he has problems functioning with his hands. He explained that a lot of his hand strength is gone, and his vision in the right eye never came back. He saw several doctors to try to recover that vision. Petitioner testified that he has limited peripheral vision and lack of strength in his left side and left hand, which is his dominant hand. He also testified that he has not had any other accidents involving his head or vision.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C) & (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 consideration of the totality of the evidence, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable accident at work as claimed. In so concluding, the Arbitrator relies on the opinions of Dr. Carroll, Respondent's Section 12 examiner.

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 2011). 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 (Ill. Sup. Ct. 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).

Petitioner testified that he struck his head at work on October 20, 2014 and had immediate onset of vision loss to his right eye. In contrast, the intake forms from Bolingbrook Hospital as well as the records of Petitioner's treating physicians, and Dr. Benjamin, reflect a gradual loss of vision after the stroke occurred. Moreover, the medical records from the Adventist Bolingbrook Hospital controvert Petitioner's claim that he sustained a blow to the head or trauma. None of the diagnostic tests reflect any signs of blunt injury and the examining physicians during Petitioner's hospitalization noted no such findings on physical examination. Respondent's Section 12 examiner, Dr. Carroll, noted the forgoing absence of medical evidence in support of Petitioner's claimed head trauma, specifically, in forming his opinions whereas Petitioner's Section 12 examiner, Dr. Eidt, did not have the benefit of reviewing the emergency room and subsequent hospitalization records. Dr. Carroll noted that the CT scans from Petitioner's hospitalization reflect an atherosclerotic plaque in his carotid artery that develops slowly over time, and in a different location on the body than claimed by Petitioner if he had sustained a blow to the head. Dr. Eidt relied on the history provided by Petitioner, but it is controverted by the

lack of objective medical evidence in the form of diagnostic test results or clinical findings that Petitioner suffered a blunt trauma. Furthermore, Dr. Carroll specializes in cardiology and internal medicine whereas Dr. Eidt specializes in ophthalmology. While both physicians are board-certified, the nature of Petitioner's symptomatology is not limited to vision loss. Petitioner had a stroke. Thus, the Arbitrator places further weight on the opinions of Dr. Carroll given his specializations.

After careful consideration of the totality of this extensive record, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable accident at work on October 20, 2014 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits including temporary total disability benefits, payment of medical bills, and permanent partial disability benefits are denied.

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

Scott Darby,

Petitioner,

vs. NO: 16WC 30302

18IWCC0681

ADT,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 10, 2017 is hereby affirmed and adopted.

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

18IWCC0681

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 8 - 2018
o110518
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

DARBY, SCOTT
Employee/Petitioner

Case# **16WC030302**

ADT
Employer/Respondent

18IWCC0681

On 8/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

18IWCC0681

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

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

Scott Darby
Employee/Petitioner

v.

ADT
Employer/Respondent

Case # **16** WC **30302**

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 **Wheaton II (Elgin)** on **July 14, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident. December 24, 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 as explained *infra*.

In the year preceding the injury, Petitioner earned $51,743.12; the average weekly wage was $995.06.

On the date of accident, Petitioner was 38 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 $9,053.43 for TTD and/or maintenance, and $0 for other benefits, for a total credit of $9,053.43. *See* AX1.

Respondent is entitled to a credit of N/A under Section 8(j) of the Act. AX1.

ORDER

As explained in the Arbitration Decision Addendum, Petitioner has established a causal connection between his current condition of ill-being and accident at work.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $663.37/week for 14 weeks, commencing April 22, 2014 through July 28, 2014 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from December 24, 2013 through July 14, 2017, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall receive a credit of $9,053.43 for TTD and/or maintenance benefits paid as agreed by the parties.

Medical Benefits

Respondent shall pay the following outstanding reasonable and necessary medical services incurred by Petitioner totaling $222.00 and submitted into evidence in Petitioner's Exhibits pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit, if any, for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. AX1.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care in the form of a right shoulder diagnostic arthroscopy with removal of loose body, revision subacromial decompression, and distal clavicle resection, to be followed by post-operative care as prescribed by Dr. Mehta pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

August 8, 2017
Date

ICArbDec19(b) p 3

AUG 10 2017

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

Scott Darby
Employee/Petitioner

v.

ADT
Employer/Respondent

Case # **16** WC **30302**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from April 22, 2014 through July 28, 2014, and whether Petitioner is entitled to prospective medical care in the form of a right shoulder diagnostic arthroscopy with removal of loose body, revision subacromial decompression, and distal clavicle resection, to be followed by post-operative care as recommended by Dr. Mehta. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Scott Darby (Petitioner) testified that he is employed by ADT (Respondent) as a Residential Alarm Installer and has been so employed for approximately four years. In this position, Petitioner installs wired and wireless security systems in residential homes. Petitioner is right-hand dominant and testified that he had no medical care to the right arm or shoulder prior to December 24, 2013.

Petitioner then sustained an undisputed accident on December 24, 2013. AX1. He explained that he was opening the back door of his work van, which was frozen shut. He pulled on it three-to-four times after which it opened, but Petitioner felt a sharp pain in the right shoulder. He took a break for a few minutes, then continued to work in pain.

Petitioner explained that he was then off for the holidays. He was sore and felt more pain raising his arm over his head during this period. Then, Petitioner first underwent medical treatment in early 2013.

Medical Treatment

The medical records reflect that Petitioner saw Dr. Mehta's physician's assistant, Cassie Mandala on January 6, 2014. PX2 at 18; PX3 at 324-326. Petitioner reported bilateral shoulder pain, right worse than left, with constant aching and radiation from his right shoulder into the lateral aspect. PX3. He reported no previous surgeries or significant injuries in his shoulders. *Id.*

On January 27, 2014, Petitioner underwent an MRI arthrogram which revealed a moderate-grade partial-thickness articular surface tear of the mid- and distal supraspinatus tendon extending 1.9 cm in length, as well as

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)."

multiple smaller high grade tears extending through the substance of the tendon toward the bursal surface; multiple small ganglion cysts; and a type I acromion process. PX2 at 18; PX3 at 322-323. The radiologist noted no loose bodies and mild subacromial/subdeltoid bursitis. *Id.*

Petitioner returned to Fox Valley Orthopedic Institute and saw Vishal Mehta, M.D. (Dr. Mehta) on January 29, 2014. PX2 at 18; PX3 at 319-320. He reported very significant right shoulder pain, worse with excess activity, and pain in his left shoulder as well. PX3 at 319-320. On examination, Petitioner exhibited reduced range of motion in his right shoulder, with positive Hawkins and Neer impingement signs. *Id.* Dr. Mehta reviewed the MRI arthrogram, which he opined showed a moderate grade partial-thickness tear involving the supraspinatus. *Id.* He discussed surgery with Petitioner, but stated that he felt it unwise to proceed until the inflammation in Petitioner's shoulder was addressed. *Id.* Dr. Mehta prescribed Naprosyn and administered a cortisone steroid injection. *Id.*

As of March 10, 2014, Petitioner continued to have significant pain, tenderness, and reduced range of motion in his right shoulder. PX3 at 315-317. Dr. Mehta recommended a right shoulder arthroscopy with subacromial decompression, as well as likely rotator cuff repair and biceps tenodesis. *Id.*

Petitioner elected to proceed with the recommended surgery, which was performed by Dr. Mehta on April 22, 2014. PX3 at 311-313. Pre-operatively, Dr. Mehta diagnosed a right partial thickness rotator cuff tear, biceps tendinopathy, and impingement syndrome. *Id.* He also noted that the pre-operative clinical examination and MRI arthrogram were both consistent with these diagnoses. *Id.* Dr. Mehta performed a right shoulder arthroscopy, subacromial decompression, biceps tenodesis, superior labral repair, posterior labral repair, glenoid chondroplasty, humeral head chondroplasty, and debridement of the rotator cuff. *Id.* Intra-operatively, Dr. Mehta observed unstable cartilage flaps in the glenoid and humeral head; he performed a chondroplasty back to stable cartilage edges. *Id.* He also observed dense, inflamed burs in the subacromial space as well as a type 2-3 acromion. *Id.* He also observed a 20% tear of the articular rotator cuff of the supraspinatus and no abnormality in the bursa rotator cuff. *Id.* Post-operatively, Dr. Mehta diagnosed a right partial thickness rotator cuff tear, biceps tendinopathy, impingement syndrome, SLAP tear, posterior labral tear, glenoid chondromalacia, and humeral head chondromalacia. *Id.*

Petitioner then underwent a course of physical therapy at Moffett Physical Therapy. PX3 at 308-310; PX4. He also continued to follow up with Dr. Mehta. PX3 at 306-310. As of June 2, 2014, Petitioner was still experiencing right shoulder pain, but he reported good progress in his recovery overall. PX3 at 302-305. Dr. Mehta released Petitioner to work with no use of his right arm. *Id.*

On July 7, 2014, Petitioner reported significant pain in his right shoulder, worse with excessive activity. PX3 at 297-301. On physical examination, Dr. Mehta noted limited range of motion with significant guarding; Petitioner reported significant pain throughout range of motion testing. *Id.* Dr. Mehta noted that Petitioner had experienced pain throughout his postoperative course and stated that he did not know the reason for this. *Id.* Thus, Dr. Mehta referred Petitioner to a rheumatologist. *Id.*

Petitioner first presented to the rheumatologist Raheemuddin Nazeer, M.D. (Dr. Nazeer) on July 23, 2014. PX3 at 292-296. Dr. Nazeer noted that Petitioner had a family history of rheumatoid arthritis, but upon examination he noted no actual evidence of inflammatory arthropathy. *Id.* He further noted that past tests, including a bone scan and nine separate labs, had each returned normal or negative for rheumatoid arthritis. *Id.* Dr. Nazeer diagnosed Petitioner with polyarthralgia and indicated that he could not diagnose rheumatoid arthritis or a connective tissue disease at that time. *Id.*

On July 28, 2014, Petitioner was evaluated by a physiatrist, Christopher Siodlarz, D.O. (Dr. Siodlarz), as referred by Dr. Mehta. PX3 at 289-291. After an examination, he diagnosed moderate-to-severe right shoulder pain, an exam that was most consistent with adhesive capsulitis, right anterior shoulder pain, and no evidence of CRPS, cervical radiculopathy or cervical pain. He referred Petitioner back to Dr. Mehta for further imaging studies. *Id.*

Petitioner returned to Dr. Mehta on August 4, 2014 complaining of motion and strength problems in his right shoulder. PX3 284-288. On examination, Dr. Mehta observed extremely limited range of motion; he determined that Petitioner was "quite clearly developing adhesive capsulitis." *Id.* He prescribed aggressive physical therapy, to be followed by a capsular release if necessary. *Id.*

On August 25, 2014, Dr. Mehta reported improvement with the last cortisone injection and great improvement with motion. PX3 at 280-283. On September 22, 2014, Petitioner reported that he continued to have some pain and discomfort; on examination, however, his range of motion had improved markedly. PX3 at 276-279. Dr. Mehta opined that he was doing reasonably well, and kept Petitioner in physical therapy to transition to home exercises after the next two to three weeks. *Id.*

On October 20, 2014, Petitioner reported continued but slow improvement in his right shoulder. PX3 at 273-275. Dr. Mehta maintained his work restrictions and kept him on home exercises. *Id.* On November 24, 2014, Petitioner reported further continued improvement. PX3 at 270-272. Dr. Mehta lessened Petitioner's work restrictions to a 20-pound restriction. *Id.*

Petitioner reported continued improvement at his follow-up appointment of January 14, 2015. PX3 at 267-269. Dr. Mehta opined that Petitioner was "improving and I am happy with his progress as is he." *Id.* Dr. Mehta released Petitioner to return to work without restrictions, instructed him to continue home exercises, and to return for follow-up in three months. *Id.*

At follow-up on April 6, 2015, Petitioner reported that he was feeling about the same as at his previous visit: he reported getting pain and achiness from time to time within his right shoulder. PX3 at 264-266. On examination, Dr. Mehta observed right shoulder range of motion of 165 degrees on forward flexion, 165 degrees on abduction, 70 degrees on external rotation, and 70 degrees on internal rotation. *Id.* Dr. Mehta noted that Petitioner's pain was much better than it was prior to surgery. *Id.* Dr. Mehta instructed Petitioner to continue home stretches and to work on his range of motion; he opined that Petitioner had reached maximum medical improvement. *Id.*

Petitioner returned to Fox Valley Orthopaedic Institute for treatment with Max Berdichevsky, M.D. (Dr. Berdichevsky) concerning low back pain emanating from an annular tear and foraminal narrowing at L5-S1. PX3 at 256-262.

Petitioner next saw Dr. Mehta on March 7, 2016 at which time he reported discomfort in his right shoulder, off and on, for close to one year. PX3 at 251-255. Specifically, he complained of anterior shoulder pain, mainly with overhead work, as well as tenderness to touch. *Id.* On physical examination, Petitioner exhibited 180 degrees of forward flexion and abduction, as well as 10 degrees of internal rotation and 90 degrees of external rotation. *Id.* No impingement signs were present. *Id.* Dr. Mehta noted that Petitioner was having trouble with internal rotation and he ordered an MRI arthrogram of the right shoulder for further evaluation. *Id.* Petitioner testified that he did not injure his shoulder again or sustain any other accidents between January 14, 2015 and

this visit with Dr. Mehta.

On March 18, 2016, Petitioner underwent an MRI arthrogram of his right shoulder at Fox Valley Orthopaedic Institute. PX3 at 36-37. Images were obtained in the axial, sagittal and coronal planes. *Id.* Among other findings, the interpreting radiologist observed a small oblong to triangular filling defect anterosuperiorly within the distended capsule, consistent with a loose body. *Id.*

Petitioner returned to Dr. Mehta on March 21, 2016 with the same complaints and his physical examination was also the same. PX3 at 248-250. Dr. Mehta reviewed the recent MRI arthrogram, which he opined showed a loose body in the distended joint anterosuperiorly. *Id.* He discussed the possibility of arthroscopy to remove the loose body, but Petitioner opted to hold off on surgery and give it time to resolve on its own. *Id.* Dr. Mehta instructed him to return in six months. *Id.*

On June 15, 2016, Petitioner continued to report intermittent pain and some soreness. PX3 at 245-247. He also reported doing more overhead activities at work that caused more pain as well as night pain after strenuous activity. *Id.* Dr. Mehta recommended an additional six weeks of observation and, if Petitioner's symptoms did not improve, he recommended a diagnostic arthroscopy. *Id.* As of July 27, 2016, Petitioner reported that his shoulder was not improving and it was getting worse. PX3 at 242-244. Dr. Mehta noted that it was "not entirely clear to [him] what the etiology of [Petitioner's] pain [was]. There is certainly a possibility that this loose body within his joint is causing his symptomatology." *Id.* He recommended the diagnostic arthroscopy and referred Petitioner to Dr. Petsche for a second opinion. *Id.*

On August 1, 2016, Petitioner saw Timothy Petsche, M.D. (Dr. Petsche) reporting intermittent discomfort for one year, particularly with overhead work. PX3 at 239-241. He also reported numbness in two fingers in his right hand and that he had been "babying" his arm at work because of the pain after being released to full duty by Dr. Mehta. *Id.* Dr. Petsche diagnosed Petitioner with right shoulder pain two years status post SLAP and posterior labrum repair as well as mild bursitis and a possible loose body. *Id.* He concurred with Dr. Mehta and recommended a diagnostic arthroscopy to remove the loose body.

Section 12 Examination – Dr. Lieber

On September 29, 2016, Petitioner underwent a medical evaluation at Respondent's request with Lawrence Lieber, M.D. (Dr. Lieber). RX1 (Dep. Ex. 2). Dr. Lieber took a history from Petitioner, performed a physical examination, reviewed various treatment records, and rendered opinions regarding the relatedness, if any, of Petitioner's right shoulder condition to the injury at work. *Id.* Specifically, Dr. Lieber noted his review of the January 27, 2014 MRI report, April 22, 2014 operative report, physical therapy records from Moffett Physical Therapy, March 18, 2016 MRI arthrogram report, and "[f]urther records from Dr. Mehta and Dr. Petsche…." *Id.*

Dr. Lieber opined that "Petitioner, via history, indicates a strain to the right shoulder area that has no relationship to the current subjective complaints. There does not appear to be any significant objective abnormalities about the shoulder area as of today's evaluation that correlate with any subjective complaints of Mr. Darby." *Id.* Dr. Lieber diagnosed Petitioner with status post arthroscopic decompression, biceps tenodesis, and stabilization of the right shoulder which were related to the alleged December 2013 work event based on his review of the records. *Id.* Dr. Lieber also opined that Petitioner's treatment was reasonable and necessary through his final evaluation by Dr. Mehta on October 20, 2014. *Id.* He stated that any further medical treatment was not related to the December 2013 injury at work. *Id.* Finally, Dr. Lieber opined that Petitioner was at

maximum medical improvement, able to work full duty, and did not require any further surgical intervention or medical treatment. *Id.*

Continued Medical Treatment

Petitioner returned On November 16, 2016, Petitioner returned to Dr. Mehta for follow-up. PX3 at 236-238. On physical examination, Dr. Mehta observed tenderness over the AC joint in Petitioner's right shoulder, with tenderness in the bicipital groove. *Id.* After discussing treatment options, Dr. Mehta ordered a right shoulder diagnostic arthroscopy with removal of loose body, revision subacromial decompression, and distal clavicle resection, to be followed by 6-8 weeks of physical therapy. *Id.* Dr. Mehta listed Petitioner's diagnosis as right shoulder loose body, impingement syndrome, and acromioclavicular degenerative joint disease. PX3. Petitioner testified that the recommended surgery has not yet been performed or approved.

Deposition Testimony – Dr. Mehta

On February 3, 2017, Petitioner called Dr. Mehta as a witness and he gave testimony at an evidence deposition regarding Petitioner's right shoulder condition and its relatedness, if any, to Petitioner's injury at work. PX2. is a board-certified orthopedic physician specializing in sports medicine. PX2 at 4-5; PX2 (Dep. Ex. 1).

Dr. Mehta testified that, post-operatively, Petitioner did not progress as he would have expected and he continued to struggle with pain and motion problems. PX2 at 8-9. He explained that they spent quite a bit time and effort trying to determine the source of Petitioner's pain. *Id.* Dr. Mehta testified that Petitioner struggled with pain "really right from the beginning" and developed adhesive capsulitis (a.k.a., frozen shoulder) after his shoulder surgery with pain that waxed and waned through the March of 2016 MRI approximately two years after surgery. *Id.*

Dr. Mehta did not see Petitioner between April of 2015 and March of 2016, when Petitioner reported pain in the front of the shoulder mostly with overhead activities. PX2 at 10. After the second MRI arthrogram, Dr. Mehta noted that the labrum and rotator cuff looked fine, but there was a question of a loose body within the joint. *Id.*, at 11. He reviewed the films again at the time of his deposition and noted a dark triangular structure in the anterior aspect of the shoulder joint that he believed was the loose body. *Id.*, at 12-13.

Ultimately, Dr. Mehta opined that the loose body was directly related to the injury at work. PX2 at 13-14. He explained that there were a couple of different possibilities. *Id.* One possibility was that a little piece of tendon or cartilage was dislodged during Petitioner's shoulder surgery or, more likely, when the labrum or biceps tendon was repaired a loose piece potentially floated free from that. *Id.* Dr. Mehta further stated that "it's an unusual finding to have [a loose body] in somebody who didn't have the surgery or any significant injury, and the only other significant shoulder issue that [Petitioner] had was that previous one. So from my perspective, I can't really say whether [the loose body is] related to the surgery or the injury, but I think it is one or the other, yes." *Id.*

Dr. Mehta testified that given Petitioner's physical examination findings as of November 16, 2016, he would not really know what was going on within the shoulder until he was performing the arthroscopic surgery and he indicated that the recommended surgical procedures were intended to address Petitioner's AC joint discomfort. PX2 at 15-17. He maintained his recommendation for surgery and indicated that it was causal connected to the injury at work. *Id.*, at 17-18.

On cross examination, Dr. Mehta acknowledged that Petitioner's first MRI did not show any loose bodies. PX2 at 18-19, 26. Dr. Mehta confirmed that he placed Petitioner at maximum medical improvement on April 6, 2015, and that he did not see Petitioner again until March 7, 2016. *Id.*, at 22-23. As of his physical examination on March 7, 2016, Dr. Mehta noted that Petitioner's internal rotation was "horrendous" at 10 degrees down from 70 degrees at his last visit. *Id.*, at 24-25. He also acknowledged that Petitioner's internal rotation was at 80 degrees as of November 16, 2016. *Id.*, at 29-30. Dr. Mehta acknowledged that he noted in his records that he was initially unsure of the etiology of Petitioner's pain, but explained that is why he sent Petitioner for a second opinion to rule out other causes and spare Petitioner from any unnecessary surgery. *Id.*, at 24-25. While Dr. Mehta noted that there was a 60-80% chance that the recommended surgery would provide Petitioner with relief, he testified that he still believed that it was reasonable and necessary given Petitioner's age (41 y.o.) with significant pain. *Id.*, at 29, 33.

Deposition Testimony – Dr. Lieber

On May 3, 2017, Respondent called Dr. Lieber as a witness and he gave testimony at an evidence deposition regarding Petitioner's right shoulder condition and its relatedness, if any, to Petitioner's injury at work in December of 2013. RX1. Dr. Lieber is a board-certified orthopedic physician. RX1 at 4-6; RX1 (Dep. Ex. 1).

Dr. Lieber testified that Petitioner's subjective complaints were slightly inconsistent with his objective findings. RX1 at 11. He maintained his opinion that Petitioner's treatment after October 20, 2014 was not reasonable as it related to Petitioner's injury at work. *Id.*, at 11-12. Dr. Lieber also maintained that Petitioner was at maximum medical improvement such that he could work without restrictions and that Petitioner did not require further surgery. *Id.*, at 11-13.

On cross examination, Dr. Lieber clarified that he did review Petitioner's March 18, 2016 MRI arthrogram films. RX1 at 13. He acknowledged that he thought it was possible that they reflected a loose body. *Id.*, at 14. Dr. Lieber testified that Petitioner's operative report confirmed that he had pre-existing chondromalacia about the humeral head and glenoid, and due to further degeneration of the chondromalacia it was possible to develop a loose body. *Id.* He testified that the loose body had nothing to do with Petitioner's accident at work; rather if it was present, it was related to Petitioner's pre-existing degenerative chondromalacia. *Id.*, at 14-15.

Additional Information

Regarding his current condition, Petitioner testified that he experiences more pain when working overhead or reaching out, which is when it is very painful. Petitioner testified that he has been accommodated recently at work with minimal over-the-shoulder work. Currently, he takes over-the-counter pain medication (i.e., Advil) every few days to help his pain.

Petitioner testified that he waited to go back to Dr. Mehta between his last visit in 2015 and the next visit in 2016 because Dr. Mehta told him to wait. Petitioner testified that during this period, he was in pain and taking prescription as well as over-the-counter pain medications and trying to work.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

Considering the record as a whole, the Arbitrator finds that Petitioner has established a causal connection between his current condition of ill-being in the right shoulder and accident at work. In so concluding, the various facts are significant.

Petitioner was a young man of 38 at the time of his accident. He had no complaints or medical treatment relative to the right shoulder before his accident at work. After December 24, 2013, Petitioner underwent treatment with Dr. Mehta including a right shoulder surgery on April 22, 2014 followed by post-operative physical therapy and follow up care. On January 14, 2015, Dr. Mehta released Petitioner back to work without restrictions and placed him at maximum medical improvement.

Petitioner did not undergo any active medical treatment addressing the right shoulder for 14 months. Then, on March 7, 2016, Petitioner returned to Dr. Mehta. He reported that he continued to experience pain in the right shoulder over the prior year. Dr. Mehta ordered another MR arthrogram. The interpreting radiologist noted a loose body. Dr. Mehta also noted a loose body. In addition, Dr. Mehta sent Petitioner for a second opinion with Dr. Petsche. He reviewed the MRI and determined that Petitioner had a loose body. Dr. Mehta initially indicated that the etiology of Petitioner's pain was elusive, but after the additional MRI, follow up, and a second opinion from Dr. Petsche, Dr. Mehta concluded that the loose body was likely the cause of Petitioner's ongoing shoulder pain. Both Dr. Mehta and Dr. Petsche believed that surgery was appropriate. Dr. Mehta ultimately recommended a right shoulder diagnostic arthroscopy with removal of loose body, revision subacromial decompression, and distal clavicle resection, to be followed by 6-8 weeks of physical therapy.

At Respondent's request, Petitioner submitted to a medical evaluation with Dr. Lieber. He evaluated Petitioner on one occasion on September 29, 2016. Dr. Lieber opined that Petitioner did not require any further medical treatment and that Petitioner was at maximum medical improvement. He opined, without explanation, that "Petitioner, via history, indicates a strain to the right shoulder area that has no relationship to the current subjective complaints. There does not appear to be any significant objective abnormalities about the shoulder area as of today's evaluation that correlate with any subjective complaints of Mr. Darby."

Both Dr. Mehta and Dr. Lieber provided testimony regarding their opinions. Dr. Lieber testified that Petitioner's operative report confirmed that Petitioner had pre-existing chondromalacia about the humeral head and glenoid. Thus, Dr. Lieber ascribed the loose body, which he believed may be reflected in the 2016 MRI, solely to further degeneration of pre-existing chondromalacia. He maintained that Petitioner's loose body was not related to Petitioner's accident at work and that no further medical care was causally related to that injury. However, Dr. Lieber's opinions are conclusory and outweighed by the medical evidence overall.

First, Dr. Lieber testified that he reviewed Petitioner's MRI films, although his Section 12 report does not indicate as much. He testified that the loose body, that may be reflected in the 2016 MRI, was wholly unrelated to the accident at work, but failed to persuasively explain how a young man of 38 who required a right shoulder

arthroscopy, subacromial decompression, biceps tenodesis, superior labral repair, posterior labral repair, glenoid chondroplasty, humeral head chondroplasty, and debridement of the rotator cuff could later develop a loose body that was solely related to pre-existing degeneration. It is not plausible given the entirety of the medical evidence that Petitioner's loose body developed solely from degeneration as opined by Dr. Lieber and not, in part, from sequelae of the injury at work necessitating a complex and significant surgery addressing tears and fraying in the right shoulder.

The other opinions offered in this case were from Petitioner's treating physician, Dr. Mehta. He testified that the loose body in Petitioner's right shoulder was likely the cause of Petitioner's pain. In so doing, Dr. Mehta noted his methodology. He also explained the objective and clinical findings over the years that he saw Petitioner after the initial accident on December 24, 2013. It is not insignificant that Petitioner did not receive medical treatment to the right shoulder for 14 months after a release to maximum medical improvement by Dr. Mehta. However, Dr. Mehta noted that Petitioner's complaints at that time included continuous shoulder pain for approximately one year at the time of the March 7, 2016 visit. There is no evidence that Petitioner sustained any intervening accident during those 14 months. When Dr. Mehta ordered an MRI, it showed a loose body which confirmed the interpreting radiologist's findings as well as the findings of Petitioner's second opinion physician, Dr. Petsche. Then, Dr. Mehta attempted to rule out other causes of Petitioner's complaints before opining that the loose body was the cause of his shoulder complaints, or opining that it was causally related to the accident at work. Dr. Mehta also had extensive opportunity to physically examine Petitioner over the years compared to Dr. Lieber, as well as the unique understanding of the extent of Petitioner's right shoulder damage because he observed it intraoperatively at the time of the April 22, 2014 surgery.

After careful consideration of the physicians' opinions and their bases, the Arbitrator finds the opinions of Dr. Mehta to be more persuasive than those of Dr. Lieber in this case. In so concluding, the Arbitrator notes Dr. Mehta's measured approach to diagnosing Petitioner's condition in 2016 and the methodology he engaged before opining that the condition was causally related to the original accident in 2013 or the medical treatment rendered thereafter. Dr. Mehta's explanations and opinions are simply more plausible given the entirety of the medical evidence and his thorough understanding of Petitioner's physical condition compared with Dr. Lieber's unyielding opinion after only one brief examination.

Given the totality of the record and in reliance on the opinions of Dr. Mehta, the Arbitrator finds that Petitioner has established a causal connection between his current condition of ill-being and accident at work.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Petitioner claims entitlement to payment of reasonable and necessary medical bills from medical providers that administered care after his accident at work. The medical bills submitted into evidence in Petitioner's Exhibits relate to hospital services, diagnostic testing, physicians' services, and conservative treatment modalities prescribed and rendered as a direct result of his injury at work. Based on a review of the medical records and bills submitted into evidence, in conjunction with Petitioner's testimony at the hearing and in light of the persuasive opinions of Dr. Mehta, the Arbitrator finds that Petitioner's medical bills are for reasonable and necessary medical care to alleviate him of the effects of his injury at work. The Arbitrator awards these outstanding medical bills admitted into evidence and orders Respondent to pay Petitioner these bills pursuant to Section 8(a) and Section 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties. AX1.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his accident at work as claimed. Petitioner's right shoulder symptoms have not improved after his accident as reflected in the medical records and explained by Petitioner's treating physician, Dr. Mehta. In consideration of the record as a whole, the Arbitrator awards the recommended prospective medical care in the form of a right shoulder diagnostic arthroscopy with removal of loose body, revision subacromial decompression, and distal clavicle resection, to be followed by post-operative care as prescribed by Dr. Mehta pursuant to Section 8(a) of the Act as these treatments are reasonable and necessary to alleviate Petitioner from the effects of his injury at work.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary partial disability benefits, the Arbitrator finds the following:

In light of the causal connection analysis explained above, the Arbitrator turns to Petitioner's claim that he is entitled to temporary partial disability benefits from April 22, 2014 through July 28, 2014.

"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 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work*. *Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

The record reflects that during the claimed temporary total disability periods Petitioner was either placed off work or under light duty work restrictions as imposed by Dr. Mehta, which were not or could not be accommodated by Respondent. Thus, the Arbitrator finds that Petitioner has established that he was temporarily totally disabled during the claimed temporary total disability period from April 22, 2014 through July 28, 2014. Respondent shall receive a credit for temporary total disability benefit payments made as agreed by the parties. *See* AX1.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steve Smith,
Petitioner,
vs.

NO: 15WC 6559

Chicago Board of Education,
Respondent.

18IWCC0682

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 May 8, 2017 is hereby affirmed and adopted.

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

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

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 8 - 2018

DATED:
o110518
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, STEVE
Employee/Petitioner

Case# **15WC006559**

CHICAGO BOARD OF EDUCATION
Employer/Respondent

18IWCC0682

On 5/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0806 LAW OFFICES OF LEO F ALT
221 N LASALLE ST
SUITE 2014
CHICAGO, IL 60601

0559 CHICAGO BOARD OF EDUCATION
MICHAEL COHEN
ONE N DEARBORN ST SUITE 900
CHICAGO, IL 60602

STATE OF ILLINOIS)
) ss
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

STEVE SMITH
Employee/Petitioner

Case # 15 WC 6559

v.

CHICAGO BOARD OF EDUCATION
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 Milton Black, arbitrator of the Industrial Commission, in the city of Chicago, on April 19, 2017. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues circled below, and attaches those findings to this document.

DISPUTED ISSUES

A. Was the respondent operating under and subject to the Illinois 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. X 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 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 the respondent?
N. Is the respondent due any credit?
O. Other _____

On January 12, 2015, the Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between the petitioner and respondent.

On this date, the petitioner ***did*** sustain injuries that arose out of and in the course of employment.

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

In the year preceding the injury, the petitioner earned **$ 64,178.92**; and the average weekly wage was **$ 1,234.21**.

At the time of injury, the petitioner was **54** years of age, ***single*** with **no** dependent 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 credit of **$ 36,171.86** for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of **$36,171.86**

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $735.37 week for 100 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

RULES REGARDING APPEALS Unless a 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 this award is reviewed by the Commission, interest of _____% shall accrue from the date listed below to the day before the date of payment; however, if an employee's appear results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

May, 4, 2017
Date

MAY 8 - 2017

FACTS

Petitioner was employed by Respondent as a custodian/engineer. Petitioner had worked Respondent for 32 years. Petitioner was in charge of the maintenance and upkeep of a school. Petitioner performed almost all of the required work including, moving furniture, disposal of garbage, maintenance and repair of the boiler, shoveling of snow, and plowing of snow. Petitioner injured his back when he was plowing snow on a tractor and the plow blade hit a concrete elevation causing his body to violently move forward and crash into the windshield of the enclosed plow cabin.

Petitioner finished his work day early on the accident date, because he did not feel well. The following day, Petitioner was in great pain and could not work. Petitioner did not return to work thereafter, eventually taking an earlier pension than he had intended.

Petitioner testified that he did not have problems with his lower back on the date of the injury or prior thereto. Petitioner testified that he was involved in an automobile accident in 2010 but that he was only slightly injured with minimal medical treatment.

Petitioner received medical attention from Dr. Chann, his primary care physician. Dr. Kesani, an orthopedic physician. Dr. Chavez, a neurosurgeon, and Dr. Kumar, a pain specialist. Petitioner was treated conservatively, underwent physical therapy, and underwent for MRI. EMG and X-ray imaging studies. The MRI indicated L5- S1 nerve root imitation. Various medical options were offered. including surgery. to cauterize nerve endings. steroid epidurals and continued physical therapy. Petitioner was placed in restrictions. Petitioner chose ongoing physical therapy and epidural injections. Petitioner chose to take an early retirement pension after his temporary total disability benefits were terminated.

Dr. Monaco, an orthopedic surgeon, examined Petitioner, on behalf of the Respondent, on June 9, 2015, which was within 6 months of the injury. Dr. Monaco did not review all of the medical records and imaging studies, and there was substantial additional medical treatment after that examination. Dr. Monaco opined that Petitioner had incurred a minor back strain and could return to work. Dr. Monaco provided an AMA impairment rating of zero.

Dr. Chmell, an orthopaedic surgeon, examined the Petitioner, on behalf of the Petitioner, on May 7, 2016. Dr. Chmell reviewed the medical treatment records and reviewed Dr. Monaco's report. His diagnosis included traumatic aggravation of degenerative disc disease of the lumbar spine and of the thoracic spine. Dr. Chmell opined that Petitioner had sustained serious injuries to his spine and opined that Petitioner could not and should not return to his previous job.

CAUSATION

Petitioner's testimony about his January 12, 2015 work injury is not rebutted. The medical treatment records are corroborative. Dr. Chmel's medical opinions are persuasive. Dr. Monaco's medical opinions are not persuasive. The Arbitrator notes that Dr. Monaco did not possess all the medical records when he examined Petitioner. The sequence of events is consistent with

Petitioner's testimony.

Based upon the foregoing, the Arbitrator finds Petitioner's present condition of ill being is causally related to the injury.

NATURE AND EXTENT

Pursuant to Section 8.1 b of the Act. for accidental injuries that occur on or after September 1, 2011, the following criteria are to be used in the determination of perm anent partial disability.

(a) A physician licensed to practice medicine in all 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 corraberate by 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), the Arbitrator notes that a zero AMA impairment rating impairment rating has been offered. As noted above, Dr. Monaco did not possess all the medical records at the time of his report. The Arbitrator gives minimal weight to this factor.

With regard to subsection (ii), the Arbitrator notes that Petitioner was employed as a custodian/engineer at the time of the work accident. His job was physically demanding. Petitioner testified that he could no longer perform the work. The Arbitrator gives substantial weight to this factor.

With regard to subsection (iii), the Arbitrator notes that the Petitioner is now 56 years old. The

Arbitrator finds that Petitioner still had some work life expectancy. The Arbitrator gives some weight to this factor.

With regard to subsection (iv), the Arbitrator notes that neither side offered any direct evidence that Petitioner's future earnings capacity would be diminished as a result of the accident, although Petitioner took an earlier retirement pension that cut down his pension. The Arbitrator gives little weight to this factor.

With regard to subsection (v), the Arbitrator has reviewed the medical treatment records. The medical records are corroborative of Petitioner's testimony. The Arbitrator gives moderate weight to this factor.

Based upon the foregoing, the Arbitrator finds that Petitioner has sustained the loss of use of a person as a whole to the extent of 20%.

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

Randa Crayton
Petitioner,

vs.

NO: 10WC 37643

18IWCC0683

State of Illinois - DHS,
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, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 15, 2017 is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: NOV 8 - 2018
o110518
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

IL' .INOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRAYTON, RANDA
Employee/Petitioner

Case# **10WC037643**

10WC037642

STATE OF ILLINOIS-DHS
Employer/Respondent

18IWCC0683

On 2/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 3
ROCKFORD, IL 61101

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

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

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

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

FEB 15 2017

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

18IWCC0683

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

Randa Crayton
Employee/Petitioner

v.

State of Illinois-DHS
Employer/Respondent

Case # 10 WC 37643

Consolidated cases: 10 WC 37642

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **January 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 1, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was* 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 **$61,660.00**; the average weekly wage was **$1,185.77**.

On the date of accident, Petitioner was **61** 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 has paid **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$339.00** for other benefits, for a total of **$339.00**.

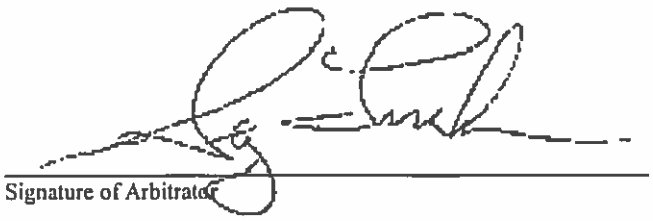
Respondent has paid **$8,832.52** under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF HER EMPLOYMENT WITH RESPONDENT ON JULY 1, 2010 AND FURTHER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HER CONDITION OF ILL BEING WAS CAUSALLY CONNECTION TO HER WORK ACTIVITIES WITH RESPONDENT, PETITIONER'S CLAIM FOR COMPENSATION IS DENIED.

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

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



Signature of Arbitrator

February 10, 2017
Date

Statement of Facts

This matter was heard in conjunction with consolidated matter 10 WC 37642 (date of accident August 28, 2000). A single record was prepared, but the Arbitrator has issues separate decisions with respect to each of these matters. At hearing Petitioner made an oral motion to amend the Application for Adjustment of Claim to reflect a date of accident of July, 1, 2010. The motion was granted without objection.

Petitioner Randa Crayton testified that she was employed by Respondent State of Illinois-Department of Human Services for 18 years. She began in the 1990's as a data entry clerk for three years. Then she worked as a caseworker until she retired in 2011. Her duties were to interview clients. She entered information into the computer, used the phone. She did a lot of paperwork and typing. She worked 37.5 hours per week. Petitioner estimated she was typing 60%-70% of the time. She would enter information into the computer while she was interviewing clients. She spent 30%-40% of her time finishing paperwork and on the telephone. A Job description prepared July 21, 2010 states Petitioner would use her hands for fine manipulation 6-8 hours per day (PX 12).

Petitioner testified that her workstation was an old desk. There was no keyboard tray. The keyboard was on the desk. She had old chairs that sat lower. The keyboard was at chest height. One time about 2008 she got a lower table. Then she got her desk back.

Petitioner testified that her hands would fall asleep and she would have pain up her arms into her shoulders. She first noticed symptoms in 1998 or 1999. It was not all the time. The symptoms got steadily worse. She had numbness at work and pain at night. She testified that she went to the doctor to see what was going on. Petitioner testified that she did not miss any time from work from 2000 to 2010 except to go to medical appointments.

Petitioner offered medical records of treatment beginning in 1998. She was seen at FHN Family Health in November, 1998 with a fractured right foot (PX 3, p 70). Petitioner testified that she had bariatric surgery. She was seen for complications from that surgery on May 19, 2005 (PX 3, p 72-73). She reported her history of Raynaud's with her middle fingers getting white in cold weather. Petitioner also suffered knee pain in August, 2005 after a night of dancing. Her height was noted at that time at 5'4" and her weight was 230 pounds. She denied using alcohol or tobacco. Petitioner saw Dr. Schleich on January 11, 2007 for restless legs (PX 3, p 76).

On January 5, 2007, Petitioner prepared a Notice of Injury report with Respondent, alleging an injury on December 4, 2006 with complaints of tingling. She claims she was performing constant data entry and developed carpal tunnel in both hands. She states she developed carpal tunnel syndrome from years of repetitive data entry and non-ergonomically correct office furniture (PX 7).

Petitioner underwent an EMG on February 1, 2007 that revealed bilateral mild to moderate carpal tunnel syndrome (PX 4). She was seen by Dr. Schleich on February 12, 2007. Dr. Schleich notes Petitioner has braces but only uses them at bedtime. He assessed carpal tunnel. He scheduled physical therapy and advised her to wear the braces all of the time. The therapy record notes that she stated that she had sought medical attention for carpal tunnel in 2000. The pain had been better for several years, but flared up again in December, 2006. She stated that repetitive typing all day seemed to increase her symptoms (PX 1). Therapy included stretching and cold laser treatment. On May 30, 2007 Petitioner reported carpal tunnel symptoms on

and off for 15 years. On June 11, 2007 the therapy notes record Petitioner reported that her right hand was nearly 100% better and the left hand was 90% better. She was discharged to full duty on June 14, 2007 (PX 1, p 8-20).

Petitioner was treated from February 14, 2008 for a right wrist fracture suffered on February 12, 2008. X-rays showed a right distal radius fracture. She was treated through her discharge by Dr. Stiles on April 14, 2008 (PX 3, p. 79-83).

On October 3, 2008, Petitioner filed another notice of injury report with Respondent, alleging an injury on October 3, 2008. She again noted carpal tunnel due to years of repetitive data entry and non-ergonomically correct office furniture. She wrote that she worked with the agency for 17 years and they do not have computer desks to rest the keyboard on (PX 9).

She was seen by Dr. Schleich on October 13, 2008. He noted that her carpal tunnel syndrome had returned and that she had not been wearing her braces. He advised her to wear her braces and referred her to orthopedics and physical therapy (PX 1, p 21). Petitioner saw Dr. Brinkman on January 1, 2009. Petitioner's complaints were pain, numbness and tingling in both hands. She stated that she knows that she has had carpal tunnel syndrome for a long time. She reported that she drinks two beers a day. Dr. Brinkman notes positive Tinel at both wrists. He diagnosed obvious bilateral carpal tunnel and recommended bilateral open carpal tunnel releases (PX 3, p 85).

Petitioner continued working without additional treatment for her hands except for an October 26, 2009 visit with Dr. Schleich for medication for her Raynaud's. Petitioner advised Dr. Schleich she was discontinuing her blood pressure medication on November 25, 2009 (PX 3, p 87). Petitioner treated with Dr. Gluscic beginning February 16, 2010 for left knee complaints. She reported 30 drinks of alcohol per week (PX 2, p 40). The March 1, 2010, November 12, 2010, and May 18, 2011 preoperative physical examinations note a social history of drinking a 6 pack of beer daily. Petitioner denied smoking or drug use (PX 1, p 23, 27, 29).

Petitioner contacted Denise Myles on April 14, 2010 by email. She stated that she needed to schedule her carpal tunnel surgery. Ms. Myles asked if this was referring to her 2008 injury. Petitioner stated it was, but mentioned that it has been going on since before then. Ms. Myles advised that in cases with a lapse in treatment, a new claim form using recent medical has been requested (PX 11).

Petitioner returned to Dr. Schleich on July 1, 2010 complaining of numbness and tingling in both hands. He notes the history of carpal tunnel and Raynaud's. Dr. Schleich's assessment is that a lot of her symptomatology is related to carpal tunnel syndrome. He recommends that she should undergo carpal tunnel release. He notes that Petitioner needs to talk to her work as this has been under Workers' Compensation (PX 1, p 25). Petitioner then saw Dr. Gluscic on July 13, 2010. He noted that she had carpal tunnel symptoms progressively worsening for a few years. She stated that it was to the point now that her left hand was numb and tingly. He found that the left wrist carpal tunnel needs to be fixed. He also notes Petitioner fell on the right wrist on Friday or Saturday. X-rays demonstrate a nondisplaced radial styloid fracture. Dr. Gluscic states the left carpal tunnel surgery will be done with Workers' Comp when approved (PX 2, p 44). Petitioner was treated for the right wrist fracture though August 17, 2010 (PX 2, p 45-46).

On July 14, 2010, Petitioner filed another notice of injury report with Respondent, alleging an injury on July 1, 2010, claiming carpal tunnel to both hands causing numbness, tingling, and loss of feeling due to non-

ergonomically correct office furniture. Petitioner reported that she had previously submitted claims on 8/28/2000, 12/4/2006, 1/5/2007, and 10/3/2008 (PX 8). On October 21, 2011, a letter approving benefits was sent by Respondent (PX 11, p 194). On November 8, 2010, Dr. Gluscic authored a letter indicating that Petitioner's symptoms had worsened on the left side and was now problematic and affecting her activities and function. He noted that surgery was now a medical necessity (PX 2, p 65).

Petitioner underwent left carpal tunnel release on April 27, 2011 and right carpal tunnel release and trigger finger release on May 18, 2011 (PX 2, p 48-50). Dr. Gluscic released Petitioner to return to full unrestricted duty work on June 6, 2011 (PX 2, p 63). She was discharged from his care on June 14, 2011 (PX 2, p 51).

Petitioner had a subsequent accident to the left wrist on March 1, 2012. Petitioner was in a bar drinking and she passed out. X-rays show a tiny avulsion fracture off the dorsal aspect of the distal radius (PX 1, p 32-34). She followed up with Dr. Brinkman (PX 3, p 90), and Dr. Gluscic (PX 2, p 53).

Dr. Gluscic testified by evidence deposition taken April 3, 2015. The transcript was admitted as Petitioner's Exhibit 5. He testified that he practices in general orthopedics. He is Board Certified in orthopedics (PX 5, Ex 2). His practice includes treating patients with carpal tunnel. He estimates he performs between 20 and 50 carpal tunnel surgeries per year. Dr. Gluscic testified to his treatment of Petitioner including the surgeries performed. He testified to his April 22, 2013 letter which stated that her work related activities exacerbated her symptoms and therefore the condition would be related to her job activities (PX 5, Ex 1). He testified that Petitioner's work activities of computer work, writing, etc. had caused her symptoms to worsen. He notes that the employer had approved the treatment as work related. The workers' compensation approval impacted his opinion on causation. The exacerbation can be temporary or permanent. Activities can increase the symptoms. They do not cause the disease. The only job related activities that specifically cause the carpal tunnel are vibratory tools and jackhammers. Keyboarding six to eight hours per day is the type of activity that can aggravate the condition to the point she would require surgical procedures. Dr. Gluscic opined that Petitioner's work activity exacerbated her symptoms and necessitated her treatment. Her Raynaud's Syndrome does not change his opinion. Petitioner's risk factors of gender, age and obesity do not change his opinion (PX 5).

Dr. Gluscic testified that he did not disagree that sleeping position could cause or aggravate carpal tunnel. It is common for patients to have symptoms at night or when not performing work activities. He has not observed Petitioner's work environment or reviewed the job description. He does not know her positioning and did not view her workstation. He discussed Petitioner's job activities with her very little, if any. Activities of daily living can cause or aggravate carpal tunnel syndrome. He defines exacerbate as manifestation of symptom and increasing frequency and severity. There is no way to know if Petitioner's symptoms were simply progressing rather than being exacerbated by activities. He is aware of other risk factors for carpal tunnel including age, gender and obesity, arthritis, probably hypertension. Carpal tunnel syndrome can be idiopathic. He is aware of studies that dispute the connection between typing and the development of carpal tunnel. He has not looked at the studies closely but it makes sense. He focuses on literature relating to treatment, not causation (PX 5).

Petitioner was examined at Respondent's request by Dr. Michael Vender on June 12, 2014 (RX 6). Following examination and review of medical records, Dr. Vender diagnosed bilateral carpal tunnel syndrome. He opined that Petitioner's work duties as a Public Aid Caseworker Specialist were office based and sedentary. The work activities were not contributory to the development of carpal tunnel syndrome. He found Petitioner's Raynaud's

syndrome can be associated with carpal tunnel. Her obesity is a major risk factor. He found her treatment was reasonable and necessary and found Petitioner at MMI and capable of work without restriction.

Dr. Vender testified by evidence deposition taken March 27, 2015. The transcript was admitted as Respondent's Exhibit 7. Dr. Vender testified that he is a hand surgeon. He is Board Certified in orthopedic surgery and for added qualifications for surgery of the hand (RX 7, Ex 1). He testified to the medical records he reviewed as well as the demands for the job form for the job title HSC. He testified Petitioner's job was a case worker and involved data entry, typing, using a telephone, talking. He noted that Petitioner had Raynaud's. He stated that this condition contributes to the development of carpal tunnel syndrome. Petitioner's increased body mass is one of the major risk factors for carpal tunnel syndrome. Petitioner's risk factors were age, gender, increased body mass index and Raynaud's. Dr. Vender testified that work activities would need to be forceful on a regular and persistent basis. He opined that Petitioner's activities would not fit that description. They are variable, sedentary, office tasks. He opined that the job would not be considered a contributing factor to carpal tunnel syndrome. Dr. Vender testified that the medical literature has shown no casual relationship between typing and carpal tunnel syndrome. The amount of keyboarding is not relevant. Suboptimal ergonomics could cause discomfort but that is different from actually causing the disease.

Petitioner testified she does not have ongoing problems with her hands. She has no numbness or tingling. She still has symptoms from her Raynaud's syndrome. Her hands get cold from the lower circulation. The surgery did not change those symptoms. Petitioner testified she does sewing two to three times per week as a hobby. She has no pain with sewing. She is taking no medications and has had no further treatment for carpal tunnel syndrome since her return to work.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, (D) Date of Accident, and (F) Causal Connection, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. Petitioner in this matter has alleged that she suffered carpal tunnel syndrome as a result of the repetitive activities of her job duties with a date of manifestation on July 1, 2010. An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden injury. In a repetitive trauma case, issues of accident and causation are intertwined. Therefore, a review of the evidence allows both issues to be resolved together." *Boettcher v. Spectrum Property Group and First Merit Venture Realty Group*, 97 W.C. 44539, 991.I.C. 0961.

Even though Petitioner had complaints of work related carpal tunnel beginning prior to the alleged date of accident on July 1, 2010, the Arbitrator finds that this is an appropriate date of manifestation for her condition. The date of an accidental injury in a repetitive-trauma compensation case is the date on which the injury 'manifests itself.' 'Manifests itself' means the date on which both the fact of the injury and the causal

relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." The standard for determining the manifestation date in a repetitive trauma case is flexible and fact-specific and is guided by considerations of fairness. Because repetitive trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. Courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. Petitioner did not miss any time from work prior to requesting surgery from Respondent in 2010. Her return visit with Dr. Schleich on July 1, 2010 confirmed her progression of symptoms and need for surgery. July 1, 2010 is therefore an appropriate date of manifestation in this matter.

Petitioner is alleging the development of her carpal tunnel syndrome resulted from her work activities for Respondent over the course of her employment. The Petitioner's testimony and the notice of accident forms she prepared allege the work activities were years of repetitive data entry and non-ergonomically correct office furniture. Petitioner testified that she was typing about 60%-70% of her work 7.5 hour work day or about 4.5 to 5.25 hours per day. She also did paperwork, interviewing and telephone work. The job description entered listed 6 to 8 hours of fine manipulation which would include typing and other activities. With respect to the workstation, Petitioner testified that her workstation was an old desk. There was no keyboard tray. The keyboard was on the desk. She had old chairs that sat lower. The keyboard was at chest height. There was no evidence submitted as to the angle of her hands or the forces that she used. No ergonomic evidence of the effect of this workstation was offered.

An employee who suffers a repetitive trauma injury must meet the same standard of proof as an employee who suffers a sudden injury. In cases relying on the repetitive-trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. Petitioner submitted the opinions of Dr. Gluscic. Respondent presented the opinions of Dr. Vender. The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. 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.

Dr. Gluscic opined that Petitioner's work related activities exacerbated her symptoms and therefore the condition would be related to her job activities. He testified that Petitioner's work activities exacerbated her symptoms and necessitated her treatment. He defines exacerbate as manifestation of symptom and increasing frequency and severity. Keyboarding six to eight hours per day is the type of activity that can aggravate the condition to the point she would require surgical procedures. Activities can increase the symptoms. They do not cause the disease. The only job related activities that specifically cause the carpal tunnel are vibratory tools and jackhammers.

Dr. Gluscic testified that he has not observed Petitioner's work environment or reviewed the job description. He does not know her positioning and did not view her workstation. He discussed Petitioner's job activities with her very little, if any. His opinions did not address the ergonomics of her workstation in any way. He also

testified that activities of daily living can cause or aggravate carpal tunnel syndrome. There is no way to know if Petitioner's symptoms were simply progressing rather than being exacerbated by activities. While he testified that Petitioner's Raynaud's and Petitioner's risk factors of gender, age and obesity do not change his opinion, he is aware of risk factors for carpal tunnel including age, gender and obesity, arthritis, probably hypertension. Carpal tunnel syndrome can be idiopathic. He is aware of studies that dispute the connection between typing and the development of carpal tunnel. He has not looked at the studies closely but it makes sense. He focuses on literature relating to treatment, not causation. The workers' compensation approval impacted his opinion on causation.

Dr. Vender, Board Certified in orthopedic surgery and for added qualifications for surgery of the hand, opined that work activities would need to be forceful on a regular and persistent basis. He opined that Petitioner's activities would not fit that description. They are variable, sedentary, office tasks. He opined that the job would not be considered a contributing factor to carpal tunnel syndrome. Dr. Vender testified that the medical literature has shown no casual relationship between typing and carpal tunnel syndrome. The amount of keyboarding is not relevant. Petitioner's increased body mass is one of the major risk factors for carpal tunnel syndrome. Petitioner's risk factors were age, gender, increased body mass index and Raynaud's.

After reviewing the opinions of the medical experts and the basis for the opinions rendered, the Arbitrator finds the opinion of Dr. Vender more persuasive.

Although Petitioner included non-ergonomic workstations as part of the work related causes of her carpal tunnel syndrome, she provided no detail as to this beyond describing her keyboard being on her desk. Dr. Gluscic presented no opinions as to this factor, but opined that typing alone was the exacerbating factor. This has been rejected by recent Commission case law. *Ramona Davis v. Winnebago County States Attorney*, 14 IWCC 0609, 14 Ill. Wrk. Comp. LEXIS 570, affirmed 16 Ill. App. 2d 150275WC-U, 2016 Ill. App. Unpub. LEXIS 212 (We do not believe it is true that a claimant could never successfully prove causal connection between certain clerical activities and carpal tunnel syndrome, but we believe that the Petitioner in this case did in fact fail to prove such a causal nexus. More than mere "frequent" keyboarding must be shown; we further note the importance of factors such as sustained hand positioning, force exerted and the duration of continuous keyboarding.); *Brandi Brooks v. Illinois-American Water*, 16 IWCC 0152, 2016 Ill. Wrk. Comp. LEXIS 201 (The Commission is not persuaded that work activities comprised only of substantial typing, using a computer mouse, and using a telephone with a headset significantly contributes to the development or aggravation of CTS.). See also *Stuart Whitson v. State of Illinois-Secretary of State,* 16 IWCC 0756, 10 WC 44094.

Dr. Gluscic testified that the work activities would exacerbate the condition, not cause it. The only job related activities that specifically cause the carpal tunnel are vibratory tools and jackhammers. He also agreed that activities of daily living can cause or aggravate carpal tunnel syndrome. There is no way to know if Petitioner's symptoms were simply progressing rather than being exacerbated by activities.

In the absence of evidence of the details of the ergomonics of Petitioner's work station or the physiological effect of such ergonomics and the failure to address this factor in Dr. Gluscic's opinions, the Arbitrator finds that Dr. Vender's opinion that work activities would need to be forceful on a regular and persistent basis, and that Petitioner's activities would not fit that description, which testimony is based upon the medical literature showing no casual relationship between typing and carpal tunnel syndrome, persuasive and based upon the facts presented in this matter.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of her employment with Respondent on July 1, 2010 and further failed to prove by a preponderance of the evidence that her condition of ill being of carpal tunnel syndrome is causally related to her employment with Respondent.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Temporary Compensation, and (L) Nature and Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to accident and Causal Connection, the issues of Medical, Temporary Compensation, and Nature and Extent are moot.

Petitioner's claim for compensation is denied.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUSTIN CUNLIFFE,

Petitioner,

vs.

NO: 16 WC 7333

BLOOMINGTON PUBLIC SCHOOL DISTRICT #87,

18IWCC0684

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, 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 the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." City of Springfield v. Indus. Comm'n, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

The Commission finds that the need for surgery to repair the Petitioner's fracture of the 4th metatarsal in his right foot is causally related to the January 10, 2016 work-related accident. As a result, Petitioner is entitled to medical expenses of $12,192.60 and prospective medical to treat the 4th metatarsal fracture.

Employers take their employees as they find them. *O'Fallen School District No. 90 v. Industrial Comm'n*, 313 Ill. App. 3d 413, 417, 729 N.E.2d 523, 246 Ill. Dec. 150 (2000). To result in compensation under the Act, a claimant's employment need only be a causative factor in his condition of ill-being; it need not be the sole cause or even the primary cause. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "[A] preexisting condition does not prevent recovery under the Act if that condition was aggravated or accelerated by the claimant's employment." *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861, 65 Ill. Dec. 6 (1982).

The evidence establishes that Petitioner fractured the 4th metatarsal in his right foot 10 to 11 years prior to the January 10, 2016 accident. At that time, he was placed in an air cast and was ultimately returned to work full-duty and without restrictions. While there is evidence that Petitioner's right foot never felt the same and that he had a non-union of the 4th metatarsal, the evidence supports that Petitioner was able to work full-duty and without restrictions for the 10 years prior to the January 10, 2016 accident. The record is devoid of any evidence that Petitioner was under active medical care prior to the accident or that there was a recommendation of surgery to treat the fractured metatarsal. It was not until after the accident that Petitioner's condition became symptomatic necessitating surgery.

Further, it is well established that "a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability *may be sufficient* circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982).

The Commission finds Dr. Scott O'Connor's opinion that the accident caused an aggravation of the 4th metatarsal persuasive. His opinion was premised upon the fact that Petitioner was not having significant pain prior to the accident, sustained an accident and has had continued significant pain since. He further opined that the accident caused the gapping, spacing and instability to increase. Because of this chain of events, he opined the accident caused an aggravation of the pre-existing condition. The Commission finds that Dr. O'Connor's opinion is supported by the record.

Conversely, the Commission is not persuaded by Dr. Holmes' opinion that the accident did not aggravate Petitioner's condition. The record clearly demonstrates that the Petitioner was able to work full-duty and without restrictions for the 10 years prior to the accident. While Petitioner may have had some difficulties prior to the accident, he was not under active medical care and there was no recommendation for surgery. It was not until after the accident, that Petitioner's

18IWCC0684

condition changed necessitating surgery. Dr. Holmes acknowledged on cross-examination that the fall could have hypothetically caused Petitioner to go from being asymptomatic to symptomatic. Dr. Homes' opinion is not supported by the record as there is little evidence that Petitioner was symptomatic prior to the accident.

Based upon the evidence, the Commission finds that the accident aggravated Petitioner's condition necessitating the need for surgery. Therefore, the Commission finds that Petitioner's fracture of the right 4th metatarsal is causally related to the January 10, 2016 accident and Petitioner is entitled to all medical expenses related to said injury. Petitioner is further entitled to prospective medical treatment relative to the fracture of the right 4th metatarsal.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 15, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $580.31 per week for a period of 12-3/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $12,192.60 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT ID FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $2,028.37 under Section 8(j) of the Act.

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

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 8 - 2018

Michael J. Brennan

MJB/tdm
O: 10/16/19
052

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the Majority's opinion reversing the Arbitrator's decision. I find the Arbitrator's decision to be thorough and well reasoned. I would affirm and adopt this decision.

Kevin W. Lamborn

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

CUNLIFFE, JUSTIN
Employee/Petitioner

Case# **16WC007333**

BLOOMINGTON PUBLIC SCHOOL DISTRICT 87
Employer/Respondent

18IWCC0684

On 12/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG YOUNG
300 HAMILTON BLVD PO BOX 6199
PEORIA, IL 61601-6199

18IWCC0684

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JUSTIN CUNLIFFE,
Employee/Petitioner

v.

BLOOMINGTON PUBLIC SCHOOL DISTRICT 87,
Employer/Respondent

Case # **16** WC **7333**

Consolidated cases: _____

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/10/16**, 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 as it relates to his 5th metatarsal *is* causally related to the accident.

Petitioner's current condition of ill-being as it relates to his 4th metatarsal *is not* causally related to the accident after 6/17/16.

In the year preceding the injury, Petitioner earned $**45,240.00**; the average weekly wage was $**870.46**.

On the date of accident, Petitioner was **27** years of age, *married* 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 $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**2,028.37** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $580.31/week for 12-3/7 weeks, commencing 1/11/16 through 4/7/16, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services for treatment of petitioner's right foot injury on 1/10/16 through 6/17/16, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall pay no medical services related to petitioner's 4th metatarsal after 6/17/16.

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

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

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

Kaureen D. Kulis

Signature of Arbitrator

12/5/17
Date

ICArbDec19(b)

DEC 15 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 27 year old custodian, alleges he sustained an accidental injury to his right foot and 4th and 5th metatarsals, that arose out of and in the course of his employment by respondent on 1/10/16. Petitioner has been employed by respondent for 7 1/2 years. Petitioner testified that prior to 1/10/16 his right foot felt normal, and he had no surgery to his right foot. However, he did see a doctor 10-11 years ago when he rolled his right ankle, and sustained a fracture to his 4th metatarsal, and had an aircast for 6 weeks. Thereafter, petitioner returned to full duty work without restrictions. Petitioner testified that was able to perform all his work duties until the injury on 1/10/16. He believed his fracture had healed.

On 1/10/16, a Sunday, petitioner arrived at Bloomington Junior High School to work some overtime. Petitioner parked in the south parking lot. As he stepped out of his car he rolled his right ankle on an uneven chunk of ice, and fell into his car and caught himself. Petitioner noticed pain in his right foot and could not put much weight on it. This incident occurred 10 minutes prior to his shift. Petitioner was not holding anything when he got out of his car.

That same day, petitioner presented to the emergency room at Advocate Bromenn. Petitioner gave a consistent history of the injury. Tenderness with mild swelling and slight bruising over the lateral right foot at the base of the 5th metatarsal. X-rays to his right foot showed fractures of the proximal ends of the 4th and 5th metatarsals. Petitioner was given a splint and medications, and told to refrain from weightbearing on the right foot. Petitioner was referred to orthopedics.

On 1/11/16 petitioner presented to Dr. Newcomber for evaluation of his right foot. He noted that petitioner sustained an inversion type injury on 1/10/16 and had pain and swelling on the lateral aspect of the foot. An examination revealed tenderness of the 4th and 5th metatarsal. Dr. Newcomber assessed a 5th metatarsal fracture and what looked to be a healing 4th metatarsal fracture. But noted that the injury to the 4th metatarsal occurred 10 years ago. Dr. Newcomber noted that it is quite possible that the base of the 4th metatarsal may be delayed/nonunion, since petitioner told him that his foot had never felt the same since he broke the base of the 4th metatarsal. Dr. Newcomber noted that the 5th metatarsal was an acute fracture that is located in the metaphyseak diaphyseal junction. He noted that it was swollen and there was pain to palpation. Dr. Newcomber's impression was an acute Jones fracture at the base of the 5th metatarsal nondisplaced, which occurred at work. Dr. Newcomber recommended that the petitioner stop smoking. He also recommended a bone stimulator be added immediately to the fracture. He applied a short leg cast and continued petitioner non-weightbearing. Petitioner was taken off work until further notice.

On 1/18/16 petitioner returned to Dr. Newcomber. He continued to have pain in the cast and difficulty sleeping due to positional pain. Dr. Newcomber again recommended a bone stimulator to facilitate healing. Petitioner was continued non-weightbearing and off work. On 2/8/16 Dr. Newcomber noted no new bone formation. He noted a nonunion from a 9 year ago fracture at the base of the 4th metatarsal. He recommended an open reduction internal fixation across the 5th metatarsal to promote bone healing and potential early weightbearing.

On 2/11/16 petitioner underwent a percutaneous screw fixation, right 5th metatarsal Jones fracture. This procedure was performed by Dr. Newcomber. Petitioner's post-operative diagnosis was right 5th metatarsal Jones fracture. Petitioner followed up with Dr. Newcomber on 2/18/16. He was continued off work. On 3/10/16 Dr. Newcomber noted that x-rays demonstrated routine healing and no change in the screw position. Range of motion was coming along, and his strength was 4/5. Dr. Newcomber began proprioception exercises and instructed petitioner to begin progression of weightbearing over the next 2-3 weeks. On 3/31/16 petitioner reported occasional shooting sharp pains. X-rays showed the fractures healed. Dr. Newcomber released petitioner to work on 4/7/16 without restrictions. Petitioner was instructed to continue working on his conditioning strengthening spurs with therapy. On 4/28/16 petitioner reported that he had been working without restrictions and doing well with minimal soreness at the end of the workday. An exam revealed full range of motion, no tenderness, full strength and good proprioception in single leg stance. X-rays showed a healed 5th metatarsal fracture with evidence of a likely nonunion of the base of the 4th metatarsal. Petitioner was to continue with regular work duties, but not run. On 6/17/16 petitioner complained of redness in the foot and pain in the lateral aspect of the lower leg and into the knee. He also reported that his foot was turning out during walking even though he felt like he was walking straight. He reported aching, even at rest. Petitioner reported persistent complaints of pain at the base of the 4th metatarsal, and no pain over the 5th metatarsal. Dr. Newcomber referred petitioner to Dr. O'Connor for his 4th metatarsal.

On 6/20/16 petitioner presented to Dr. O'Connor, a podiatrist, on the referral of Dr. Newcomber, for consultation and evaluation of a right foot/ankle problem. He reported moderate aching, and instability. He reported that he had an open reduction internal fixation of the 5th metatarsal. He stated that this had healed, but he broke the one next to it and did not have surgery and it did not heal. He stated that it still aches and now affects his gait up to the knee. Dr. O'Connor noted minimal swelling that was not changed, tenderness of the 4th metatarsal (base) and 5th metatarsal base, and the tarsometatarsal of the peroneus brevis tendon. Dr. O'Connor assessed multiple closed fractures of the metatarsal (nondisplaced

fracture of the 4th metatarsal bone of the right foot). Dr. O'Connor ordered a pneumatic short walking boot, and exogen bone stimulator. He also noted that petitioner may need surgery and rehab.

Petitioner last followed up with Dr. Newcomber on 6/30/16. Petitioner had full range of motion, and mild tenderness over the base of the 4th metatarsal. Dr. Newcomber noted that petitioner needed further treatment for the delayed union of the base of the 4th metatarsal fracture. He noted that petitioner had been approved for the bone stimulator and would continue care with Dr. O'Connor for the 4th metatarsal fracture. Dr. Newcomber was of the opinion that petitioner was at maximum medical improvement for the 5th metatarsal.

On 7/28/16 Dr. O'Connor diagnosed a nondisplaced fracture of the 4th metatarsal of the right foot. He instructed petitioner to continue with the boot with Evenup and bone stimulator. Dr. O'Connor noted signs of improvement. He noted they may be looking at surgical repair, but discussed the difficulty of such a repair and length of recovery. He also noted that petitioner may need marginal debridement/drilling and packing with bone chips, considering the location, with possible plate/interfrag screw. Petitioner elected to proceed with surgical intervention.

Petitioner followed up with Dr. O'Connor on 10/24/16 and 11/10/16. On 11/10/16 petitioner had tenderness of the lateral right ankle and 4th metatarsal base, and tarsometatarsal joints. Dr. O'Connor discussed with petitioner that the only way he would be able to render a judgment would be to review the oldest/first x-rays to check if the fracture looks acute or chronic.

On 12/7/16 petitioner underwent a Section 12 examination performed by Dr. George Holmes Jr., at the request of the respondent. Dr. Holmes examined petitioner's right foot as it pertains to his injury on 1/10/16. Dr. Holmes noted that petitioner presented with increasing pain with weightbearing activities. Dr. Holmes performed a record review and examined petitioner. He also reviewed x-rays of the right foot that showed the 5th metatarsal appeared to be healed, and a chronic nonunion at the base of the 4th metatarsal. Dr. Holmes diagnosis was that petitioner had reached maximum medical improvement with regard to his 5th metatarsal. Dr. Holmes was of the opinion that the nonunion at the base of the 4th metatarsal was present prior to the fall and the injury that resulted in the 5th metatarsal fracture. He noted that the 4th metatarsal fracture occurred some 9-10 years prior to the alleged injury. He agreed that the petitioner was in need of additional surgery for the 4th metatarsal that would be related to the pre-injury condition. He did not see any evidence radiographically that would show that the 4th metatarsal fracture was exacerbated. He was of the opinion that the only way to be sure though was to review previous x-rays. Dr. Holmes was of the opinion that it appeared from the report that petitioner had what appeared to

be a quite mature and preexisting 4th metatarsal nonunion, and the petitioner had some symptomatology over time at this area prior to the injury to the 5th metatarsal. Dr. Holmes was of the opinion that petitioner was not at maximum medical improvement as it relates to his 4th metatarsal nonunion and that can be considered now to be the cause or factor of his current ongoing pain issues.

On 12/22/16 petitioner last followed-up with Dr. O'Connor. Petitioner had instability, aching and throbbing of the right foot. Dr. O'Connor noted tenderness of the lateral right ankle, the 4th metatarsal base, and the tarsometatarsal joints. Petitioner was assessed with a nondisplaced fracture of the 4th metatarsal bone of the right foot, and non-union of the joint of the right foot without infection. A pneumatic short walking boot was dispensed.

On 2/7/17 the evidence deposition of Dr. O'Connor was taken of behalf of petitioner. Dr. O'Connor opined that petitioner had a nonunion of the 4th metatarsal base, fracture. He further opined that the injury he described could have aggravated his condition of ill-being. He based this on the fact that from January to December of 2016, the gapping and the spacing, and the instability in that fracture, had gotten worse; and that prior to then petitioner had not been having pain in that location. Dr. O'Connor noted that when he reviewed the first x-rays of petitioner's foot the fracture of the 5th metatarsal was acute, but the fracture of the 4th metatarsal base did not appear to be a fresh fracture. Dr. O'Connor had no x-rays to review from 10 year ago. Dr. O'Connor, after reading a record of Dr. Newcomber, noted that petitioner's 4th metatarsal was not asymptomatic for the past ten years before the injury. Despite this new information Dr. O'Connor opined that his opinions would not change. Dr. O'Connor was of the opinion that absent the alleged injury petitioner's nonunion 4th metatarsal fracture could have become symptomatic on its own.

On 8/22/17 the evidence deposition of Dr. Holmes, Jr. was taken on behalf of respondent. Dr. Holmes is an orthopedic surgeon that specializes in foot and ankle surgery. Dr. Holmes was of the opinion that a nonunion cannot be made worse by a subsequent injury. He opined that the 4th metatarsal condition was not aggravated or materially changed by the reported work injury. He further opined that even though petitioner needs additional surgery for his 4th metatarsal, it is not related to the work injury. Dr. Holmes testified that he never reviewed any actual radiographs until the day of the deposition. Dr. Holmes opined that it is possible that the fall as described by petitioner could take an asymptomatic 4th metatarsal condition and make it symptomatic and in need of medical treatment, but he did not believe that was the case here.

Petitioner testified that the north and south parking lots at Bloomington Junior High School are owned, controlled, and maintained by respondent. He further testified that the parking lots are for teachers, faculty, and other employees, unless there is an event at the school. In that case, the lot is used by those attending the special event. Although petitioner can park in either the north or south lot, or on the street, he typically parked in the south lot, and entered the building through the south entrance, which is only accessible by employees that have ID key cards. Non-employees cannot enter through the south entrance unless the school is open for a special event in the gym, since the gym is closest to the south parking lot. The front entrance of the school is where non-employees generally would enter once they are buzzed in. The non-employee entrance is by the north parking lot. Petitioner testified that there is only one assigned space in the south parking lot and that is for the kitchen manager. Petitioner does not have an assigned parking spot. Petitioner testified that the parking lots are not open to the general public unless they are attending an event at the school.

David Moore, Facilities and Custodial Supervisor, was called as a witness on behalf of respondent. Moore has worked for respondent since 4/29/13. His duties include overseeing and scheduling custodial staff. He deals with maintenance issues. He confirmed that the south parking lot was where petitioner was injured.

Moore stated that Bloomington Junior High School has a north and south parking lot, and there is limited street parking in the area. He testified that on school days the south and north lot are for staff parking. For events he stated that the lots can be used by people attending the events. Moore testified that the lots are owned, controlled, and maintained by respondent, and confirmed that the only assigned parking space is for the kitchen manager. Otherwise, parking is on a first-come, first-serve basis.

Moore testified that on school days it is usually the staff and faculty that park in the south lot because non-employees cannot access the school from the south lot. They have to enter through the main entrance which is by the north parking lot. Moore also testified that if there is a special sporting event at the school the people attending the event can enter through the south entrance since it is the closest entrance to the school gym.

Moore testified that the respondent does not police the parking lots, but that the lots are only supposed to be used for school events. Moore stated that if there is a vehicle in the lot that is not there for school business it would be towed. Moore stated that if someone from the neighborhood was using the basketball courts or softball field they would usually walk from their home or park in the north lot.

Moore testified that the door to the school in the south parking lot is only unlocked for extracurricular events. Otherwise it is locked, and only accessible with an employee ID key card.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

The threshold issue here is whether or not the petitioner was at any greater risk than the general public when he slipped and fell in the respondent's south parking lot on 1/10/16. The parties stipulated that the north and south parking lots of Bloomington Junior High School are owned, controlled, and maintained by respondent. Both petitioner and Moore testified that the parking lots, and particularly the south parking lot, are for teachers, faculty, staff, and other employees on school days during school hours. Both petitioner and Moore also testified that the general public cannot gain access to the school from the south lot during school hours , since that south entrance is only accessible to school employees that have an ID key card they can scan in order to open the door. The general public can only gain access to the school through the north entrance, and must be buzzed in by the school Staff. Not just anyone can enter the school during school hours.

Both petitioner and Moore testified that when the school has a special event or sporting event after school hours, there will be someone at the south door to let those attending the special event or sporting event into the school, since the south entrance is closest to the gym.

Moore testified that although the respondent does not police the parking lots, the north and south lots are only to be used for staff, and those attending school events. He further testified that if there is a vehicle in the school lots that is not there for school business he would have it towed. He further testified that if someone from the neighborhood was using the school's basketball courts or softball fields they would usually walk from their home, or park in the north lot which was closest to those areas.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner was at a greater risk than the general public when he parked in the respondent's south lot each day to come to work. The arbitrator finds that not only did the school own, control and maintain the south parking lot, there would be no reason for anyone from the general public to park in that lot unless they were there for school business, and if that was the case, they would be more likely to park in the north lot. However, just because someone parked in respondent's lot, they are not automatically allowed access to the school. They would have to present to the north entrance and would have to be screened by the School Staff before being buzzed in. At no time could the general public enter through the south entrance of the school, unless they were there for a special event or school sporting event, and school staff was at the

door allowing them admittance. During school hours or when the building is closed, the only ones who could enter school from the south entrance would be staff members that had an employee ID key card that allowed them to scan it to gain entry entrance to the building. The arbitrator also finds it significant that Moore testified that any vehicle in the school's parking lot that was not there for school business would be towed. The arbitrator also finds it reasonable that petitioner would park in the south lot each day he worked since that is where the entrance is located whereby he can enter the building at any time with his employee ID card.

For these reasons, the arbitrator finds the petitioner was at a greater risk than the general public when he parked in the respondent's south lot when he arrived for work. Having found the petitioner was at a greater risk than the general public when parking in the south lot on 1/10/16 for work, the arbitrator also notes that respondent does not dispute the fact that the petitioner slipped on the ice in the south lot injuring his right foot on 1/10/16.

Therefore, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his right foot that arose out of and in the course of his employment by respondent on 1/10/16.

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

The parties stipulate that petitioner's current condition of ill-being as it relates to his 5th metatarsal on the right foot is causally related to the injury he sustained on 1/10/16, if the petitioner is found to have sustained an accidental injury that arose out of and in the course of his employment by respondent on 1/10/16, which the arbitrator did. However, an issue exists as to whether or not petitioner's current condition of ill-being as it relates to his 4th metatarsal on his right foot is causally related to the injury he sustained on 1/10/16.

It is unrebutted that petitioner sustained a fracture to his 4th metatarsal on his right foot 10-12 years ago. Petitioner testified that he wore an air cast for 6 weeks and then returned to full duty work without restrictions and performed all his work duties until the injury on 1/10/16. Petitioner testified at trial that he believed his fracture had healed. However, the arbitrator finds the credible medical records do not necessarily support this claim.

X-rays of petitioner's right foot on 1/10/16 showed fractures of the proximal ends of the 4th and 5th metatarsals. Dr. Newcomber assessed a 5th metatarsal fracture and what looked to be a healing 4th metatarsal fracture, but that injury occurred 10 years ago. Dr. Newcomber's notes also indicate that

petitioner reported that his right foot has never felt the same since he broke the base of the 4. and that it is quite possible that it is a delayed/nonunion. Dr. Newcomber's impression was an acute Jones fracture at the base of the 5th metatarsal nondisplaced, that occurred at work. On 1/18/16 Dr. Newcomber noted a nonunion from a 9 year ago fracture at the base of the 4th metatarsal.

Surgery was performed on the 5th metatarsal on 2/11/16. Petitioner treated with Dr. Newcomber until 4/7/16 when he was released to work without restrictions. On 4/28/16 petitioner told Dr. Newcomber that he had been working without restrictions and doing well with minimal soreness at the end of the workday. X-rays showed a healed 5th metatarsal fracture, with evidence of a likely nonunion of the base of the 4th metatarsal.

Two months later, on 6/17/16 petitioner returned to Dr. Newcomber with complaints of pain at the base of the 4th metatarsal. Petitioner had no pain over the 5th metatarsal. Dr. Newcomber referred petitioner to Dr. O'Connor for his 4th metatarsal.

Petitioner began seeing Dr. O'Connor for his 4th metatarsal on 6/20/16. He told Dr. O'Connor that had broke the 4th metatarsal when he broke the 5th metatarsal, but did not have surgery on that toe. He stated that it still aches and affects his gait. Dr. O'Connor believed petitioner may need surgery. He ordered a short walking boot and bone stimulator. On 7/28/16 Dr. O'Connor noted signs of improvement. He noted that surgical repair may be needed, but also discussed the difficulty of such a repair and length of recovery. Petitioner continued to treat with Dr. O'Connor and by 11/10/16 had not improved. Dr. O'Connor discussed with petitioner that the only way he would be able to render a judgment on whether or not the 4th metatarsal nonunion was related to the injury on 1/10/16 was to review the oldest/first x-rays to check if the fracture looked acute or chronic. Dr. O'Connor never reported that he reviewed these x-rays.

Respondent had petitioner examined by Dr. Holmes, Jr. Dr. Holmes reviewed x-rays that showed the 5th metatarsal appeared to be healed, and a chronic nonunion at the base of the 4th metatarsal. Dr. Holmes opined that the nonunion at the base of the 4th metatarsal was present prior to the fall on 1/10/16 and that the injury on 1/10/16 only resulted in the 5th metatarsal fracture. He noted that the 4th metatarsal fracture occurred some 9-10 years ago. He agreed petitioner was in need of surgery, but it was not related to the fall on 1/10/16, but rather to the pre-injury condition. He opined that there is no radiographic evidence that shows the 4th metatarsal fracture was exacerbated by the injury on 1/10/16. He stated that the only sure way to determine this would be to see x-rays of the right foot prior to the injury on 1/10/16, which petitioner did not offer into evidence. Dr. Holmes opined that the x-ray showed what

ppeared to be a quite mature and preexisting 4th metatarsal nonunion, and that the petitioner had some symptomatology over time at this area prior to the injury on 1/10/16. Dr. Holmes opined that a nonunion cannot be made worse by a subsequent injury. He further opined that the 4th metatarsal condition was not aggravated or materially changed by the work injury.

Dr. O'Connor opined that the injury petitioner described could have aggravated his 4th metatarsal. He was further of the opinion that the gapping and the spacing, and the instability in that fracture had worsened from January to December of 2016. However, the arbitrator notes that there were no new x-rays of the right foot after March of 2016, and when Dr. O'Connor viewed the x-rays from 1/10/16 he noted that the fracture of the 5th metatarsal was acute, and the fracture of the 4th metatarsal base did not appear to be a fresh fracture. Additionally, Dr. O'Connor did not review any x-rays prior to 1/10/16. Dr. O'Connor was of the opinion that even if petitioner had not sustained an injury on 1/10/16 his nonunion of the 4th metatarsal fracture could have become symptomatic on its own.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Newcomber and Dr. Holmes more persuasive than those of Dr. O'Connor. The arbitrator specifically notes that Dr. O'Connor's opinion that petitioner's 4th metatarsal condition worsened from January to December 2016, cannot be confirmed since petitioner did not undergo any x-rays of his foot after March of 2016. Therefore, the arbitrator does not see how Dr. O'Conner could opine that petitioner's gapping and spacing of the 4th metatarsal fracture had worsened from January to December 2016. The arbitrator also finds it significant that Dr. O'Connor and Dr. Newcomber were of the opinion that the best evidence to see if the injury on 1/10/16 could have aggravated petitioner's prior 4th metatarsal condition was an x-ray from when petitioner fractured the 4th metatarsal 9 years ago, but petitioner never presented that evidence to any treating or examining doctor.

Having found the opinions of Dr. Newcomber and Dr. Holmes more persuasive than those of Dr. O'Connor, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his 4th metatarsal is causally related to the injury he sustained on 1/10/16 after 6/17/16.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner has failed to prove by a preponderance of the credible record that his current condition of ill-being as it relates to his 4th metatarsal is causally related to the injury he sustained

on 1/10/16 after 6/17/16, the arbitrator finds all treatment for petitioner's 4th metatarsal after not reasonable or necessary to cure or relieve petitioner from the effects of the injury on 1/10/16.

Having found the petitioner has proven by a preponderance of the credible record that his current condition of ill-being as it relates to his 5th metatarsal is causally related to the injury he sustained on 1/10/16, the arbitrator finds all treatment for petitioner's 5th metatarsal from 1/10/17 through 6/17/16 was reasonable and necessary to cure or relieve petitioner from the effects of the injury on 1/10/16.

Respondent shall pay reasonable and necessary medical services for treatment of petitioner's right foot injury on 1/10/16 through 6/17/16, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall pay no medical services related to petitioner's 4th metatarsal after 6/17/16.

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

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner has failed to prove by a preponderance of the credible record that his current condition of ill-being as it relates to his 4th metatarsal is causally related to the injury he sustained on 1/10/16, the arbitrator finds this issue moot.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is alleging that he is entitled to temporary total disability benefits from 1/11/16 through 4/7/16. Having found petitioner sustained an accidental injury to his right 5th metatarsal, that arose out of and in the course of his employment by respondent on 1/10/16; that petitioner's current condition of ill-being as it relates to his right 5th metatarsal is causally related to his injury on 1/10/16; and that Dr. Newcomber released petitioner to full duty work without restrictions beginning on 4/8/16, the arbitrator finds the petitioner was temporarily totally disabled from 1/11/17 through 4/7/16, a period of 12-3/7 weeks.

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

Kathy Walters,
Petitioner,

vs.

NO: 11WC 46583

State of Illinois - Department of Human Services,
Respondent.

18IWCC0685

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2017 is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: NOV 8 - 2018
o110518
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALTERS, KATHY
Employee/Petitioner

Case# **11WC046583**

ST OF IL-DEPT OF HUMAN SERVICES
Employer/Respondent

18IWCC0685

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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TRACY JONES
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ROCKFORD, IL 61101

5946 ASSISTANT ATTORNEY GENERAL
HELEN LOZANO
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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
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SPRINGFIELD, IL 62794-9255

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

FEB 14 2017

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

18IWCC0685

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

Kathy Walters
Employee/Petitioner

Case # 11 WC 46583

v.

State of Illinois – 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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **December 16, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,506.40**; the average weekly wage was **$798.20**.

On the date of accident alleged, Petitioner was **50** 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 **$35,958.07** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$34,792.00** for other benefits, for which credit may be allowed under Section 8(j) of the Act, for a total credit of **$70,750.07**.

ORDER

Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

February 7, 2017
Date

FEB 14 2017

FACTS:

On May 1, 2008 the Petitioner was employed by the Respondent as an office coordinator in the child support department, having been so employed for approximately eleven years. The Petitioner testified that she typically worked thirty seven and a half hours per week; Monday through Friday form 8 a.m. to 4 p.m. with two fifteen-minute breaks and one thirty minute lunch break. The Petitioner testified that her job duties included: keyboarding, entering child support information into a data base, filing, speaking with customers over the phone, shredding documents, and conducting court research. The Petitioner testified she typically did keyboarding for five and a half hours per day, and that the rest of her time was spent on the phone, filing, faxing, copying, shredding, and stapling using both hands. The Petitioner testified that her job also required her to travel to conduct court research about once a week for approximately one hour during which she pulled files, made photocopies, and reviewed orders, docket sheets, and payment ledgers.

The Petitioner described her work station as a regular type desk, a chair with adjustable armrests, a keyboard with no gel pad, a mouse and a mouse pad to the right of her keyboard, a non-adjustable monitor, a phone to her left on top of a printer desk, and a shredder which was behind her to the left.

The Petitioner testified that sometime in 2008 she began to experience pain in her wrists as well as numbness in her hands and fingers, and that she sought treatment for her complaints with her primary care physician, Dr. Kelly. Dr. Kelly referred the Petitioner to Dr. Perry, whom the Petitioner saw on May 13, 2008.

Dr. Perry's records reflect that he saw the Petitioner on May 13, 2008 and that she was a "50 year old right handed female self-referred for evaluation of bilateral hand numbness" Dr. Perry noted a history of bilateral right greater than left median distribution numbness and tingling which started "years ago", and a report of some pain running down the right forearm into the first, second, and third digits. Dr. Perry's impression was "question carpal tunnel syndrome bilaterally right greater than left", and he ordered an EMG. On May 27, 2008 Dr. Perry noted the Petitioner's EMG findings and his impression was "mild carpal tunnel syndrome of the right hand documented on EMG." Dr. Perry also noted that he suspected minimal to mild carpal tunnel syndrome on the left since she had similar but lesser symptoms on that side. The Arbitrator notes that there is no mention of the Petitioner's job activities contained in Dr. Perry's records.

On May 28, 2008 the Petitioner submitted a notice of injury report to the Respondent citing an injury to both right and left hands which occurred because of "uninterrupted repetitive motion performed in the course of the normal workday."

The Petitioner also sought treatment for her left elbow. On July 1, 2008, Petitioner saw Carl DePauw, PA-C and reported that she sustained an injury to her elbow in April 2008. A tennis elbow strap was offered and it was recommended that she undergo therapy.

The Petitioner then came under the care of Dr. Sathoff at the Monroe Clinic. The Petitioner testified that she was referred to Dr. Sathoff by Dr. Kelley for "tennis elbow" complaints which started six months prior to 2008. The Petitioner underwent a left elbow MRI on August 15, 2008, which revealed no evidence of bone bruise or radiographic occult fracture, trace joint effusion, minor edema at the origin of the extensor tendons of the lateral epicondyle. On August 18, 2008 Dr. Satoff noted

the Petitioner's MRI findings, and his impression was that the Petitioner had a left elbow lateral epicondylitis. On August 20, 2008, the Petitioner received a cortisone injection over the lateral epicondyle and on September 25, 2008 the Petitioner was released from treatment for her left elbow and was advised to return as needed.

The Petitioner returned to Dr. Sathoff on December 15, 2008 for a recheck of her left elbow and she reported that she injured her elbow in May of 2008, when she hit her elbow on a filing cabinet. The Petitioner received a second cortisone injection over the left lateral epicondyle at that visit. The Petitioner returned to Dr. Sathoff on January 12, 2009 and was again released from treatment and advised to return as needed. The Petitioner returned on August 5, 2009 and was prescribed more physical therapy. Ultimately, the Petitioner reported that conservative treatment failed to provide relief of her symptoms and she underwent a left carpal tunnel release and a left lateral epicondylitis release on April 7, 2011 performed by Dr. Sathoff.

On July 29, 2011, the Petitioner saw Dr. Goldberg for complaints of left shoulder pain. An MRI was performed and was reported to demonstrate rotator cuff tendinopathy supraspinatus tendon, possible small cuff tear in the distal lateral part of the posterior aspect of the supraspinatus, AC joint arthritis, and biceps tendinopathy without a tear or SLAP type lesion. On August 12, 2011, the Petitioner elected to undergo six weeks of physical therapy for her left shoulder. On August 17, 2011, the Petitioner submitted a notice of injury report to the Respondent claiming a left rotator cuff injury on April 21, 2011.

The Petitioner testified that she also presented to Dr. Gonzalez on August 12, 2011 for problems with her left thumb. On July 6, 2012, the Petitioner underwent another EMG. The Petitioner testified that she returned to Dr. Gonzalez on July 25, 2012 and was then diagnosed with anterior interosseus nerve palsy.

The Petitioner testified that she currently experiences pain in her left hand, left elbow, and left thumb, and has no range of motion in her left thumb when her left hand is flexed. Regarding her right hand, the Petitioner testified that she experiences numbness and lack of strength. The Petitioner has not sought additional treatment for her right or left hand, her left elbow, or her left shoulder, and does not have any follow up appointments pending. The Petitioner retired on June 30, 2015.

At the request of the Respondent, the Petitioner was examined by Dr. James Williams on September 12, 2012. Dr. Williams' report was admitted into the record as Respondent's Exhibit 4 and his testimony was admitted into the record as Respondent's Exhibit 5. Dr. Williams testified that he reviewed the Petitioner's medical records, a position description form which included demands of the Petitioner's job, and a description of the job activities and workstation ergonomics provided by the Petitioner.

Dr. Williams' impression was that the Petitioner was status post left carpal tunnel release, left elbow lateral epicondylectomy, and debridement with no further signs of left carpal tunnel syndrome with still evidence of some left elbow complaints, left shoulder partial rotator cuff tear, as well as left thumb anterior interosseous nerve palsy. Dr. Williams opined that neither the Petitioner's anterior interosseous nerve palsy nor her shoulder problems were related to her job duties and that her job activities of computer work, filing, and/or data entry did not cause, contribute to, or aggravate her carpal tunnel syndrome and/or left elbow lateral epicondylitis." Dr. Williams explained that carpal tunnel syndrome is caused by forceful, sustained repetitive gripping, and pinching and that the

Petitioner's job activities did not involve any significant forceful repetitive pinching, gripping, or grasping and did not involve any vibration or impact. Petitioner's work did not cause or aggravate Petitioner's injuries. Regarding the Petitioner's left shoulder; Dr. Williams opined that there is no reason to believe that the Petitioner's shoulder complaints are related to either her elbow surgery or her wrist surgery, nor were they caused or contributed to by her job duties.

At the request of her attorney, the Petitioner was examined by Dr. Jeffrey Coe on January 20, 2015. Dr. Coe's testimony was admitted into the record as Petitioner's Exhibit 5. Dr. Coe testified that he reviewed the Petitioner's medical records from Dr. Perry, Dr. Sathoff, Dr. Gonzalez, Dr. Goldberg, and Dr. Reshef but he did not review medical records from Dr. Kelly, Dr. DePauw, or Dr. Morrison.

Dr. Coe opined that Petitioner's work activities were a factor causing the development of her bilateral carpal tunnel syndrome, that the alleged May 28, 2008 left elbow contusion on the filing cabinet caused traumatic left lateral epicondylitis, and that there is a causal relationship between the Petitioner's symptomatic left shoulder impingement and the recovery from the left upper extremity surgery the Petitioner underwent in April 2011. Dr. Coe explained that he based his opinion on the Petitioner's own account of injury history, past medical history, treatment medical records, his examination of the Petitioner, and the Petitioner's description of her work activities. Dr. Coe also testified that he did not have a job description or ergonomic assessment from the Respondent.

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

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

Initially, the Arbitrator notes that there are no causation opinions from any of the Petitioner's treating physicians contained anywhere in the record. In fact, there is no mention of the Petitioner's job duties or activities contained anywhere in the records of the Petitioner's treating physicians. The Arbitrator considers the absence of any mention of the Petitioner's job duties in the records of her treating physicians to be significant. Similarly, the Arbitrator finds the lack of any causation opinions from any of the Petitioner's treating physicians to be significant.

As none of the Petitioner's treating physicians noted the Petitioner's job activities or opined that there was any relationship between the Petitioner's conditions and her job activities, the Arbitrator is left to consider only the opinions of examining physicians. The Respondent's examining physician, Dr. Williams, opined that neither the Petitioner's anterior interosseous nerve palsy nor her shoulder problems were related to her job duties and that her job activities of computer work, filing, and/or data entry did not cause, contribute to, or aggravate her carpal tunnel syndrome and/or left elbow lateral epicondylitis. The Petitioner's examining physician, Dr. Coe, opined that Petitioner's work activities were a factor causing the development of her bilateral carpal tunnel syndrome, that

the alleged May 28, 2008 left elbow contusion on the filing cabinet caused traumatic left lateral epicondylitis, and that there is a causal relationship between the Petitioner's symptomatic left shoulder impingement and the recovery from the left upper extremity surgery the Petitioner underwent in April 2011.

The Arbitrator notes that while both Dr. Williams and Dr. Coe relied on the Petitioner's report of her job duties, Dr. Williams also reviewed a job description form which reflected the demands of the Petitioner's job. Dr. Williams noted that the Petitioner's job activities did not involve any significant forceful repetitive pinching, gripping, or grasping and did not involve any vibration or impact. Dr. Coe did not have the benefit of the job description form. While the Arbitrator notes Dr. Coe's opinions, the Arbitrator finds the opinions of Dr. Williams to be more credible, reliable, and persuasive in the instant matter.

With regard to the Petitioner's bilateral carpal tunnel syndrome claim, because the Petitioner's treating physicians did not provide a causation opinion and because the Arbitrator finds the opinions of Dr. Williams to be more credible, reliable, and persuasive than those of Dr. Coe in the instant matter, the Arbitrator finds that the Petitioner failed to prove that a work accident occurred and failed to prove that a causal connection exists between the Petitioner's work activities and her development of bilateral carpal tunnel syndrome.

Similarly, with regard to the Petitioner's left elbow epicondylitis, the Arbitrator finds that the Petitioner failed to meet her burden of proof. The Arbitrator notes that the Petitioner did not report her alleged May 28, 2008 accident date and cause of her left elbow symptoms to her initial treating physicians. After months of treatment for her elbow, the Petitioner vaguely described bumping her elbow at work to subsequent treating physicians. Furthermore, The Petitioner's notice of injury, filled out on May 28, 2008 makes no mention of her left elbow, left elbow injury, or left elbow symptoms. It was not until her independent medical examination with Dr. Coe in 2015 that she gave an exact date of injury and a more thorough description of her alleged accident.

Dr. Coe unconvincingly causally related the Petitioner's alleged May 28, 2008 bump into a filling cabinet as the traumatic cause of the Petitioner's left elbow epicondylitis. In his deposition testimony he admitted to basing this opinion solely on Petitioner's account of an alleged accident and belief that this was the cause of her symptoms. The Arbitrator finds it difficult to give this opinion any weight. Conversely, Dr. Williams opined that her left lateral epicondylitis was not caused by any work related activity or repetitive motions nor trauma.

The Arbitrator finds that the Petitioner failed to prove a work accident involving her left elbow and failed to prove a causal connection between her work activities and her development of left lateral epicondylitis.

With regard to the Petitioner's left shoulder claim, the Arbitrator notes that while Dr. Coe opined that there is a causal relationship between the Petitioner's symptomatic left shoulder impingement and the recovery from her left upper extremity surgery, Dr. Williams opined that there is no reason to believe that Petitioner's shoulder complaints are related to either her elbow surgery or her wrist surgery. There is no evidence from which it can be concluded that the Petitioner's job activities caused or contributed to her left shoulder impingement. Again, the Arbitrator finds the opinions of Dr. Williams to be more credible, reliable, and persuasive than those of Dr. Coe in the instant matter.

The Arbitrator finds that the Petitioner failed to prove a work accident involving her left shoulder and failed to prove a causal connection between her left upper extremity surgeries and her development of left shoulder problems.

With regard to the Petitioner's left thumb condition, the Arbitrator notes that the Petitioner's treating physician, Dr. Gonzalez, diagnosed her with anterior interosseus nerve palsy of viral origin. Dr. Williams then further explained in his deposition testimony that "We do not honestly know exactly why those start. It obviously was not related to any treatment of which she underwent nor to any traumatic problem at work." Therefore, the Arbitrator finds that there was no work accident and no causal connection between Petitioner's surgeries and her development of left thumb problems.

As the Arbitrator has found that the Petitioner failed to meet her burden of proof with regard to the issues of accident and causation, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emigdio Maldonado-Ruiz,

Petitioner,

vs. NO: 13WC 18533

18IWCC0686

Freedman Seating Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical, 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 July 11, 2017 is hereby affirmed and adopted.

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

18IWCC0686

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 $67,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 8 - 2018
o110518
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

MALDONADO-RUIZ, EMIGDIO
Employee/Petitioner

Case# **13WC018533**

FREEMAN SEATING COMPANY
Employer/Respondent

18IWCC0686

On 7/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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CHICAGO, IL 60603

18IWCC0686

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)

Emigdio Maldonado-Ruiz
Employee/Petitioner

v.

Freedman Seating Company
Employer/Respondent

Case # **13** WC **18533**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **May 11, 2017, May 12, 2017, May 19, 2017, and June 19, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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?
[x] 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, **May 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* causally related to the accident.

In the year preceding the injury, Petitioner earned $**31,200.00**; the average weekly wage was $**650.00**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **4** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $**27,546.12** for TTD, for all medical benefits paid, for a total credit of $**27,546.12** plus all medical benefits paid.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**433.33**/week for **183 4/7^{ths}** weeks, commencing **May 31, 2013** through **August 21, 2015**, and commencing **January 16, 2016** through **May 11, 2017**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **May 31, 2013** through **May 11, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $**27,546.12** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner temporary partial disability benefits of $**196.66** /week for **21** weeks, commencing **August 22, 2015** through **January 15, 2016**, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $**290.00** to **Romano Orthopedics**, $**215.00** to **Illinois Laboratory Medicine Associates**, and $**15,167.00** to **Function 1st Physical Therapy**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all medical benefits that have been paid.

Respondent shall authorize and pay for cubital tunnel surgery, physical therapy, and a functional capacity evaluation as ordered by Dr. Victor Romano.

Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of Petitioner's accidental injuries.

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

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

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

Signature of Arbitrator

July 11, 2017
Date

ICArbDec19(b) JUL 11 2017

FACTS

Petitioner was working for Respondent as an assembler of seats on May 31, 2013. Petitioner testified that he worked as an assembler 10 to 12 hours daily, five or six days per week. Petitioner worked for Respondent for approximately fourteen years, ending in May 2013. For approximately nine of those years, he worked as an assembler. Petitioner is right-hand dominant. (PX2, p. 056.)

Aldo Jimenez, Petitioner's former coworker, testified that he assembled seats for Respondent from 2008 through 2013 and that they performed the same job activities for Respondent. Jimenez testified that Respondent's main product is seats for trucks and buses. Jimenez estimated that there were over one hundred bolts and screws per seat. He testified that the bolts could be secured using a machine or tool, but they had to be secured by hand first, then finished with tools like an impact gun and screw gun. Jimenez testified that the bolts had to be screwed in by hand until they were tight, and only then could the impact gun or the screw gun be used because otherwise the bolt would lock in place incorrectly, and it would be difficult to fix. Screwing the bolts by hand involves turning the wrist.

Jimenez testified that he and Petitioner would use impact guns connected to an air compressor while assembling a seat. The impact guns kicked, and had to be held steady. The impact guns were very hard to control because they pulled on the user's hands during operation. They also used electric screw guns when assembling a seat. Jimenez testified that the screw guns moved and vibrated, putting stress on the user's hands and arms, and were generally hard to control. Jimenez testified that there were different kinds of seats, from singles to three-seaters. Singles were the easiest, and took 10 to 15 minutes to assemble, while three-seaters weighed over 150 pounds, and took an hour and a half to assemble. The three-seaters, they would have to assemble and then take apart due to weight issues during shipping. Jimenez testified that three-seaters comprised the majority of their work each day as opposed to singles. He testified that they would assemble a minimum of three triple seats per day. He testified that he had a Worker's Compensation claim against Respondent.

Petitioner testified that he performed the same job as Jimenez and that he also assembled special assemblies, like seats for bus drivers, which required more extensive use of his hands and arms. Petitioner described the process for assembling rigid seats. That process would begin by manually fitting each bolt and screwing the bolts onto the seats by hand. They would use a great deal of force to install and secure the bolts, place the washers on by hand, then tighten them using an impact gun which required a great deal of control and force. The flip seats, especially, required an enormous number of bolts, which Petitioner estimated approximately 100 bolts when completed. Many times he would need to use his hand to hit the seat back or the seat itself into place. Petitioner testified that he assembled up to 15 chairs per day and that if they were doubles, it would mean hammering the seat with his hand.

Prior to his employment with Respondent, Petitioner had no injuries to his hands, arms, or wrists. At some point during or after his employment, Petitioner noticed swelling in his hands, as well as pain and tingling. He began periodically dropping things that he was holding in his hand. He felt pain from his fingers up to his armpits in both arms. He noticed the pain and numbness in his hands and wrists first, and when he worked more, the pain increased and moved up his arms.

Respondent presented Armando Rivera as a witness. Rivera testified that he was a supervisor and he had been working for Respondent over ten years He testified that he oversaw the Petitioner from 2008 until the end of his employment. Rivera testified that Petitioner assembled three to four seats per day and that the maximum bolts per seat was 18 to 20 and the use of an impact gun. Rivera was present at the time the job video was created. He testified that the actions and movements in the video were the same as those performed by Petitioner. Rivera testified that the seats in the video were flip seats. Rivera testified that Petitioner primarily worked on flip seats. Rivera testified that Petitioner would assemble 2 t0 3 three flip seats a day and that it takes seconds to drive seconds to drive a bolt into a chair with an impact gun. He testified that Petitioner was never instructed to strike bolts with his hands.

Petitioner sought treatment with his primary care physician, Dr. Kaleka, who referred him to an orthopedic surgeon, Dr. Romano. On May 15, 2014, Petitioner presented to Dr. Romano for treatment of a problem to both of his hands. He complained of pain, stiffness, redness, and numbness in his hands, worse on the right, and especially at night. He reported radiation to his upper arms bilaterally, as well as dropping objects and difficulty gripping. Petitioner reported that he had been experiencing these symptoms for the past six years, that he had been managing them on his own with 800 mg ibuprofen for the year prior, but that the ibuprofen was bothering his stomach. He told Dr. Romano that he used to work on an assembly line using air pumps that put pressure on his hand to operate the machinery, in addition to screwing parts together. (PX2, p. 046.)

Dr. Romano diagnosed Petitioner with moderate bilateral carpal tunnel syndrome, took Petitioner off work, and instructed him to return in one month. (PX2, p. 048.)

On August 13, 2014, Petitioner complained of pain in his hands for the past four months, with radiation to the shoulders and difficulty holding even very light objects. (PX2, p. 042.) Petitioner's wrists were tender to palpation and were positive for Phalen's test at less than 30 seconds bilaterally. Petitioner was diagnosed with bilateral carpal tunnel syndrome, right worse than left, with mild to moderate exacerbation of symptoms and/or progression of disease with a fair amount of pain and disability. Conservative care had been unsuccessful and recommended a right carpal tunnel release pending the results of an EMG test. (PX2, pp. 034-044.)

On October 22, 2014, Petitioner returned to Dr. Romano. Petitioner complained of sharp, burning, stabbing, throbbing pain radiating from his wrists to his elbow, aggravated by twisting, lifting, and holding

objects, and relieved by home exercises. (PX2, p. 038.) The wrists were tender to palpation and positive for Phalen's test at less than 30 seconds bilaterally. Dr. Romano diagnosed Petitioner with bilateral carpal tunnel syndrome, right worse than left, with mild to moderate exacerbation of symptoms and/or progression of disease with a fair amount of pain and disability, as well as mild bilateral cubital tunnel syndrome. (PX2, pp. 039-040.) Dr. Romano released Petitioner to work modified duty, with restrictions of 10 pounds maximum lift and 10 pounds maximum push and pull. (PX2, p. 041.)

On November 26, 2014, Petitioner returned to Dr. Romano and complained of bilateral numbness and sharp, aching, stabbing wrist pain radiating to his elbows. Petitioner had been unable to continue physical therapy due to insurance but that he was continuing to perform stretches at home. (PX2, p. 033.) Dr. Romano elicited positive Phalen's tests on both hands at less than 45 seconds. (PX2, pp. 034-035.) Dr. Romano diagnosed carpal tunnel syndrome of the left and right hand, noting that "Patient has severe exacerbation of symptoms." (PX2, p. 035.) Dr. Romano stated that Petitioner's right sided carpal tunnel syndrome was worse than his left and opined that it would require surgical correction. (PX2, p. 037.) Dr. Romano recommended a right carpal tunnel release surgery, to which Petitioner agreed. (PX2, p. 035.) He released Petitioner to work modified duty, with specific work modifications of 10 pounds maximum lift and 10 pounds maximum push and pull. (PX2, p. 036.)

On January 6, 2015, Dr. Romano performed right carpal tunnel release surgery on. The indications for surgery included the fact that Petitioner had been suffering persistent pain, numbness and weakness of the right hand, resistant to conservative care. Dr. Romano freed the transverse fascial ligament distally and then released it under direct visualization. The preoperative diagnosis and the postoperative diagnosis was carpal tunnel syndrome, right hand. (PX2, p. 027.)

On February 18, 2015, Petitioner reported that he was going to physical therapy and that he had been advised to continue for 4 to 6 more weeks, followed by left carpal tunnel surgery. Petitioner complained of numbness and tingling in his left hand and intermittent right hand pain at rest and with movement as well as continued numbness in his index, middle, and ring fingers and at the base of his thumb. Petitioner complained that the shooting and throbbing pain in his right hand was better. Pain was associated with swelling, numbness or tingling, difficulty gripping, and dropping objects. (PX2, pp. 029-031.) Petitioner's left hand was positive for Phalen's test at less than 45 seconds, with strength at 4 out of 5 in the abductor pollicis brevis. (PX2, p. 031.) Dr. Romano charted that Petitioner's right hand was improving nicely, with some remaining weakness and sensitivity. Dr. Romano diagnosed Petitioner with persistent carpal tunnel syndrome of the left hand and stated that surgical correction on the left would be considered. (PX2, p. 031.) He kept Petitioner on modified duty for four weeks due to his ongoing right wrist pain and weakness, with restrictions of 10 pounds maximum lift, only occasional lift/carry, and limited use of the right hand. (PX2, p. 032.)

On August 24, 2015, Petitioner returned to Dr. Romano and complained of ongoing aching, numbness and tingling in his left hand and wrist. Petitioner reported that he had been having trouble opening doors and gripping objects, he had been wearing a left wrist brace, doing grip exercises, and using heat therapy, which were helping. He reported that he had no pain, numbness or tingling in his right wrist at that time. Petitioner's wrists exhibited carpal tunnel syndrome bilaterally, and tenderness over the dorsum of the wrist, with pain on full dorsiflexion and strength at 4/5. (PX4, pp. 025-026.)

On September 21, 2015, Petitioner complained of pain bilaterally in his wrists, some discomfort in his right wrist aggravated by heavy lifting, and deep aching pain in his left wrist, with numbness and tingling after heavy lifting. He reported that he was icing his wrist and taking ibuprofen. (PX4, pp. 029-030.)

On October 21, 2015, Petitioner complained of left wrist pain. (PX4, p. 035.) Dr. Romano reviewed an unremarkable MRI. Dr. Romano noted tenderness in the dorsum of the left wrist, pain with full dorsiflexion, strength at 4/5, a mild deficiency in balance and stability, and a positive Phalen's sign. (PX4, p. 035.)

On December 10, 2015, Petitioner complained of constant, dull left wrist pain. Dr. Romano noted that Petitioner had undergone an EMG study on December 4, 2015 showing left mild to moderate carpal tunnel syndrome with left ulnar sensory neurapraxic neuropathy likely localized at the left ulnar wrist. Dr. Romano discussed treatment options, and Petitioner elected surgery. (PX4, pp. 039-041.)

Petitioner returned to Dr. Romano on January 7, 2016. Petitioner reported that the pain and swelling in his wrist had grown worse, and he complained of constant left wrist pain, aggravated by moving the wrist. Petitioner reported numbness on his outer two fingers and thumb, as well as a bump on his wrist. He reported that he was now working with someone else on assembly activities but that it was very painful to do any wrist bending activities. Petitioner was using a wrist brace and taking ibuprofen for his pain, with limited effectiveness. (PX4, p. 045.) Dr. Romano recommended a left cubital tunnel release procedure. (PX4, p. 047.) He noted: "Due to exacerbation of symptoms and exhaustion of conservative treatment plans, surgical correction was recommended and patient consented to proceed". (PX4, p. 047.)

Dr. Romano testified at evidence depositions on March 23, 2016 and July 27, 2016. Dr. Romano opined that Petitioner's carpal tunnel syndrome, cubital tunnel syndrome and the resulting surgeries were causally related to Petitioner's work activities. (PX7, p. 008.) Dr. Romano based his opinions on Petitioner's complaints, his reports of when symptoms were bothering him during work, and how his symptoms began. (PX7, p. 009.) He opined that his were consistent with Petitioner's complaints. (PX7, p. 009.) Dr. Romano testified that he became more aware of Petitioner's symptoms in his left ulnar nerve in October 2015. (PX7, p. 008.) Dr. Romano testified that he believed Petitioner's cubital tunnel syndrome was present the entire length of his treatment, but that the carpal tunnel syndrome had masked his cubital tunnel symptoms. (PX7, p. 008.)

Dr. Carroll, Respondent's Section 12 examining orthopedic physician, examined Petitioner on February 3, 2016 and testified at an evidence deposition on August 15, 2016. He testified that he observed evidence of left ulnar neuritis. (RX4, p. 10.) He testified that Petitioner had a positive elbow flexion test, positive Tinel's sign, and positive ulnar nerve compression test. (RX4, p. 11.) Dr. Carroll testified that Petitioner's right carpal tunnel syndrome had resolved but that Petitioner had a mildly positive medial nerve compression test on the left, with some left sided weakness of grip. (RX4, p. 11.) Dr. Carroll diagnosed Petitioner with bilateral carpal tunnel syndrome and left ulnar neuritis at the elbow. (RX4, p. 12.) He opined that Petitioner was at maximum medical improvement with regard to his right carpal tunnel syndrome but not with regard to his left ulnar neuritis, and that a corticosteroid injection would be helpful. (RX4, p. 13-14; 17-18.) He testified that all of the treatment of Petitioner was reasonable and appropriate, but was unsure about "a test". (RX4, p. 32.)

Dr. Carroll testified that he initially did not offer an opinion as to whether there was a causal connection between Petitioner's work activities and his conditions, as he did not have enough information about Petitioner's job. (RX4, p. 12-13; 24.) He testified that Petitioner described a history of forceful, repetitive activities at work. (RX4, p. 15,) He found Petitioner to be honest and truthful. (RX4, p. 33.) He testified that generating more than 40 pounds of torque would be considered "medium" and might play a role. (RX4, p. 22.) Dr. Carroll testified that ulnar neuritis and carpal tunnel syndrome might be consistent with highly forceful or repetitive activity over the course of 14 years. (RX4, p. 27.)

Respondent subsequently provided Dr. Carroll with a video purporting to depict the activities Petitioner might perform at work. (RX4, p. 14-15; 25-26.) Dr. Carroll did not find that the activities depicted in the video, performed 3 or 4 times per day, would cause carpal tunnel syndrome or ulnar neuritis. (RX4, p. 17.) However, he did not know if the activities shown in the video were what actually Petitioner did at work. (RX4, p. 26.) Dr. Carroll testified that the video did not match Petitioner's description of his duties, and that he could not tell which was true without independently going to the job site and looking for himself, which he had not done. (RX4, pp. 26-27.)

Dr. Carroll testified that his opinion might change if he learned that Petitioner had to hit an insert or metal bolt with his hand 10 to 20 times per hour as part of his job duties. (RX4, p. 28-29.) Dr. Carroll testified that his opinion might change if the chairs Petitioner had to assemble were larger than the chairs in the video, with a lot more bolts than were described in the job analysis. (RX4, p. 30-31.) Dr. Carroll testified that his opinion might change if Petitioner had been required to assemble four or five seats together, requiring even more bolts and screws to be turned by hand. (RX4, p. 31-32.) Dr. Carroll testified that his opinion might change if Petitioner had assembled more than 3 or 4 chairs per day. (RX4, p. 34.) Dr. Carroll testified that lifting 75 to 100 pounds could cause bilateral carpal tunnel syndrome and ulnar neuritis depending upon the frequency of the lifting and the way it's lifted, and turning the wrist might make the effect of the lifting worse. (RX4, pp. 35-36.)

Respondent submitted a video purporting to depict the process of assembling a seat. (RX10) Petitioner testified that the video depicted very little of the process of assembling a seat. He testified that the video did not accurately depict the amount of pressure needed to assemble a seat, the quantity of the bolts, or the hand mobility needed.

Petitioner testified that his left carpal tunnel release surgery did not resolve his left arm symptoms. Petitioner testified that he still feels the same pains in his left wrist, radiating up his arm. Dr. Romano testified that he would like to perform a cubital tunnel release to help Petitioner's ongoing left upper extremity symptoms. Dr. Romano opined that after the surgery Petitioner would need physical therapy, and a functional capacity evaluation. (PX7, p. 009.)

ACCIDENT

Petitioner l worked for Respondent for approximately 14 years total, and for 9 of those years, he worked as an assembler for 10 to 12 hours daily, five to six days per week. His job activities placed a great amount of stress on his upper extremities. He was required to repeatedly fit, screw, hammer, secure and place bolts and washers by hand, and to use power tools to complete the process, creating additional stress on his upper extremities.

The Arbitrator finds that Petitioner's testimony was credible. The Arbitrator finds that Petitioner's credible testimony and was corroborated by the persuasive and detailed testimony from his former coworker, Aldo Jimenez.

The Arbitrator finds the testimony of Armando Rivera was unpersuasive. Petitioner's employment predated Armando Rivera's employment by several years. Furthermore, Respondent's video depicted only a selective microcosm of the chair assembly process.

Based upon the foregoing, the Arbitrator finds that Petitioner's bilateral carpal tunnel syndrome and cubital tunnel syndrome arose out of and in the course of Petitioner's employment.

CAUSATION

Prior to his employment with Respondent, Petitioner had no injuries to his hands, arms, or wrists. At some point during or after his employment, Petitioner noticed swelling in his hands, as well as pain and tingling. He began periodically dropping things that he was holding in his hand. He felt pain from his fingers up to his armpits in both arms. He noticed the pain and numbness in his hands and wrists at first. When he worked more, the pain increased and moved up his arms.

Petitioner's testimony is consistent with and corroborated by the medical records. Additionally, Petitioner was in a condition of good health, and after exposure to repetitive work activities, he developed symptoms of carpal tunnel and cubital tunnel syndrome. Dr. Romano's consistent testimonial opinions regarding causation are persuasive. Dr. Carroll's opinions are based on an incomplete job video that does not depict all of Petitioner's work duties.

Based upon the foregoing, the Arbitrator finds that petitioner's current condition of ill being is causally related to the accident.

PAST MEDICAL CARE, PROSPECTIVE MEDICAL CARE, TEMPORARY TOTAL DISABILITY BENEFITS, TEMPORARY PARTIAL DISABILITY BENEFITS

Respondent's defenses on these issues are premised upon accident and causation. Since the issues of accident and causation have been resolved in Petitioner's favor, the claimed temporary benefits are awarded.

CREDIT

Respondent has claimed a credit for temporary weekly benefits paid and for medical benefits paid.

The Arbitrator finds that Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injuries.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHELLEY WOOD,

Petitioner,

vs.

NO: 13 WC 28164

GENERAL GRIND & MACHINE,

18IWCC0687

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner sustained an undisputed work-related injury on July 31, 2013 when a 28-30-pound steel piece of equipment fell onto Petitioner's foot, causing a comminuted fracture of the left fifth proximal and middle phalanx. (Px1, Rx5) Respondent does not dispute accident, causation, medical or temporary total disability as it relates to the foot injury and has stipulated to same. Respondent, however, disputes Petitioner's claimed accident to her lower back, disputes that Petitioner's current condition of ill-being as to her back is related to the July 31, 2013 accident, and disputes that Petitioner should receive maintenance or vocational rehabilitation.

At the time of accident, although Petitioner was wearing steel-toed shoes, she also suffered a puncture wound to the bottom of her foot. Petitioner had a complicated road to recovery, including suffering from an infection resulting in irrigation and debridement on September 17, 2013, and several courses of antibiotics. Further Petitioner complained of on-going problems of pain, numbness, tingling, swelling and difficulty standing. Petitioner was released back to work October 31, 2013, though had on-going problems.

Petitioner treated with Dr. Thornton throughout 2014 for her ongoing foot complaints and sequala to her crush injury. As the Arbitrator noted, Dr. Thorton's records do not memorialize complaints of back pain, but the records document Petitioner's repeated history of difficulty with ambulation and gait abnormality. PX1.

Petitioner initially sought treatment for back complaints on July 23, 2014 with both Dr. Robert Padgett, in the morning and Samuel Paik, P.A. in the evening. Petitioner relayed a history to Dr. Padgett of generalized back pain which was constant with an unknown duration. Dr. Padgett did not note any gait abnormality, diagnosed Petitioner with back pain, and referred Petitioner to her primary care physician. Petitioner was evaluated by Samuel Paik later that same day with continued complaints of back pain beginning the night previously. P.A. Paik diagnosed a back strain and advised Petitioner to follow-up with ORA, Orthopaedic & Rheumatology Associates. PX1.

On July 28, 2014, Dr. Julio Santiago, Petitioner's primary care physician, evaluated Petitioner who complained of moderate back pain for an approximate three-day duration. Dr. Santiago diagnosed back pain and recommended conservative care consisting of medication and physical therapy. PX1.

On September 19, 2014, Dr. Sundar, a pain management physician partnering with Dr. Thornton, evaluated Petitioner who complained of chronic foot pain as well as back pain which Dr. Sundar believed might be compensatory. Dr. Sundar diagnosed chronic pain and recommended on-going pain intervention such as physical therapy and medication. PX1.

Thereafter, and MRI was performed, and on October 6, 2014, Dr. Purighalla reviewed the scan and recommended continued pain management and no surgery. PX1.

Dr. Santiago released Petitioner to return to work beginning December 15, 2014 with restrictions of no bending, stooping, prolonged standing, and no lifting greater than 10 lbs. PX1.

On December 10, 2014, Dr. Sundar re-evaluated Petitioner who continued to complain of left foot and back pain. DR. Sundar reviewed the MRI and found small disc bulges without stenosis. Dr. Sundar recommended a course of anti-inflammatories but cautioned against spinal interventional procedures. As to causation between the foot injury and Petitioner's low back complaints, Dr. Sundar stated "I've explained to her that it is possible that the antalgic gain that resulted from her foot injury may be causing chronic muscle spasms of the lumbar paraspinal muscles, however I cannot say that the two are related with absolute certainty." PX1.

On February 27, 2015, Petitioner was evaluated for a final time at the pain clinic by the nurse practitioner for both Dr. Thornton and Dr. Sundar. Nurse Practitioner Mary Kozlov placed Petitioner at maximum medical improvement regarding her treatment but would need ongoing medication for her chronic pain. PX1.

Ten months later on November 16, 2015, Dr. Santiago evaluated Petitioner who continued to complain of low back pain with a recent onset of knee pain. Dr. Santiago related Petitioner's complaints of back pain and knee pain to her foot injury. On November 22, 2016, approximately one year later, Dr. Santiago's nurse Kayl Vyncke on Dr. Santiago's behalf authored updated

restrictions of no prolonged bending, stooping, standing, and sitting and no lifting. PX3. On November 4, 2015, Dr. Santiago provided testimony consistent with his prior treating records. PX2.

On March 17, 2016, Dr. Alexander Ghanayem evaluated Petitioner pursuant to Section 12 of the Act at the request of Respondent. Dr. Ghanayem reviewed the MRI and performed a physical evaluation. Dr. Ghanayem diagnosed Petitioner with subjective complaints of back and leg pain. Dr. Ghanayem opined if Petitioner experienced an altered gait, it was resolved as he personally watched Petitioner walk in the hallway and parking lot. Dr. Ghanayem opined Petitioner did not sustain a back injury and was able to return to work without restrictions. RX3. On August 17, 2016, Dr. Ghanayem provided testimony consistent with his report of March 17, 2016. RX1.

The Commission agrees with the Arbitrator's conclusion that Petitioner provided a causal relationship between her left foot injury sustained on July 31, 2013 and her subsequent development of low back pain. In so finding, the Commission affords greater weight to the opinions of Dr. Sundar and Dr. Santiago over those of Dr. Ghanayem and Dr. D'Souza. Both Dr. Ghanayem and Dr. D'Souza predicated their opinions on Petitioner's lack of a gait abnormality in essence finding Petitioner not believable as to her pain and limp. Dr. Sundar and Dr. Santiago found Petitioner truthful as to complaints of pain and altered gait as such finding causation. The Arbitrator who personally observed Petitioner found her credible and forthright and also observed an altered gait. There is nothing contained in the medical records which contradicts Petitioner's continued complaints of foot pain which would be a plausible cause of an altered gait at times.

As for temporary total disability benefits, the Commission modifies the Arbitrator's decision as to the disputed periods of temporary total disability benefits and finds Petitioner is entitled to benefits for the period of August 5, 2014 through February 27, 2015 for a period of 29 and 4/7 weeks. "The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized. [citations omitted]." *Mechanical Devices v. Industrial Commission (Johnson)*, 344 Ill. App. 3d 752, 760, 800 N.E.2d 819 (2003). "Once an injured employee's physical condition has stabilized, the employee is no longer eligible for TTD benefits because the disabling condition has become permanent. [citation omitted]." *Id.* at 759.

Dr. Santiago released Petitioner to return to work with restrictions as of December 15, 2014. Respondent did not provide work with in the restrictions. T. 49. Thereafter, Petitioner was placed at maximum medical improvement as of February 27, 2015 by Nurse Practitioner Mary Kozlov for Dr. Sundar and Dr. Thornton. Dr. Santiago periodically evaluated Petitioner thereafter, but no treatment was provided. As such, Petitioner's condition stabilized as of February 27, 2015 and no further temporary total disability benefits are due.

Regarding maintenance benefits and vocational rehabilitation, the Commission modifies the decision of the Arbitrator and finds Petitioner failed to prove entitlement to maintenance benefits and vocational rehabilitation and vacates the award for both. Section 8(a) of the Act allows for the award of maintenance benefits when Petitioner is participating a prescribe vocational rehabilitation program. *W.B. Olsen v. Illinois Workers' Compensation Commission*, 2012 IL App (1st) 113129WC. Such program may include a self-directed job search. Petitioner testified she attempted to find work through temp agencies but that was the sum total of the evidence. T. 51. The Commission does not find this sufficient evidence to prove entitlement to maintenance benefits.

18IWCC0687

Further, Petitioner testified to potential transferable skills such CNA certificate as well as a past CDL license and high school diploma, so it is not clear Petitioner is in need of vocational assistance. As such, the Commission awards a vocational assessment regarding Petitioner's need for formal vocational assistance.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the award for maintenance is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall initiate a vocational assessment under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $331.33 per week for a period of 42 3/7 weeks, commencing August 2, 2013 through October 30, 2013, and August 5, 2014 through February 27, 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 $18,768.00 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $29,202.91. 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 8 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 91218
49

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

WOOD, SHELLEY
Employee/Petitioner

Case# **13WC028164**

GENERAL GRIND & MACHINE
Employer/Respondent

18IWCC0687

On 6/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
STEPHEN J SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
THOMAS P CROWLEY
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

18IWCC0687

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)

Shelley Wood
Employee/Petitioner

v.

General Grind & Machine
Employer/Respondent

Case # 13 WC 28164

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **2/8/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/31/13**, 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 **$25,844.00**; the average weekly wage was **$497.00**.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,723.56** for other benefits, for a total credit of **$3,723.56**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $18,768.00, as set forth in Petitioner's exhibit 7, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $331.33/week for 12 5/7 weeks, commencing 8/2/13 through 10/30/13, and 120 1/7 weeks, commencing 8/5/14 through 11/22/16, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $331.33/week for 11 1/7 weeks, commencing 11/23/16 through 2/8/17, as provided in Section 8(a) of the Act.

Respondent shall be given a credit for temporary benefits that have been paid.

Respondent shall authorize and pay for vocational rehabilitation

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

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

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

Michael K. Nowak, Arbitrator

6/22/17
Date

ICArbDec19(b)

JUN 27 2017

On July 31, 2013, the Petitioner was employed by the Respondent as a CNC machine operator. On that date the Petitioner sustained an injury to her left foot when a part she was machining rolled from a table and struck her on her left foot. The part weighed 25-30 pounds and was described as a "kingpin".

There is no dispute among the parties that the Petitioner sustained the accident on July 31, 2013, and that the employer was promptly notified of the accident. The dispute in this case concerns whether the Petitioner's lumbar spine condition of ill being is causally related to the injury to her left foot of July 31, 2013.

Petitioner testified that after she was released to return to work with regard to her foot she began to experience low back pain and symptoms due to an altered gait which resulted from the foot injury.

FINDINGS OF FACT

Following the undisputed accident Petitioner immediately experienced severe pain and was taken to Mercer County Hospital and subsequently directed to Dr. Steven Boardman at the direction of Respondent. (P.X.5). Dr. Boardman examined her on that date and diagnosed her condition as a crush injury to the left foot with fifth toe proximal and middle phalanx fracture. Dr. Boardman placed her in a short leg cast for approximately five weeks. Petitioner developed an infection in the foot at the trauma sight and on September 17, 2013, Dr. Boardman performed an irrigation and debridement of the left foot. (P.X. 5). She was placed in a pneumatic boot and continued to follow up at that facility. She was ultimately released to return to work on October 31, 2013.

As of November 13, 2013, it was noted that the crush injury to the left foot was healing but she continued to experience lateral foot pain. Dr. Boardman recommended referral to Dr. Pyevich, a foot specialist, for additional opinions regarding treatment secondary to her continued and worsening pain in the foot after returning to work.

On November 26, 2013, Petitioner was examined by Dr. Pyevich who saw no indication for surgical intervention. He counseled her on how her foot would never be the same after the injury as the nerves over the top of the foot were crushed and become hypersensitive. (P.X. 5).

Given the Petitioner's ongoing complaints of pain, she sought treatment at Genesis Health Systems and initially saw Dr. Martha Thornton, a Podiatrist. (P.X. 1, pg. 12). Dr. Thornton first examined her on January 24, 2014 and noted that her pain condition was chronic in nature. Dr. Thornton diagnosed a contusion of the foot, closed fracture of the toe, gait abnormality and neurolgia. It was recommended Petitioner undergo a therapeutic steroid injection of the fifth metatarsal joint together with pain medication and icing of the foot. In a follow up visit of February 3, 2014, it was noted that the Petitioner felt like she was walking on rocks and her condition was aggravated on weight bearing, ambulation and with shoe gear intact. (P.X. 1, p. 16). Surgical intervention was discussed for the correction of the varus non-reducible and contacted deformity of the fifth toe of the left foot. On February 10, 2014, Dr. Thornton rendered additional diagnosis' of hammer toe, arthralgia of the left foot together with difficulty in walking. (P.X. 1, p.20)

On March 19, 2014, Petitioner was examined by Dr. D'Souza, at the direction of the Respondent pursuant to Section 12 of the Act. (R.X. 10). Dr. D'Souza felt that the Petitioner's subjective complaints particularly relating to the pain in the region of the fourth and fifth toes correlated with his subjective findings.

His diagnosis was crush injury of the foot with capsular contracture and adhesions of the fourth and fifth MTP joints and chronic swelling of the fifth toe. He believed those conditions to be causally related to the subject injury and it was possible she had an overlap of traumatic injury to peripheral nerves and cutaneous nerves in her foot. He did not agree with the surgical recommendation of Dr. Thornton. Although he understood the rationale for attempting to straighten out her toes to prevent ulcerations and infections he was concerned the additional procedures would lead to more chronic swelling and exacerbate her complaints of pain. He recommended an MRI and concurred with ongoing iontophoresis treatment and continued pain medication.

As of March 21, 2014, Petitioner was noted to be experiencing pain in the evenings while at rest and placed the pain level at 8 out of 10 with prolonged ambulation and weight bearing. It was further noted that her foot was sensitive to the touch from her shoes, socks and bedding. Dr. Thornton felt the pain may be attributable to chronic regional pain syndrome and referred her to Dr. Sundar, a pain specialist for a second opinion. (P.X. 1, p.39).

On May 2, 2014, Petitioner was reexamined by Dr. Thornton. She continued to suffer from Morton's neuroma, neuralgia, hammer toe, arthralgia of the foot, difficulty with walking and gait abnormality. Dr. Thornton responded to Dr. D'Souza's opinions and treatment recommendations. (P.X. 1, pgs. 57(a) and 57(b)). It was noted that Petitioner had significant unresolved chronic pain possibly secondary to the crushing/contusion injury to the left foot. An ultrasound and MRI performed were negative for which she recommended a fiber density biopsy to rule out peripheral neuropathy of the foot. She further recommended custom made steel toe boots and custom made biomechanical orthotics be obtained.

Petitioner was examined by Dr. Thornton on June 28, 2014. (P.X. 1, pg. 73). It was noted she was still awaiting authorization for evaluation with Dr. Sundar at the pain clinic. She had not received authorization for the proposed surgical procedure and the burning pain she experienced in the foot was very intense. The diagnosis of neuralgia, hammer toe, arthralgia of the foot, gait abnormality and difficulty with walking were further confirmed. It is not lost on the Arbitrator that Dr. Thornton's records up to this point are devoid of any mention of low back pain. However those records do consistently record gait abnormality.

On July 23, 2014, the Petitioner presented to Samuel Paik P.A. with complaints of back pain. (P.X. 1, pg. 78). Petitioner testified she experienced no acute trauma but rather the pain developed over a period of time and increased in intensity until such time as she required medical treatment. She also saw Dr. Robert Padgett on that date who diagnosed her as having back pain and advised to follow up with her primary care provider, Dr. Julio Santiago.

The Petitioner was first examined by Dr. Santiago on July 28, 2014 at which time he diagnosed a back strain, prescribed medication and an MRI. (P.X. 1, pg. 84).

On September 19, 2014, Petitioner was examined by Dr. Sundar at the Valley View Pain Center. (P.X. 1, pg. 97-100). Dr. Sundar believed she was suffering from a persistent and chronic pruritus of the left foot after the work related crush injury in 2013. He did not believe there were any signs suggestive of CRPS and recommended a trial of Gabapentin as well as a compound cream. In the event she did not respond, he would consider a lumbar sympathetic block the following month.

On February 27, 2015, the Petitioner was last examined by Dr. Martha Thornton. At that time, it was noted she continued to experience a burning sensation over the lateral aspect of the foot together with numbness. Dr. Thornton concurred she was suffering from a persistent and chronic pruritus of the left foot following the crush injury. Her Lyrica was refilled and Dr. Thornton deemed her to be at maximum medical improvement for her foot. She further opined that she would require this medication for the remainder of her life given the specific pain in her foot. (P.X. 1, pg. 140).

With respect to her back condition, Dr. Santiago continued his care and treatment and ultimately referred her to Dr. Purighalla, a neurosurgeon on October 6, 2014. (P.X. 1, pg. 108). Based upon the results of the MRI, Dr. Purighalla did not believe Petitioner was a surgical candidate and recommended ongoing conservative treatment in the form of medications, therapy and injections. He further raised the issue of implantation of a spinal cord stimulator for the left leg and foot pain. (P.X. 1, pg. 109).

Petitioner returned to the care of Dr. Santiago who referred her to Dr. Sundar for a pain management evaluation on December 10, 2014. (P.X. 1, pg. 124-126). Dr. Sundar believed she was presenting with symptoms suggestive of myofascial pain over the lumbosacral area secondary to her antalgic gait. He recommended additional anti-inflammatories and perhaps trigger point injections in the event the symptoms did not resolve.

Petitioner testified she has remained under the care of Dr. Santiago for her back who prescribed physical therapy and injections. (P.X. 1, pg. 212). On November 3, 2014, Dr. Santiago released Petitioner to return to work effective December 15, 2014 with restrictions of no bending, no stooping, no prolonged standing and no lifting greater than 10 pounds. (P.X. 1, pg. 120)

Petitioner testified that she presented the initial restrictions to the Respondent on or about November 3, 2014. Thereafter, her employment was terminated given that she was unable to return to work full duty and her FMLA had been exhausted. (P.X. 10).

The Petitioner underwent an additional Section 12 evaluation with Dr. Alexander Ghanayem on March 17, 2016. Dr. Ghanayem noted the Petitioner's injury history to her left foot which resulted in a fracture of her small toe. The Petitioner stated that she was off work for three months and then when she returned she developed low back pain. Petitioner stated she had a prior low back injury at work which was a back strain and was only back to work for a couple days prior to her injury of March 31, 2013. Dr. Ghanayem' s examination noted that the Petitioner was limping when she walked in the exam room. However when she walked out of the exam room and down the hall, she was observed by Dr. Ghanayem, and she walked without a limp, including walking into the parking lot. Dr. Ghanayem's impression was that the Petitioner had subjective complaints of back and leg pain which were not substantiated by the rather subtle degenerative changes in the lumbar spine without any neurologic compression. Dr. Ghanayem noted that if she had an altered gait at one time causing her soft tissue back pain that that issue had resolved. Dr. Ghanayem again noted that when she walked a longer distance down the hallway and in the parking lot she had no gait disturbance. Dr. Ghanayem felt the Petitioner could return to her regular job. (R.X. 1).

Petitioner continued to follow up with Dr. Santiago. When Petitioner last saw Dr. Santiago on November 22, 2016 she was given restrictions of no lifting and no bending, stooping, standing or sitting for prolonged periods of time (P.X. 3).

Petitioner testified she continues to seek employment but has not been extended a job offer.

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 does not dispute that the Petitioner sustained an accident to her left foot on July 31, 2013. Respondent also does not deny that the Petitioner provided the appropriate notice to the employer regarding the accident to her left foot on July 31, 2013. The primary dispute of the Respondent is whether the Petitioner's lumbar spine condition is causally related to her left foot injury of July 31, 2013.

Accordingly, the Arbitrator finds that the Petitioner sustained an accident that arose out of and occurred in the course of her employment with Respondent on July 31, 2013, and provided the appropriate notice to the employer.

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

Respondent does not dispute the causal relationship between Petitioner's left foot condition and the undisputed accident. Respondent does, however dispute the causal relationship between Petitioner's low back condition and the accident.

The Arbitrator found Petitioner to be a credible witness. Petitioner testified that after she was released to return to work with regard to her foot she began to experience low back pain and symptoms due to an altered gait which resulted from the foot injury. While the medical records do not document a complaint of low back pain following the accident until Petitioner saw Samuel Paik P.A. on July 23, 2014, the records do reflect consistent notations of gait abnormality.

Respondent's examiners Dr. D'Souza and Dr. Ghanayem dispute that Petitioner was experiencing an alteration in her gait.. Dr. Ghanayem testified that an altered gait can in fact cause soft tissue back pain in an individual. (R.X. 1, pg. 17). He described the mechanism as an individual walking out of balance for a period of time, swaying side to side as a result of which an individual asymmetrically loads the muscles in the back and the muscles work harder on one side and not so harder on the other side which can cause pain. The treatment of that scenario is to normalize the gait pattern. (R.X. 1, pg. 18). However Dr. Ghanayem concluded that the Petitioner did not walk with any limp or antalgia when out of the doctor's office, but still under his observation. (R.X. 1, pg. 19). Dr. D'Souza noted that the Petitioner does walk with antalgia; however she has a normal foot progression and does place weight on the lateral border of the foot and lateral toes with normal progression. Dr. D'Souza also noted that when the Petitioner did not realize he was observing her she walked without antalgia. Once the Petitioner realized that Dr. D'Souza was in fact observing her, then her antalgic gait returned (R.X. 10). Both concluded that Petitioner had no altered gait therefore her low back condition was not related to sequella of the left foot injury.

Dr. Santiago testified that as a result of the injury to the foot, Petitioner developed an antalgic gait as she could not put any pressure on the foot. Given that she was moving with hesitancy, it caused the mechanics of her walking to change. (P.X. 2, pgs. 14-15) The painful condition in her foot actually resulted in the production of low back pain. (P.X. 2, pgs. 20-21). Dr. Sundar opined that she was presenting with signs and symptoms suggestive of a myofascial pain over the right lumbosacral area secondary to her antalgic gait. (P.X. 1, pg. 125) Although he could not say so with 100% certainty, it is possible the antalgic gait resulting from her foot injury may be causing the chronic muscle spasm of the lumbar paraspinal muscles. (P.X. 1, p. 126)

The Arbitrator finds the testimony and opinions of Petitioner's treating physicians, particularly Dr. Santiago, more persuasive than Respondent's examiners Dr. Ghanayem and Dr. D'Souza.

Further the Arbitrator had the opportunity to not only observe the Petitioner while testifying, but while ambulating as well. The Arbitrator found the testimony forthright and credible and observed altered gait at all times.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds the current condition of ill-being with respect to Petitioner's low back is causally related to the accident of July 31, 2013

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Respondent stipulated that all medical treatment rendered to the Petitioner for the injuries sustained to her left foot were reasonable and necessary and that they were liable for payment of them subject to the fee schedule. Respondent does not dispute that the medical treatment received by the Petitioner with respect to her low back condition was reasonable and necessary, but does dispute liability therefor based upon the issues of accident and causation. Having found that the Petitioner's low back condition is causally related to the subject accident, the Arbitrator finds that the Respondent is responsible for payment of all medical expenses incurred in conjunction therewith.

Petitioner's Exhibit 7 consists of a medical expenses totaling $18,768.00.

Respondent shall pay reasonable and necessary medical services of $18,768.00, as set forth in Petitioner's exhibit 7, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

TTD

Petitioner claims TTD benefits from August 2, 2013 through October 30, 2013 and July 24, 2014 through February 8, 2017, the date of hearing. Respondent does not dispute the first period of claimed benefits as that pertains to time lost due to the injuries sustained to the left foot, but does dispute any TTD benefits thereafter.

On July 23, 2014, Petitioner presented to Dr. Padgett with complaints of moderate back pain which was noted to be constant. (P.X. 1, pg. 81). She was advised to follow up with her primary care physician. There is

no indication in the record that she was authorized off of work at that time. Petitioner then followed up with Dr. Santiago who diagnosed her with back pain, degenerative disc disease and removed her from work on August 5, 2014. (P.X. 1, pg. 89). Petitioner remained off work until November 3, 2014 at which time she was released to return to work subject to restrictions effective December 15, 2014. (P.X. 1, pg. 120, P.X. 10)

Petitioner conveyed her restrictions to Respondent but was informed that her restrictions could not be accommodated by the Respondent and she was instructed to apply for short and long term disability benefits. (P.X. 10)

Dr. Santiago testified that as of November 4, 2015 Petitioner remained under his care for her low back condition and the work restrictions imposed as of December 15, 2014 had never been modified. (P.X. 2, pg. 30-31). Since that date, Petitioner has undergone injections at the pain clinic under the care of Dr. Richard Maynard. On November 22, 2016, Dr. Santiago modified her restrictions to preclude her from lifting any weight in addition to those previous restrictions and made them permanent. (P.X. 3). Petitioner testified that she has not returned to work since that date.

Based upon the foregoing, and the record taken as a whole, and having found that Petitioner's low back condition is causally related to the undisputed accident the Arbitrator finds Petitioner is entitled to TTD benefits from August 2, 2013 through October 30, 2013 (12 5/7 weeks) and August 5, 2014 through November 22, 2016 (120 1/7 weeks).

Maintenance Benefits

Petitioner testified that she was not offered work by the Respondent which accommodated the permanent restrictions imposed on November 22, 2016. (P.X. 3). Lisa Holtschalg, Respondent's director of human resources, confirmed that the Respondent could not accommodate the permanent restrictions imposed by Dr. Santiago. In light of the extent of the permanent restrictions placed upon Petitioner the Arbitrator finds she is not capable of returning to her former occupation.

Pursuant to the Act, a Respondent is obligated to pay for the vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto when the injuries preclude the Petitioner from returning to his or her former occupation. (820 ILCS 305/6(d) For the reasons addressed in Section "O" below, Petitioner is entitled to vocational rehabilitation as contemplated by the Act and accordingly, the Respondent is obligated to pay maintenance benefits commencing November 23, 2016 through the February 8, 2017, the date of hearing (11 1/7 weeks).

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

Issue (O) Vocational Rehabilitation.

Petitioner reached maximum medical improvement for her left foot condition on or about February 27, 2015. (P.X. 1, pg. 137-140). As set forth above, the Arbitrator finds the opinions of Dr. Santiago, including those regarding Petitioner's ability to return to restricted work only, persuasive. The Arbitrator further finds that Petitioner reached maximum medical improvement on November 22, 2016 with regard to her low back condition, as that is the date of the imposition of permanent restrictions which could not be accommodated by

the Respondent. As a result of the foregoing, the Arbitrator finds that Petitioner is not capable of returning to her former occupation.

Respondent shall authorize the preparation of a written assessment of the rehabilitation required to return Petitioner to employment and shall authorize a vocational rehabilitation plan designed to return Petitioner to employment as provided by the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Janice M. Liddell,
Petitioner,

vs. No. 15 WC 30928

18IWCC0688

Springfield Clinic,
Respondent.

DECISION AND OPINION ON REVIEW

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

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. The Commission further affirms the Arbitrator's determinations as to accident, causal connection between the accident and the injuries sustained, and the medical expenses incurred of $675.00, subject to the limits of Sections 8(a) and 8.2 of the Act.

With regards to the nature and extent of the injury, the Commission does view the evidence differently than the Arbitrator. The Arbitrator performed the proper analysis pursuant to Section 8.1b of the Act, specifically (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. Applying this process, the Commission first notes, as did the Arbitrator, that no AMA rating is apparent, and therefore no weight is provided to this factor. The Commission generally adopts the Arbitrator's analysis and findings, we disagree with the weight provided to the factors. Specifically, with regard to factors (ii) and (iv) (or "b" and "d" in the Arbitrator's decision), the Arbitrator noted that the claimant has continued to pursue her pre-injury employment as a lab assistant, and at the time of the hearing was earning as much or more as she was earning at the time of the injury. The Arbitrator noted the Petitioner questioned her ability to continue in this occupation to her expected retirement age, and the Arbitrator viewed that testimony as "speculative, self-serving and lacking any corroboration." The Commission wholly concurs with this latter analysis, and provides that with greater weight than did the Arbitrator.

The facts of this case demonstrate that this was a minor injury, an ankle sprain with relatively little treatment, no internal derangement, and no time lost from work. No credible evidence of any loss of salary or impairment of likely future earnings is apparent from the record. The Commission finds these factors significant and mitigating. In light of all the facts and circumstances, the Commission finds an award of 1% loss to the right foot as permanent partial disability pursuant to Section 8(e) is appropriate, and modifies the Arbitrator's award accordingly.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.67 per week for a period of 1.67 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 1% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $675.00 for medical expenses under §8(a) of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,300.00. 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 8 - 2018

o-09/12/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

DISSENTING OPINION

I respectfully dissent. I believe Petitioner failed to prove she sustained an accident which arose out of her employment.

Petitioner bears the burden of establishing her injury arose out of and in the course of her employment. *Shafer v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100505WC, ¶ 35. "In the course of" speaks to the time, place, and circumstances of the occurrence of the injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 52, 57, 541 N.E.2d 665 (1989). "Arising out of" speaks to risk. "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. [citation omitted]." *Id.* at 58.

A. In the Course of

Petitioner proved the fall occurred in the course of her employment with Respondent. Petitioner was on a sanctioned break during her normal work hours in a place she might reasonably be expected to be. See *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 52, 57, 541 N.E.2d 665 (1989). Relying on *Segler v. Industrial Commission*, 81 Ill. 2d 125, 406 N.E.2d 542 (1980), Respondent argues Petitioner's actions were so unreasonable and unexpected, such actions removed her from the course of her employment. I do not believe Petitioner's actions were so egregious that it rendered her outside of her employment. Even such, Petitioner must prove her injury arose out of her employment.

B. Arising Out of

Petitioner failed to prove her injury arose out of her employment. "There are three types of risk an employee might be exposed to, namely: 1) risks distinctly associated with the employment; 2) risks which are personal to the employee; and 3) 'neutral risks which have no particular employment or personal characteristics.' [citation omitted]." *Potenzo v. Illinois Workers' Compensation Commission*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523 (2007). Petitioner exposed herself to a personal risk when she chose to step off the paved parking lot onto the grassy area. This matter is similar to the facts presented in both *Dodson v. Industrial Commission*, 308 Ill. App. 3d 572, 720 N.E.2d 275 (1999) and *Hanson v. Trinity Express Care*, 09 WC 7350- affirmed by appellate court in Rule 23 Order.

In *Dodson*, claimant after completing her shift fell en route to her car located in the employee parking lot. Claimant left the paved sidewalk instead opting to utilize a grassy slope due to the inclement weather. The Commission denied compensation benefits. In affirming the Commission's denial, the Appellate Court held claimant was in the course of her employment, but she failed to prove her injury arose out of her employment. In so holding, the Court found "an injury does not arise out of the employment where an employee voluntarily exposes himself or herself to an unnecessary personal danger solely for his own convenience. *Orsini, 117 Ill. 2d at 47.*" *Dodson* at 576.

In *Hanson*, claimant, a front desk clerk, arrived at work and realized she forgot her computer login credentials in her car. Claimant was en route to her car located in the employee parking lot when she deviated from the paved sidewalk onto a grassy area further negotiating a retaining wall to reach her vehicle. The Commission denied compensation benefits finding claimant failed to prove her injuries arose out of her employment as the risk encountered was a personal risk. The Appellate Court affirmed the Commission in a Rule 23 Order dated December 18, 2013.

As the claimants in both *Dodson* and *Hanson*, Petitioner chose to expose herself to an unnecessary risk purely for her own convenience. Petitioner testified she parked in the lot provided by Respondent by backing into the parking space. T. 25. Petitioner testified she parked in such a manner by her own choice. *Id.* Petitioner testified she chose to step off the paved parking lot into the grass in order to access the back of her vehicle. T. 27-28. Petitioner was performing a voluntary act- stepping into the grass for her own personal convenience- loading a cooler. Petitioner chose to step into the grass. It is grass; by its nature it is uneven which is why Respondent provided a paved parking lot and paved sidewalks.

For the reasons stated above, I would find Petitioner failed to prove she sustained an accident which arose out of her employment. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LIDDELL, JANICE M
Employee/Petitioner

Case# **15WC030928**

SPRINGFIELD CLINIC
Employer/Respondent

18IWCC0688

On 4/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0834 KANOSKI BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0265 HEYL ROYSTER VOELKER & ALLEN
DANIEL R SIMMONS
3731 WABASH AVE PO BOX 9678
SPRINGFIELD, IL 62791

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

Janice M. Liddell
Employee/Petitioner

v.

Springfield Clinic
Employer/Respondent

Case # 15 WC 30928

Consolidated cases: N/A

18IWCC0688

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **February 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 26, 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 **$27,791.40**; the average weekly wage was **$534.45**.

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

Respondent is not entitled to a credit for any medical bills paid by a group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$675.00**, as provided in Sections 8(a) and subject to the medical fee schedule of 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$320.67/week** for **16.7 weeks**, because the injuries sustained caused the **10% loss of the right foot**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued between **August 26, 2015** and **February 21, 2017** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

April 14, 2017
Date

APR 20 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner's case proceeded to arbitration on February 21, 2017. The disputed issues were accident, medical bills, and nature and extent. Respondent tendered no exhibits. Petitioner was the sole witness testifying at the hearing.

The Arbitrator finds:

Petitioner testified that on August 26, 2015, she was employed as a Lab Assistant 2 for Respondent in Springfield, Illinois. Petitioner testified that during her work day on August 26, 2015, they were very busy so everyone was going on breaks later than usual. Petitioner testified that she chose to take her break before going to lunch. Petitioner further testified that Respondent's main lab receives certain items in Styrofoam coolers and these coolers are then placed in a hallway and are "up for grabs" for employees to take home. Petitioner testified that a co-worker brought her one of these coolers on that date and Petitioner decided to place the cooler in her car so that it would be out of the way should they get busy. Petitioner testified that the cooler was about two feet wide and about a foot and a half tall. Petitioner testified that she was still on the clock at this time.

Petitioner further testified that the Clinic is located between 6th and 7th streets, and her car was parked across 7th Street in Springfield in the "east lot." Petitioner testified that this lot belongs to Respondent and was a designated parking area for employees though she acknowledged that she is not assigned a particular parking space. She testified that, to her knowledge, patients do not park in that lot. Petitioner testified that she had backed into her parking lot that morning, which was how she customarily parked. She testified that she doesn't like to back out of a parking space and prefers to drive out forward so that she can have a better view coming out of the space and she feels that it is safer to park that way. She was parked in a spot on the outside edge of the lot, stating that usually by the time she arrives at work the other spaces are taken. Petitioner testified that she used her automatic opener to unlock her car and was stepping behind the car to open the hatchback on her vehicle, a Chevy Equinox SUV, so she could place the cooler in the back. She testified that there was a curb at the back of the parking space that she had to step over to get to the grassy area beside the lot to access the back of her vehicle. Petitioner testified that when she stepped onto the grassy area behind the lot, she unexpectedly stepped into a hole that was about six or eight inches wide and about a foot long and 2 or 3 inches deep, causing her to twist her ankle and stumble against her car. Petitioner further testified that there was grass growing around this hole so that she did not notice that there was a hole there until she stepped into it. Petitioner testified that she had immediate pain in her ankle and she rested against her car for a minute before she limped back into the clinic. When she got back into the clinic, Petitioner told her supervisor about the incident and was directed to prepare an incident report. She testified that in the process of preparing this report, she also told one of the managers about the incident.

Petitioner testified that she was sent to Midwest Occupational Health Associates (MOHA) on August 26, 2015 by Respondent. Records from MOHA show that she was seen that day by Dr. Yociss, who recorded that Petitioner was on break for lunch when she went out to a truck and stepped up into a grassy area, rolling her right ankle. Petitioner reported spraining her right foot and ankle in the past but never having a fracture. After "stumbling" Petitioner went back to the building and ate her lunch. (PX 1, pp. 22-26)

Petitioner complained of pain in her right ankle as well as some discomfort in her back, which she thought might have been due to the alteration in her gait. On examination, Dr. Yociss noted pain throughout the lateral ankle over the malleolus and associated ligaments. Tenderness was noted over the dorsum of the foot, specifically the mid portion of the second and third metatarsals. X-rays of Petitioner's right foot were negative for fracture or dislocation. Petitioner's low back was also tender to palpation in the right paralumbar musculature in the L3-S1 area, with a pulling sensation during forward flexion to her knees. Petitioner was diagnosed with an acute lumbar strain and a right ankle and foot sprain. Petitioner was provided with an ankle splint and advised to use Tylenol for pain. Petitioner was to engage in activity as tolerated and required no formal restrictions at that time. She was to return in five to seven days or sooner if she had new problems or difficulty performing her regular job. (PX 1, p. 23)

A First Report of Injury form was completed on August 26, 2015 by Susan Weber. Petitioner gave an accident date and time of August 26, 2015 (11:15 a.m.). Petitioner reported she was taking "something" to her trunk in the east parking lot when her right foot went into a hole. (PX 1, p. 27)

Petitioner followed up with Todd Peterson, PA and Dr. Brower at MOHA on September 11, 2015. (PX 1, pp. 16-17) It was noted that she had been advised to use caution at work with stepping and stair activities at her last appointment. Petitioner reported about 25% improvement in her ankle pain, but still complained of pain with walking as well as medial and lateral movement. She had no complaints of back pain at that time. On examination, it was noted that she had a mild antalgic gait secondary to her pain. She had pain to the lateral aspect of her right ankle with inversion movement and some tenderness to palpation to the anterior talofibular and calcaneal fibular ligaments. It was felt that her ankle sprain was mildly improved, and she was advised to continue using Tylenol and to use ice three or four times per day for 30 minutes. She was also sent to physical therapy. Following this visit, Petitioner was provided with work restrictions requiring that she be permitted to sit down for 15 minutes every hour. Petitioner testified that this restriction was accommodated and she continued working.

Petitioner underwent an evaluation for physical therapy on September 21, 2015. (PX 1, pp. 9-11) Petitioner reported a consistent history of her accident and complaints of ankle and back pain. Petitioner reported that her pain was inhibiting her ability to be on her feet for long hours. Petitioner reported 7/10 pain in her ankle, worse with walking and standing. Petitioner reported pain with resisted motions of her ankle and she demonstrated some decreased strength. She was noted to walk with a limp and to avoid dorsiflexion as she walked. She reported pain when climbing stairs.

Petitioner signed her Application for Adjustment of Claim herein on September 22, 2015 alleging a fall on August 26, 2015. (AX 2)

Petitioner attended a second therapy session on September 23, 2015, reporting that she had been doing her exercises and noted decreased stiffness in her ankle, though she was still observed to walk with a mild limp. (PX 1, pp. 12-13) She continued to complain of tenderness around the lateral malleolus.

Petitioner also returned to see PA Peterson and Dr. Clem at MOHA on September 23, 2015, reporting 75% improvement since the accident. (PX 1, pp. 5-6) She continued to complain of aching in her right ankle with prolonged standing and walking. She was noted to have a mildly antalgic gait and reported pain with inversion. She was noted to have mild visible and palpable edema on the lateral aspect of the ankle. She was directed to continue therapy and use of the splint and ice as previously instructed. Petitioner's work restriction of sitting 15 minutes of every hour remained in effect.

Petitioner returned to PA Peterson and Dr. Brower on September 30, 2015. (PX 1, pp. 29-30) Petitioner reported 85% to 90% improvement from her initial injury. Petitioner denied any low back pain that day and for several weeks before. She had no specific complaints regarding her ankle other than some intermittent aching. Petitioner reported that she felt that she could return to regular duties. Petitioner was noted to have a non-antalgic gait, but continued to report mild pain with ankle inversion and plantar flexion. She was instructed to use ice as needed and continue her home exercise program as outlined by physical therapy. She was released to full duty at that time but told to return if her symptoms worsened.

Physical Therapy issued a Progress Note on October 2, 2015. According to it, Petitioner did not show up for her appointment on September 30, 2015. She was contacted to remind her about her next scheduled appointment at which time she reported she was feeling much better and had been released to return to work with no restrictions. Petitioner further stated she wished to keep her last appointment so that she could learn her home exercise program. Petitioner called in on the 2nd cancelling her appointment as she had a family emergency and felt comfortable discontinuing therapy at that time. Per her request, therapy was discontinued. (PX 1, p. 31)

There is no evidence of any further medical treatment in the records.

At the arbitration hearing Petitioner testified that her ankle still swells up two or three times per week with pain. She testified that the swelling is brought on by being on her feet for too long. Petitioner testified that her work requires that she be on her feet for 8 hours on a concrete floor, except for breaks and lunch. Petitioner testified that she no longer goes walking like she used to do with her daughter. Petitioner testified that when she goes home from work she sits down and has to alternate sitting and standing while she cooks. She testified that she limits doing laundry to once per week rather than two or three times as she previously did, since her laundry is in the basement and she has difficulty with stairs. Petitioner testified to pain in her ankles with climbing stairs. Petitioner testified that she takes Tylenol for pain though she tries to limit its use for fear that it will affect her liver. She testified that she soaks her ankle in Epsom salts three or four times per week and her fiancé massages her ankle.

Petitioner also testified that she was not experiencing pain in this ankle prior to this accident but has been experiencing pain ever since then.

Petitioner further testified that she is still working in the same capacity as prior to her accident and makes as much, or more, than she did at the time of her accident. Petitioner testified that she plans to continue working there until she retires, though she expressed some concern that she could work that long due to the pain in her ankle, which at times can be "excruciating." She testified that she occasionally brings up her pain when seeing her doctor for other issues and she is instructed to use Tylenol.

The Arbitrator concludes:

1. **Accident:**

   Petitioner sustained an accident that arose out of and in the course of her employment with Respondent on August 26, 2015.

At the outset the Arbitrator notes that the facts were not really in dispute. Despite the fact the First Report of Injury states Petitioner was carrying "something" to her car when she had her accident and the medical records never indicate Petitioner was carrying anything whatsoever when she fell, Petitioner's testimony that she was injured while taking a cooler that had been given to her by Respondent to her vehicle in the employee parking lot on a break was unrebutted. She testified that she had not had a break that morning and was taking the large cooler to her car so that it would not obstruct activity in the lab area that could become quite busy at times. She was injured when she stepped in a hole behind her vehicle that was obscured by grass. Petitioner was "in the course of her employment" as she remained on the Respondent's premises and was removing the large cooler from the busy workplace for the benefit of the employer. She remained "on the clock," and to the extent she was taking the cooler to her car for her personal use, she was engaged in an act of personal comfort.

Petitioner's accident also "arose out of her employment." Petitioner's testimony that Respondent allowed its employees to take the coolers for their own use was unrebutted. No evidence was presented that Respondent did not encourage or allow this activity. Furthermore, Petitioner's motive in taking the cooler to her car was not personal to her but for the benefit of Respondent as it left the area where she worked clear. Respondent produced no evidence to the contrary. Furthermore, it appears that the accident occurred in the designated employee parking lot as a result of a defect in Respondent's premises – a hidden hole in the grassy area at the edge of the parking lot. Petitioner was not engaged in any unreasonable, unforeseeable or inherently dangerous conduct that placed her at some unreasonable risk of injury. Backing into a parking spot, placing an item in a hatchback (rather than a back door of a vehicle), or stepping off of a parking area into a grassy yard are not inherently dangerous. The danger existed in this case only due to a defect in Respondent's premises—an obscured hole in the ground--that directly resulted in her twisted ankle. Petitioner's actions were not for her own benefit nor were her actions unnecessary or inherently dangerous.

The Arbitrator finds that Petitioner suffered an accident that arose out of and in the course of and in the course of her employment by Respondent.

2. Medical expenses:

Petitioner is awarded the medical bills found in PX 2 totaling $675.00.

Respondent disputed medical bills on accident/liability grounds. Having found in Petitioner's favor on that issue, the Arbitrator orders Respondent to satisfy the medical bills, including reimbursement to Medicaid and satisfaction of the outstanding balance pursuant to the medical fee schedule.

3. Nature and extent:

Petitioner suffered a low back strain and an ankle sprain as a result of her work-related accident. Petitioner was diagnosed initially with a low back strain but subsequent doctor's visits indicate that her low back strain, ultimately, resolved. Furthermore, Petitioner did not testify to any ongoing low back symptoms or concerns. In light thereof, the Arbitrator finds that Petitioiner failed to prove any permanent, partial disability with regard to her low back.

With regard to her right ankle sprain, Petitioner was treated with bracing, therapy, ice, Tylenol and work restrictions. She lost no time from work.

In addressing the permanency issue regarding Petitioner's right ankle/foot, the Arbitrator must consider the factors set forth in 8.2 of the Act:

a. **AMA impairment evaluation:** Neither party submitted an AMA impairment rating. Therefore, the Arbitrator gives this factor no weight.

b. **Occupation of the injured employee:** Petitioner continues to work in the same occupation as a lab assistant which requires that she be on her feet for long periods of time. According to Petitioner's unrebutted testimony, this activity exacerbates her residual ankle pain. Petitioner has questioned her ability to continue to her normal retirement age. The Arbitrator views Petitioner's testimony regarding her ability to continue in her current employment speculative, self-serving and lacking any corroboration. This factor is given some weight.

c. **Age of the employee at time of injury:** Petitioner is now 53 years old and, as such, can reasonably be expected to work and live with the effects of her right ankle sprain for another 12 or 13 years of work life to reach a normal retirement age. This factor is given some weight.

d. **Employee's future earning capacity:** Petitioner remains in the same employment and is earning as much, or more, than she was at the time of her injury. While she questions her ability to continue that employment through retirement age no doctor has suggested she retire early or look for alternative employment. Again, the Arbitrator views Petitioner's testimony regarding her ability to continue in her current employment speculative, self-serving and without any corroboration. The fact that Petitioner has sustained no current loss of earning capacity is given some weight.

e. **Evidence of disability corroborated by medical records** Petitioner testified to considerable residual pain exacerbated by being on her feet as required by her job. She also testified to alteration of her activities at home to accommodate her chronic pain. The Arbitrator also notes that Petitioner cancelled her last therapy appointment indicating she was feeling much better. When last seen by PA Peterson and Dr. Brower on September 30, 2015 she was encouraged to return back if she had any problems or concerns. She hasn't. While she testified that she continues to mention her ongoing pain to her family doctor, no corroborating medical records were admitted into evidence.

The Arbitrator had the opportunity to observe Petitioner while she was testifying and took note that Petitioner began to laugh when asked to testify about any current complaints or symptoms and, at times, her testimony seemed somewhat exaggerating or dramatic. While the Arbitrator believes that Petitioner does indeed have some residuals as a result of her accident herein, she questions the extent of those difficulties in light of Petitioner's demeanor during the hearing and her failure to document any ongoing problems through doctor's notes/records. Petitioner's last medical appointment for her ankle was on September 30, 2015. Her case went to arbitration approximately seventeen months later with no additional medical evidence being introduced. This factor is given moderate weight.

Based upon the foregoing, the Arbitrator finds that Petitioner has suffered permanent partial disability to the extent of 10% loss of use of the right foot.

****

STATE OF ILLINOIS)
)
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thaddeus Galloway,
Petitioner,

vs. No. 16 WC 35102

Trade Industries,
Respondent.

18IWCC0689

DECISION AND OPINION ON REVIEW

Both parties have timely filed a Petition for Review of the March 24, 2017 Decision of the Arbitrator. Notice has been given to all parties. The Commission, after considering issues including accident, causal connection, wage calculation, medical expenses, temporary total disability, permanent partial disability, and deduction for prior awards under §8(e)17, and being advised of the facts and law, modifies the Decision of the Arbitrator, as stated herein. In particular, the Commission finds a compensable accident and: (1) affirms the Arbitrator's wage calculation, inasmuch as Petitioner has inadequately proven alleged concurrent employment; (2) reduces the Arbitrator's determination of §8(e) permanent partial disability ("PPD award") representing 25% loss of use of the left leg to 10% loss of use of the left leg; and (3) reverses the Arbitrator's deduction of an alleged previous PPD award from the award in the instant case, inasmuch as Respondent has inadequately proven the previous PPD award.

The Commission otherwise affirms and adopts the Decision of the Arbitrator, a copy of which is attached hereto and made a part hereof.

BACKGROUND

Petitioner, 31 at the time of accident, started working at Respondent on June 11, 2012 and quit (with no notice) on November 9, 2016. Trade Industries is an organization that provides occupational rehabilitation services to adults with developmental disabilities. Petitioner's employment duties there as an "adult habilitation coordinator" included supervising support staff members and overseeing the day-to-day operations of Respondent's day training program. The clients were often combative. (Tr. 11-15). During all relevant times, Petitioner ministered at three churches, as discussed in more detail below.

Accident: On the morning of July 22, 2016, an agitated client was causing a commotion. Petitioner testified that this client was walking through the hallway, yelling obscenities, and saying that he was going to leave the building and start smashing car windows. Petitioner and his supervisor stood in front of the door to block this client, who then tried to hit them. At that point, Petitioner and his supervisor attempted to physically restrain the client. During the ensuing scuffle, the client knocked Petitioner's right shoulder against the wall and kicked Petitioner repeatedly in the shin and "kneecap area" of his left leg. The client eventually calmed down after a third person arrived to assist. (Tr. 16-19). That day, Petitioner filled out an OSHA report of injury, describing the incident. (PX 3).

Petitioner finished his shift that day, a Friday, despite pain. He testified that his knee symptoms (pain and swelling) increased over the weekend (but his right shoulder pain went away). That Sunday, he was able to perform his "second job" as a Methodist minister. On Monday, July 25, 2016, he showed up at work for Respondent but left early because of his knee pain.

Treatment: The next morning, July 26, 2016, Petitioner presented to Primary Care Associates, where he was seen by PCP Dr. Matthew Winkleman. (PX 5). Petitioner related the scuffle with the client at work, that the injury was from a direct blow to the leg/shin area, and that his knee "started hurting later that day." The knee symptoms included pain, swelling, and instability, but no redness, "popping" sound, bruising, locking, clicking, or abrasion. An x-ray of that day revealed no fractures. Dr. Winkleman noted a history of ACL (anterior cruciate ligament) repair from 10 years ago. Dr. Winkleman's assessment was left knee injury. Petitioner was placed off-work.

An MRI of the left knee done on July 29, 2016 revealed a minor meniscus tear; the radiologist's impression was "minimal radial tear along the inferior margin of the meniscus body with normal medial meniscus, anterior horn, posterior horn, posterior and anterior central attachments." On a follow-up visit to the PCP on July 28, 2016, it was noted that "the course of the disease has been decreasing."

On August 1, 2016, Petitioner's symptoms included knee pain, decreased range of motion and difficulty bearing weight. On that day, Petitioner "describe[d] his symptoms as improving," but related that he "deals with combative residents regularly and doesn't feel that he will be able to do his job yet." Petitioner was referred to physical therapy. By late August, Petitioner reported that the physical therapy was helpful, and Dr. Winkleman referred him for a course of work hardening. However, after about a week of sessions, Petitioner complained that the work hardening was causing his knee pain to recur or become worse, so Dr. Winkleman terminated the work hardening in mid-September 2016. At that point, Petitioner was referred to an orthopedist.

On September 27, 2016, Petitioner presented to orthopedic surgeon Dr. Kevin Koth of Harrisburg Orthopedic Clinic. (PX 7). Dr. Koth's impression was "left knee pain, left medial meniscus tear, left patellar tendonitis, infrapatellar and insertional tendinitis (Jumper's knee)." Dr. Koth prescribed NSAIDs and continued physical therapy. The orthopedic surgeon also wrote, "From my standpoint, he can return to work without restrictions, however, his primary care [physician] is in charge of his work restrictions. He is seeing his PCP on Friday and will hopefully be given a return to work without restrictions." (PX 7). Subsequently, Dr. Winkleman released Petitioner to full duty as well. On October 3, 2016, Petitioner reported to work at Respondent, after having been off-work since July 2016. Petitioner testified that, his physicians' full release notwithstanding, he was still having knee problems.

On November 3, 2016, Petitioner returned to Dr. Koth (for the second and last time) for ongoing knee pain. Dr. Koth wrote, "I really believe that the majority of Thad's problem and pain is coming from his patellar tendinitis. He has had previous surgery on his patella by Dr. Wood 11 years ago for a patella fracture. His radial meniscus tear is very minimal. My recommendation is for a cortical steroid injection to try and give him some relief. He will return to work without restrictions. I will see him back on a PRN basis." Dr. Koth administered an injection that day. (PX 7).

Resignation: As noted above, Petitioner returned to work at Respondent on October 3, 2016. On his first day back, he was informed that he had a new supervisor, Tabitha Somerville, and that his job description had changed. (PX 4). His job duties now required more direct contact with clients and entailed more physically demanding tasks, such as lifting and transferring clients from chair to wheelchair. On November 9, 2016, after an especially rough day, Petitioner quit without notice. At hearing, he stated that he resigned because his knee pain prevented him from fulfilling his new duties, and he also disliked being "constantly micro-managed." (Tr. 47-48). He also provided some equivocal testimony regarding whether he has since actively looked for another job; he also stated that a similar facility had offered him a job and/or extended an invitation to apply for employment, which he turned down allegedly because of his knee condition. (Tr. 62-63).

Concurrent Employment as Alleged: Petitioner testified without rebuttal that, during all relevant times (and with Respondent's knowledge), he worked a "second job" ministering at three named churches. Petitioner alleged that this job arose from a contract with the United Methodist Church, signed in 2014. His duties included giving Sunday sermons, attending church business meetings, and visiting nursing homes, hospitals, and the like. Petitioner testified that each church issued him a paycheck individually and that he was paid on a regular basis (on the first, second, and third week of the month). (Tr. 27-28). The only documentary evidence regarding this alleged concurrent employment are federal 1099 forms from the three churches for the year 2015; these forms indicate that he earned a total of $14,020. (Tr. 26; PX 2). Petitioner testified that he expected to receive 1099s in similar amounts for 2016. (Tr. 40). The Arbitrator noted with interest that Petitioner continued to do his work for the churches while he was off-work from Respondent with no diminution in earnings. (Arbitrator's decision at 8).

Present Condition: Regarding his symptoms today, Petitioner stated, "At times I do have a lot of aching pain in my left knee, and there are times where I will be sitting down or laying down, and I have to stand up because the knee feels like it gets stiff." Navigating stairs "sometimes" causes pain; stooping and squatting causes "a little bit" of pain. The pain occurs "a couple of times a day" and then subsides on its own. He takes no pain medication. (Tr. 52-55).

Prior PPD award: On cross examination, Petitioner testified that he injured his left knee on March 9, 2005 while working for a different employer; he underwent ACL repair in 2005 for this injury; and he settled a workers' compensation claim for this injury. (Tr. 55-57). As to further details regarding the settlement, Petitioner testified that he could not recall; no further testimony regarding the settlement was elicited. (Tr. 56). Respondent alleges that Petitioner received a settlement of 15% loss of use of the left leg, but did not offer into evidence a copy, or any other documentary evidence, of this settlement agreement.

DISCUSSION

A. Accident/ Causation

Respondent requests that the Commission reverse the Arbitrator's decision as to accident/causation or "in the alternative, award a much lower percentage award." (Respondent's Statement of Exceptions at 6). Respondent's primary contention is that Petitioner's testimony is generally not credible, that any symptoms of his were not disabling, and that he quit his job at Respondent because he chafed at further management oversight.

The Commission finds, as did the Arbitrator, that Petitioner proved occurrence of accident as well as causation as to current ill-being. He reported the altercation immediately and described the altercation with the client consistently to providers. Petitioner's chain-of-events evidence demonstrating that his current knee condition was caused by the subject work incident (as opposed to the 2005 injury or another event) is not that strong. However, the Commission finds that he has on balance carried his burden of proof. He complained of knee symptoms immediately and continued to do so thereafter. He also testified that he had no issues with his left knee after recovery from the 2005 ACL surgery up until the July 2016 incident. Respondent did not offer evidence to the contrary, other than allusions to Petitioner's lack of credibility.

B. Wage calculation / Concurrent Employment

The Arbitrator found that Petitioner earned $26,000 in the year prior to the accident and that his average weekly wage was $ 500.00, based on evidence regarding his employment with Respondent (wage statement of PX 2). Earnings from Petitioner's work as a minister were not included, as Petitioner failed to prove these earnings arose from an employer-employee relationship. In the Arbitrator's words, the limited evidence "did not allow for a true determination of whether the alleged employment with the [Methodist] church involved Petitioner working as an employee, pursuant to the Act and case law, or whether it involved working as an independent contractor." (Arbitrator's decision at 8). The Arbitrator added that that the 1099 tax documents offered into evidence by Petitioner supported a determination that he was an independent contractor.

The Commission agrees that no concurrent employment has been proven. The existence of an employer-employee relationship is a prerequisite for any award of benefits under the Act. There is no rigid rule of law governing the determination of whether this relationship exists. Netzel v. Industrial Comm'n, 286 Ill. App. 3d 550, 553-554, 676 N.E.2d 270, 273, 1997 Ill. App. LEXIS 9, *6-9, 221 Ill. Dec. 749, 752 (Ill. App. Ct. 1st Dist. Jan. 14, 1997) citing Ragler Motor Sales v. Industrial Comm'n, 93 Ill. 2d 66, 71, 442 N.E.2d 903, 905, 66 Ill. Dec. 342 (1982). While the right to control the work is the single most important factor in determining the parties' relationship (see Wenholdt v. Industrial Comm'n.,

95 Ill. 2d 76, 81, 447 N.E.2d 404, 407, 69 Ill. Dec. 187 (1983), no one factor is determinative (Davis v. Industrial Comm'n, 261 Ill. App. 3d at 853, 634 N.E.2d at 1119; Young America Realty v. Industrial Comm'n, 199 Ill. App. 3d at 189, 556 N.E.2d at 799).

The evidence proffered by Petitioner falls short of proving an employer-employee relationship with the Methodist Church. The Commission notes that the 1099 documents on their face indicate that the wages were "nonemployee compensation." Petitioner failed to submit any supplemental evidence to support his claim that he was an employee of the Methodist Church. Submissions could have included information on who controlled his activities, who directed his work, or detailed employment schedules. Such information may have been contained in the contract which Petitioner alleged was signed with the Methodist Church in 2014; however, he provided no copy of this written agreement.

C. Nature and Extent of injury

For injuries that occur after September 1, 2011, the determination of extent of permanent partial disability is governed by §8.1b of the Act. This section outlines five factors to be used by the Commission in determining the level of permanent partial disability: (i) the reported level of impairment (the "AMA impairment rating"); (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.

In the instant case, no AMA impairment rating has been submitted by either party. Regarding the remaining factors of §8.1b, the Commission makes the following analysis:

- Occupation: The record reveals that Petitioner was employed as an adult habilitation coordinator at the time of accident, that he was released to unrestricted duty by his treating physicians, and that he did initially return to regular duty with Respondent. As noted by the Arbitrator, the Petitioner provided somewhat contradictory testimony that, after he left Respondent's employ, he sought work in the same type of position at other facilities, while also testifying that he did not believe he could continue performing the same type of work. At any rate, the Commission does not believe this factor militates towards a finding of extensive permanent disability.

- Age: Petitioner was 31 at the time of accident. While he is a younger person (youth usually has been found to militate towards a finding of a higher level of permanent disability, insofar as a young claimant is presumed to be foregoing income over the course of many years in his or her remaining lifetime), the record shows that Petitioner recovered significantly from his injury – again, he was released to unrestricted duty by early October 2016, after which he has not required further treatment for his left leg. As such, Petitioner's relative youth militates little towards a finding of extensive permanent disability.

- Earnings capacity: Petitioner did not testify as to any loss in future earning capacity. As noted by the Arbitrator, Petitioner continued to do his work for the churches while he was off-work for Respondent with no diminution in earnings. This lack of evidence militates against a finding of extensive permanent disability.

- Evidence of disability: The medical records indicate that Petitioner underwent about ten weeks of conservative treatment and, notwithstanding his residual complaints, was released to unrestricted duty by his PCP and orthopedic surgeon – who characterized his meniscus tear as "very minimal." The medical records and other evidence regarding disability, including Petitioner's testimony, weigh significantly against a finding of extensive permanent disability.

In consideration of the above factors, and based on the record as a whole, the Commission deems excessive the Arbitrator's award of 25% loss of use of his left leg. The Commission finds that Petitioner sustained a 10% loss of use of his left leg pursuant to §8(e) of the Act.

D. Deduction of Prior Award

The Arbitrator found that Respondent was entitled to credit under §8(e)17 for a purported prior award/settlement of 15% of the left leg. The Commission finds that the Arbitrator erred in granting Respondent this deduction, insofar as Respondent did not sufficiently prove the amount of the prior award/settlement. While Respondent elicited from Petitioner the testimony that a prior settlement existed, there was no further evidence submitted (in the form of a copy of the settlement agreement or otherwise) as to its details. In short, there is inadequate evidence that the prior settlement reflected 15% or any percentage loss of use of the left leg. As such, the Arbitrator's application of credit against the instant award is vacated. Compare Judd v. SOI/Menard Correctional Center, 13 IWCC 1108; 2013 Ill. Wrk. Comp. LEXIS 1157.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on March 24, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner total temporary disability benefits of **$333.33 per week for 9 and 6/7 weeks**, commencing July 26, 2016 through October 2, 2016, as provided in §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits of **$300.00 per week for 21.5 weeks,** because the accidental injury sustained caused **10% loss of use of the left leg**, as provided in §8(e) of the Act. Respondent is not entitled to credit based on an asserted prior settlement from 2005.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall 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.

18IWCC0689

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,000.00 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 8 - 2018

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jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

SPECIAL CONCURRING OPINION

I agree with the result reached by the majority. I write separately to provide additional analysis regarding the average weekly wage issue.

Petitioner worked for Respondent as an adult habilitation coordinator. T. 12. While employed by Respondent, he also worked for the Methodist Church ministering at three parishes. T. 26. Petitioner testified he advised Respondent in writing in 2014 of his work at the Methodist Church. T. 25. Petitioner, though, provided no testimony he advised Respondent that he earned wages for the work he performed at the Methodist Church.

The matter of *Bagwell v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160407WC, is instructive. In *Bagwell*, claimant worked for his employer at a candy factory while also serving as a pastor at Mt. Zion Missionary Baptist Church. At trial, claimant testified his employer was not aware that claimant was compensated for the services he provided to Mt. Zion. The Commission did not include the monies claimant received for his pastoral duties in the calculation of his average weekly wage.

In affirming the decision of the Commission, the Appellate Court examined the meaning of "employment" under Section 10 of the Act, holding "the common, ordinary meaning of the term 'employment' as used in section 10 of the Act encompasses the concept of payment for work or services rendered." *Bagwell* at ¶ 27. The Court did not address whether claimant's work as a pastor established Mt. Zion as an employer for purposes of Section 10 of the Act given the Act's definitions of both employer and employee in Section 1 of the Act.

As the claimant in *Bagwell*, Petitioner failed to prove Respondent had knowledge that Petitioner received payment for his pastoral work with the Methodist Church. Petitioner testified Respondent was aware of his work with the Methodist Church, but there is no testimony Respondent was aware Petitioner received compensation for his work which pursuant to *Bagwell* is a necessary component. To find such an awareness, the Commission would be required to make an inference which it declines to do.

18IWCC0689

Further, I believe even if such inference were made regarding "employment" for purposes of Section 10 as defined by the Court in *Bagwell*, Petitioner failed to prove a necessary pre-condition for establishment of concurrent wages that being the Methodist Church was his employer. Section 10 of the Act governs the calculation of a claimant's average weekly wage. Section 10 states, in part, "When the *employee* is working concurrently with two or more *employers* and the respondent *employer* has knowledge of such employment prior to the injury, his wages from all such *employers* shall be considered as if earned from the *employer* liable for compensation. (Emphasis added)." *820 ILCS 305/10* (West 2013). The best indication of the intent of the legislature is the language of the statute, and the language is to be given its plain and ordinary meaning. See *Washington Dist. 50 Schs v. Illinois Workers' Compensation Commission*, 394 Ill. App. 3d 1087, 1090, 917 N.E.2d 586 (2009) ("The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature. [citation omitted]. The best indication of the legislature's intent is the language of the statute, which must be given its plain and ordinary meaning. [citation omitted] (noting that where statutory language is clear, there is no need for other tools of construction).").

Section 1(a) of the Act states as follows: "The term 'employer' as used in this Act means:...2. Every person, firm, public or private corporation, including hospitals, public service, eleemonsynary, religious or charitable corporations or associations who has any person in service or under any contract for hire, express or implied, oral or written..." *820 ILCS 305/1(a)* (West 2013). Section 1(b) states as follows: "The term 'employee' as used in the Act means:...2. Every person in the service of another under any contract of hire, express or implied, oral or written..." *820 ILCS 305/1(b)* (West 2013). Presumably, if the legislature meant to define employer or employee differently for purposes of Section 10 of the Act, it would have done so. It did not. Therefore, given the plain language of the Act and the definitions provided by the legislature, it must be determined whether "a contract of hire, express or implied, oral or written" exists between Petitioner and the Methodist Church.

As the Supreme Court of Illinois noted in *Roberson v. Industrial Commission*, 225 Ill. 2d 159, 174, 866 N.E.2d 191 (2007),

> An employment relationship is a prerequisite for an award of benefits under the Act, and the question of whether a person is an employee remains "one of the most vexatious *** in the law of compensation." [citation omitted]. The difficulty arises not from the complexity of the applicable legal rules, but from the fact-specific nature of the inquiry.

As the majority noted, the right to control the manner of work is generally afforded the most consideration. Again, as found by the majority, Petitioner failed to offer any evidence that he was an employee of the Methodist Church and/or the Methodist Church was his employer. As the majority noted the wage evidence offered by Petitioner supports a finding of no employer/employee relationship.

For the reasons stated above, I concur with the decision reached by the majority as it relates to concurrent wages and concur with the decision reached by the majority on the remaining issues.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GALLOWAY, THADDEUS
Employee/Petitioner

Case# **16WC035102**

TRADE INDUSTRIES
Employer/Respondent

18IWCC0689

On 3/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4617 HOFFEE LAW OFFICES
HEIDI A HOFFEE
109 W MAIN ST
FAIRFIELD, IL 62837

5001 GAIDO & FINTZEN
MICHAEL T CHALCRAFT
30 N LASALLE SUITE 3010
CHICAGO, IL 60602

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

THADDEUS GALLOWAY
Employee/Petitioner

v.

TRADE INDUSTRIES
Employer/Respondent

Case # **16** WC **35102**

Consolidated cases: _____

18IWCC0689

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **February 3, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 22, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,000.00**; the average weekly wage was **$500.00**.

On the date of accident, Petitioner was **31** 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.

To date, Respondent has paid **$2,331.30** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of **$2,331.30** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,331.30**.

ORDER

The Arbitrator finds that the Petitioner sustained his burden of proof that he had an accident which arose out of and in the course of his employment with the Respondent on **July 22, 2016**, and that his left knee injury is causally related to this accident.

Respondent shall pay Petitioner temporary total disability benefits of **$333.33 per week** for **9-6/7 weeks**, commencing **July 26, 2016 through October 2, 2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$2,331.30** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of **$24,564.12**, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of **$300.00 per week** for **53.75 weeks**, because the injuries sustained caused the **25% loss of use of the left leg**, as provided in Section 8(e) of the Act.

Respondent is entitled to credit based on a prior settlement in 2005 of **15% of the left leg**, pursuant to Section 8(e)17 of the Act. Thus, the net award in this case is 10% of the left leg, following deduction of this PPD credit.

Respondent shall pay Petitioner compensation that has accrued from **November 3, 2016** through **February 3, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 6, 2017
Date

MAR 24 2017

ICArbDec p. 2

STATEMENT OF FACTS

The Petitioner testified that he started working for the Respondent as an adult habitation coordinator on 6/11/12. He alleges that he was injured at work on 7/22/16, at which time he was 31 years old. He is a high school graduate. Prior to working for Respondent, he worked for Macedonia Water System reading meters.

Petitioner supervised direct support staff members in a day training program, who work with individuals with mental and physical developmental disabilities, called "consumers." They teach the consumers how to work independently and to achieve quarterly goals. This would include janitorial, recycling and highway rest area cleaning. Petitioner was in charge of 35 consumers, along with the direct care staff, noting they often can be combative.

On 7/22/16, at 9:30 am, an angry, yelling consumer entered his building and threatened to go out and start smashing car windows. Petitioner and his supervisor, Robert Anderson, tried to block him at the door. When he tried to hit them with his lunchbox, they attempted to put him into CPI (crisis prevention intervention, i.e. physical restraint). The consumer was able to get out of it and pushed the Petitioner, causing his right shoulder to hit the wall. He then started to kick Petitioner's left knee and shin area. Help arrived and they got the consumer calmed down.

Petitioner was required to complete an OSHA report for the incident, which he did that same day, a Friday. This document is consistent with Petitioner's testimony, and notes the consumer was "mule kicking" Petitioner in the left knee with boots, causing bruising and scratches. The document indicates Petitioner reported right shoulder, neck and upper back pain. Nothing specific was noted regarding leg or knee symptoms. (Px3).

Petitioner testified that he also worked for various Methodist churches (Big Prairie United Methodist Church, Concord United Methodist Church and Maunie United Methodist Church) from 7/1/14 through the 7/22/16 accident date. He had a contract with the Methodist Church that he signed in 2014 which involved him performing weekly services / sermons on Sunday, business meetings, and visits to nursing homes, assisted living facilities, hospitals and funerals on their behalf. He testified that Respondent was aware of this, and his supervisor Anderson made him put in writing that while he had other job(s) in 2014, his job with Respondent was his primary job.

Petitioner testified that after the accident he had pain in the right shoulder, left knee and shin areas. He completed his shift that day but indicated his knee swelled and the pain increased as the day went on and over the weekend. He did perform his regular church duties over that weekend (see below).

He elevated and iced the knee. His right shoulder pain resolved over the weekend. He returned to work on Monday, 7/25/15, but went home early due to knee pain. He was struggling to walk, Anderson saw this, and they reported it to Respondent CEO Mark Auten, who indicated Petitioner should see a doctor.

On Tuesday, 7/26/16, the Petitioner sought treatment with his primary care provider and reported that he was injured at work on Friday 7/22/16, when he tried to restrain a client and was thrown into the wall and kicked in the left leg with a boot. His knee began to hurt later that day. The Petitioner reported he underwent a left ACL repair 10 years prior. X-rays showed a suspect bipartite patella in an uncommon location, while a fracture was less likely. Otherwise, films were unremarkable. A left knee MRI was prescribed and he was held off work through 7/29/16.

The 7/29/16 left knee MRI reflected minimal radial tear along the inferior margin of the meniscus body with normal medial meniscus, anterior horn, posterior horn, and posterior and anterior central attachments. Additionally, early medial and lateral femorotibial arthrosis were indicated. (Px5).

At an 8/1/16 follow up, Petitioner noted ongoing knee pain, decreased range of motion and difficulty bearing weight, but no swelling, locking or instability. Examination again noted painful flexion, but no other indicated abnormalities. He did report improvement, and physical therapy was prescribed. Petitioner was held off work through 8/15/16. (Px5).

The initial therapy record from 8/4/16 notes Petitioner reported he had been kicked, mule style, in the leg and knee, developed knee pain but continued to work. The pain got worse over the weekend, but he still tried to work the following Monday. The pain had increased and weight-bearing and walking became difficult. The report indicates the MRI showed a torn lateral meniscus. (Px5).

At 8/16/16 follow up with the primary care provider, the Petitioner indicated his symptoms were improving. The diagnosis was minimal radial tear inferior margin of meniscus with normal medial meniscus, and he was to continue therapy. He was held off work an additional two weeks. On 8/30/16, Petitioner saw Dr. Winkleman and again reported improvement. He indicated that therapy really helped and he was supposed to start work conditioning, so the Petitioner was continued off work while waiting for insurance approval. (Px5).

Petitioner testified that his initial work conditioning evaluation on 9/7/16 indicated that he had a weak knee and was unable to perform his regular job duties. The report from this date notes the Petitioner's job was at the "heavy" work level, and that Petitioner had demonstrated the ability to perform 87.8% of his physical job duties.

On 9/15/16, Petitioner reported to the primary provider that he had been attending work conditioning, but that the knee had really been bothering him the last couple of days, and that it felt like it gave out on him, and he couldn't attend. He testified that his pain and swelling increased. At that time, conditioning was put on hold and Petitioner was referred to Dr. Koth.

Petitioner saw orthopedic surgeon Dr. Koth on 9/27/2016. He reported that he had been kicked in the left knee repeatedly at work with immediate pain, underwent MRI, and had therapy and work conditioning without significant improvement. He also reported his knee had locked up on him twice, causing him to twist his ankle. Petitioner noted a previous left patella fracture in 2005 and that he recovered from that without difficulty. Other than tenderness, physical examination of the knee was normal. The doctor's review of the MRI noted a small medial meniscus radial tear and inflammation in the infrapatellar tendon. Dr. Koth diagnosed left knee pain, left medial meniscus tear, left patellar tendinitis, and infrapatellar and insertional tendinitis (jumper's knee). He prescribed nonsteroidal anti-inflammatory's medication and physical therapy. From Dr. Koth's standpoint, Petitioner was able to return to unrestricted work duties, but noted the primary care physician was in charge of his work restrictions. He was to follow up in six weeks. (Px7)

On 9/30/16, Dr. Winkleman indicated that Dr. Koth had released Petitioner to return to work without restrictions, and advised Petitioner to continue therapy for 2 to 3 weeks. (Px5).

Petitioner testified that he returned to full duty with Respondent on 10/3/16, after being off work since 7/26/16, but that his job description had changed (see Px4). That day he was called into the conference room to meet with Residential Manager, Tabitha Somerville, was informed of the job changes, and that she would now be his supervisor. He was to spend more time on the floor working with the consumers, rather than in his office, and to perform more direct care with consumers, which involved more physical requirements. This included transferring up to 150 pound consumers to and from bed/chair/wheelchair approximately 10 times per day. He would also have to help direct support staff in the morning to transport consumers. When he returned to these new duties, he testified that transferring consumers and doing more walking caused increased left knee pain.

The Petitioner submitted a 9/16/14 job description for the DT Coordinator position into evidence. The physical requirements indicated are the ability to carry 20 pounds for up to 20 feet, and the ability to stand, sit, transport self, bend or stoop for periods up to 2 hours. While they are very similar, the newer 10/6/16 job description adds the requirements of actively assisting in the direct care of staff worker with front line duties by devoting 50% of time in the presence of individuals, and coordinating weekly outing and planned activities with assigned supervisor. Another section indicated a need to visit a rest area as a fill in as needed, but the way this portion is written it appears it may have been part of the prior description as well. (Px4).

On 10/28/16, Dr. Watters noted Petitioner reported a history of anxiety and IBS, and that Petitioner had abdominal improvement. Medication was continued for these. (Px5).

The records from Southern Illinois Healthcare/RIC support the fact that the Petitioner complained of increasing symptoms once work conditioning was instituted, and the therapist's recommendation that he instead perform a regular physical therapy program. The 11/2/2016 discharge note from therapy indicates the Petitioner felt stronger but still had intermittent pain. He was no longer taking pain medication and was working full duty. The assessment indicated minimal pain improvement and that Petitioner may have reached a plateau. He did the progress with flexibility and strength as well as stability. He was discharged after achieving almost all goals with a home exercise program. (Px6).

Petitioner returned it to Dr. Koth on 11/3/16. Petitioner reported that his knee was stronger with therapy, but his pain continued. Petitioner felt that the increased walking at work and increased job responsibilities were causing him pain and difficulty. Dr. Koth believed that the Petitioners pain was mainly due to patellar tendonitis, noting the Petitioner's prior surgery for patella fracture and that his radial meniscus tear was very minimal. He performed a steroid injection and Petitioner was released to full duty and to return as needed. (Px7). Petitioner testified that while he still had ongoing knee problems, he didn't seek further treatment because it seemed that Respondent would not allow further treatment.

Petitioner continued to work for Respondent until 11/9/16. He testified that the consumers were very combative that morning and he had to perform a lot of CPI procedures. He felt like he could not continue to do this due to weakness in his knee and pain, so he resigned, testifying that he indicated to Respondent that the reason was because of his knee, as well as being constantly micromanaged with the new job duties.

Petitioner initially testified that sought employment in a similar job after 11/9/16, received an offer from another facility about a week later but did not accept it because he felt like he was no longer able to work in that field due to his knee. On cross examination, he testified that he didn't actively look for any jobs on his own, but that the other facility contacted him to come in and apply, but he didn't end up applying and wasn't technically offered the job. He also testified that his grandmother broke her hip in 11/16 and was in a nursing home, so he has tried to help with keeping up her home.

Petitioner testified that he still has aching left knee pain at times, and at times has to get up from sitting or lying down due to knee stiffness. He doesn't take any pain medications. He can use stairs, but it causes pain at times. Stooping and squatting results in a little bit of pain. He has an aching pain a couple of times a day, and then the pain subsides on its own. He will elevate the leg and use ice.

On cross examination, Petitioner agreed he had a 3/9/05 work-related left knee injury while working for Crownline Boats. He made a claim, underwent left ACL repair and settled the case for 15% of the left leg. He testified on redirect exam that he didn't have any ongoing left knee problems, and did not seek medical treatment after his release until this accident.

Petitioner testified that he continued and continues to work for all three churches since the 7/22/16 accident. He was able to deliver the sermons, but testified that he couldn't go out to the offsite visits. His wages/earnings were not reduced, however, due to not performing the offsite visits. Petitioner's Exhibit 2 contains a wage statement from Respondent, as well as 2015 1099 forms from Big Prairie United Methodist Church, Concord United Methodist Church and Maunie United Methodist Church. Petitioner testified that he was paid on a regular basis – on the first, second and third weeks of each month – with each church writing him an individual check. He testified that he earned $14,020 in 2015, and the records in Px2 support that he earned $14,020.04 between the three churches in that year. He believed that he earned about the same amount in 2016. He testified that he informed the Respondent's insurer of this separate employment when he was interviewed after the accident, and was told that it would not be included in his benefit rate.

The Petitioner submitted his claimed causally related medical expenses as Petitioner's Exhibit 8. The documentation therein indicates charges totaling $24,564.12.

CONCLUSIONS OF LAW

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

Based upon the foregoing evidence, including Petitioner's credible description of the accident and his immediate report of an injury at a specific time and place on 7/22/16, the Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on that date. He testified that he was performing his regular job duties and restraining a combative consumer and was repeatedly kicked in the knee area, which is consistent with his written report of the accident to Respondent on 7/22/16 and consistent with the medical history he gave to his medical providers. The Respondent offered no evidence which disputes the Petitioner's description of the incident. The Arbitrator concludes that Petitioner has established by the preponderance of the evidence that an accident occurred which arose out of and in the course of Petitioner's employment with 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 the Petitioner has sustained his burden of proof that his left knee condition following the accident was causally related to the 7/22/16 accident, and remains so.

It is clear that the Petitioner had a significant prior surgery involving an ACL repair in 2005. However, the Petitioner testified that he'd had no ongoing left knee problems since that time, and no evidence was presented to indicate otherwise. Dr. Koth's records are also consistent with Petitioner's testimony, as they also indicate Petitioner reported he recovered without difficulty after the 2005 knee injury..

The Arbitrator's finding with regard to Petitioner's left knee is based upon the evidence introduced by Petitioner, including his testimony and the contemporaneous accident report describing a consumer "mule kicking" him in the left knee and shin area, with resulting bruising and scratching. The initial medical report from primary care provider Dr. Winkleman notes left knee complaints. The chain of events in this case supports a determination that the 7/22/16 accident caused the Petitioner's current symptoms.

The records support a final diagnosis of partial left medial meniscus tear, left patellar tendinitis, infrapatellar and insertional tendinitis (Jumper's knee). Dr. Koth indicated it was his belief that the Petitioner's ongoing symptoms were mainly due to patellar tendonitis. While the medical records indicate that Petitioner had good improvement with physical therapy, they also indicate that he had a recurrence of pain with work conditioning. Thus, they are consistent with Petitioner's testimony regarding a level of ongoing left knee pain.

With regard to the right shoulder, while the Petitioner did testify, and the records support, that he complained of that body part at the time of the accident, he also testified that the condition resolved within days of the accident. There is no evidence that he sought treatment with or made complaints to any of his medical providers with regard to the right shoulder. As a result, the Arbitrator finds that the Petitioner has failed to prove any causally related right shoulder condition.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

The parties have indicated that the dispute with regard to the Petitioner's average weekly wage is based on whether concurrent employment should be included in the calculation.

The Arbitrator finds that the Petitioner earned $26,000 in the year prior to the accident, and that his average weekly wage was $500.00. This is based on his testimony and the wage statement in Px2. The Arbitrator notes that the Respondent did not offer any documentary or testimonial evidence in rebuttal.

With regard to the alleged concurrent employment, the Arbitrator finds that the Petitioner failed to prove that these earnings should be included in the average weekly wage calculation. The evidence presented in this case simply did not allow for a true determination of whether the alleged employment with the Lutheran Church involved Petitioner working as an employee, pursuant to the Act and case law, or whether it involved working as an independent contractor. The fact that 1099 documents were provided to Respondent supports a determination that the Petitioner was an independent contractor. There was limited testimony and no documentary evidence presented with regard to the indicia of employment that are dictated by case law in Illinois. For example, there was no evidence presented with regard to whether the Petitioner's church activities were controlled or directed by the Lutheran Church. While the Petitioner ultimately could be an employee of the Lutheran Church, the evidence is simply lacking in this case, and thus the determination is that he failed to prove concurrent employment. The Arbitrator also notes with interest the fact that the Petitioner continued to work for the Church while he was off work for the Respondent with no diminution in earnings.

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:

Respondent's dispute regarding medical expenses was based on liability only, not the reasonableness or necessity of the treatment itself. The Arbitrator finds that the Respondent shall pay the causally related medical expenses contained in Px8, pursuant to Section 8(a) and the Medical Fee Schedule contained in Section 8.2 of the Act. The billing totals $24,564.12. (Px8). The Arbitrator notes that the bills indicate that some payments have been made by workers compensation, and Respondent is entitled to credit for any payments towards the awarded bills that were made prior to the hearing date.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, and WITH RESPECT TO ISSUE (O), UNDERPAYMENT OF TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent indicated that the only dispute with regard to TTD involved liability for same, as well as the TTD rate based on the dispute regarding average weekly wage. As the average weekly wage issue has been determined, and thus the TTD rate has been established, the only TTD issue is whether Petitioner is entitled to TTD and, if so, for what period.

The Arbitrator finds that the Petitioner is entitled to TTD benefits from 7/26/16 to 10/2/16, a total of 9-6/7 weeks. He testified that he was off work during this period, and returned to full duty with Respondent as of 10/3/16. This is supported by the off work notes from the primary care provider and the full duty return to work notes of Dr. Koth on 9/27/16 and 11/3/16.

Petitioner testified that he did continue to work with the Lutheran Church, but testified that he did not perform the off site visits that he normally would perform. The Arbitrator does not believe that this limited part time

work precludes a finding of TTD from 7/26/16 to 10/2/16, as the evidence supports an inability to perform his job with the Respondent.

Respondent is entitled to a stipulated credit for its prior payment of TTD in the amount of $2,331.30.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA impairment rating or report was submitted into evidence by either party.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an adult habitation coordinator at the time of the accident and that he was released to unrestricted duty by orthopedic surgeon Dr. Koth.

The Arbitrator notes that Petitioner did initially return to regular duty. However, he testified that upon his return, his job duties were modified to include significantly more direct consumer care, and that this made the job more physical than it had been before, which he testified was a factor in his subsequent resignation from the job. At the same time, he also testified that part of his decision to resign was that he was being more micromanaged by management, which involved a new supervisor. The Petitioner also had some somewhat contradictory testimony that he was seeking work in the same type of position at other facilities, while also testifying that he didn't believe he could continue performing the same type of work. He also initially testified that he was offered a position with a similar facility but turned it down, but on cross examination indicated he had been contacted by the facility to apply, but never did.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 32 years old at the time of the accident. No evidence was presented by either party with regard to the impact of the Petitioner's age on his

permanent partial disability condition. On one hand, he is young and will have to live with the left knee condition for a relatively long work life. On the other hand, he is younger and potentially more resilient than an older worker might be to such injury. The Arbitrator does note that the Petitioner is only 32 and has now undergone his second left knee surgery.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the evidence does not really reflect solid information with regard to this factor. The Petitioner's employment with the Respondent ended approximately three months prior to the hearing date. He testified that he has looked for work, however no documentary evidence was presented to support this, and no detailed testimony was obtained with regard to such a job search. The Petitioner has testified, as noted, that he doesn't believe he would have been able to continue performing his job with the Respondent, however that included the added duties that were assigned to him upon his return to work, and this is also tempered by the fact that no medical provider has indicated that Petitioner was unable to return to unrestricted work.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the medical records do support the Petitioner's testimony regarding ongoing left knee pain and symptoms. The Petitioner testified that the work conditioning program seemed to have made him worse, and his reports to the facility performing the conditioning corroborate and support this testimony. At his last visit with Dr. Koth, the Petitioner had ongoing symptoms, which Koth opined were mainly due to patellar tendonitis. An injection was performed that day, yet Dr. Koth released the Petitioner without scheduling a post-injection follow up visit. Petitioner testified that it seemed to him that the Respondent did not want to allow him to obtain further treatment, however despite Dr. Koth indicating he could return as needed, Petitioner agreed that he did not do so. No evidence was presented indicating that he actually tried to return to the doctor and that it was specifically not authorized or allowed by Respondent.

The Arbitrator gives no or minimal weight to factors (i), (iii) and (iv). As noted, there is no impairment rating, it does not appear that the Petitioner's age has great impact upon his disability at this point based on current evidence, and the evidence supporting an impact to the Petitioner's earning capacity is lacking.

The Arbitrator does give greater weight to factors (ii) and (v). As to factor (ii), the Petitioner has left his occupation. Whether he can return to such a position is speculative, given he has not attempted to do so outside of the Respondent, and medically he has been released to unrestricted work duties. At the same time, the evidence is undisputed that between the time he was injured and the time he returned to work, the physical aspect of his job duties appears to have been significantly increased. He testified to having to move consumers from/to chairs and beds approximately 10 times per day. He also had to have more direct contact with consumers, and thus it stands to reason that the likelihood he would be involved in a physical confrontation, such as occurred on the date of accident, would be increased. As to factor (v), again, the Petitioner's ongoing subjective complaints of pain are supported by the record. However, this is tempered to some degree by the fact that the objective evidence, i.e. the MRI and x-ray findings, were not tremendously significant, and no surgery had been recommended.

The Arbitrator does take into account that the Petitioner believed he was unable to work, despite the full release, in a job that was changed while he was injured and off work through no fault of his own, and that this change in large part is the basis of his belief following his attempt to perform said work. This must be balanced with the full duty release and lack of evidence of significant objective knee derangement, but acknowledges that the Petitioner was diagnosed with a small left medial meniscus tear, left patellar tendinitis, infrapatellar and insertional tendinitis (jumper's knee), which appears to have resulted in a nagging knee problem. He did have a

prior, more significant knee derangement and surgery, however, again, there was no evidence that he had an ongoing problem with the knee prior to the accident.

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 25% loss of use of the left leg pursuant to §8(e) of the Act.

The Arbitrator notes that the Petitioner testified to prior work-related left knee injury in 2005, at which time he obtained a settlement for 15% of the left leg. Pursuant to Section 8(e)(17) of the Act, the Respondent is entitled to credit for this prior award/settlement. Thus, the Petitioner's "net" award, after deducting the 15% credit, is 10% of the left leg.

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS)
)
)
COUNTY OF SANGAMON)

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

Lois M. Vaughan,
Petitioner,

vs. NO: 16 WC 17341

18IWCC0690

Memorial Medical Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent and Petitioner herein and notice given to all parties, the Commission, after considering issues including accident, causal connection, temporary total disability, and nature and extent of permanent partial disability, and being advised of the facts and law, hereby reverses the February 23, 2017 decision of Arbitrator McCarthy as described below. The Arbitrator's decision is attached hereto and made a part hereof.

The Arbitrator found that Petitioner's right knee injury arose out of and in the course of employment with Respondent. He awarded temporary total disability benefits under §8(b), medical expenses under §8(a), and permanent partial disability compensation representing 25% loss of use of the right leg under §8(e)12. The Commission, after reviewing the entire record, disagrees with the Arbitrator's finding of compensable accident. Particularly, the Commission finds that Petitioner's injury – incurred in a fall while stepping off a sidewalk curb onto a parking lot – did not "arise out of" her employment. Accordingly, the Commission reverses the Arbitrator's decision and vacates all awards of benefits.

I. BACKGROUND

Petitioner, 60 years old at the time of accident, was hired in June 2015 by Memorial Medical Center as a technician in its "Central Processing" department, where her duties included cleaning and sterilizing surgical instruments, assembling trays of instruments needed for surgeries, carting the trays to the operating room in preparation for the following day's surgeries, etc. She worked from 10:30 p.m. to 7 a.m. (Tr. 11-14).

On the morning of October 29, 2015, after completing her shift and exiting the building, Petitioner fell while headed for the parking lot. The parking lot's surface was made of black asphalt, and alongside its edge ran a light-colored (concrete and cement) sidewalk. Petitioner was alighting the sidewalk when she stumbled and fell. She landed on the blacktop on her right knee, sustaining a communited fracture of the patella. (Tr. 36; PX 1). There was no snow, ice or any precipitation on the ground. (Tr. 26). Nor were there any holes, debris, obstructions, or the like that caused her to trip. (Tr. 60). Quite simply, she had just taken a misstep with her left foot and stumbled over the curb, which was about 1½ to 2 inches higher than the blacktop surface. (Tr. 32-33).

Both parties submitted photographs into evidence depicting various views of the parking lot and curbed sidewalk, including the particular spot where Petitioner stumbled. (PX 4; RX 4; RX 5). The photographs show that at the end of the sidewalk was a wheelchair access ramp. The height difference between the sidewalk and blacktop diminished and their surfaces became level with each other at the point of this access ramp. Petitioner attempted to alight the sidewalk before the point where the surfaces became level. Although the boundary between the light-colored, curbed sidewalk and the blacktop is distinct, Petitioner stated it looked to her that the sidewalk's surface was even with the blacktop – that is, she did not notice the difference in height between the sidewalk and the blacktop -- because it was 7 a.m. and dark. (Tr. 32-33; 66-67). She also stated that only one of the two lights by the door of a nearby building was on at the time, and only "partially" illuminated the area where she ultimately fell. (Tr. 29-30).

Petitioner acknowledged that these sidewalks are open to the public. (Tr. 55). She also testified that, while performing duties for Respondent in the preceding months, she had traversed this same general area multiple times and was familiar with these sidewalks and surroundings. (Tr. 55-57). In fact, she had stepped off that curbed sidewalk to the parking lot before, but "in different places." (Tr. 68).

II. DISCUSSION

A. The Arbitrator's finding of a hazard or defect is erroneous.

The Arbitrator's decision is based on finding of a hazard or defect. He wrote:

> "It is clear from the evidence that the uneven surface between the sidewalk and the asphalt parking lot where the Petitioner fell was a hazard or defect. This is especially true when you add in the fact that the asphalt lot was not flat and instead sloped away from where Petitioner placed her left foot."

(Arbitrator's decision at 9). He cited Litchfield Healthcare Center v. Industrial Comm'n, 349 Ill.App.3d 486 (2004), wherein the claimant "tripped while walking across a sidewalk at work which had uneven slabs of concrete to the extent of 1¼ inches." (Arbitrator's decision at 9). The claimant in that case identified an exhibit which showed one slab of concrete higher than the adjoining slab. The Litchfield court determined that the sidewalk was "uneven and defective." Litchfield at 491. The Litchfield court further found that the condition created a risk that was neutral, but one to which the claimant was exposed to a greater degree than the general public by virtue of her regular use of the parking lot to

which she was headed. Id. In the instant case, the Arbitrator found that the uneven ground, combined with the darkness that Petitioner allegedly encountered at 7 a.m., warranted the determination that she was exposed to a risk of tripping greater than that met by the general public. (Arbitrator's decision at 9).

The Arbitrator's citation to Litchfield is misplaced. Here, the height differential (diminishing towards the access ramp at the end of the sidewalk) between the curb and the blacktop was by design and not a defect. As Respondent points out, "common sense dictates that sidewalk slabs should be even or the same height; whereas curbs are, by nature, raised boundaries. Thus, demonstrating height differences between slabs within the same sidewalk evidences defectiveness; where demonstrating height differences between a curb and the area it borders does not." (Respondent's Statement of Exceptions at 9-10). The multiple photographs submitted by both parties -- of views of the parking lot, sidewalk, and the exact site of Petitioner's fall – show that the premises were neither defective nor hazardous. (PX 4; RX 4; RX 5).

B. Petitioner's injury did not "arise out of" employment.

As there was no defect, special hazard or risk on Respondent's premises, the Commission finds that Petitioner has failed to prove that her injury "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 between the employment and the accidental injury. Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 58 (1989). Petitioner's case in fact bears a remarkable similarity to the circumstances of Caterpillar, where the claimant was injured when he stepped off a curb (featuring a "slight slope between the curb and the driveway") in front of his place of employment. The Supreme Court found that the claimant provided nothing in the record to indicate that the curb was either defective or hazardous.[1] Thus, the condition of the premises in Caterpillar was not a contributing cause of his injury. The Supreme Court further found that the fact that the claimant took an accepted route does not satisfy the "arising out of" element. As the Court noted:

> "We recognize that in prior cases this court held that injuries sustained on the employer's premises by an employee going to or from his actual employment by a customary or permitted way, within a reasonable time before or after work, were incurred in the course of and arose out of the employment. [citations omitted]. While the broad language of these cases might appear to imply that any accidental injury sustained on the employer's

[1] The circumstances in Caterpillar were described as follows: "On July 7, 1979, after completing his shift, [claimant] Price left the building through the door normally used by the employees, intending to go to his car, which was parked in the employee parking lot. Immediately in front of the building was a sidewalk with a curb running along its edge. Price walked along the sidewalk for about 30 feet and then stepped off the curb onto the blacktop driveway. There was a slight cement slope, apparently for drainage, between the curb and the blacktop driveway. As Price stepped off the curb, his right foot landed half on the cement incline and half on the blacktop driveway and he twisted his ankle. The driveway was part of the company premises and was used both by employees and by the general public to pick up employees. There is no evidence of holes, rocks or obstructions on the pavement." Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 56-57.

> premises is compensable, that is not the law in this State. An examination of the cases indicates this court's continued adherence to the maxim that an injury is not compensable unless it is causally connected to the employment. Where liability has been imposed, the injury occurred either as a direct result of a hazardous condition on the employer's premises [citations omitted] or arose from some risk connected with, or incidental to, the employment [citations omitted]."

Caterpillar, 129 Ill. 2d at 61-62. The Court concluded that the claimant did not establish that he was exposed to a risk not common to the general public to a greater degree. "Curbs, and the risks inherent in traversing them, confront all members of the public." Recovery to the claimant was denied. Id.

Similarly, the Commission finds that Petitioner is not entitled to recovery. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed February 23, 2017, is hereby reversed as discussed above. Benefits 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 8 - 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-09/12/18
jdl/ac
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VAUGHAN, LOIS M
Employee/Petitioner

Case# **16WC017341**

MEMORIAL MEDICAL CENTER
Employer/Respondent

18IWCC0690

On 2/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0490 SORLING NORTHUP
DAVID ROLF
1 N OLD STATE CAPITAL PLZ #200
SPRINGFIELD, IL 62701

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON

18IWCC0690

☐ 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

Lois M. Vaughan
Employee/Petitioner

v.

Memorial Medical Center
Employer/Respondent

Case # 16 WC 17341

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 January 18, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 29, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **20** weeks preceding the injury, Petitioner earned **$12,430.95**; the average weekly wage was **$621.55**.

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

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

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

Respondent shall be given a credit of **$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 **$9,652.32** under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of **$414.37**/week for **9 4/7** weeks from **10/30/15** through **1/4/16**, as provided in Section 8(b) of the Act.
- Respondent shall pay Petitioner the sum of **$372.93**/week for a further period of 53.75 weeks, as provided in Section 8(e)(12) of the Act, because the injuries sustained caused **25% loss of use of the right leg**.
- Respondent shall pay Petitioner compensation that has accrued from **10/29/15** through **1/18/17**, and shall pay the remainder of the award, if any, in weekly payments.
- Respondent shall pay the further sum of **$5,108.07** for necessary medical services, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act, and shall be given a credit for payments made by the group medical plan, and shall hold Petitioner harmless from any and all claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

D. Dfan McCarty 2/13/17

Signature of Arbitrator Date

DEC 2 3 2017

The Arbitrator hereby makes the following Findings of Facts on all issues:

Petitioner became employed by Respondent in June of 2015 as a Central Processing Technician and held that position on 10/29/15, but had worked as a traveler for Respondent since January or February of 2015. The duties of a Central Processing Technician involve processing all surgical instruments and other equipment for the operating rooms including cleaning, decontaminating, and sterilizing the surgical instruments and equipment, assembling trays with the instruments and equipment, obtaining the trays for the following day, loading the trays onto carts, pushing the carts to the operating rooms, and emptying the carts, laundry, and trash from the operating rooms. Petitioner estimated orthopedic surgical trays weighed approximately 25 pounds, non-orthopedic surgical trays weighed 10-15 pounds, carts with trays weighed up to 300 pounds, and full laundry bags weighed 20 pounds. As a Central Processing Technician, Petitioner was required to be on her feet all day. Petitioner worked the third shift as a Central Processing Technician with her hours from 10:30 p.m. to 7:00 a.m. On 10/29/15, Petitioner's direct supervisor was Brenda Sturdy.

As an employee of Respondent, Petitioner stated she was assigned to Parking Lot 3 and received a parking sticker but was not assigned a particular spot in that lot. Petitioner acknowledged as an employee of Respondent she was able to park in any of the employee parking lots but the closest lot for Petitioner was Parking Lot 3, and Respondent had only suggested but did not instruct Petitioner to park in Parking Lot 3. The parking sticker Petitioner received did not restrict Petitioner to parking in Parking Lot 3, but allowed Petitioner to park in any of the employee parking lots. Parking Lot 3 is north of the emergency room of Respondent and Petitioner identified Parking Lot 3 on PX 4, an older version of Respondent's campus map.

Petitioner was given instructions on where to enter and exit Respondent's facility as an employee of Respondent by Ms. Sturdy, and was initially instructed to enter through the emergency room or the front of the Medical Arts building where the garden center is located. Petitioner circled two areas on PX 4 where she had been instructed to enter and exit Respondent's facility when she was initially hired. Petitioner acknowledged she was not limited to use only those doors, only that Respondent had suggested these doors to enter and exit Respondent's facility, as these doors were convenient to where Petitioner was going to perform her duties as a Central Processing Technician.

Petitioner used the emergency room to enter and exit as an employee of Respondent for several months, and was then given further directions on where to enter and exit Respondent's facility by memos and word of mouth, which included a door behind Human Resources that goes to Central Sterilization. Petitioner marked an X on PX 4 for the door that went to Central Sterilization. The door to Central Sterilization is not a door that can be entered or exited by members of the public as a badge is needed to open the door either way. After entering the door to Central Sterilization, the time clock Petitioner uses as an employee of Respondent is located down some steps and through another door. As an employee of Respondent, Petitioner is required to clock in and out.

Petitioner indicated when leaving through the door to Central Sterilization, an employee can go either left or right, but she always went to the left and walked on the west sidewalk there. Petitioner acknowledged there is a sidewalk on the eastside of the Medical Arts building and it was her choice which direction she went when coming out the door to Central Sterilization. Petitioner also acknowledged the west and east sidewalks by the door to Central Sterilization are open to the public. Petitioner further acknowledged she had traversed this same general area as a traveler at Respondent and was familiar with the sidewalks, doors, and buildings.

The west sidewalk Petitioner encountered upon leaving the door to Central Sterilization intersected with another sidewalk in front of the security office which Petitioner identified in PX 5, p. 4 and leads to a parking lot. Petitioner identified the building to the left of the sidewalk in PX 5, p. 4 as the Human Resources building and thought the building to the right was laundry. Petitioner described the sidewalks were concrete and the parking lot was blacktop and there is a visual difference between them.

Before 10/29/15, Petitioner did not have any medical condition that caused her to trip, stumble or fall. On 10/29/15, Petitioner had worked the third shift, clocked out, and was leaving work at approximately 7:00 a.m. to go to her car in Parking Lot 3. Petitioner indicated it was cold and dark outside as the sun had not come up, but there was no precipitation occurring when she left, and there was no ice, water, or snow on the ground from prior precipitation. Petitioner walked out of the door to Central Sterilization with a co-worker, Tracy Gomez, on 10/29/15, but then Petitioner had walked in front of Ms. Gomez on the sidewalk shown in PX 5, p. 4. Petitioner did not encounter any members of the public as she left work on 10/29/15 and stated she had never encountered any members of the public on that sidewalk when she went into work or left work.

Petitioner noted PX 5, p. 4 showed two lights by the door in that photograph, but explained only one of those lights was on at the time Petitioner left work on 10/29/15 at approximately 7:00 a.m. and it only partially illuminated the area where Petitioner ultimately fell. Petitioner also noted PX 5, p. 4 and RX 5 showed a light on the building to the right, but explained the lights present on that building on 10/29/15 were lower on the building and behind the rose bushes. Petitioner further explained on 10/29/15, there was a security vehicle parked in the area for security personnel that caused the lights behind the rose bushes to make the area where Petitioner fell not as illuminated.

On 10/29/15, as Petitioner was walking on the sidewalk shown in PX 5, p. 4, it appeared the sidewalk was even with the blacktop, when there was actually a difference of 1 ½ - 2 inches, and as Petitioner stepped off the sidewalk onto the blacktop, she tripped, stumbled, and fell landing on her right knee. Petitioner marked the spot on the blacktop area where she tripped with an X on PX 5, p. 7 and described the blacktop area as slanting or sloping down. Petitioner also indicated she was completely off the curb when she stepped onto the sloped blacktop area. Petitioner stepped with her left foot which did not land like it was supposed to and Petitioner tripped. Petitioner stated the darkness made the blacktop area look even or level with the sidewalk at that area and marked the spot where she actually landed with a check mark on PX 5, p. 7. On 10/29/15, there were no guardrails, barricades, signs, colored paint, or markings of any kind where Petitioner stepped off the sidewalk onto the sloped blacktop area.

Petitioner confirmed RX 6, p. 2 showed the sidewalk area where she fell and at one point, the sidewalk is level with the sloped blacktop area and then the blacktop area tapers down to the curb and that is how the area existed on 10/29/15. Petitioner further explained at a certain point when a person steps off the sidewalk in that area, they will be level with the blacktop area but the blacktop area where she stepped off the sidewalk on 10/29/15 had a 1 ½-2 inch difference between the sidewalk and the sloped blacktop area. Petitioner did not know why the blacktop area tapered in that area and said the reason she fell was because she did not see the difference in height between the sidewalk and blacktop area as it looked even to her since it was dark. Petitioner acknowledged she had stepped off the curb to the parking lot in that area in different places before 10/29/15.

Petitioner identified RX 4 as a series of photographs that showed the approximate area where Petitioner stepped off the curb to the parking lot and Petitioner would have been walking toward the top of the 2nd photograph that showed the sidewalk continued and then made a right angle down an accessibility ramp into the parking lot. Petitioner acknowledged she was cutting across the area rather than going further on the sidewalk and turning down the ramp. Petitioner also acknowledged RX 4 was an accurate portrayal of the condition of the sidewalk and parking lot at the location where Petitioner fell and there were no chunks, defects, or holes nor any rocks or debris where Petitioner tripped.

After Petitioner fell, she noticed she was unable to move her right leg and started screaming and her co-worker and security personnel came to her aid and the security personnel then went to obtain ER staff. Petitioner estimated she was on the ground for approximately 10 minutes before she was brought into the ER in a wheelchair. While in the ER, Petitioner initially saw a nurse, an ER physician, and radiologist, and told them she had tripped and fallen on the blacktop area not the curb. Petitioner also indicated her supervisor, Ms. Sturdy, came to the ER and Petitioner told Ms. Sturdy what had happened in that she had tripped, fallen, and landed on the concrete lip.

The records of Memorial Medical Center reported Petitioner was seen in the emergency room on 10/29/15 at 7:12 a.m., initially by an ER nurse, with the history Petitioner tripped and fell in parking lot and complained of right knee pain and did not hit head (PX 1, p. 6, 7). It was also reported by the ER physician Petitioner was walking in the parking lot and tripped on a curb and landed directly on her right knee and complained of pain to the anterior knee (PX 1, p. 8). On physical examination, Petitioner had a superficial abrasion over the anterior right knee, was able to flex and bend the knee without difficulty, and there was normal sensation and motor function to the distal extremity (PX 1, p. 9). Petitioner was sent for an X-ray of the right knee and the radiologist reported Petitioner tripped and fell in parking lot this morning, with right knee pain, more on the medial aspect (PX 1, p. 9). The X-rays showed a comminuted fracture along the inferior aspect of the patella, the superior patellar pole was somewhat high-riding in the inferior portion which was inferiorly displaced, and there was a large adjacent soft tissue swelling (PX 1, p. 9-10). Petitioner was diagnosed with a comminuted fracture of the patella, placed in a knee immobilizer and referred to Dr. Razavi, an orthopedic surgeon, for worsening/continued problems (PX 1, p. 10).

The records of the Orthopedic Center of Illinois reported Petitioner was seen by Dr. Razavi on 11/2/15, for evaluation of a knee problem that occurred 4 days ago from a fall while walking in a parking lot at work on 10/29/15 (PX 2, p. 3). Petitioner presented in a wheelchair with a knee immobilizer on the right knee and Dr. Razavi found significant ecchymosis and edema about the knee joint, and diagnosed Petitioner with a closed fracture of the right patella and offered Petitioner surgical repair of the right knee patella fracture and extensor mechanism (PX 2, p. 4). Petitioner underwent a history and physical examination for this surgery with her family physician, Dr. Lee, on 11/6/15 (PX 2, p. 11-13). On 11/11/15, Dr. Razavi performed a repair of the infrapatellar tendon on the right side and noted the fracture in the inferior pole of the patella was significantly comminuted which precluded stable fixation of it (PX 2, p. 21-22).

Petitioner was seen by Dr. Razavi on 12/11/15, and reported excessive pain but there was no calf swelling, no leg pain, and no shortness of breath (PX 2, p. 25-27). Petitioner was instructed to be weight-bearing as tolerated, to keep the knee immobilizer on at all times to keep the knee getting complete extension, and allowed Petitioner to return to work with standing as tolerable and limited use of the right

leg based on pain and strength tolerance (PX 2, p. 28). Petitioner returned to work as a Central Processing Technician in a restricted capacity on 1/5/16. Petitioner saw Dr. Razavi again on 1/8/16, and reported her symptoms were moderate in severity and improving, and Dr. Razavi prescribed intensive physical therapy for range of motion and knee strengthening (PX 2, p. 29-31).

The records of Memorial Medical Center reported Petitioner received physical therapy services from 1/20/16 through 4/22/16 (PX 1, p. 37-101). At the initial evaluation of 1/20/16, the therapist reported Petitioner's pain had been present since 10/29/15 after she fell directly onto the right knee onto concrete when leaving work and Petitioner had significant swelling in her right knee and lower leg into the ankle with increased WB (weight bearing) positions or prolonged sitting (PX 1, p. 44-47). On physical examination, Petitioner had an antalgic gait, decreased WB RLE, decreased heel toe contact, right knee in slight flexion, flexion of 65 degrees, extension of -11 degrees, and 3+ strength iliopsoas (PX 1, p. 45-46). While receiving physical therapy, Petitioner reported stiffness, deep ache, tightness, soreness, tiredness, and a feeling the knee was going to give out (PX 1, p.52-53, 57-58, 61-62, 75-76, 84-85, 97-98, 99-101). The physical examination of Petitioner on 4/22/16 showed flexion of 132 degrees and extension within normal limits (PX 1, p. 100).

Petitioner returned to Dr. Razavi on 2/22/16, and reported joint swelling, but no calf swelling, no leg pain, no shortness of breath, and partial weight bearing status (PX 2, p. 44-46). On physical examination, Dr. Razavi found knee tenderness, ROM as expected given post-op status, strength as expected given post-op status, stiffness, and active range of motion 5-95 degrees (PX 2, p. 44). Dr. Razavi instructed Petitioner to continue with physical therapy and return in 3 months, and released Petitioner to light duty with 15 minute breaks every 2 hours (PX 2, p. 47-48). Petitioner saw Dr. Razavi again on 5/31/16, with some complaints of knee pain and swelling (PX 2, p. 50-52). On physical examination, Dr. Razavi found no drainage or erythema around the incision, active range of motion from 0-115 degrees, released Petitioner from his care and instructed Petitioner to return to work without restrictions (PX 2, p. 53). Petitioner has not returned to see Dr. Razavi since 5/31/16.

Petitioner returned to work in a full duty capacity as a Central Processing Technician after 5/31/16 but noticed it was difficult for her to stand on her right leg for hours and perform her duties with the trays and carts. Sometime in November of 2016, Petitioner discussed with her supervisor's manager, Becky Douglas, a change in position. At the time of this discussion, Petitioner earned the sum of $16.17 per hour as a Central Processing Technician. As a result of the discussion with Ms. Douglas, Petitioner accepted an alternative position as a Central Processing Aide at the rate of $14.00 per hour. The duties of a Central Processing Aide include making linen packs for sterilization, making basins and trays for labor and delivery and the ER that weigh 5 pounds at most.

Petitioner returned to her family physician, Dr. Lee, on 12/22/16 for right knee pain, and reported right anterior knee pain for one year, the pain was a constant dull pain, worse with standing and walking, and associated symptoms include stiffness, decreased range of motion, difficulty bearing weight, and difficulty ambulating (PX 3, p. 64-65). On physical examination, Dr. Lee found diffuse tenderness in the anterior knee, limited ROM in all planes, and painful in all planes, and prescribed Norco for Petitioner and instructed her to return in 3 months for pain management (PX 3, p. 65).

At the time of the accident, Petitioner was 60 years of age, and earned the sum of $15.70 per hour as a Central Processing Technician. Petitioner anticipates working until she is 66 years of age and notices her

right knee swells all the time and hurts under the kneecap down toward the shin. Petitioner has been using a cane suggested by her husband for approximately 5-6 months mainly when she is out walking as her knee buckles and Petitioner takes the cane to work. Petitioner confirmed no physician had prescribed the cane she uses. Petitioner also notices the right knee is swollen and frequently pops.

Petitioner identified several recreational activities she is limited in performing because of pain in her right knee and ankle, including hiking, walking on uneven ground, riding her bicycle, and playing with her dogs. Petitioner performs the exercises she learned in physical therapy all the time including walking one step at a time. Petitioner explained she was from Virginia and when she traveled, she would go sightseeing and hike around. Petitioner further explained she used to ride her bicycle every day after she got off work or in the mornings and especially on the weekends but acknowledged she did not do this to the same frequency given the weather in Illinois. Petitioner also explained she did not pedal any stationary bicycle in physical therapy because she was unable to put her foot on the pedal and bring the pedal back up but pushed pedals while sitting down.

Petitioner stated none of the photographs in PX5 showed the darkness in the area where Petitioner fell as it existed on 10/29/15. Petitioner also stated none of the photographs in RX 4, RX 5, and RX 6 showed the lighting conditions in the area where Petitioner fell on 10/29/15.

PX 6 contained medical bills incurred by Petitioner at Memorial Medical Center, Orthopedic Center of Illinois, Dispatch Medical Treatment, Clinical Radiologists, Midwest Emergency Physicians, Associated Anesthesiologists, Prairie Cardiovascular, Memorial Home Services, and Memorial Physician Services, as well as prescription medications. PX 6 showed payments by group health insurance totaled the sum of $9,652.32, payments by Petitioner totaled the sum of $267.70, and unpaid bills totaled the sum of $4,840.37.

Rachel Moore has been employed by Respondent since 2008, initially as an Employee Specialist, and then since March 2015 as the Worker's Compensation (WC) Coordinator. As an Employee Specialist, Ms. Moore's duties included recruiting employees, offering jobs, performing compliance and background checks, handling agency contracts, ensuring bonuses were received, performing audits, and providing instructions to new employees. As the WC Coordinator, Ms. Moore's duties included reviewing injuries that come in, following up with employees and their managers, seeing if a department was able to accommodate restrictions an employee may have, and paying benefits that may be due. Ms. Moore has a BS in Business Administration and Management and an MBA but does not have a law degree.

Ms. Moore explained employees of Respondent are not told where to park, and there was no requirement an employee park anywhere, but employees were told where they could park as shown on various campus maps and included any employee parking lot. Ms. Moore explained Respondent used to have red hanging tags for parking lots but moved to red parking stickers which allow an employee to park in any of the employee parking lots.

Ms. Moore reviewed the incident report for the accident Petitioner sustained which is utilized in the course of her duties as the WC Coordinator and noted that report stated "while walking out of work Petitioner tripped on the curb, falling on right knee". Ms. Moore assumed the incident report was completed by Brenda Sturdy because if an employee completed the incident report, the appropriate pronoun would have been used, and acknowledged the incident report does not document the person

who completed it, as the incident report can be completed online with an employee ID number. The incident report noted the accident occurred at 7:11 a.m. but Ms. Moore did not know when Petitioner was seen in the ER as she did not have Petitioner's medical records and did not know when the incident report was completed. Ms. Moore never spoke directly with Petitioner but noted Petitioner spoke with the prior WC Coordinator, Christina Reed, as Ms. Moore was not the WC Coordinator on 10/29/15. While Ms. Moore had access to the notes of Ms. Reed, she did not bring those notes to the hearing.

Ms. Moore was aware of where the fall took place and is able to see the area where Petitioner fell from her office as the WC Coordinator in the Medical Arts building. Security services, Human Resources services, Patient Financial Services, some IS services, and the library are located in the Medical Arts building. The sidewalk Petitioner was walking on at the time she fell is open to the public, there is nothing that indicates it is not a public sidewalk, and the sidewalk is no different than any of the other sidewalks throughout the campus of Respondent. The sidewalk does not require anyone to have an employee badge to enter that area or be on the sidewalk and the sidewalk is not in a restricted area. While the public can go and walk on the sidewalks throughout the campus of Respondent, the sidewalks are not maintained by the City of Springfield but are maintained by employees of Respondent.

Ms. Moore noted the sidewalk on the east side of the Medical Arts building is also open to the public and leads to Dodge Street across the street from Parking Lot 3 and then to the hospital proper. Ms. Moore is able to see people traverse the east sidewalk as she has a window in her office and has seen members of the general public utilize the east sidewalk. Ms. Moore identified RX 5 as two photographs which showed the parking lot behind and next to the Medical Arts building as well as Security services. Ms. Moore is familiar with that area at approximately 7:00 a.m., and with the lighting in that area as she had been in that area at that time.

Ms. Moore looked at the two photographs in RX 6 and described the area as the back entrance to the Medical Arts building and noted there is a wheelchair ramp there and if a person continued on the sidewalk you get to the front of the Medical Arts building and then to Dodge Street and then to various parking lots. Ms. Moore noted the parking lot in the photographs of RX 5 is open to the public and these photographs showed the location of Petitioner's fall. Ms. Moore noted a person walking south on the sidewalk shown in these photographs can get to several areas of Respondent's facility.

Ms. Moore confirmed the sidewalk shown in RX 4 had a curb similar to the curb in the area where Petitioner fell, but explained the sidewalk shown in RX 4 is for people to pull up and park, whereas the sidewalk where Petitioner fell is an area where a person cannot drive through. Ms. Moore confirmed to the west of where Petitioner fell, there are parking spaces for security vehicles and attending physicians and where Petitioner fell, there are no parking spaces for members of the public and the curb in the area where Petitioner fell was not painted yellow as was the curb in front of the Medical Arts building.

Ms. Moore was present when the photographs in RX 4 were taken and the last photograph in that exhibit showed a foot off the curb in the blacktop area and there was about a 2 inch difference between the blacktop and curb at that point. Ms. Moore described the blacktop area as being angled from south to north and then east to west and the blacktop is level at one point with the sidewalk and then tapers down to the normal curb height. Ms. Moore did not know why the blacktop area was that way but it had been that way since she started working for Respondent and noted just beyond the blacktop area that tapers down there is an actual ramp.

Ms. Moore confirmed the route Petitioner was on at the time she fell on 10/29/15, was an accepted route for Petitioner to take but not necessarily the quickest route as she thought the sidewalk on the east side of the Medical Arts building would be the quickest route. Ms. Moore noted she may not see a total of 10 people on the sidewalk Petitioner was on when she fell on a daily basis. Ms. Moore agreed the last photograph in RX 4 showed a foot touching the curb but not on the curb itself. Ms. Moore never asked anyone, including Brenda Sturdy or Chris Reed, what their understanding was of the involvement of the curb with reference to the accident Petitioner sustained. Ms. Moore understood the last photograph in RX 4 was in proximity to where Petitioner fell.

Therefore, the Arbitrator concludes as follows:

1. Petitioner sustained an accident arising out of and in the course of her employment on 10/29/15. The "in the course of" element refers to the time, place, and circumstances under which the accident occurred. Injuries that occur on an employer's premises within a reasonable time before and after work are generally compensable. In this case, Petitioner had clocked out from work, had exited through a properly designated door, and was walking to her car parked in one of the employee parking lots when she fell and injured herself while on an accepted route. Petitioner's injuries were incurred within a reasonable time after leaving work and were incurred on Respondent's premises. Thus, Petitioner's injuries were sustained in the course of her employment. Dodson v. Industrial Commission, 308 Ill.App.3d 572, 720 N.E.2d 275 (5th Dist. 1999).

   For an injury to "arise out of" the employment its origin must be in some risk connected with, or incidental to, the employment, so as to create a causal connection between the employment and the accidental injury. As has been done in numerous Illinois cases analyzing this issue, the Arbitrator first must characterize the type of risk to which the Petitioner was exposed. It is clear from the evidence that the uneven surface between the sidewalk and the asphalt parking lot where the Petitioner fell was a hazard or defect. This is especially true when you add in the fact that the asphalt lot was not flat and instead sloped away from where the Petitioner placed her left foot. The Appellate Court in the case of Litchfield Healthcare v. The Industrial Commission, 349 Ill. App. 3d 486 (2004) involved a very similar fact pattern. The petitioner tripped while walking across a sidewalk at work which had uneven slabs of concrete to the extent of 1 ¼ inches. The Court determined that the condition created a risk which was neutral, but one to which the petitioner was exposed to a greater degree because she encountered it frequently, as it was on her regular route to work.

   In the instant case, Ms. Vaughn tripped while walking on her normal, accepted route between the door she exited at work and her parking lot. Not only was the spot where she tripped on uneven ground, but it was also encountered in darkness when she left her work shift at 7:00 A.M. Those facts together exposed the Petitioner to a risk of tripping greater than that encountered by the general public.

   Respondent argues that the Petitioner's accident did not arise out of her employment because she route that she took to her parking lot was of her own choice. It argues that she could have gone around her building using a sidewalk on the other side and presumably avoided

encountering any defects. The Arbitrator is not persuaded by this argument. Ms. Moore, the Respondent's Workers Compensation Coordinator, testified that the route the Petitioner took, while not the quickest route was an accepted route. At least one other employee, Tracy Gomez, apparently felt the same way. This was clearly not a situation where the Petitioner was unnecessarily exposing herself to danger in taking the route that she took to her car.

Based upon the above, the Arbitrator finds the Petitioner's accident arose out of her employment.

2. The medical services provided to Petitioner were reasonable and necessary. Medical bills incurred by Petitioner in treatment of her right leg condition of ill-being were submitted in PX 6 and Respondent had no objection to this exhibit, including liability or reasonableness and necessity of the services. In addition, the medical records support the reasonableness and necessity of the services Petitioner received to her right leg (PX 1-3).

3. Petitioner was temporarily totally disabled for the period of 10/30/15 through 1/4/16, or 9 4/7 weeks. Respondent disputed only its liability for TTD benefits, not the period claimed. The undisputed evidence showed Petitioner was off work following the accident on 10/29/15, until she returned to work in a restricted capacity by Dr. Razavi on 1/5/16.

4. Pursuant to Section 8.1b of the Act for accidental injuries that occur on or after 9/1/11, in determining the level of permanent partial disability, the Commission shall base its determination on several factors, including (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) the evidence of disability corroborated by the treating medical records, and further provides that no single enumerated factor shall be the sole determinant of disability.

With regard to Section 8.1(b)(i) of the Act, the parties stipulated this requirement was waived, so no weight is given to this factor. With regard to Section 8.1(b)(ii), Petitioner was a Central Processing Technician at the time of the accident, which is a job that required Petitioner to be on her feet all day and lift trays, laundry bags, and trash weighing 10-25 pounds, and push and pull carts weighing up to 300 pounds. She testified that she had symptoms with her knee after returning to her job such that she transferred to one les demanding. The Arbitrator finds this factor favors the Petitioner's claim.. With regard to Section 8.1(b)(iii), Petitioner was 60 years of age at the time of the accident, which means Petitioner does not have the work life expectancy of a younger worker. This factor weighs for the Respondent. With regard to Section 8.1(b)(iv), Petitioner's future earning capacity has not been impacted by the injury herein. While she did switch to a lower paying job, the switch was of her own volition. Her treating doctor released her without restrictions on May 31, 2016. (PX 2) With regard to Section 8.1(b)(v), Petitioner's condition of ill-being was diagnosed as a comminuted fracture along the inferior pole of the patella, the superior patellar pole was somewhat high-riding in the inferior portion which was inferiorly displaced, and there was a large adjacent soft tissue swelling. On 11/11/15, Petitioner underwent a repair of the infrapatellar tendon on the right side, but the fracture in the inferior pole of the patella was significantly comminuted which precluded stable fixation. Following surgery, Petitioner received extensive physical therapy to

her right knee, and reported to the therapist complaints of stiffness, deep ache, tightness, soreness, tiredness, and a feeling the knee was going to give out. The undisputed evidence showed following Petitioner's return to work as a Central Processing Technician, she experienced difficulties performing her duties due to the injury she sustained and eventually began using a cane at the suggestion of her husband. When Petitioner was last seen by a medical provider for her right knee on 12/22/16, it was reported Petitioner had anterior knee pain, worse with standing and walking, and associated symptoms included stiffness, decreased range of motion, difficulty bearing weight, and difficulty ambulating. On physical examination of Petitioner's right knee, findings included tenderness in the anterior knee, limited range of motion in all planes along with pain, and Petitioner was prescribed Norco. (PX 3) Petitioner credibly testified to limitations she has in performing certain recreational as well as daily activities.

Based upon the above, the Arbitrator finds the Petitioner disabled to the extent of 25 % of the right leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deborah Markusson,
Petitioner,

vs. No. 14 WC 10822

18IWCC0691

Illinois State Fire Marshal,
Respondent.

DECISION AND OPINION ON REVIEW

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

On February 14, 2014, Petitioner, a 45-year-old clerk employed by Respondent, slipped on ice and injured her left knee while walking from the employer-provided parking lot to her office building. At the time of Petitioner's fall, the parking lot had not been plowed.

On that date, Petitioner was still in treatment and recovering from two recent surgeries to that same knee. On August 23, 2013, Petitioner underwent a partial medial meniscectomy, chondroplasty and plica removal; on November 27, 2013, she underwent an ACL reconstruction with hamstring graft. Those surgeries followed an accident in April 2013 in which Petitioner fell down camper stairs while vacationing.

Following Petitioner's February 14, 2014 accident, Dr. Saadiq El-Amin initially treated her conservatively for new injuries to her left knee: a left lateral meniscus root avulsion and a contusion of the femoral condyle. When that treatment was unsuccessful, he performed a 3rd left surgery to Petitioner's left knee on April 2, 2014: an arthroscopic chondroplasty and synovectomy. Because Petitioner continued to have pain and buckling after that, Dr. El-Amin performed a 4th arthroscopic surgery on January 14, 2015: an ACL revision, shaving chondroplasty and partial medial meniscectomy. Thereafter, Petitioner was able to return to work at Respondent and has since received a pay increase and promotion. Her most recent FCE found her able to perform work at the medium physical demand level. At arbitration, Petitioner testified she was receiving treatment for bilateral knee osteoarthritis which she claims is causally related, and for bilateral plantar fasciitis, which she concedes is not.

The Arbitrator found Petitioner failed to prove her slip and fall arose out of and in the course of her employment. The Arbitrator concluded Petitioner had not been exposed to a risk greater than that faced by the general public. The Arbitrator also found that Petitioner did not fit within the "parking-lot exception" to the general rule that absent defects, falls en route to work in parking lots not owned and controlled by Respondents are not compensable.

The Commission finds Petitioner did prove an accident which arose out of and in the course of her employment. The case, *Vill v. Industrial Comm'n,* 365 Ill.App.3d 906, 814 N.E.2d 917 (1st Dist., 2006), provides the general rule that injuries from slip and falls off an employer's premises while traveling to or from work are ordinarily not compensable under the Workers' Compensation Act. But it also allowed recovery for the so-called "parking lot exception," when an employee is injured in a parking lot provided by and under the control of the employer. *Vill, at 922.* In such circumstances, the rationale for awarding workers' compensation benefits is that the, "employer-provided parking lot is considered part of the employer's premises." *Mores-Harvey v. Industrial Comm'n (Bob Evans Restaurant)*, 345 Ill. App. 3d 1034 at 1038, 804 N.E.2d 1086 (3rd Dist. 2004); *Suter v. Ill. Workers' Comp. Comm'n,* 2013 IL App (4th) 130049WC (2013).

In *Mores-Harvey v. Industrial Comm'n (Bob Evans Restaurant)*, 345 Ill. App. 3d 1034, 804 N.E.2d 1086 (3rd Dist. 2004), the appellate court held that an employee's slip and fall in an icy parking lot arose out of that claimant's employment and that the claimant faced a greater risk than the general public because the closest parking spots were reserved for guests. The Court noted that the employer's control over its employee's actions increased the claimant's risk to a greater extent than faced by the general public. In the current claim, Respondent exercised the same control by requiring employees to park only in certain sections of the parking lot.

In the present case, the Commission finds that although Respondent did not own the parking lot where Petitioner fell, it both provided exclusive use to its employees and exercised control of the lot by specifically designating areas where employees could and could not park.

In *Johnson v. Illinois Workers' Compensation Comm'n, 2011 IL App (2d) 100418WC, 956 N.E.2d543, 353 Ill.Dec 681,* the court held, "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties and while a claimant is at work, *or within a reasonable time before and after work,* are generally deemed to have been received in the course of employment." *(Emphasis added.)* The Supreme Court has also held, "[A]n employee who falls on a parking lot provided by his employer while proceeding to work, we believe, is subjected to hazards to which the general public is not exposed." *De Hoyos v. Industrial Com., 26 Ill. 2d 110, 185 N.E.2d 885 (1962).* Petitioner's accident occurred within a reasonable time before work. For the foregoing reasons, the Commission reverses the Arbitrator's finding that Petitioner did not prove accident.

Regarding Petitioner's condition of ill-being and medical expenses, Dr. El-Amin was the only physician to offer causal connection opinions. He opined that all of Petitioner's medical care between February 14, 2014 and June 18, 2015 was casually related to her left knee work injury. The Commission adopts Dr. El-Amin's opinions, and finds Respondent liable to Petitioner for all such medical expenses for treatment to her left knee during that period, pursuant to the fee schedule. Because Petitioner offered no medical opinion to show that any of her treatment received after June 18, 2015 was causally related to her work injury, the Commission finds Petitioner attained MMI on that date and denies all medical expenses incurred thereafter.

Regarding temporary total disability, the Commission finds Petitioner proved reasonable and necessary the following two periods during which she was unable to work following her two post-accident surgeries: April 2, 2014 to April 29, 2014, and January 14, 2015 to February 2, 2015. The Commission finds Respondent liable to Petitioner for 6-6/7 weeks of TTD for those two periods.

In determining the level of Petitioner's permanent partial disability, the Commission assigns the following weights to the five factors enumerated in §8.1b of the Act:

(i) Disability impairment rating: *no weight,* because no AMA Impairment rating was offered into evidence;

(ii) Employee's occupation: *little weight,* because Petitioner was able to resume her prior position;

(iii) Employee's age of 45: *some weight,* because Petitioner can expect to work for 20 or more years after her accident;

(iv) Future earning capacity: *moderate weight,* because Petitioner received a promotion and pay increase following her return to work after her work accident, and therefore had no loss of earnings capacity, and

(v) Evidence of disability corroborated by the treating records: *moderate weight,* because Dr. El-Amin believed Petitioner may develop arthritis in her knees sooner than if she hadn't suffered her work injury and because she has permanent restrictions per her FCE.

18IWCC0691

The Commission finds Petitioner entitled to 53.75 weeks of PPD at a rate of $530.92 per week representing 25% loss of use of the left leg pursuant to §8(e)12 of the Act. Because Petitioner presented no medical opinion showing that her right knee osteoarthritis condition was causally related to her: work accident, subsequent treatment, or overuse of her right leg, the Commission denies a permanency award for Petitioner's right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 19, 2017, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $589.91 per week for 6-6/7 weeks, for the periods of April 2, 2014 through April 29, 2014, and from January 14, 2015 through February 2, 2015, as provided by §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the outstanding reasonable and necessary medical expenses incurred in treating Petitioner's left knee between February 14, 2014 and June 18, 2015, as provided by §8(a) and §8.2 of the Act. Respondent shall additionally reimburse Petitioner for her out-of-pocket expenses for left knee treatment during this period and hold Petitioner harmless with regard to payments made by her health insurance. Respondent is entitled to a credit under §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $530.92 per week for a period of 53.75 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the loss of use of 25% of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay 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 8 - 2018

o-09/12/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

SPECIAL CONCURRING OPINION

I agree with the result reached by the majority. I write separately as I utilize a slightly different analysis as it relates to the finding of accident.

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. [citations omitted]. 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Sisbro Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). "Arising out of" speaks to risk- is the risk encountered by the employee a risk incidental to the employment as not all injures suffered while at work are compensable. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements expressed by the legislature in the Act"). "To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro* at 203.

A. In the Course of

Petitioner proved the fall occurred in the course of her employment with Respondent. As the court noted in *Illinois Bell Tel. Co. v. Industrial Commission*, "when an employee slips and falls, or is otherwise injured, at a point off the employer's premises while traveling to or from work, his injuries are not compensable." 131 Ill. 2d 478, 483-484 (1989) (quoting *Reed v. Industrial Commission*, 63 Ill. 2d 247, 248-49 (1976)). Two exceptions to this general rule exist: 1) when an employee falls in a parking lot maintained or controlled by the employer; or 2) when an employee is required to be at a place in fulfillment of her job duties, and the employee is exposed to a risk to a greater degree than the general public. *Illinois Bell Tel. Co* at 484.

Under certain factual scenarios, the employer's premise extends to an employer-provided parking lot. See *e.g. DeHoyos v. The Industrial Commission*, 26 Ill. 2d 110, 113, 185 N.E.2d 885 (1962) ("Whether or not the employer owned the parking lot is immaterial; for if the employer provides a parking lot which is customarily used by its employees, the employer is responsible for the maintenance and control of the parking lot"). The parking lot exception applies to the present facts. Respondent provided a parking lot to its employees and further, directed the employees as to where they could park. T. 16-17. The area where Petitioner fell was on the driveway into the parking lot which is part and parcel of the parking lot. Petitioner's fall occurred in the course of her employment.

B. Arising Out of

Petitioner is also required to establish her injury "arose out of" her employment. "'Arising out of' the employment refers to the origin or cause of a claimant's injury. [citation omitted]. For an injury caused by a fall to arise out of employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment. [citation omitted]." *Suter v. The Illinois Workers' Compensation Commission*, 2013 IL App (4th) 130049WC, ¶39. Further, "slips or falls on an employer-provided lot when hazardous conditions are present are generally compensable. [citations omitted]." *Morse-Harvey v. The Industrial Commission*, 345 Ill. App. 3d 1034, 1038, 804 N.E.2d 1086 (2004). Petitioner testified she slipped and fell on ice and snow. T. 21. Snow and/or ice is a hazardous condition. The existence of the hazardous condition renders the risk an employment risk. Petitioner's fall arose out of her employment.

For the reasons stated above, I concur with the decision reached by the majority as it relates to accident and concur with the decision reached by the majority on the remaining issues.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARKUSSON, DEBORAH
Employee/Petitioner

Case# **14WC010822**

ILLINOIS STATE FIRE MARSHALL
Employer/Respondent

18IWCC0691

On 1/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1189 WOLTER BEEMAN LYNCH & ET AL
BRENT A BEEMAN
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SPRINGFIELD, IL 62703

0499 CMS RISK MANAGEMENT
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SPRINGFIELD, IL 62794-9208

0988 ASSISTANT ATTORNEY GENERAL
JORDAN D HOMER
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

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

JAN 19 2017

RICHARD J. PARRILLO, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0691

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

Deborah Markusson
Employee/Petitioner

v.

Illinois State Fire Marshall
Employer/Respondent

Case # 14 WC 010822

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **November 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 _____

FINDINGS

On **February 14, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$46,013.00**; the average weekly wage was **$884.87**.

On the date of accident, Petitioner was **45** 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 **$n/a** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$n/a**.

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

ORDER

Petitioner failed to prove she sustained an accident on February 14, 2014 that arose out of and in the course of her employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

January 13, 2017
Date

JAN 19 2017

Findings of Fact and Conclusions of Law

The Arbitrator finds:

The medical records show that Petitioner treated for left knee pain beginning in April of 2013. On April 15, 2013 Petitioner presented to Dr. Varney regarding pain and grinding in her left knee of two weeks duration. Petitioner reported her knee was more painful when sitting and lying down. She could recall no injury but felt the onset was acute. Petitioner also reported occasional joint swelling in the knee and that her leg had bucked twice in the preceding week bringing tears to her eyes. Ibuprofen was providing no relief. On examination Petitioner had medial and lateral joint line pain with positive patella straight leg raising with knee flexed and in extension with crepitus. Imaging studies taken that day showed mild osteoarthritis of the medial compartment. Dr. Varney's impression was that of left knee pain and a medial meniscus tear. He referred Petitioner to an orthopedist. (RX 3)

On April 18, 2013, pending her appointment with the orthopedist, Petitioner telephoned Dr. Varney's office requesting advice as to what to do with her knee as it didn't feel stable. Dr. Varney's office contacted the orthopedist's office and was told they usually recommended a knee brace but without seeing it first it was hard to recommend it. Dr. Varney issued a script for a brace. (RX 3)

On May 14, 2013 Petitioner presented to Dr. Saadiq El-Amin's office and was examined by his Physician's Assistant, Patty Lacy, for knee pain, swelling, and instability. Petitioner advised Ms. Lacy that her left knee pain had started six weeks earlier after a fall down the stairs of her camper. She was seen by Dr. Varney a week later after concluding her vacation. Petitioner reported two episodes of her knee twisting and giving out. In the past, she had been a professional dancer. Petitioner described her pain as "2/10" and "achy." An MRI was ordered along with physical therapy. (RX 3)

Petitioner began physical therapy on May 16, 2013. (RX 3)

Petitioner's left knee MRI was taken on June 10, 2013 and revealed cartilage irregularity and deep cartilage tears involving the weight bearing surface of the medial femoral condyle, mild chondromalacia of the patella, and lobulated fluid collecting deep to the region of the pes anserine tendons most likely representing a ganglion cyst or pes anserine bursitis. (RX 3)

Petitioner followed up with P.A. Lacy on June 18, 2013 reporting that the physical therapy had done very little and she was still experiencing a constant ache in her knee with no other changes in her symptoms being reported. On exam her left knee was mildly swollen and she had pain with palpation of the lateral and medial joint lines. Petitioner also had a positive McMurray's on the lateral meniscus. They reviewed Petitioner's MRI and Petitioner's diagnoses of a lateral meniscus tear, osteoarthritis with deep cartilage tear and cartilage loss of the medial femoral condyle weight bearing surface, mild chondromalacia of the patella, and a possible ganglion cyst or pes anserine bursitis. Ms. Lacy referred Petitioner to Dr. El-Amin for a surgical consultation which took place on August 8, 2013. By the time of that visit Petitioner was reporting pain going up and down stairs along with any type of activity. He recommended an arthroscopic lateral and medial partial meniscectomy as well as a shaving chondroplasty. (RX 3)

On August 28, 2013 Petitioner underwent a left knee partial medial meniscectomy, shaving chondroplasty and plica removal. Physical therapy followed and at the initial evaluation Petitioner expressed disappointment that she would most likely need to undergo another knee surgery due to intra-operative findings of an ACL tear. She further noted that since her surgery she had been experiencing instability in her knee causing minor falls around her home, even with use of a brace. (RX 3)

Petitioner followed up with Dr. El-Amin on October 24, 2013 having undergone six weeks of physical therapy for quadriceps strengthening. Petitioner reported increased buckling on almost a daily basis and the inability to engage in daily activities or activities with her sons. Petitioner reported feeling strong in her knee but she still had medial joint line tenderness and wished to be re-evaluated and considered for an ACL reconstruction. Dr. El-Amin noted that a partial ACL tear was found intra-operatively and he felt Petitioner was an ideal candidate for a hamstring autograft. As her job involved sitting down, the doctor felt she could return to work in about a week. (RX 3)

Petitioner underwent a left arthroscopic ACL reconstruction with a hamstring graft on November 27, 2013. Thereafter she followed up with the doctor's office and eventually began physical therapy. At the time of the initial exam on December 30 2013 she reported gait impairment, edema and loss of lower extremity range of motion. When Dr. El-Amin examined her on January 16, 2014 she was described as doing well with no complications or issues. Her strength was noted to be 3.5/5. Dr. El-Amin advised Petitioner to discontinue her long brace, continue with therapy and return in six weeks. According to the physical therapy note of February 4, 2014 Petitioner was showing good range of motion, performing daily stretching at home and still experiencing some limitation by pain symptoms lateral to the patellar tendon and posterior knee. She had a mildly antalgic gait but didn't need an assistive device or brace. Petitioner was still using ice and massage on her knee and limiting her activities based upon her pain level. She was wearing a "Cho-Pat" on her patella tendon. Therapy was to continued. (RX 3)

On February 14, 2014 Petitioner notified Respondent of an accident occurring that same day. (RX 4) According to the Tristar Workers' Compensation Employee's Notice of Injury form Petitioner slipped on snow and ice and fell on the walkway between the parking lot and the front office door. (See also RX 5) In a Witness Statement Kensie Proctor wrote that she was sitting at the front desk watching the security cameras as people walked through the lot and she watched as Petitioner walked, slipped and fell in the snow and ice. She and Jim Boone went outside to help Petitioner get back up. (RX 6)

On February 14, 2014 Petitioner telephoned Dr. El-Amin's office advising the staff that she had undergone surgery before Thanksgiving and had slipped on ice earlier that morning and bent her knee back underneath her. Petitioner reported pain and swelling and wished to see the doctor. An appointment was scheduled for February 20th. (PX 4)

Petitioner presented to Dr. El-Amin on February 20, 2014 reporting that she had been doing well after her ACL reconstruction but had fallen on ice at work resulting in a hyperflexion injury to her left knee. Her complaints included mild pain over the medial and lateral joint line with some mild buckling. She had full range of motion but some mild laxity on Lachman examination. X-rays taken of Petitioner's left knee on February 20, 2014 revealed small suprapatellar joint effusion similar to that shown on prior examination. No acute osseous abnormality was seen. (PX 4) Dr. El-Amin suspected a partial ACL tear and a lateral or medial meniscal tear. An MRI was ordered. (PX 4)

Petitioner's MRI was taken on March 6, 2014 and revealed the following: anterior convexity of the anterior and inferior fibers of the ACL graft (which itself remained intact); moderate chondromalacia over the inferior aspect of the lateral patellar facet; subcortical fracture within the anterior and mid aspect of the lateral femoral condyle; increased T2 signal within the lateral femoral condyle which could be related to the recent chondral fracture or the recent surgical intervention or represent a contusion in the setting of trauma; and moderate joint effusion. The radiologist also noted that the anterior convexity could be related to laxity or potentially some degree of fibrosis or scarring. (PX 4)

Petitioner followed up with Dr. El-Amin on March 20, 2014. In his notes he described Petitioner has being four months out from her left ACL reconstruction followed by a fall on the ice on February 14th. Petitioner was reporting multiple falls since "that time" with continued locking of her knee upon extreme flexion and associated popping and instability. On examination the doctor noted on increased laxity with the locking anterior drawer test on the left but she was tender to palpation along the lateral joint line with effusion. Dr. El-Amin interpreted the MRI as showing a root avulsion of the lateral meniscus with a contusion of the left lateral femoral condyle for which he recommended a repair. Dr. El-Amin wrote, "We would like to mention that this injury did not occur on the same side as her previous injury that was work related." Petitioner was planning a trip to New Zealand in June and wished to proceed with surgery as soon as possible to allow for a recovery which would include six weeks of being non-weight bearing. (PX 4)

On March 20, 2014, Petitioner signed her Application for Adjustment of Claim herein alleging she injured her left knee in a fall on February 14, 2014. Specifically, Petitioner alleged a fracture and torn meniscus. (AX 2)

Petitioner underwent a left knee arthroscopy on April 2, 2014. At that time she underwent a chondroplasty and synovectomy. No meniscal tears were noted. Following the surgery, Petitioner was off work until April 29, 2014. (PX 4)

On June 6, 2014 Petitioner telephoned Dr. El-Amin's office reporting a problem with her knee cap as it would "catch and try to roll" when she straightened it. (PX 4)

On June 12, 2014 Petitioner was examined by Dr. El-Amin and he descried her procedure as showing grade ¾ chondromalacia as well as tri-compartmental arthritis. He noted she was doing well with full range of motion but weakness in her quads. She was to continue with the brace and therapy and return in six weeks. The doctor also cleared her to fly internationally. (PX 4)

Petitioner followed up with the doctor on July 24, 2014 and described her as doing well. She reported an occasional buckle, overall weakness, and some mild lateral subluxation of the patella but, otherwise, functioning well. No other complaints were noted. Therapy was to continue. (PX 4)

Dr. El-Amin re-examined Petitioner on September 4, 2014 noting no tenderness, full range of motion, no atrophy and a negative Lachman. He described her as doing "extremely well" and felt she was probably at maximum medical improvement; however, he wished to have her undergo an FCE to confirm no long-term problems.

The Functional Capacity Evaluation ("FCE") was performed on September 12, 2014, the results of which indicated that Petitioner was able to perform work in the medium work classification with a safe maximum lift from the floor to the knuckle of 50 pounds. (PX 4) Petitioner was also able to demonstrate the ability to perform constant sitting and fine manipulation with occasional stooping, squatting, stair climbing and overhead reaching. (PX 4, 5)

Petitioner returned to see Dr. El-Amin on October 2, 2014. He noted that she was still having some pain along her lateral posterior horn of her meniscus and, as such, he was concerned about the FCE results. He started her on Celebrex for thirty days and if there was no improvement, he wished for her to undergo another MRI. (PX 4)

The MRI performed on October 17, 2014 revealed osteoarthritic changes increased in severity, knee effusion, decreased marrow edema of the lateral femoral condyle, and small meniscal tears. (PX 4)

Petitioner followed up with Dr. El-Amin on December 1, 2014 and reported ongoing significant pain and instability of her left knee. The doctor believed she had torn her anterolateral meniscus and, possibly, her ACL. She had failed physical therapy and injections and felt she should undergo an ACL reconstruction and possible lateral partial meniscectomy. (PX 4)

Dr. El-Amin performed a left knee ACL revision, arthroscopic shaving chondroplasty, and partial medial meniscectomy on January 14, 2015. (PX 4) As of January 29, 2015 she was doing extremely well with no complications or issues. Physical therapy was ordered. As of February 12, 2015 Dr. El-Amin recorded that Petitioner was experiencing some left knee soreness and discomfort which he felt was normal given the surgery. She was being compliant with wearing her brace which the doctor discontinued at that point. She was to continue with therapy. (PX 4)

When Petitioner returned to see Dr. El-Amin on April 2, 2015 she reporting doing fairly well and feeling the best she had ever felt. She had full active and passive knee extension and was ligamentously stable to Lachman examination testing. She was to return in ten weeks. (PX 4)

From this surgery, Petitioner was off work from January 14, 2015, through February 2, 2015. (RX 2) During this period, Petitioner again used comp time for the majority of the time except January 16, a state holiday for which holiday time was used. As such, Petitioner received her full pay during this time and did not use earned benefit time, such as sick or vacation time. Petitioner then attended 10 physical therapy sessions over the course of 11 weeks. (PX 5) Dr. El-Amin again placed Petitioner at MMI on June 11, 2015, and ordered a second FCE. (PX 4) The results of the second FCE were that Petitioner, again, demonstrated the ability to perform work in the medium work classification, including occasional stooping, squatting and overhead reaching. (PX 4, 5) Petitioner last presented to Dr. El-Amin for treatment for her left knee in June 2015. (PX dep. p. 28)

On March 16, 2016 Petitioner presented to Dr. Romanelli at the Orthopedic Center of Illinois complaining of left knee symptoms described as dull and aching and exacerbated by knee movement, weight bearing, walking and stair climbing. Petitioner gave a history of multiple surgeries to the knee including two meniscectomies in 2013 and 2014. She was also told that while her MRI at that time showed a normal ACL the doctor advised her after the August of 2013 surgery that she had partial tearing of her ACL and needed a reconstruction which was performed in November of 2013. She then fell on

February 14, 2014 and tore her ACL with a subsequent surgery being performed and ongoing pain since the last surgery. Petitioner was noted to be walking with a mild antalgic gait. Her right knee had a valgus deformity and grade 2 effusion on the right. Her left knee also had a valgus deformity and a grade 2 effusion. Petitioner's left knee showed some apprehension around the knee and tenderness at the medial lateral joint line but the doctor couldn't say she had a true meniscus tear as she displayed a lot of guarding and discomfort. Dr. Romanelli wrote:

> At this point in time there is some questions about this case. I am a little concerned because she states that the ACL was normal on the MRI pre-operatively but then intra-operatively Dr. El-Amin saw meniscus tear and stated she had a problem with the ACL. After that he performed an ACL reconstruction. Apparently she had some trouble with this ACL reconstruction and ended up falling which resulted in her having to have a Revision ACL reconstruction. She never really got better from the surgery. Since all the surgeries she has gained a lot of weight and she now feels her knee is unstable he [sic] when she gets in and out of the chair at work. She works as a secretary. She has stiffness and discomfort in the knee. She has pain and discomfort that [the doctor] cannot really put [his] finger on at this point in time. (PX 7)

Dr. Romanelli recommended an MRI. On April 8, 2016 he injected her left knee. At that time she also had the doctor examine her right knee as it had been painful for the preceding three weeks. Petitioner's diagnosis for the left knee was osteoarthritis. The right knee had good range of motion and no evidence of swelling. When Petitioner returned on May 6, 2016 she reported that the injection really made a world of difference. She was taking Mobic and had lost twenty pounds. She further reported that the bilateral knee swelling had improved and she hadn't felt this good in quite some time. He recommended some therapy and home exercises. As of June 3, 2016 Petitioner's knee were feeling stronger and she reported good days and bad days and ongoing catching but it wasn't painful. Dr. Romanelli noted that he was glad she was feeling better as she was "way to[sic] young" for knee replacements. She needed to continue with strengthening and aquatic exercises. He also suggested Viscosupplement injections rather than cortisone ones with consideration being given to trying one before Petitioner left on a month long trip to Australia in December. (PX 7)

Petitioner presented for physical therapy on April 22, 2016 at Midwest Rehab. She reported originally slipping and falling on the ice injuring her left knee and undergoing a partial meniscectomy in August of 2013 during which time the doctor saw a partial ACL tear for which she underwent reconstruction in November of 2013. She then had another fall in February of 2014 and tore the other meniscus and had surgery in April of 2014 followed by a second ACL reconstruction in January of 2015. She was doing well and was released in October of 2015 but noted increased aching, popping and grinding in December of 2015. She had received a cortisone injection the week before and the pain was better but she still had lots of creaking, popping, and "carrying on." Her range of motion was noted to be within functional limits and she didn't demonstrate significant ligamentous laxity but ongoing pain and mild weakness was noted. Petitioner was to undergo therapy twice a week for four weeks. (PX 7)

The deposition of Dr. El-Amin was taken on June 7, 2016. (PX 2) Dr. El-Amin testified that he is an orthopedic surgeon presently practicing in the Atlanta, Georgia area. Dr. El-Amin testified that he initially examined Petitioner on February 20, 2014 after her February 14, 2014 accident. He acknowledged having treated her before February 14, 2014 as he had performed surgery on her left knee on September 12, 2013 in the form of a meniscectomy and a left ACL reconstruction on November 27, 2013. (PX 2, pp. 1 – 8)

Dr. El-Amin testified that when he saw Petitioner on February 20, 2014 he took a history wherein she reported having been doing well, heading to work that day and falling on ice sustaining a hyperflexion injury to her left knee. Petitioner's complaints included pain on both the inside and outside of her knee and some buckling (ie., giving out). Dr. El-Amin testified consistent with his office notes regarding his examination explaining that he was concerned and worried that Petitioner had re-torn her ACL, stretched it out, or suffered an injury to her meniscus. He ordered a second MRI that showed a re-injury to her knee in that there was laxity of the graft or fibrosis and scarring of her ACL. She also had a bone bruise and a subcortical fracture within the anterior and mid aspect of her lateral femoral condyle which is usually indicative of an ACL injury or hyperflexion and twisting injury and bone contusion. He recommended surgery.

Dr. El-Amin testified that his office note of March 20, 2014 contained a typographical error as he stated that her re-injury did not occur on the same side as her previous injury that was work-related. He further testified that he believed she suffered a new injury because the MRI signaled a new injury as the T/2 signal was increased in the lateral femoral condyle which "could" be related to a recent condyle fracture or a recent surgical intervention or intrusion from a trauma. He also noted that her exam demonstrated increased laxity compared to the previous examination. Dr. El-Amin further added that something had happened because Petitioner was ready to return to work in November of 2013. (PX 2, pp. 8 – 13)

Dr. El-Amin further testified that they proceeded with surgery on April 2, 2014 and performed a left knee arthroscopy with a shaving chondroplasty and a synovectomy. While the operative report (dictated by a resident) wasn't as thorough as he would have liked, they did find an injury to the meniscus and some laxity in the graft. Petitioner was taken off work as of April 2, 2014. Post-operatively Petitioner underwent physical therapy. Dr. El-Amin further testified that he did not exam her on June 12, 2014 but she was seen in the clinic. He then re-examined her on July 24, 2014 at which time he noted she had not yet gone back to her original state before her fall. Her ACL remained dysfunctional and he recommended ongoing physical therapy. At the time of their next visit on September 4, 2014 he recommended an FCE. As of the next visit on October 2, 2014 Dr. El-Amin noted ongoing pain along the lateral horn of her meniscus. The FCE showed she could work at a medium level. As of December 4, 2014 she had undergone another MRI which showed knee effusion and some small meniscal tears. The ACL grafts were unchanged and the femoral condyle edema was decreased and minimal. Since he suspected some meniscus pathology he recommended an injection. (PX 2, pp. 13 – 22)

Dr. El-Amin testified that the findings of December 4, 2014 were related to the February 14, 2014 accident because Petitioner never got better. By the December appointment, the doctor felt Petitioner needed an ACL reconstruction because she had failed conservative treatment including injections and bracing. She had gone through physical therapy but the FCE indicated she wasn't back to where she had been and she still complained of knee buckling and give-away. That surgery was performed on January 14, 2015 and involved trimming up the meniscus, shaving the cartilage defect and performing the ACL reconstruction. She was off work from January 14, 2015 through February 2, 2015. Petitioner again underwent physical therapy and as of June 11, 2015, six months post-reconstruction, she was working with a personal trainer and trying to regain strength in her lower extremity. He again sent her for an FCE which showed she could work in a medium work capacity with a safe maximum lift of fifty pounds from the floor. He placed her at maximum medical improvement. (PX 2, pp. 22 – 29)

Dr. El-Amin also testified that he saw Petitioner for some bilateral ankle and Achilles tendinitis problems unrelated to her work injury. Dr. El-Amin was of the opinion that Petitioner suffered an injury on February 14, 2014 involving her ACL, meniscus, and medial and lateral condyles. He was further of the opinion that the work injury of February 14, 2014 caused the ill condition of Petitioner's knee and necessitated the treatment he provided up through June of 2015. He also felt her time off work while he treated her was due to the work injury of February 14, 2014. When asked about any permanent disability, Dr. El-Amin testified that "anytime you sustain an injury to the knee, you don't know what the long-term effects are....You know that you can get arthritis – what they call traumatic arthritis. You don't know exactly at what rate and how fast....But if she has arthritis or her knee develops arthritis five, six years, or seven years from now, then that would be associated or that will happen a lot faster than in someone who did not have an injury." (PX 2, pp. 29, 33) He did not anticipate that she would need any medical treatment in the future. He hoped he had done a good enough job that she would be okay but "that's not to be determined yet." (PX 2, pp. 29 – 34)

On cross-examination Dr. El-Amin was asked if he knew what the mechanism of injury for Petitioner's prior left knee injuries were and he didn't know. He did not have any records from prior to February 14, 2014 with him at the time of the deposition as he was no longer with SIU and couldn't access them. When asked "So would you be able to answer whether you treated [Petitioner] for any injuries caused by falling prior to February 14, 2014?" he replied, "No." (PX 2, p. 35) When asked if he was still treating Petitioner on February 13, 2014 the day before her accident, he testified, "Well, yes. I mean, anytime you do an ACL, you ...follow them. You usually see them yearly, unless you sign off on them." (PX 2, pp. 35-36) He wasn't seeing her on a regular basis but she was still under his care. It was his understanding that she was ready to go back to work prior to the February 14, 2014 accident. (PX 2, p. 36)

Dr. El-Amin was asked if the increased signal on the March 2014 MRI could have been from the 2013 reconstruction surgery and he replied, "Typically – it could be, but, typically, it's not, because at that point.. at that point, usually the bone bruises on MRIs only last about three months" and her ACL reconstruction was way before then so it's less likely. How much time one spends in physical therapy after an ACL reconstruction depends upon what insurance will cover. He usually recommends it up until nine months or they're ready to go back. Patients often have to transition to a home therapy program because of the expense. Therefore, patients usually go to therapy for 2 to 5 months and then proceed with a home exercise program. (PX 2, p. 38)

On redirect examination Dr. El-Amin testified to have an independent recollection of Petitioner as he had just seen her five months earlier at Sonic. He also testified that she was absolutely doing better before February 14, 2014 as he usually doesn't send people back to work unless they're doing well. He further testified that none of the questions posed to him on cr0ss-examination would cause him to change his earlier opinions. (PX 2, p. 40)

Petitioner returned to see Dr. Romanelli on July 8, 2016 at which time she received bilateral knee injections as the doctor felt Petitioner had early bilateral osteoarthritis. She returned on July 15, 2016 for a second set of injections. Another set was given bilaterally on July 22, 2016.

Petitioner's case proceeded to arbitration on November 15, 2016. The issues in dispute were accident, causal connection, medical bills, temporary total disability benefits, and the nature and extent of any injury. At the time of the hearing the attorneys for both parties agreed that Respondent could submit an exhibit post-hearing pertaining to the amount of medical bills that had been paid by Respondent. The exhibit was tendered thereafter, marked as "RX 7" and has been included as part of the record. Witnesses testifying at the hearing included: Petitioner; Ronnie Wickenhauser; Jodi Schrage; and Kensie Proctor.

Petitioner testified that she works for Respondent as an office associate. Petitioner's duties were clerical in nature. She worked from 7:30 a.m. to 5:00 p.m. Petitioner recalled that on the morning of February 14, 2014 there had been a lot of snow and ice accumulating overnight. That morning, as she left her apartment, she fell on her back side. She denied injuring her knee at all at that time. Petitioner testified that she went back in and changed her clothes and proceeded to go to work after notifying her supervisor she'd be late.

Petitioner testified that Respondent has certain rules for parking and employees are not allowed to park in the visitor spots. Rather, they are to park in an area somewhat further from the building. Petitioner testified that she arrived at work between 8:00 and 8:30 in the morning. She testified that the general public usually doesn't come into the building before 8:30 as the receptionist is normally on duty from that time through 5:00 p.m. As Petitioner walked into work she was right outside the main doors of the building when she went down really fast and her left leg was twisted up underneath her back side. Kensie Proctor and Jim Boone came to her assistance.

Petitioner testified that the parking lot was covered in snow and there was ice underneath it that couldn't be seen. It was very slippery and had not yet been plowed or anything. After she fell the Deputy Director put ice melt on the area. Due to parking rules, Petitioner had to walk a greater distance into the building than a visitor would have to do. After the accident Petitioner went inside and called her doctor.

On cross-examination Petitioner testified that she was not in a hurry as she approached the building and she was not carrying any work materials. Petitioner testified that the sidewalk where she fell was covered in snow and ice.

Ronnie Wickenhauser testified on behalf of Petitioner. He is married to Petitioner and was Chief Fiscal Officer for Respondent at the time of the accident. Currently, he is Chief Administrative Officer and Chief Fiscal officer. Mr. Wickenhauser testified that Petitioner fell twice on February 14, 2014 – once at home and then at work. Mr. Wickenhauser witnessed the fall at home and saw her walking out of the apartment door and she fell backwards on her body in the snow. She did not complain about a twisting injury and her legs did not twist when she fell. Rather, she fell straight back onto her rear end. After falling, she went inside, changed clothes, and left to go to work.

Mr. Wickenhauser reported to work on the 14th at about 9:00 a.m., entering through the same door Petitioner had used earlier in the day. He noticed the area had been de-iced and shoveled by the time he arrived. The parking lot, however, was still a sheet of ice as Mr. Wickenhauser, himself, had slipped when getting out of his car. Mr. Wickenhauser also agreed that employees must traverse a farther distance into the building than visitors because they are required to park in a different location.

On cross-examination Mr. Wickenhauser testified that Charles Robbins owns the property where Respondent's facility is located and it is leased from him. He did not believe that the State of Illinois was

responsible for maintaining the parking lot. On redirect examination Mr. Wickenhauser testified that during the winter a bucket of salt is usually kept inside the building and they will spread it themselves if needed. He believed that Jim Boone spread the salt.

Jodi Schrage testified on behalf of Respondent. She is employed by Respondent. Ms. Schrage testified that Respondent's building is leased by Charles Robbins Realtor and Mr. Robbins is in charge of snow and ice removal. Ms. Schrage further testified that both employees and members of the general public can use the same parking lot. There are also parking lots in the back of the building that some employees use and then enter from a different door. The entrance used by Petitioner was also the one used by the general public.

On cross-examination Ms. Schrage testified that visitors can really park wherever they wish but employees are not supposed to park in the visitor parking.

Kensie Proctor testified on behalf of Respondent. She is an office assistant for Respondent and was working at the front desk in the receptionist area when Petitioner fell. She saw it happen on a monitor and went out to help Petitioner. She described the weather that morning as "wintery" but didn't know how much snow had accumulated and she thought the parking lot had been plowed. The area where Petitioner fell would have been shoveled.

The Arbitrator concludes:

C. Did an accident occur on February 14, 2014 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove that she sustained an accident on February 14, 2014 that arose out of her employment with Respondent.

An injury "arises out of" employment only when there is some risk connected with, or incidental to, Petitioner's employment so as to create a causal connection between the employment and the accidental injury. *Jewel Cos. V. Industrial Comm'n, 57 Ill.2d 38, 40, 310 N.E.2d 12; Chmelik v. Vana (1964), 31 Ill.2d 272, 277, 201 N.E.2d 434 (1974).* Often, such a nexus exists when an employee performs acts as instructed by the employer, when the employee had a common law or statutory duty to perform an act, or when the employee might reasonably be expected to perform an act within the scope of her duties. *Howell Tractor & Equipment Co. v. Industrial Comm'n, 78 Ill.2d 567, 573, 38 Ill.Dec. 127, 403, N.E.2d 215 (1980.* A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling her duties. *Fisher Body Division, General Motors Corp. v. Industrial Comm'n, 40 Ill.2d 514, 516, 240, N.E.2d 694 (1968).* "If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of [her] employment." *Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d. 52, 58, 541N.E.2d 665, 667 (1989).* With specific regard to falls on icy parking lots, *Bays v. Birmingham Steel Corp*, is particularly instructive. *01 I.I.C. 03.74 (Ill. Indus. Com'n), 99 Il. W.C. 35213, 2001 WL 952690 (2001).* There, the Commission noted:

> Unless there is some evidence to show that the employment presented a risk or increased the risk, i.e. an employer's parking lot was somehow defective, such as in the case of pot holes, parking bumpers, etc., then such conditions are not

"risks" of the employment and injuries sustained from such general weather conditions should not be held compensable. Moreover, the Commission observes that general weather conditions, such as rain, ice, snow, etc. are not under an employer's control, unless the employer somehow contributes to the risk, such as improper or defective show and/or ice removal.

Petitioner fell while walking into work on February 14, 2014. She was on a sidewalk outside the entrance to the building when she slipped on ice and snow and fell. The sidewalk where she fell was open to the public as the public generally used the door Petitioner used to enter the building. She did not fall in the parking lot. The property where Petitioner fell was not owned by Respondent nor was it responsible for ice/snow removal.

In the present case, the mechanism of Petitioner's fall was the icy sidewalk. None of the witnesses at trial observed any defects of the sidewalk or abutting driveway. Petitioner slipped as a result of a natural accumulation of ice and snow, for which Respondent did not have any control. Moreover, the Arbitrator notes that any person in Illinois is, at one point or another, subject to the perils of an icy walkway. That Petitioner encountered an icy walkway while walking into work does not increase such a risk or separate her from the general public. In fact, the fall at work was not the first encounter with an icy walkway Petitioner had on February 14, 2014. That she fell at home earlier in the morning shows she was equally exposed to the risk of encountering ice apart from her work.

Petitioner argued several times at trial that the timing of her fall and the placement of ice melt/salt indicated that Petitioner faced a greater risk than members of the general public. The Arbitrator does not find this argument compelling for several reasons. First, Petitioner testified she arrived to work at approximately 8:00 a.m. However, the notice of injury documents and witness testimony indicate that the fall occurred closer to 8:30 a.m. Moreover, Petitioner testified that the building opened to the public when a receptionist staffed the front desk so as to sign them into the building. Ms. Proctor was that staff person on the date Petitioner fell and she was at her post at the time Petitioner fell, thereby suggesting that Respondent was open to the public when Petitioner fell. Second, the time difference between Petitioner's fall and Respondent being open to the public was negligible. While the building was generally open to the public at approximately 8:30 a.m. does not mean that the public would not encounter the entry way until exactly 8:30 a.m.

Furthermore, while Mr. Boone may have gone outside the building after Petitioner's fall and spread salt/icy melt on the area where Petitioner fell, that does not necessarily mean Petitioner was at an increased risk when she fell. Mr. Boone's actions seemed reasonable in light of what had occurred. Mr. Wickenhauser testified that a bucket of salt was usually kept inside the building for use if needed. He did not state that any of Respondent's employees (such as Mr. Boone) were mandated or required to salt the sidewalk in bad weather. Petitioner's fall occurred on property leased to Respondent. Charles Robbins Realty was the party responsible for ice and snow removal. The Arbitrator does not find that the presence of a bag of ice melt, available to Respondent's employees for sporadic spreading, if needed, establishes that the entryway/sidewalk where Petitioner fell was under the care, maintenance and control of Respondent.

For an injury to arise out of one's employment the employment must subject one to an increased risk beyond that of the general public. The mere fact Petitioner herein was on the sidewalk because of her

job doesn't prove her injury arose out of her employment. Illinois has not adopted the positional risk doctrine. Petitioner's claim for compensation is denied.

F. Is Petitioner's current condition of ill-being causally related to the injury?
J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. What temporary benefits (TTD) are in dispute?
L. What is the nature and extent of the injury?

Given the Arbitrator's determination on accident, these remaining issues are moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL H. HALL,

Petitioner,

vs.

NO: 14 WC 12521

STATE OF ILLINOIS, CMS,

18IWCC0692

Respondent.

DECISION AND OPINION ON REVIEW

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

Respondent contends the permanence award is excessive. Rather than addressing the particulars of the Arbitrator's analysis, Respondent cites Section 19(e) and argues the Arbitrator "deviated from his recent awards in similar cases, ordering two times more than previous decisions, and thus frustrating the statutory purposes of the Act." Respondent's Statement of Exceptions, p. 6. There are two fatal flaws with Respondent's argument: 1) it misconstrues the language of Section 19(e), and 2) it ignores Section 8.1b.

Section 19(e) states, in pertinent part, "Decisions rendered by the Commission and dissents, if any, shall be published together by the Commission. The conclusions of law set out in such decisions shall be regarded as precedents by arbitrators for the purpose of achieving a more uniform administration of this Act." *820 ILCS 305/19(e)* (Emphasis added). The extent of a claimant's permanent partial disability is not a conclusion of law; rather, the determination of the extent or permanency of an employee's disability is a question of fact to be made by the Commission. *Amoco Oil Co. v. Industrial Commission*, 218 Ill. App. 3d 737, 748, 578 N.E.2d

1043 (1991). Section 19(e) does not bind an arbitrator to his/her prior permanence awards, and Respondent's interpretation of it as such runs afoul of the mandate in Section 8.1b of the Act.

For injuries occurring on or after September 1, 2011, as herein, Section 8.1b sets forth how "permanent partial disability shall be established" (*820 ILCS 305/8.1b*); "It lists five factors upon which the Commission must base its determination of the level of PPD benefits to which a claimant is entitled, including (1) the level of impairment contained within a PPD impairment report, (2) the claimant's occupation, (3) the claimant's age at the time of injury, (4) the claimant's future earning capacity, and (5) evidence of disability corroborated by the treating medical records." *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶46, 56 N.E.3d 1101. The analysis required by §8.1b is precisely what the Arbitrator executed. Nonetheless, while we do not find Respondent's argument persuasive, we do view the evidence regarding permanent disability differently than the Arbitrator.

Section 8.1b(b)(i) – §8.1b(a) impairment report

Neither party submitted a §8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits (*Corn Belt Energy Corp.*, 2016 IL App (3d) 150311WC, ¶47), the Commission will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner worked as an auto repair technician. The record evidences this position requires regularly lifting up to 100 pounds. Following his injury, Petitioner resumed his normal job on an unrestricted basis and continued in that position until April 2015, when he elected to transfer to a new position with the State. Petitioner testified his job change was necessitated by his pain, but no physician has deviated from the release to unrestricted duty. Certainly Dr. Smucker provided the nebulous instruction to "avoid activities that cause or worsen the pain," but we emphasize the doctor declined to impose any specific restrictions. PX6. The Commission finds the full duty release to his physically demanding pre-accident position is significant and weighs heavily in favor of decreased permanent disability.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 48 years old on the date of his accidental injury. The Commission finds Petitioner is well past middle age and will therefore face any residual disability for a shorter period. The Commission finds this factor weighs in favor of decreased permanent disability.

Section 8.1b(b)(iv) - future earning capacity

There is no evidence Petitioner's future earning capacity is diminished as a result of his work accident. Petitioner obtained a new position with the State and testified his earnings have increased approximately $700 per month. T. 36. The Commission finds this weighs in favor of reduced permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner underwent a fairly extensive course of conservative care including multiple rounds of therapy, two epidural steroid injections, and a facet injection procedure. As of October 3, 2016, Petitioner was "significantly" improved following the facet injection, but Dr. Dave suggested further intervention would be considered when recurring symptoms warranted. PX18.

Petitioner testified he has ongoing pain episodes, the intensity of which depend on the activity level involved. T. 32. The Commission finds Petitioner's testimony is consistent with the medical records which document the treating physicians' diagnoses of chronic thoracic pain. We also note Dr. O'Leary, Respondent's Section 12 examiner, opined Petitioner's condition "is almost certainly something that is likely to be chronic." RX2. The Commission finds this factor weighs in favor of increased permanent disability.

Based on the above, the Commission finds Petitioner sustained a 6% loss of use of the person as a whole under Section 8(d)2. Petitioner's PPD rate as calculated pursuant to §8(b)2.1 is $817.06 ($1,361.77 x 60% = $817.06); this, however, exceeds the statutory maximum for Petitioner's date of accident which is $721.66. Therefore, the Commission finds Respondent shall pay to Petitioner $721.66 per week for a period of 30 weeks.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 30 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 6% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $24,909.18 for medical expenses under §§8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

18IWCC0692

DATED:

NOV 9 - 2018

LEC/mck

O: 9/11/18

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HALL, MICHAEL
Employee/Petitioner

Case# **14WC012521**

STATE OF ILLINOIS CMS
Employer/Respondent

18IWCC0692

On 12/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% 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:

0352 LaMARCA LAW OFFICE PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4993 ASSISTANT ATTORNEY GENERAL
CHELSEA GRUBB
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

DEC 6 - 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Hall
Employee/Petitioner

v.

State of Illinois, CMS
Employer/Respondent

Case # 14 WC 12521

Consolidated cases: None

18IWCC0692

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **October 23, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 6, 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 $**51,724.52**; the average weekly wage was $**1,361.77**.

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

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services of $24,909.18, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

11/30/2017
Date

Michael Hall v. State of Illinois, CMS
14 WC 12521

Statement of Facts

Petitioner testified at the time of his injury he was employed by the State of Illinois, CMS, Division of Vehicles and that he is currently employed by the Department of Corrections. Petitioner testified he had been employed by CMS for seven years. Petitioner testified he was employed by CMS as an Automotive Repair Technician. He was responsible for repairing cars and light trucks. Petitioner was located at the State garage at 200 East Ash Street in Springfield.

At the time of his accident Petitioner testified he was replacing an accuator motor on a Chevrolet Impala located under the dashboard. In order to access the motor Petitioner had to lay in an awkward position with his head on the floor of the vehicle and his arms above his head reaching behind the dashboard. While performing this task Petitioner testified, "...when I went to sit up, there was a very awful pain in my back starting about between my shoulder blades and going down on either side of my spine."

After attempting to alleviate the pain by standing up and walking around and stretching, Petitioner completed the task of removing the motor from the vehicle and reported the accident to his boss. When asked exactly where the pain was located, Petitioner testified it was towards the bottom of his shoulder blades and in his back area.

Petitioner testified when his symptoms did not improve he sought medical care from Springfield Clinic Prompt Care. He then saw his family doctor, Dr. Pittman a week later. Petitioner testified Dr. Pittman took him off work and prescribed several medications including Skelaxin and Vicodin. After a period of time Dr. Pittman recommended physical therapy. However, it was not initially approved by workers' comp. Dr. Pittman also referred Petitioner to Dr. Pineda for an orthopedic evaluation. Dr. Pineda ordered an MRI of Petitioner's spine.

Petitioner testified that while under Dr. Pineda's care his back symptoms improved somewhat. However, any activity such as bending over caused increased symptoms. Petitioner remained off work. Dr. Pineda placed certain restrictions on Petitioner's activities of no lifting more than eight pounds. Dr. Pineda also recommended physical therapy and pain management which was finally approved in April, 2014 after being referred to Dr. Smucker. Dr. Smucker offered pain management, including two epidural injections, one in June and one in September.

Petitioner introduced medical records as Petitioner's Exhibit 5 from Dr. Chad Johnston for treatment from March 14, 2014 to March 7, 2016. In reviewing the records it appears Dr. Johnston provided general medical treatment to Petitioner including symptoms associated with his accident of November 6, 2013. Dr. Johnston's initial assessment was thoracic back pain. On March 14, 2014 Dr. Johnson took Petitioner off work pending further diagnostic testing and treatment.

Petitioner returned to see Dr. Smucker after returning to work full duty due to increased symptoms. Petitioner testified he was again taken off work as of March 12, 2014. Dr. Smucker placed restrictions on him that Respondent was unable to accommodate. He remained off work until September 30, 2014.

Petitioner testified the first injection he received from Dr. Smucker provided him with some relief. However, the second injection did not improve his symptoms. He was also seen by Dr. Watson and Dr. Michaels in Dr. Smucker's office after Dr. Smucker relocated his practice. It appears that the Petitioner complained to Dr. Michaels of thoracic pain. Dr. Michaels said that the Petitioner's thoracic pain was related to discogenic low back pain. Petitioner disagreed and elected to seek care in the St. Louis area.

Petitioner testified that due to persistent symptoms he sought medical care at Washington University in St. Louis. Initially he was seen by Dr. Zeballa. Petitioner testified he was then sent by Dr. Zeballa to Dr. Metzler, who performed an EMG. Petitioner testified he was then referred to Dr. Prather and then Dr. Dave'. Petitioner testified he underwent a series of facet joint injections.

Petitioner testified he returned to his regular work on or about October 1, 2014. Petitioner testified at that time he continued noticing pain when bending over and working in certain positions such as removing items from trunks, working under the dashboard or bending over the hood of a car. Petitioner testified it was necessary for him to take Vicodin, Hydrocodone and Tramadol, "just to get through the days."

Petitioner testified he had a flare up of symptoms on January 7, 2015 while removing items from an Illinois State Police vehicle. He sought medical care at Prompt Care and was taken off of work. He was released to return to work by Dr. Smucker on January 30, 2015.

Petitioner testified that in April, 2015 he had an opportunity to accept a position with the Illinois Department of Corrections. Petitioner testified he was concerned that after the flare up in January, 2015 he would not be able to continue performing his regular work and was concerned about continuing to have to take narcotic medication. Petitioner testified the reason for changing jobs was the physical demands of the job he had for Respondent.

Petitioner testified his new job for the Department of Corrections was located in Galesburg. His position was a Vehicle Coordinator or Fleet Manager. Petitioner testified his new job was less physically demanding and did not require him to lift as much or physically work on vehicles. The new position is located approximately 140 miles from his home in Edinburg. Petitioner testified for that reason he rented an apartment closer to his new job. He testified his monthly expenses include $550.00 for rent plus utilities for a total of $900.00 a month. Since taking the new job Petitioner testified he still experiences flare ups in his condition, especially when performing increased activities.

Petitioner confirmed he was still under Dr. Prather and Dr. Dave's care. Petitioner testified he has been told he is at maximum medical improvement and, "that this is chronic, that I am going to have to live with this and treat it the rest of my life." Petitioner confirmed that he had another appointment with Dr. Prather sometime in November of this year.

Petitioner confirmed that prior to his accident he had never injured his back or had the type of symptoms he is currently experiencing.

With respect to his present condition, Petitioner testified that sitting in a static position was not bad and he only has a small amount of pain when doing so. Twisting, standing up or bending the wrong way or picking something up heavy increases his pain symptoms. He also continues to experience muscle spasms with certain activity. He recently was asked to assist a yard maintenance co-worker by mowing the outer perimeter of the prison where he works. Petitioner testified that after performing those activities he noticed increased symptoms in his back pain.

Petitioner was asked to review what had been marked as Petitioner's Exhibit 20 containing copies of medical bills and a medical bill summary. Petitioner confirmed that these bills were related to some of the treatment he had received for the condition of his back.

On cross-examination Petitioner testified he had never experienced or complained of pain in his lumbar spine.

Petitioner also confirmed he is paid at a higher rate in his new job than he was earning at the time of his accident. However, he has increased expenses due to the location of his job. Petitioner also testified on cross-examination that he takes Tramadol and Skelaxin and Gabapentin on a daily basis but does not take Vicodin unless his pain is worse.

Petitioner introduced a total of twenty-one exhibits. Nineteen of the exhibits contained medical records for treatment Petitioner received for the condition of his back. The medical records corroborate Petitioner's testimony regarding the symptoms that developed in his thoracic back subsequent to his accident.

Petitioner's Exhibit 10 is a narrative report dated November 2, 2015 from Dr. Paul Smucker written in response to a letter written by Petitioner's attorney dated September 30, 2015. In the request Petitioner's attorney asked Dr. Smucker whether the disc herniation revealed by the MRI performed on February 17, 2014 marked as Petitioner's Exhibit 4 and an EMG dated June 3, 2014 marked as Petitioner's Exhibit 8, "would be consistent with Mr. Hall's lower thoracic symptoms." Petitioner's attorney also asked Dr. Smucker if he believed the accident Petitioner sustained on November 6, 2013 may have caused or contributed to the development of the disc herniation, "thereby leading to the neurological findings revealed by the EMG."

In his report Dr. Smucker stated, "the disc herniation at T2-3 as well as a small disc protrusion at T3-4 could have been part of a degenerative disc disease process and may have been aggravated by positioning with lifting, twisting/turning, etc. on the job creating symptoms of thoracic back pain. The EMG testing revealed there was identifiable radiculopathy, which could have been related to the disc protrusions or other factors." Dr. Smucker also stated he believed Petitioner's symptoms, "likely were caused or exacerbated by the work related incident." Dr. Smucker also pointed out in his report that because Petitioner had diabetes and evidence of peripheral polyneuropathy, it is possible the EMG findings are associated with those conditions. For that reason, Dr. Smucker stated, "the presence of the EMG findings does not either confirm for certain or refute the work relatedness of his back pain. His history, in my opinion, does indicate that he had thoracic pain related to the work activity."

Petitioner's Exhibit 19 is a narrative report dated March 8, 2017 from Dr. Heidi Prather. Dr. Prather's report was written at the request of Petitioner's attorney in response to a letter dated January 10, 2017. In the letter Petitioner's attorney asked Dr. Prather if she believed the disc herniation revealed in the MRI dated February 17, 2014 and EMG findings contained in an EMG report dated June 3, 2014 were consistent with Petitioner's lower thoracic symptoms. Petitioner's attorney also asked Dr. Prather whether she believed that Petitioner's accident of November 6, 2013 may have caused or contributed to the development of the disc herniation and other conditions associated with Petitioner's persistent symptoms. Petitioner's attorney also asked Dr. Prather if she was recommending any further treatment and whether Petitioner would need any treatment in the future.

In her report Dr. Prather pointed out that a more recent EMG performed on June 30, 2016 marked as Petitioner's Exhibit 17 was negative. "That would be consistent with an injury that is healing." With respect to the multi-level degenerative changes in Petitioner's thoracic spine x-ray and disc herniations, Dr. Prather was unable to state if there was a cause and effect with the structural changes. Dr. Prather also stated Petitioner's pain at T6-8, "can be caused by upper thoracic disc herniation." "In light of this, the mechanism of injury he describes could be consistent with exacerbation of pre-existing disorders, including degenerative changes and DISH (diffuse idiopathic sclerosing hyperostosis) that he exhibits." "His symptom of chronic mid-thoracic pain is consistent with the findings on his MRI, his pain complaints, and his injury as he relayed it to me that occurred three years prior to me seeing him." With respect to ongoing or future treatment, Dr. Prather stated she recommended Petitioner undergo epidural injections or medial branch blocks and possible radio frequency ablations. Dr. Prather also stated that depending on Petitioner's response to the injections, she might recommend physical therapy. She also believed these treatments would be, "necessary for him now and in the future."

Respondent offered five exhibits. Respondent's Exhibit 2 is an IME report dated June 23, 2016 from Dr. Patrick T. O'Leary. Dr. O'Leary examined Petitioner at the request of Respondent on June 23, 2016. Based on his understanding of the history provided by Petitioner, a review of certain medical records listed in his report and his examination, it was Dr. O'Leary's opinion that there was no evidence Petitioner was suffering from a pre-existing injury or health condition at the time of his accident. Dr. O'Leary's diagnosis was, "ill-defined mid-back pain." Dr. O'Leary was unable to explain why Petitioner's symptoms persisted for 2 and 1/2 years or the source of the symptoms. Dr. O'Leary believed the treatment Petitioner had received to date was both reasonable and necessary. Dr. O'Leary also believed Petitioner's condition was chronic. He recommended a repeat EMG. His prognosis was, "fair." Regarding whether Petitioner had reached maximum medical improvement, Dr. O'Leary stated if a repeat EMG was normal, he believed Petitioner had reached maximum medical improvement. Dr. O'Leary did not place any restrictions on the Petitioner. He also did not review any of the medical from the St. Louis physicians.

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

The Arbitrator concludes that the condition of Petitioner's thoracic back is causally related to his accident of November 6, 2013. Petitioner testified that prior to his accident he had not experienced symptoms similar to the symptoms that developed subsequent to his accident. Medical records from Petitioner's treating physicians show a clear pattern of symptomatology developing subsequent to his accident. Both Dr. Smucker and Dr. Prather indicated in their reports that the symptoms Petitioner is experiencing in his thoracic back may have been caused or aggravated by his accident of November 6, 2013. Dr. O'Leary, who examined Petitioner at the request of Respondent was unclear as to whether he believed there was a causal relationship between claimant's condition and the reported accident.

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

Petitioner marked and introduced Petitioner's Exhibit 20, a summary of medical bills copies of the bills pertaining to treatment to he received for the condition of his back. the Arbitrator has reviewed the exhibit and corresponding medical records introduced into evidence. The bills appear to be reasonable and related and therefore the responsibility of Respondent to pay.

The Arbitrator has reviewed the medical exhibits introduced by Petitioner and the medical bills contained in Petitioner's Exhibit 20. The medical expenses appear to be reasonable and necessary and related to Petitioner's accident of November 6, 2013. Having ruled that Petitioner sustained an accidental injury that arose out of and in the course of his employment for Respondent and that his current back condition is causally related to his accident, the Arbitrator finds that Respondent is responsible for the payment of any and all unpaid related medical expenses incurred by Petitioner for the treatment of these conditions.

What is the nature and extent of the injury?

With respect to Section 8.1b of the Act, the Arbitrator first notes that no AMA ratings were offered into evidence. Accordingly, that factor is deemed to have been waived.

The Petitioner worked as an auto technician repairing State vehicles. He testified and also consistently told his treating doctors that his job was strenuous, requiring heavy lifting. RX 3 is a job description which verifies the strenuous nature of the job. Dr. Smucker released him to full duty work on October 1, 2014. It appears from the doctors notes covering the rest of the year, that the Petitioner tolerated the work but continued to have pain. On January 30, 2015, Dr. Smucker declared the Petitioner to be at MMI and diagnosed him with chronic thoracolumbar pain. In April, the Petitioner decided to take a less strenuous job. While there is no direct evidence proving that the job switch was prescribed by his doctors, the Arbitrator finds it significant given the ongoing consistent pain symptoms the Petitioner was reporting to Dr. Smucker. This factor favors the Petitioner.

The Petitioner was 48 years old. The Arbitrator finds this factor to be neutral.

Petitioner admitted that his pay has increased in his new job, so there is no showing of future wage loss.

Finally, an MRI dated February 17, 2014 of Petitioner's thoracic spine revealed a small moderate sized central focal disc herniation at T2-3, a very small central focal disc protrusion at T1-2, a very small left posterior lateral disc protrusion at T3-4 and moderate hypertrophic facet arthrophy at T5-6. An EMG performed on June 3, 2014 revealed bilateral subacute thoracic radiculopathy. Dr. Smucker in his narrative report dated November 2, 2015 believed that the thoracic disc herniations and protrusions could have been part of the degenerative disc disease that was aggravated by Petitioner's accident of November 6, 2013. The Arbitrator also notes the EMG taken on June 30, 2016 was unremarkable. In her report dated March 8, 2017, Dr. Prather believed Petitioner had evidence of multi-level degenerative changes in the thoracic spine and that his accident could have aggravated this condition and made it symptomatic. Petitioner was also diagnosed with a strain of the thoracic paraspinal muscles.

The Arbitrator notes Petitioner testified to having persistent mid-back pain since his accident of November 6, 2013. He also testified to having received some relief through epidural injections from Dr. Smucker and Dr. Dave'. The Arbitrator also notes Petitioner changed jobs, in large part due to his persistent symptoms going from a job requiring lifting and working in awkward positions, to a less physically demanding position. The distance to this job was 140 miles. Petitioner decided to obtain an apartment near his new job to avoid traveling to and from work on a daily basis.

The Arbitrator concludes Petitioner sustained permanent partial disability to the extent 10% man 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

JOHN CHAMNIK,

Petitioner,

vs.

NO: 14 WC 30466

ILLINOIS CONSTRUCTORS,

Respondent.

18IWCC0693

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 (TTD) benefits, permanent partial disability (PPD) benefits, Respondent's Motion to Strike Dr. Leikin's Deposition, and the parties' stipulation pertaining to the second corrected Arbitrator's Decision, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

The Commission writes to expound on Respondent's failure to prove that Petitioner was impaired at the time of the August 26, 2014 work-related accident.

The Commission agrees with the Arbitrator, finding that Petitioner's alleged violation of a safety rule did not remove him from the scope of his employment. Respondent argued in its Brief that Petitioner had disregarded specific instructions to move out of the excavation area where the backhoe was operating. The Arbitrator relied on *Chadwick v. Indus. Comm'n*, 179 Ill. App. 3d 715 (4th Dist. 1989), for the proposition that Petitioner's failure to stop marking I-beams immediately as requested by Steven Brinkman, Respondent's project superintendent, was not a bar to his recovery in this claim. As asserted in *Chadwick*, Petitioner was where he was supposed to be and doing what he was hired to do; whether the risk was negligent or unreasonable is immaterial since the violation occurred within the course of Petitioner's employment. *Id. at 719.*

The Commission further agrees with the Arbitrator's Decision to exclude the admissibility of any drug screen performed on Petitioner. Petitioner had completed a urine test at Weiss Memorial Hospital on August 26, 2014. The Arbitrator noted that any such test did not conform to the specific requirements provided in Section 11 of the Act and the Rules of the Commission [Section 9140]. For example, Respondent offered no evidence or testimony that the test had been performed by an accredited or certified testing laboratory, or that split testing procedures were utilized, or performed in a manner so as to prevent sample contamination or adulteration. 820 ILCS 305/11. Section 9140.30 of our Rules provide specific requirements for the collection of urine, including who can collect the urine, the type of container the urine should be collected in, and other collection procedures. No such evidence was offered by Respondent at arbitration.

Notwithstanding the admissibility of the drug screen, and of more important consideration, the Commission finds that Respondent offered no evidence demonstrating that Petitioner was so intoxicated at the time of the accident that he was unable to perform his duties. *Paganelis v. Indus. Comm'n*, 132 Ill. 2d 468 (1989). For injuries that occurred after the September 1, 2011 amendments to the Act, as in this claim, compensation will be denied if the intoxication was the proximate cause of the injury or where the intoxication constitutes a departure from the employment. 820 ILCS 305/11(i) and (ii). In other words, compensation will be denied if the employee was so intoxicated that he could no longer perform his duties. *Paganelis v. Indus. Comm'n*, 132 Ill. 2d 468 (1989).

Evidence presented at arbitration included Respondent's project superintendent, Steven Brinkman, who testified that his interactions with Petitioner on August 26, 2014 were normal. (T.22). Petitioner's witness, Joseph Wright, also testified that he had worked as Respondent's foreman on August 26, 2014. (T.26-27). Mr. Wright testified that on that date, he did not believe Petitioner was under the influence of any drug or alcohol. (T.30). Mr. Wright further confirmed that Petitioner was marking beams on August 26, 2014, and he did not notice any inaccuracies in his work. (T.33).

Based on the record in its entirety, the Commission finds Respondent's evidence insufficient to demonstrate that Petitioner was so intoxicated or impaired at the time of the accident that he was unable to perform his duties.

The Commission further writes to correct the clerical error contained in subsection (j) of the Arbitrator's Conclusions of Law. The Commission modifies the total amount due per the Illinois Medical Fee Schedule from $8,735.30 to $9,144.22 in accordance with the parties'

stipulation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed March 9, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $885.58 per week for a period of 14 1/7 weeks, commencing August 27, 2014 through December 4, 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 the sum of $735.37 per week for a period of 25.05 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the sum of $16,726.82 subject to reductions afforded by the Illinois Medical Fee Schedule as provided in §8(a) and §8.2 of the Act. The parties have represented to the Commission that the Illinois Medical Fee Schedule reduces the medical bills to $9,144.22.

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 $40,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 9 – 2018

Michael J. Brennan

MJB/pm
O: 10-23-18
052

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the Majority's opinion modifying the Arbitrator's Decision. I find the Arbitrator's Decision to be thorough and well-reasoned. I would affirm and adopt this Decision.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
SECOND CORRECTED

CHAMNIK, JOHN
Employee/Petitioner

Case# 14WC030466

ILLINOIS CONSTRUCTORS
Employer/Respondent

18IWCC0693

On 3/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN & CAIRO
JAMES J NAWROCKI
ONE N LASALLE ST SUITE 3900
CHICAGO, IL 60601

1505 SLAVIN & SLAVIN LLC
KATHERINE BARNES GAINER
100 N LASALLE ST 25TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
2nd CORRECTED DECISION

JOHN CHAMNIK
Employee/Petitioner

v.

ILLINOIS CONSTRUCTORS
Employer/Respondent

Case # 14 WC 30466

Consolidated cases:

18IWCC0693

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Michael Glaub, Arbitrator of the Commission, in the city of Chicago, on 10/6/17. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. X Other Respondent's Motion to Strike Dr. Leikin's testimony (in part) relative to the evidence Deposition taken on May 9, 2017.

FINDINGS

On 8/26/2014, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $69,075.24; the average weekly wage was $1,328.37.

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

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

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

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, pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $885.58/week for 14 1/7 weeks, commencing 8/2714 through 12/04/2014, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical service of $16,726.82 subject to reductions afforded by the Illinois Medical fee Schedule as provided in Section 8(a) of the Act. The Parties have represented to the Commission that the Illinois Medical Fee schedule reduces the medical bills to $9,144.22.

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 25.05 weeks, because the injuries sustained caused the 15% loss of the right foot, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

March 9, 2018

Date

MAR 9 - 2018

JOHN CHAMNIK v ILLINOIS CONSTRUCTORS,
14 WC 30466

FACTS

On 8/26/2014, Petitioner was employed in a pile driver crew at Montrose Harbor in Chicago. The purpose of the work was to drive 60' I-beams into the ground, with the area behind to be back filled so as to create more parkland into Lake Michigan. (T. 13-14)

These beams were stacked horizontally in piles near where they were to be installed with a crane. (T. 14) These beams were marked (with a tape measure and marking pencil) at 10', and then 5', and finally at 1' intervals (with the last few feet further marked at every 1"). This had to be done because as the I-beams are driven into the ground vertically, the depth of the beam can always be monitored. (T. 28, 47-48)

It was the testimony of Mr. Joseph "Mickey" Wright, who was Petitioner's foreman, that it was the usual duty of Petitioner to mark the I-beams on this project. (T. 31) Petitioner testified that on 8/26/2017, the superintendent, Mr. Steve Brinkman, was also present on this jobsite and he wanted to keep busy. (T. 53)

Petitioner had been marking beams anywhere from 20-30 minutes when a backhoe began working near him. (T. 29, 51) The way the beams were stacked allowed Petitioner to mark 3 beams at once. (T. 48) When walking past Petitioner, Mr. Brinkman said he told Petitioner he should move due to the presence of the backhoe. (T. 21) Mr. Wright testified that he said much the same thing to Petitioner, but Petitioner replied that he was near the end of this task, and wanted to complete making the final marks. (T. 37)

However, unexpectedly, the backhoe bumped the pile of I-beams causing one to fall onto Petitioner' right foot. (T. 15) Mr. Brinkman said this event occurred in the time it took for him to walk the distance from where Petitioner was working to the end of the beam pile. (T. 15) Mr. Wright testified that this accident happened just a few seconds after he warned Petitioner. (T. 39-40)

Petitioner was immediately taken to the nearby Weiss Hospital where x-rays and a drug screen were taken, and the foot casted. The x-rays were read and interpreted to reveal an acute displaced fracture of 3 metatarsal bones. A contemporaneous MRI also showed a Grade 1-2 sprain of the lisfranc ligament. Petitioner was referred to an orthopedic surgeon, Dr. Ari Kaz, M.D. for follow-up. The drug screen reported positive for the presence of opioids, cannabinoids, and benzodiazepine. (Px 1)

Petitioner was examined by Dr. Kaz on 9/03/2014, who concurred with the x-ray and MRI findings; prescribed a "Jones splint" and recommended a CT scan. Petitioner was also authorized to continue to be off work. (Px 2)

Petitioner did not follow up with Dr. Kaz as he was informed the workers' compensation carrier was denying benefits due to the results of the drug screen (see 10/01/2014 note, p. 40, Px 3). Petitioner then sought medical treatment at the VA Chicago Westside Medical Center (Px 3).

Petitioner was treated conservatively at the VA. He was re-casted, had to use crutches for a length of time, and he received physical therapy. Petitioner was discharged to full duty for this injury on 12/04/2014 (see 12/04/2014 note, p. 34, Px 3).

Petitioner testified that since his discharge, he often has to wear a pressure sock on his right foot, and that the foot becomes discomforting if he either walks over uneven ground or if the weather is cold or wet. (T. 60)

Petitioner testified that he smoked marijuana at a party approximately 1 week prior to the accident, and that he was prescribed temazepam (a benzodiazepine) for sleep/anxiety and hydrocodone/Vicodin (an opioid) for back pain. (T. 54-57) Petitioner did have a valid prescription for both temazepam and hydrocodone valid from 5/23/2014 – 11/23/2014 in his VA clinic chart (see p. 12, Px 3) and had been prescribed pain medication for his back pain by Dr. Cha on 12/20/2013. Mr. Wright testified that taking this medication was not a violation of company policy so long as the employee had a script for it. (T. 43)

Both Mr. Brinkman and Mr. Wright testified that they saw no evidence of intoxication or impairment by Petitioner on the date of injury. (T. 30, 41, 78) Mr. Wright said all of the beams that Petitioner had marked either before the date of accident and those done on the date of accident, were done correctly, and the beams were able to be used as intended. (T. 32, 33, 40-41)

Petitioner retained the services of Dr. Jerrold Leikin, M.D., a board certified toxicologist and certified medical review officer (MRO) who issued a report on 1/03/2017. Dr. Leikin concluded that since no gas chromatography/mass spectroscopy was apparently performed the results were subject to false positives and not forensically defensible and that urine drug screens without quantitative analysis can remain positive for about 1 week post exposure and do not provide enough specific information as to acute intoxication and that as an MRO no verification of impairment or intoxication could be made (see Leikin evidence deposition #4, Px 6), or to put it in another way, there is no correlation between the findings of this drug screen to any impairment (p. 17, Px 6).

Dr. Leikin was deposed pursuant to a dedimus potestatem on 5/09/2017. During the course of the deposition, Respondent made a number of objections, mostly based on the case of Ghere vs. Industrial Commission, 278 Ill. App 3d 840, 663 N.E. 2d 1046, 215 Ill. Dec 532 (4th

Dist. 1996). Respondent does not object to the entire deposition, just to certain specific questions.

This case proceeded to trial on 10/06/2017 on the issues of accident, TTD, medical, nature and extent, and to strike certain portions of Dr. Leikin's deposition testimony.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision regarding (C): did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

After considering all of the evidence, the Arbitrator finds that Petitioner did sustain a compensable work injury that arose out of and in the course of his employment with Respondent.

There is no dispute that Petitioner's job duties were to mark I-beams so that they could be driven to the proper depth during this project at Montrose Harbor. There is also no dispute that this was the activity in which he was engaged when the backhoe accidently bumped the pile of beams causing one to fall onto his right foot.

Illinois courts have addressed the issue of whether an employee who violates a safety rule is removed from the scope of their employment. In Chadwick v. Industrial Commission, 179 Ill. App 3d 715, 534 N.E. 2d 1000, Ill. Dec. 555 (4th Dist. 1989), a worker fell to his death because he was not tied off on a lifeline installed on the scaffold. This was after he had attended a safety meeting several days before where he was instructed to remain tied to the lifeline at all times.

> **Where the violation of a rule or order of the employer takes the employee entirely out of the sphere of his employment and he is injured while violating such rule or order it cannot be then said that the accident arose out of the employment, and in such a case no compensation can be recovered. If, however, in violating such a rule or order the employee does not put himself out of the sphere of his employment, so that it may be said he is not acting in the course of it, he is only guilty of negligence in violating such rule or order and recovery is not thereby barred. [Citation.] ... [I]t does not matter in the slightest degree how many orders the employee disobeys or how bad his conduct may have been, if he was still acting in this sphere of his employment and in the course of it the accident arose out of it.** 534 N.E.2d at 1001, quoting *Republic Iron & Steel Co. v. Industrial Commission*, 302 Ill. 401, 134 N.E. 754, 755-756 (1922).

The *Chadwick* court noted that if the employee is doing permitted work in a prohibited manner, compensation will be awarded. Because the decedent was where he was supposed to be and doing what he was hired to do, though in an obviously negligent manner, the safety violation occurred while acting within the scope of his employment, rendering the unreasonableness of the risk immaterial. 534 N.E. 2d at 1002.

Petitioner's failure to stop marking I-beams immediately because he wanted to complete the task, may have, at worst, been negligent. The Arbitrator notes that Chamnik was trying to finish marking the beams he had started and that the request or warning to vacate the area due to the presence of the backhoe in the area was made only a relatively short time before the accident. Accordingly, Chamnik's actions in this regard are not a bar to recovery. The Arbitrator also relies upon the ruling in Gerald D. Hines v. Industrial Commission, 191 Ill. App 3d 913, 548 N.E. 2d 342, 138 Ill. Dec. 929 (1st Dist 1989) in concluding that the employer's actions, although negligent, were for the benefit of the employer, stating:

> **Once that well-supported factual finding is made, the legal question is whether an employee acting negligently and against**

> the employer's orders is precluded from recovering under the Act. It has long been recognized that one of the Act's objectives was to do away with defenses of contributory negligence or assumed risk. Recklessly doing something persons are employed to do which is incidental to their work, differs considerably from doing something totally unconnected to the work. (*Mount Olive & Staunton Coal Co. vs. Industrial Com.* (1934), 355 Ill. 222, 189 N.E. 296.) It matters not how negligently the employee acted, if at the time he was injured he was still within the sphere of his employment and if the accident arose out of it. *Brooks Tomato Products Co. v. Industrial Com.* (1924), 311 Ill. 207, 142 N.E. 451. 548 N.E.2d at 345.

Respondent also raised the defense of intoxication based on the positive drug test. Respondent maintains that Petitioner was intoxicated due to the effects of marijuana or other substance and that his intoxication was the proximate cause of his injury or that the intoxication was to a degree that it constituted a departure from the employment.

Section 11 of the Act sets out specific requirements in situations where intoxication due to alcohol or drugs is raised, and creates a rebuttable prescription that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury, if certain prerequisites are met.

The chart from Weiss Hospital was admitted as Px 1. At the conclusion of documentary evidence submission, Petitioner's counsel asked that any drug screens not be considered as evidence as Section 11 states:

> **Any testing that has not been performed by an accredited or certified testing laboratory shall not be admissible in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injury.**

No such evidence was introduced by Respondent. The statute further mandates that the collection for alcohol or drugs be performed in accordance with the rules adopted by the Commission (50 Illinois Administrative Code 9140.5 – 9140.80, effective 11/5/2012).

Accordingly, the Arbitrator excludes the admissibility of any drug screen performed on Petitioner at Weiss Hospital on 8/26/2014.

However, even if the validity of these tests were accepted, the Arbitrator finds that the evidence showed that the petitioner was successful in rebutting the rebuttable presumption that Petitioner was intoxicated and that this intoxication was the proximate cause of the petitioner's injury.

The relevant section of Section 11 states:

Intoxication

No compensation shall be payable if

(i) the employee's intoxication is the proximate cause of the employee's accidental injury or

(ii) at the time the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment. Admissible evidence of the concentration of

(1) alcohol,

(2) cannabis as defined in the Cannabis Control Act,

(3) a controlled substance listed in the Illinois Controlled Substances Act, or

(4) an intoxicating compound listed in the Use of Intoxicating Compounds Act in the employee's blood, breath, or urine at the time the employee incurred the accidental injury shall be considered in any hearing under This Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injuries.

If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath, or urine or if there is any evidence of impairment due to the unlawful or unauthorized use of

(1) cannabis as defined in the Cannabis Control Act,

(2) a controlled substance listed in the Illinois Controlled Substances Act, or
(3) an intoxicating compound listed in the Use of Intoxicating Compounds Act or if the employee refuses to submit to testing of blood, breath, or urine,

then there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury.

The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries. Percentage by weight of alcohol in the blood shall be based on grams of alcohol per 100 milliliters of blood. Percentage by weight of alcohol in the breath shall be based upon grams of alcohol per 210 liters of breath. Any testing that has not been performed by an accredited or certified testing laboratory shall not be admissible in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injury.

All sample collection and testing for alcohol and drugs under this Section shall be performed in accordance with rules to be adopted by the Commission. These rules shall ensure:

(1) compliance with the National Labor Relations Act regarding collective bargaining agreements or regulations promulgated by the United States Department of Transportation;
(2) that samples are collected and tested in conformance with national and State legal and regulatory standards for the privacy of the individual being tested, and in a manner reasonably calculated to prevent substitutions or interference with the collection or testing of reliable sample;
(3) that split testing procedures are utilized;
(4) that sample collection is documented, and the documentation procedures include;
   (A) the labeling of samples in a manner so as to reasonable preclude the probability of erroneous identification of test result; and
   (B) an opportunity for the employee to provide notification of any information which he or she considers relevant to the test, including identification of currently or recently used prescription or nonprescription drugs and other relevant medical information;

(5) that sample collection, storage, and transportation to the place of testing is performed in a manner so as to reasonably preclude the probability of sample contamination or adulteration; and
(6) that chemical analyses of blood, urine, breath, or other bodily substance are performed according to nationally scientifically accepted analytical methods and procedures.

The petitioner testified that he smoked marijuana approximately one week prior to the accident. There was no evidence offered to rebut the petitioner's testimony. The evidence shows petitioner was working and performing his duties in a normal manner on the date of the accident. Two separate witnesses, Mr. Brinkman and Mr. Wright testified they observed the petitioner work on August 26, 2014 and neither could identify any evidence that the petitioner was performing his work for the respondent in an impaired manner. Dr. Leikin testified that had the petitioner smoked marijuana one week prior to the accident, it could still appear in a drug screen on the day of the accident. With reference to the other positive results in the drug tests, Dr Leikin testified that the petitioner's legal prescriptions for hydrocodone/Vicodin (for pre-existing back pain) and for temazepam (for sleep anxiety) would have caused the positive results in the drug test for opiates and benzodiazepines. The respondent offered no medical evidence to rebut any of the testimony of Dr. Leikin,

Petitioner's job performance and behavior showed no incapacity or impairment. As testified by both Mr. Brinkman and Mr. Wright, there were no reported problems with the way Petitioner had marked off the I-beams or of intoxication either in the days preceding the accident date or with the ones he completed on the morning of the accident. Furthermore, Dr. Leikin testified that no correlation can be made between the mere presence of a drug metabolite and intoxication.

Based on all of the above, the Arbitrator finds that did sustain an accident which arose out of and in the course of his employment by Respondent on August 26, 2014.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the 8/26/2014 injury, the Arbitrator finds the following:

In (C) the Arbitrator found that Petitioner sustained an accident that arose out of, and in the course of Petitioner's employment by Respondent. There is no dispute that a heavy steel beam fell on to Petitioner's right foot, the aftermath witnessed by both Mr. Wright and Mr. Brinkman. X-rays taken at Weiss Memorial Hospital immediately afterwards revealed the fractures of 3 metatarsal bones (see Px 1 and 2). Petitioner's testimony is in accord with all of the treating medical records. No evidence was introduced to show Petitioner has received medical treatment to his right foot since his 12/04/2014 full duty discharge from the VA Chicago Westside Medical Center.

The undisputed medical and testimonial evidence cause the Arbitrator to find that Petitioner's current condition of ill-being is related to the work accident of 8/26/2014.

In support of the Arbitrator's decision regarding (J), whether the medical services that were provided to Petitioner were reasonable and necessary?

In (C) and (F) the Arbitrator found that Petitioner sustained a compensable work injury and that injury is the proximate cause of his current condition of ill-being. Respondent objected to the bills claimed in Px 7 on the basis of liability, only. (T. 96) Accordingly, the Arbitrator finds Petitioner is entitled to the award of the following medical bills as follows:

Unpaid Medical Bills & Fee Schedule

Date of Service	Procedure Code	Amount Charged	Fee Schedule
VA Chicago Westside Medical Center (606) (UB4 per guidelines)			
9/09/14	99214	$ 220.50	$ 115.91
9/09/14	99214 GR	$ 257.66 (53.2%)	$ 137.08
9/12/14	73701 RT	$ 1,508.90 (53.2%)	$ 802.74
	29405 GR	$ 545.41 (53.2%)	$ 290.16
	99203 GR/25	$ 240.15 (53.2%)	$ 127.76
9/12/14	99203	$ 212.35	$ 122.57
	29405	$ 412.66	$ 243.03
9/12/14	6134672 (pharmacy)	$ 15.95 (53.2%)	$ 8.49
9/12/14	73701/26 RT	$ 476.22	$ 129.42
9/25/14	73630 RT	$ 394.37 (53.2%)	$ 209.81
9/25/14	73630/26 RT	$ 69.32	$ 36.33
10/01/14	29405 RT	$ 545.41 (53.2%)	$ 290.16
	99212/25 GR	$ 152.22 (53.2%)	$ 80.98
10/01/14	29405 RT	$ 412.66	$ 243.03
	99212/25 GR	$ 69.73	$ 54.94
10/01/14	6146687 (pharmacy)	$ 15.95 (53.2%)	$ 8.49
10/10/14	60953483 (pharmacy)	$ 16.24 (53.2%)	$ 8.64
10/21/14	5560799 (pharmacy)	$ 19.04 (53.2%)	$ 10.13
10/30/14	61053772 (pharmacy)	$ 13.40 (53.2%)	$ 7.13
	61053773 (pharmacy)	$ 20.16 (53.2%)	$ 10.73
11/12/14	73630 RT	$ 394.37 (53.2%)	$ 209.81
	97116 GP	$ 76.82 (53.2%)	$ 40.87
	99212 GR	$ 152.22 (53.2%)	$ 80.98
11/12/14	73630/26 RT	$ 69.32	$ 36.33
11/12/14	99212 GR	$ 69.73	$ 54.94
Total:		**$ 6,380.76**	**$3,360.46**

IL Bone & Joint Institute (606)

9/03/14	99244	$ 253.00	$ 242.24
	29515	$ 146.00	$ 132.61
	Q4046	$ 87.00	$ 52.85
Total:		**$ 486.00**	**$ 427.70**

Weiss Memorial Hospital (UB4 per guidelines) (606)

8/26/14		$ 5,681.00 (53.2%)	$3,022.29
8/27/14	73718 RT (MRI)	$ 3,103.00 (53.2%)	$1,650.80
Total:		**$ 8,784.00**	**$4,673.09**

Emergency Room Care SC (606)

8/26/14	99284	$ 484.00	$ 276.31
8/26/14	29515 (not 3/25/15)	$ 265.00	$ 132.61
Total:		**$ 749.00**	**$ 408.92**

Home Care Plus, Inc. (606)

8/26/14	E0114 (crutches)	$ 60.00 (53.2%)	$ 31.92
Total:		**$ 60.00**	**$ 31.92**

Metropolitan Advanced Radiological (606)

8/26/14	73610/26	$ 52.00	$ 38.80
	73630/26	$ 48.00	$ 36.33
8/27/14	73718/26	$ 167.00	$218.84 (pay167.00)
Total:		**$ 267.00**	**$ 242.13**
TOTAL:		**$16,726.82**	**$9,144.22**

Based on the above, the Arbitrator awards the petitioner $16,726.82 in medical bills; however, those medical bills are subject to reduction and payable at the lower rates provided for in the Illinois Medical Fee Schedule for a total amount of $8,735.30.

In support of the Arbitrator's decision regarding (K), what temporary total disability (TTD) benefits are in dispute, the Arbitrator finds the following:

In (C) and (F) the Arbitrator found Petitioner to have sustained a compensable work accident and that his injury is the proximate cause of his current condition of ill-being. There is no dispute that Petitioner was totally disabled from work, and under doctor's care between 8/26/2014 until his full duty release on 12/04/2014.

Accordingly, Respondent is ordered to pay Petitioner the sum of $885.58 per week for the period of 8/27/2014 – 12/04/2014 (14 1/7 weeks), for a total of $12,524.76 in TTD benefits.

In support of the Arbitrator's decision regarding (L), the nature and extent of the injury, the Arbitrator finds the following:

In applying the five factors in Section 8.1b of the Illinois Workers' Compensation Act, the Arbitrator finds as follows:

1. As to the AMA impairment rating, neither the Petitioner nor the Respondent admitted an AMA impairment rating into evidence in this case. As such, the Arbitrator gives this factor no weight.

2. As to occupation, the Petitioner testified that he was marking beams at a construction site on the date of the accident. There is little other testimony regarding the petitioner's occupational duties. The Arbitrator gives this factor little weight based upon the limited testimony regarding the Petitioner's job duties presented at the Hearing and the petitioner's testimony that he is now semi-retired.

3. As to the Petitioner's age, the Petitioner testified that he was 54 years old at the time of his August 26, 2014 injury. The Arbitrator notes that the Petitioner is closer toward the end of his career and thus, will not have to deal with the effects of his disability for as long as a

younger worker or somebody just entering the workforce. At the Arbitration Hearing, the petitioner was 57 years old and testified that he was now semi-retired. As such, the Arbitrator finds that this factor weighs in favor of a lower PPD Award.

4. As to future earning capacity, the Arbitrator finds that the Petitioner's future earning capacity has not been diminished given the fact that he was released to return to work in a full duty capacity. As such, the Arbitrator finds that this factor weighs in favor of a lower PPD Award.

5. As to evidence of disability in the medical records, the Arbitrator notes that the Petitioner sustained a fracture of the 1st and 2nd metatarsal according to the radiology report. The MRI report revealed fractures of the 1st, 2nd and 3rd metatarsals and a Grade 1-2 sprain of the Lisfranc ligament. The medical treatment consisted of immobilization and physical therapy. Petitioner did receive a full duty release on 12/04/2014.

Based on all of the above, the Arbitrator finds the Petitioner's injury to be both serious and permanent, and awards the loss of 15% of the right foot pursuant to Section 8-e-11 of the Act (25.05 weeks x $735.37 = $18,421.02).

In support of the Arbitrator's decision regarding (O) whether to Strike portions of Dr. Leikin's Testimony Relative to the Evidence Deposition Taken on May 9, 2017, the Arbitrator finds as follows:

After reviewing the transcript of the deposition taken on May 9, 2017 and Respondent's Motion to Strike Dr. Jerrold Leikin's Testimony, in part, Relative to the Evidence Deposition Taken on May 9, 2017, the Arbitrator overrules the Ghere objections of the respondent. The deposition of Dr. Leikin was taken pursuant to a Dedimus Order on May 9, 2017 with all parties represented by counsel. Respondent had received the narrative report of Dr. Leikin which is dated January 3, 2107 well in advance of the May 9, 2017 deposition. That narrative report includes

Dr. Leikin's opinions regarding his belief about the possible inadequacies of the drug testing and references regarding the petitioner's use of prescription medicine hydrocodone and temazepam (benzodiazepine). The narrative report contains Dr. Leikin's opinion that using drug screens without quantitative analysis can remain positive for about one week post exposure and do not provide enough specific information as to acute intoxication. All of the medical records upon which Dr. Leikin reviewed had been provided to the respondent's attorney up to one year prior to the deposition. The Arbitrator also notes the respondent attorney was allowed to review the chart of Dr. Leikin prior to the deposition. The Arbitrator has reviewed the deposition testimony, the narrative report of Dr. Leikin and the medical records offered into evidence. Based on all of the above, the Arbitrator does not believe the respondent attorney can reasonably assert that they were surprised by any of the testimony of Dr. Leikin at his deposition on May 9, 2017 pursuant to the Appellate Court ruling in *Ghere*. Stated alternatively, the Arbitrator finds that none of Dr. Leikin's testimony falls outside of what would have been reasonably anticipated from reading his narrative report.

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

Steve Sutton,

Petitioner,

vs.

NO: 11 WC 33205

G & D Integrated,

18IWCC0694

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 (15 IWCC 0220) dated March 27, 2015. A hearing on the petition was held before Commissioner Joshua Luskin on April 9, 2018 in Peoria, 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 an Arbitration Decision filed June 2, 2014, the Arbitrator found that Petitioner was entitled to reasonable and necessary medical services of $4,510.39 and permanent partial disability benefits of $281.05/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. (Arb.Dec.[Form], p.2). The Arbitrator found that "... Petitioner's current condition of ill-being [regarding his left inguinal hernia] is causally related to the injury of February 15, 2013" and that treatment was reasonable, necessary and causally related to said injury. (Arb.Dec.[Addendum], p.4). Furthermore, the Arbitrator found that Petitioner was entitled to TTD, based on the parties' stipulation, from 2/16/12 through 9/4/12, for a period of 28-1/7 weeks. (Id.). However, the Arbitrator found that Petitioner failed to prove that he is entitled to vocational rehabilitation services or maintenance benefits after May 16, 2013.

(Id., p.6). In addition, the Arbitrator found that "... Petitioner failed to prove that he is permanently and totally disabled and has failed to prove he is entitled to a wage differential award." (Id., p.7). In support of this finding, the Arbitrator noted that "... no physician has opined that the Petitioner is totally disabled from working and the Petitioner is not obviously unable to work. Daniel Minnich, a certified vocational counselor, opined that there are jobs available for the Petitioner within his restrictions. While the Respondent's examining physician has opined that the Petitioner is not able to return to his previous employment and is in need of permanent restrictions, no evidence was presented regarding a diminution in earning capacity." (Id.).

Petitioner subsequently filed a Petition for Review on June 16, 2014.

In a Decision and Opinion on Review dated March 27, 2015, the Commission affirmed and adopted the Arbitrator's decision "... in all respects except for the determination of the permanency award. With regard to permanency, the Commission increase[d] the award from 10% of the man as a whole to 12.5% of the man as a whole..." (15 IWCC 0220, p.1). The Commission noted that "... the impact of Petitioner's pre-existing skin condition on his ultimate post-hernia condition must be taken into account in this case." (Id.). In addition, "[t]he Commission agree[d] that the Petitioner did not sustain his burden of proof with regard to entitlement to additional vocational rehabilitation and/or a wage differential award, however we do believe that his permanent condition is significantly worse than the vast majority of hernia cases reviewed at the Commission level. As such, we believe the Petitioner sustained permanent disability to the extent of 12.5% of the man as a whole." (Id., p.2).

The matter was appealed to the circuit court. In an Order dated August 24, 2015, the circuit court confirmed the Commission's decision. (RX2).

Petitioner appealed the matter to the appellate court. In a Rule 23 decision filed September 26, 2016, the appellate court determined that the Commission's finding – to the effect that the claimant was not entitled to vocational rehabilitation benefits after May 16, 2013 -- was not against the manifest weight of the evidence. *Steve Sutton v. Illinois Workers' Compensation Commission*, 2016 IL Ap (3d) (150657WC-U, NO. 3-15-06557WC). In summarizing the case, the court found that "[e]ssentially, the Commission found that claimant's actions failed to show he made a good faith effort to cooperate with the vocational rehabilitation services he had already been offered and further indicated a lack of motivation to commit to additional vocational rehabilitation services." (Id, p.11). The court thereupon affirmed the circuit court's confirmation of the Commission decision. (Id.).

Petitioner subsequently filed multiple §§19(h)/8(a) Petitions – styled "Motion[s] to Review Award Due to Employee[']s Condition Change" -- on December 6, 2016, February 14, 2017, August 17, 2017 and March 27, 2018, respectively.

II. FINDINGS OF FACT

The Commission incorporates by reference herein the findings of fact and conclusions of law set forth in the above decisions.

The Commission does wish to note, however, that at the time of his original testimony at arbitration on April 11, 2014, Petitioner indicated that he continued to have left-sided problems and that he takes Lorezepam three times a day for his complaints. He also indicated that he experiences burning and throbbing pain with excessive bending, stretching and walking. Specifically, he noted that he has tried to lift groceries at which time he noticed "the pull and the burn starting." He testified that he tries to stay within his doctor's restrictions. He also acknowledged a history of preexisting and unrelated medical conditions, including chronic osteoarthritis as well as abdominal and pelvic skin infections and open sores. He also admitted that he is a 1 to 2 pack-a-day smoker and that he continues to smoke despite being advised by his physicians that it was important to stop prior to his medical procedures. Furthermore, the record reflects that Dr. Wyffels released Petitioner from treatment with a 30-pound lifting restriction on August 3, 2012, and that Respondent's §12 examining physician agreed with restriction with respect to Mr. Sutton's hernia condition. Petitioner testified this 30-pound restriction impacts his ability to lift and do his normal daily activities, and that walking is difficult.

At the §§19(h)/8(a) hearing held on April 9, 2018, Petitioner agreed that he suffered a hernia as a result of his February 8, 2011 work accident. (T.7-8). He indicated that following the prior decision he continued to treat with his family physician Dr. Brune for pain management. (T.8). Petitioner testified that he continued to treat for "[j]ust the constant burning and pressure" in the groin area, and that he continued to be prescribed Norco, which he noted helped with his pain complaints. (T.9).

Petitioner agreed that Dr. Brune then referred him to Dr. Cummings "[b]ecause the pain was increasing." (T.9-10). He agreed that Dr. Cummings recommended a functional capacity evaluation, which was performed on August 27, 2015. (T.10). He also agreed his understanding was that his restrictions were then increased to 10 pounds lifting, which he agreed was greater than what they were beforehand. (T.10-11). He likewise agreed that he then returned to Dr. Brune. (T.11). Petitioner indicated that at a point in 2016, 2017 he tried to wean himself from narcotics because he "... just didn't like the lifestyle, thought maybe I could manage this myself and just the pain got worse... I kept some off to the side to wean myself off, and it just turned out the pain [in the groin area] was too much." (T.11-12).

Petitioner agreed that from 2017 to the present he has treated with pain specialist Dr. Gilbert, who has him on morphine. (T.12). He agreed that he is no longer treating with Dr. Brune, who felt he was doing too many narcotics. (T.12-13).

Petitioner agreed that since the prior trial his pain complaints have increased, noting that "[j]ust the daily activities I try to do, squatting, walking. It just constantly burns and stretches down there", indicating the left side of his groin radiating towards his left hip. (T.13-14). He agreed that this is where his hernia surgery was. (T.14). He also agreed that he has increased pain from this site and that it is what is limiting his activities. (T.14).

When asked to describe some activities that he has problems with and that cause pain -- after agreeing that he has issues like walking his dog and daily activities – Petitioner responded: "... cleaning, cooking, standing, squatting. Just getting out of bed in the morning. As for walking I can't even do that." (T.15). He indicated that "I think it's just as time goes on it's just – it's just

gotten worse." (T.16). When asked whether cooking increases his pain, Petitioner replied: "[j]ust bending over trying to get pots and pans out of the oven to cook on. The pulling and the bending there, I can just feel the burn and the stretch. And the numbness where I got to go sit down to where prior I didn't." (T.17). When asked about walking the dog, Petitioner noted that it was an issue "... just walking down the driveway, walking up the driveway, trying to go up the sidewalk. It just again starts to burn and I have to stop and regroup or sit down... The pain just increases with each step, so therefore I have to try to find a place to sit down, preferably like a bench or hillside where I don't have to get down on the concrete, you know, as low." (T.17-19). When asked whether he had these problems at the time of the last arbitration hearing, Petitioner responded: "[y]es, but now they are [*sic*] seemed to have gotten worse." (T.19). He noted that the morphine "[g]ets me out of bed each day. Helps me to put my shoes on, to move better." (T.19). He indicated that when he attempted to get off the narcotics "[i]t was just too much, just it was unbearable, just the constant discomfort you are in." (T.20). He agreed the narcotics help with his daily functioning. (T.20).

On cross examination, Petitioner agreed that Dr. Brune was his primary care physician prior to the accident in question, and that he would agree with Dr. Brune's records if they show he was taking narcotics such as Hydrocodone and Lorcet before the accident. (T.21). He also agreed that he had conditions prior to this accident for which he was prescribed those narcotic medications, and that he had suffered from back pain for many years even prior to this accident. (T.22). In addition, he agreed that he still suffers from back pain today, and that he suffers from a psoriasis-like condition that is very painful and which pre-existed the accident in question. (T.22). When asked whether his hernia surgery was put off somewhat because of this condition, Petitioner indicated that his skin "... was inflamed so they wanted to bring it down before they done [*sic*] the surgery." (T.23). However, Petitioner denied that the same area of the skin affected by this condition is the same area that he experienced pain from the accident, noting that "[w]here he done [*sic*] the surgery is where the skin condition was, but where the pain was coming from was down below that." (T.23-24). He agreed that he is still experiencing pain and irritation from this skin condition, and that he is still seeking treatment for same. (T.24-25). When asked whether this skin condition impacts his ability to do certain things, Petitioner responded: "[I] [w]ear tight paints [*sic*]." (T.25). He agreed that this is because it is irritating to rub against it. (T.25).

When asked if he would agree with Dr. Brune's records if they note that before the accident the Lorcet was keeping him working every day, Petitioner responded: "[u]m, no." (T.25-26). He agreed that at the time of the accident he continued to take the pain medications prescribed by Dr. Brune. (T.26). He also agreed that Dr. Wyffels was managing his care and was the physician who performed his hernia surgery. (T.26). He indicated that he believed he had not seen Dr. Wyffels since 2013, and conceded that at this point no one is recommending any additional surgery for his hernia condition. (T.26-27).

Petitioner agreed that at the time of the previous trial he complained of continuing burning and pulling in that area as well as trouble lifting. (T.27-28). In addition, he agreed that at that time he was having trouble lifting a two-liter bottle of soda weighing less than ten pounds. (T.28). Likewise, he agreed that he was having trouble bending and squatting. (T.28).

Petitioner agreed that he stopped seeing Dr. Wyffels and went back to seeing Dr. Brune in 2014. (T.29). He indicated that he stopped seeing Dr. Brune, but he denied that it was because he was told by Dr. Brune that he was terminating the physical [*sic*] patient relationship. (T.29). He testified that "... I just went to his office and I had enough. I was weaning myself off the pain meds and trying to get my life back, and I didn't get back to see Doctor Brune, there was no letter, no nothing that you are stating. And then later on in life I realized my life is better with them because I can move around because the pain and the hernia was too extreme, so I got referred to by [*sic*] another doctor, and that's what I done [*sic*]." (T.29-30). He noted that Dr. Baer – whom he saw a few months after he stopped seeing Dr. Brune – was the one that referred him to someone else. (T.30). He agreed that he saw Dr. Baer in April of 2017 after he fell in his bathtub and broke a rib. (T.30-31). He noted that at that time he spoke to Dr. Baer about his ribs and busted thumb, and that he "... discussed my hernia... [and] probably talked about [his] back pain" as well. (T.31). Petitioner indicated that he still sees Dr. Baer to this day, as well as Dr. Gilbert, but for different reasons. (T.32-33). He noted that "[o]ne is for pain management and the other one is for my just cold and flu doctor, I guess." (T.33). He thought that it sounded right that he first treated with Dr. Gilbert in February of 2018. (T.33). He noted that "... if you want to say Doctor Baer is my primary [physician] you can, or you can say Doctor Gilbert is, I just do what they tell me." (T.33). He agreed that when he sees Dr. Gilbert he tells him all the problems that he is experiencing. (T.34).

Petitioner agreed that when he saw Dr. Cummings and went for the FCE in about 2015 he was seeing Dr. Brune as his primary care physician. (T.34). He also agreed that he had the FCE in August of 2015 and that he never saw Dr. Cummings before the FCE, only after. (T.35). In addition, he agreed that Dr. Brune did not tell him to go and get an FCE. (T.36).

On re-direct examination, Petitioner agreed that he is not denying he had pain and problems bending and stooping at that time he last testified, and that his testimony was that it's just gotten worse. (T.37). In addition, he agreed he is not denying he had psoriasis or back pain. (T.37). Instead, he indicated that in conjunction with those problems he has increased pain with his hernia site. (T.37-38).

A review of the medical records since the prior hearing show that a Functional Capacity Evaluation performed on August 27, 2015 at the request of Petitioner's attorney, Chris Doscotch, found that the "[c]lient demonstrates the physical capabilities and tolerances to function at the Light physical demand level, as delineated by a 2-hand occasional shoulder lift of 15# and a 2-hand frequent shoulder lift of 10#." (PX4).

In an office note dated October 8, 2015, Dr. Alexander Cummings recorded that the patient underwent hernia surgery and "... had a very difficult postop course... [and] ended up needing to get drainage tubes placed and had infections. He also states that he had to get re-stitched and was having trouble. He states the surgery itself was very difficult and he could not get a mesh placed because of boils and contaminated skin. He states he has gotten better but the pain is still there and he is having problems even till this day. He states it is almost a constant pain burning and throbbing. It is worse if he twists, lifts too much or does thinks like that. He states that he is on a 15 pound weight restriction and that is about all he can do. His primary care doctor referred him to see if there were [*sic*] something interventional I could offer him." (PX5). Dr. Cummings noted

"ER records from OSF and radiologic studies [were] reviewed. Patient is experiencing chronic postop hernia abdominal pain. By his history he has limitations on what he can lift and do. This may be because of scar tissue and adhesions and/or nerve entrapment. Risk-benefit analysis was done and it was discussed at length with patient about any interventional attempts to transcutaneous oblate this nerve or oblate and lyse any scar tissue to try to provide some relief. Because of the unpredictability and results we could achieve, his very difficult problematic postop course, and his obvious high risk with his contaminated skin I do not feel this is prudent. Patient agrees. Patient has also followed up and treaty [*sic*] with his surgeon for considerable length of time and there's nothing else surgical he can offer patient. Patient will likely have to deal with this on a permanent basis. He is to continue to follow his primary care physician and surgeon and see me as needed." (PX5).

In a letter to Petitioner's counsel Mr. Doscotch dated December 28, 2015, Dr. Cummings noted that "[m]y impression of [Petitioner] was consistent with some of the information contained in the FCE. I concur with the report that Mr[.] Sutton is limited to sedentary/light work duties. I agree that he should have a 15 pound weight lifting restriction on an occasional basis and a frequent lifting restriction of 10 pounds and under as [a] result of his hernia condition. It was a year after the accident until Mr. Sutton was able to have surgery on February 16, 2012. Two months after surgery he had an IME performed which recommended a 20 pound weight lifting restriction. A third IME on January 29, 2013 recommended a 30 pound weight restriction. The restrictions at that time were based on experienced medical judgment, not a formal and methodical FCE. Additionally, Mr. Sutton's hernia surgery likely resulted in scar tissue. This combined with his weight, smoking history and need for methotrexate may have weakened his abdominal wall further at this point. Mr. Sutton has had a long and protracted course with his hernia, the repair of, and the subsequent complications. I believe at this point, at this many years out, he is at maximum medical improvement and any future employment opportunities should be respectful of his work restrictions." (PX5).

In a letter dated December 30, 2016, Dr. Brune informed Petitioner that he was "... terminating care as your physician due to your abuse of prescribed narcotic medication." (PX2). Dr. Brune stated Petitioner had 30 days from the receipt of the letter to find a new physician, during which time he would continue to provide care but not prescribe narcotic medication. (PX2). The Commission notes that Dr. Brune's handwritten office notes are otherwise illegible.

In a progress note dated April 12, 2017, Dr. John Baer at OSFMG recorded that Petitioner had fallen in the bathtub and suffered a nondisplaced 6th rib on the left and a small chip fracture involving the proximal aspect of the distal phalanx of the left thumb. (PX3). However, Dr. Baer noted that "[t]he more significant transition of care involves Mr. Sutton seeking a new PCP. His primary difficulty revolves around a very painful skin problem that is perhaps inexorably progressive or at any rate not resolving after perhaps a 14-year duration." (PX3). Dr. Baer recorded that "[t]he skin rash continues on. He continues with new eruptions. They are very painful... and impact his gait, and also his ability to lift. He also tells me that he has undergone a left inguinal herniorrhaphy in the past, but he has been told that he has bilateral inguinal hernias at this time but that they cannot be operated on due to the skin condition." (PX3). Petitioner visited Dr. Baer again on June 21, 2017, July 17, 2017, August 28, 2017 and December 21, 2017 with little change in his ongoing skin condition. (PX3).

In an office note dated February 27, 2018, Dr. George Gilbert recorded that "PT IS HERE FOR FOLLOW UP. PT HAS A LOT OF PAIN IN HIS BACK. PT HAS HAD TO TAKE MORE MORPHINE THAN PRESCRIBED." (Capitalization in original). (PX8).

In an office note dated March 22, 2018, Dr. Gilbert recorded that "PT IS HERE TODAY FOR HIS FOLLOW UP. PT IS HAVING LOWER BACK PAIN. PT BELIEVES THAT HE DID SOMETHING TO HERNIA IN THE LAST FEW WEEKS. PT IS HAVING NECK PAIN ALSO. PT HAS NO OTHER CONCERNS AT THIS TIME." (Capitalization in original) (PX8).

Dr. Cummings testified by way of evidence deposition on December 18, 2017. He noted that he does occupational medicine, sports medicine and some cosmetics and that he is board certified in emergency medicine and pain management. (PX6, pp.3-4). Dr. Cummings indicated that he first saw Petitioner as a patient on October 8, 2015. (PX6, p.5). He agreed that he saw Petitioner after his previous hernia surgery and after restrictions had been imposed, as well as after an FCE had been performed. (PX6, p.6). Upon examination, Dr. Cummings noted that the patient was "... tender to palpation in both his lower quadrants, but especially on the left." (PX6, p.7). He also noted "[a]cross the lower part of his pannus and his groin area he had seeping of transudate-like fluid coming out from any irregularities on the surface of his skin, and he had a lot of old scars from previous infections, skin infections. The area was almost literally covered with scars and crevices and irregularities in the skin surface with superficial contamination." (PX6, pp.7-8). Dr. Cummings stated that he "... tried to do a digital inguinal canal exam, but his body habitus and scarring made it difficult. When I attempted it, he had pain on both sides, especially the left. No gross protrusion of any hernia material. He seemed depressed to me with a depressed mood." (PX6, p.8). Dr. Cummings' assessment was "[c]hronic abdominal pain." (PX6, p.8).

Dr. Cummings believed that Petitioner's chronic abdominal pain was related to his work accident, noting that "[h]is history was consistent with something that would cause a hernia ..." (PX6, p.8). Dr. Cummings also noted that Petitioner "... had a complicated presentation with all of the skin, history of chronic cutaneous infections, and I put him at higher risk for having another recurring infection if any procedures were done in that area. Also, I thought there was probably nothing more that we could offer him. He also had been treated with the surgeon for a considerable period of time, so there was really nothing surgical or interventional that I thought we could do for him." (PX6, p.9). He indicated that he "... didn't feel the need to see him again..." (PX6, p.9).

Dr. Cummings agreed that he prepared a letter dated December 28, 2015 in response to Petitioner's counsel request. (PX6, p.10). He indicated that he thought the FCE was reliable and that "... we could use it to see where [Petitioner] would be at as far as any permanent restrictions. And I agreed that overall he would be limited to sedentary/light type of work duties with a fifteen-pound weight restriction on an occasional basis and frequent restriction of ten pounds – and able to frequently lift ten pounds in that it was a result of the hernia condition." (PX6, p.11).

When asked to detail how Petitioner's hernia condition and subsequent surgery resulted in these restrictions, Dr. Cummings stated that "I think he had a pretty protracted postop surgical course, and there is a couple of things that can happen: You can get some scar tissue developing

around the surgical site and also some of that scar tissue can cause some entrapment of the nerves, and that occasionally happens. And there is also the issue that a lot of time – or sometimes the repair is just not as strong as when he didn't have a hernia, and so when he strains and tries to lift, he can still experience some of that pain where the hernia was repaired at." (PX6, p.12). Dr. Cummings felt that the new increased, permanent restrictions were related to the original hernia injury, noting that the repair was "… just not as strong as his native tissue would be before he had the hernia and/or he may have some chronic pain there from some nerve entrapment." (PX6, pp.12-13). Dr. Cummings believed Petitioner was having symptoms of nerve entrapment, including "[c]hronic pain in that area, pain to palpation and pain when he tries to lift heavier objects." (PX6, p.13).

On cross examination, Dr. Cummings agreed that he only saw Petitioner on one occasion, at which time Mr. Sutton "… wanted to know if there was anything else that could be done for his chronic pain." (PX6, pp.16-17). Dr. Cummings noted that he is board certified in pain management and that he treats patients with hernia conditions. (PX6, p.17). He agreed that Petitioner had other co-morbidities and that those would not be related to the work-related accident. (PX6, p.17). In addition, he indicated that his belief that Petitioner may have a nerve entrapment issue is "… based on his history and physical findings." (PX6, p.19). However, he agreed that there was no nerve block or EMG done to confirm any kind of nerve entrapment. (PX6, p.19).

Dr. Cummings agreed that in his letter he attributed the restrictions found in the FCE to the likelihood of scar tissue, his weight, smoking history and the need for Methotrexate, noting that the latter medication "… suppresses your body's response to things, and he may not have healed as well because of a combination of those things…" (PX6, p.20). However, he indicated that the Methotrexate "… would have just been one of the factors that led him to this chronic pain condition. I don't think it would have clouded the FCE or made the FCE not reliable or not accurate." (PX6, p.21). Dr. Cummings believed that Petitioner may have been on the Methotrexate because of his chronic skin conditions. (PX6, p.21). He acknowledged that it could be an indication that the chronic skin condition might not have been symptomatic if Petitioner was no longer on the Methotrexate in 2017, and that his pain symptoms may have improved if he was no longer taking Norco. (PX6, pp.21-22). He also noted that he may have stopped it for other reasons. (PX6, p.22).

In addition, Dr. Cummings agreed the FCE noted the development of lower back pain since the injury, and that Petitioner was tender to the touch in his groin and lumbar spinal paraspinals. (PX6, pp.22-23). He then went on to agree that the FCE results could have been impacted by Petitioner's low back pain, and that the restrictions per the FCE could therefore be related in part to same. (PX6, p.23). He also seemed to agree that the low back pain was not something associated with the work-related hernia condition, and that the records of Dr. Wyffels reflected that Petitioner was experiencing low back pain in 2015 at or around the time that he would have performed this FCE. (PX6, pp.23-24). Dr. Cummings indicated that the low back pain could have impacted the FCE results, but doubted that the psoriatic skin condition did "[b]ecause it wouldn't have affected his strength and ability to move, lift things, not related to the physical, demanding-type of stuff." (PX6, p.26). He indicated that both low back pain and the hernia could have been a factor in the increased work restrictions. (PX6, p.26). He also agreed that it was possible that those restrictions had possibly improved, assuming that his symptoms and underlying condition had improved.

(PX6, p.27),

On re-direct examination, Dr. Cummings indicated that he expected Petitioner's symptoms to be consistent, and that he would still have the same symptoms if he saw him now. (PX6, pp.27-28). He also thought that Mr. Sutton would have good days and bad days, and that "[s]omebody could have low back pain and it not limit them." (PX6, pp.28-29). In addition, Dr. Cummings testified that "[b]ased on what [Petitioner] was telling me..." all of the restrictions were related to the hernia. (PX6, p.30). He also noted that he did not record a history of any significant low back problems with Mr. Sutton. (PX6, p.31).

At the request of the Respondent, Petitioner visited Dr. Peter Mihalakakos on May 30, 2017 for purposes of a §12 examination. (RX4, p.7). Dr. Mihalakakos testified by way of evidence deposition on January 19, 2018. He indicated that he is a board certified general surgeon concentrating mostly on hernias and laparoscopic surgery. (RX4, pp.4-5). Dr. Mihalakakos testified that he did not believe Petitioner was suffering from any kind of nerve entrapment by way of history or upon examination. (RX4, p.10). He also stated that he reviewed the FCE performed on August 27, 2015 restricting Petitioner to no lifting more than 15 pounds on an occasional basis and 10 pounds on a frequent basis. (RX4, p.11). Dr. Mihalakakos opined that this FCE might have been valid in 2015, but he saw Petitioner in 2017 and "I thought he had marked improvement from what – how he had performed on FCE." (RX4, p.12). He also noted that on the date of his exam Petitioner not only complained of low back pain, but there also was some tenderness with palpation of the lumbar area. (RX4, p.12). When asked how low back pain might affect an FCE, Dr. Mihalakakos noted that "... with low back pain, you're going to be limited in the amount that you are going to be able to lift. You will do poorly in anything that requires any bending, climbing. Any type of activity where you need your back to be engaged, you would probably have a worse performance than if you did not have the back pain." (RX4, pp.12-13).

Upon examination, Dr. Mihalakakos found no evidence for recurrence of his hernia or ongoing infection in the left groin, and no evidence of a nerve entrapment. (RX4, p.14). He noted that Petitioner had no specific point tenderness in the usual distribution of any of the nerves and "... did not have any pain at rest. He was sleeping through the night. He was off of his Norco. Usually somebody who has a nerve entrapment has constant severe burning pain... [Petitioner] did not give me a history consistent with [nerve entrapment], nor was there an exam consistent with it either." (RX4, pp.14-15).

Based on his examination and review of the records, including three previous IME reports, Dr. Mihalakakos testified that "[i]t would appear that he had recovered from his left inguinal hernia repair, but he still appeared to be suffering from this skin condition, which is most likely psoriasis." (RX4, p.16). Dr. Mihalakakos also noted that he did not agree that the physical demand level and recommendations of the 2015 FCE were permanent in nature, noting that he "... believe[d] that [Petitioner] at the time of my examination was actually doing better than what had been indicated in the FCE." (RX4, p.16). As a result, Dr. Mihalakakos did not believe Petitioner's work-related disability recurred or increased since the case was tried in April of 2014. (RX4, pp.16-17). He also did not feel Petitioner needed any ongoing treatment as to his hernia, other than for his psoriasis. (RX4, p.17).

On cross examination, Dr. Mihalakakos noted that he "... would imagine that the FCE [in 2015] is an accurate assessment of his abilities at that time..." (RX4, pp.17-18). He also indicated that he did not believe Petitioner needed any restrictions at the time he saw him in 2017 "... based on the available medical records, based on the history I obtained, based on my exam, based on my training, my education, my experience." (RX4, pp.18-19). He agreed as well that whether or not Petitioner was still using Norco would factor into his causation opinion. (RX4, pp.20-21). In addition, Dr. Mihalakakos agreed that Petitioner did not claim he was symptom-free in the left groin area. (RX4, p.21). Instead, he noted Petitioner still had subjective complaints of pain in the groin, but that Mr. Sutton told him he wasn't taking any pain medication. (RX4, p.22). Dr. Mihalakakos indicated that these pain complaints "... could be related to, you know, scar tissue [from the hernia repair]. Could be related to his psoriasis. Psoriasis is known to cause pain. Could be due to deconditioning or weakening of the abdominal muscles. He's been pretty sedentary. He hasn't been really doing anything to strengthen them back up again." (RX4, p.22).

Dr. Mihalakakos noted the FCE indicates Petitioner complained of both groin and back pain at that time, while Mr. Sutton did not complain of back pain when he saw him in 2017. (RX4, p.23). He conceded that he did not ask Petitioner if his low back affected his performance during the FCE, and that he did not mention low back complaints in his IME report because he was asked to give an opinion about the groin. (RX4, pp.23-24). Furthermore, he indicated that the restrictions previously given by Drs. Wyffels and Boghossian "... might have been valid at the time that Dr. Wyffels and Dr. Boghossian saw Mr. Sutton... [and that] based on their training, their experience [they] were using their judgment as to what capabilities Mr. Sutton had at that time." (RX4, pp.24-25). When asked whether he had any issue with their permanent restrictions, Dr. Mihalakakos responded: "[n]o. That was their opinion." (RX4, p.25).

When asked whether the FCE showed more limiting restrictions, Dr. Mihalakakos agreed that it did, but noted that "... you can't really compare an FCE exam to what a surgeon's restrictions are going to be. You're comparing apples and oranges there." (RX4, p.25).

On re-direct examination, Dr. Mihalakakos agreed that he did not see Petitioner in 2015 and that he saw him about two years later in 2017. (RX4, p.35). He also reiterated that he did not believe Petitioner's condition had worsened or increased since the case was tried in April of 2014. (RX4, p.36).

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."

18IWCC0694

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 of Petitioner's disability submitted as part of the present §§19(h)/8(a) Petition differs little from the evidence submitted at the time of arbitration. More to the point, nothing has really changed in terms of Mr. Sutton's hernia condition other than the fact that he has subsequently undergone a functional capacity evaluation wherein it was determined that he was capable of functioning at the Light physical demand level, with occasional two-handed shoulder lifting of 15 pounds and frequent two-handed shoulder lifting of 10 pounds – this compared to the 30-pound lifting restrictions imposed previously. Petitioner continues to complain of left-sided pain and burning in his groin area, only now he claims that this pain and burning has increased since the last hearing. Unfortunately, other than his own self-serving testimony along these lines, there is no objective evidence and/or diagnostic studies to support such a claim. Petitioner's attempt to characterize the August 2015 FCE results as proof of a material change is unconvincing. Indeed, as Dr. Mihalakakos pointed out, Petitioner's unrelated complaints of low back pain could have just as easily limited the amount he was able to lift at the time of the FCE, affecting his performance. (RX4, pp.12-13).

Furthermore, at the time of his examination on May 30, 2017 (or almost two years post-FCE), Dr. Mihalakakos found no evidence of recurrence of his hernia or ongoing infection in the left groin, and no evidence of a nerve entrapment. (RX4, p.14). In fact, Dr. Mihalakakos noted that at the time of his exam Petitioner exhibited "… marked improvement from what – how he had performed on FCE." (RX4, p.12). In this respect, the Commission finds the opinions of Dr. Mihalakakos to be much more persuasive than those offered by Dr. Cummings, who likewise saw Petitioner on only one occasion and who, interestingly enough, ordered the aforementioned FCE before he had even seen Petitioner.

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.

The Commission also denies Petitioner's "Motion to Supplement Record", filed the day after oral arguments in this matter. The Commission notes that while its records do not contain a copy of a §§19(h)/8(a) Petition date-stamped December 6, 2016, as contained in Petitioner's motion, Commission computer records do show that timely §§19(h)/8(a) Petitions were filed on February 14, 2017 and August 17, 2017, or within 30 months of the Commission's prior decision on March 27, 2015. Accordingly, the Commission maintained jurisdiction to hear this matter.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) and §8(a) of the Act is hereby denied.

18IWCC0694

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 - 2018
o: 9/11/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

Darryl Davis,

Petitioner,

vs.

NO: 15 WC 34602
18IWCC0695

Tyson Fresh Meats,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 September 27, 2017, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 9 - 2018
TJT:yl
o 11/5/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

DAVIS, DARRYL
Employee/Petitioner

Case# **15WC034602**

TYSON FRESH MEATS
Employer/Respondent

18IWCC0695

On 9/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0307 ELFENBAUM EVERS & AMARILIO
KAROLINA ZIELINSKA
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

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

18IWCC0695

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)

Darryl Davis
Employee/Petitioner

Case # 15 WC 34602

v.

Consolidated cases: n/a

Tyson Fresh Meats
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 William R. Gallagher, Arbitrator of the Commission, in the city of Rock Island, on August 3, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, January 22, 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 $27,191.03; the average weekly wage was $567.78.

On the date of accident, Petitioner was 56 years of age, single with 0 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the right shoulder arthroscopic surgery recommended by Dr. Waqas Hussain and Dr. Jason Hurbanek.

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)

September 22, 2017
Date

SEP 27 2017

Findings of Fact

Petitioner filed an Amended Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on January 22, 2015. According to the Amended Application, Petitioner was "Injured at work" and sustained an injury to the "Right shoulder; MAW" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a "sticker" and, at trial, Petitioner testified in detail regarding his job duties. Petitioner stated that cattle carcasses were suspended from a device above his work area and were then moved to his workstation. Petitioner had to hold one leg of the carcass up with his left hand and use a knife with his right hand to cut the carcass and main artery to drain the blood. Petitioner said he was right hand dominant and would typically perform the job duties of a sticker with another employee for approximately 30 minutes at a time and then switch with the other employee. Petitioner testified he would perform the sticker job about four hours a day, but said there were occasions in which he was required to perform the duties for an entire day if the other employee was a no show.

Because of the thickness of the hide, Petitioner stated that a significant amount of force was required to perform the job. Petitioner would initially insert the knife into the lower portion of the carcass and then move it upward to about the level of either his chest or head, depending on the size of the carcass. When Petitioner performed this job, he wore a heavy wire mesh suit that covered his entire body which was then covered by a plastic apron.

Petitioner testified that on January 22, 2015, he had worked as a sticker in the morning. When Petitioner subsequently was in the process of removing the apron and wire mesh suit, he felt a sharp pain in his right shoulder describing it as being like it had been stuck with a knife. Petitioner stated he informed his supervisor, someone named "Chris" and was seen by the plant nurse.

A written report was prepared and signed by Petitioner on January 22, 2015. According to the report, Petitioner was removing a mesh apron and experienced sudden pain in his right shoulder (Respondent's Exhibit 2).

Nicole Smith, the plant nurse, saw Petitioner on January 22, 2015. According to her record of that date, Petitioner raised his arms to remove the mesh and felt sudden right shoulder pain. Smith gave Petitioner some medication and directed him to apply ice four times a day. She also authorized Petitioner to work with restrictions. Petitioner was subsequently seen by Smith on several occasions in February/March, 2015 (Petitioner's Exhibit 7).

Smith referred Petitioner to physical therapy where he was initially evaluated on February 6, 2015. The record of that date did not contain a history of how Petitioner injured his right shoulder; however, when Petitioner was seen there on February 25, 2015, the record noted that Petitioner's right shoulder pain started at the end of January and came on suddenly when he removed a mesh apron at work (Petitioner's Exhibit 5).

On February 23, 2015, Petitioner was evaluated by Dr. J. R. Hallman. At that time, Petitioner continued to complain of right shoulder pain. According to Dr. Hallman's record of that date, Petitioner stated he hurt his right shoulder at work on January 29, after repetitive movement. Dr. Hallman opined Petitioner had right shoulder pain and possible tendinitis (Petitioner's Exhibit 4).

In March/April, 2015, Petitioner continued to receive physical therapy, but his symptoms did not improve to any significant degree. On March 11, 2015, Petitioner was examined by Dr. Rajiv Khanna for his right shoulder symptoms. According to Dr. Khanna's record of that date, Petitioner had a two month history of right shoulder pain which started spontaneously when he was at work. His record noted that Petitioner worked at a butcher plant where he constantly dealt with cleaning and heavy lifting with his right upper extremity; however, Petitioner did not recall a "...single incident of injury." Dr. Khanna diagnosed Petitioner with impingement of right shoulder, frozen shoulder and ruled out a rotator cuff tear. He opined that an MRI might be indicated (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Dr. Waqas Hussain, an orthopedic surgeon, on May 21, 2015. At that time, Petitioner advised he had right shoulder pain which began in January, 2015. Petitioner stated he was removing a uniform and felt a sharp pain/tearing in the shoulder. Dr. Hussain ordered an MRI scan to be performed concurrent with a steroid injection (Petitioner's Exhibit 3).

An MRI/arthrogram was performed on June 4, 2015. According to the radiologist, the study revealed tendinopathy supraspinatus from impingement from bony spurs of the AC joint; articular surface tear of the subscapularis rotator; and small glenoid labral tear. Pursuant to Dr. Hussain's order, Petitioner also received a steroid injection as well (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Hussain on June 16, 2015. Dr. Hussain reviewed the MRI/arthrogram and his examination was consistent with its findings. Dr. Hussain administered another steroid injection and ordered further physical therapy (Petitioner's Exhibit 3).

Petitioner received physical therapy in June/July, 2015, but only made minimal progress in regard to his right shoulder symptoms. The physical therapy record of June 23, 2015, noted that Petitioner only had relief from his right shoulder symptoms for a couple of days following the steroid injections (Petitioner's Exhibit 5).

Petitioner was subsequently seen by Dr. Hussain on August 13, 2015. Petitioner continued to complain of right shoulder pain. Dr. Hussain noted that Petitioner had not had any significant relief from his symptoms from his prior nonsurgical management. Dr. Hussain recommended Petitioner undergo arthroscopic surgery on the right shoulder (Petitioner's Exhibit 3).

Respondent scheduled Petitioner to be examined by Dr. Nikhil Verma, an orthopedic surgeon, on August 17, 2015. However, Respondent did not send Petitioner a check for his mileage expense so Petitioner did not keep the appointment.

In preparation for the scheduled examination of Petitioner on August 17, 2015, Dr. Verma reviewed medical records provided to him by Respondent. Dr. Verma prepared a report dated September 2, 2015, regarding his review of the medical records. Based upon his review of the records, Dr. Verma opined Petitioner had right shoulder pain, but that he would need to examine the Petitioner and review the MRI scan to ascertain an accurate diagnosis. However, Dr. Verma indicated that the MRI report did not describe a functional tear and the findings were consistent with age related changes. Dr. Verma also noted that additional medical records would need to be reviewed before he could opine as to whether Petitioner's right shoulder condition was work-related (Respondent's Exhibit 1; Deposition Exhibit 2).

Petitioner continued to be treated by Dr. Hussain from November, 2015, through February, 2016. When Dr. Hussain saw Petitioner on January 8, 2016, he administered another steroid injection. When Petitioner was seen by Dr. Hussain on February 6, 2016, Dr. Hussain renewed his recommendation that Petitioner undergo arthroscopic surgery on the right shoulder. He noted that all nonsurgical options had been exhausted (Petitioner's Exhibit 3).

At the direction of Petitioner's counsel, Petitioner was examined by Dr. Jason Hurbanek, an orthopedic surgeon, on October 3, 2016. When seen by Dr. Hurbanek, Petitioner advised that his right shoulder pain began in January, 2015, while at work. Petitioner described his job duties and stated that after bleeding cattle, he removed his apron and felt a sharp pain in his right shoulder. Petitioner informed Dr. Hurbanek that an MRI had been performed. In connection with his examination of Petitioner, Dr. Hurbanek reviewed the MRI/arthrogram and opined it revealed a partial rotator cuff tear, possible subcoracoid cyst and labral tear. Dr. Hurbanek noted Petitioner had received conservative treatment including physical therapy, medication and injections, but without any significant relief. He recommended Petitioner undergo arthroscopic surgery on the right shoulder (Petitioner's Exhibit 2).

At the direction of Respondent, Dr. Verma reviewed additional medical records as well as Respondent's written job description of a "sticker" and prepared a report dated January 12, 2017. Dr. Verma opined that the MRI/arthrogram did not reveal a rotator cuff tear. He stated Petitioner had a frozen shoulder and possible impingement of the AC joint, but that these conditions were not related to Petitioner's job activities. Dr. Verma deferred making any treatment recommendation, but noted Petitioner had conservative treatment that had failed so arthroscopic surgery was a possibility (Respondent's Exhibit 1; Deposition Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Verma on April 10, 2017. Dr. Verma's report of that date was consistent with his prior reports. He opined Petitioner had right shoulder impingement with rotator cuff tendinopathy, but that there was not a causal relationship between either Petitioner's repetitive work duties or Petitioner's removal of what Dr. Verma described as a "vest." He opined that the treatment that had been rendered to Petitioner to date was reasonable and necessary and that arthroscopic surgery might be indicated, although not related to Petitioner's work activities (Respondent's Exhibit 1; Deposition Exhibit 4).

Dr. Hurbanek was deposed on March 9, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Hurbanek's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to his review of the MRI/arthrogram, he opined it revealed a partial subscapularis tendon tear as well as a labral tear and that arthroscopic surgery was appropriate (Petitioner's Exhibit 1; pp 8-9, 15-16).

In regard to causality, Dr. Hurbanek testified that when Petitioner removed the apron, he likely aggravated the condition and stated "I think it potentially was the incident that sort of put him over the edge and aggravated what was happening in his shoulder." Dr. Hurbanek also stated that Petitioner's sticking a cow with a knife through its hide was a forceful activity. He also referenced the job description that had been provided to Dr. Verma and noted the physical demands indicated therein which included shoulder flexion from 0 to 90° and grasping. He opined this repetitive use of the shoulder would be a chronic component of Petitioner's shoulder condition (Petitioner's Exhibit 1; pp 11-14).

On cross-examination, Dr. Hurbanek stated that Petitioner's repetitive job duties caused the right shoulder condition, but that the symptoms started after he removed the apron. He conceded that one or the other could have caused Petitioner's right shoulder condition but could not state which one (Petitioner's Exhibit 1; pp 22-23).

Dr. Verma was deposed on May 24, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Verma's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Dr. Verma stated that his medical reports of September 2, 2015, and January 12, 2017, were based upon the medical records and job description he reviewed and he did not examine Petitioner on those occasions. He also opined that the MRI/arthrogram did not reveal any evidence of either partial or full thickness rotator cuff tears (Respondent's Exhibit 1; pp 8-11).

In regard to causality, Dr. Verma testified that neither the repetitive use of Petitioner's right shoulder nor the removal of the "vest" caused Petitioner's right shoulder condition. This opinion was based, in part, on Dr. Verma's review of the job description noting that "minimal force" was required to perform the job. Dr. Verma also reviewed a video of approximately 30 seconds which he stated showed animals hanging upside down on a conveyor and individuals using a knife to open the animal's throat to allow it to bleed out. He stated he did not observe any significant lifting or forceful movement of the arms or use of the arms above shoulder level. Dr. Verma stated there was nothing in the video to cause him to change any of his opinions regarding causality (Respondent's Exhibit 1; pp 16-19).

When Dr. Verma was deposed, Respondent's counsel did not tender the video into evidence at that time. Petitioner's counsel did not raise an objection to Dr. Verma's testimony about what he observed in the video without the video been tendered at the time of the deposition. At trial, Petitioner's counsel objected to that portion of Dr. Verma's testimony. The Arbitrator reserved his ruling on the objection at that time and directed counsel for the parties to address that issue in their proposed decisions.

David Hayes testified on behalf of Respondent at trial. Hayes was Respondent's in house ergonomics expert. He identified the job description and stated that he had observed individuals performing the job. Hayes had never performed Petitioner's job and had no specific knowledge how much force was required to cut the hide; however, he still testified that the amount of force required was "minimal."

At trial, Petitioner testified that he had not sustained any prior or subsequent right shoulder injuries. Petitioner continued to work for Respondent on light duty and still has right shoulder pain especially when he would reach out or lift with his right arm. Petitioner wants to proceed with the right shoulder arthroscopic surgery.

Evidentiary Ruling

As noted herein, at trial, Petitioner's counsel objected to that portion of Dr. Verma's testimony wherein he referenced the video of individuals performing Petitioner's job duties. However, Petitioner's counsel made no objection to Dr. Verma's testimony regarding his review of the video at the time of the deposition. The Arbitrator overrules the objection and finds that by not objecting to Dr. Verma's testimony regarding same at the time of the deposition, Petitioner's counsel waived any objection she may have had. This is not a ruling by the Arbitrator as to what probative value, if any, Dr. Verma's testimony regarding the video may have.

Conclusions of Law

In regard to disputed issues (C) and (F) Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on January 22, 2015, and that his current condition of ill-being in regard to his right shoulder is causally related to same.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner reported that he had sustained an injury to his right shoulder on January 22, 2015. A report was prepared and signed by Petitioner on that day and noted that he experienced shoulder pain in his right shoulder while removing a mesh apron. Further, Petitioner was also seen and treated by the plant nurse on that same day.

The Arbitrator acknowledges that there were some inconsistencies in the history Petitioner provided to various medical providers. When seen by Dr. Hallman, Petitioner erroneously stated the date of accident to be January 29 and described repetitive movement of the right shoulder. When initially seen by Dr. Khanna, Petitioner did not describe a single incident of injury. It appeared as though Petitioner was uncertain whether his right shoulder condition was because of the repetitive movement of his shoulder while at work or when he removed the apron.

Petitioner testified in detail regarding the job duties of a "sticker" and that the insertion of the knife into the carcass required a significant amount of force, primarily because of the thickness of the hide. The Arbitrator found Petitioner's testimony in regard to the job duties of a sticker to be credible.

The Arbitrator was not persuaded by the testimony of David Hayes, because he agreed he had never performed the job duties of a sticker, agreed he had no specific knowledge of how much force was required, but then somehow concluded that the amount of force required was "minimal."

Respondent's Section 12 examiner (who initially only reviewed medical records) Dr. Verma's opinion that Petitioner's right shoulder condition was not related to his work activities was based, in part, upon the job description which noted that only minimal force was required. As aforestated, the Arbitrator was not persuaded that only minimal force was required in the performance of Petitioner's job duties. Dr. Verma's opinion was also based, in part, on the video of other individuals performing Petitioner's job duties. The probative value of this testimony is limited because the video was not tendered into evidence and the Arbitrator had no opportunity to review same.

Petitioner's Section 12 examiner, Dr. Hurbanek, was not certain whether Petitioner's right shoulder condition was related to either the repetitive nature of his work activities or the removal of the apron. However, it was clear to Dr. Hurbanek and he opined that Petitioner's right shoulder condition was work-related. Dr. Hurbanek's opinion was based, in part, on the fact that sticking a cow with a knife was a forceful activity which required flexion of the right shoulder.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Hurbanek to be more persuasive than that of Dr. Verma.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that all of the medical services provided to Petitioner were reasonable and necessary.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the arthroscopic right shoulder surgery recommended by Dr. Hussain and Dr. Hurbanek.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner requires arthroscopic surgery on his right shoulder.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rachel Porrata,
Petitioner,

vs. NO: 16 WC 27670

State of Illinois/Illinois Department of Human Services,
Respondent.

18IWCC0696

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 April 17, 2018 is hereby affirmed and adopted.

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

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

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

DATED: NOV 14 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PORRATA, RACHEL
Employee/Petitioner

Case# **16WC027670**

SOI/DEPT OF HUMAN SERVICES
Employer/Respondent

18IWCC0696

On 4/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 62701

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

0988 ASSISTANT ATTORNEY GENERAL
JORDAN HOMER
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

APR 17 2018

DONALD A. PORRATA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0696

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rachel Porrata
Employee/Petitioner

v.

State of Illinois/Department of Human Services
Employer/Respondent

Case # **16** WC **27670**

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 **Bloomington**, on **3-26-17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8-18-16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,688.00**; the average weekly wage was **$494.00**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **4** dependent children.

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

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

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

Respondent is entitled to a credit for all medical bills paid by its group carrier under Section 8(j) of the Act.

ORDER

Credits

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

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.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for all services that Petitioner received from Dr. Li at Applied Pain Institute from 8-19-16 through the date of arbitration, as provided in Sections 8(a) and 8.2 of the Act as contained in Petitioner's Exhibits 12 and 18.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $326.33/week for 34 1/7 weeks, commencing 8-19-16 through 4-14-17, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of the minimum of $300.00/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.

D. Dglas McEwen

Signature of Arbitrator

4/13/2018
Date

APR 17 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 42 year old personal assistant, was employed by the State of Illinois/Department of Human Services, since 2012 (TR 10, 11, 27, 28). Petitioner's job consisted of assisting a totally dependent disabled woman who weighed over 300 pounds in her house. Petitioner said that on 8-18-16, she was using a Hoyer lift to transfer the patient from her bed to her chair. Petitioner testified that while the patient was still in the Hoyer lift, she was bending over and pushing the patient into her chair when she felt a sudden sharp pain in her low back and left leg. Petitioner said that the patient noticed that she was injured and told her to go home for the day (TR 9-12).

Petitioner testified that her low back and left leg pain increased over night and that she treated with Dr. Ji Li, a pain specialist, at his clinic in Pontiac on an emergency basis on 8-19-16. Petitioner said that Dr. Li took her off work (TR 12, 13).

On 8-19-16, Dr. Li took Petitioner off work and stated that she had severe low back pain and lumbar radiculopathy (PX 10). On 8-19-16, Dr. Li took a history that Petitioner injured her left lower back and leg while guiding a 325 pound woman to her wheelchair using a Hoyer lift. Dr. Li prescribed Relafen 750 mg (PX 4).

On 8-25-16, Dr. Li stated that Petitioner was being treated for a work related injury for pain in her low back which radiated down her left leg. Dr. Li stated that Petitioner had numbness and tingling into her left foot as a result of her work accident. On exam, Dr. Li noted numbness and tingling in the left leg to the toes. Dr. Li diagnosed lumbar radiculopathy and requested workers' compensation authorization to get an MRI of Petitioner's lumbar spine (PX 5).

On 9-23-16, Dr. Li treated Petitioner for left sided low back which radiated into her left hip and thigh. Dr. Li's record states that Petitioner was able to stand if she switched her weight from her right to her left leg. Dr. Li stated that Petitioner had numbness and tingling into her left leg. Dr. Li again recommended that Petitioner undergo an MRI of her lumbar spine (PX 6).

Petitioner testified that the workers' compensation carrier would not authorize the MRI and that her workers' compensation case was denied (TR 15, 16). The parties stated that Respondent, State of Illinois, was unable to pay any benefits until the Fourth District Appellate Court reached a determination in *Michael L. Hoffman v Lisa Madigan*, 2017 Ill.App. (4th), 160392. The Fourth District Appellate Court entered a decision on 6-22-17 (TR 4, 5).

Petitioner testified that because her case was denied, it affected her ability to treat medically. Petitioner said that she continued to treat with Dr. Li every few months for medication and limited care (TR 16, 30, 31).

On 11-18-16, Dr. Li stated that Petitioner continued to experience numbness and tingling on the left side with a decrease in sensory and motor function of her left leg. Dr. Li stated that he was still waiting for the MRI approval and he continued her pain medications (PX 8, p.p. 2, 3). On 1-20-17, Dr. Li noted continuing numbness and tingling into the left foot with pain radiating from the tailbone, to the left hip and into the left foot (PX 8, p. 1). On 4-7-17, Dr. Li stated that Petitioner was having left sided low back pain that radiated to the posterior of her left knee. Dr. Li stated that Petitioner had cramping in her toes of her left foot occasionally. Dr. Li stated that Petitioner had a loss of sleep due to pain (PX 9, p. 1).

Petitioner testified that after her accident, she continued to experience radiation of pain down her left leg and that she began to experience numbness into her left toes. Petitioner said that her toes started contracting and that she discussed this with Dr. Li (TR 17, 18).

Petitioner testified that after her accident, it was difficult to live without an income. Petitioner testified that she began performing some part-time cleaning work at ESSI on 4-15-17. After she began working at ESSI, she experienced increased left hip and leg pain while vacuuming. Petitioner stopped working at ESSI after two months because of increased pain. Petitioner then began working at the Hampton Inn cleaning. Petitioner testified that she had difficulty performing her cleaning duties at Hampton Inn and that she began working for The Pointe, an assisted senior living center, performing light cleaning duties, for approximately 25 hours a week (TR 19-22, 23, 24). Petitioner continued to work for The Pointe through the date of arbitration (TR 23, 24).

Petitioner testified that she had a previous back injury at work on 7-5-09 and that she treated with Dr. Ji Li after that injury. Petitioner said that after her 7-5-09 accident at Flanagan-Rehabilitation and Health Center, she had right sided lower back and hip pain involving her piriformis muscle. Petitioner said that she had continued to treat with Dr. Li every three months for the right sided pain (TR 13, 14). Petitioner said that she resolved her workers' compensation case in 2011 and that she was able to perform her regular duties as a personal assistant for the State of Illinois/Illinois Department of Human Services from 2012 until the date of her accident on 8-18-16 (TR 24, 25).

On 12-12-11, the Workers' Compensation Commission approved a settlement for $75,000 for Petitioner's 7-5-09 work accident. The terms of the settlement states that this was for a disputed PSOAS muscle/piriformis syndrome (PX 13).

Petitioner testified that prior to 8-18-16, her pain was right sided low back and hip and that after her 8-18-16 accident, her pain was left sided and that it radiated down the posterior side of her left leg with tingling into her toes. Petitioner testified that prior to 8-18-16, she did not have left leg or left hip pain (TR 13, 14, 25, 26).

Dr. Li testified by deposition taken November 17, 2016. Dr. Li testified that he had treated Petitioner since 2009. Dr. Li stated that prior to 8-18-16, he treated her primarily for right sided back and hip pain (PX 1, p. 6). Dr. Li testified that after Petitioner's work accident on 8-18-16, he began treating her for left sided low

back pain, left hip pain and pain into the left leg. Dr. Li stated that the left sided pain after the 8-18-16 accident was quite different from her previous right sided complaints. Dr. Li testified that prior to 8-18-16, he did not recall treating Petitioner for left sided pain or left leg pain (PX 1, p.p. 8, 9).

Dr. Li testified that on 8-25-16, Petitioner had positive straight leg raising on both sides and that her Patrick's sign was positive which indicated there could be nerve pinching and muscle strain. Dr. Li stated that on exam, Petitioner had left sided decreased reflexes and that the left heel reflexes were decreased. Dr. Li said that Petitioner's left sided motor function was decreased indicating that there could be some nerve impingement in the lumbar spine. Dr. Li testified that these were new findings and he recommended that Petitioner undergo an MRI of the lumbar spine to assess Petitioner's new symptoms after her August, 2016 accident. Dr. Li opined that Petitioner's new findings were left sided radiculopathy with tingling and numbness sensation indicating there could be some compromise in the neurological functions (PX 1, p.p. 10, 11).

Dr. Li opined that as a result of Petitioner's 8-18-16 accident, Petitioner likely sustained lumbar radiculopathy secondary to lumbar disc disease. Dr. Li opined that Petitioner's differential diagnosis was a back strain which included a strain to the back muscles, SI joint strain, and facet joint strain. Dr. Li opined that Petitioner had remained off work since 8-19-16 (PX 1, p.p. 14, 15).

Petitioner offered the deposition of Dr. Ji Li taken July 18, 2011 for her previous claim against Flanagan Rehab and Health Center (09 WC 33368). Dr. Li testified that an MRI of 7-27-09 revealed minor degenerative changes and some bulging at L4-5 and L5-S1 on the right (PX 14, p. 7). Dr. Li performed right S1 joint injections, right piriformis muscle injections, right bursitis injections and greater trochanteric bursitis injections (PX 14, p. 9). Dr. Li stated that an EMG and nerve conduction study done in May of 2010 was read as normal (PX 14, p. 31). Dr. Ji diagnosed Petitioner with severe muscle damage primarily in the piriformis muscle, PSOAS muscles, and some bursitis pain as a result of her 7-5-09 accident. Dr. Li opined that as of 7-18-11, Petitioner was not at maximum medical improvement. Dr. Li opined that Petitioner's injury could be chronic, but was not likely permanent because it was muscular pain (PX 14, p.p. 25, 26, 39).

On 3-2-18, Petitioner treated with Dr. Li. Dr. Li stated that Petitioner's pain was overall the same. Dr. Li stated that Petitioner had low back and buttock pain that radiated to her left leg and down to her left foot. Dr. Li diagnosed SI pain and myofascial pain (PX 17).

Petitioner testified that at the time of arbitration she was taking Oxycodone as needed, Gabapentin, and Ibuprofen 2 to 3 times a day. Petitioner said that she took Oxycodone approximately 4 times a day. Petitioner said that she takes more Oxycodone when she works and she takes less on days she does not work. Petitioner said that if she can limit her hours to 6 hours a day, she has less pain and takes less medication (TR 22, 23).

Based on the above, as well as the credible record, the Arbitrator finds that Petitioner sustained a 10% loss of use of person as a whole under Section 8(d)2 as a result of the accident on 8-18-16. Pursuant to Section 8.1(b) of the Act, the Arbitrator in determining the level of permanent partial disability, bases his decision 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.

(i) In the case at bar, the parties did not offer into evidence the reported level of impairment under the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. The Arbitrator therefore places no weight in this factor. (ii). Petitioner was employed as a personal assistant at the time of the injury for Respondent. Petitioner did not return to her employment as a personal assistant, but found lighter work as a light housekeeper for The Pointe, an assisted living facility in Pontiac. The Arbitrator places greater weight in this factor. (iii). Petitioner was 42 years of age at the time of her accident. The Arbitrator considers Petitioner to be a somewhat younger individual and concludes that Petitioner's permanent partial disability will be more extensive than that of an older individual as she will have to live with the permanent partial disability longer. The Arbitrator places greater weight in this factor. (iv). At the time of the injury, Petitioner was earning $13 an hour and was working 38 hours a week. At the time of arbitration, Petitioner was making $9 an hour and was working 25 hours a week. Petitioner testified that she had difficulty working more than 6 hours a day. The Arbitrator therefore places some weight in this factor. (v). Petitioner has evidence of disability as corroborated by the medical records. Dr. Li's final examination of March 2, 2018 shows the Petitioner with diffuse tenderness of the left SI joint and hip and positive Patrick's and Straight Leg Raising tests on the left side. (PX 8) At the time of arbitration, Petitioner had continued to experience pain into her left lower back, left hip, with radiculopathy down her left leg. Petitioner testified that she continued to have numbness into her left foot and toes with some contraction of her toes at night. This is consistent with Dr. Li's diagnosis of left sided lumbar radiculopathy with decreased heel and foot reflexes. The Arbitrator therefore gives greater weight to this factor.

Petitioner testified that when she worked for Respondent, she made $13 an hour and worked 38 hours a week. Petitioner said that at the time of arbitration, she worked in light housekeeping at The Pointe in Pontiac making $9 an hour and that she worked an average of 25 hours a week (TR 24, 27).

Petitioner testified that at the time of arbitration, she continued to experience pain in her left lower back and left hip which extended down her left leg. Petitioner said that she has continued to experience numbness into her left foot and toes and that she experiences some contraction of her toes at night (TR 25, 26).

On cross examination, Petitioner testified that she did not have work restrictions before 8-18-16 and that she had no work restrictions at the time of arbitration. Petitioner said that she had an eighth grade education, that she did not complete her GED, and that she had taken some placement tests which allowed her to take some college courses in technology (TR 28, 29). On cross, Petitioner said that she had a follow up with Dr. Li in three months. Petitioner testified that since her 8-18-16 accident, she did not really feel her right sided pain as much because her left hip and leg hurt much more (TR 30, 31).

(J) Were the Medical Services That Were Provided To Petitioner Reasonable And Necessary? Has The Respondent Paid All Appropriate Charges For All Reasonable And Necessary Medical Services?

The Respondent stipulated, and the Arbitrator finds, that Dr. Li's treatment at Applied Pain Institute from 8-19-16 through the date of arbitration is reasonable and necessary medical care to treat the ill effects from Petitioner's 8-18-16 work accident. The Arbitrator therefore orders Respondent to pay for all medical services, pursuant to the Medical Fee Schedule, that Petitioner received from Dr. Li at Applied Pain Institute from 8-19-16 through the date of arbitration, as provided in Section 8(a) and 8.2 of the Act as contained in Petitioner's Exhibits 12 and 18.

(K) What Temporary Benefits Are In Dispute?

The Respondent stipulated, and the Arbitrator finds, that Petitioner is entitled to temporary total disability benefits of $326.33/week for 34 1/7 weeks, commencing 8-19-16 through 4-14-17, as provided in Section 8(b) of the Act.

(L) What Is The Nature And Extent Of The Injury?

The Arbitrator relies on Dr. Li's records and testimony and finds that as a result of Petitioner's 8-18-16 accident Petitioner sustained an injury to her left lower back, left hip, with accompanying radiculopathy into the leg and left foot. The Arbitrator relies on Dr. Li's records and testimony and further finds that as a result of the 8-18-16 accident and resulting radiculopathy, Petitioner has left sided decreased reflexes in her left leg and left heel.

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

Tracy W Asbury,
Petitioner,

18IWCC0697

vs. NO: 15 WC 17089

Marshall Ryan, Indv, Marti Ryan Indv and d/b/a Ryan Field Services, Safeguard Properties LLC and Michael Frerichs, as Illinois State Treasurer as *ex-officio* custodian of the Illinois Injured Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 2017, is hereby affirmed and adopted.

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

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

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

18IWCC0697

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 14 2018
o10/11/18
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0697

ASBURY, TRACY W
Employee/Petitioner

Case# 15WC017089

RYAN, MARSHALL INDV RYAN, MARTI INDV AND D/B/A RYAN FIELD SERVICES SAFEGUARD PROPERTIES LLC AND FRERICHS, MICHAL W AS ILLINOIS STATE TREASURER AS CUSTODIAN OF THE ILLINOIS [INJURED] WORKERS' BENEFIT FUND
Employer/Respondent

On 8/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

1454 THOMAS & ASSOCIATES
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18IWCC0697

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tracy W. Asbury
Employee/Petitioner

v.

Marshall Ryan, Individually, Marti Ryan, Individually, and d/b/a Ryan Field Services, Safeguard Properties, LLC, and Michael W. Frerichs as Illinois State Treasurer as Custodian of the Illinois [Injured] Workers' Benefit Fund
Employer/Respondent

Case # 15 WC 17089

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on July 20, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 26, 2015, Respondents were operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent, Safeguard Properties, LLC, "statutory employer" pursuant to Section 1(a)3 of the Act.

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 Respondents.

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

In the year preceding the injury, it was stipulated that Petitioner earned $22,880.00; and it was stipulated that the average weekly wage was $440.00.

On the date of accident, Petitioner was 37 years of age, single with 3 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent, Safeguard Properties, LLC, has not paid all appropriate charges for all reasonable and necessary medical services.

Respondent, Safeguard Properties, LLC, shall be given a credit of $1,580.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,580.00.

Respondents are entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent, Safeguard Properties, LLC, shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 5, in regard to the left wrist and right knee conditions, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent, Safeguard Properties, LLC, shall pay Petitioner temporary total disability benefits of $319.00 per week for 14 6/7 weeks commencing January 27, 2015, through May 10, 2015, as provided in Section 8(b) of the Act.

Respondent, Safeguard Properties, LLC, shall pay Petitioner maintenance benefits of $319.00 per week for 23 5/7 weeks commencing May 11, 2015, through October 23, 2015, as provided in Section 8(a) of the Act.

Respondent, Safeguard Properties, LLC, shall pay Petitioner permanent partial disability benefits of $319.00 per week for 95.75 weeks because the injury sustained caused the 35% loss of use of the right leg and 10% loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

August 12, 2017
Date

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment on January 26, 2015. The Application named as Respondents, Marshall Ryan, Individually, Marti Ryan, Individually and d/b/a Ryan Field Services (hereinafter referred to as "RFS"), Safeguard Properties, LLC (hereinafter referred to as "Safeguard") and Michael W. Frerichs as Illinois State Treasurer as Custodian of the Illinois [Injured] Workers' Benefit Fund (herein after referred to as "IWBF"). According to the Application, Petitioner sustained the accident "In course of employment" and sustained injuries to "Multiple body parts" (Arbitrator's Exhibit 3).

RFS was previously incorporated in Illinois; however, the corporation was involuntarily dissolved on September 12, 2014 (Petitioner's Exhibit 9). Further, workers' compensation insurance coverage for RFS was canceled effective November 5, 2014 (Petitioner's Exhibit 10).

RFS was in the business of providing various repairs, maintenance, yard work, etc. for properties that had been foreclosed. Sometime prior to January, 2015, RFS and Safeguard entered into a contract wherein RFS would provide the aforementioned services to Safeguard.

The contract entered into by RFS and Safeguard was received into evidence at trial. The contract was not dated; however, it was signed by Marti Ryan on behalf of RFS and Joe Iafigliola on behalf of Safeguard. Safeguard was a company that serviced properties in the mortgage industry and its services included inspections, repairs, maintenance, etc. The contract entered into by RFS and Safeguard provided that RFS was a contractor and would perform various services to be specified by Safeguard in work orders. (Petitioner's Exhibit 14; Respondent Safeguard's Exhibits 1, 2 and 3). Based upon the preceding contractual agreement and the facts regarding Petitioner's work-related accident, Petitioner and the IWBF sought to have liability found against Safeguard as a "statutory employer" pursuant to Section 1(a)3 of the Act.

At trial, two stipulation sheets were prepared and received into evidence. The first stipulation sheet was in regard to the Petitioner and RFS/IWBF. The second stipulation she was in regard to Petitioner and Safeguard. Initially, it was noted that RFS had been served with notices that the case was going to proceed to trial on more than one occasion, but RFS did not respond or appear at any time. Accordingly, representation of the interest of RFS was by the Attorney General's office on behalf of the IWBF.

In the first stipulation sheet, it was agreed that there was an employee-employer relationship, but that Petitioner was an "employee" of Safeguard. Further, the IWBF stipulated that Petitioner sustained an accident, gave notice of same, had an average weekly wage of $440.00, was 37 years old, single with three dependents, but disputed liability on the basis of causality. The IWBF also denied liability for medical expenses as well as temporary total disability and maintenance benefits (Arbitrator's Exhibit 1).

In the second stipulation sheet, Safeguard denied that there was an employee-employer relationship. Based upon the preceding, Safeguard denied all of the other claims of Petitioner other than his age, marital status and number of dependents (Arbitrator's Exhibit 2).

Petitioner testified that he began working for RFS in March, 2013, as a laborer. Petitioner stated that his job required him to perform a wide variety of duties, including painting, maintenance, yard work, cleaning, drywalling, etc. Petitioner said he would get written work orders from RFS which would contain the address of the property, the work to be performed at the property, etc. He also stated that the work order would have at the top of it the name of either "Five Brothers" or "Safeguard."

Petitioner stated that he normally worked 40 hours a week and was initially paid $10.00 an hour, but subsequently received a raise to $11.00 an hour. At trial, wage records and a one page summary of wage data were received into evidence. The summary included pay periods ending January 4, 2014, to January 24, 2015. There were a number of weeks in which Petitioner worked less than five days per week and the total amount he was paid was $18,458.46. Excluding the days Petitioner did not work, the average weekly wage was computed as $444.03, which was slightly higher than the stipulated average weekly wage of $440.00 (Petitioner's Exhibit 6).

In January, 2015, pursuant to a work order from Safeguard, Petitioner was working at a foreclosed residence at 204 Belaire Drive, Washington, IL (hereinafter referred to as "Belaire"). Various documents regarding the work performed by RFS at Belaire at the direction of Safeguard were received into evidence at trial. In a text from Safeguard to RFS dated December 23, 2014, RFS was authorized to perform mold remediation at Belaire in the amount of $14,220.42 (Petitioner's Exhibit 15; Respondent Safeguard's Exhibits 1, 2 and 3).

There was communication between RFS and Safeguard dated January 15, 2015, which noted that there was a delay in completing the work at Belaire. There were e-mails dated January 26, January 27, and January 29, 2015, which also referenced the work being performed by RFS at Belaire. The e-mail of January 26, 2015, specifically referenced that drywall would be completed on January 27, 2015. However, an invoice dated February 6, 2015, was also included and indicated a completion date of February 5, 2015 (Petitioner's Exhibit 15; pp 1, 25-27; Respondent Safeguard's Exhibits 1, 2 and 3).

Petitioner tendered into evidence photographs of Petitioner performing work at Belaire on January 13 and 23, 2015 (Petitioner's Exhibit 16; pp 4-7). Photographs of the front door of Belaire were also tendered into evidence. A written notice was affixed to the front door which, in part, stated that the property was "vacant/abandon" and that if it was found to be occupied, Safeguard was to be notified. Two of the four photographs of the front door were dated February 5, 2015 (Petitioner's Exhibit 16; pp 1-2, 8-9).

Petitioner tendered into evidence receipts for various supplies purchased by RFS from Menards from January 2 through January 30, 2015. The items purchased at Menards included tape, vapor barrier primer, sandpaper, shoe covers and other items. On January 27, 2015 (the day after Petitioner's accident) RFS purchased 65 sheets of what was described as "1/2"X4X8 MOISTURE RESIST 58 LBS" (Petitioner's Exhibit 8; P 38).

At trial, Petitioner testified that he worked at Belaire for several days during January, 2015. He acknowledged that he was the individual photographed while working at Belaire on January 13 and 23, 2015 (Petitioner's Exhibit 16; pp 4-7). Petitioner stated that he initially tore out the old drywall, insulation and studding to prepare the area for the mold treatment. The initial part of the mold treatment consisted of washing down the surfaces with what Petitioner called "mold stat." Petitioner said that after the mold stat was applied to the walls, the walls would then be painted before the application of the new drywall.

Petitioner testified he was directed by RFS to install new drywall at Belaire on January 26, 2015, pursuant to a work order from Safeguard. Petitioner reported for work at the RFS office on the morning of January 26, 2015, and he was ordered by Marshall Ryan to hook up a trailer to a truck, both of which were owned by RFS. Petitioner stated that the trailer was needed for various items required for performing the work at Belaire including generators in the event of the power being off at Belaire.

The trailer and truck were in a parking lot at RFS and only RFS or its employees used the lot. As Petitioner was in the process of walking and holding the trailer up to hitch if to the truck, Petitioner slipped and fell on the ice. When this occurred, the trailer landed on Petitioner's right knee and wedged his left hand under the tailgate of the truck.

Following the accident, Petitioner was seen in the ER of St. Joseph's Medical Center on January 26, 2015. At that time, Petitioner stated he had sustained a fall at work and injured his right knee and left wrist. In regard to the right knee, x-rays, a CT scan and an MRI were ordered. The diagnostic studies revealed Petitioner had sustained multiple complex fractures of the tibial plateau and spines. In regard to the left wrist, x-rays and a CT scan were ordered. The diagnostic tests revealed a volar distal radial joint dislocation (Petitioner's Exhibit 1). Petitioner was subsequently treated by Dr. Jerome Oakey, an orthopedic surgeon, and Dr. Joseph Norris, an orthopedic surgeon, for his right knee and left wrist injuries, respectively. On January 26, 2015, Dr. Oakey performed a closed reduction of the left wrist dislocation and applied a long arm splint (Petitioner's Exhibit 1).

Dr. Norris initially evaluated Petitioner on February 2, 2015. At that time, Dr. Norris recommended Petitioner undergo arthroscopic surgery on the right knee. On February 6, 2015, Dr. Norris performed arthroscopic surgery which consisted of reduction and fixation of tibial eminence fracture. Subsequent to the surgery, Dr. Norris ordered physical therapy which Petitioner received between March 6, 2015, and April 9, 2015. Dr. Norris released Petitioner to return to work to sit down work commencing April 14, 2015. He subsequently discharged

Petitioner from care on May 11, 2015, with the restriction of Petitioner avoiding climbing on roofs for a short term basis (Petitioner's Exhibits 1 and 2).

Petitioner also received physical therapy for his left wrist injury. When evaluated on April 22, 2015, Petitioner complained of wrist pain, weakness and tingling. On examination, the range of motion of the left wrist was limited (Petitioner's Exhibit 3).

At the direction of Safeguard, Petitioner was examined by Dr. James Stiehl, an orthopedic surgeon, on August 27, 2015. In connection with his examination of Petitioner, Dr. Stiehl reviewed medical records provided to him by Safeguard. In regard to Petitioner's right knee condition, Dr. Stiehl noted that Petitioner had chronic pain in his right knee and opined that there was a possible tear of the medial meniscus. He stated Petitioner could do light duty work with no standing over four hours per day, no lifting over 20 pounds and no climbing, bending or stooping. In regard to the left wrist condition, Dr. Stiehl opined that the dislocation had resolved. Dr. Stiehl also noted that Petitioner had complaints of low back symptoms; however, Dr. Stiehl opined that these were not related to the accident (Petitioner's Exhibit 4).

Petitioner testified that he did not return to work for RFS or any other employer after the accident of January 26, 2015. RFS never offered any work to Petitioner that conformed to his work restrictions. Further, Petitioner stated that RFS went out of business completely sometime in February, 2015.

Petitioner conducted a self-directed job search from May, 2015, (concurrent with his release from Dr. Norris) through October 23, 2015. Petitioner's job search logs were received into evidence at trial. Petitioner was subsequently diagnosed with a brain tumor which has caused him to be totally disabled. Petitioner did not claim that the brain tumor was related to the accident of January 26, 2015.

In regard to his left wrist, Petitioner stated that it is still painful and throbs with movement and continues to feel like it will pop out of place. In regard to his right knee, Petitioner stated it feels like it will lock up on him and it constantly itches. Petitioner stated that he stays off of his right leg as much as possible and he walks with a limp.

Conclusions of Law

In regard to disputed issue (B) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that there was an employee-employer relationship between Petitioner and RFS as well as Safeguard, with Safeguard being a statutory employer pursuant to Section 1(a)3 of the Act.

In support of this conclusion the Arbitrator notes the following:

RFS, through the IWBF, stipulated that there was an employee-employer relationship between Petitioner and RFS.

Petitioner's testimony that he was employed by RFS as a laborer and his description of his job duties was unrebutted.

RFS did not have workers' compensation insurance coverage at the time Petitioner sustained the accident on January 26, 2015.

At the time of the accident of January 26, 2015, Safeguard was a company that provided services primarily to foreclosed properties which included inspection, repairs, maintenance, etc. Clearly, Safeguard was performing work automatically covered by the Act, as provided in Section 3 of the Act which mandates coverage for businesses engaged in, among other things, "The erection, maintaining, removing, remodeling, altering or demolishing of any structure."

At the time of the accident of January 26, 2015, RFS and Safeguard had a contractual relationship wherein RFS provided services to Safeguard at various foreclosed properties, the services including repairs, maintenance, yard work, etc.

The evidence clearly established that RFS was performing work at Belaire at the direction of Safeguard. Specifically, RFS was directed to perform mold remediation at Belaire by Safeguard on December 23, 2014, and work continued at Belaire through February 5, 2015.

Safeguard's name was on a written notice affixed to the front door of the Belaire property.

Petitioner's testimony that he was going to be applying drywall on January 26, 2015, was consistent with the communication between RFS and Safeguard, the photos of Petitioner performing work at Belaire on January 13, and January 23, 2015, his testimony that he had applied "mold stat" and the items purchased by RFS at Menards in January, 2015.

Based upon the preceding, the Arbitrator concludes that Petitioner was scheduled to perform drywall work at Belaire on January 26, 2015.

Based upon the preceding, the Arbitrator further concludes that pursuant to Section 1(a)3 of the Act, Safeguard was the "statutory employer" of Petitioner.

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent, Safeguard.

In support of this conclusion the Arbitrator notes the following:

At the time Petitioner sustained the accident, he was in the parking lot of RFS and was in the process of hitching a trailer to a truck, both of which were owned by RFS and was going to return to Belaire to continue work which had been ordered by Safeguard.

In regard to disputed issue (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that timely notice was given to Respondent.

In support of this conclusion the Arbitrator notes the following:

RFS, through the IWBF, stipulated that Petitioner gave notice of the accident of January 26, 2015.

It was not clear when Safeguard received notice that Petitioner had sustained an accident on January 26, 2015; however, Safeguard learned of its occurrence as evidenced by the fact that Safeguard paid Petitioner temporary total disability benefits in July, 2015, and sought a Section 12 examination in August, 2015.

Further, Section 6(c)(2) of the Act provides that "No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." Safeguard did not tender any evidence which demonstrated any such prejudice.

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 his left wrist and right knee are related to the accident of January 26, 2015.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a work-related accident on January 26, 2015, and sustained injuries to his left wrist and right knee. There was no evidence tendered that either or both of these conditions were related to any other cause.

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 $440.00 as stipulated by Petitioner and RFS, through IWBF.

In support of this conclusion the Arbitrator notes the following:

Petitioner and RFS, through IWBF, stipulated to an average weekly wage of $440.00 although the wage statement indicated a slightly higher average weekly wage of $444.03.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent, Safeguard, is liable for payment of the medical expenses incurred therewith.

Respondent, Safeguard, shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 5, for treatment for Petitioner's left wrist and right knee injuries, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In regard to disputed issue (K) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits of 14 6/7 weeks commencing January 27, 2015, through May 10, 2015, from Respondent, Safeguard.

The Arbitrator concludes Petitioner is entitled to payment of maintenance of 23 5/7 weeks commencing May 11, 2015, through October 23, 2015, from Respondent, Safeguard.

In support of these conclusions the Arbitrator notes the following:

Petitioner was authorized to be off work by his treating physician through May 10, 2015. Petitioner was released return to work with restrictions on May 11, 2015. When examined by Dr. Stiehl on August 27, 2015, further permanent work restrictions were imposed.

Petitioner conducted a self-directed unsuccessful job search through October 23, 2015.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 35% loss of use of the right leg and 10% loss of use of the left hand, from Respondent, Safeguard.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondents tendered into evidence an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked as a laborer and his job duties were physically demanding. Petitioner was required to perform various duties which included painting, maintenance, yard work, cleaning, drywalling, etc. The Arbitrator gives this factor significant weight.

Petitioner was 37 years old at the time of the accident. He will have to live with the effects of this injury for the remainder of his natural life. The Arbitrator gives this factor moderate weight.

Petitioner conducted an unsuccessful job search after he was released from medical care and was not able to return to work for RFS or any other employer. However, as noted herein, Petitioner's total disability is due to a brain tumor which is not work-related. While the accident may have had a potential effect upon Petitioner's future earning capacity, the extent of same cannot be determined. Accordingly, because it would be based upon speculation, the Arbitrator gives this factor no weight.

The medical treatment records indicated Petitioner sustained injuries to his right knee and left wrist. The right knee injury required arthroscopic surgery and Respondent Safeguard's Section 12 examiner, imposed significant work restrictions because of this injury. Petitioner still has subjective complaints in regard to the left wrist injury, but the medical records indicate that condition has, to a large extent, resolved. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSH GOSS,

Petitioner,

18IWCC0698

vs.

NOS: 14 WC 31071 & 14 WC 31072

CATERPILLAR,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decisions of the Arbitrator as stated below and otherwise affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof. In the interests of clarity, the Commission hereby issues a single Decision and Opinion to dispose of both reviews.

It was stipulated by the parties that Petitioner sustained work-related accidents in which he injured his back on November 12, 2012 and August 20, 2014, respectively. The cases were consolidated and arbitrated together. The Arbitrator issued two separate decisions. In claim number 14 WC 31071, the Arbitrator awarded Petitioner 25 weeks of permanent partial disability benefits representing loss of the use of 5% of the person-as-a-whole for his injury on November 12, 2012. In claim number 14 WC 31072, the Arbitrator awarded Petitioner 10&6/7 weeks of temporary total disability benefits and 10 weeks of permanent partial disability benefits representing loss of the use of 2% of the person-as-a-whole for his injury on August 20, 2014. Other than the different awards, the analyses in the decisions were identical. The Commission agrees with the determinations of the Arbitrator on the issues of causal connection, temporary total disability, and permanent partial disability and affirms and adopts those portions of the Decisions of the Arbitrator.

In both claims the Arbitrator denied expenses for all medical treatment incurred subsequent to November 12, 2014. In both decisions, the Arbitrator concluded "that the medical services provided to Petitioner subsequent to November 12, 2014, were not reasonable and necessary, particularly the chiropractic treatment provided by Dr. Dickhut from February 18, 2015 through November 11, 2015, and Respondent is not liable for payment of same."

Also in both decisions, the Arbitrator noted that in his deposition, Dr. Dickhut explained that his treatment of Petitioner involved the use of the DRX9000 device, which is similar to traction, and agreed "that much of the treatment he provides is not performed by other doctors or chiropractors. He also stated that many times, his patients pay him up to $10,000.00 out of their own pocket for the treatment he provides." The unconventional treatment provided by Dr. Dickhut appears to be a basis for the Arbitrator's denial of his bill of $40,688.33.

Dr. Dickhut sought appeal of a Utilization Review of his chiropractic treatment. On such appeal, two chiropractors, Dr. Humberstone and Dr. Malartsik, separately certified 18 chiropractic visits to Dr. Dickhut between February 18, 2015 and January 5, 2016. The Commission agrees with the Arbitrator's decision that the award of what appears to be unconventional treatment rendered by Dr. Dickhut would be inappropriate. Nevertheless, the Commission also believes it is appropriate to award traditional chiropractic treatment certified by the Utilization Review chiropractors. Therefore, the Commission awards Petitioner 18 chiropractic visits with Dr. Dickhut after February 18, 2015. However, such award shall not include charges for use of the DRX9000 device, which the Arbitrator found troublesome.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $693.62 per week for a period of 10&6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $624.26 per week for a period of 35 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 7% of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses associated with 18 visits to Dr. Dickhut for traditional chiropractic treatment after February 18, 2015, under §8(a) of the Act pursuant to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that pursuant to the paragraph immediately above, Respondent is not liable for any treatment rendered by Dr. Dickhut using the DRX9000 device in the awarded 18 visits for traditional chiropractic treatment.

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 injuries.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 14 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-10/10/18
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0698

GOSS, JOSH
Employee/Petitioner

Case# **14WC031071**

14WC031072

CATERPILLAR INC
Employer/Respondent

On 6/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

5411 CATERPILLAR INC
AMANDA WATSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

18IWCC0698

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Josh Goss
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # 14 WC 31071

Consolidated cases: 14 WC 31072

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on April 12, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ 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 6, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $52,520.00; the average weekly wage was $1,040.43.

On the date of accident, Petitioner was 32 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $8,422.94 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $8,422.94. The parties stipulated at trial that TTD benefits had been paid in full.

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner from November 12, 2012, through November 12, 2014, as identified in Petitioner's Exhibit 13, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $624.26 per week for 25 weeks because the injury sustained caused the five percent (5%) loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

June 1, 2017
Date

ICArbDec p 2

JUN 7 - 2017

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 14 WC 31071, the Application alleged that on November 6, 2012, a "Liner fell - pulling & lifting" and Petitioner sustained an injury to his "Back." In case number 14 WC 31072, the Application alleged that on August 20, 2014, Petitioner was "Picking up scrap parts - liners" and sustained an injury to his "Back" (Petitioner's Exhibit 1). The cases were consolidated on the day of trial.

In regard to case number 14 WC 31071, Petitioner and Respondent stipulated that Petitioner sustained a work-related accident on November 6, 2012; however, Respondent disputed liability on the basis of causal relationship. There was also a dispute regarding Respondent's liability for medical services provided to Petitioner, primarily chiropractic charges of approximately $45,000.00 incurred in connection with both cases. Petitioner claimed he was entitled to payment of temporary total disability benefits of 12 1/7 weeks, commencing November 6, 2012, through January 29, 2013. Respondent did not dispute Petitioner's entitlement to temporary total disability benefits for that period of time and, at trial, Petitioner and Respondent stipulated that Respondent had made payment of same (Arbitrator's Exhibit 1).

In regard to case number 14 WC 31072, Petitioner and Respondent stipulated that Petitioner sustained a work-related injury on August 20, 2014; however, Respondent disputed liability on the basis of causal relationship. There was also a dispute regarding Respondent's liability for medical services provided to Petitioner, primarily chiropractic charges of approximately $45,000.00 incurred in connection with both cases. Petitioner claimed he was entitled to payment of temporary total disability benefits of 10 6/7 weeks, commencing August 22, 2014, through November 5, 2014. Respondent claimed that Petitioner was entitled to payment of temporary total disability benefits for six and three-sevenths weeks, commencing August 22, 2014, through October 5, 2014, meaning that there was a disputed period of temporary total disability benefits of four and three-sevenths weeks (Arbitrator's Exhibit 2).

Petitioner began working for Respondent in 1998. Since that time, Petitioner has worked in various facilities and performed different jobs. At the time Petitioner sustained both injuries, he worked as a lathe operator. When the cases were tried, Petitioner was working as an inspector.

On November 6, 2012, Petitioner was bending forward and reaching over a conveyor system so that he could pick up a liner. Petitioner testified that the liner weighed approximately 30 pounds and when he picked it up, he experienced an onset of sharp/stabbing pain in his low back.

Following the accident, Petitioner was seen in the ER of St. Francis Medical Center on November 6, 2012. At that time, Petitioner had left sided low back pain but no radiation into either leg. Petitioner was diagnosed as having sustained an acute low back strain, given prescribed medications and discharged (Petitioner's Exhibit 11).

Petitioner was subsequently seen by Dr. Richard O'Connor in Respondent's medical department on November 8, 2012. Dr. O'Connor opined Petitioner had sustained an acute low back strain and authorized Petitioner to be off work. When he saw Petitioner on November 19, 2012, he ordered physical therapy (Petitioner's Exhibit 3).

When Dr. O'Connor saw Petitioner on December 6, 2012, Petitioner's symptoms had improved; however, Dr. O'Connor was concerned about the possibility of Petitioner having sustained a disc herniation in the lumbar spine. He ordered an MRI scan which was performed on December 12, 2012. The MRI revealed disc bulges at L3-L4 and L4-L5 (Petitioner's Exhibit 3).

Petitioner continued to be seen by Dr. O'Connor and his condition gradually improved. When Dr. O'Connor saw Petitioner on January 29, 2013, he noted that Petitioner's low back pain was almost resolved. He authorized Petitioner to return to work without restrictions the following day (Petitioner's Exhibit 3).

Petitioner was able to return to work to his regular job when released by Dr. O'Connor. Petitioner did not lose any time from work from that date until he sustained the injury of August 20, 2014. When Dr. O'Connor saw Petitioner on February 12, 2013, Petitioner asked that he be referred to a chiropractor because of how the physical therapy had previously relieved his symptoms. Dr. O'Connor declined to make such a referral at that time (Petitioner's Exhibit 3).

Petitioner was again seen by Dr. O'Connor in March and April, 2013, and reported an increase in his low back pain. On April 30, 2013, Dr. O'Connor agreed to refer Petitioner to a chiropractor (Petitioner's Exhibit 3).

On May 8, 2013, Petitioner was seen by Dr. Michael Funk, a chiropractor, who diagnosed him with a chronic subluxation complex at L4-L5. Dr. Funk provided chiropractic treatment to Petitioner on a regular basis through September 24, 2013 (Petitioner's Exhibit 6).

Petitioner continued to be seen by Dr. O'Connor while he received chiropractic treatment. When Petitioner had an acute increase of pain in his low back in July, 2013, Dr. O'Connor referred Petitioner to Dr. Daniel Mulconrey, an orthopedic surgeon (Petitioner's Exhibit 3).

Dr. Mulconrey examined Petitioner on July 29, 2013. He also reviewed the MRI scan and opined it revealed a disc bulge and annular tear at L4-L5 and a disc protrusion at L3-L4. He noted Petitioner was making progress press with chiropractic care and he recommended Petitioner continue with same (Petitioner's Exhibit 9).

When Dr. O'Connor saw Petitioner on August 1, 2013, he noted Petitioner's condition had improved. Shortly thereafter, Petitioner moved to a different facility of the Respondent and he was subsequently seen by Dr. Christopher Dea, another physician with Respondent's medical department (Petitioner's Exhibit 3).

When Dr. Dea saw Petitioner in August and September, 2013, he questioned whether continued chiropractic care was indicated. He reviewed the MRI and agreed it revealed disc bulges at L3-L4 and L4-L5. Because of Petitioner's continued symptoms, Dr. Dea referred Petitioner to Dr. Kevin Henry, a pain management physician (Petitioner's Exhibit 3).

Dr. Henry evaluated Petitioner on September 16, 2013, and agreed Petitioner had an annular tear at L4-L5. He recommended Petitioner undergo an epidural steroid injection at that level. Dr. Henry administered that injection on October 18, 2013 (Petitioner's Exhibit 8).

When Dr. Henry saw Petitioner on November 8, 2013, Petitioner advised that his symptoms had improved. However, when Petitioner subsequently saw Dr. Henry on December 20, 2013, he stated that his symptoms had worsened. Dr. Henry administered another epidural steroid injection on January 13, 2014. When Dr. Henry subsequently saw Petitioner on January 31, 2014, Petitioner advised he was doing much better (Petitioner's Exhibit 8).

While being treated by Dr. Henry, Petitioner continued to be seen by Dr. Dea. When seen by Dr. Dea on January 23, 2014, Petitioner advised that the second steroid injection gave him much more relief than the first (Petitioner's Exhibit 3).

On March 14, 2014, Petitioner was again seen by Dr. Henry. Petitioner still had some symptoms, but was doing well. Dr. Henry recommended Petitioner do some core strengthening exercises and follow up with Dr. Dea (Petitioner's Exhibit 8).

Petitioner was seen by Dr. Dea on March 20, 2014, complaining of back pain. He was subsequently directed to make an appointment with Dr. Henry, but apparently did not do so at that time. Dr. Dea saw Petitioner on May 15, 2014, and Petitioner advised his back pain was substantially worse, but he did not advise of any new trauma. Dr. Dea was uncertain why Petitioner had such an increase in his symptoms and referred him back to Dr. Henry (Petitioner's Exhibit 3).

Dr. Henry saw Petitioner on June 20, 2014. At that time, Petitioner complained of low back pain with radiation down the right leg to the knee. Dr. Henry administered another epidural injection. When Dr. Henry saw Petitioner on July 11, 2014, Petitioner's condition had improved. Dr. Henry recommended Petitioner use a TENS unit. Petitioner was seen by Dr. Dea on July 17, 2014, and he agreed that Petitioner's use of a TENS unit was appropriate (Petitioner's Exhibits 3 and 8).

Petitioner did not seek any further medical treatment until after he sustained the accident of August 20, 2014. At trial, Petitioner testified he was in the process of picking up some parts to put them in a bin. Petitioner bent over the side of the bin so he could rearrange the parts. When Petitioner did so, Petitioner stated he sustained an injury to his mid and upper back.

Petitioner initially sought medical treatment from Dr. Daniel Hoffman, his family physician, on August 22, 2014. At that time, Petitioner complained of low back pain with radiation to both hips. Dr. Hoffman ordered an MRI of the lumbar spine which was performed on August 26, 2014. The findings of this MRI were consistent with those of the MRI that was previously performed (Petitioner's Exhibit 7).

Dr. Dea saw Petitioner on August 26 and August 28, 2014, and Petitioner complained of left parascapular and neck pain. Dr. Dea's findings on examination were normal; however, he stated he wanted to review Dr. Hoffman's records (Respondent's Exhibit 1).

Petitioner was again seen by Dr. Henry on September 12, 2014, and advised he had sustained another injury on August 20, 2014, primarily to his left shoulder blade. He also advised he had an appointment to see Dr. Mulconrey. Dr. Henry recommended Petitioner use the TENS unit on his neck and ordered physical therapy (Petitioner's Exhibit 8).

Dr. Mulconrey saw Petitioner on September 24, 2014. At that time, Petitioner complained of pain in the neck with radiation into the left trapezial based region. Dr. Mulconrey diagnosed Petitioner with axial neck pain and ordered an MRI of the cervical spine. However, that MRI was never performed (Petitioner's Exhibit 9).

Dr. Dea saw Petitioner on October 2, 2014, and noted that Petitioner had axial neck pain. He opined that the mechanism of injury of August 20, 2014, would not have caused the axial neck pain because Petitioner's initial complaints were in the parascapular area and upper back. He also opined that, in regard to Petitioner's low back symptoms, Petitioner was at his baseline and he experienced no increased back pain (Respondent's Exhibit 1).

Petitioner saw Dr. Henry on October 24, 2014, and Petitioner's neck, shoulder and back pain symptoms were all improved. Petitioner also advised he continued to use the TENS unit and it was helping him. Dr. Henry opined Petitioner could return to work without restrictions; however, he stated he would defer to Dr. Dea's recommendation as to Petitioner's work status (Petitioner's Exhibit 8).

Petitioner was again seen by Dr. Mulconrey on November 3, 2014. At that time, Petitioner's neck pain had significantly improved and he had an excellent range of motion of the cervical spine. Dr. Mulconrey authorized Petitioner to return to work (Petitioner's Exhibit 9).

Petitioner returned to work for Respondent on November 6, 2014; however, Petitioner continued to receive chiropractic treatment from Dr. Funk through December 1, 2014. When seen by Dr. Funk on November 17, and December 1, 2014, Petitioner stated his neck and shoulder symptoms were good, but his low back symptoms were bad (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, on November 12, 2014. Dr. Weiss evaluated Petitioner in regard to the injuries he sustained in both accidents. In connection with his examination of Petitioner, Dr. Weiss reviewed medical records provided to him by Respondent. Dr. Weiss' examination of Petitioner's upper and lower back areas was normal and he noted Petitioner was working without restrictions. He opined Petitioner had pre-existing lumbar degenerative disc disease and a lumbar strain secondary to the accident of November 6, 2012, which was resolved on February 12, 2013. He also opined that Petitioner had an upper back strain secondary to the accident of August 20, 2014, which was resolved as of September 24, 2014. He further opined Petitioner was at MMI in regard to both injuries and Petitioner had zero percent (0%) impairment ratings in regard to both injuries using the AMA guides (Respondent's Exhibit 4).

Petitioner continued to work full time and did not receive any further treatment until February 18, 2015, when he was seen by Dr. Jeffrey Dickhut, a chiropractor. Dr. Dickhut treated Petitioner from February 18, 2015, through November 11, 2015 (Petitioner's Exhibit 2). At trial, Petitioner testified he first heard of Dr. Dickhut on late night television and made the decision to seek treatment from him at that time.

Dr. Dickhut opined Petitioner had various lumbar conditions which he related to the November, 2012, accident. He stated Petitioner's injury had not yet resolved and Petitioner continued to work under duress. For approximately nine months, Dr. Dickhut treated Petitioner with various chiropractic treatments which included the use of a DRX9000 device, which was similar to using traction on the lumbar spine. Dr. Dickhut's bill for chiropractic services was $40,688.33 (Petitioner's Exhibit 1 and 13).

On December 17, 2015, Respondent obtained a utilization review of Dr. Dickhut's treatment from Dr. Lawrence Humberstone, a chiropractor. Dr. Humberstone opined that chiropractic care should have been limited to 18 visits over a six to eight week time period (Respondent's Exhibit 2).

Dr. Dickhut requested a review of Dr. Humberstone's utilization review. Dr. Humberstone's utilization review was then analyzed and reviewed by Dr. Peter Malartsik, a chiropractor, on March 23, 2016. He concurred with Dr. Humberstone's recommendation of 18 visits for chiropractic care (Respondent's Exhibit 2).

Dr. Dickhut was deposed on June 16, 2016, and his deposition testimony was received into evidence at trial. Dr. Dickhut explained in detail the chiropractic treatment he provided to Petitioner including the use of the DRX9000 device. On cross-examination, he agreed that much of the treatment he provides is not performed by either doctors or chiropractors. He also stated that many times, his patients pay him up to $10,000.00 out of their own pocket for the treatment he provides (Petitioner's Exhibit 10; p 75).

Dr. Malartsik was deposed on October 5, 2016, and his deposition testimony was received into evidence at trial. Dr. Malartsik's testimony was consistent with his report and he reaffirmed his opinion that he would only certify 18 visits of chiropractic care. He explained that this was based on ODG guidelines (Respondent's Exhibit 3; pp 14-16).

On cross-examination, Dr. Malartsik conceded that he was not opining that Dr. Dickhut's treatment was unnecessary or unreasonable, only that it exceeded the stated ODG guidelines. Further, Dr. Malartsik did not specifically address the use of the DRX9000 device (Respondent's Exhibit 3; pp 25-30).

At trial, Petitioner agreed that he had returned to work to his regular job in November, 2014. In regard to his low back, Petitioner stated he was doing fine now and only had some occasional pain which he described as minimal. In regard to his mid back and neck, Petitioner also stated he was doing well with only a little bit of pain and discomfort.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to the low back is causally related to the accident of November 6, 2012.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on November 6, 2012, to his low back.

An MRI scan was performed which revealed disc bulges at L3-L4 and L4-L5. An annular tear at L4-L5 was also diagnosed.

Respondent's Section 12 examiner, Dr. Weiss, opined Petitioner had sustained a lumbar strain with pre-existing degenerative disc disease.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the medical services provided to Petitioner from November 12, 2012, through November 12, 2014, were reasonable and necessary and that Respondent is liable for payment of same.

The Arbitrator concludes that the medical services provided to Petitioner subsequent to November 12, 2014, were not reasonable and necessary, in particular, the chiropractic treatment provided by Dr. Dickhut from February 18, 2015, through November 11, 2015, and Respondent is not liable for payment of same.

Respondent shall pay reasonable and necessary medical services provided to Petitioner from November 12, 2012, through November 12, 2014, as identified in Petitioner's Exhibit 13, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

Petitioner was seen and treated by numerous physicians, received physical therapy, epidural steroid injections, chiropractic treatment and made use of a TENS unit.

Petitioner periodically reported improvement of his symptoms and, after he returned to work on January 30, 2013, Petitioner did not lose any time from work until he sustained the accident of August 20, 2014.

When Petitioner was examined by Dr. Weiss on November 12, 2014, he was found to be at MMI.

The chiropractic treatment provided by Dr. Dickhut was, by his own admission, treatment not usually provided by either physicians or chiropractors. Further, Dr. Dickhut also stated that many times his patients pay him up to $10,000.00 for the treatment he provides out of their own funds.

Dr. Dickhut's treatment was provided to Petitioner after he was found to be at MMI.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Dr. Weiss opined Petitioner had a zero percent (0%) impairment rating based on the AMA guides. The Arbitrator gives this factor moderate weight.

At the time of the accident, Petitioner worked as a lathe operator. At the time of trial, Petitioner worked as an inspector. Petitioner described the job he worked at the time of the accident as requiring lifting. The Arbitrator gives this factor moderate weight.

Petitioner was 32 years old at the time of the accident. At trial, Petitioner testified he had minimal low back pain and only occasionally. This suggests that the injury will not have a significant long term effect. The Arbitrator gives us factor significant weight.

There was no evidence that this injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner sustained a lumbar strain with pre-existing degenerative disc disease and bulging discs at L3-L4 and L4-L5 as well as an annular tear at L4-L5. Petitioner received extensive medical treatment after the accident. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0698

GOSS, JOSH
Employee/Petitioner

Case# **14WC031072**

14WC031071

CATERPILLAR INC
Employer/Respondent

On 6/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

5411 CATERPILLAR INC
AMANDA WATSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

18IWCC0698

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Josh Goss
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # 14 WC 31072

Consolidated cases: 14 WC 31071

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on April 12, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On August 20, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $52,520.00; the average weekly wage was $1,040.43.

On the date of accident, Petitioner was 34 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $3,974.54 for TTD, $0.00 for TPD, $0.00 for maintenance, and $2,558.80 for other benefits, for a total credit of $6,533.34.

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner from August 20, 2014, through November 12, 2014, as identified in Petitioner's Exhibit 13, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $693.62 per week for 10 6/7 weeks commencing August 22, 2014, through November 5, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $624.26 per week for 10 weeks because the injury sustained caused the two percent (2%) loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

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June 1, 2017
Date

ICArbDec p. 2

JUN 7 - 2017

Findings of Fact

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Dr. Dea saw Petitioner on August 26 and August 28, 2014, and Petitioner complained of left parascapular and neck pain. Dr. Dea's findings on examination were normal; however, he stated he wanted to review Dr. Hoffman's records (Respondent's Exhibit 1).

Petitioner was again seen by Dr. Henry on September 12, 2014, and advised he had sustained another injury on August 20, 2014, primarily to his left shoulder blade. He also advised he had an appointment to see Dr. Mulconrey. Dr. Henry recommended Petitioner use the TENS unit on his neck and ordered physical therapy (Petitioner's Exhibit 8).

Dr. Mulconrey saw Petitioner on September 24, 2014. At that time, Petitioner complained of pain in the neck with radiation into the left trapezial based region. Dr. Mulconrey diagnosed Petitioner with axial neck pain and ordered an MRI of the cervical spine. However, that MRI was never performed (Petitioner's Exhibit 9).

Dr. Dea saw Petitioner on October 2, 2014, and noted that Petitioner had axial neck pain. He opined that the mechanism of injury of August 20, 2014, would not have caused the axial neck pain because Petitioner's initial complaints were in the parascapular area and upper back. He also opined that, in regard to Petitioner's low back symptoms, Petitioner was at his baseline and he experienced no increased back pain (Respondent's Exhibit 1).

Petitioner saw Dr. Henry on October 24, 2014, and Petitioner's neck, shoulder and back pain symptoms were all improved. Petitioner also advised he continued to use the TENS unit and it was helping him. Dr. Henry opined Petitioner could return to work without restrictions; however, he stated he would defer to Dr. Dea's recommendation as to Petitioner's work status (Petitioner's Exhibit 8).

Petitioner was again seen by Dr. Mulconrey on November 3, 2014. At that time, Petitioner's neck pain had significantly improved and he had an excellent range of motion of the cervical spine. Dr. Mulconrey authorized Petitioner to return to work (Petitioner's Exhibit 9).

Petitioner returned to work for Respondent on November 6, 2014; however, Petitioner continued to receive chiropractic treatment from Dr. Funk through December 1, 2014. When seen by Dr. Funk on November 17, and December 1, 2014, Petitioner stated his neck and shoulder symptoms were good, but his low back symptoms were bad (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, on November 12, 2014. Dr. Weiss evaluated Petitioner in regard to the injuries he sustained in both accidents. In connection with his examination of Petitioner, Dr. Weiss reviewed medical records provided to him by Respondent. Dr. Weiss' examination of Petitioner's upper and lower back areas was normal and he noted Petitioner was working without restrictions. He opined Petitioner had pre-existing lumbar degenerative disc disease and a lumbar strain secondary to the accident of November 6, 2012, which was resolved on February 12, 2013. He also opined that Petitioner had an upper back strain secondary to the accident of August 20, 2014, which was resolved as of September 24, 2014. He further opined Petitioner was at MMI in regard to both injuries and Petitioner had zero percent (0%) impairment ratings in regard to both injuries using the AMA guides (Respondent's Exhibit 4).

Petitioner continued to work full time and did not receive any further treatment until February 18, 2015, when he was seen by Dr. Jeffrey Dickhut, a chiropractor. Dr. Dickhut treated Petitioner from February 18, 2015, through November 11, 2015 (Petitioner's Exhibit 2). At trial, Petitioner testified he first heard of Dr. Dickhut on late night television and made the decision to seek treatment from him at that time.

Dr. Dickhut opined Petitioner had various lumbar conditions which he related to the November, 2012, accident. He stated Petitioner's injury had not yet resolved and Petitioner continued to work under duress. For approximately nine months, Dr. Dickhut treated Petitioner with various chiropractic treatments which included the use of a DRX9000 device, which was similar to using traction on the lumbar spine. Dr. Dickhut's bill for chiropractic services was $40,688.33 (Petitioner's Exhibit 1 and 13).

On December 17, 2015, Respondent obtained a utilization review of Dr. Dickhut's treatment from Dr. Lawrence Humberstone, a chiropractor. Dr. Humberstone opined that chiropractic care should have been limited to 18 visits over a six to eight week time period (Respondent's Exhibit 2).

Dr. Dickhut requested a review of Dr. Humberstone's utilization review. Dr. Humberstone's utilization review was then analyzed and reviewed by Dr. Peter Malartsik, a chiropractor, on March 23, 2016. He concurred with Dr. Humberstone's recommendation of 18 visits for chiropractic care (Respondent's Exhibit 2).

Dr. Dickhut was deposed on June 16, 2016, and his deposition testimony was received into evidence at trial. Dr. Dickhut explained in detail the chiropractic treatment he provided to Petitioner including the use of the DRX9000 device. On cross-examination, he agreed that much of the treatment he provides is not performed by either doctors or chiropractors. He also stated that many times, his patients pay him up to $10,000.00 out of their own pocket for the treatment he provides (Petitioner's Exhibit 10; p 75).

Dr. Malartsik was deposed on October 5, 2016, and his deposition testimony was received into evidence at trial. Dr. Malartsik's testimony was consistent with his report and he reaffirmed his opinion that he would only certify 18 visits of chiropractic care. He explained that this was based on ODG guidelines (Respondent's Exhibit 3; pp 14-16).

On cross-examination, Dr. Malartsik conceded that he was not opining that Dr. Dickhut's treatment was unnecessary or unreasonable, only that it exceeded the stated ODG guidelines. Further, Dr. Malartsik did not specifically address the use of the DRX9000 device (Respondent's Exhibit 3; pp 25-30).

At trial, Petitioner agreed that he had returned to work to his regular job in November, 2014. In regard to his low back, Petitioner stated he was doing fine now and only had some occasional pain which he described as minimal. In regard to his mid back and neck, Petitioner also stated he was doing well with only a little bit of pain and discomfort.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to the upper back, neck and left scapular area are causally related to the accident of August 20, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident to his neck and upper back on August 20, 2014, and that he subsequently had complaints referable to the neck and left scapular areas.

Petitioner was subsequently diagnosed with axial neck pain and received chiropractic treatment and used the TENS unit he received in connection with his other claim.

The Arbitrator was not persuaded by Dr. Dea's opinion that the axial neck pain was not related to the injury of August 20, 2014.

Respondent's Section 12 examiner, Dr. Weiss, opined Petitioner had sustained an upper back strain.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the medical services provided to Petitioner from August 20, 2014, to November 12, 2014, were reasonable and necessary and that Respondent is liable for payment of same.

The Arbitrator concludes that the medical services provided to Petitioner subsequent to November 12, 2014, were not reasonable and necessary, in particular, the chiropractic treatment provided by Dr. Dickhut from February 18, 2015, through November 11, 2015, and Respondent is not liable for payment of same.

Respondent shall pay reasonable and necessary medical services provided to Petitioner from August 20, 2014, to November 12, 2014, as identified in Petitioner's Exhibit 13, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

Petitioner was treated by various physicians, received chiropractic treatment and used the TENS unit he had obtained in connection with the prior claim.

Petitioner informed Dr. Mulconrey on November 3, 2014, that his neck symptoms had significantly improved.

Petitioner returned to work on November 6, 2014, and continued to work without restrictions thereafter.

When examined by Dr. Weiss on November 12, 2014, Petitioner was found to be at MMI.

The treatment provided by Dr. Dickhut was, by his own admission, treatment not usually provided by other physicians or chiropractors. Further, Dr. Dickhut also stated that many times his patients pay him up to $10,000.00 for the treatment he provides out of their own funds.

Dr. Dickhut's treatment was rendered after Petitioner was found to be at MMI.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 10 6/7 weeks commencing August 22, 2014, through November 5, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner was temporarily totally disabled from August 22, 2014, through October 5, 2014.

Respondent terminated payment of temporary total disability benefits effective October 6, 2014, based upon Dr. Dea's opinion that Petitioner's neck condition was not work-related.

As aforestated, the Arbitrator was not persuaded by Dr. Dea's opinion as to the etiology of Petitioner's neck condition.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of two percent (2%) loss of use of the whole person.

Dr. Weiss opined Petitioner had a zero percent (0%) impairment rating based upon the AMA guides. The Arbitrator gives this factor moderate weight.

At the time of the accident Petitioner was a lathe operator. At the time of trial, Petitioner was an inspector. Petitioner described the job he worked at the time of the accident as requiring lifting. The Arbitrator gives this factor moderate weight.

Petitioner was 34 years old at the time of the accident. At trial, Petitioner testified he had little pain and discomfort. This suggested that Petitioner will not experience a significant long term effect as a result of this work-related injury. The Arbitrator gives this factor significant weight.

There was no evidence that this injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner sustained a neck and scapular strain as result of the accident of August 20, 2014. Dr. Mulconrey's record of November 3, 2014, indicated that most of the symptoms had resolved. This was consistent with Petitioner's testimony at trial. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ryan E. Meehan,
Petitioner,

vs.

NO: 14 WC 12534,
16 WC 28115

18IWCC0699

Tabitha Ventures, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2017, is hereby affirmed and adopted.

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

18IWCC0699

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 $23,600.00. 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 15 2018

Joshua D. Luskin

o-11/14/18
jdl-wj
68

Charles J. DeVriendt

Elizabeth Coppoletti

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

MEEHAN, RYAN E
Employee/Petitioner

Case# **14WC012534**

16WC028115

TABITHA VENTURES INC
Employer/Respondent

18IWCC0699

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0491 SOSTRIN AND SOSTRIN PC
NEAL K WISHNICK
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

1596 MEACHUM & STARCK
KYLE P CARLSON
225 W WASHINGTON ST SUITE 500
CHICAGO, IL 60606

18IWCC0699

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)

Ryan E. Meehan
Employee/Petitioner

v.

Tabitha Ventures, Inc.
Employer/Respondent

Case # 14 WC 012534

Consolidated cases: 16WC028115

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **November 14, 2016** and the decision being rendered by the Honorable Frank J. Soto, Arbitrator of the Commission, pursuant to an agreement and stipulation of the parties. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **03/18/2014 & 03/25/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,492.00**; the average weekly wage was **$1,221.00**.

On the date of accident, Petitioner was **40** years of age, ***married*** 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 **$88,726.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$88,726.00**.

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 **$814.00** per week for **137 6/7** weeks, commencing 03/26/2014 through 11/14/2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 03/26/2014 through 11/14/2016, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a **credit** of **$88,726.00** for temporary total disability benefits that have been paid.

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

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

Signature of Arbitrator

4/11/2017
Date

ICArbDec19(b)

APR 17 2017

FINDINGS OF FACT

Petitioner filed two claim applications against Respondent before the Illinois Workers' Compensation Commission. The first claim (14WC012534) alleges an accident date of March 25, 2014 affecting his left leg which occurred while lifting and carrying plywood. The second claim (16WC028115) alleges an accident date of March 18, 2014 and lists the body part affected as "to be shown" which occurred "in the course of employment". The claims were not consolidated but had been assigned to the same arbitrator and were tried together. The parties submitted a single Request For Hearing, combining both claims, agreeing to try both matters at the same time. (ARB. 1) Each party submitted a single set of exhibits for both claims. Because the parties agreed to try both claims together, submitted a combined Request For Hearing and tendered a single set of exhibits, for both claims, and because the claims involve the same body part with accident dates within a week of each other, a single decision will be authored for both claims. The parties agree Petitioner is not claiming that Respondent is liable for unpaid medical bills nor is there a claim for prospective medical treatment. At the hearing the contested issues were accident, causal connection and TTD. (ARB. 1)

Petitioner worked for Respondent as a laborer. Prior to the accident date, Petitioner was a seasonal worker who had worked continuously for eleven months continuously in 2013 through November of 2013. (PX 2) Petitioner was off of work for the winter from November of 2013 until March 17, 2014. Petitioner, a union laborer, started working for Respondent on March 17, 2014. Prior to becoming a laborer Petitioner worked as a cement finisher. Petitioner testified, when he returned to work after being off for the winter, he was able to perform his laborer job duties and he had not previously injured himself at work or filed any workers' compensation claims. (T. 101)

On March 18, 2014, Petitioner arrived at the job site on 6:45 A.M. Petitioner testified that around 11:00 A.M. he was pulling a cart, with 10 inch air pneumatic wheels, filled with materials for the carpenters. At that time, it was raining and, while pulling the cart, he stepped into a hole which caused his body to twist around. Petitioner felt immediate pain on the left side of his body including his left knee and left hip. Petitioner continued working and did not report the accident. Petitioner testified that on his way home from work, he picked up a knee brace at Walgreens and took Ibuprofen. (T. 17-19)

Petitioner continued to work, wearing the brace on his left knee, until March 25, 2014. On that date, Petitioner arrived at work around 7 A.M. and was assigned to work on the roof. Petitioner was carrying Styrofoam blocks up to the roof. To get up to the roof, Petitioner had to walk up a set of stairs that looked like two cracked pieces of material stacked on top of each other. As Petitioner stepped on the stairs, they came out from underneath him causing him to tweak his back and left knee. (T.21) Petitioner continued working for Respondent for about another 45 minutes to an hour before he reinjured himself again. At that time, Petitioner and his foreman, Robert Moreno, were moving 4x8 foot sheets of plywood off of a Bobcat. While lifting a sheet of plywood, Petitioner turned and he heard a pop is his left knee causing him to drop the plywood he was carrying and causing Robert Moreno to drop the other end of the sheet of plywood. Petitioner testified he fell to his side and felt excruciating pain from his left knee and hip. (T.25) Petitioner said he told his supervisor, Robert Moreno, that he hurt his knee and he was instructed by his supervisor to pick up the plywood because "we gotta get going". (T.65, 66) Petitioner testified he finished the job but he didn't feel well and he felt sick to his stomach. Petitioner said because of the pain, he had to first walked off of the stone and Styrofoam surface he was standing on and lean against something. A few minutes later, Petitioner went to the trailer to advise the project engineer. Petitioner told the engineer what had happened and that he was not feeling well. The project engineer told him to sit down, rest, or go home. Petitioner decided to go home. (T.25)

Petitioner testified he was experiencing knee pain that went all the way up to his the lower part of his back and left side. Petitioner went home and took a warm shower, laid down in bed, took Ibuprofen and put ice on his leg. Petitioner said his children placed frozen peas on his leg. The following day, Petitioner went to work and filled out a First Report of Injury form before going to the emergency room at Palos Community Hospital (T.69, 70)

Petitioner arrived at the emergency room around 10:47 A.M. The history provided at the emergency room states a 40 year old male with left knee pain who injured left knee after stepping in a hole on the 18th of this month, apparently at work, and reinjured his leg yesterday after slipped on stairs. At that time, Patient felt a pop and he complains of constant moderate pain to left knee both medially and laterally. The medical records show that Petitioner had difficulty bending the knee because of pain. The examination records show Petitioner had mild discomfort in the left hip with range of motion testing. The records show that Petitioner stated, at the emergency room, the source of his pain was his knee. X-Rays did not show any fractures or dislocations or suprapatellar joint effusion. The emergency room diagnosis was acute left knee strain. The hospital referred Petitioner to Dr. Kedainis, his PCP, and to Dr. Atkenson. (PX 3)

On March 28, 2014, Petitioner followed up with Dr. Paul Atkenson. Petitioner completed a questioner at Dr. Atkenson's office. The onset of the condition occurred on March 25, 2014 when he stepped in a hole at work while pulling at cart. Petitioner noted his symptoms came on slowly and were progressively getting worse. The chief complaints consisted of left knee swelling, excruciating pain, toes turning blue and his knee was popping. Petitioner wrote down he was experiencing radiating pain. (RX 4) On a diagram of a person, Petitioner was asked to mark the location of the pain. On the front facing diagram, Petitioner marked the left knee and hip as the source of his pain. On the back facing diagram, Petitioner marked from the left knee up the left thigh just under the buttock and the left hip as the source of pain. (PX 4) Petitioner was given a document called "Associated Factors" to complete. Petitioner indicated he was experiencing numbness, weakness and giving way. Petitioner indicated his left leg muscle was weak. Petitioner was asked what he was not able to do now that he could do before. Petitioner wrote work, walk, play with kids, have a life and drive a car. (RX 4) Petitioner was taken off of work. Dr. Paul Atkenson suspected internal derangement and he believed some of Petitioner's pain could be referred from his back and could be compatible with lumbar radiculopathy. (RX 4) In the records, Petitioner's past medical included hypertension, attention deficit disorder and anxiety.

On April 14, 2014, Dr. Robert Atkenson, brother of Dr. Paul Atkenson, authored a letter to the claims adjuster at Liberty Mutual Insurance Company. In his letter, the doctor wrote Petitioner was diagnosed with a twisting injury with low-grade sprain of the left knee and possible symptoms of a reflex sympathetic dystrophy. Various tests were recommended including a venous Doppler and an MRI of the knee. On April 18, 2014, Petitioner returned for a follow up appointment. Petitioner was examined by Dr. Paul Atkenson who noted during his examination: patient unable to fully weight bear on his affected leg, markedly antalgic gait, left lower extremity had a mild blush hue, soft tissue tenderness most prominent throughout the entire knee. An MRI of the hip was taken which revealed a scant effusion with a mild stretch of the ACL. The venous Doppler did not show evidence of a deep venous thrombosis. Dr. Paul Atkneson noted Petitioner had clinical signs and symptoms of a suspected causalgia or reflex sympathetic dystrophy. Dr. Paul Atkenson proscribed Vicodin, physical therapy, TENs unit and a knee sleeve. (PX 4)

On May 16, 2014, Petitioner retuned to Dr. Paul Atkenson. At that time, Petitioner complains of pain in his left knee, hip and groin. The pain is of a magnitude that he is unable to bear weight on his leg and he still needs to use crutches. The medical records show Petitioner's gait is markedly antalgic and his left knee buckles. Dr. Paul Atkenson notes the left lower extremity experienced some vasomotor changes with some slight swelling as well as a venous hue which became prevalent during his examination. Knee spasms and inhibition were noted at extremes of knee flection. Tenderness was noted upon deep palpation of the left groin as well as over the greater trochanter of the left hip. Petitioner was diagnosed with symptoms of reflex sympathetic dystrophy which appears to be affecting his left lower extremity, in particular, his hip and knee. (PX 4)

Respondent scheduled an examination of Petitioner with Dr. Timothy Lubenow, pursuant to Section 12 of the Act. The date of the exam was July 3, 2014. The chief complaints included pain to the left knee, hip, testicular area and right thigh. The history states the present illness began on March 17, 2014, when Petitioner was attempting to move some equipment at work at a construction site when he twisted his ankle while moving several large pieces of Styrofoam. Petitioner did not report the injury to his supervisor at that time. One week later, on March 25th, Petitioner was carrying a 4x8 sheet of plywood when he fell into a hole and twisted both of his knees and his hip and felt a pop is his left knee. At that time, he had significant pain (10 out of scale of 10) in his left knee, left hip and into the groin and upper right leg. Petitioner said the pain had begun traveling down his left lower extremity into the dorsal portion of his left foot during the past month. At the examination, Petitioner weighed 280 pounds. Dr. Lubenow noted Petitioner's left side demonstrated 1/5 muscle strength in both dorsiflexion and plantarflection with a range of approximately 5 degrees in dorsiflexion and 10 degrees in plantarflection. In terms of muscle strength, Dr. Lubenow said "patient's strength is clearly reduced on the left side". The sensory exam indicated that Petitioner had significantly reduced sensation to pinprick on the lateral left foot in approximately the L5-S1 distribution as compared to the right foot. Petitioner had significant diminishment of vibratory sensation on the left lateral foot as compared to the right lateral foot. (PX 5)

Dr. Lubenow reviewed the MRIs of the left knee and hip. The MRI of the knee, performed on April 17, 2014, showed an acute, Grade 1 sprain of the anterior cruciate ligament and medial collateral ligament at the femoral insertion. The MRI of the left hip, performed on May 12, 2014, showed a bone marrow edema of the left femoral head, neck and intertrochanteric regions, which could be secondary potentially a bone contusion or avascular necrosis. The MRI also showed mild greater trochanteric bursitis and atrophy of the rectus femoris muscle and degenerative disc disease at L5-S1. A sweat test was performed and it showed greater sweat production on the right leg than the left leg. (PX 5) Dr. Lubenow found that Petitioner had clinical symptoms but not physical findings of complex regional pain syndrome. The MRI of the left hip demonstrated a possible bone contusion or avascular necrosis. Dr. Lubenow said it was likely that Petitioner's accident contributed to the pain he is currently having. Regarding the radiculopathy of the L5-S1, Dr. Lubenow said Petitioner's back pain certainly has a neuropathic component to it. Dr. Lubenow recommend Petitioner have a consultation with an orthopedic surgeon and repeat of the left hip MRI. Regarding the left knee, Dr. Lubenow said Petitioner's left knee pain was likely secondary to a Grade I sprain and the MRI showed myxoid degeneration of the knee joint which may have been a chronic problem that was worsened in the acute setting due to an accident like that. (PX 5)

Dr. Lubenow referred Petitioner to Dr. Charles Bush-Joseph of Midwest Orthopaedics at Rush for evaluation of the hip. At the initial examination, Petitioner said he tripped on a piece of loose flooring, twisted his left knee while pulling two large pieces of foam. He took ibuprofen, used a knee brace and tried to continue working. Approximately a week later, Petitioner said he had two other twisting events

in which he felt a pop is his left knee after falling off some makeshift stairs. Petitioner complained of anterior hip, groin pain with radiating symptoms into his buttock and pain in the anterior of his knee. During the examination of the left hip, Dr. Bush-Joseph noted significant discomfort with both range of motions but more with flexion internal rotation. Petitioner had pain with forced abduction to 45 degrees anteriorly in the groin and pain with resisted straight leg and hip flexion. Dr. Bush-Joseph's diagnosis was left hip pain most likely due to a small labral tear. Petitioner was proscribed physical therapy and lidocaine injection. In a report dated September 2403, 2014, Dr. Bush-Joseph continued to keep Petitioner off of work. (PX 6)

Dr. Bush-Joseph reexamined Petitioner on October 28, 2014. Petitioner did not experience any relief from the injection and he continues to experience radicular burning stemming from his low back down the side of his leg and groin discomfort. Dr. Bush-Joseph noted, during the examination of Petitioner's right hip had diffused non-localized tenderness to palpation both of both the lateral aspect and posterior aspect of his hip. Discomfort with anterior palpation over the iliopsoas and into the groin. Pain with palpation of his proximal adductors and Petitioner has pain and weakness with resisted straight leg raises anteriorly, pain and weakness with resisted abduction laterally and posteriorly in the groove. Petitioner also had provocative low back discomfort with radicular symptoms on the lateral side of his leg with a seated straight legged hip flexion. In his report dated October 28, 2014 to the adjuster, Dr. Bush-Joseph said he did not believe the majority of the Petitioner's symptoms were coming from the hip and the primary source was low back pain. Dr. Bush-Joseph wrote Petitioner had evidence of a disc herniation at L5-S1 and stenosis, based upon the MRIs, which may be contributing to his radicular symptoms of pain. Dr. Bush-Joseph said the knee pain was compensatory pain based upon the Petitioner's gait and Dr. Bush-Joseph referred Petitioner to Dr. David Cheng for evaluation of the lumbar spine and possible lumbar epidural injections. (PX 6)

On December 10, 2014, Petitioner was examined by Dr. David Cheng, assistant professor, Department of Orthopedic Surgery at Rush University Medical Center. At that time, Petitioner said the pain was worse in his low back then his leg. Petitioner said his condition continues to worsen and it is difficult for him to walk, sit or stand for any length of time. At the examination Petitioner weighed 297 pounds. During the examination Dr. Cheng noted Petitioner's extension was limited to 10 degrees and Petitioner was unable to walk on his toes and heels due to increased pain. Tenderness over the L5 spinous process was noted and mild discomfort in the left gluteus medius and iliotibial band. Petitioner had weakness with ankle dorsiflection and plantar flexion, decreased sensation over the anterior knee and the entire calf on the left side. Dr. Cheng also noted increased pain in the lower back with seated slump test, left greater than right, and the straight leg raise test was positive at 30 degrees with low back and left-sided leg pain. Dr. Cheng diagnosed L5-S1 degenerative disc disease with left L5 radiculitis. Dr. Cheng proscribed physical therapy and lumbar spine epidural steroid injections at the L5-level. (PX 6)

On January 13, 2015, Petitioner was reexamined by Dr. Cheng. At that time Dr. Cheng noted Petitioner had had not had relief of pain after the epidural steroid injection. Petitioner continued to rate his low back and left-sided leg pain as 10 out of 10 and he continued to experience difficulty walking. Dr. Cheng also noted numbness in Petitioner's left leg. A neurologic exam revealed pain-related weakness with left ankle dorsiflexion and decreased sensation to light touching throughout the entire left leg and positive dural tension signs with seated slump test. Dr. Cheng's diagnosis L5-Si herniated nucleus pulposus with left L5 radiculitis. In his letter to the claims adjuster Dr. Cheng thanked the adjuster for allowing him to participate in the care of Petitioner and Dr. Cheng continued to keep Petitioner off of work. (PX 6)

On January 27, 2015, Dr. Cheng authored a response to various questions submitted by the claims adjuster. Regarding the etiology of Petitioner's low back pain, Dr. Cheng wrote "I believe that this is related to L5-S1 disc protrusion and circumferential disc bulge with foraminal stenosis at this level. It is consistent with the L5 dermatome." Dr. Cheng recommended a surgical consultation with Dr. Kern Singh. The other questions the adjuster requested Dr. Cheng to respond include what was both the subjective an objective outcome of the 1/13/2015 medication and treatment plan, what ongoing evidence based treatment plan is being recommended and what is your anticipated length of treatment for your diagnosis, prove the objective exam findings that will support the need for ongoing disability for left knee or lumbar strain and what is your anticipated timeframe for the use of narcotics. The adjuster did not ask Dr. Cheng whether Petitioner's condition occurred during the course and scope of Petitioner's employment or whether his condition was not causally related to the work accidents. (PX 6) Dr. Cheng referred Petitioner to Dr. Kern Sigh.

On February 18, 2015, Petitioner was examined by Dr. Kern Singh, associate professor of orthopaedic surgery and co-director of Minimally Invasive Spine Institute at Rush University Medical Center. During the initial examination Petitioner said the onset of his symptoms occurred on March 25, 2014, when he was carrying a large cart of Styrofoam weighing approximately 100 pounds. The following week he had a subsequent injury while lifting stacks of foam when he lost his grip, tripped and fell in a twisting motion. Dr. Singh testified that Petitioner had a central disc protrusion at L5-S1 and a retrolisthesis or backwards slip of his L5 vertebra on S1 and that resulted in nerve root compression or neuroforminal narrowing at the L5-S1 level. Dr. Singh said the examination was consistent with L5 and S1 nerve root involvement because Petitioner had weakness in the plantar flexor distribution and Achilles weakness on the left side and that correlated with an L5-S1 pattern. Dr. Singh said Petitioner's pain and complaints correlated with the MRI findings. The exam confirmed his pain complaints. Dr. Singh testified, based upon a reasonable degree of medical certainty, he believed the Petitioner had an aggravation of his underlying degenerative condition at the L5-S1 level and the aggravation was his work related injury of which the first event occurred March 25, 2014. Dr. Singh recommended surgery. (PX 9. Pgs. 13,14). In support of his opinions, Dr. Singh testified Petitioner had low back pain and nerve root involvement that was not based upon Petitioner's pain complaints but upon objective data which Petitioner can't contribute to such as muscle weakness and reflex changes. Dr. Singh said the motor changes and weakness were the reasons for recommending surgery, independent of back pain. Dr. Singh testified the leg weakness correlated with his back pain and correlated to the MRI findings. (PX 9, pg. 21). Dr. Singh further testified Petitioner's condition of disability and being unable to perform his occupation was related to his work accident. (PX. 9, pg. 14)

Respondent retained Dr. Ryon Hennessy for an examination pursuant to Section 12 of the Act. Dr. Hennessy, an orthopedic surgeon, examined Petitioner on April 29, 2016. Dr. Hennessy testified that he was provided various records including medical reports, Dr. Singh's deposition transcript and ISO ClaimsSearch, a recorded interview between Petitioner and a claims adjuster, a workers' compensation investigative report with witness statements. It is important to note the workers compensation investigative report was not allowed into evidence at trial and, therefore, not reviewed by the Arbitrator. Dr. Hennessy testified the investigative report was included in a list of the most significant records he relied upon. (RX 10, 8, 9) During the examination, Petitioner told Dr. Hennessy that on March 18, 2014 he had an unwitnessed injury to his left lower extremity. He said it had been raining and he was pulling a cart and stepped into a hole in the Geofoam or Styrofoam structure and he spun 180 degrees with his left knee, but he finished his job and continued to work. (RX 10, pg. 11) Dr. Hennessy testified that he reviewed the recorded interview dated March 27, 2014 an insurance company investigative report and

information contained in those reports, which was not allowed into evidence at the trial, to form his beliefs and opinions.

Dr. Hennessy opined the lumbar spine complaints were due to a preexisting degenerate change that was not affected by the accident. (RX 10, pg. 43) Dr. Hennessy testified that he agrees with Dr. Singh regarding the radiculopathy, but, disagrees with Dr. Singh's opinions regarding causation. (RX 10, pg. 79) Dr. Hennessy testified he disagreed with Dr. Singh's causation opinion because of the inconsistencies in the history and subjective complaints and some of the findings during in the examination which did not correlated with an MRI and first EMG. (RX 10, pg. 80) Dr. Hennessy also disagreed with Dr. Lubenow's findings. (RX 10, pg. 54) Dr. Hennessy said the medical records contained only sparse complaints of the lumbar spine early on in the treatment after the alleged accident and profound complaints and multiple dermatomes of the leg were out of proportion with the MRI report. (RX 10, pg. 42)

Dr. Hennessy acknowledges Dr. Atkenson focused on the knee and RSD and did not fully explore the radiculopathy. (RX 10, pg. 56) Dr. Hennessy admitted the records from Dr. Atkenson, two days after Petitioner was released from the emergency room, shows complaints of left buttock pain, left sciatic notch tenderness and Dr. Atkenson's diagnosis of possible lumbar radiculopathy. (RX 10, pg. 71. 72) Dr. Hennessy said he believed the sciatic notch tenderness and lumbar radiculopathy came from the hip injury and was not related to the back. (RX 10, pg. 72)

During cross-examination, Dr. Hennessy acknowledged he did not find retrolisthesis but Dr. Singh did after Dr. Singh reviewed the actual MRI films rather than relying on the radiologist impressions. (RX 10, pg. 65) Dr. Hennessy did not disagree with Dr. Singh's finding of retrolisthesis. Dr. Hennessy testified he did not review the MRI films because the films were never forwarded to him. Dr. Hennessy acknowledged reviewing the films is an integral part determining diagnosis and conclusions drawn regarding a person's injury and the type of treatment needed. (RX 10, pg. 64, 65) He further testified that he would almost never perform a surgery without reviewing films.

Dr. Hennessy endorsed causation between the Petitioner's work accidents and his hip and left knee conditions. (RX 10, pg. 44) He testified the hip had evidence of a contusion and this was objectified by the first MRI showing edema and the second MRI showing the edema had resolved. That, he said, showed there was some type of injury to the hip. (RX 10, pg. 43) Dr. Hennessy also acknowledged Petitioner sustained a left knee sprain resulting from his work accident. (PX 10, pg. 44)

Dr. Hennessy testified that everybody agrees there was degenerative disc disease at L5-S1. Dr. Hennessy said he disagrees with Dr. Singh because Petitioner gave him a different subjective complaint of his radiculopathies than he seemed to give to Dr. Singh and "I didn't find those correlated". (RX 10, pg. 76)

Dr. Singh testified he believes the Petitioner had an aggravation of his underlying degenerative condition at the L5-S1 level as the result of his work related injury. (PX 9, pg. 12) Dr. Singh said Petitioner had objective evidence of a nerve root compression and Petitioner had weakness in a defined anatomic distribution. Petitioner had weakness in his leg and gastrocnemius and plantar flexor. (PX 9, 54) Dr. Singh testified that he was unaware that Petitioner had any leg pain and leg weakness prior to his work related accident. (PX 9, pg. 29) Dr. Singh said Petitioner's symptoms were identified in Dr. Lubenow's report and Petitioner had a defined motor weakness in the L5 distribution on his left side. (PX 9, pgs. 38, 20) Dr. Sigh further testified Petitioner had low back pain and nerve root involvement-not based upon his pain complaints but based upon objective data which Petitioner can't contribute to. (PX 9, pg. 21)

Petitioner received treatment for his low back at Advocate Medical Group from his PCP in 2012 and 2013. In May of 2013, Petitioner had significant lower back pain and muscle spasms. Physical therapy and possibly a follow up with an orthopedic surgeon or pain management consultation were recommended. (RX 9) On November 6, 2014, the Advocate records show Petitioner was still having significant lower back pain and muscle spasm. It was recommended that Petitioner obtain physical therapy and follow up with an orthopedic surgeon or pain management consultation. (RX 9)

Petitioner testified he did treat with his family doctor for his back but he was still able to work. He said his back pain was different after his work accidents. (T. 98) The pain before was on his right side and now it was on his left side. (T. 45) Petitioner admits being referred to a pain clinic or to physical therapy by his family doctor but said he didn't need it. (T. 94) Petitioner testified he did not get treatment because he felt fine, he didn't feel that he needed it at that time, so he didn't go. (T. 98) Petitioner testified up until this accident, he was able to do his job as a laborer. (T. 101)

Petitioner testified he put on 65 pounds after his work accident because his left side is completely numb and hurts. (T. 47) Petitioner testified he was still off of work pursuant to Dr. Singh's restrictions and he has lifting restrictions of 10 pounds. (T. 43, 44). Petitioner testified he can't do anything because he has lost some much strength and it is hard to walk because he gets his foot caught on the littlest piece of carpet. (T. 48)

CONCLUSIONS OF LAW

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

It is important to note that the Parties agreed that unpaid medical treatment and bills are not at issue, nor was prospective medical treatment at issue. Therefore, the Arbitrator is not going to address the Utilization Review or issues regarding prospective medical treatment.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980)) including that the accidental injury both arose out of and occurred in the course of his employment (*Horath v. Industrial Commission*, 96 Ill 2d 349 (1983)) and that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc Co. v. Industrial Board*, 284 Ill. 378 (1918). To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 205 (2003). Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e).

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

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill2d 30, 36-37. When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982). When an employee with a preexisting condition is injured in the course and of his employment the Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. *Sisbro, Inc. Industrial Comm'n*, 207 Ill.2d 193, 278 Ill.Dec 70, 797 N.E.2d 665 (2003). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator has carefully reviewed and considered all of the medical evidence along with all of the testimony. The Arbitrator concludes Petitioner has proven by a preponderance of the credible evidence that his back, left leg and hip conditions are conditions are causally related to his work injury as set forth more fully below.

The Arbitrator finds the opinions of Dr. Singh, Dr. Cheng, Dr. Bush-Joseph and Dr. Lubenow to be more persuasive than the opinions of Dr. Hennessy. Dr. Singh testified, based upon a reasonable degree of medical certainty, he believed the Petitioner had an aggravation of his underlying degenerative condition at the L5-S1 level and the aggravation was his work related injury in March of 2014. (PX 9. Pgs. 13,14). Dr. Hennessy testified his causation opinion was based, in part, upon inconsistencies in the subjective complaints of Petitioner's radiculopathies and sparseness of those complaints in the initial treatment records and upon the inconsistencies of histories Petitioner gave to several of the medical providers.

The Arbitrator does not find that Petitioner's radicular symptoms to be inconsistent or sparsely referenced in Petitioner's initial treatment. The symptoms were present since the onset of treatment but the cause of those symptoms was not identified until after the RSD, left knee, left hip as the potential sources of those symptoms. Dr. Hennessy testified Dr. Atkenson focused on the knee and RSD and did not fully explore Petitioner's radiculopathy. (RX 10, pg. 56) Dr. Hennessy also testified Dr. Atkenson's records, two days after Petitioner was released from the emergency room, showed complaints of left buttock pain, left sciatic notch tenderness. (RX 10, pg. 71. 72)

Complaints of radicular symptoms were contained in Dr. Atkenson's records of March 28, 2014. The records show Petitioner had pain radiating down his leg and the pain started slowly but became progressively worse. (RX 4) On a diagram Petitioner was asked to mark the location of the pain. On the diagram Petitioner marked from the left knee up the left thigh just under the buttock as a source of pain. (PX 4) During the examination Petitioner was given a document called "Associated Factors" and Petitioner wrote down that he was experiencing numbness, weakness and giving way and he his leg muscle was becoming weak. Dr. Paul Atkenson diagnosed possible lumbar radiculopathy days after Petitioner was released from the emergency room. (RX 4)

The Arbitrator finds the radicular complaints were also present in the records of Dr. Lubenow, who performed the first IME, and the medical records of Dr. Cheng and Dr. Bush-Joseph. Dr. Lubenow examined Petitioner approximately four months after the accident, said Petitioner's back pain certainly had a neuropathic component to it. Dr. Lubenow referred Petitioner to Dr. Bush-Joseph who also noted

that Petitioner was experiencing radicular burning low back pain that went down the side of his leg and groin. Dr. Bush-Joseph also found left leg weakness with resisted straight leg raises and radicular symptoms on the lateral side of his leg with a seated straight legged hip flexion. Dr. Cheng's neurologic exam also found weakness with left ankle dorsiflexion and decreased sensation to light touching throughout the entire left leg and positive dural tension signs with seated slump test. Dr.
The Arbitrator found Dr. Singh's testimony persuasive that Petitioner had objective evidence of a nerve root compression after the work accident and Petitioner's weakness was defined anatomic distribution and he was not aware of any leg weakness prior to Petitioner's work related accident. (PX 9, pg. 29) The Arbitrator notes the existence of some inconsistence regarding the subjective complaints Petitioner made to his doctors. However, Dr. Sigh testified his opinions were not based upon Petitioner's pain complaints but based upon objective data which Petitioner can't contribute to. (PX 9, pg. 21)

Petitioner testified since his work accident he can't perform any physical activity and he had gained over 65 pounds since his work accident. The weight gain appears to be consistent with Petitioner's testimony regarding his inability to resume the same level of activity as before his work accident. Petitioner may have experienced back prior back pain and radicular symptoms causing him to seek treatment from his family doctor. However, the pain or symptoms Petitioner had experienced, prior to March of 2014, was not serious enough or painful enough to cause Petitioner to seek additional medical treatment or miss work. Petitioner testified he did not seek additional medical treatment because he didn't need it and he had never been unable to work due to back problems prior to March of 2014. Petitioner was able to work as a laborer for 11 months in 2013 until being off of work for the winter. (PX 2) Petitioner testified his prior back symptoms were different than what he experienced after his work injuries in March of 2014. On March 28, 2014, Dr. Atkenson asked Petitioner what he was not able to do now that he could do before the work accident and Petitioner wrote work, walk, play with kids, have a life and drive a car. (RX 4) Petitioner testified that he has been unable to work since his work accident of March 25, 2014. The testimony of the employee, if not impeached or rebutted, is sufficient to support an award. *Phoell Manufacturing Co. v. Industrial Commission*, 54 Ill.2d 119, 295 N.E.2d 469 (1973)

Dr. Hennessy did not proffer an opinions or testimony regarding Petitioner having a loss of left sided strength prior to March of 2014 nor was any testimony presented, at trial, showing Petitioner was unable to perform his job duties prior to March 18, 2014. Regarding inconsistencies involving the histories of the accident, Dr. Hennessy testified that he relied upon various reports and medical records including the workers' compensation investigative report which was not allowed into evidence. Dr. Hennessy testified the investigative report was identified as one of the most significant records he relied upon. (RX 10, 8, 9) Because Dr. Hennessy relied, in part, upon a report not allowed into evidence, the Arbitrator is unable to determine review and weigh the significance of the potential inconsistencies. The Arbitrator reviewed the histories from the emergency room, Dr. Atkenson, Dr. Bush-Joseph, Dr. Lubenow, Dr. Hennessy, Dr. Cheng, Dr. Singh, the Employer's First Report of Injury and recorded interview of Petitioner dated march 27, 2014 and found the histories to be generally consistent.

Based upon the above the Arbitrator gives greater deference to the opinions for Dr. Singh than Dr. Hennessy regarding whether or not Petitioner's condition was causally connected to Petitioner's work injury.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

To show entitlement to TTD, Petitioner must not only show that he did not work, but that he was incapable of working and attempted to locate work within his abilities. *Robert F. Beuse, Sr. v Industrial Commission of Illinois*, (1998) 299 Ill.App.3d 180, 701 N.E.2d 96, 233 Ill.Dec. 453. Petitioner testified was still off of work pursuant to Dr. Singh's restrictions and he has lifting restrictions of 10 pounds. Petitioner testified he can't do anything because he has lost some much strength and it is hard to walk. (T. 48) The Arbitrator finds Petitioner's condition has not stabilized or has otherwise reached MMI. The Arbitrator further finds Petitioner proved by the preponderance of the evidence he did not work and he was unable to work from March 26, 2014 through November 14, 2014. Petitioner's claim for 137 6/7^{ths} weeks of TTD benefits from March 26, 2014 through November 14, 2016 is granted. Respondent is entitled to a credit of $88,726.00 in TTD benefits paid by 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL HORNER,

Petitioner,

vs.

NO: 11 WC 2891

18IWCC0700

COOK COUNTY,
CERMAK HEALTH SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

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

A separate decision has been issued for case 12 WC 27140 and case 14 WC 31198.

After reviewing the record, the Commission modifies the Arbitrator's Decision relative to the award of medical expenses. The Arbitrator awarded $11,647.08 in medical expenses. However, the record establishes that, after the application of the fee schedule, a balance of $8,050.55 remains from ATI Physical Therapy that was not included in the Arbitrator's award of medical expenses. At oral argument, Respondent asserted that all charges were satisfied. But, upon questioning,

18IWCC0700

Respondent admitted that Respondent does not possess any documentation that suggests that the ATI charges are fully paid. Absent such documentation, the Commission is compelled to award the additional amount of $8,050.55, per the fee schedule.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 27, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $19,697.63 for medical expenses under §8(a) of the Act, and subject to the 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.

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 16 2018

Michael J. Brennan

MJB/tdm
O: 11/5/18
052

Thomas J. Tyrrell

Kevin W. Lamborn

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

HORNER, MICHAEL J
Employee/Petitioner

Case# **11WC002891**

12WC027140
14WC031198

COOK COUNTY CERMAK HEALTH SERVICES
Employer/Respondent

18IWCC0700

On 2/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 STEVEN B SALK & ASSOC LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0132 COOK COUNTY STATE'S ATTORNEY
SUYON FLOWERS
500 RICHARD J DALEY CENTER
CHICAGO, IL 60602

18IWCC0700

STATE OF ILLINOIS)
)
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael J. Horner
Employee/Petitioner

v.

Cook County, Cermak Health Services
Employer/Respondent

Case # 11 WC 02891

Consolidated cases: 12 WC 027140
14 WC 031198

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Frank J. Soto, arbitrator of the Industrial Commission, in the city of Chicago, on 12/13/2017. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was 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 current 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? 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 the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Other

FINDINGS

- On 11/30/2010 , the respondent Cook County, Cermak Health Services *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* given to the respondent.
- Petitioner's current condition of ill-being is not causally related to the accident.
- In the year preceding the injury, the petitioner earned $ 58,198.40 ; the average weekly wage was $ 1,119.20
- On the date of accident, Petitioner was 43 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, $ 0 for maintenance, and $ 0 for other benefits, for a total credits of $0..
- Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Petitioner failed to prove by a preponderance of the credible evidence that his current condition of ill-being is not causally related to his work injury of November 30, 2010, as set forth in the Conclusions of Law attached herein.

Respondent shall pay to Petitioner the sum of $11,647.08 for the reasonable and necessary medical services outlined above, pursuant to Section 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall also hold Petitioner harmless for any claims by any providers for services for which Respondent is receiving a credit, as provided in Section 8(j) of the Act

Petitioner's request for perspective medical treatment is denied as set forth in the Conclusions of Law attached herein.

In no instance shall this awarded 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 date before the date of payment' however, if an employee's appeal results in either no change or a decreased in this award, interest shall not accrue.

Signature of arbitrator

2/27/2018
Date

FEB 27 2018

PROCEDURAL HISTORY

Petitioner filed three Application of Adjustment of Claims. The cases were consolidated and tried, pursuant to Section 19(b) of the Act, before Arbitrator Frank Soto on December 13, 2017. The claims and disputed issues are as follows:

Case No: 11 WC 02891: **(F)** Whether Petitioner's current condition of ill-being is causally connected to his injury; **(J)** Whether Respondent is liable for medical provided by ATI in the amount of $11,647.08 and **(K)** whether Petitioner is entitled to prospective medical treatment. (Arb. Ex. #1)

Case No: 12 WC 027140: **(F)** Whether Petitioner's current condition of ill-being is causally connected to his injury and **(K)** whether Petitioner is entitled to prospective medical treatment. (Arb. Ex. #2)

Case No: 14 WC 031198: **(F)** Whether Petitioner's current condition of Ill-being is causally connected to his injury; **(J)** Whether Respondent is liable for an medical services provided by Advocate Christ Medical Center in the amount of $131.33, ATI in the amount of $16,093.74, Midwest Orthopedic in the amount of $252.00 and Midwest Anesthesiologists in the amount of $9,555.00; **(K)** whether Petitioner is entitled to prospective medical treatment and **(L)** whether Petitioner is entitled to TTD benefits from May 13, 2017 to the date of the trial. (Arb. Ex. #3)

FINDINGS OF FACT

Michael Horner (hereinafter referred to as "Petitioner") has been employed by Cook County, Cermak Health Services (hereinafter referred to as "Respondent") since April of 1995 as a paramedic and emergency response technician assigned to the Cook County jail at 26th and California in the City of Chicago. Petitioner's date of birth is May 10, 1967.

On November 30, 2010, Petitioner was working the 3:00 p.m. to 11:00 p.m. shift when, approximately 8:00 p.m., he responded an emergency call in Division I of the jail. Petitioner found an inmate in a pump room basement area who had been badly beaten. Petitioner was the first one who arrived at the scene. Petitioner testified he lifted the inmate and dragged him out into a hallway. After bringing the inmate into the hallway, Petitioner noticed pain in his low back. After getting the injured inmate to the hallway, Petitioner lifted the inmate and place him on a backboard. Thereafter, others arrived and they helped Petitioner place the inmate on a stretcher. Petitioner testified that he began to experience severe low back pain. Petitioner transported the inmate to the emergency room while loading the inmate in a bed he tripped over a safety belt jarring his lower back. *(See 11 WC 02891).*

Petitioner testified that he completed his shift but he was unable to report the work the following day due to back pain. Petitioner scheduled an appointment with his primary care physician. Petitioner testified that he reported the accident to his supervisor, Ms. Withers, and completed a written accident report.

On December 2, 2010, Petitioner presented himself to Dr. Kaza, his primary care physician. After the examination and taking x-rays, Dr. Kaza referred Petitioner to Dr. Schaible, a neurosurgeon. Petitioner testified that Dr. Kaza took him off work, proscribed medication and ordered an MRI.

On December 16, 2010, Petitioner was examined by Dr. Schaible. Petitioner reported back pain after lifting at work and he had "band-like" pain across his back. Dr. Schaible told Petitioner to return after the MRI. Petitioner had the MRI on December 23, 2010 which showed herniated disc/osteophyte complex on the right at L5-S1 causing moderate right foraminal stenosis that may be impressing upon the exiting right L5 nerve root and a dorsal root ganglion within the right foramen. (PX 3)

On January 4, 2011, Petitioner returned to Dr. Schaible, who reviewed the MRI, indicated the MRI showed degenerative disc spaces changes at L5-S1 and questionable foraminal disc osteophytes. Dr. Schaible noted that Petitioner did not have radicular symptoms. Dr. Schaible recommended continuing conservative treatment with Dr. Kaza. On March 1, 2011, Petitioner returned to Dr. Schaible who recommended therapy and epidural injections. (PX 3)

On March 15, 2011, Petitioner presented himself to Dr. Jonathan Wyatts for a consultation and pain management. Dr. Kaza referred Petitioner to Dr. Wyatts. After reviewing the MRI, Dr. Wyatt wrote in his records, "*...Given his history and the MRI findings it is within a high degree of reasonable medical certainty that more likely than not his back pain is due to the herniated disc that was seen on his MRI that most likely was secondary to him attempting to lift the patient.*" (PX 1A)

On May 19, 2011, Petitioner returned to Dr. Schaible who noted that Petitioner was still in pain and could not return to work. Dr. Schaible recommended physical therapy and another injection. (PX 3)

On May 20, 2011, Petitioner was examined by Dr. Anthony Rinella pursuant to Section 12 of the Act. In his report dated May 20, 2011, Dr. Rinella indicated Petitioner has a lumbar strain and Petitioner's treatment was reasonable and necessary. Dr. Rinella stated Petitioner's current symptoms were related to his work injury and Dr. Rinella also recommended additional physical therapy and work conditioning. (RX 1) Petitioner attended physical therapy and cork conditioning at ATI. (PX 6)

On August 26, 2011, Petitioner returned to Dr. Rinella, pursuant to Section 12 of the Act. Dr. Rinella noted Petitioner continues to have lumbar back pain but without significant radiculopathy. Dr. Rinella recommended completing the work conditioning program and, upon completing the work conditioning, Petitioner should undergo a functional capacity examination. In his August 26, 2011 report, Dr. Rinella stated Petitioner's treatment was reasonable, necessary and related to his work injury. (RX 2)

Petitioner underwent a functional compacity examination (FCE) on October 13, 2011. The FCE determined that Petitioner could perform at a medium level job. Petitioner's position, as a paramedic, was classified as a very heavy level job. (PX 6)

On December 2, 2011, Respondent sent Petitioner to Dr. Edward Goldberg, of Midwest Orthopedics, for a second opinion. Dr. Goldberg reviewed the December 23, 2011 MRI. Dr. Goldberg indicated the MRI shows lumbar disc degeneration at L5-S1 with modic changes anteriorly, reduced disk height posteriorly with annular bulging. Dr. Goldberg did not find spondylolisthesis or spondylolysis. Dr. Goldberg indicated that Petitioner would like to return to full-duty work. Dr. Goldberg recommended Petitioner could return to full duty for a six-week trial period and, if tolerated, Petitioner could remain working full duty. (RX 3) Dr. Schaible agreed to allow Petitioner to return to work. Petitioner returned to work on December 26, 2011.

Petitioner returned to full duty work on December 26, 2011 and continued to work until sustaining a second injury to his low back on July 18, 2012. *(see 12 IWC 027140).* During this period, Petitioner testified he occasionally would see his primary care physician for back pain. Petitioner testified, during this period, he continued to perform his full job duties.

On July 18, 2012, Petitioner fell to the floor striking his buttocks, left arm and head after a plastic floor mat, located at a nurse's station, slid out from underneath his feet. Immediately after

the fall, Petitioner testified he experienced back pain and pain in his legs, especially, the left leg. Petitioner also testified to numbness radiating down his arm from his shoulder. Petitioner reported the incident to his supervisor.

On July 19, 2012, Petitioner sought treatment with his primary care physician, Dr. Macri. Petitioner reported right wrist and back pain after falling at work. Petitioner was diagnosed with lower back and wrist strains. On July 23, 2012 Petitioner returned to Dr. Macr and reported persistent low back pain radiating down his left leg. Petitioner was taken off work and issued a prescription for an MRI and Naproxen. (PX 1B)

On August 3, 2012, Petitioner underwent the MRI at Advocate Medical Group. The MRI showed no lumbar disc herniation or central stenosis, mild facet degeneration, worse on the left, at L4-L5, and mild to moderate degenerative stenosis of the right foramen at L5-S1. (PX 1B)

On August 11, 2012, Petitioner was released to returned to work, without restrictions. Petitioner continued to work full duty performing his all his job duties until September 4, 2014.

On September 4, 2014, Petitioner testified that he was at work when a patient collapsed in the dialysis center. Petitioner said the patient was very large weighing about 260 lbs. Petitioner said when he arrived at the scene, the patient was unconscious and he had to place the patient on a backboard and Petitioner assisted loading the patient into a hospital bed. While loading the patient into the hospital bed, a corner of the backboard started to fall and Petitioner grabbed the corner and lifted it so the patient would not fall to the floor. Petitioner testified that he felt immediate pain in his low back and left knee. Petitioner reported the incident to his supervisor and he completed his shift. Petitioner testified he experienced difficulty existing his car when he returned home from work and when he tried to get into his car the following day.

On September 5, 2014, Petitioner saw his primary care physician, Dr. Patel. Petitioner reported low back pain radiating down his leg. Dr. Patel ordered an MRI and referred Petitioner to a neurosurgeon. Dr. Patel assessed lumbar radiculopathy and foot pain. (PX 1D)

On September 9, 2014, Petitioner had an MRI at Advocate Medical Group which showed L5-S1 moderate right and mild left foraminal stenosis secondary to a disc bulge and endplate osteophytes, L1-L2 disc bulging with a small broad based right paracentral disc protrusion with

no stenosis and L3-L4 and L4-L5 very mild bilateral foraminal stenosis secondary to a very light bulging of the intervertebral disc and mild bilateral foraminal stenosis secondary to a very slight bulging of the intervertebral disc and mild degenerative changes of the facet joints. (PX 1D)

Petitioner testified he was directed to go to the Cook County Employee Health Services (hereafter referred to as "CCEHS") by Respondent. Petitioner presented himself at CCEHS on September 10, 15 and 18th. The medical records show Petitioner reported low back pain radiating down his left leg and numbness in the left foot. Petitioner was assessed with lumbar radiculopathy and stenosis. (PX 7)

On October 8, 2014, Petitioner presented himself to Dr. Ebby Jido, a pain specialist at Advocate Medical Group. During the examination, Dr. Jido noted a positive straight leg-raise test on the right but not on the left and Petitioner had a paresthesia in the left leg and left thigh. Dr. Jido recommended a series of three epidural injections. (PX 1 D, 5C)

On October 16, 2014, Petitioner returned to Dr. Patel. At visit, Petitioner complained of low back pain and left knee pain. Dr. Patel ordered a MRI of the left knee. On October 27, 2014, Petitioner had the MRI of the left knee at High Tech Medical Park. The MRI revealed a medial meniscal tear, degenerative joint disease, chondromalacia and effusion. After review of the MRI, Dr. Patel referred Petitioner to Dr. Brooker of Midland Orthopedic Associates. (PX 1D)

On November 14, 2014, Petitioner was examined by Dr. Brooker who administered a left knee steroid injection. Dr. Brooker noted that Petitioner had prior left knee scope in 2003. Dr. Brooker records indicate Petitioner was experiencing a flare-up of knee pain and swelling. The examination showed tenderness along the joint margin, crepitus on range of motion and Petitioner had a positive medial McMurray's test. Dr. Brooker said the MRI showed degenerative meniscal pathology and assessed degenerative medial meniscus tear with early degenerative arthritis because of having a meniscectomy and meniscal tear years ago. On December 5, 2014, Petitioner returned to Dr. Brooker complaining of knee soreness and stiffness. Dr. Brooker assessed a degenerative meniscal tear which had improved with injections. (PX 9)

On December 8, 2014, Petitioner treated with Dr. Farha. Petitioner was referred to Dr. Farha by Dr. Patel. Dr. Farha's records state that Petitioner could not identify any other inciting events for his symptoms other than that it had occurred after attempting to move a patient who

weighed between 150-200 lbs. Petitioner reported no significant improvement after physical therapy and only minimal relief after epidural injections. Dr. Farhat assessed lumbar pain, radiculopathy and ordered an EMG. (PX 1D)

On December 15, 2014, Petitioner returned to Dr. Patel complaining left shoulder pain. Petitioner reported left shoulder pain for the past week. Petitioner reported the pain was not the result of a known injury and the pain was worse with certain position. Dr. Patel ordered an x-ray and referred Petitioner to Midland Orthopedics. The x-ray showed mild degenerative changes of the left glenohumeral and AC joints. (PX 1D)

On January 9, 2015, Petitioner returned to Dr. Brooker for left shoulder pain for several months. Dr. Brooker's examination showed pain with palpation over the insertion of the biceps tendon in the bicipital groove and posterior aspect of the shoulder, positive Speeds and Yergason's and Hawkins tests. Dr. Brooker assessed left shoulder bicipital and RTC tendinitis. Dr. Brooker recommended corticosteroid injections and therapy. (PX 9)

On January 26, 2015 Petitioner underwent EMG of the lower back at Advocate Medical Group. The EMG of both the lower extremities and the paraspinal muscles showed no abnormal spontaneous single muscle fiber discharges. (PX 1E)

On January 29, 2015, Petitioner returned to Dr. Patel for his low back and left knee complaints. Dr. Patel referred Petitioner to an orthopedic physician to have a second opinion. (PX 1E) On February 6, 2015, Petitioner was examined by Dr. Moravek, of MidAmerica Orthopaedics. Dr. Moravek noted focal tenderness over the biceps tendon of the left shoulder. Petitioner's rotator cuff had full range of motion and full strength. Dr. Moravek also noted that Petitioner had pain on the inside of his knee and the McMurray's test was positive. Dr. Moravek assessed a left medical meniscus tear and a left shoulder bicipital tenosynovitis. Dr. Moravek ordered a MRI of the shoulder, injections for the knee and therapy for the knee and shoulder. (PX 10)

On February 18, 2016, Petitioner returned to Dr. Jido of Advocate Christ Medical Center. Dr. Jido noted that Petitioner's leg pain was better but his back pain had not improved. Dr. Jido said the MRI showed that Petitioner has facet joint hypertrophy. Dr. Jido ordered bilateral lumbar facet block at L3-L4, L4-L5 and L5-S1. Petitioner underwent the lumbar facet joint injections on February 23, 2015 at Advocate Christ Medical Center. (PX 5D)

On March 26, 2015, Petitioner returned to Dr. Maravek. Petitioner reported his knee pain was 70-80 % resolved but the injection did not relieve his biceps tendinitis. Dr. Maravek ordered a MRI of the left shoulder. (PX 10) On April 8, 2015, Petitioner had an MRI of the left shoulder which showed supraspinatus tendinopathy with undersurface partial thickness footplate tears of the rotator cuff, infraspinatus tendinopathy and hypertrophic arthropathic changes to the A/C joint with undersurface spurring (PX 2)

On April 1, 2015, Petitioner returned to Dr. Jido. Petitioner reported the lumbar epidural steroid injections provided only several days of relief. Dr. Jido recommend a radiofrequency ablation of the posterior medial branch nerve which supplies the facets. Dr. Jido opined that if Petitioner does not respond well to the radiofrequency ablation, then the Petitioner could be a candidate for a spinal cord stimulator. (PX 5D)

On April 13, 2015, Petitioner underwent the left sided radiofrequency ablation and the right sided radiofrequency ablation on April 27, 2015. Petitioner returned to Dr. Jido on June 15, 2015. Petitioner reported no relief from the radiofrequency ablations. Dr. Jido referred Petitioner to Dr. Lim, of Midwest Orthopedic Group, for a second opinion. Dr. Jido proscribed a fentanyl patch and hydrocodone. (PX 5D)

On June 30, 2015, Petitioner was examined by Dr. Lim. Petitioner reported midline lower back pain since a September 4, 2014 accident at work. Dr. Lim diagnosed discogenic low backpain. Dr. Lim reviewed the MRI of September of 2014 which shows well-maintained disc height with right-sided osteophyte and Modic changes with moderate foraminal stenosis on the right and mild on the left. Dr. Lim recommended a new MRI of the lumbar spine, which was performed on July 15, 2015. Dr. Lim indicated the new MRI shows asymmetric L5-L1 disc space collapse, Modic changes asymmetrically on the right side greater than the left side and he recommend a discogram. (PX 11)

On August 18, 2015, Petitioner returned to Dr. Lim. Petitioner reported the discogram was not approved. Petitioner discussed attempting returned to work, on a trial bases, with restrictions of no bending, twisting, lifting, patient care and a 10-pound weight limit. (PX 11) Petitioner testified that Respondent was unable to accommodate Petitioner's work restrictions.

On September 2, 2015, Petitioner was examined by Dr. Hsu, pursuant to section 12 of the Act. At that appointment, Petitioner reported a sudden onset of backpain and left lower extremity radiating pain after picking up a patient on a backboard. Dr. Hsu diagnosed a resolved lumbar strain and lumbar spondylosis. Dr. Hsu opined that Petitioner's current symptoms were not related to his work accident of September 4, 2014. Dr. Hsu further opined that Petitioner sustained a temporary lumbar strain that had resolved with appropriate conservative care.

Dr. Hsu did not recommend the discogram because he did not believe discograms are appropriate indictors for surgical treatment and they cause more harm than benefits. Dr. Hsu did not recommend any further medical treatment but he opined that Petitioner's treatment through March 16, 2015 was reasonable and necessary treatment for Petitioner's lumbar strain. Dr. Hsu opined that all medical treatment after March 16, 2015 was related to Petitioner's preexisting condition of lumbar spondylosis which was not related to his work injury. Dr. Hsu recommended Petitioner undergo a functional capacity examination. (RX 5)

On September 29, 2015, Petitioner followed up with Dr. Lim. Petitioner reported moderate low back pain which is worsens with sitting, bending, stairs, twisting, moving and lying in bed. Dr. Lim also recommended Petitioner undergo an FCE. On November 6, 2016, Petitioner returned to Dr. Lim to review the FCE results. Dr. Lim issued a 40-pound weight limit lifting restriction. Dr. Lim's medical records contain the following passage, "*...is irrefutable that the patient had pre-existing lumbar degenerative conditions these conditions were entirely asymptomatic not requiring any treatment until his work-related injury. Work-related injury he has been in a state of constant pain and resulting disability. In my opinion it is not realistic to state that he is at maximal medical improvement as he has not returned to his preinjury status.*" Dr. Lim referred Petitioner for pain management treatment. (PX 11)

On November 10, 2015, Petitioner returned to CCEHS. At that time, CCEHS allowed Petitioner to return to work with 40-pound light duty restriction (PX 7). Petitioner testified he returned to work on November 18, 2015 performing computer work and bed control.

On December 4. 2015, Petitioner returned to Dr. Lim. Petitioner reported his symptoms had worsened since the last visit. Dr. Lim recommended physical therapy. Petitioner attended physical therapy at ATI from January 20, 2016 through March 3, 2016. (PX 6) On February 5,

2016, Petitioner returned to Dr. Lim. Petitioner reported making some progress. Dr. Lim recommended work conditioning which Petitioner attended at ATI. On April 15, 2016, Petitioner returned to Dr. Lim. Petitioner reported no changes in his current symptoms. Dr. Lim did not recommend additional work conditioning. Dr. Lim found Petitioner not to be a surgical candidate and he recommended Petitioner obtain a FCE. (PX 11)

On January 30, 2017, Petitioner returned to Dr. Jido. Petitioner reported pain associated with radiculopathy involving the left leg and neck pain. Dr. Jido recommended lumbar epidural steroid injections and discussed a spinal cord stimulator as a possible treatment option. Petitioner underwent the epidural injections on February 3, 2017 and February 23, 2017. (PX 5F)

On March 27, 2017, Petitioner returned to Dr. Hsu pursuant to Section 12 of the Act. Petitioner reported returning to work for about a year and that his pain never resolved. Petitioner further reported that he started to experience low back pain and left-sided buttock pain worse than before. Dr. Hsu reviewed Petitioner's October 23, 2015 FCE which showed inconsistent performance and an unacceptable effort. Dr. Hsu assessed a resolved lumbar strain and lumbar spondylosis.

In his report dated April 5, 2017, Dr. Hsu noted that Petitioner's medical complaints were not consistent with the objective medical findings of his exam. Dr. Hsu opined that Petitioner's current complaints were not attributable to Petitioner's work injury of September 4, 2014. Dr. Hsu opined that Petitioner's current symptoms were related to a pre-existing lumbar spondylosis, which was not work-related. Dr. Hsu further opined that Petitioner's employment did not aggravate or exacerbate Petitioner's pre-existing condition and that Petitioner's current condition was age and genetic related. Dr. Hsu did not recommend further medical treatment and found Petitioner to be at maximum medical improvement as of March 16, 2015. Dr. Hsu opined that Petitioner was capable for returning to work without restrictions based upon the Petitioner's inconsistent effort during the FCE. (RX 6)

On March 30, 2017, Petitioner returned to Dr. Jido complaining of increased back pain. Dr. Jido proscribed an epidural injection which were administered to Petitioner on April 10, 2017. (PX 5F)

On April 11, 2017, Petitioner returned to Dr. Lim. In is records, Dr. Lim wrote "*Patient has been experiencing low back pain with left leg pain since September of 2016, no definite history of injury...Patient is noticing a generalized feeling that he is off balance...he feels significant weakness in his lower extremities from the knee distally. The problem has been bad enough that he has fallen, recently he presented to the emergency room after a fall had a Ct scan of his face and discovered that he had fractured his nose because his legs gave out.*" Dr. Lim diagnosed intervertebral disc disorders with radiculopathy said Petitioner has signs and symptoms of progressive neurologic deterioration with weakness in bilateral lower extremities. Dr. Lim ordered a new MRI. (PX 11)

Petitioner returned to Dr. Lim on April 19, 2017. Dr. Lim noted his examination showed a definite improvement in Petitioner and no new problems. Dr. Lim reviewed the new MRI which showed L1-L2 disc pathology with no cord compression. Dr. Lim diagnosed Petitioner with low back pain and intervertebral disc disorders with radiculopathy. Dr. Lim did not recommend surgery but he did recommend that Petitioner continue with pain management. Dr. Lim discharged Petitioner from care at that time.

On April 14, 2017, Respondent terminated TTD benefits as of May 12, 2017 based upon Dr. Hsu's report of April 5, 2017. (RX 12) Petitioner returned to CCEHS on April 24, 2017, April 27, 2017 and May 3, 2017 and CCEHS kept Petitioner off work. (PX 7)

On May 11, 2017, Petitioner returned to see Dr. Jido. Petitioner reported radicular pain on the left side. Dr. Jido recommended epidural steroid injections using the transforaminal approach and, if no relief, a spinal cord stipulator or lumbar fusion could be considered. On June 1, 2017, Petitioner underwent the lumbar transforaminal epidural steroid injection at L5-S1 and L4-L5. (PX 5F)

On June 19, 2017, Petitioner returned to Dr. Patel who diagnosed a left rotator cuff tear, left knee pain and lumbar radiculopathy. Dr. Patel indicated Petitioner could return to work light duty with no lifting. (PX 17) On June 19, 2017, Petitioner returned to CCEHS and presented Respondent his restriction. Respondent was unable to accommodate the restrictions. (PX 17)

On July 19, 2017, Petitioner returned to Dr. Jido. Petitioner reported the epidural injection did not provide relief. In Dr. Jido's records it states that the radiological evidence of disc

degeneration in the back is the cause of Petitioner's back pain. Petitioner was given information on spinal cord stimulation and Petitioner indicted he would consider his options. Petitioner did not return to Dr. Jido. (PX 5F)

On August 31, 2017, Petitioner was examined by Dr. Lawrence Lieber, pursuant to Section 12 of the Act, for his left knee and left shoulder. Petitioner reported a work event on September 4, 2014 but Petitioner also reported that he did not feel an isolated injury to the left shoulder or the left knee which he noticed 4 weeks later. Dr. Lieber reviewed the left shoulder MRI and indicated the MRI showed minor supraspinatus tendinopathy and the left knee MRI, which showed degenerative joint disease with chondromalacia and degenerative medical meniscal tear.

Dr. Lieber opined that Petitioner's current complaints have no relationship to Petitioner's work accident of September 4, 2014 and this current condition represent pre-existing abnormalities which have no relationship to Petitioner's work accident. Dr. Lieber further opined that Petitioner's pre-existing condition was not aggravated and/or exacerbated by Petitioner's work accident of September 4, 2014. (RX 7)

Petitioner testified that he would like to try the spinal cord stimulator recommended by Dr. Jido. Petitioner testified that he experiences a lot of pain in his daily activities such as vacuuming and laundry. Petitioner also experiences pain in his left arm, especially when driving, and his left knee feels tight again. Petitioner testified that he had not experienced left knee pain after his 2002 left knee surgery.

The Arbitrator found the testimony of the Petitioner to be credible.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 ILL.2d 214 (1969).

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

When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). If a claimant is in a certain condition, and accident occurs, and following the accident, the Claimant's condition has deteriorated, it is inferable that the intervening accident caused the deterioration and the salient factor is not the precise previous condition, it is the resulting deterioration from whatever from that previous condition. *Natette Schroeder v. Illinois Workers' compensation Comm'n*, 217 IL. App (4th) 106192WC. In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner's current condition of ill-being is not causally related to his work accident of November 30, 2010.

Petitioner sustained a low back injury which resolved by December 26, 2011 and Petitioner returned to his previous position, performing his previous job duties from December 26, 2011 until sustaining a subsequent injury, to his low back, on July 18, 2012 (12 WC 027140) and on September 4, 2014 (14 WC 031198). The Arbitrator finds that the subsequent low back injuries were independent intervening accidents breaking the chain of causation between Petitioner's work injury of November 30, 2010 and his current condition of ill-being.

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 claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, treat, relieve or cure the effects of the claimant's injury. *F&B Manufacturing Co.*, 325 Ill.App.3d 527, 534 (2001) The Petitioner seeks Respondent to pay for medical treatment from ATI Physical Therapy, in the amount of $11,647.08. (Arb. Ex. 1). The ATI Patient Ledger Report shows Petitioner received treatment for his low back condition from May 25, 2011 through August 26, 2011. The sum due ATI is $11,647.08. (PX 11)

The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the services provided by ATI Physical Therapy were required to treat, relieve or cure the effects of Petitioner's work injury of November 30, 2010. Therefore, Respondent shall pay to Petitioner the sum of $11,647.08 for the reasonable and necessary medical services outlined above, pursuant to Section 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been pain and Respondent shall also hold Petitioner harmless for any claims by any providers for services for which Respondent is receiving a credit, as provided in Section 8(j) of the Act.

WITH REGARD TO ISSUE (K) WHETHER OR NOT THE PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator has carefully reviewed and considered all the medical evidence and all the testimony and finds that Petitioner is not entitled to prospective medical care. As stated above, the Arbitrator found that Petitioner's current condition of ill-being is not causally related to his work injury of November 30, 2010. The Petitioner as failed to prove be the preponderance of the

evidence that he is entitled to perspective medical treatment resulting from his November 30, 2010 work injury. Therefore, Petitioner's request for perspective medical treatment 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

MICHAEL HORNER,

Petitioner,

vs.

NO: 12 WC 27140

COOK COUNTY,
CERMAK HEALTH SERVICES,

18IWCC0701

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, causal connection, prospective medical, and temporary total disability (TTD), and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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).

A separate decision has been issued for case 11 WC 2891 and case 14 WC 31198.

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

18IWCC0701

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 16 2018

Michael J. Brennan

MJB/tdm
O: 11/5/18
052

Thomas J. Tyrrell

Kevin W. Lamborn

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

HORNER, MICHAEL J
Employee/Petitioner

Case# **12WC027140**

11WC002891
14WC031198

COOK COUNTY CERMAK HEALTH CENTER
Employer/Respondent

18IWCC0701

On 2/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 STEVEN B SALK & ASSOC LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0132 COOK COUNTY STATE'S ATTORNEY
SUYON FLOWERS
500 RICHARD J DALEY CENTER
CHICAGO, IL 60602

18IWCC0701

STATE OF ILLINOIS)
)
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael J. Horner
Employee/Petitioner

v.

Cook County, Cermak Health Services
Employer/Respondent

Case # 12 WC 027140

Consolidated cases: 11 WC 02891
14 WC 031198

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Frank J. Soto, arbitrator of the Industrial Commission, in the city of Chicago, on 12/13/2017. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was 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 current 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? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. ☐ Other

FINDINGS

- On 7/18/2012 , the respondent Cook County, Cermak Health Services *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* given to the respondent.
- Petitioner's current condition of ill-being is not causally related to the accident.
- In the year preceding the injury, the petitioner earned $ 57,817.76 ; the average weekly wage was $ 1,111.88
- On the date of accident, Petitioner was 45 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, $ 0 for maintenance, and $ 0 for other benefits, for a total credits of $0..
- Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Petitioner failed to prove by a preponderance of the credible evidence that his current condition of ill-being is not causally related to his work injury of July 18, 2012, as set forth in the Conclusions of Law attached herein.

Petitioner's request for perspective medical treatment is denied as set forth in the Conclusions of Law attached herein.

In no instance shall this awarded 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 date before the date of payment' however, if an employee's appeal results in either no change or a decreased in this award, interest shall not accrue.

Signature of arbitrator

2/27/2018
Date

FEB 27 2018

18IWCC0701

PROCEDURAL HISTORY

Petitioner filed three Application of Adjustment of Claims. The cases were consolidated and tried, pursuant to Section 19(b) of the Act, before Arbitrator Frank Soto on December 13, 2017. The claims and disputed issues are as follows:

Case No: 11 WC 02891: (F) Whether Petitioner's current condition of ill-being is causally connected to his injury; (J) Whether Respondent is liable for medical provided by ATI in the amount of $11,647.08 and (K) whether Petitioner is entitled to prospective medical treatment. (Arb. Ex. #1)

Case No: 12 WC 027140: (F) Whether Petitioner's current condition of ill-being is causally connected to his injury and (K) whether Petitioner is entitled to prospective medical treatment. (Arb. Ex. #2)

Case No: 14 WC 031198: (F) Whether Petitioner's current condition of Ill-being is causally connected to his injury; (J) Whether Respondent is liable for an medical services provided by Advocate Christ Medical Center in the amount of $131.33, ATI in the amount of $16,093.74, Midwest Orthopedic in the amount of $252.00 and Midwest Anesthesiologists in the amount of $9,555.00; (K) whether Petitioner is entitled to prospective medical treatment and (L) whether Petitioner is entitled to TTD benefits from May 13, 2017 to the date of the trial. (Arb. Ex. #3)

FINDINGS OF FACT

Michael Horner (hereinafter referred to as "Petitioner") has been employed by Cook County, Cermak Health Services (hereinafter referred to as "Respondent") since April of 1995 as a paramedic and emergency response technician assigned to the Cook County jail at 26th and California in the City of Chicago. Petitioner's date of birth is May 10, 1967.

On November 30, 2010, Petitioner was working the 3:00 p.m. to 11:00 p.m. shift when, approximately 8:00 p.m., he responded an emergency call in Division I of the jail. Petitioner found an inmate in a pump room basement area who had been badly beaten. Petitioner was the first one who arrived at the scene. Petitioner testified he lifted the inmate and dragged him out into a hallway. After bringing the inmate into the hallway, Petitioner noticed pain in his low back. After getting the injured inmate to the hallway, Petitioner lifted the inmate and place him on a backboard. Thereafter, others arrived and they helped Petitioner place the inmate on a stretcher. Petitioner testified that he began to experience severe low back pain. Petitioner transported the inmate to the emergency room while loading the inmate in a bed he tripped over a safety belt jarring his lower back. *(See 11 WC 02891).*

Petitioner testified that he completed his shift but he was unable to report the work the following day due to back pain. Petitioner scheduled an appointment with his primary care physician. Petitioner testified that he reported the accident to his supervisor, Ms. Withers, and completed a written accident report.

On December 2, 2010, Petitioner presented himself to Dr. Kaza, his primary care physician. After the examination and taking x-rays, Dr. Kaza referred Petitioner to Dr. Schaible, a neurosurgeon. Petitioner testified that Dr. Kaza took him off work, proscribed medication and ordered an MRI.

On December 16, 2010, Petitioner was examined by Dr. Schaible. Petitioner reported back pain after lifting at work and he had "band-like' pain across his back. Dr. Schaible told Petitioner to return after the MRI. Petitioner had the MRI on December 23, 2010 which showed herniated disc/osteophyte complex on the right at L5-S1 causing moderate right foraminal stenosis that may be impressing upon the exiting right L5 nerve root and a dorsal root ganglion within the right foramen. (PX 3)

On January 4, 2011, Petitioner returned to Dr. Schaible, who reviewed the MRI, indicated the MRI showed degenerative disc spaces changes at L5-S1 and questionable foraminal disc osteophytes. Dr. Schaible noted that Petitioner did not have radicular symptoms. Dr. Schaible recommended continuing conservative treatment with Dr. Kaza. On March 1, 2011, Petitioner returned to Dr. Schaible who recommended therapy and epidural injections. (PX 3)

On March 15, 2011, Petitioner presented himself to Dr. Jonathan Wyatts for a consultation and pain management. Dr. Kaza referred Petitioner to Dr. Wyatts. After reviewing the MRI, Dr. Wyatt wrote in his records, "*...Given his history and the MRI findings it is within a high degree of reasonable medical certainty that more likely than not his back pain is due to the herniated disc that was seen on his MRI that most likely was secondary to him attempting to lift the patient.*" (PX 1A)

On May 19, 2011, Petitioner returned to Dr. Schaible who noted that Petitioner was still in pain and could not return to work. Dr. Schaible recommended physical therapy and another injection. (PX 3)

On May 20, 2011, Petitioner was examined by Dr. Anthony Rinella pursuant to Section 12 of the Act. In his report dated May 20, 2011, Dr. Rinella indicated Petitioner has a lumbar strain and Petitioner's treatment was reasonable and necessary. Dr. Rinella stated Petitioner's current symptoms were related to his work injury and Dr. Rinella also recommended additional physical therapy and work conditioning. (RX 1) Petitioner attended physical therapy and cork conditioning at ATI. (PX 6)

On August 26, 2011, Petitioner returned to Dr. Rinella, pursuant to Section 12 of the Act. Dr. Rinella noted Petitioner continues to have lumbar back pain but without significant radiculopathy. Dr. Rinella recommended completing the work conditioning program and, upon completing the work conditioning, Petitioner should undergo a functional capacity examination. In his August 26, 2011 report, Dr. Rinella stated Petitioner's treatment was reasonable, necessary and related to his work injury. (RX 2)

Petitioner underwent a functional compacity examination (FCE) on October 13, 2011. The FCE determined that Petitioner could perform at a medium level job. Petitioner's position, as a paramedic, was classified as a very heavy level job. (PX 6)

On December 2, 2011, Respondent sent Petitioner to Dr. Edward Goldberg, of Midwest Orthopedics, for a second opinion. Dr. Goldberg reviewed the December 23, 2011 MRI. Dr. Goldberg indicated the MRI shows lumbar disc degeneration at L5-S1 with modic changes anteriorly, reduced disk height posteriorly with annular bulging. Dr. Goldberg did not find spondylolisthesis or spondylolysis. Dr. Goldberg indicated that Petitioner would like to return to full-duty work. Dr. Goldberg recommended Petitioner could return to full duty for a six-week trial period and, if tolerated, Petitioner could remain working full duty. (RX 3) Dr. Schaible agreed to allow Petitioner to return to work. Petitioner returned to work on December 26, 2011.

Petitioner returned to full duty work on December 26, 2011 and continued to work until sustaining a second injury to his low back on July 18, 2012. *(see 12 WC 027140).* During this period, Petitioner testified he occasionally would see his primary care physician for back pain. Petitioner testified, during this period, he continued to perform his full job duties.

On July 18, 2012, Petitioner fell to the floor striking his buttocks, left arm and head after a plastic floor mat, located at a nurse's station, slid out from underneath his feet. Immediately after

the fall, Petitioner testified he experienced back pain and pain in his legs, especially, the left leg. Petitioner also testified to numbness radiating down his arm from his shoulder. Petitioner reported the incident to his supervisor.

On July 19, 2012, Petitioner sought treatment with his primary care physician, Dr. Macri. Petitioner reported right wrist and back pain after falling at work. Petitioner was diagnosed with lower back and wrist strains. On July 23, 2012 Petitioner returned to Dr. Macr and reported persistent low back pain radiating down his left leg. Petitioner was taken off work and issued a prescription for an MRI and Naproxen. (PX 1B)

On August 3, 2012, Petitioner underwent the MRI at Advocate Medical Group. The MRI showed no lumbar disc herniation or central stenosis, mild facet degeneration, worse on the left. at L4-L5, and mild to moderate degenerative stenosis of the right foramen at L5-S1. (PX 1B)

On August 11, 2012, Petitioner was released to returned to work, without restrictions. Petitioner continued to work full duty performing his all his job duties until September 4, 2014.

On September 4, 2014, Petitioner testified that he was at work when a patient collapsed in the dialysis center. Petitioner said the patient was very large weighing about 260 lbs. Petitioner said when he arrived at the scene, the patient was unconscious and he had to place the patient on a backboard and Petitioner assisted loading the patient into a hospital bed. While loading the patient into the hospital bed, a corner of the backboard started to fall and Petitioner grabbed the corner and lifted it so the patient would not fall to the floor. Petitioner testified that he felt immediate pain in his low back and left knee. Petitioner reported the incident to his supervisor and he completed his shift. Petitioner testified he experienced difficulty existing his car when he returned home from work and when he tried to get into his car the following day.

On September 5, 2014, Petitioner saw his primary care physician, Dr. Patel. Petitioner reported low back pain radiating down his leg. Dr. Patel ordered an MRI and referred Petitioner to a neurosurgeon. Dr. Patel assessed lumbar radiculopathy and foot pain. (PX 1D)

On September 9, 2014, Petitioner had an MRI at Advocate Medical Group which showed L5-S1 moderate right and mild left foraminal stenosis secondary to a disc bulge and endplate osteophytes, L1-L2 disc bulging with a small broad based right paracentral disc protrusion with

no stenosis and L3-L4 and L4-L5 very mild bilateral foraminal stenosis secondary to a very light bulging of the intervertebral disc and mild bilateral foraminal stenosis secondary to a very slight bulging of the intervertebral disc and mild degenerative changes of the facet joints. (PX 1D)

Petitioner testified he was directed to go to the Cook County Employee Health Services (hereafter referred to as "CCEHS") by Respondent. Petitioner presented himself at CCEHS on September 10, 15 and 18th. The medical records show Petitioner reported low back pain radiating down his left leg and numbness in the left foot. Petitioner was assessed with lumbar radiculopathy and stenosis. (PX 7)

On October 8, 2014, Petitioner presented himself to Dr. Ebby Jido, a pain specialist at Advocate Medical Group. During the examination, Dr. Jido noted a positive straight leg-raise test on the right but not on the left and Petitioner had a paresthesia in the left leg and left thigh. Dr. Jido recommended a series of three epidural injections. (PX 1 D, 5C)

On October 16, 2014, Petitioner returned to Dr. Patel. At visit, Petitioner complained of low back pain and left knee pain. Dr. Patel ordered a MRI of the left knee. On October 27, 2014, Petitioner had the MRI of the left knee at High Tech Medical Park. The MRI revealed a medial meniscal tear, degenerative joint disease, chondromalacia and effusion. After review of the MRI, Dr. Patel referred Petitioner to Dr. Brooker of Midland Orthopedic Associates. (PX 1D)

On November 14, 2014, Petitioner was examined by Dr. Brooker who administered a left knee steroid injection. Dr. Brooker noted that Petitioner had prior left knee scope in 2003. Dr. Brooker records indicate Petitioner was experiencing a flare-up of knee pain and swelling. The examination showed tenderness along the joint margin, crepitus on range of motion and Petitioner had a positive medial McMurray's test. Dr. Brooker said the MRI showed degenerative meniscal pathology and assessed degenerative medial meniscus tear with early degenerative arthritis because of having a meniscectomy and meniscal tear years ago. On December 5, 2014, Petitioner returned to Dr. Brooker complaining of knee soreness and stiffness. Dr. Brooker assessed a degenerative meniscal tear which had improved with injections. (PX 9)

On December 8, 2014, Petitioner treated with Dr. Farha. Petitioner was referred to Dr. Farha by Dr. Patel. Dr. Farha's records state that Petitioner could not identify any other inciting events for his symptoms other than that it had occurred after attempting to move a patient who

weighed between 150-200 lbs. Petitioner reported no significant improvement after physical therapy and only minimal relief after epidural injections. Dr. Farhat assessed lumbar pain, radiculopathy and ordered an EMG. (PX 1D)

On December 15, 2014, Petitioner returned to Dr. Patel complaining left shoulder pain. Petitioner reported left shoulder pain for the past week. Petitioner reported the pain was not the result of a known injury and the pain was worse with certain position. Dr. Patel ordered an x-ray and referred Petitioner to Midland Orthopedics. The x-ray showed mild degenerative changes of the left glenohumeral and AC joints. (PX 1D)

On January 9, 2015, Petitioner returned to Dr. Brooker for left shoulder pain for several months. Dr. Brooker's examination showed pain with palpation over the insertion of the biceps tendon in the bicipital groove and posterior aspect of the shoulder, positive Speeds and Yergason's and Hawkins tests. Dr. Brooker assessed left shoulder bicipital and RTC tendinitis. Dr. Brooker recommended corticosteroid injections and therapy. (PX 9)

On January 26, 2015 Petitioner underwent EMG of the lower back at Advocate Medical Group. The EMG of both the lower extremities and the paraspinal muscles showed no abnormal spontaneous single muscle fiber discharges. (PX 1E)

On January 29, 2015, Petitioner returned to Dr. Patel for his low back and left knee complaints. Dr. Patel referred Petitioner to an orthopedic physician to have a second opinion. (PX 1E) On February 6, 2015, Petitioner was examined by Dr. Moravek, of MidAmerica Orthopaedics. Dr. Moravek noted focal tenderness over the biceps tendon of the left shoulder. Petitioner's rotator cuff had full range of motion and full strength. Dr. Moravek also noted that Petitioner had pain on the inside of his knee and the McMurray's test was positive. Dr. Moravek assessed a left medical meniscus tear and a left shoulder bicipital tenosynovitis. Dr. Moravek ordered a MRI of the shoulder, injections for the knee and therapy for the knee and shoulder. (PX 10)

On February 18, 2016, Petitioner returned to Dr. Jido of Advocate Christ Medical Center. Dr. Jido noted that Petitioner's leg pain was better but his back pain had not improved. Dr. Jido said the MRI showed that Petitioner has facet joint hypertrophy. Dr. Jido ordered bilateral lumbar facet block at L3-L4, L4-L5 and L5-S1. Petitioner underwent the lumbar facet joint injections on February 23, 2015 at Advocate Christ Medical Center. (PX 5D)

On March 26, 2015, Petitioner returned to Dr. Maravek. Petitioner reported his knee pain was 70-80 % resolved but the injection did not relieve his biceps tendinitis. Dr. Maravek ordered a MRI of the left shoulder. (PX 10) On April 8, 2015, Petitioner had an MRI of the left shoulder which showed supraspinatus tendinopathy with undersurface partial thickness footplate tears of the rotator cuff, infraspinatus tendinopathy and hypertrophic arthropathic changes to the A/C joint with undersurface spurring (PX 2)

On April 1, 2015, Petitioner returned to Dr. Jido. Petitioner reported the lumbar epidural steroid injections provided only several days of relief. Dr. Jido recommend a radiofrequency ablation of the posterior medial branch nerve which supplies the facets. Dr. Jido opined that if Petitioner does not respond well to the radiofrequency ablation, then the Petitioner could be a candidate for a spinal cord stimulator. (PX 5D)

On April 13, 2015, Petitioner underwent the left sided radiofrequency ablation and the right sided radiofrequency ablation on April 27, 2015. Petitioner returned to Dr. Jido on June 15, 2015. Petitioner reported no relief from the radiofrequency ablations. Dr. Jido referred Petitioner to Dr. Lim, of Midwest Orthopedic Group, for a second opinion. Dr. Jido proscribed a fentanyl patch and hydrocodone. (PX 5D)

On June 30, 2015, Petitioner was examined by Dr. Lim. Petitioner reported midline lower back pain since a September 4, 2014 accident at work. Dr. Lim diagnosed discogenic low backpain. Dr. Lim reviewed the MRI of September of 2014 which shows well-maintained disc height with right-sided osteophyte and Modic changes with moderate foraminal stenosis on the right and mild on the left. Dr. Lim recommended a new MRI of the lumbar spine, which was performed on July 15, 2015. Dr. Lim indicated the new MRI shows asymmetric L5-L1 disc space collapse, Modic changes asymmetrically on the right side greater than the left side and he recommend a discogram. (PX 11)

On August 18, 2015, Petitioner returned to Dr. Lim. Petitioner reported the discogram was not approved. Petitioner discussed attempting returned to work, on a trial bases, with restrictions of no bending, twisting, lifting, patient care and a 10-pound weight limit. (PX 11) Petitioner testified that Respondent was unable to accommodate Petitioner's work restrictions.

On September 2, 2015, Petitioner was examined by Dr. Hsu, pursuant to section 12 of the Act. At that appointment, Petitioner reported a sudden onset of backpain and left lower extremity radiating pain after picking up a patient on a backboard. Dr. Hsu diagnosed a resolved lumbar strain and lumbar spondylosis. Dr. Hsu opined that Petitioner's current symptoms were not related to his work accident of September 4, 2014. Dr. Hsu further opined that Petitioner sustained a temporary lumbar strain that had resolved with appropriate conservative care.

Dr. Hsu did not recommend the discogram because he did not believe discograms are appropriate indictors for surgical treatment and they cause more harm than benefits. Dr. Hsu did not recommend any further medical treatment but he opined that Petitioner's treatment through March 16, 2015 was reasonable and necessary treatment for Petitioner's lumbar strain. Dr. Hsu opined that all medical treatment after March 16, 2015 was related to Petitioner's preexisting condition of lumbar spondylosis which was not related to his work injury. Dr. Hsu recommended Petitioner undergo a functional capacity examination. (RX 5)

On September 29, 2015, Petitioner followed up with Dr. Lim. Petitioner reported moderate low back pain which is worsens with sitting, bending, stairs, twisting, moving and lying in bed. Dr. Lim also recommended Petitioner undergo an FCE. On November 6, 2016, Petitioner returned to Dr. Lim to review the FCE results. Dr. Lim issued a 40-pound weight limit lifting restriction. Dr. Lim's medical records contain the following passage, "*...is irrefutable that the patient had pre-existing lumbar degenerative conditions these conditions were entirely asymptomatic not requiring any treatment until his work-related injury. Work-related injury he has been in a state of constant pain and resulting disability. In my opinion it is not realistic to state that he is at maximal medical improvement as he has not returned to his preinjury status.*" Dr. Lim referred Petitioner for pain management treatment. (PX 11)

On November 10, 2015, Petitioner returned to CCEHS. At that time, CCEHS allowed Petitioner to return to work with 40-pound light duty restriction (PX 7). Petitioner testified he returned to work on November 18, 2015 performing computer work and bed control.

On December 4. 2015, Petitioner returned to Dr. Lim. Petitioner reported his symptoms had worsened since the last visit. Dr. Lim recommended physical therapy. Petitioner attended physical therapy at ATI from January 20, 2016 through March 3, 2016. (PX 6) On February 5,

2016, Petitioner returned to Dr. Lim. Petitioner reported making some progress. Dr. Lim recommended work conditioning which Petitioner attended at ATI. On April 15, 2016, Petitioner returned to Dr. Lim. Petitioner reported no changes in his current symptoms. Dr. Lim did not recommend additional work conditioning. Dr. Lim found Petitioner not to be a surgical candidate and he recommended Petitioner obtain a FCE. (PX 11)

On January 30, 2017, Petitioner returned to Dr. Jido. Petitioner reported pain associated with radiculopathy involving the left leg and neck pain. Dr. Jido recommended lumbar epidural steroid injections and discussed a spinal cord stimulator as a possible treatment option. Petitioner underwent the epidural injections on February 3, 2017 and February 23, 2017. (PX 5F)

On March 27, 2017, Petitioner returned to Dr. Hsu pursuant to Section 12 of the Act. Petitioner reported returning to work for about a year and that his pain never resolved. Petitioner further reported that he started to experience low back pain and left-sided buttock pain worse than before. Dr. Hsu reviewed Petitioner's October 23, 2015 FCE which showed inconsistent performance and an unacceptable effort. Dr. Hsu assessed a resolved lumbar strain and lumbar spondylosis.

In his report dated April 5, 2017, Dr. Hsu noted that Petitioner's medical complaints were not consistent with the objective medical findings of his exam. Dr. Hsu opined that Petitioner's current complaints were not attributable to Petitioner's work injury of September 4, 2014. Dr. Hsu opined that Petitioner's current symptoms were related to a pre-existing lumbar spondylosis, which was not work-related. Dr. Hsu further opined that Petitioner's employment did not aggravate or exacerbate Petitioner's pre-existing condition and that Petitioner's current condition was age and genetic related. Dr. Hsu did not recommend further medical treatment and found Petitioner to be at maximum medical improvement as of March 16, 2015. Dr. Hsu opined that Petitioner was capable for returning to work without restrictions based upon the Petitioner's inconsistent effort during the FCE. (RX 6)

On March 30, 2017, Petitioner returned to Dr. Jido complaining of increased back pain. Dr. Jido proscribed an epidural injection which were administered to Petitioner on April 10, 2017. (PX 5F)

On April 11, 2017, Petitioner returned to Dr. Lim. In is records, Dr. Lim wrote "*Patient has been experiencing low back pain with left leg pain since September of 2016, no definite history of injury...Patient is noticing a generalized feeling that he is off balance...he feels significant weakness in his lower extremities from the knee distally. The problem has been bad enough that he has fallen, recently he presented to the emergency room after a fall had a Ct scan of his face and discovered that he had fractured his nose because his legs gave out.*" Dr. Lim diagnosed intervertebral disc disorders with radiculopathy said Petitioner has signs and symptoms of progressive neurologic deterioration with weakness in bilateral lower extremities. Dr. Lim ordered a new MRI. (PX 11)

Petitioner returned to Dr. Lim on April 19, 2017. Dr. Lim noted his examination showed a definite improvement in Petitioner and no new problems. Dr. Lim reviewed the new MRI which showed L1-L2 disc pathology with no cord compression. Dr. Lim diagnosed Petitioner with low back pain and intervertebral disc disorders with radiculopathy. Dr. Lim did not recommend surgery but he did recommend that Petitioner continue with pain management. Dr. Lim discharged Petitioner from care at that time.

On April 14, 2017, Respondent terminated TTD benefits as of May 12, 2017 based upon Dr. Hsu's report of April 5, 2017. (RX 12) Petitioner returned to CCEHS on April 24, 2017, April 27, 2017 and May 3, 2017 and CCEHS kept Petitioner off work. (PX 7)

On May 11, 2017, Petitioner returned to see Dr. Jido. Petitioner reported radicular pain on the left side. Dr. Jido recommended epidural steroid injections using the transforaminal approach and, if no relief, a spinal cord stipulator or lumbar fusion could be considered. On June 1, 2017, Petitioner underwent the lumbar transforaminal epidural steroid injection at L5-S1 and L4-L5. (PX 5F)

On June 19, 2017, Petitioner returned to Dr. Patel who diagnosed a left rotator cuff tear, left knee pain and lumbar radiculopathy. Dr. Patel indicated Petitioner could return to work light duty with no lifting. (PX 17) On June 19, 2017, Petitioner returned to CCEHS and presented Respondent his restriction. Respondent was unable to accommodate the restrictions. (PX 17)

On July 19, 2017, Petitioner returned to Dr. Jido. Petitioner reported the epidural injection did not provide relief. In Dr. Jido's records it states that the radiological evidence of disc

degeneration in the back is the cause of Petitioner's back pain. Petitioner was given information on spinal cord stimulation and Petitioner indicted he would consider his options. Petitioner did not return to Dr. Jido. (PX 5F)

On August 31, 2017, Petitioner was examined by Dr. Lawrence Lieber, pursuant to Section 12 of the Act, for his left knee and left shoulder. Petitioner reported a work event on September 4, 2014 but Petitioner also reported that he did not feel an isolated injury to the left shoulder or the left knee which he noticed 4 weeks later. Dr. Lieber reviewed the left shoulder MRI and indicated the MRI showed minor supraspinatus tendinopathy and the left knee MRI, which showed degenerative joint disease with chondromalacia and degenerative medical meniscal tear.

Dr. Lieber opined that Petitioner's current complaints have no relationship to Petitioner's work accident of September 4, 2014 and this current condition represent pre-existing abnormalities which have no relationship to Petitioner's work accident. Dr. Lieber further opined that Petitioner's pre-existing condition was not aggravated and/or exacerbated by Petitioner's work accident of September 4, 2014. (RX 7)

Petitioner testified that he would like to try the spinal cord stimulator recommended by Dr. Jido. Petitioner testified that he experiences a lot of pain in his daily activities such as vacuuming and laundry. Petitioner also experiences pain in his left arm, especially when driving, and his left knee feels tight again. Petitioner testified that he had not experienced left knee pain after his 2002 left knee surgery.

The Arbitrator found the testimony of the Petitioner to be credible.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 ILL.2d 214 (1969).

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

When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). If a claimant is in a certain condition, and accident occurs, and following the accident, the Claimant's condition has deteriorated, it is inferable that the intervening accident caused the deterioration and the salient factor is not the precise previous condition, it is the resulting deterioration from whatever from that previous condition. *Natette Schroeder v. Illinois Workers' compensation Comm'n*, 217 IL. App (4^{th}) 106192WC. In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner's current condition of ill-being is not causally related to his work accident of July 18, 2012.

Petitioner sustained a low back injury which was resolved by August 11, 2012, when Petitioner was released to returned to work. Petitioner returned to his prior position and performed the same duties until September 4, 2014 when he sustained another injury to his lower back. Petitioner filed an Application for Adjustment of Claim for the September 4, 2014 injury, which was assigned case number 14 WC 031198. The Arbitrator finds that the subsequent low back injury, which occurred on September 4, 2014, was an independent intervening accident breaking the chain of causation between Petitioner's work injury of July 18, 2012 and his current condition of ill-being.

WITH REGARD TO ISSUE (K) WHETHER OR NOT THE PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator has carefully reviewed and considered all the medical evidence and all the testimony and finds that Petitioner is not entitled to prospective medical care. As stated above, the Arbitrator found that Petitioner's current condition of ill-being is not causally related to his work injury of July 18, 2012. The Arbitrator finds that the Petitioner has failed to prove by the preponderance of the evidence that he is entitled to prospective medical treatment resulting from his work-related injury of July 18, 2012 work injury. Therefore, Petitioner's request for perspective medical treatment 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL HORNER,

Petitioner,

vs.

NO: 14 WC 31198

COOK COUNTY,
CERMAK HEALTH SERVICES,

18IWCC0702

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, 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).

A separate decision has been issued for case 11 WC 2891 and case 12 WC 27140.

After reviewing the record, the Commission modifies the Arbitrator's Decision relative to the award of medical expenses. The Commission finds that Petitioner is entitled to medical expenses totaling $6,702.08. The Petitioner claims that, after the application of the fee schedule, the following amounts are outstanding: $160.71 to Advocate Christ; $6,400.33 to ATI Physical Therapy; and, $141.04 to Midwest Orthopedic Consultants. The Respondent has offered no

evidence establishing that those bills have been satisfied. Therefore, the Commission modifies the Arbitrator's decision and finds that Petitioner is entitled to the above-referenced medical expenses.

The Commission notes that the majority of doctors concede that Petitioner is not a surgical candidate and that the next logical step to ameliorate Petitioner's pain is a spinal cord stimulator. However, as noted by the Arbitrator, the record does not contain a prescription for a spinal cord stimulator. While the Commission agrees that a spinal cord stimulator is a reasonable procedure in this case, absent a prescription of formal recommendation for the stimulator, the Commission is left with no choice but to affirm the Arbitrator's denial of Petitioner's request for the spinal cord stimulator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 27, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $827.52 per week for a period of 28-1/7 weeks, May 13, 2017 through December 13, 2017, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(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 $32,482.15 for medical expenses under §8(a) of the Act and subject to the 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.

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.

18IWCC0702

DATED: NOV 16 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 11/5/18
052

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

HORNER, MICHAEL J
Employee/Petitioner

Case# **14WC031198**

11WC002891
12WC027140

COOK COUNTY CERMAK HEALTH SERVICES
Employer/Respondent

18IWCC0702

On 2/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 STEVEN B SALK & ASSOC LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0132 COOK COUNTY STATE'S ATTORNEY
SUYON FLOWERS
500 RICHARD J DALEY CENTER
CHICAGO, IL 60602

STATE OF ILLINOIS)
)
COUNTY OF Cook)

18IWCC0702

☐ 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)

Michael J. Horner
Employee/Petitioner

v.

Cook County, Cermak Health Services
Employer/Respondent

Case # 14 WC 31198

Consolidated cases: 11 WC 02891
12 WC 27140

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Frank J. Soto, arbitrator of the Industrial Commission, in the city of Chicago, on 12/13/2017. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was 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 current 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? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. ☐ Other

18IWCC0702

FINDINGS

- On 9/4/2014, the respondent Cook County, Cermak Health Services was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* given to the respondent.
- Petitioner's current condition of ill-being **is, in part,** causally related to the accident.
- In the year preceding the injury, the petitioner earned $ 64,546.56 ; the average weekly wage was $ 1,241.28
- On the date of accident, Petitioner was 47 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, $ 0 for maintenance, and $ 0 for other benefits, for a total credits of $0..
- Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Petitioner has proved by a preponderance of the credible evidence that his current condition of ill-being is, in part, causally related to his work injury of September 4, 2014, as set forth in the Conclusions of Law attached herein.

Respondent shall pay the petitioner Temporary Total Disability benefits of $827.52 /week for 28 1/7 weeks from May 13, 2017 through December 13, 2017, provided in Section 8(b) of the Act, as set forth in the Conclusions of Law attached herein.

Respondent shall pay to Petitioner for the medical expenses as set forth the in the Conclusions of Law attached herein.

Petitioner's request for perspective medical treatment is denied as set forth in the Conclusions of Law attached herein.

In no instance shall this awarded 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 date before the date of payment' however, if an employee's appeal results in either no change or a decreased in this award, interest shall not accrue.

Signature of arbitrator

2/27/2018
Date

ICArbDec19(b) p. 2

FEB 27 2018

PROCEDURAL HISTORY

Petitioner filed three Application of Adjustment of Claims. The cases were consolidated and tried, pursuant to Section 19(b) of the Act, before Arbitrator Frank Soto on December 13, 2017. The claims and disputed issues are as follows:

Case No: 11 WC 02891: (F) Whether Petitioner's current condition of ill-being is causally connected to his injury; (J) Whether Respondent is liable for medical provided by ATI in the amount of $11,647.08 and (K) whether Petitioner is entitled to prospective medical treatment. (Arb. Ex. #1)

Case No: 12 WC 027140: (F) Whether Petitioner's current condition of ill-being is causally connected to his injury and (K) whether Petitioner is entitled to prospective medical treatment. (Arb. Ex. #2)

Case No: 14 WC 031198: (F) Whether Petitioner's current condition of ill-being is causally connected to his injury; (J) Whether Respondent is liable for an medical services provided by Advocate Christ Medical Center in the amount of $131.33, ATI in the amount of $16,093.74, Midwest Orthopedic in the amount of $252.00 and Midwest Anesthesiologists in the amount of $9,555.00; (K) whether Petitioner is entitled to prospective medical treatment and (L) whether Petitioner is entitled to TTD benefits from May 13, 2017 to the date of the trial. (Arb. Ex. #3)

FINDINGS OF FACT

Michael Horner (hereinafter referred to as "Petitioner") has been employed by Cook County, Cermak Health Services (hereinafter referred to as "Respondent") since April of 1995 as a paramedic and emergency response technician assigned to the Cook County jail at 26th and California in the City of Chicago. Petitioner's date of birth is May 10, 1967.

On November 30, 2010, Petitioner was working the 3:00 p.m. to 11:00 p.m. shift when, approximately 8:00 p.m., he responded an emergency call in Division I of the jail. Petitioner found an inmate in a pump room basement area who had been badly beaten. Petitioner was the first one who arrived at the scene. Petitioner testified he lifted the inmate and dragged him out into a hallway. After bringing the inmate into the hallway, Petitioner noticed pain in his low back. After getting the injured inmate to the hallway, Petitioner lifted the inmate and place him on a backboard. Thereafter, others arrived and they helped Petitioner place the inmate on a stretcher. Petitioner testified that he began to experience severe low back pain. Petitioner transported the inmate to the emergency room while loading the inmate in a bed he tripped over a safety belt jarring his lower back. *(See 11 WC 02891).*

Petitioner testified that he completed his shift but he was unable to report the work the following day due to back pain. Petitioner scheduled an appointment with his primary care physician. Petitioner testified that he reported the accident to his supervisor, Ms. Withers, and completed a written accident report.

On December 2, 2010, Petitioner presented himself to Dr. Kaza, his primary care physician. After the examination and taking x-rays, Dr. Kaza referred Petitioner to Dr. Schaible, a neurosurgeon. Petitioner testified that Dr. Kaza took him off work, proscribed medication and ordered an MRI.

On December 16, 2010, Petitioner was examined by Dr. Schaible. Petitioner reported back pain after lifting at work and he had "band-like' pain across his back. Dr. Schaible told Petitioner to return after the MRI. Petitioner had the MRI on December 23, 2010 which showed herniated disc/osteophyte complex on the right at L5-S1 causing moderate right foraminal stenosis that may be impressing upon the exiting right L5 nerve root and a dorsal root ganglion within the right foramen. (PX 3)

On January 4, 2011, Petitioner returned to Dr. Schaible, who reviewed the MRI, indicated the MRI showed degenerative disc spaces changes at L5-S1 and questionable foraminal disc osteophytes. Dr. Schaible noted that Petitioner did not have radicular symptoms. Dr. Schaible recommended continuing conservative treatment with Dr. Kaza. On March 1, 2011, Petitioner returned to Dr. Schaible who recommended therapy and epidural injections. (PX 3)

On March 15, 2011, Petitioner presented himself to Dr. Jonathan Wyatts for a consultation and pain management. Dr. Kaza referred Petitioner to Dr. Wyatts. After reviewing the MRI, Dr. Wyatt wrote in his records, "*...Given his history and the MRI findings it is within a high degree of reasonable medical certainty that more likely than not his back pain is due to the herniated disc that was seen on his MRI that most likely was secondary to him attempting to lift the patient.*" (PX 1A)

On May 19, 2011, Petitioner returned to Dr. Schaible who noted that Petitioner was still in pain and could not return to work. Dr. Schaible recommended physical therapy and another injection. (PX 3)

On May 20, 2011, Petitioner was examined by Dr. Anthony Rinella pursuant to Section 12 of the Act. In his report dated May 20, 2011, Dr. Rinella indicated Petitioner has a lumbar strain and Petitioner's treatment was reasonable and necessary. Dr. Rinella stated Petitioner's current symptoms were related to his work injury and Dr. Rinella also recommended additional physical therapy and work conditioning. (RX 1) Petitioner attended physical therapy and cork conditioning at ATI. (PX 6)

On August 26, 2011, Petitioner returned to Dr. Rinella, pursuant to Section 12 of the Act. Dr. Rinella noted Petitioner continues to have lumbar back pain but without significant radiculopathy. Dr. Rinella recommended completing the work conditioning program and, upon completing the work conditioning, Petitioner should undergo a functional capacity examination. In his August 26, 2011 report, Dr. Rinella stated Petitioner's treatment was reasonable, necessary and related to his work injury. (RX 2)

Petitioner underwent a functional compacity examination (FCE) on October 13, 2011. The FCE determined that Petitioner could perform at a medium level job. Petitioner's position, as a paramedic, was classified as a very heavy level job. (PX 6)

On December 2, 2011, Respondent sent Petitioner to Dr. Edward Goldberg, of Midwest Orthopedics, for a second opinion. Dr. Goldberg reviewed the December 23, 2011 MRI. Dr. Goldberg indicated the MRI shows lumbar disc degeneration at L5-S1 with modic changes anteriorly, reduced disk height posteriorly with annular bulging. Dr. Goldberg did not find spondylolisthesis or spondylolysis. Dr. Goldberg indicated that Petitioner would like to return to full-duty work. Dr. Goldberg recommended Petitioner could return to full duty for a six-week trial period and, if tolerated, Petitioner could remain working full duty. (RX 3) Dr. Schaible agreed to allow Petitioner to return to work. Petitioner returned to work on December 26, 2011.

Petitioner returned to full duty work on December 26, 2011 and continued to work until sustaining a second injury to his low back on July 18, 2012. *(see 12 IWC 027140).* During this period, Petitioner testified he occasionally would see his primary care physician for back pain. Petitioner testified, during this period, he continued to perform his full job duties.

On July 18, 2012, Petitioner fell to the floor striking his buttocks, left arm and head after a plastic floor mat, located at a nurse's station, slid out from underneath his feet. Immediately after

the fall, Petitioner testified he experienced back pain and pain in his legs, especially, the left leg. Petitioner also testified to numbness radiating down his arm from his shoulder. Petitioner reported the incident to his supervisor.

On July 19, 2012, Petitioner sought treatment with his primary care physician, Dr. Macri. Petitioner reported right wrist and back pain after falling at work. Petitioner was diagnosed with lower back and wrist strains. On July 23, 2012 Petitioner returned to Dr. Macr and reported persistent low back pain radiating down his left leg. Petitioner was taken off work and issued a prescription for an MRI and Naproxen. (PX 1B)

On August 3, 2012, Petitioner underwent the MRI at Advocate Medical Group. The MRI showed no lumbar disc herniation or central stenosis, mild facet degeneration, worse on the left, at L4-L5, and mild to moderate degenerative stenosis of the right foramen at L5-S1. (PX 1B)

On August 11, 2012, Petitioner was released to returned to work, without restrictions. Petitioner continued to work full duty performing his all his job duties until September 4, 2014.

On September 4, 2014, Petitioner testified that he was at work when a patient collapsed in the dialysis center. Petitioner said the patient was very large weighing about 260 lbs. Petitioner said when he arrived at the scene, the patient was unconscious and he had to place the patient on a backboard and Petitioner assisted loading the patient into a hospital bed. While loading the patient into the hospital bed, a corner of the backboard started to fall and Petitioner grabbed the corner and lifted it so the patient would not fall to the floor. Petitioner testified that he felt immediate pain in his low back and left knee. Petitioner reported the incident to his supervisor and he completed his shift. Petitioner testified he experienced difficulty existing his car when he returned home from work and when he tried to get into his car the following day.

On September 5, 2014, Petitioner saw his primary care physician, Dr. Patel. Petitioner reported low back pain radiating down his leg. Dr. Patel ordered an MRI and referred Petitioner to a neurosurgeon. Dr. Patel assessed lumbar radiculopathy and foot pain. (PX 1D)

On September 9, 2014, Petitioner had an MRI at Advocate Medical Group which showed L5-S1 moderate right and mild left foraminal stenosis secondary to a disc bulge and endplate osteophytes, L1-L2 disc bulging with a small broad based right paracentral disc protrusion with

no stenosis and L3-L4 and L4-L5 very mild bilateral foraminal stenosis secondary to a very light bulging of the intervertebral disc and mild bilateral foraminal stenosis secondary to a very slight bulging of the intervertebral disc and mild degenerative changes of the facet joints. (PX 1D)

Petitioner testified he was directed to go to the Cook County Employee Health Services (hereafter referred to as "CCEHS") by Respondent. Petitioner presented himself at CCEHS on September 10, 15 and 18th. The medical records show Petitioner reported low back pain radiating down his left leg and numbness in the left foot. Petitioner was assessed with lumbar radiculopathy and stenosis. (PX 7)

On October 8, 2014, Petitioner presented himself to Dr. Ebby Jido, a pain specialist at Advocate Medical Group. During the examination, Dr. Jido noted a positive straight leg-raise test on the right but not on the left and Petitioner had a paresthesia in the left leg and left thigh. Dr. Jido recommended a series of three epidural injections. (PX 1 D, 5C)

On October 16, 2014, Petitioner returned to Dr. Patel. At visit, Petitioner complained of low back pain and left knee pain. Dr. Patel ordered a MRI of the left knee. On October 27, 2014, Petitioner had the MRI of the left knee at High Tech Medical Park. The MRI revealed a medial meniscal tear, degenerative joint disease, chondromalacia and effusion. After review of the MRI, Dr. Patel referred Petitioner to Dr. Brooker of Midland Orthopedic Associates. (PX 1D)

On November 14, 2014, Petitioner was examined by Dr. Brooker who administered a left knee steroid injection. Dr. Brooker noted that Petitioner had prior left knee scope in 2003. Dr. Brooker records indicate Petitioner was experiencing a flare-up of knee pain and swelling. The examination showed tenderness along the joint margin, crepitus on range of motion and Petitioner had a positive medial McMurray's test. Dr. Brooker said the MRI showed degenerative meniscal pathology and assessed degenerative medial meniscus tear with early degenerative arthritis because of having a meniscectomy and meniscal tear years ago. On December 5, 2014, Petitioner returned to Dr. Brooker complaining of knee soreness and stiffness. Dr. Brooker assessed a degenerative meniscal tear which had improved with injections. (PX 9)

On December 8, 2014, Petitioner treated with Dr. Farha. Petitioner was referred to Dr. Farha by Dr. Patel. Dr. Farha's records state that Petitioner could not identify any other inciting events for his symptoms other than that it had occurred after attempting to move a patient who

weighed between 150-200 lbs. Petitioner reported no significant improvement after physical therapy and only minimal relief after epidural injections. Dr. Farhat assessed lumbar pain, radiculopathy and ordered an EMG. (PX 1D)

On December 15, 2014, Petitioner returned to Dr. Patel complaining left shoulder pain. Petitioner reported left shoulder pain for the past week. Petitioner reported the pain was not the result of a known injury and the pain was worse with certain position. Dr. Patel ordered an x-ray and referred Petitioner to Midland Orthopedics. The x-ray showed mild degenerative changes of the left glenohumeral and AC joints. (PX 1D)

On January 9, 2015, Petitioner returned to Dr. Brooker for left shoulder pain for several months. Dr. Brooker's examination showed pain with palpation over the insertion of the biceps tendon in the bicipital groove and posterior aspect of the shoulder, positive Speeds and Yergason's and Hawkins tests. Dr. Brooker assessed left shoulder bicipital and RTC tendinitis. Dr. Brooker recommended corticosteroid injections and therapy. (PX 9)

On January 26, 2015 Petitioner underwent EMG of the lower back at Advocate Medical Group. The EMG of both the lower extremities and the paraspinal muscles showed no abnormal spontaneous single muscle fiber discharges. (PX 1E)

On January 29, 2015, Petitioner returned to Dr. Patel for his low back and left knee complaints. Dr. Patel referred Petitioner to an orthopedic physician to have a second opinion. (PX 1E) On February 6, 2015, Petitioner was examined by Dr. Moravek, of MidAmerica Orthopaedics. Dr. Moravek noted focal tenderness over the biceps tendon of the left shoulder. Petitioner's rotator cuff had full range of motion and full strength. Dr. Moravek also noted that Petitioner had pain on the inside of his knee and the McMurray's test was positive. Dr. Moravek assessed a left medical meniscus tear and a left shoulder bicipital tenosynovitis. Dr. Moravek ordered a MRI of the shoulder, injections for the knee and therapy for the knee and shoulder. (PX 10)

On February 18, 2016, Petitioner returned to Dr. Jido of Advocate Christ Medical Center. Dr. Jido noted that Petitioner's leg pain was better but his back pain had not improved. Dr. Jido said the MRI showed that Petitioner has facet joint hypertrophy. Dr. Jido ordered bilateral lumbar facet block at L3-L4, L4-L5 and L5-S1. Petitioner underwent the lumbar facet joint injections on February 23, 2015 at Advocate Christ Medical Center. (PX 5D)

On March 26, 2015, Petitioner returned to Dr. Maravek. Petitioner reported his knee pain was 70-80 % resolved but the injection did not relieve his biceps tendinitis. Dr. Maravek ordered a MRI of the left shoulder. (PX 10) On April 8, 2015, Petitioner had an MRI of the left shoulder which showed supraspinatus tendinopathy with undersurface partial thickness footplate tears of the rotator cuff, infraspinatus tendinopathy and hypertrophic arthropathic changes to the A/C joint with undersurface spurring (PX 2)

On April 1, 2015, Petitioner returned to Dr. Jido. Petitioner reported the lumbar epidural steroid injections provided only several days of relief. Dr. Jido recommend a radiofrequency ablation of the posterior medial branch nerve which supplies the facets. Dr. Jido opined that if Petitioner does not respond well to the radiofrequency ablation, then the Petitioner could be a candidate for a spinal cord stimulator. (PX 5D)

On April 13, 2015, Petitioner underwent the left sided radiofrequency ablation and the right sided radiofrequency ablation on April 27, 2015. Petitioner returned to Dr. Jido on June 15, 2015. Petitioner reported no relief from the radiofrequency ablations. Dr. Jido referred Petitioner to Dr. Lim, of Midwest Orthopedic Group, for a second opinion. Dr. Jido proscribed a fentanyl patch and hydrocodone. (PX 5D)

On June 30, 2015, Petitioner was examined by Dr. Lim. Petitioner reported midline lower back pain since a September 4, 2014 accident at work. Dr. Lim diagnosed discogenic low backpain. Dr. Lim reviewed the MRI of September of 2014 which shows well-maintained disc height with right-sided osteophyte and Modic changes with moderate foraminal stenosis on the right and mild on the left. Dr. Lim recommended a new MRI of the lumbar spine, which was performed on July 15, 2015. Dr. Lim indicated the new MRI shows asymmetric L5-L1 disc space collapse, Modic changes asymmetrically on the right side greater than the left side and he recommend a discogram. (PX 11)

On August 18, 2015, Petitioner returned to Dr. Lim. Petitioner reported the discogram was not approved. Petitioner discussed attempting returned to work, on a trial bases, with restrictions of no bending, twisting, lifting, patient care and a 10-pound weight limit. (PX 11) Petitioner testified that Respondent was unable to accommodate Petitioner's work restrictions.

On September 2, 2015, Petitioner was examined by Dr. Hsu, pursuant to section 12 of the Act. At that appointment, Petitioner reported a sudden onset of backpain and left lower extremity radiating pain after picking up a patient on a backboard. Dr. Hsu diagnosed a resolved lumbar strain and lumbar spondylosis. Dr. Hsu opined that Petitioner's current symptoms were not related to his work accident of September 4, 2014. Dr. Hsu further opined that Petitioner sustained a temporary lumbar strain that had resolved with appropriate conservative care.

Dr. Hsu did not recommend the discogram because he did not believe discograms are appropriate indictors for surgical treatment and they cause more harm than benefits. Dr. Hsu did not recommend any further medical treatment but he opined that Petitioner's treatment through March 16, 2015 was reasonable and necessary treatment for Petitioner's lumbar strain. Dr. Hsu opined that all medical treatment after March 16, 2015 was related to Petitioner's preexisting condition of lumbar spondylosis which was not related to his work injury. Dr. Hsu recommended Petitioner undergo a functional capacity examination. (RX 5)

On September 29, 2015, Petitioner followed up with Dr. Lim. Petitioner reported moderate low back pain which is worsens with sitting, bending, stairs, twisting, moving and lying in bed. Dr. Lim also recommended Petitioner undergo an FCE. On November 6, 2016, Petitioner returned to Dr. Lim to review the FCE results. Dr. Lim issued a 40-pound weight limit lifting restriction. Dr. Lim's medical records contain the following passage, "*...is irrefutable that the patient had pre-existing lumbar degenerative conditions these conditions were entirely asymptomatic not requiring any treatment until his work-related injury. Work-related injury he has been in a state of constant pain and resulting disability. In my opinion it is not realistic to state that he is at maximal medical improvement as he has not returned to his preinjury status.*" Dr. Lim referred Petitioner for pain management treatment. (PX 11)

On November 10, 2015, Petitioner returned to CCEHS. At that time, CCEHS allowed Petitioner to return to work with 40-pound light duty restriction (PX 7). Petitioner testified he returned to work on November 18, 2015 performing computer work and bed control.

On December 4. 2015, Petitioner returned to Dr. Lim. Petitioner reported his symptoms had worsened since the last visit. Dr. Lim recommended physical therapy. Petitioner attended physical therapy at ATI from January 20, 2016 through March 3, 2016. (PX 6) On February 5,

2016, Petitioner returned to Dr. Lim. Petitioner reported making some progress. Dr. Lim recommended work conditioning which Petitioner attended at ATI. On April 15, 2016, Petitioner returned to Dr. Lim. Petitioner reported no changes in his current symptoms. Dr. Lim did not recommend additional work conditioning. Dr. Lim found Petitioner not to be a surgical candidate and he recommended Petitioner obtain a FCE. (PX 11)

On January 30, 2017, Petitioner returned to Dr. Jido. Petitioner reported pain associated with radiculopathy involving the left leg and neck pain. Dr. Jido recommended lumbar epidural steroid injections and discussed a spinal cord stimulator as a possible treatment option. Petitioner underwent the epidural injections on February 3, 2017 and February 23, 2017. (PX 5F)

On March 27, 2017, Petitioner returned to Dr. Hsu pursuant to Section 12 of the Act. Petitioner reported returning to work for about a year and that his pain never resolved. Petitioner further reported that he started to experience low back pain and left-sided buttock pain worse than before. Dr. Hsu reviewed Petitioner's October 23, 2015 FCE which showed inconsistent performance and an unacceptable effort. Dr. Hsu assessed a resolved lumbar strain and lumbar spondylosis.

In his report dated April 5, 2017, Dr. Hsu noted that Petitioner's medical complaints were not consistent with the objective medical findings of his exam. Dr. Hsu opined that Petitioner's current complaints were not attributable to Petitioner's work injury of September 4, 2014. Dr. Hsu opined that Petitioner's current symptoms were related to a pre-existing lumbar spondylosis, which was not work-related. Dr. Hsu further opined that Petitioner's employment did not aggravate or exacerbate Petitioner's pre-existing condition and that Petitioner's current condition was age and genetic related. Dr. Hsu did not recommend further medical treatment and found Petitioner to be at maximum medical improvement as of March 16, 2015. Dr. Hsu opined that Petitioner was capable for returning to work without restrictions based upon the Petitioner's inconsistent effort during the FCE. (RX 6)

On March 30, 2017, Petitioner returned to Dr. Jido complaining of increased back pain. Dr. Jido proscribed an epidural injection which were administered to Petitioner on April 10, 2017. (PX 5F)

On April 11, 2017, Petitioner returned to Dr. Lim. In is records, Dr. Lim wrote "*Patient has been experiencing low back pain with left leg pain since September of 2016, no definite history of injury...Patient is noticing a generalized feeling that he is off balance...he feels significant weakness in his lower extremities from the knee distally. The problem has been bad enough that he has fallen, recently he presented to the emergency room after a fall had a Ct scan of his face and discovered that he had fractured his nose because his legs gave out.*" Dr. Lim diagnosed intervertebral disc disorders with radiculopathy said Petitioner has signs and symptoms of progressive neurologic deterioration with weakness in bilateral lower extremities. Dr. Lim ordered a new MRI. (PX 11)

Petitioner returned to Dr. Lim on April 19, 2017. Dr. Lim noted his examination showed a definite improvement in Petitioner and no new problems. Dr. Lim reviewed the new MRI which showed L1-L2 disc pathology with no cord compression. Dr. Lim diagnosed Petitioner with low back pain and intervertebral disc disorders with radiculopathy. Dr. Lim did not recommend surgery but he did recommend that Petitioner continue with pain management. Dr. Lim discharged Petitioner from care at that time.

On April 14, 2017, Respondent terminated TTD benefits as of May 12, 2017 based upon Dr. Hsu's report of April 5, 2017. (RX 12) Petitioner returned to CCEHS on April 24, 2017, April 27, 2017 and May 3, 2017 and CCEHS kept Petitioner off work. (PX 7)

On May 11, 2017, Petitioner returned to see Dr. Jido. Petitioner reported radicular pain on the left side. Dr. Jido recommended epidural steroid injections using the transforaminal approach and, if no relief, a spinal cord stipulator or lumbar fusion could be considered. On June 1, 2017, Petitioner underwent the lumbar transforaminal epidural steroid injection at L5-S1 and L4-L5. (PX 5F)

On June 19, 2017, Petitioner returned to Dr. Patel who diagnosed a left rotator cuff tear, left knee pain and lumbar radiculopathy. Dr. Patel indicated Petitioner could return to work light duty with no lifting. (PX 17) On June 19, 2017, Petitioner returned to CCEHS and presented Respondent his restriction. Respondent was unable to accommodate the restrictions. (PX 17)

On July 19, 2017, Petitioner returned to Dr. Jido. Petitioner reported the epidural injection did not provide relief. In Dr. Jido's records it states that the radiological evidence of disc

degeneration in the back is the cause of Petitioner's back pain. Petitioner was given information on spinal cord stimulation and Petitioner indicted he would consider his options. Petitioner did not return to Dr. Jido. (PX 5F)

On August 31, 2017, Petitioner was examined by Dr. Lawrence Lieber, pursuant to Section 12 of the Act, for his left knee and left shoulder. Petitioner reported a work event on September 4, 2014 but Petitioner also reported that he did not feel an isolated injury to the left shoulder or the left knee which he noticed 4 weeks later. Dr. Lieber reviewed the left shoulder MRI and indicated the MRI showed minor supraspinatus tendinopathy and the left knee MRI, which showed degenerative joint disease with chondromalacia and degenerative medical meniscal tear.

Dr. Lieber opined that Petitioner's current complaints have no relationship to Petitioner's work accident of September 4, 2014 and this current condition represent pre-existing abnormalities which have no relationship to Petitioner's work accident. Dr. Lieber further opined that Petitioner's pre-existing condition was not aggravated and/or exacerbated by Petitioner's work accident of September 4, 2014. (RX 7)

Petitioner testified that he would like to try the spinal cord stimulator recommended by Dr. Jido. Petitioner testified that he experiences a lot of pain in his daily activities such as vacuuming and laundry. Petitioner also experiences pain in his left arm, especially when driving, and his left knee feels tight again. Petitioner testified that he had not experienced left knee pain after his 2002 left knee surgery.

The Arbitrator found the testimony of the Petitioner to be credible.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 ILL.2d 214 (1969).

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

When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). If a claimant is in a certain condition, and accident occurs, and following the accident, the Claimant's condition has deteriorated, it is inferable that the intervening accident caused the deterioration and the salient factor is not the precise previous condition, it is the resulting deterioration from whatever from that previous condition. *Natette Schroeder v. Illinois Workers' compensation Comm'n*, 217 IL. App (4th) 106192WC. In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner's current condition of ill-being is, in part, causally related to his work accident of September 4, 2014.

The Arbitrator finds Petitioner failed to prove by the preponderance of the evidence that his left knee and left shoulder conditions were causally related to his work accident of September 4, 2014. Petitioner did not complain of left knee or shoulder pain immediately after his September 4, 2014 work injury. Petitioner saw Dr. Patel and the doctors at CCEHS on multiple occasions and did not make any left knee or shoulder complaints.

Petitioner first complaint of left knee pain occurred on October 16, 2014. At that time, Dr. Patel referred Petitioner to Dr. Brooker, who performed left knee surgery on Petitioner in 2003. Petitioner completed a medical history form at Dr. Brooker's office. On that form, Petitioner stated he did not know how he injured his knee. Petitioner also reported walking up stairs and using a stationary bike aggravates his symptoms. Dr. Brooker stated that Petitioner's knee complaints were a flare-up and he assessed a degenerative medical meniscus tear, early degenerative arthritis because of having meniscectomy and meniscal tear years ago. (PX 9)

Petitioner complained of left shoulder pain to Dr. Patel on December 15, 2014. At that visit, Petitioner reported having left shoulder pain for the past week. Dr. Patel's records indicate Petitioner's left shoulder pain was not from a known injury.

Dr. Patel referred Petitioner back to Dr. Brooker. Petitioner completed a second medical history form on January 9, 2015. On the medical history form, Petitioner stated he did not know how he injured his shoulder. Dr. Brooker assessed left shoulder bicipital and RTC tendinitis. Dr. Brooker's records do not contribute Petitioner's work accident of September 4, 2014 as being causally related to Petitioner's condition. (PX 9) On February 6, 2015, Petitioner had a second opinion from Dr. Moravek, of MidAmerica Orthopaedics. Dr. Moravek's records fail to contribute Petitioner's shoulder condition to his work accident of September 4, 2014. (PX 10)

On August 31, 2017, Petitioner was examined by Dr. Lieber, pursuant to Section 12 of the Act. Petitioner reported that he did not feel that he had an isolated injury to his left shoulder or left knee and that he noticed the pain approximately 4 weeks after his September 4, 2014 accident. (RX 7) Dr. Lieber did not find that Petitioner's knee and shoulder condition was related to Petitioner's work accident of September 4, 2014.

However, the Arbitrator finds Petitioner has proven by the preponderance of the evidence that his current low back condition is causally related to his work accident of September 4, 2014 as more fully described below.

Petitioner immediately reported low back pain after his September 4, 2014 work accident. Petitioner went to his primary care physician, Dr. Patel, and reported low back pain which radiated down his leg. Dr. Patel diagnosed lumbar radiculopathy, ordered an MRI and referred Petitioner to a neurosurgeon. Petitioner received conservative treatment including epidural injections, lumbar facet joint injections and radiofrequency ablation. Dr. Lim stated it is irrefutable that the patient had pre-existing lumbar degenerative conditions which were asymptomatic, not requiring any treatment, until his work-related injury and since his work-related accident he has been in a state of constant pain. On April 19, 2017, Dr. Lim recommended Petitioner continue with pain management treatment. (PX 11)

The Arbitrator finds the opinions of Dr. Lim and Dr. Jido to be more persuasive than those of Dr. Hsu. Petitioner had a preexisting condition. Petitioner has sustained two prior back injuries at work. After both back injuries, Petitioner was treated conservatively and returned to work without restrictions. Petitioner worked for two years before his September 4, 2014 injury. Following Petitioner's work injury of September 4, 2014, Petitioner's condition deteriorated. Petitioner complained of radicular symptoms and pain. Petitioner's radicular complaints appear in Dr. Patel's medical records of September 5, 2014 and the medical records of the various medical providers who treated Petitioner following his September 4, 2014 work injury. Since Petitioner's work accident of September 4, 2014, he has been receiving medical treatment for his low back and Petitioner has not been released to work full duty. Dr. Lim said that Petitioner had a pre-existing lumbar degenerate condition which as asymptomatic until his work-related injury. Since that time, Petitioner has been in of constant pain. Dr. Lim also said Petitioner has signs and symptoms of progressive neurologic deterioration with weakness in his extremities. (PX 11)

The Arbitrator finds that Petitioner's work accident of September 4, 2014 caused the deterioration of Petitioner's current condition pursuant to *Natette Schroeder v. Illinois Workers' compensation Comm'n*, 217 IL. App (4th) 106192WC.

The Arbitrator does not find the opinions of Dr. Hsu to be persuasive. Dr. Hsu believes Petitioner's current condition are related to Petitioner's pre-existing lumbar spondylosis which, he states, is not work related. Dr. Hsu failed to address that Dr. Goldberg did not find spondylolysis after reviewing Petitioner's December 23, 2011 MRI. Dr. Hsu further opines that Petitioner's work accident of September 4, 2014 did not aggravate or exacerbate Petitioner's pre-existing condition and that Petitioner's current complaints were because of Petitioner's age and genetics. Dr. Hsu report does not contain any facts supporting this opinion. The Arbitrator finds Dr. Hsu's opinion to be based upon surmise or conjecture because of the lack of any facts supporting his conclusions. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it' an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-515 (1st Dist. 2000), see also, *Illinois Bell Telephone v. Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994)

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 claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, treat, relieve or cure the effects of the claimant's injury. *F&B Manufacturing Co.*, 325 Ill.App.3d 527, 534 (2001) The Petitioner requests payment for medical bills from Advocate Christ Medical Center, in the amount of $131.33, ATI Physical Therapy, in the amount of $16,093.74, Midwest Orthopedic, in the amount of $252.00, and Midwest Anesthesiologist in the amount of $9,555.00. (Arb. Ex. #3)

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the services provided Advocate Christ Medical Center, in the amount of $131.33, ATI Physical Therapy, in the amount of $16,093.74, and Midwest Anesthesiologist, in the amount of $9,555.00 were required to treat, relieve or cure the effects of Petitioner's work injury of September 4, 2014. The Arbitrator finds the treatment was for Petitioner's lumbar condition causally related to Petitioner's work accident of September 4, 2014 and the treatment was necessary and reasonable.

Respondent shall pay to Petitioner, for the medical services outlined above, pursuant to Section 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for

all medical benefits that has been paid and Respondent shall hold Petitioner harmless for any claims by any providers for services for which Respondent is receiving a credit, as provided in Section 8(j) of the At.

The Arbitrator finds the treatment provided by Midwest Orthopedic, in the amount of $252.00, was not to necessary to treat, cure or relieve the Petitioner from the effects of his September 4, 2014 work injury. The services for Midwest Orthopedic involved treatment for Petitioner's left leg and shoulder which was found not to be causally related to Petitioner's work injury of September 4, 20154.

WITH REGARD TO ISSUE (K) WHETHER OR NOT THE PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator has carefully reviewed and considered all the medical evidence and all the testimony and finds that Petitioner is not entitled to prospective medical care. Dr. Lim found that Petitioner was not a surgical candidate. Dr. Lim recommended Petitioner continue with pain management treatment. Petitioner returned to Dr. Jido for treatment as of July 14, 2017. Petitioner testified that he wished to proceed with a spinal stimulator has recommended by Dr. Jido. However, Dr. Jido's medical records of July 14, 2017 states that Petitioner was given a DVD on spinal cord stimulators and that the procedure was discussed. Petitioner was to review the DVD. Dr. Jido's last treatment records states that Petitioner was considering options and he would return for further discussions. Petitioner did not return to see Dr. Jido. The Arbitrator finds that Dr. Lim and Dr. Jido did not issue a prescription or recommend the procedure. Because the medical records do not contain a specific recommendation for treatment or a prescription, the Arbitrator is unable to grant Petitioner's request for prospective medical care and, therefore, Petitioner's request for perspective medical treatment is denied.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY BENEFITS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is seeking temporary total disability benefits from May 13, 2017 through December 13, 2017, the date of the trial. (Arb. Ex. No. 1) Petitioner's TTD benefits terminated on May 12, 2017 based upon Dr. Hsu's April 5, 2017 report. (RX 12)

When a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized (*i.e.* whether the claimant has reached maximum medical improvement). *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n, 236 Ill. 2d 132, 142, 923 N.E.2d 266, 271, 337 Ill. Dec. 707 (2010).* Once an injured employee's physical condition stabilizes, he is no longer eligible for TTD benefits. *Archer Daniels, 138 Ill.2d at 118, 561N.E.2d at 627.* The duration of TTD is controlled by the claimant's ability to work and his continuation in the healing process. *City of Granite City v. Industrial Comm'n, 279 Ill. App. 3d 1087,1090, 666 N.E.2d 827, 828, 217 Ill. Dec. 158 (1996).*

The Arbitrator finds that Petitioner's condition has not stabilized. Dr. Lim recommended Petitioner resume pain management treatment. Petitioner returned to Dr. Jido for treatment and Dr. Jido was to address treatment options upon Petitioner's return. Petitioner's benefits had been denied and Petitioner did not return to Dr. Jido. Petitioner continues to take opioids for pain. Dr. Lim and Dr. Jido indicate that additional medical treatment was warranted but Petitioner's benefits were denied based upon Dr. Hsu's report dated April 5, 2017. Petitioner testified he has not returned to work and he has significant restrictions which Respondent was unable to accommodate.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proved by the preponderance of the credible evidence that he is presently entitled to temporary total disability benefits from May 13, 2017 through December 13, 2017, representing 28 1/7 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EGAN COLEMAN,

Petitioner,

vs. NO: 14 WC 38286

AKMG and the Illinois State Treasurer as Ex Officio Custodian of the Injured Workers' Benefit Fund,

Respondent.

18IWCC0703

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On May 13, 2014 Petitioner was a Bartender working in Respondent's establishment (Jaster's Bar). He worked part-time hours and had his schedule set by the Manager. He worked three 8-10 hour shifts per week and clocked in and out at the register.

2. Prior to working at Jaster's, Petitioner was already familiar with Adam, one of Jaster's Co-Owners at the time. Adam used to be a patron at a bar owned by Petitioner's father. In April 2014 Petitioner had a conversation with Adam, during which Petitioner was offered $5/hour plus tips to bartend at Jaster's. Petitioner was required to report his tips.

3. If Petitioner wanted a day off, he would have to discuss it with either Adam or the Manager (Tanya). He was trained on how to operate the register, setting up and

cleaning the bar and how to make specialty drinks that Jaster's offered.

4. Petitioner was asked to complete a W-4 form, and had taxes, Medicare and withholdings taken out of his checks. His breaks were approved by either Adam or Tanya, and he was told to wear a black shirt for each shift.

5. On May 13, 2014 Petitioner was wiping down a piece of metal in front of the beer stands. He testified that Adam routinely wanted the bar to be wiped down. The metal was not attached to the wood on the bar, so it slid and hit a stack of pint glasses. Petitioner reached to catch the glasses before they fell, but by the time he grabbed them, the pints had become broken glass and cut Petitioner's left hand. Petitioner stated that he was bleeding "pretty bad" and wrapped his hand in a towel.

6. Adam took Petitioner to the hospital, where he received stitches. The stitches were removed on or about May 24, 2014.

7. On May 29, 2014 Petitioner followed up at the hospital because his hand was "still bad." He testified that his wound had not closed, and he believed it had become infected. He was referred to a hand surgeon.

8. The following day, Dr. Patel examined Petitioner and recommended surgery for wound exploration and repair of the ulnar digital nerve and possible tendon repair.

9. Surgery was performed June 4, 2014 and Petitioner was taken off work. Stitches were removed June 12, 2014 and physical therapy was prescribed. However, therapy was denied due to the therapist not receiving any payments. Subsequently, Petitioner was returned to work on June 19, 2014.

10. On July 3, 2014 Dr. Patel recommended a home exercise program and soft tissue massage. Petitioner continued periodic follow ups, but still complained of pain and numbness in early November 2014.

11. Petitioner resigned from employment with Jaster's in July 2014 due to a disagreement with the Co-Owners.

12. Petitioner is right handed. He now works for Paylocity, which is a payroll company, where his duties require him to type 90% of the day. He has difficulty typing with his left hand, cannot feel the tip of one of the fingers on his left hand, and has lost grip strength. He takes over-the-counter medication.

13. On the date in question, Melissa Neupert was the other Co-Owner of Jaster's, and was married to Adam. They have since divorced and Ms. Neupert is now the sole owner of the establishment.

14. Ms. Neupert testified that Jaster's always had employees complete W-4 forms, as it was required before she could input them into the Pay Core payroll system. She also

18IWCC0703

testified that anyone who was working the bar was an employee.

Upon review, the Commission affirms the Arbitrator's findings regarding employer/employee relationship, accident, and medical expenses.

The Commission, however, views the evidence slightly different than does the Arbitrator regarding the permanent partial disability award. No American Medical Association impairment rating was offered by either party. Petitioner was a 29-year old Bartender at the time of accident and was able to return to work for Respondent after the accident. His subsequent resignation was unrelated to his physical condition. There was no evidence offered detailing the potential effects Petitioner's condition will have on his future earning capacity, although he does still suffer from some lingering effects of the injury. Based on the above factors, the Commission finds that Petitioner's level of impairment equates to a 27.5% loss of use of his left small finger. This award is modified down from a previously awarded 35% loss of use of said finger.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner met his burden of proof regarding an employer/employee relationship.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $212.08 per week for a period of 6.05 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 27.5% LOSS OF USE OF Petitioner's little finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $12,991.06 for medical expenses under §8(a) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,100.00. 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.

NOV 16 2018

DATED:
O: 9/20/18
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLEMAN, EGAN
Employee/Petitioner

Case# **14WC038286**

AKMG AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0703

On 1/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & EVANS
LEANDRO ALHAMBRA
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0143 CRAIG & CRAIG
GREGORY RAY
1807 BROADWAY
MATTON, IL 61938

5746 ASSISTANT ATTORNEY GENERAL
HELEN LOZANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Egan Coleman
Employee/Petitioner

Case # **14** WC **38286**

v.

Consolidated cases: _____

AKMG and the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund
Employer/Respondent

18IWCC0703

An *Application for Adjustment 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 **Woodstock, Illinois**, on **December 6, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0703

FINDINGS

On **05/13/14**, 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 **$11,028**; the average weekly wage was **$212.08**.

On the date of accident, Petitioner was **29** 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 **$n/a** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$n/a**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $212.08/week for 2-1/7 weeks, commencing 06/04/2014 through 06/19/2014, as provided in Section 8(b) of the Act.

Respondent shall pay permanent partial disability benefits of $212.08 a week for 7.7 weeks, because the injury sustained caused the 35% loss of use of the left small finger, pursuant to Section 8(e) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of $11,067.93, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further pay to Petitioner $8.00 for reimbursement of Petitioner's out-of-pocket expenses and $282.11 for reimbursement payments put through Petitioner's third party group insurance.

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

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

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

Signature of Arbitrator

1/12/18
Date

ICArbDec p 2

JAN 17 2018

18IWCC0703

FINDINGS OF FACT:

Petitioner, Egan Coleman's, date of birth is March 16, 1985. Petitioner was single and had no dependents on the date of the accident, May 13, 2014. Petitioner testified that he was employed by Respondent, AKMG d/b/a Jaster's, as a bartender. Jaster's is a bar located on Route 14 in Crystal Lake, Illinois. At the time of the accident, Jaster's was owned by Adam Harjung and Melissa Nuepert. Petitioner testified that his duties as a bartender included the following: making and serving drinks, bar cleanup, checking out the customers, opening and closing the bar.

Petitioner testified that he knew Mr. Harjung because Mr. Harjung was a patron at his father's bar. Petitioner testified that he was hired by Mr. Harjung as a bartender and began working for Jaster's late April/early May 2014. Petitioner testified that he and Mr. Harjung agreed to a wage of $5.00 per hour, plus tips. Petitioner was a part-time employee.

Petitioner testified that he reported to Mr. Harjung and his manager, Tanya. He testified that his hours were set by the manager, Tanya. Petitioner was required to clock in and out at the register. Breaks were set by Tanya or Mr. Harjung. Petitioner testified that if he needed a day off he would have to request it from Tanya or Mr. Harjung. Petitioner also testified that the manager, Tanya, assigned him to work either the bar or tables during his shifts. Petitioner further testified that he was required by Respondent to wear a black shirt while working.

Petitioner testified he received training for the cash register system. He was also trained on how to make specialty craft cocktails that Jaster's served.

Petitioner was required to complete a W-4 form. Respondent provided a W-2 form at the end of the year. Respondent withheld federal, state and social security taxes. Petitioner was also required to report his tips to Respondent. The tips were included as earnings on Petitioner's paystubs.

Petitioner testified that he was working on the evening of May 13, 2014. At that time, he was bartending during a Blackhawks game. Petitioner testified that he was wiping down the bar and knocked a metal board into a stack of glasses. Petitioner attempted to catch the glasses with his left hand. The pint glasses broke, and Petitioner's hand began to bleed. Petitioner stated that he initially did not know where the blood was coming from.

Petitioner testified Mr. Harjung, was sitting at the bar at the time of the accident. Mr. Harjung grabbed a towel for Petitioner's hand and took Petitioner downstairs to the basement to get him cleaned up. Mr. Harjung then drove Petitioner to the emergency room at Advocate Good Shepherd.

The medical records from Good Shepherd Hospital provide a history of Petitioner working at his bar and cutting his finger on broken glass. The laceration was located at the base of the left little finger. The wound was irrigated and sutures were placed. Petitioner was discharged from the emergency room and recommended to follow up with a doctor in 1 to 3 days. (PX 1) Once discharged, Mr. Harjung drove Petitioner back to Petitioner's car at Jaster's.

Petitioner testified that his sutures were removed at an urgent care facility on May 24, 2014. Petitioner presented at the emergency room at Good Shepherd Hospital on May 29, 2014, with complaints of opening of the wound along with drainage. Examination revealed some diminished two-point discrimination distally. The

wound was irrigated and a splint was applied. Petitioner was started on antibiotics. The diagnosis at that time was a wound infection. (PX 1)

Petitioner followed up with Dr. Patel at McHenry County Orthopedics on May 30, 2014. At that time, Petitioner complained of numbness and tingling of the finger. Petitioner described the pain as 7/10. Dr. Patel diagnosed Petitioner with a left small finger laceration and a left small finger ulnar digital nerve laceration. Dr. Patel recommended wound exploration and repair of the ulnar digital nerve. Dr. Patel cleared him to return to work as his symptoms allowed. (PX 2)

On June 4, 2014, Dr. Patel performed surgery on the left small finger. Specifically, he performed a left small finger ulnar digital nerve repair and wound exploration. (PX 2) Petitioner testified that he was taken off work as of June 4, 2014.

Petitioner followed up with Dr. Patel on June 12, 2014. At that time, Petitioner said that he was doing well but still had discomfort. Dr. Patel gave an order for physical therapy and continued to keep him off work. (PX 2) Petitioner testified that physical therapy was never approved.

Petitioner followed up with Dr. Patel on June 19, 2014. At that time, the sutures were removed. He was also given a prescription for pain medication and was instructed to follow up in 2 to 3 weeks for a wound check. Dr. Patel released Petitioner to return to work as tolerated. (PX 2)

Petitioner followed up with Dr. Patel on July 3, 2014. He continued to have complaints of redness and increasing pain at the surgery site. Petitioner had not begun physical therapy at this time. Thus, Dr. Patel recommended a home exercise program and soft tissue massage. Petitioner was next examined by Dr. Patel on July 31, 2014. At that time, Dr. Patel recommended a range of motion and desensitization home exercise program. Dr. Patel instructed Petitioner to return to the clinic in 2 months. Petitioner was seen by Dr. Patel on September 25, 2014. At that time, Petitioner continued to have complaints of a buzzing sensation. Once again, Dr. Patel recommended that he do home exercises and scar massage. (PX 2)

Petitioner was last seen by Dr. Patel on November 6, 2014. At that time, Petitioner indicated that his sensation was improving. He continued to have complaints of a buzzing sensation in the left little finger. Dr. Patel released Petitioner from his care at that time. (PX 2)

Ms. Melissa Nuepert testified on behalf of Respondent, AKMG. Ms. Nuepert testified that she was a co-owner of AKMG at the time of the accident. She testified that the other owner was her then husband, Adam Harjung. Currently, she is the sole principal and member of AKMG. Jasters opened for business in November 2013. She testified that in May 2014, Mr. Harjung was primarily responsible for the day to day managing of employees while she was responsible for the administration of the business. Ms. Neupert explained that the payroll records, including W-4 (RX 1), W2 (RX 2), Paycor payroll records (RX 2), and employee status reports (RX 3) were all maintained within AKGM's ordinary course of business. She further explained that payroll hours are maintained through Jasters' point of sale system, Breadcrumb, which records employees' clock in and clock out times. She is unable to change or tamper with these times as they were directly submitted to Paycor for processing.

Ms. Nuepert testified that she did not witness Petitioner's accident of May 13, 2014. Ms. Nuepert did not deny that Petitioner worked as a bartender for AKMG at the time of the accident. Ms. Neupert admitted that non-employees were prohibited from serving drinks or being behind the bar. Additionally, Ms. Neupert testified that AKMG, including Jasters, did not maintain workers' compensation insurance coverage. She searched her business records and consulted with her current insurance broker to verify the lack of insurance. Sometime in midsummer 2014, AKMG secured workers' compensation insurance coverage.

Petitioner testified that he continues to have numbness and tingling in his left little finger. Petitioner last worked for AKMG in the summer of 2014. Petitioner now works at Paylocity as sales support. This job requires extensive typing throughout the day. Petitioner testified that he feels that there is less sensation in his left ring finger. This affects his typing accuracy because he is not able to feel the keys.

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

On May 13, 2014, Petitioner and Respondent, AKMG, were operating under the Illinois Workers' Compensation Act. Respondent, doing business as Jaster's, is in the business of restaurant/bar industry within the meaning of Section 3 of the Act. Petitioner was engaged in work for Respondent-AKMG that day.

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

The Arbitrator finds that on May 13, 2014, the relationship between Petitioner and Respondent-AKMG was one of employee/employer. Courts have articulated a number of factors to consider in determining whether an individual is an employee or independent contractor. The two most important factors are whether the purported employer has a right to control the nature of the work performed by the alleged employee in relation to the general business of the employer. Additional factors include the skill the work requires, the right to discharge, which party provides the needed instrumentalities, and whether income tax is withheld.

Right of Control:

According to Petitioner's unrebutted, credible testimony, he reported to Mr. Harjung and Tanya, the manager of the bar. Petitioner did not dictate his own schedule and could not come and go as he pleased. Petitioner worked a set schedule, which was dictated by Tanya. Petitioner was required to clock in and out. Petitioner also testified that he would have to get permission from Tanya to take breaks during his shift. If Petitioner needed a day off, he would have to make a request from Tanya ahead of time. Tanya also directed him on whether he was working the bar or tables during his shifts. Respondent required Petitioner to wear a black shirt while working. Petitioner was also required to report his tips to Respondent.

Nature of work/business:

Respondent is in the restaurant/bar business. Petitioner was hired to as a bartender/server. At the time of the accident, Petitioner's was tending the bar and serving customers. Accordingly, Petitioner's work was intimately related to Respondent's bar and restaurant business.

Instrumentalities:

All the tools and equipment (glasses, registers, liquor etc.) to perform Petitioner's bartending duties were provided by AKMG.

Skill/training:

Prior to working for AKMG Petitioner was an experienced bar tender. However, as part of his training, he was trained in specific craft cocktails served by Jaster's. Petitioner also received training for the registers and checkout software used by Jaster's.

Payment and Tax withholding:

Petitioner completed a W-4 form at Respondent's request. Respondent provided Petitioner with a W-2 tax form at the end of the year. Petitioner was paid by check on bi-weekly basis. Respondent withheld FICA taxes and State taxes. Petitioner was required to report his tips to AKMG, which were included as Petitioner's earnings.

All of the factors discussed above, strongly indicate that Petitioner was an employee. Thus, the Arbitrator finds that on May 14, 2014, the relationship between Petitioner and Respondent was one of employee and employer.

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

At the time of the accident, Petitioner was bartending for Jaster's. Petitioner was cleaning the bar and knocked a piece of metal into a stack of pint glasses. Petitioner sustained a laceration of his left small finger when he caught a broken pint glass. The accident history is corroborated throughout the medical records of Good Shepherd Hospital and Dr. Patel. Thus, Arbitrator finds that Petitioner sustained an accident arising out of and in the course of Petitioner's employment by Respondent.

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

Based on Petitioner's unrebutted testimony and the medical records, the Arbitrator finds the date of accident is May 13, 2014.

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

According to Petitioner's unrebutted testimony, the owner, Adam Harjung, was present and sitting at the bar at the time of the accident. Mr. Harjung got Petitioner a towel, took him to the basement and helped clean the wound. Mr. Harjung drove Petitioner to the emergency room and drove Petitioner back to Jaster's after he was discharged. Thus, the Arbitrator finds that notice of the accident was given.

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

Petitioner's current condition of ill-being is causally related to the injury. The Arbitrator relies on Petitioner's credible testimony and the medical records. The medical records show an accident history consistent with Petitioner's testimony at trial. All doctors relate, by history, Petitioner's complaints to this trauma. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the May 14, 2014, work injury.

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

Petitioner testified that he began working for Respondent in late April or beginning May 2014. Petitioner testified that he and Mr. Harjung agreed to a wage of $5 per hour plus tips. As indicated on the Request for Hearing (Arb. Ex. 1), Respondent AKMG claimed an AWW of $212.08 per week, which Petitioner agreed with. (see Arb Ex. 1) Thus by admission of AKMG, the Arbitrator finds that Petitioner's AWW is $212.08.

With respect to H.) What was Petitioner's age that time of injury and I.) What was Petitioner's martial status at the time of injury, the Arbitrator finds as follows:

Based on Petitioner's testimony, the Arbitrator finds that he was 29 years old, single with no dependent children on the date of the accident.

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

Petitioner sustained a severe trauma to his left small finger, which required emergency medical service, wound care and surgery. Additionally, Petitioner followed up post-operatively with Dr. Patel and was discharged on November 6, 2014. The Arbitrator finds that the treatments received by Petitioner for his left small finger injury were reasonable and necessary.

According to Petitioner's Exhibits 4a through 4f, the total outstanding balance from Petitioner's medical providers is $11,067.93. Respondent shall pay said medical bills, pursuant to the medical fee schedule.

Furthermore, Respondent shall pay to Petitioner out-of-pocket expenses of $8.00. Petitioner testified that this expense was for steri-strips used to buddy tape his finger. Lastly, Respondent shall pay to Petitioner $282.11 for payments put through Petitioner third-party group insurance provider, Blue Cross Blue Shield.

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

Petitioner underwent surgery for his left small finger on June 4, 2014. Dr. Patel took Petitioner off work as of the date of surgery. Dr. Patel gave Petitioner a full-duty release as tolerated work on June 19, 2014. Accordingly, the Arbitrator finds that Petitioner is entitled to TTD from June 4, 2014 through June 19, 2014.

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

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

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

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 regard to Section 8.1(b)(i) of the Act, the 8.1(a), the Arbitrator finds neither party presented an AMA Impairment Rating. Therefore, the Arbitrator gives no weight to this factor.

With regard to Section 8.1(b)(ii) of the Act, the occupation of the injured employee, the Arbitrator finds Petitioner was employed as a bartender on the date of accident, and was able to return to his prior line of work after his injuries. Therefore, the Arbitrator gives little weight to this factor.

With regard to Section 8.1(b)(iii) of the Act, the age of the injured employee at the time of the injury, the Arbitrator finds Petitioner was 29 years old at the time of the accident. As Petitioner is a younger individual who has to live with his disability for an extended period, the Arbitrator gives greater weight to this factor.

With regard to Section 8.1(b)(iv) of the Act, the employee's future earning capacity, the Arbitrator finds that no evidence was submitted regarding Petitioner's future earning capacity. As such, the Arbitrator gives no weight to this factor.

With regard to Section 8.1(b)(v) of the Act, evidence of disability corroborated by the treating medical records. The Arbitrator notes that when Petitioner was last seen by Dr. Patel on November 6, 2014, he reported that his sensation was improving. Petitioner also complained of a buzzing sensation in his finger. Petitioner testified that he continues to have numbness on the top of his left small finger. Petitioner also continues to have a buzzing sensation. Petitioner credibly testified that he has loss of sensation of his small finger. Petitioner no longer works for AKMG. He now works for Paylocity, which requires frequent typing throughout the day. The loss of sensation in his finger makes it difficult for him to type because he is not able to feel the keys. Petitioner sustained left small finger laceration and left small finger ulnar digital nerve laceration. Dr. Patel performed surgery for wound exploration and repair of the ulnar digital nerve. The Arbitrator gives greater weight to this factor.

Therefore, taking into consideration the factors above, the Arbitrator finds Petitioner sustained a 35% loss of use of the left small finger pursuant to Section 8(e) of the Act, or 7.7 weeks at a rate of $212.08, totaling $1,633.02

With respect to O.) IWBF Liability, the Arbitrator finds as follows:

Respondent stipulated that they did not have workers' compensation insurance coverage on the date of the accident, May 14, 2014. Proper notice of the hearing was sent to Respondents-AKMG attorney of record. All parties were represented and present at trial. The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured

Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRYON KAWA,

Petitioner,

vs. NO: 07 WC 23805

FORD MOTOR COMPANY,

Respondent.

18IWCC0704

DECISION AND OPINION ON REMAND

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, maximum medical improvement, temporary total disability, medical expenses, vocational rehabilitation and maintenance benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FACTUAL BACKGROUND

This matter was previously heard, and the Decision of the Arbitrator was filed October 26, 2010. Petitioner filed a timely Petition for Review. The Commission affirmed the Decision of the Arbitrator, finding no causal connection to Petitioner's current cervical condition of ill being. On appeal the Circuit Court affirmed. Petitioner then appealed to the Appellate Court, which remanded the case to the Commission to modify the Decision.

The Appellate Court affirmed in part and reversed in part the ruling of the Circuit Court, finding that it was of no consequence whether Petitioner's complaints as of February 25, 2008 are physical or psychological in nature. The Appellate Court found that the evidence established that the onset of Petitioner's conditions began no sooner than his work-related accident, and nothing in the record broke the chain of events leading up to the arbitration hearing. The Appellate Court remanded the case to the Commission for a determination on causation, maximum medical improvement and TTD benefits, medical expenses and vocational rehabilitation and maintenance benefits. The issues of penalties and fees and wage calculation were affirmed, however.

The Commission issued a Remand Decision in 2014, but said Decision was once again appealed. This time the Circuit Court remanded the case with instructions for additional findings and determinations.

FACTUAL BACKGROUND

Following a stipulated work-related motor vehicle accident on February 13, 2007, Petitioner suffered injuries to his neck, chest, right shoulder, low back and right knee. He received conservative treatment and eventually underwent right shoulder surgery for a separated shoulder on May 10, 2007.

Following the surgery, Petitioner underwent physical therapy and pain management, but continued complaining of severe pain and loss of range of motion in his shoulder. On June 15, 2007 an MRI revealed small joint effusion in his right knee. Physical therapy notes in July 2007 revealed Petitioner was progressing slowly with respect to his shoulder and knee.

In September 2007 a lumbar MRI revealed mild degenerative changes in the lower spine but no spinal canal or neuroforaminal stenosis. Physical therapy was prescribed.

After two additional months of pain complaints, in November 2007 an IME physician (Dr. Rhode) noted a significant psychological component to Petitioner's shoulder condition that required attention. Dr. Rhode recommended continued aggressive physical therapy with respect to the right shoulder and a multidisciplinary approach with respect to the lumbar spine.

In December 2007 Dr. Koh, Petitioner's treating physician, met with a vocational rehabilitation consultant. They determined that a comprehensive pain evaluation complete with a psychological evaluation was in order. Dr. Koh recommended Petitioner undergo this with the Rehabilitation Institute of Chicago (RIC). They have a multidisciplinary program. This recommendation was approved by the employer.

On February 25, 2008 Petitioner was interviewed at RIC by various doctors and vocational specialists. A report indicated that his pain problem appeared to be affected by psychological factors that could be addressed with psychological intervention. Petitioner indicated that he was not comfortable treating with RIC because he did not like the topics he was questioned about during the evaluation. He was also not fond of having to drive to Chicago every day from Indiana

to attend the program, despite the fact that the employer agreed to furnish Petitioner with lodging nearby RIC. Petitioner never participated in the program.

Dr. Koh recommended another program at St. Margaret Mercy Hospital in Northwest Indiana. The vocational rehabilitation consultant stated that the program was not multidisciplinary in nature, but rather anesthesiology-based. Due to this fact, Respondent did not approve this program.

Nevertheless, Petitioner began treating at St. Margaret in September 2008 with Dr. Kanakamedala. By April 2009, Dr. Kanakamedala reported that Petitioner's shoulder, back and knee pain was being managed by Norco and Celebrex and had reduced his pain by 70%. Dr. Kanakamedala also recommended chiropractic treatment. Chiropractic treatment helped to control his neck and leg pain. Petitioner had significant improvement in range of motion (ROM) in his cervical spine.

Petitioner underwent work hardening in mid-2009, along with a Functional Capacity Exam (FCE) on July 22, 2009. The July 2009 FCE indicated:

-Petitioner was capable of sitting 5-6 hours, in 60-minute durations with regular breaks;
-Can stand for 4 hours, in 45-minute durations with regular breaks;
-Can occasionally stand and stoop and squat, with minimal crawling and occasional stair climbing;
-Can crouch with minimal kneeling and occasional balancing on his leg;
-Has significant right shoulder limitations and can do occasional above right shoulder work at 15 pounds, lift chair to desk height and return up to 17.4 pounds and can carry weight up to 27 pounds with the right shoulder.

These were permanent restrictions and on August 13, 2009 Dr. Koh reviewed this report and found Petitioner to either be at or near maximum medical improvement (MMI) on this date due to his continued shoulder and knee complaints. Petitioner underwent shoulder and knee corticosteroid injections.

DECISION ON REMAND

Based on the Appellate Court's discussion, Petitioner's current condition of ill-being is causally related to the accident in question. In keeping with this ruling, the Commission finds that the evidence establishes that the onset of Petitioner's conditions began no sooner than his work-related accident, and nothing in the record broke the chain of events leading up to the arbitration hearing.

The Appellate Court notes that Petitioner's refusal to participate in the RIC program is not a basis for the denial of TTD benefits. This is the only program Petitioner declined to

participate in, and the employer failed to suggest or approve any other multidisciplinary program despite Dr. Koh's recommendation that an alternative program be considered.

Despite an early June 2008 letter from Respondent to Petitioner indicating that Respondent had the ability to accommodate Petitioner's work restrictions, no formal job offer was ever made. Thus, since Petitioner was still suffering from accident-related symptoms at that time, benefits were incorrectly terminated by the Arbitrator on February 25, 2008.

Subsequent to February 2008, Petitioner continued treating conservatively, culminating in chiropractic treatment and work hardening in the summer of 2009. On August 13, 2009, after reviewing a July 22, 2009 FCE report, Petitioner's treating physician, Dr. Koh, opined that Petitioner was at or near MMI. Although Respondent's physician, Dr. Bare, found MMI on June 17, 2009, medical records indicate that Petitioner was still receiving beneficial medical care into July of 2009. The Commission finds the opinion of Dr. Koh to be more persuasive, and thus the Commission terminates TTD benefits as of August 13, 2009, at a rate of $776.16 per week.

In its discussion, the Appellate Court found that all medical expenses subsequent to February 25, 2008 were reasonable and necessary. This includes any expenses related to the treatment program at St. Margaret Mercy Hospital, including chiropractic treatments.

Accordingly, the Commission modifies the Arbitrator's ruling and finds Respondent liable for all reasonable and necessary medical expenses subsequent to February 25, 2008 in relation to Petitioner's neck, chest, right shoulder, low back and right knee injuries.

Even though the Commission finds MMI as of August 13, 2009, this does not necessarily terminate additional medical expenses, as stated above, Petitioner was ordered to return for follow up with Dr. Koh after his MMI designation.

The Appellate Court also remanded the issues of vocational rehabilitation and maintenance after determining that Petitioner is in fact entitled to these benefits. In keeping with this ruling, the Commission awards the same to Petitioner.

Since Petitioner receives TTD benefits through August 13, 2009, Maintenance benefits begin on August 14, 2009 and continue until Petitioner's vocational rehabilitation is completed or terminated for any valid legal reason. Maintenance benefits are awarded at a rate of $776.16 per week.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's condition of ill-being at the time of the arbitration hearing was causally connected to his work accident on February 13, 2007.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner reached maximum medical improvement as of August 13, 2009.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $776.16 per week for a period of 129-6/7 weeks, that being the period of temporary

total incapacity for work under §8(b) of the Act. 18IWCC0704

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to his neck, chest, right shoulder, low back and right knee injuries. This award shall include all related medical expenses incurred between February 25, 2008 and the maximum medical improvement date of August 13, 2009. This award shall include any expenses related to the treatment program at St. Margaret Mercy Hospital, including chiropractic treatments, under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to receive vocational rehabilitation benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to maintenance benefits of $776.16 per week, beginning August 14, 2009, and continuing until his vocational rehabilitation is either completed or terminated for any valid legal reason, whichever arises first.

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.

NOV 16 2018

DATED:
O: 8/30/18 (DISCUSSION)
DLG/wde
45

David L. Gore

Stephen Mathis

Kevin Lamborn

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

Czeslaw Kula,

Petitioner,

vs.

NO: 13 WC 13778
14 WC 07495

A.E.R.O. Special Education Cooperative,

Respondent.

18IWCC0705

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, wages/rate, medical expenses, penalties, nature and extent and credit, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes, as stated below, said decision attached hereto and made a part hereof.

The Commission corrects the decision of the Arbitrator to find that Petitioner's average weekly wage in claim 13 WC 13778 was equal to $494.47, based on the paystubs submitted at PX18 evidencing bi-monthly payments totaling $11,867.23 during the year preceding the injury ($11,867.23 ÷ 24).

Furthermore, in light of the above, the Commission corrects the decision of the Arbitrator to find that the minimum PTD rate of $495.01 would apply in claim 13 WC 13778, given a date of injury of 4/16/13.

Finally, the Commission finds that Respondent is entitled to a credit in the amount of $1,521.20 for an advance made towards permanency during the pendency of this matter at arbitration, in addition to the previously awarded credit for the payment of TTD and maintenance in the amount of $32,175.51.

18IWCC0705

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 4/17/17 is affirmed with changes as stated herein.

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 19 2018
o:9/25/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

KULA, CZESLAWA
Employee/Petitioner

Case# **13WC013778**
14WC007495

A E R O SPECIAL EDUCATION COOPERATIVE
Employer/Respondent

18IWCC0705

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1938 BELCHER LAW OFFICE
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0075 POWER & CRONIN LTD
ELENA CINCIONE
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

18IWCC0705

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

Czeslawa Kula
Employee/Petitioner

v.

A.E.R.O. Special Education Cooperative
Employer/Respondent

Case # 13 WC 13778

Consolidated cases: **14 WC 07495**

An *Application for Adjustment 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 **December 14, 2016; December 15,2016; December 19, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

CORRECTED FINDINGS

On **3/7/2011; 4/16/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

Timely notice of both accidents ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is in part*** causally related to the 3/7/11 accident in case number 14 WC 7495, having reached MMI in December 2011.

Petitioner's current condition of ill-being ***is*** causally related to the 4/13/16 accident in case number 13 WC 13778.

For case 14 WC 7495, in the year preceding the 3/7/11 injury, Petitioner earned **$22,198.80**; the average weekly wage was **$426.90**.

For case 13 WC 13778, in the year preceding the 4/16/13 injury, Petitioner earned **$25,724.40**; the average weekly wage was **$494.70**.

On both dates of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$20,400.48** for TTD, **$0** for TPD, **$11,775.03** for maintenance, and **$0** for other benefits, for a total credit of **$32,175.51**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

CORRECTED ORDER

For case 13 WC 13778, Respondent shall pay Petitioner temporary total disability benefits of **$329.80**/week for **63** weeks, commencing **4/17/13** through **7/1/14**, as provided in Section 8(a) of the Act. Respondent shall be given a credit of **$20,400.48** for TTD.

For case 13 WC 13778, Respondent shall pay Petitioner maintenance benefits of **$329.80**/week for **128-5/7th** weeks, commencing **7/2/14** through **11/16/14** and **11/18/14** through **12/19/16**, as provided in Section 8(a) of the Act. Respondent shall be given a credit of **$11,775.03**.

For case 13 WC 13778, Respondent shall pay the gross reasonable and necessary medical services of **$30,253.76**, subject to Sections 8(a) and 8.2 of the Act. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent 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.

For case 13 WC 13778, Respondent shall pay Petitioner permanent and total disability benefits of **$329.80**/week for life, commencing **12/19/16**, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

For case 14 WC 7495, Respondent shall pay Petitioner permanent partial disability benefits of **$256.14/week** for **20.5 weeks**, because the injuries sustained caused the **10%** loss of the **right hand**, as provided in Section **8(e)** of the Act

As to both claims, penalties and fees are ***denied***. As to both claims, Request for prospective medical care 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

4-17-2017
Date

ICArbDec p. 2

APR 17 2017

BACKGROUND

Czeslawa Kula ("Petitioner") alleged accidental injuries arising out of and in the course of her employment with A.E.R.O. Special Education Cooperative ("Respondent") on 3/7/11 and 4/16/13. By agreement, the parties proceeded to arbitration over three days on 12/14/16, 12/15/16 and 12/19/16. Each party was afforded an opportunity to make an opening statement and only Petitioner did so. Where indicated, objections made during the course of evidence depositions are ruled on as follows: sustained ("s") and overruled ("o/r"). The following is a recitation of the facts adduced at trial.

CORRECTED FINDINGS OF FACT

Testimony of Insurance Adjuster Thea Sledge

Thea Sledge ("Sledge") testified on behalf of Respondent at the arbitration proceeding. Sledge is an insurance adjuster for Sedgwick and has been so employed for 29 years. She was assigned to Petitioner's claim and as such, contacted the insured and eventually sent Petitioner to two section 12 evaluations.

Sledge testified that after reviewing both section 12 exams from Drs. Neri and Patari, she determined that both the carpal tunnel syndrome and the left elbow claims were compensable. Sledge then authorized Petitioner's bilateral hand surgeries and her eventual left elbow surgical treatment plan. Sledge also paid medical benefits for the bilateral hands, left elbow and eventual wage replacement benefits. Sledge agreed Petitioner provided notice of her claims and agreed that the section 12 exams appeared to support Petitioner's claims. She admitted at some point wage replacement benefits stopped but could not recall the date. On 12/24/14, she received a letter from Respondent and had further conversation with the insured and Respondent's legal counsel about accommodated work pursuant to Dr. Patari's recommendations. Janell Babulic notified her that Respondent could accommodate. According to Sledge, based on this information, no further benefits issued as a result.

Sledge has since determined that Petitioner is not entitled to further treatment per the Section 12 report for the left lateral epicondylitis and for carpal tunnel syndrome. Sledge did not review Julie Bose's opinions and did not factor them. The last time Sledge spoke to the insured on this file was sometime in 2014 and to her knowledge, the situation has not changed. Sledge reviewed the surveillance video and believed Petitioner exceeded some of her restrictions but could not recall which restriction. Sledge recalled receiving a labor market survey and that it indicated Petitioner was not able to return to work and that she had permanent restrictions. Sledge confirmed Rx8 and Rx9 as regular business records showing medical and TTD payments made. Exhibit 9 showed that benefits terminated 2/2/15, after her conversation with the insured. Sledge testified that at no time after this date did she learn Petitioner could not be accommodated.

Testimony of Erin Sheahan

Erin Sheahan ("Sheahan") was called a witness to testify by Petitioner. Sheahan testified she is a vocational case manager and ergonomic specialist for Genex and has been so for the last 8 years. She has a Master's degree and is a certified rehab counselor. At the request of claims adjuster Sledge, she performed an ergonomic job evaluation and job analysis for Petitioner's job sometime in July 2014 describing the physical demands of a given position and essential daily job duties. Sheahan typically does not obtain job descriptions as those can be outdated. Instead, she speaks directly to the onsite manager or supervisor and conducts on site observation. In this case, due to privacy concerns, job tasks had to be simulated because Sheahan was

prohibited from photographing or videoing the students. Sheahan testified that staff simulated amongst themselves the job duties in question. Sheahan identified Px26 as the job analysis she created.[1] She understood Petitioner's job to be of heavy physical demand level, involving 18-22 year old students. Duties included assisting in activities of daily living such as bathroom/toileting, chaining diapers, feeding and changing clothes and assisted lifting of students with an average of 8 students per classroom. Each instructor is assigned 4 instructional assistants. Sheahan also described participating in hand over hand activity, assisting out of a wheelchair, maintaining correct position and lifts 20-25 times per day, constant repositioning, lifting from top to bottom and side to side. Since no students involved in the analysis, Sheahan did not observe what specific needs any student would have had, their weight, resistance and non-cooperation. Activities that were not demonstrated included: clothing, feeding, bus drop off and pick up, toileting and use of the gait belt. On cross, Sheahan confirmed she had not been given the job description in Px19.

Testimony of Vocational Counselor - Julie Bose

Julie Bose ("Bose") of MedVoc was called to testify by both parties in this matter. Bose is a certified rehabilitation counselor who primarily conducts work for Respondents. In this case, she was aware of the FCE and agreed Petitioner could not return to work and she was further aware there was no accommodated job. She was asked to perform a labor market survey (LMS) which is a snap shot of the demands of jobs in a given area. A job placement specialist will make phone calls for the LMS and creates a list of questions to ask. Bose will spot check that list. Here, she looked for light positions, asking employers whether they would hire Petitioner given her history as a teacher's assistant and asking whether the employer could accommodate an individual fluent in Polish and who could orally communicate in basic English. Bose believed basic English meant no reading and no writing but that basic English was more skilled than limited English. She agreed that although it's impractical to provide the entire FCE to an employer, one violation would make a position incompatible with Petitioner's abilities. Bose agreed that of the employers listed in the LMS, all but 4 were either not hiring or possibly hiring in 90 days. She concluded there was a valid labor market for Petitioner, that she possessed basic oral and limited speaking and writing English skills and that Petitioner would benefit from vocational services. Bose reviewed the surveillance video and did not believe she saw Petitioner exceeded her restrictions.

Testimony of Vocational Counselor - Lisa Helma

Lisa Helma ("Helma") testified on behalf of Petitioner. Helma is a certified rehab counselor working for Vocamotive and does work for both employees and employers. Her biggest client is the City of Chicago. Helma speaks Polish and has worked in Polish candidates since 2008 in helping to try to place them into various positions. Here, she was asked to evaluate Petitioner and did so in August 2014. Helma looks at various factors to determine whether there was access to a stable labor market, such as transferability of skill sets, education, socioeconomic status, access to transportation and criminal history. Helma also looked to the Social Security Administration, the Department of Labor and Bureau of Labor Statistics in further identifying factors. From the SSA, Helma noted neutral, positive and negative factors for re-employment. Negative factors included advance age over 55, lack of education, lack of transferable skills and narrow work histories as compared to a younger person or a person approaching advanced age.

Helma performed her analysis for this case and noted that Petitioner's FCE recommended that she avoid or decrease to occasional repetitive motion of right and left upper extremities, which she took to mean occasional reaching, fingering and handling activities up to 1/3 of a day. She further noted Petitioner's English

[1] Px26 was ultimately not submitted into evidence.

was self-taught with an inability to read or write in English. Helma viewed this as a negative factor affecting employability. Helma further noted that Petitioner's job most closely resembled a nurse's assistant at the medium physical demand level. Her work history was a neutral factor but considering the foregoing, Petitioner still faced barriers. Namely, her lack of education. Helma noted that the GED is not offered in Polish and thus Petitioner would first have to learn English in order to study for and take the GED. Still further, ESL courses would only keep Petitioner out of the work force longer and Helma did not recommend that. Helma further stated that placement was extremely difficulty for the Polish speaking community and even more difficult given Petitioner's language barrier alone. Regarding transferable skills, Helma ran Petitioner's information through OASYS and determined she had no transferable skills.

Helma concluded that in her opinion, Petitioner lost access to usual and customary employment, given her age, language skills, work history, physical capabilities and lack of transferrable skills. Thus, Petitioner had no access to any stable labor market. Helma's opinions remained unchanged in her follow up reports. Helma further reviewed Petitioner's self-directed job search logs and determined Petitioner was searching to the best of her abilities and confirmed for Helma that Petitioner had not received any job offers. Alternatively, Helma stated that while Vocamotive could provide placement services, she declined to do so where ethically it would be of no benefit. Helma did contact the employers listed on Bose's LMS and disagreed that the employers reflected an accurate assessment of Petitioner's current capabilities or jobs that are available.

Testimony of Co-Worker Krista Schmitz

Krista Schmitz ("Schmitz") was called to testify by both parties in this matter. Schmitz worked with Petitioner at Respondent's place of employment. The first and only time she ever met Petitioner was for part of the day on 11/17/14 for 3 hours, when Petitioner was assigned to Schmitz's classroom. On that date, she recalled Petitioner arrived around 8am and was given her assignment. She said Petitioner communicated in English. She recalled Petitioner lifted 1-2 children with another aide. She recalled Petitioner used both her hands in a palm up fashion to lift the child from the bottom. Schmitz stated that Petitioner later left at 11:30am and claimed she hurt her hand.

She testified that Petitioner would be trained for MENTA restraining, which requires two or more staff and a specific process. Maneuvers include standing rack and seated wrap. She said one must use hands and squeeze down against resistance. Schmitz's students are aged 8-10 years old and weigh up to about 40 pounds. Schmitz testified that tasks are performed by teachers and aides, involving gripping, hands in an upward motion, hands with palms down, and lifting with palms down. Schmitz recalled she typed an email and sent it to the principal regarding Petitioner. Schmitz believed a letter was created using her email sometime after.

Testimony of Director of A.E.R.O. – James Gunnell, MD

James Gunnell ("Gunnell") was called to testify by both parties. Gunnell, who is executive director for Respondent's business, acknowledged that the parties, outside of the worker's compensation claim, were involved in litigation concerning federal and state lawsuits. Gunnell stated there was a licensing change in Illinois whereby all instructional aides were now required to obtain a certificate in order to obtain or maintain employment. As a result of the change, Respondent created non-instructional assistant positions so workers would not lose their jobs. He said there was no difference in the physical demands of either position. Gunnell recognized the job description for the non-instructional assistant. Px19. He stated that any student over 50 pounds requires a 2-person lift. He agreed the job requires lifting up to 100 pounds. It was his understanding Petitioner could only lift under 50 pounds.

Gunnell confirmed that Petitioner last worked for Respondent on 11/17/14. Respondent sent Petitioner an offer of employment to work with smaller children and Gunnell stated it was intended to be a long term assignment. He felt Petitioner had good conversational English. He asked Schmitz to write what she observed that day. Gunnell stated Petitioner was unable to meet certain criteria essential job functions of the non-instructional assistant position because of her physical restrictions. Gunnell ultimately determined in December 2014 that Respondent could not accommodate the work restrictions. Gunnell eventually issued a letter instructing that TTD should be reinstated. At no time after December 2014 has Respondent changed its position that it could not accommodate Petitioner. It was Gunnell understands that Petitioner would continue to receive TTD. He said she was never fired but that she resigned.

Testimony of Petitioner

Petitioner attempted to begin her testimony in English but eventually called a translator/interpreter for assistance. Petitioner testified via Polish interpreter/translator Muroski, that she resides in Oak Lawn, has a husband and an adult autistic son. She is originally from Poland but has resided in the US for 26 years. She has no United Stated education and was 59 years old at the time of trial. She worked for Respondent from 1997 as an assistant and last worked for Respondent on 11/17/14. Her duties included lots of physical work, lots of lifting students, lots of pushing wheelchairs with students, transferring students, transferring from wheelchair to another position. In addition, she also helped with activities of daily living such as changing diapers, toileting, feeding, pushing wheelchairs outdoors, involvement in playground activities, placing students on swings, tying wheelchairs to swings and transporting. She worked 8:15am to either 2:45pm or 3:45pm and received summers and holidays off. She was paid only while school was in session.

She described a typical work day as follows: accommodate the room for the children's arrival; meet the children at the bus and take them down using a lift and grabbing a brake to operate. She then pushes the wheelchair with the student into the classroom, lifts the student out of the chair, removes any strapping and coating using fingering and squeezing with her hands. After, most children are toileted, which involves lifting the student onto a table to unbuckle safety restraints, undress, toilet, change diaper, re-clothe, re-buckle and lift back into the chair. For this, she uses her hands and her arms. Diapers were changed around 3 times per day or more per student. The task of transferring from chair to chair involves lifting with another co-worker and use of safety belts. After, she aides students in daily assigned activities such as gluing or easy cooking. For this, Petitioner sometimes performed hand on hand technique, guiding the students hand using her hand. Petitioner also aided in feeding and noted some children used a special utensil with Velcro and she used her hand to guide the utensil for feeding. Her job also required repositioning of students. Afternoon duties also include gym activities and quiet time. Petitioner also aided in cleaning classrooms after activities by moving chairs, cleaning and wiping. She also helped prep materials for the teacher, which could include a lot of cutting with scissors, photocopying, lifting laundry baskets, moving laundry into and out of washers and dryers using two hands and arms. Between 1997 and 2013 she worked with the same group of children aged 15-22 years.

Petitioner testified she is unable to do her job because she cannot use her hands. She showed her arms and demonstrated her inability to fully straighten her left arm at the elbow. Petitioner believes her work activities aggravate her wrists. She said they feel numb from the fingers to the forearm and would get painful. Petitioner testified that in November 2014, she attempted to return to work but felt severe pain in the left hand and left elbow. Petitioner confirmed she communicated with Schmitz in English that day. She went to the emergency room when her regular doctor could not see her.

Today, Petitioner said she feels no pain but always has discomfort in the left elbow. She feels her RA is under control but admits she has a deformity in the right ring finger joint and that sometimes her knee and ankles swell. She was able to work in 2008 and 2009 and the RA has not prevented her from working. She did not think the RA affected her hand as much as after her surgeries. She feels depressed from not being able to work.

Petitioner described her English skills as basic and that she is unable to speak or write a lot. She described difficulty in writing and understanding all English in her community. Petitioner viewed the surveillance video and testified she is allowed to perform all of the activities seen. She agreed she used gripping, grasping and fingering for certain activities. Petitioner stated she has attempted to look for work as shown in Px11 and Px12 and that it was her writing in the documents and some of it is in English. She said she had assistance with the search. Petitioner agreed she signed various personal documents that were written in English. Rx12-17. She also agreed that sometimes she spoke English to doctors, co-workers and to restaurant workers.

Testimony of Dan Lindbald

Dan Lindbald ("Lindbald") testified on behalf of Respondent. He is a senior investigator for Sedgwick as has been so for the last 10 years. He has been an investigator for 26 years. He received training on surveilling and report writing. He was assigned to surveil Petitioner in this case and recognized her in court. He conducted surveillance in November 2015 and February 2016. The video was viewed in open court. Rx1-3. He testified he transferred the files for viewing and did not manipulate the video in an effort to speed or slow the tape. He admitted that the video was cut down but that it was not his decision.

Testimony of Carl Schnurstein

Carl Schnurstein ("Schnurstein") testified on behalf of Respondent. He is a private investigator with Sedgwick and has been so for 15-1/2 years. He has received training and has testified in matters related to his surveillance. He obtained surveillance in 2016 of Petitioner and said it reflected what he observed. Rx3.

Petitioner's Medical History

Records show that in 2008, Petitioner underwent a left carpal tunnel release and carpectomy. Px3. For this, she treated with Dr. Fakhouri and was followed by her primary, Dr. Kowalcyzk. Petitioner's prior history is also positive for rheumatoid arthritis (RA) for which primarily treated with Dr. Daniel Hirsen beginning in 2001. Px4. Petitioner's previous medical records disclose an initial RA diagnosis in 1996. Rx18.

In 2001, Petitioner regularly and continuously began treating with Dr. Daniel Hirsen for her RA. In October 2004, Petitioner began complaining of increased pain in her left elbow and left wrist. Exam at that time showed small effusion in the left elbow and tenderness over the lateral epicondyle. The left elbow was injected with Kenalog and Xylocaine. In March 2006, x-rays hinted of very early destructive arthropathy due to RA in the hands. It was noted in the right hand only at the base of the proximal phalanx with question of small erosion on the radial side of the bone as well as mild metacarpophalangeal joint space narrowing on the right hand. She remained on medications for her RA. By December 2006, her doctor noted that she had mild evidence of joint inflammation with improvement.

In June 2007, slight swelling of the right wrist was noted but Petitioner was otherwise recommended to continue her prescribed RA regiment. In September 2007, it was noted Petitioner had severe paresthesias of the fingers of the left hand every morning for the last two weeks. However, clinical exam showed no joint inflammation. Carpal tunnel evaluation showed positive Phalan test on the left reproducing paresthesias in all five fingers on flexion of the wrists. The doctor noted that while Petitioner's joint inflammation was doing well, she appeared to have carpal tunnel syndrome possibly secondary to the RA. The left flexor retinaculum was injected to take pressure off the median nerve. She was advised to brace the left wrist at night. The next notation of any wrist problems are in March 2008 where Petitioner complained of mild pain over the ulnar aspect of the right wrist for one week along with a primary complaint of continuous paresthesias of the left fingers. The doctor noted that in the past, he thought she had carpal tunnel syndrome on the left. The left was injected one more time to treat the carpal tunnel syndrome. By June 2008, Dr. Hirsen noted Petitioner had undergone carpal tunnel surgery on the left by Dr. Fakhouri. She reported pain at the ulnar aspect of the right wrist and exam show tenosynovitis of the right wrist over the owner attendance.

In March 2011, Petitioner began complaining of numbness and tingling in the right hand. In October 2011, Petitioner underwent a right carpal tunnel release with Dr. Fakhouri. Px1. Petitioner underwent usual post-operative care and was eventually released to full duty on 12/5/11. *Id.*

In March 2012, Dr. Hirsen, noted Petitioner had tenderness at the left elbow at the lateral epicondyles. In August 2012, Dr. Hirsen noted Petitioners RA was not quite optimally controlled.

In April 2013, Petitioner re-entered treatment with Dr. Fakhouri complaining of pain in the lateral aspect of the left elbow and proximal forearm. She related that she often had to lift children and that it had been aggravating her condition. She related that she been on medical leave since March of that same year. She was diagnosed with lateral epicondylitis of the left elbow, left radial tunnel syndrome and eventually underwent left elbow and proximal forearm injections. Subsequent EMGs eventually confirmed left carpal tunnel syndrome. In follow-up, Dr. Fakhouri noted that Petitioner had bilateral carpal tunnel releases previously and now had a recurrence of symptoms but in addition developed lateral epicondylitis and left ulnar tunnel syndrome. In May 2013, the doctor noted that her lifting of handicapped children may be related. Px1.

In June 2013, Dr. Patari's Section 12 exam concluded that he believed her pain with regard to her left elbow was work-related but not the carpal tunnel symptoms because of prior involvement. On 6/3/13, Petitioner underwent left carpal tunnel release, left ulnar tunnel release and left elbow lateral epicondylitis release with extensor tendon repair. Px1, 3. During this time she was off of work. Postoperatively, she underwent physical therapy and aspiration of seroma over the left elbow. Petitioner began physical therapy for the left hand, left forearm and left elbow with Mid-America Hand to Shoulder Clinic on 6/13/13 and would continue with such therapies through 6/20/14. Px5.

In August 2013, Petitioner returned to Dr. Fakhouri complaining this time of numbness and tingling in the right hand. After discussion, Petitioner elected for additional right carpal tunnel release. The doctor opined that her job requires a lot of lifting and grasping and he believed her upper extremity conditions were related to her work activities. He further noted that he believed her bilateral hand symptoms were work related. She remained off of work and continued to follow up. In October 2013, Dr. Fakhouri diagnosed Petitioner with left radial tunnel syndrome based on her present condition, which he also opined was related to her work activities. For this, he recommended conservative measures, ongoing light-duty and follow-up.

In October 2013, Dr. Gene Neri, performed a section 12 evaluation at Respondent's request. Rx7. The doctor opined that Petitioner had recurrent right carpal tunnel syndrome present prior to April 2013 that was not a direct result of any April 2013 work incident but may have been exacerbated by work. The doctor noted that Petitioner's RA was a factor to be considered. During that exam, the doctor noted that although her history did not correlate perfectly with the information passed along to him he did not find any evidence of deception but rather was a poor historian. Dr. Neri agreed with Dr. Patari that at a minimum the left lateral epicondylitis was compensatory.

Dr. Neri's testimony was eventually taken. He testified that he did not have any specific knowledge as to the weights or age of the special needs children that Petitioner worked with. He further testified that her RA was complicating factor but agreed that RA would not cause numbness and tingling only pain. However, he testified that RA can disrupt joints and in turn cause traction in the nerves thereby causing symptoms of carpal tunnel. The doctor testified that Petitioner was treating very aggressively for the unrelated RA. The doctor testified that the multiple potential factors that could account for Petitioners carpal tunnel syndrome.

In November 2013, Petitioner returned to Dr. Fakhouri who diagnosed Petitioner with the left radial tunnel syndrome and right carpal tunnel syndrome. He noted that she had become recalcitrant to the left radial tunnel syndrome and recommended a left radial tunnel release. Consideration will be given later to another right carpal tunnel release. He again noted that her present condition was related to her work activities. He recommended ongoing light duty. At that time, the right carpal tunnel was injected with cortisone. On 11/25/13, Petitioner underwent left radial tunnel release. She continued to follow up with Dr. Fakhouri. During that time she remained off of work. Px1.

In January 2014, x-rays of the bilateral hands performed at Advocate Christ showed significant increase in advancement of arthritic changes in both hands. Specifically, there is suggestion for bone erosion and destruction of the left scaphoid bone and large subchondral cyst in the right scaphoid bone.

On 3/7/14, Petitioner underwent a right carpal tunnel release. Px1.

In May 2014, Petitioner returned to Dr. Fakhouri. He recommended that she returned to work with no lifting, carrying, pulling or pushing greater than 15 pounds and a functional capacity evaluation or FCE.

In June 2014, Petitioner's FCE showed that Petitioner gave reliable effort and that the results were valid representation of her present functional capabilities. Px1, 5, 6. It was noted that Petitioner did not meet any of the specified job demands and she was placed at the light physical demand level. The therapist concluded that manipulation of the right hand should be occasional and noted decreased strength or deficits of the bilateral hands. It was further recommended avoiding or decreasing to occasional repetitive motion of the right and left upper extremity.

On 7/1/14, Dr. Fakhouri reviewed the FCE and noted that she did not demonstrate the ability to meet specific job demands. He released her per FCE and placed her at MMI. The document was faxed and copied to claims adjuster Sledge and Dr. Kowalcyzk.

In November 2014, Petitioner returned to Dr. Fakhouri who noted that she had returned to work continuing to work with special needs children and was unable to carry out her normal work duties as it related to the left upper extremity. He noted that she reached MMI prior to this most recent visit as it relates to the left upper extremity.

Petitioner testified that on 11/17/14, she attempted to return to work experience difficulties in performing her assigned tasks. As a result, Petitioner reported to Advocate Christ Hospital and medical center on an emergency basis. Px7. Records confirm that on that date at approximately 12:51 PM, Petitioner presented with a chief complaint of left arm pain. Patient reported that she had a history of several surgeries as a result of Worker's Compensation claims. She related that she was released to return to work without restrictions and today was her first day back as an aid working with handicapped children involving a lot of lifting and pulling. She felt unable to perform these duties because it caused increased pain in the left arm. She noted that her lawyer advised her to go to the emergency room. Dr. performed an exam and concluded no signs of acute injury but that her problems involving more chronic pain issues and she suggested Petitioner follow up with her doctor.

In July 2015, Petitioner presented to Dr. Victor Forys for ongoing pain and weakness of both hands and the left elbow and forearm. She was prescribed physical therapy, splint, medication and was removed from work. In August 2015, Dr. Hirsen noted Petitioner had severe destructive RA and severe destruction in her hands as well as active swelling. Therefore, Petitioner was unable even to do sedentary work and in his opinion she was 100% permanently disabled.

In August 2015, Petitioner returned to Dr. Forys and medications were refilled. She remained off of work. Assessment at that time was bilateral CTS, left ulnar tunnel syndrome, left radial tunnel syndrome, chronic forearm hand and elbow pain, decreased elbow flexion and extension, decreased stamina and pace, decreased finger dexterity all related to work activities. Petitioner continued to follow up with Dr. Forys monthly through November 2016. During this time, he noted she remained largely unchanged and she had difficulty doing most light housework and lifting over 15 pounds.

Video Surveillance

Respondent submitted surveillance video of Petitioner obtained in 11/2015, 2/2016 and 9/2016, which was viewed in court. Rx1-3. Petitioner is observed driving a vehicle, getting in and out of a car, walking to and from stores, ordering fast food and using a garden hose.

Testimony of Dr. Richard Noren

In March 2016, Petitioner was evaluated by Dr. Richard Noren at the request of Respondent. Px16. His testimony was essentially that at least 51% of Petitioner's current condition was related to RA and not left lateral epicondylitis or carpal tunnel syndrome. The doctor testified that Petitioner's pain was related to her RA. He agreed, however, that multiple surgeries at the same site or same location put her at risk of having continued pain. The doctor further agreed that a combination of RA with occupational risk factors predisposes that person to the development of carpal tunnel syndrome. The same would hold true for lateral epicondylitis.

Testimony of Dr. Victor Forys

In August 2016, the parties took the evidence deposition of Dr. Victor Forys. Px17. The doctor testified that he is familiar with Petitioner and has been treating her RA for some time. He testified her RA was well controlled, not debilitating and that no work restrictions were due to the RA. He believed her other conditions were preventing her from returning to work.

18IWCC0705

Deposition Testimony of Dr. Sanjay Patari

In March 2014, the parties to the evidence deposition of Dr. Sanjay Patari. Px13. He was initially asked to evaluate Petitioner's left elbow and concluded that the condition was related to the April 2013 work accident. He concluded Petitioner's other conditions were not work related because, in part, she had an EMG in May 2008 consistent with bilateral carpal tunnel. In addition, in 2011 Petitioner status post carpal tunnel release from several years prior. Thus, the doctor believed these other conditions pre-dated the work accident. He agreed he received an incomplete set of records. He agreed it was possible that his report was incomplete if he also had incomplete records.

Regarding carpal tunnel, the doctor stated it can recur where there is scarring or when there is incomplete release. The doctor further testified that it was possible that Petitioner was engaged in forceful gripping and or pressure on the palm services for the years of 2011 and 2012 that she could be the cause of the left carpal tunnel syndrome in 2013. When asked whether he agreed asked agree with Dr. Neri's opinion that recurrent carpal tunnel had been exacerbated over the years by Petitioner's work, the doctor had no opinion. Dr. Patari issued a new report and he was once again deposed. He continued to opine the left lateral epicondylitis was work related. The doctor found Petitioner to be at MMI when he last saw her based upon his reading of Dr. Fakhouri's November 2013 office note. He continued to opine her other conditions were not work related.

The doctor testified that the FCE was not valid because Petitioner did not complete all of the testing The doctor performed an AMA impairment rating for a diagnosis of lateral epicondylitis yielding a 6% impairment rating of the left upper extremity converting to a whole person impairment rating of 4%. He further determined that Petitioner was able to work in the heavy physical demand level of work. The doctor testified that aggravation of symptoms of left lateral epicondylitis are usually from a pulling motion with palms down, a pick up motion with palms down or palms facing the ground. Other activities include a forceful grip with palm down position. He stated that palm up pulling up in the promo position is not expected to aggravate or cause lateral epicondylitis. But he agreed that you cannot isolate one activity in an occupational setting. When questioned under cross-examination as to the amount of money he may have received from MES solutions, the doctor refused to disclose his compensation.

Job Search

From May 2016 through September 2016, Petitioner contacted 28 potential employers using Respondent's labor market survey. Px12. Between September 2014 and December 2016, Petitioner contacted potential employers for work. PX 11. A majority of these notations are partially in English but predominately appeared to be in her native language, Polish. Approximately 234 contacts were documented. Of these contacts a majority of the contents identified by MedVoc were also contacted. In December 2016, Lisa Helma likewise initiated contact to the potential employers identified in Respondent's labor market survey.

CORRECTED CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator finds Petitioner's testimony to be credible and believable. In addition, the witness testimonies of Sledge, Sheahan, Schmitz and Gunnell were also credible and forthright in disclosing what each witness believed they knew concerning the testimony presented. The Arbitrator finds the testimony of Helma more credible than that of Bose concerning Petitioner's ability to undertake vocational services and ability to

find work given her true restrictions. As to the testimonies of all doctors, the Arbitrator finds Petitioner's treating doctor's testimonies more credible than Drs. Noren, Neri and Patari, but elects to adopt the portions of Drs. Noren and Patari's testimonies finding causation in favor of Petitioner.

ISSUE (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
ISSUE (D) What was the date of the accident?
ISSUE (E) Was timely notice of the accident given to Respondent?

The Arbitrator incorporates the foregoing findings of fact as though fully set forth herein. Having carefully reviewed, considered and weighed all evidence presented, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she sustained repetitive injuries to her right hand on 3/7/11 (14 WC 7495) and to her bilateral hands and left arm on 4/16/13 (13 WC 13778).

In so finding, the Arbitrator finds Petitioner's testimonial extensive description of her job duties credible, detailed and in conformity with other records describing a similar although non-exhaustive list of her job duties, such as the non-instructional assistant position and her FCE. Px19. The job duties she described leave little doubt that Petitioner's job required the ongoing and extensive use of her fingers, hands, wrists and arms to perform a litany of tasks. Her description of the required use of her hands and arms were not seriously challenged by any witness or document. The Arbitrator finds the dates of accident appropriate and in conformity with Petitioner's medical history, lost time and when she first learned of her conditions as related to work. The Arbitrator further finds proper notice was given as noted by the accident reports, Petitioner's testimony and Sledge's agreement that Petitioner provided adequate notice.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having carefully reviewed, considered and weighed all evidence presented, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her current condition of ill-being as it relates to her bilateral carpal tunnel syndromes, left ulnar tunnel syndrome, left radial tunnel syndrome and left lateral epicondylitis is causally related to her work accidents.

In so finding, the Arbitrator finds that as to the date of accident 3/7/11 for case 14 WC 7495, Petitioner's job activities caused or was at least a causative factor in the development of her right carpal tunnel syndrome. In support thereof, the Arbitrator notes that Petitioner's right hand/wrist was otherwise symptom and treatment free for years prior to 2011. For this injury, Petitioner underwent a right carpal tunnel release in 2011 and was eventually released to full duty in December 2011. The Arbitrator is not persuaded that RA caused, led to, by percentage or otherwise, to Petitioner's right carpal tunnel syndrome. Petitioner's prior medical record at most noted right hand problems in the areas of the fingers and not the wrist. There was one notation of right wrist swelling but no treatment or diagnosis was formulated from that. Therefore, the Arbitrator concludes that Petitioner's initial right carpal tunnel syndrome for date of accident 3/7/11 is ***in part*** causally related to her current condition of ill-being, having reached MMI in December 2011.

As to the date of accident of 4/16/13 for case 13 WC 13778, the Arbitrator finds Petitioner's left carpal tunnel syndrome, recurrent right carpal tunnel syndrome, left lateral epicondylitis, left ulnar and radial tunnel syndromes are all causally related to her current condition of ill-being as supported by the opinions of Drs. Fakhouri and Patari. The Arbitrator resolves the dispute over Petitioner's recurrent right carpal tunnel syndrome

in favor of Petitioner based in part upon Dr. Neri's concession that her work may have exacerbated the pre-existing right carpal tunnel syndrome. The Arbitrator rejects Dr. Neri's opinion, however, that Petitioner's RA could be more responsible for the cause of her recurrent right CTS due to collapse of surrounding structures and/or due to RA medication use. Even if RA had played any role, the standard for causation in this State is well settled. Further, Dr. Fakhouri opined that the recurrent CTS was likely due to her lifting children. As to the recurrent left carpal tunnel syndrome, the Arbitrator, for similar reasons set forth above, finds in favor of Petitioner that her left CTS is related to her 4/16/13 work accident. The Arbitrator also notes that no evidence was given in support of any Section 12 doctor's suggestion that any prior CT release was performed incorrectly. To the extent either initial CT releases resulted in scarring, an incomplete release or iatrogenic injury, the Arbitrator could also conclude that such subsequent recurrent bilateral CTS is causally related as a sequelae of her initial injuries. As to the left ulnar and radial tunnel syndromes, the Arbitrator also finds these to be causally related to Petitioner's 4/16/13 work accident. In so concluding, the Arbitrator notes Dr. Fakhouri opined the conditions were related to Petitioner's work activates. These opinions are unrebutted. Finally, the Arbitrator notes that claims adjuster Sledge determined that at least Petitioner's bilateral carpal tunnel syndromes and epicondylitis were compensable and relies on same.

Regarding the video surveillance, the Arbitrator does not find any of the videos probative on the issue of causation. In so finding, the Arbitrator notes Bose did not find the videos to show Petitioner exceeding any restriction. In addition, Dr. Noren testified that the videos did not lead him to conclude that her condition was or was not work related. The doctor agreed that the video did not depict Petitioner exceeding restrictions. Thus, the surveillance is insufficient to support any finding that Petitioner's current condition of ill-being is not related to her work accidents. Thus, the Arbitrator concludes Petitioner's current condition of ill-being ***is*** causally related to her 4/16/13 date of accident.

ISSUE (G) What were Petitioner's earnings?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having carefully reviewed, considered and weighed all evidence presented, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her earnings were as follows for each accident:

For date of accident 3/7/11 in case 14 WC 7495, the Arbitrator concludes Petitioner failed to prove her average weekly wage as alleged in Ax1. Petitioner alleged an average weekly wage of $528.00 and Respondent alleged an average weekly wage of $426.90. Ax1. Neither party presented evidence or testimony in to substantiate the allegations contained in Ax1. The Arbitrator notes that neither Petitioner's paystubs nor her employment contracts aid in this analysis. Px18-19, Rx12-14. Likewise, Petitioner offered no testimony as to her earnings in the year preceding her 3/7/11 injury. However, the stipulations made between the parties on Ax1 suggest that the parties agree that Petitioner's average weekly wage was at least **$426.90** and therefore the Arbitrator concludes this to be Petitioner's average weekly wage for 14 WC 7495.

For date of accident 4/16/13 in case 13 WC 13778, the Arbitrator concludes Petitioner's average weekly wage was **$494.70** based upon the most persuasive and reliable evidence submitted, namely Rx9, which showed Petitioner was paid $659.60 in bi-weekly TTD benefits, resulting in an average weekly wage of $494.70. ($659.60 ÷ 2 = 329.80 ÷ .66 = $494.70). The Arbitrator rejects the figures submitted in Px18 as they reflect net pay to Petitioner on a bi-weekly basis and would therefore result in an incorrect AWW and an overpayment of benefits per Rx9. The Arbitrator also rejects the allegations offered in Ax1 for this date of accident as they too are not supported by the evidence.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having carefully reviewed, considered and weighed all evidence presented, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the medical services provided to her in both claims were reasonable and necessary and that Respondent has not yet paid all appropriate charges for same.

As Section 8(a) requires an employer to "provide and pay" for all first aid, medical, surgical, and hospital services necessary to cure an injured employee from the effects of a work-related injury, the Arbitrator finds that the medical treatment provided has been medically necessary and has been reasonably required to relieve the injured employee from the effect of the injury but that the Respondent has failed to pay for the same. Petitioner alleged the following outstanding unpaid medical bills as part of both of her claims:

Dr. Fakhouri $16,321.00
Dr. Daniel Hirsen $25.00
Advocate Christ Medical Center $1,150.00
Dr. Victor Forys $4,915.00
ATI Physical Therapy $7,867.76

Ax1. As to the bill of Dr. Fakhouri, the Arbitrator notes the charges represent physical therapy, injections and regular visits with Dr. Fakhouri at Mid-America Hand to Shoulder Clinic from 8/14/13 through 6/20/14 for which there was provided adequate medical documentation of same. The Arbitrator finds this treatment was reasonable and necessary to treat Petitioner for her 4/16/13 accidental injuries sustained to her bilateral hands/wrists, left forearm and elbow. Ax1, Px1. Thus, Petitioner is awarded the gross charges of **$16,321.00** for Dr. Fakhouri's bill and Respondent shall receive credit for payments made against this award as noted in Rx8.

As to the bill of Dr. Hirsen, of DJH Rheumatology Consultants, the Arbitrator declines to award the outstanding $25.00 charge to Petitioner. Dr. Hirsen is Petitioner's RA doctor and no evidence was shown that he actively participated in or treated Petitioner for any of the causally related conditions herein. The Arbitrator is unable to locate any medical record from 2011 through August 2015, the last note in Px4, to suggest Dr. Hirsen treated Petitioner for these claims.

As to the bill of Advocate Christ Medical Center, the Arbitrator notes the charges represent an 11/17/14 date of service for Petitioner's emergency room visit following a flare up of causally related left arm pain. There was provided adequate medical documentation of same. The Arbitrator finds this treatment was reasonable and necessary to treat Petitioner for her 4/16/13 accidental injuries sustained to her bilateral hands/wrists, left forearm and elbow. Ax1, Px7. Thus, Petitioner is awarded the gross charges of **$1,150.00** for Advocate Christ Medical Center's bill and Respondent shall receive credit for any payments made against this award as noted in Rx8.

As to the bill of Dr. Victor Forys, the Arbitrator notes the charges represent treatment and follow up for bilateral hand, elbow and forearm complaints from 7/24/15 through 11/21/16 for which there was provided adequate medical documentation of same. The Arbitrator finds this treatment was reasonable and necessary to

treat Petitioner for her 4/16/13 accidental injuries sustained to her bilateral hands/wrists, left forearm and elbow. Ax1, Px8. Petitioner was properly referred to Dr. Forys by Dr. Kowalcyzk. Px2. Thus, Petitioner is awarded the gross charges of **$4,915.00** for Dr. Fory's bill and Respondent shall receive credit for any payments made against this award as noted in Rx8.

As to the bill of ATI Physical Therapy, the Arbitrator notes the charges represent physical therapy treatment for bilateral hand, elbow and forearm complaints from 8/6/15 through 9/17/15 for which there was provided adequate medical documentation of same. The Arbitrator finds this treatment was reasonable and necessary to treat Petitioner for her 4/16/13 accidental injuries sustained to her bilateral hands/wrists, left forearm and elbow. Ax1, Px9. Petitioner was properly referred to ATI by Dr. Fakhouri. Thus, Petitioner is awarded the gross charges of **$7,867.76** for ATI's bill and Respondent shall receive credit for any payments made against this award as noted in Rx8.

In summary of the foregoing, Respondent shall pay the gross reasonable and necessary medical services of **$30,253.76**, subject to Sections 8(a) and 8.2 of the Act. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ISSUE (K) ***What temporary benefits are in dispute?***
ISSUE (N) ***Is Respondent due any credit?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having carefully reviewed, considered and weighed all evidence presented, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to both temporary total disability benefits and maintenance benefits as a result of her injuries sustained from the 4/16/13 work accident in case number 13 WC 13778. Petitioner seeks no temporary benefits relative to the 14 WC 7495 claim. Ax1. Instead, Petitioner seeks benefits from 4/17/13 through 7/1/14 and maintenance benefits from 7/2/14 through 11/16/14 and again from 11/16/14 through 12/14/16.

Regarding TTD, consistent with the credible testimony of the claimant and his medical treatment records, the Arbitrator finds that the claimant's condition resulting from her accident destabilized 4/17/13 and stabilized as of 7/1/14, which is the date Ms. Kula reached maximum medical improvement per Dr. Fakhouri. Respondent shall pay TTD pursuant to 8(b) of the Act from 4/17/13 to 7/1/14. In so finding, the Arbitrator adopts the work restrictions set forth by Dr. Fakhouri during this time.

Regarding maintenance, the Arbitrator finds that Petitioner is entitled to maintenance benefits from 7/2/14 through 11/16/14 and again from 11/18/14 through 12/14/16. As to the first period of benefits awarded, the Arbitrator bases this conclusion on testimony from Petitioner and Gunnell that Petitioner's permanent restrictions outlined in the FCE were unable to be accommodated during this time. Gunnell testified that an offer of employment was later made and Petitioner attempted to return to work but was unsuccessful. Respondent relied heavily on Schmitz's description of the work Petitioner performed in November 2014 but the Arbitrator notes that Schmitz did not observe Petitioner the entire time. The Arbitrator believes Petitioner performed duties consistent with her testimony and consistent with Sheahan's observations noted at the time of the job analysis. Thus, the Arbitrator further awards additional maintenance benefits from 11/18/14 through

12/14/16. In support thereof, the Arbitrator relies on Gunnell's testimony that he determined in December 2014 that Respondent could not accommodate the work restrictions and directed issuance of benefits.

The Arbitrator declines to adopt Dr. Patari's opinion that because Petitioner declined to perform tests at the FCE, which ultimately bear no relevance to Petitioner's capabilities in relation to her job, Petitioner is able to work full duty. The FCE results were still determined to be valid as a sufficient representation of Petitioner's capabilities. In addition, the whole of Petitioner's restrictions detail recommendations for lifting, pushing, pulling, grip strength, handling repetitive motions, fingering, handling and reaching. Px6. Thus, the Arbitrator concludes Petitioner remained at MMI following her attempt to work per the FCE.

As to Respondent's credits against the above awards, regarding the alleged advance payment issued by Respondent in the amount of $1,521.20 on March 13, 2015; the Arbitrator concludes that Respondent has failed to prove entitlement to such a credit. Ax1. Specifically, nothing in Rx8 and Rx9 show or suggest that such a payment was ever made. Moreover, the testimony of claims adjuster Sledge established that benefits were terminated on February 2, 2015. The Arbitrator awards credits for TTD in the amount of $20,400.48 and $11,775.03 for maintenance benefits paid. Ax1, Rx9.

ISSUE (L) What is the nature and extent of the injury?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having carefully reviewed, considered and weighed all evidence presented, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to an award of permanency for each of her claims as follows:

As to date of accident 3/7/11 in case number 14 WC 7495, the record demonstrates that Petitioner underwent a right carpal tunnel release and was eventually placed at MMI in December 2011. Petitioner did not return to treat specifically for this claim after that date. The Arbitrator adopts and relies on Dr. Fakhouri's treatment records during this time. Based on the record as a whole and the credible evidence, Respondent shall pay Petitioner permanent partial disability benefits of **$256.14/week** for **20.5 weeks**, because the injuries sustained caused the **10%** loss of the **right hand**, as provided in Section **8(e)** of the Act.

As to date of accident 4/16/13 in case number 13 WC 13778, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is permanently and totally disabled under the odd-lot category. A person is permanently and totally disabled when he cannot perform any services except those for which no reasonably stable labor market exists. *A.M.T.C. of Illinois, Inc. v. Indus. Comm'n*, 77 Ill. 2d 482, 487, 397 N.E.2d 804 (1979). She need not show she has been reduced to total physical incapacity before being entitled to a permanent and total disability award. *Interlake, Inc. v. Indus. Comm'n*, 86 Ill. 2d 168, 176, 427 N.E.2d 103 (1981). In addition, where an employee's disability is limited in nature so that he is not obviously unemployable or if there is no medical evidence to support a claim of permanent total disability, the burden is on the employee to establish by a preponderance of the evidence that he falls into the "odd lot" category, "that is, one who, although not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market." *Westin Hotel v. Ill. Workers' Comp. Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342 (2007).

A claimant may establish she is permanently and totally disabled under the odd lot theory by showing that: (1) considering his age, education, skills, training, physical limitations and work history she would not be regularly employable in any well-known branch of the labor market or (2) following a diligent job search, he

was unable to find gainful employment. When a claimant makes a *prima facie* showing that she falls into the odd lot category, the burden shifts to the employer to show that a reasonably stable job market nevertheless exists for that employee.

In the present case, the evidence supports a conclusion that Petitioner has established by a preponderance of the credible evidence that she falls within the odd lot category. Here, there is no explicit restriction preventing Petitioner from being medically unable to work. Instead and consistent with the odd-lot category, Petitioner has permanent restrictions as a result her conditions of ill being, which include recurrent bilateral carpal tunnel syndrome, left radial tunnel syndrome, left ulnar tunnel syndrome and left lateral epicondylitis. These permanent restrictions prevent Petitioner from returning to her usual and customary employment.

As to the first prong of the odd-lot analysis, vocational expert Helma credibly explained that Petitioner was not an ideal candidate for vocational services due to factors such as age, skills, education, experience and her significant language deficits. In addition, there existed negative factors contributing to the overall conclusion that Petitioner was not a candidate for such services. For example, Helma explained Petitioner's advanced age, coupled with other factors, was considered negative in terms of re-employment. Helma also described at length that Petitioner had basic English skills for which ESL courses would be required just to place Petitioner in a GED program, which is not offered in Polish, thereby further delaying re-entry into the work force. Regarding education, Helma similarly iterated that obtaining a GED for Petitioner would be time consuming and likely not result in any access to gainful employment. Helma credibly concluded Petitioner would not be suitable for any stable employment and that such restrictions impede transferability of skill.

As to the second prong of the odd-lot analysis, Petitioner's efforts to obtain employment via her job search logs demonstrate not only reasonable efforts on her part to look for work but also demonstrate a clear deficit in Petitioner being able to obtain employment given her overall vocational state. The Arbitrator concludes that Petitioner has carried her burden in meeting both prongs of the analysis.

Once Petitioner has met her burden, the burden shifts to Respondent to show that a reasonably stable job market nevertheless exists for that employee. Respondent presents several arguments in support of its assertion that there is suitable work that is regularly and continuously available to Petitioner. Namely – Petitioner's November 2014 job offer by Respondent, Dr. Patari's full duty release and the vocational opinions of Bose.

Regarding Petitioner's job offer, the Arbitrator concludes that the evidence demonstrates Petitioner attempted to return to work per the offer of light duty but was unsuccessful. Despite the job offer to work with younger aged children, Respondent has not shown Petitioner did not attempt to work or did not work. Respondent focused on Petitioner lifting a child as observed by Schmitz, however in the Arbitrator's opinion, this does capture Petitioner's ability to perform such work given her overall restrictions as outlined in the FCE and in relation to the job demands. Here, there was sufficient evidence presented by Petitioner that her work involved more than the lifting – there is clear and repetitive use of the hands and arms to perform gripping, grabbing, pinching, reaching, lifting, pushing and pulling. Such movements involve more than lifting children as evidence shows the job demands also included room preparation, assistance with activities of daily living, cutting and preparing for projects, dressing and undressing children, assistance with wheelchairs and walkers, and playground assistance. Thus, the weight of a student was but one consideration. The Arbitrator is not persuaded that Petitioner did not attempt to also perform some or all of the aforementioned. Finally, Gunnell acknowledged that Petitioner attempted work as offered and Respondent did not offer any similar accommodation after this attempt.

Instead and to the second point, Respondent offered Petitioner a full duty job based upon Dr. Patari's opinion that Petitioner was capable of working full duty by virtue of declining to perform some of the tasks during the FCE and because she was at MMI for the related left lateral epicondylitis. Dr. Patari's opinion is entitled to less weight as he ignored the fact that the FCE was valid and contained other restrictions more relevant to all causally related conditions at issue.

Finally, in addressing Bose's vocational opinions, the Arbitrator is not persuaded by the conclusion that Petitioner is employable after having reviewed medical records, transferable skills, the labor market survey and factors affecting employability.

Bose testified that part of the FCE restrictions were vague but admitted she failed to seek clarification. Instead, Bose developed her opinions based on a modified interpretation of the FCE and the Arbitrator assigns less weight to that opinion. In the Arbitrator's view, the FCE is not vague and directly describes ultimately recommending either avoiding repetitive motion of the bilateral upper extremities or decreasing to occasional repetitive motion of the bilateral upper extremities.

Bose also stated that her labor market survey only disclosed a light lifting restriction of 10 to 20 pounds but did not disclose any other restriction in the FCE. The Arbitrator concludes that the survey is flawed in that it lacked a complete understanding of Petitioner's true physical capabilities as outlined in the FCE, which detailed her ability to finger, handle and engage in repetitive bilateral upper extremity motions. In addition, although certain employers were not hiring, they were included in the survey anyway because Petitioner could perform the work based on her work history and residual functional capabilities. The Arbitrator views this differently since the overriding question is whether there is a labor market and whether Petitioner has access to that labor market. Thus, not hiring or possibly hiring in the future is not evidence of an available and accessible labor market. As to the employers that were hiring, the Arbitrator concludes those job requirements are in excess of Petitioner's permanent restrictions based upon a complete reading of Petitioner's medical restrictions, which include Dr. Fakhouri's recommendations as well as the FCE.

In addition, Bose testified that Petitioner was employable despite her opinions being predicated on Petitioner's "ability to have very little English communicative skills," and that Petitioner could not read or write English. (T.163) Bose stated Petitioner's basic oral communication skills meant greetings, simple conversations and things not of a detailed nature. In the Arbitrator's opinion, Petitioner demonstrated little ability to communicate in English. At trial, the Arbitrator observed Petitioner's difficulty communicating in even basic English during the early portion of her testimony. In addition, Petitioner's notations in her job searches are predominantly in Polish.

In addressing the video surveillance, the Arbitrator assigns little weight to the video surveillance submitted as it fails to shed any light on Petitioner's ability to work, which is at the center of the nature and extent dispute. As noted by Bose and Dr. Noren, the videos depict Petitioner performing activities that do not exceed her restrictions. Petitioner was not prohibited from engaging in any of these activities of daily living and what the video does show is not incompatible with what Petitioner's medical records and what her testimony was as to her ability to use her hands and arms. Based on the foregoing, the Arbitrator concludes that Respondent has failed to rebut Petitioner's odd-lot status.

Therefore, Respondent shall pay Petitioner permanent and total disability benefits of **$329.80**/week for life, commencing **12/19/16**, as provided in Section 8(f) of the Act. Commencing on the second July 15th after

the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Based on the record as a whole, the Arbitrator declines to assess penalties or fees against Respondent. Here, there is no late payment issue where there was no evidence presented that a demand for same had been made and where Respondent reasonably questioned whether Petitioner could in fact return to the job as offered in November 2014. This is so despite Gunnell's testimony that he thought benefits would be reinstated – it was clear that Respondent ultimately decided to dispute Petitioner's claims at that point. Therefore, it also follows that Petitioner has not shown unreasonable or vexatious delay in the payment or intentional underpayment of benefits. Therefore, Petitioner's request for penalties and fees is denied.

ISSUE (O) Prospective medical treatment, adjudication of permanent total disability

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner is at MMI and that she is not a candidate for vocational services, the Arbitrator declines to award any prospective medical as no medical treatment plan is of record. However, the benefits afforded under Section 8(a) remain available as long as the treatment is consistent with this award and the Act.

Signature of Arbitrator

4-17-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Brandt,
Petitioner,

vs. No. 16 WC 31077

18IWCC0706

Wilmington School District 209U,
Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner, a 55-year-old maintenance custodian, testified that on September 6, 2016, he injured his left knee while unloading a 200 lb. gas grill off a truck with a co-worker, Andy Stanton. They had just lowered the grill from the truck's bed, via the automatic liftgate, to ground level. Petitioner and Stanton each picked up one end of the grill, lifting it one inch off the tailgate to move it to the grass. Petitioner testified he took two steps sideways and then his knee made a loud popping sound, which his co-worker heard. Stanton asked what the noise was; Petitioner told him it was his knee popping. Petitioner noticed he could not bend his knee.

Nine years earlier, Petitioner had undergone a left knee ACL repair following a work injury at a different employer; he settled that claim for 30% left leg. Since returning to work after that injury, Petitioner had been able to work at physical jobs without restrictions. Days before Petitioner's current injury, he had begun a course of physical therapy at Athletico for low back pain, a problem unrelated to his current claim. He admitted that his low back problem caused sciatica-like pain, numbness and tingling in his left leg.

Following his current accident, Petitioner underwent arthroscopic left knee surgery with Dr. Hurbanek to repair a torn left meniscus. Less than 3 months later, he returned to his prior occupation with no restrictions.

Respondent presented the testimony of two witnesses. Co-worker Stanton testified he was near Petitioner when his knee popped and heard the pop. Although he testified Petitioner was not lifting or touching the grill when he heard the pop, Stanton did not observe what Petitioner had been doing because Petitioner was behind him. Valerie Viano testified she was an Human Resources person at Respondent; she confirmed that Petitioner reported the accident to her on the day it occurred. When Petitioner seemed hesitant to file a written accident report, she told him he had 45 days to do so. Petitioner turned in his claim paperwork approximately 3 weeks after that.

The Commission affirms the Arbitrator's findings that Petitioner proved accident. Petitioner's histories and descriptions of his mechanism of injury were consistent and corroborated by contemporaneous medical records. Witness Stanton admitted his recollection of some details was, "fuzzy." The Commission finds Petitioner's testimony and version of events more credible than Stanton's.

Much of Stanton's testimony was based on his assumptions, not actual observations. When he heard a pop, he assumed the sound came from Petitioner's knee, even though he was turned away from Petitioner. He also assumed Petitioner had been walking toward the liftgate switch when he heard the pop, even though he did not observe this. When Stanton was asked whether there were any holes in the ground where the grill was put down, he did not answer that question, instead testifying that, "It should be a groomed surface for softball players to walk back and forth to the field so it can't have any holes or very obvious, you know, tripping hazards."

At times, Stanton's answers were contradictory. He gave the impression that Petitioner was not with him when he brought the grill to the softball field in the truck; Stanton testified he was told to move the grill, "all on his own." Stanton further testified that Petitioner just happened to be "swinging by" at the moment Stanton was unloading the grill from the truck. Yet Stanton also admitted Petitioner was with him when they brought the grill to the field; he testified, "*we* were unloading a grill for a cookout for a softball game… So *we* moved the grill over to the softball field." The Commission finds that testimony contradicts Stanton's testimony that Petitioner just happened to "swinging by" when Stanton was unloading the grill from the truck.

18IWCC0706

The Commission affirms the Arbitrator's finding that Petitioner proved causal connection of his knee injury. Respondent's argument that Petitioner's injury was idiopathic is unsupported by the evidence. Dr. Hurbanek's causation opinion in evidence was unrebutted.

The Commission affirms the Arbitrator's award of 7 weeks of temporary total disability benefits. Petitioner's time off was followed his left knee surgery and was supported by the medical records in evidence.

For the reasons stated in the Arbitrator's decision, the Commission also affirms the Arbitrator's permanent partial disability award of 21.5 weeks, representing 40% loss of use of the left leg, pursuant to §8(e)12 of the Act. The Commission likewise affirms the Arbitrator's deduction of 30% left leg for Petitioner's 2007 workers' compensation claim, pursuant to §8(e)17. The Petitioner made a good recovery from his current injury and returned to his prior occupation without restrictions and with only minimal residual symptoms.

With regard to Petitioner's medical expenses, the Commission modifies the Arbitrator's award. Among the medical expenses the Arbitrator awarded Petitioner were 15 physical therapy sessions first prescribed *before* Petitioner's September 6, 2016 accident – for low back pain unrelated to his September 6, 2016 work injury. Petitioner underwent two courses of physical therapy at Athletico: the first, from September 3, 2016 to October 26, 2016, was for his pre-existing low back pain. The second, following his November 30, 2016 knee surgery, was from December 16, 2016 through January 17, 2017. The Commission finds the award for Petitioner's first course of therapy between September 3, 2016 to October 26, 2016, to be unrelated to his current claim, and reverses the Arbitrator's award of those medical expenses, only.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 22, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is affirmed, and Respondent shall pay Petitioner benefits of $580.95 per week for 7 weeks, commencing November 30, 2016 through January 17, 2017, as provided in §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of permanent partial disability benefits is affirmed. Respondent shall pay Petitioner permanent partial disability benefits of $522.85 per week for 21.5 weeks, as provided in §8(e)12 and §8(e)17 of the Act, because the injuries Petitioner sustained caused an additional 10% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses awarded by the Arbitrator to Petitioner for his physical therapy sessions at Athletico between September 3, 2016 and October 26, 2016, is reversed. The award of all other medical expenses is affirmed.

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

18IWCC0706

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 0 2018

o-10/03/18
jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRANDT, JEFF
Employee/Petitioner

Case# **16WC031077**

WILMINGTON SCHOOL DISTRICT 209U
Employer/Respondent

18IWCC0706

On 5/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK KLUKAS MANZELLA & SHELL
BRYAN SHELL
19 W JEFFERSON ST
JOLIET, IL 60432

0863 ANCEL GLINK
W BRITT ISALY
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

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

JEFF BRANDT
Employee/Petitioner

v.

WILMINGTON SCHOOL DISTRICT 209U
Employer/Respondent

18IWCC0706

Case # 16 WC 31077

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **4/10/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 6, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**45,313.75**; the average weekly wage was $**871.42**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

Respondent is entitled to a credit of $**9,201.46** 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 the remaining unpaid reasonable, necessary and related medical bills to the Petitioner, which total $22,032.27 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $580.95/week for 7 weeks, commencing 11/30/16 through 1/17/17, as provided in Section 8(b) of the Act.

Petitioner sustained permanent partial disability to the extent of 40% loss of use of the left leg pursuant to §8(e)(12) of the Act. Pursuant to §8(e)(17) of the Act, the Arbitrator has taken the prior settlement from 07 WC 52292, which was 30% of the left leg, into consideration and deducted from this award leaving a net award of 10% of the left leg. Respondent shall pay Petitioner permanent partial disability benefits of $522.85/week for 21.5 weeks, because the injuries sustained caused an additional 10% loss of use of the left 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

5/22/17
Date

MAY 23 2017

18IWCC0706

STATEMENT OF FACTS:

At the time of the alleged injury, Petitioner was 55 years old. Petitioner's highest level of education was receiving his GED. Petitioner testified he worked mostly manual labor positions since high school, including building playgrounds and a job in maintenance work at a nursing home. Petitioner testified that he has been working for Respondent in custodial maintenance since 2010. As a custodial maintenance worker, Petitioner would perform grounds work and building work. Grounds work consisted of outside duties, which included cutting grass, edging weeds and maintaining the sports fields. The maintenance of the sports fields included painting stripes, or putting down chalk stripes onto football, baseball and softball fields. Building work, or indoor work, included janitorial work, which was sweeping, mopping, cleaning, dusting as well as building maintenance which included changing light bulbs or ceiling tiles.

Petitioner testified that prior to September 6, 2016 he had no issues or pain with his left leg while employed with Respondent, either working outdoor grounds work, or indoor janitorial work. Before his employment with Respondent, Petitioner had a prior work injury where he suffered an ACL tear. At that time, Petitioner was employed with The Kenneth Company, where he installed playgrounds. (Resp. Ex 1) Petitioner received a settlement of 30% loss of use of the left leg. Petitioner testified that he returned to work full duty for The Kenneth Company and had no issues with the left leg since. Petitioner testified and the records submitted show that on September 3, 2016, he was seen at Athletico Physical Therapy complaining of low back pain, with some numbness into his left foot, but no pain to the left knee. (Pet. Ex. 1 at 31)

Petitioner testified that on September 6, 2016, he was directed to take a grill to the softball fields for a cookout that was occurring later that evening after the softball game/practice. Petitioner testified that this was a two-person job. Petitioner indicated they were directed by Respondent to not lift this grill alone as it was heavy, unstable and awkward to carry. Petitioner provided that he and a co-worker, Andy Stanton, had to load the grill onto a truck. The truck was equipped with an automatic lift gate operated by a switch on the rear passenger side of the truck. Petitioner stated he and his co-worker had to retrieve the grill from the old laundry room of the middle school. They rolled it out of the building onto the lift gate of the truck, raised the lift gate up to the truck and rolled it into the back of the truck, securing the grill with bungee cords. They then drove the truck to the softball fields where they backed the truck into the area where the grill was supposed to be placed. (Pet. Ex. 21-24) They parked the truck in the gravel area with the back of the truck almost into the grass. (Pet. Ex. 23 and 24) Petitioner stated that he was riding in the passenger side of the truck to the softball area. When they arrived, he went to the driver side and his co-worker went to the passenger side. As they were standing on the ground, they both grabbed their respective sides of the grill and wheeled it onto the lift gate of the truck. Petitioner stated that his co-worker operated the button to lower the lift gate. Once the lift gate was lowered, they both lifted their respective sides of the grill by the side trays and had to side step into the grass. Petitioner testified that the grill weighed approximately 200-250lbs. Petitioner's Exhibit 11 shows a similar grill to the one moved on September 6, 2016. The specifications of the weight show that it weighed 190lbs., without a propane tank included. Petitioner conveyed that as he was on the driver's side of the vehicle and his co-worker on the passenger side, they lifted the grill together. Petitioner stated he was side shuffling while carrying the grill and felt a pop in his left knee, as well as heard a loud pop. Petitioner testified that the pop was so loud that his co-worker asked what was the loud popping noise. Petitioner informed Andy that it was his knee. Petitioner stated he could not stand or put weight on the knee after the occurrence. He sat the grill down and they called the supervisor on the radio to report the injury. Petitioner provided that he continued working, but mostly sat around trying not to do anything.

Petitioner testified that he scheduled a doctor's appointment for September 9, 2016 at Morris Hospital Healthcare Center. Petitioner indicated that prior to this visit, he had a physical therapy appointment on September 7, 2016 for his low back pain complaints. (Pet. Ex 1 at 35) Records show Petitioner "…reports extreme left knee pain rated 10/10 following moving a grill at work, states to have felt and heard a loud "pop" resulting in increased pain and swelling. The therapist strongly recommended to seek an MD assessment of left knee secondary to recent traumatic event. (*Id.*)

Petitioner presented to Morris Hospital Healthcare Center where he saw Dr. Passerman on September 9, 2016. Petitioner provided a history that he had pain for approximately four (4) days after he was at work, twisted funny, heard a snap and had swelling since. Dr. Passerman noted a positive McMurray test on examination, diagnosed internal derangement of the left knee and recommended an MRI as well as referred Petitioner to an orthopedic surgeon. (Pet. Ex. 2 at 7-8)

Petitioner underwent the recommended MRI at Joliet Open MRI on September 12, 2016. Same revealed a joint effusion, Grade III tear in body and posterior horn of the meniscus and marrow edema along the anterior aspect of lower pole of patella. (Pet. Ex. 3 at 8)

Petitioner testified that he had previously scheduled for vacation and went to Myrtle Beach with his family. Petitioner testified that he was confined to his hotel room due to the injury. After he returned, he scheduled an appointment with Dr. Jason Hurbanek, with Hinsdale Orthopedics. Petitioner presented to the doctor on October 13, 2016. At this visit Dr. Hurbanek took a history from Petitioner that he was hurt at work on September 6, 2016 while "…moving a grill from a lift gate with another guy. He went to lift it up off the gate, took 2-3 lateral steps and the knee popped. Lateral steps. Immediate pain in the left knee.." Dr. Hurbanek reviewed the MRI and found a tear in the medial meniscus, a large effusion and a potentially torn ACL. Dr. Hurbanek assessed left knee medial meniscus tear with anterior cruciate ligament tear. The doctor recommended a higher quality MRI and placed Petitioner on light duty restrictions. Dr. Hurbanek also stated that he believed Petitioner had an injury that caused the medial meniscus tear and most likely an anterior cruciate ligament re-tear. (Pet. Ex. 4 at 7-9)

Petitioner underwent the MRI on October 18, 2016. The scan revealed 1.) complex medial meniscus tear involving the posterior horn and body with suggestion of a medially flipped bucket handle fragment; 2.) small to moderate joint effusion; and 3.) an intact ACL graft. (Pet. Ex. 4 at 11)

On October 25, 2016, Dr. Hurbanek reviewed the MRI and opined that his work injury caused the pathology present in his knee and recommended arthroscopy with partial medial meniscectomy as well as postoperative physical therapy. Petitioner's light duty restrictions were continued. (Pet. Ex. 4 at 13-15)

On November 30, 2016, Dr. Hurbanek performed left knee arthroscopy, partial medial meniscectomy. During the procedure, the doctor found a complex tear of the medial meniscus with a fragment flipped into the medial gutter. The medial meniscus was debrided 40-50% to a stable border. The post-operative diagnosis was left knee torn medial meniscus. (Pet. Ex. 4 at 16)

Petitioner's initial physical therapy evaluation took place on December 6, 2016 at Athletico. The therapist noted the September 2016 work injury and the plan was to attend therapy two (2) to three (3) times per week for six (6) weeks. (Pet. Ex. 1 at 66-68)

Petitioner followed up with Dr. Hurbanek December 8, 2016. The doctor noted Petitioner's pain scale was at 5/10 and had started formal physical therapy, but he was still in pain. Dr. Hurbanek kept Petitioner off work and told Petitioner to follow up in four (4) to five (5) weeks. (Pet. Ex. 4 at 18-19)

Petitioner was discharged from physical therapy on January 12, 2017. The therapist noted Petitioner demonstrated marked improvements in left knee ROM, strength, dynamic stability and functional activities without report of pain or swelling. It was felt Petitioner had met all established physical therapy goals. (Pet. Ex. 4A at 9-10)

That same day, January 12, 2017, Petitioner presented to Dr. Hurbanek. The doctor recorded that Petitioner reported that he was feeling well and had no pain in his knee. Petitioner was taking Ibuprofen as needed. A physical examination revealed no effusion. His motion was 0 – 135 and he had 5/5 strength. Dr. Hurbanek released Petitioner to return to unrestricted work effective January 17, 2017. The doctor indicated Petitioner could follow up as needed and noted that if he worked for a month without issues, Petitioner would be at maximum medical improvement. (Pet. Ex. 4A at 6-7).

Respondent called Andy Stanton, a twenty (20) year old high school graduate who was employed with Respondent as assistant maintenance manager. Mr. Stanton testified that on the date of injury, he had been working with Petitioner all day on several different tasks. Mr. Stanton testified that he loaded and unloaded the grill by himself on the date of injury. Mr. Stanton stated that he could not recall if Petitioner was present when loading the grill onto the truck indicating because his recollection was getting fuzzier by the day. Mr. Stanton provided however, that he specifically remembers the alleged accident because something significant happened, i.e., hearing a loud pop which ultimately was the pop in Petitioner's knee.

Mr. Stanton also testified Petitioner was not working with him that day, but just swung by the area. He indicated that for the sake of convenience, Petitioner was there to push the lift gate toggle switch to lower the gate and make life a little faster and easier so he didn't have to reach over the grill and hit the button himself. Andy provided he himself held on to the grill and moved it onto and off the lift gate. Mr. Stanton stated that as he was on the lift gate and Petitioner was behind him on the ground, he heard a loud pop. He did not see Petitioner and stated Petitioner did not have his hands on the grill assisting in moving the grill in any way. Mr. Stanton provided he then lowered the lift gate himself and then pulled the grill off the gate by himself moving it to where it needed to go. Mr. Stanton testified he received instructions from his supervisor to do all the work, stating he was to move the grill "all by myself."

Mr. Stanton later testified that he and Petitioner had been working together all day, taking out garbage, working on the softball field and working in the general area of the softball field. Mr. Stanton also approximated that the grill weighed between 100 – 200lbs. He provided Respondent had no instructions regarding lifting and had not implemented any policies regarding same.

Respondent called Valerie Viano, an 18-year employee of Respondent who works in Payroll/H.R. Ms. Viano testified that Petitioner reported a work injury to her on the date of the injury, September 6, 2016. She indicated Petitioner told her he injured his knee and heard a pop while moving the grill. Ms. Viano provided that Petitioner informed her that he didn't fall or step off the truck. He told her that he "wasn't doing anything physical, was just moving to get [the] grill off the truck." Ms. Viano provided she gave him an Illinois Form 45, but Petitioner indicated he was not sure he wanted to fill that out. Ms. Viano indicated that the next time she saw Petitioner was later in the week of September 6th when he brought in a doctor's note and a prescription for a MRI. She indicated that Petitioner did not complete and submit the forms until September 26, 2016. He also submitted photos of the claimed incident area.

Ms. Viano testified that she was responsible for preparing portions of the Form 45 as well as the Employee's Report of Injury (Petitioner's Ex. 7). She indicated that she is required to fill out part of the report on the day a work injury is reported and send same to the insurance company. Ms. Viano completed both the Form 45 and the Employee's Report of Injury on September 26, 2016.

In support of the Arbitrator's Decision regarding "C" Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

According to *Caterpillar Tractor v. Industrial Commission*, 215 Ill. App. 3d 229, 574 N.E.2d 1198, 158 Ill. Dec. 805, (4th Dist. 1991), it is clear that the proceedings in Workers' Compensation cases are informal and are designed to expedite and to achieve a right result.

The Supreme Court of Illinois has held that the word accident is not a technical legal term, but encompasses anything that happens without design, or an event that is unforeseen by the person to whom it happens. *E.Baggot Co. v. Industrial Comm'n,* 290 Ill. 530, 125 N.E. 254 (1919). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hageler Zinc. Co v. Industrial Board,* 284 Ill. 378, 120 N.E. 249 (1918).

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 (West 2006). 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, 137 Ill.Dec. 658, 546 N.E.2d 603, 605 (1989). "In the course of" the employment refers to the time, place, and circumstances under which the claimant is injured. *Scheffler Greenhouses, Inc. v. Industrial Comm'n,* 66 Ill.2d 361, 366–67, 5 Ill.Dec. 854, 362 N.E.2d 325, 327 (1977). "A compensable injury occurs 'in the course of' employment when it is sustained while a claimant is at work or while he performs reasonable activities in conjunction with his employment." *Wise v. Industrial Comm'n,* 54 Ill.2d 138, 142, 295 N.E.2d 459, 461 (1973).

"Arising out of" the employment refers to the origin or cause of the claimant's injury. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill.2d 193, 203, 278 Ill.Dec. 70, 797 N.E.2d 665, 672 (2003). An accident arises out of one's employment if its origin is in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665, 667 (1989). "Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties." *Caterpillar Tractor,* 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d at 667. "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Caterpillar Tractor,* 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d at 667.

Petitioner established that he sustained an accident on September 6, 2016 when he was lifting one side of the grill and moving it with his coworker, Andy Stanton. They were directed by the employer to deliver an approximately 200# grill to the softball field. This is definitely within the scope of and arising out of the employment.

Petitioner and his coworker testified to two different versions of the event. The similarities in their testimony is that they both heard a loud pop. Andy Stanton provided that he did not see what happened, but heard the pop. Both Petitioner and his coworker testified that they were working together all day. They both testified that they had a lot of things to do that day to get fields ready for games, set up for the cookout after the softball game and setup for a magic show, which included setting up chairs and risers. They both testified that they were near the softball field/shed when the injury occurred. Andy Stanton filled out a witness statement, written out on September 27, 2016, three weeks after the date of the injury, where he states he did not see anything occur, but heard it and they were both near the softball shed. (Resp. Ex. 4)

The differences in the testimony began with loading the grill into the truck from the old laundry room in the middle school. Petitioner testified he remembered having to get the grill from the old laundry room of the middle school with his coworker. Petitioner testified that they loaded it into the truck and proceeded to the softball field, Mr. Stanton drove the truck, while Petitioner sat in the passenger side of the vehicle. Andy Stanton testified that what he remembered was fuzzier by the day, but that he loaded the grill from the middle school by himself and drove alone to the softball field. Further, Andy Stanton testified that he was working alone while unloading the grill when Petitioner happened to swing by the area, despite his testimony that they had been working together all day. Mr. Stanton further stated that Petitioner was only there to push the button to lower the lift gate, which is the hardest part of his testimony for the Arbitrator to comprehend. They both testified that they had been working together all day, but when asked about the delivery of a large and heavy grill, Mr. Stanton changed his testimony and stated that from his fuzzy memory, he was loading and unloading the grill by himself. Mr. Stanton's testimony was that Petitioner only later happened to be in the area and his only responsibility was to help only by pushing a button on the lift gate. Mr. Stanton testified he was directed to move the grill by himself. Conversely, Petitioner testified that they were told not to lift the grill alone. Petitioner testified that they both were in the process of unloading the grill. Petitioner was lifting the grill from the driver's side of the vehicle holding his side tray and the coworker was lifting from the passenger side of the vehicle holding the opposite side tray of the grill to get it off the lift gate and into the grass. Petitioner testified that as they lifted the grill and stepped sideways on the grass he felt and heard a loud pop in his knee. Mr. Stanton testified that he heard a pop as he was on the bed of the truck placing the grill onto the lift gate and didn't see Petitioner, but knew he was several feet away from the truck when he heard the loud pop. Petitioner testified that the grassy area was not perfectly level, which seems accurate when reviewing Petitioners' Exhibits 23 and 24, the photos of the area where the incident occurred.

The Arbitrator finds Petitioner to be a credible witness. Petitioner gave a consistent history of the injury from the first report of injury dated September 6, 2016 (Pet. Ex. 7), which was contemporaneous with the injury, as well as giving a consistent history to all treating physicians and his testimony at the hearing. He was forthright when reporting the injury that he had a prior left leg injury approximately 10 year earlier, which adds to his credibility. The Arbitrator finds that the testimony of Andy Stanton was not persuasive regarding his version of the accident. Moreover, the Arbitrator notes the dubious story that the only thing Petitioner was supposed to be doing while unloading the 200-250# grill off the lift gate of the truck was to push the button to lower Mr. Stanton down and not assist with lifting the large, heavy and awkward grill.

The testimony of Valerie Viola did not add any value when considering accident, other than the fact that the injury was reported immediately after it happened, as well as Petitioner followed up with her with a doctor's note and an order for an MRI for his left knee days after the accident. Both times Valerie did not fill out an injury report, did not contact the workers' compensation insurance carrier and the claim was not investigated further until September 26, 2016.

Lastly, the medical records provide convincing circumstantial evidence that there is no basis for Respondent's theory that this injury occurred while he was standing watching Andy unload the grill or standing by the truck pressing a button/switch and not assisting in lifting the grill. The MRI revealed a complex medial meniscus tear involving the posterior horn and body with suggestion of a medially flipped bucket handle fragment. (Pet. Ex. 4 at 18) Further, Dr. Hurbanek opined that the work injury where he was lifting a grill and taking 2-3 lateral steps hearing a loud pop and feeling immediate pain caused the pathology in his knee. (Pet. Ex. 4 at 13)

The Arbitrator finds that Petitioner sustained an accident on September 6, 2016, while lifting a grill and stepping laterally when he felt and heard a loud pop in his left knee.

In support of the Arbitrator's Decision regarding "F" Is Petitioner's current condition of ill-being casually related to the injury, the Arbitrator finds as follows:

The claimant in a Workers' Compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Comm'n,* 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980). Included within that burden is proof that his current condition of ill-being is causally connected to a work-related injury. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 192, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

Expert medical evidence is not essential to support the Commission's conclusion that a causal relationship exists between a claimant's work duties and his condition of ill-being. *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63, 442 N.E.2d 908, 911, 66 Ill. Dec. 347 (1982). A chain of events suggesting a causal connection may suffice to prove causation. *Consolidation Coal Co. v. Industrial Comm'n,* 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892, 203 Ill. Dec. 327 (1994).

In this case, Petitioner had a pre-existing ACL tear, which was repaired with an ACL graft and Petitioner was returned to work full duty in 2007. Petitioner's unrebutted testimony provides that he has not had any issues with the left knee since being returned to work full duty. He has worked in manual labor positions installing playgrounds, which did not bother his left knee. He began working for Respondent in 2010 and had no issues performing his work activities, which he testified was a lot of walking both outdoors, maintaining the grounds of the school campus as well as indoor work, including mopping, sweeping, dusting and building maintenance. Petitioner performed such duties that day up to the time of the accident in a normal fashion, which was not rebutted by Respondent's witness.

On September 3, 2016, three days prior to the work injury, Petitioner was participating in physical therapy for a low back injury causing numbness down his left leg, but did not complain of left knee pain. (Pet. Ex. 3 at 31) The day after the work injury, Petitioner returned for physical therapy for his low back, but had new complaints of 10/10 left knee pain following moving a grill at work, feeling and hearing a loud pop resulting in increased pain and swelling. (Pet. Ex. 3 at 35) The Arbitrator notes that the left knee pain complaints at the time of the injury are not only consistent with Petitioner's testimony, but that they differ from the September 3, 2016 therapy visit concerning the low back pain and left leg numbness.

Dr. Jason Hurbanek, a board certified orthopedic surgeon with an added qualification of orthopedic sports medicine, opined that the work injury caused the pathology present in his knee. (Pet. Ex. 4 at 13) Respondent offered no evidence or testimony to rebut the opinion of Dr. Hurbanek. Further, the chain of events clearly shows causal connection. Petitioner was working full duties on September 6, 2016 and there were no subjective complaints of left knee pain prior to the work injury. The day after the work injury Petitioner complained of 10/10 pain and swelling of the left knee. Petitioner reported the injury immediately and sought medical treatment immediately.

The Arbitrator finds that Petitioner has proved by a preponderance of the evidence that his condition of ill-being in the left knee is causally connected to the work injury sustained on September 6, 2016.

In support of the Arbitrator's Decision regarding "J" Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The evidence supports Petitioner's claim for medical bills, which total $43,439.55 prior to any payments made by Petitioner's group insurance and awards payment of same pursuant to §8 and §8.2 of the Act. The Arbitrator has reviewed the bills and finds the following:

- Pet. Ex. 12- Athletico Physical Therapy
  - Respondent credit: $2,607.00
  - Petitioner out of pocket expense: $45.00
  - $7,147.01 balance subject to §8 and §8.2 of the Act
- Pet. Ex. 13- Healthcare Centers of Morris
  - Respondent credit: $79.36
  - Petitioner out of pocket expense: $8.82
- Pet. Ex. 14- Healthcare Centers of Morris
  - Respondent credit: $79.36
  - Petitioner out of pocket expense: $8.82
- Pet. Ex. 15- Joliet Open MRI
  - $1,500.00 Respondent credit
- Pet. Ex. 16- Hinsdale Orthopedics
  - $14,238.00 balance subject to §8 and §8.2 of the Act paid to Petitioner
- Pet. Ex. 17- Morris Hospital
  - $580.00 balance subject to §8 and §8.2 of the Act paid to Petitioner
- Pet. Ex. 18- Presence Saint Joseph Medical Center
  - Respondent credit:$4,466.74
  - $67.26 balance subject to §8 and §8.2 of the Act paid to Petitioner
- Pet. Ex. 19- Joliet Anesthesia Practice
  - Respondent credit; $469.00

Based on the above, Respondent shall be given a total credit of $9,201.46 for medical benefits that have been paid by Cigna, 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. Additionally, the Arbitrator awards $22,032.27 for the unpaid medical bills pursuant to §8 and §8.2 of the Act payable to Petitioner, which is not subject to the 8(j) credit. Lastly, the Arbitrator awards $62.64 to Petitioner for the out of pocket expense paid as reflected in the medical bills.

In support of the Arbitrator's Decision regarding "K" What temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

Having found in favor of Petitioner on the requisite issues of accident and causal connection, the Arbitrator finds that the medical records support Petitioner's claim for TTD from November 30, 2016 through January 17, 2017, or a period of seven (7) weeks at a TTD rate of $580.95 per week.

In Support of the Arbitrator's Decision regarding "L" What is the nature and extent of the injury, the Arbitrator finds as follows:

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

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

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 regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record does not contain an impairment rating and the Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a janitor/maintenance at the time of the accident and that he is able to return to work, although does complain of soreness and throbbing, especially after working on his feet 7-8 hours per day, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the accident. Because Petitioner is an individual who will live with his permanent disability for a shorter period than a younger individual, some weight is given to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner is earning the same or more than prior to the date of the injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner now has a surgically repaired meniscal tear superimposed on a prior surgically replaced ACL. Petitioner underwent an arthroscopy where the meniscus was debrided 40-50%. There have been anatomical changes to his knee including removal of a significant portion of the meniscus. Petitioner was discharged from physical therapy on January 12, 2017. The therapist noted Petitioner demonstrated marked improvements in left knee ROM, strength, dynamic stability and functional activities without report of pain or swelling. That same day, Dr. Hurbanek released Petitioner to return to unrestricted work effective January 17, 2017. The doctor indicated Petitioner could follow up as needed and noted that if he worked for a month without issues, Petitioner would be at maximum medical improvement. A physical examination revealed no effusion. His motion was 0 – 135 and he had 5/5 strength. Petitioner continues to complain of pain to the left knee, especially at his new position, where he now works second shift in a different location, Bruning Elementary, where most of his shift is spent standing and cleaning the hallways or classrooms, which causes left knee pain. Petitioner takes two Ibuprofen per day, which he never required prior to the September 6, 2016 work injury. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

The Arbitrator notes the prior credit under §8(e)(12) of the Act, which was 30% of the left leg from case number 07 WC 52292. Section 8(e)17 of the Act provides as follows:

> In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the loss by amputation or partial loss by amputation of any member, including hand, arm, thumb or fingers, leg, foot or any toes, such loss or partial loss of any such member shall be deducted from any award made for the subsequent injury. For the permanent loss of use or the permanent partial loss of use of any such member or the partial sight of an eye, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury.

820 ILCS 305, § 8(e)17 (emphasis added).

The Arbitrator has taken the credit into consideration and has deducted it from the award for the September 6, 2016 work injury.

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 the left leg pursuant to §8(e)(12) of the Act. Further, pursuant to §8(e)(17) of the Act, the Arbitrator has taken the prior settlement from 07 WC 52292, which was 30% of the left leg, into consideration and deducted from this award leaving a net award of 10% of the left leg.

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

Nicole St. Pierre,

Petitioner,

vs. No. 16 WC 00205

La Leche League International,

Respondent.

18IWCC0707

DECISION AND OPINION ON REVIEW

A Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the record and hearing oral argument, dismisses the petition for review for lack of jurisdiction.

On January 5, 2016, Petitioner filed an application for adjustment of claim alleging that on December 20, 2013, she sustained injuries to the low back when she slipped and fell on ice in a parking lot. On February 27, 2018, the parties appeared for hearing before the Arbitrator on Petitioner's motion to enforce a subpoena and for other relief, and a record was made. Petitioner's counsel stated the subpoena "specifically asks for any and all non-privileged materials in the Hartford claim file regarding this petitioner." In response to the subpoena, Petitioner's counsel received "about 80 pages of records." However, in the accompanying letter, Respondent's counsel stated that Hartford withheld "communications between the Hartford, its insured, and the attorney and or this firm," as well as "claim loss evaluations, insurance reserve information and file handling directives." Petitioner's counsel was specifically interested in notes of any conversations between Petitioner and the claims adjuster. Respondent's position was the notes were privileged or a work product. Petitioner's counsel was of the opinion that "these types of disputes are not resolved by an Arbitrator or by the Commission. They're resolved in the Circuit Court, and petitioner has a right to ask the Circuit Court Judge if he agrees that that's an appropriate assertion of privilege." Petitioner therefore asked the Arbitrator to grant the motion "and allow this matter to be removed to the Circuit Court of Cook County to

allow petitioner to enforce the subpoena and also to seek attorney's fees and costs which are also provided under the Supreme Court rules and the rules of the Commission."

Respondent responded that Petitioner's subpoena is "tantamount to discovery," and there is no discovery in workers' compensation. Rather, Rule 9030.50 of the Rules Governing Practice Before the Workers' Compensation Commission provides that witnesses or documents may only be subpoenaed to appear or be produced at the time and place set for hearing of the cause. Respondent further asserted there had been no personal service or payment of statutory fee and travel expenses. Respondent's counsel had elected to provide Petitioner's counsel "with medical records and medical records only." Respondent maintained it did not waive any objections to the subpoena, and "formally" objected to the subpoena before the Arbitrator. Respondent reiterated the adjuster's notes were privileged and protected as a work product, as they were prepared in anticipation of litigation of a disputed claim. Petitioner's counsel agreed the subpoena was objectionable. However, counsel maintained that Respondent had waived any objections.

On March 13, 2018, the Arbitrator filed an order denying Petitioner's motion. The Arbitrator found "the subpoena plainly failed to comply with applicable Section 9030.50, Subpoena Practice at the Commission," and "[t]he subpoena was fatally invalid and defective at the moment it was drafted." The Arbitrator further found that Respondent had timely objected to the subpoena before and during the hearing. The same day, March 13, 2018, Petitioner filed a petition for review challenging the Arbitrator's ruling.

The Commission notes that Petitioner's filings on review repeatedly concede the Arbitrator's ruling was not a final and appealable decision. Petitioner's April 9, 2018, motion to supplement the record states, among other things: "This is not *** a decision and award, this is a supplemental and non-final motion proceeding to enforce a subpoena." (Emphasis in original.) Petitioner's July 17, 2018, motion to reinstate review states, among other things: "This is not an appeal of an Arbitration decision, nor does this even involve the Respondent employer. This is a request for initiation of an original action in the Circuit Court as authorized by statute, more specifically an action on behalf of Petitioner against a non-party, Hartford Insurance Company, to compel them to comply with a subpoena issued by the Illinois Workers' Compensation Commission (Commission) pursuant to 820 ILCS 305/16 (West 2008)."

However, the Arbitrator found the subpoena fatally invalid and defective. Petitioner, instead of attempting to cure the defects, filed a petition for review of the Arbitrator's interlocutory order. The Commission lacks jurisdiction to review such interlocutory orders. See *Ralph v. Currier's Hydro Service*, 15 IWCC 0502; *Branham v. Lenny Szarek, Inc.*, 06 IWCC 0699 ("The Arbitrator's rulings on both the Penalties Petition and Motion to Disqualify are non-final, interlocutory and not reviewable until a hearing that comported with Section 19(b) has occurred").

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition for review is dismissed.

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 1 2018
o-11/15/2018
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

17WC30770
Page 1

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

Christie Robinson,
Petitioner,
vs.

NO: 17 WC 30770

SOI/Vienna Correctional Center,
Respondent.

18IWCC0708

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 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 2, 2018, is hereby affirmed and adopted.

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

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

DATED: NOV 21 2018

o110118
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

ROBINSON, CHRISTIE
Employee/Petitioner

Case# **17WC030770**

SOI/VIENNA CORRECTIONAL CENTER
Employer/Respondent

18IWCC0708

On 3/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
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0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
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CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
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1350 CENTRAL MANAGEMENT SERVICES
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0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

MAR 2 - 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTIE ROBINSON
Employee/Petitioner

v.

STATE OF ILLINOIS/VIENNA CORRECTIONAL CENTER
Employer/Respondent

Case # 17 WC 30770

Consolidated cases: _____

18IWCC0708

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **December 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **September 15, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,062.26**; the average weekly wage was **$947.90**.

On the date of accident, Petitioner was **41** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of her employment with Respondent on September 15, 2017. Petitioner has not reached maximum medical improvement and Respondent shall pay for ongoing medical care.

Respondent shall pay reasonable and necessary medical services totaling **$8,150.57**, as set forth in Petitioner's Exhibit 1 and itemized in the Arbitration Decision, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers for which Respondent is receiving credit under Section 8(j).

Respondent shall pay temporary total disability benefits of **$631.93/week for 3/7 weeks**, for the period of September 19, 2017, through September 21, 2017, 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.

Signature of Arbitrator

February 27, 2018
Date

ICArbDec19(b)

MAR 2 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTIE ROBINSON
Employee/Petitioner

18IWCC0708

v.

Case #: 17 WC 30770

STATE OF ILLINOIS/VIENNA CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On September 15, 2017, Petitioner was 41 years old, married, and had no dependent children. She was employed as a Correctional Officer at Respondent's Vienna facility and had been so employed since May 1, 2017.

Petitioner testified that on September 15, 2017, she was working as the lobby desk officer, whose duty it is to check visitors in and out of the facility. She went to the visiting room to relieve the visiting room officer, who left to shake down some inmates. When the other officer returned, Petitioner exited the visiting room and turned to shut the door, and the door slammed shut on her left hand. Petitioner described the door as being made of very heavy steel. She believed that the weight of the door caused it to move rapidly and slam shut.

Petitioner reported the accident and completed an Employee's Notice of Injury. She described how the injury occurred as, "I was exiting the visiting room of building 19 when the medal [sic] door to the visiting room slammed shut on my fingers on my left hand." RX1

On cross-examination, Petitioner testified that she reached back to close the door and as she was reaching for the handle, the door slammed on her hand and bounced off. She agreed that the visiting room door is where the public enters and exits the prison.

Mr. Mark Dixon was present on behalf of Respondent and was called to testify by Petitioner. He is a Maintenance Carpenter at the Vienna facility. Mr. Dixon was present throughout the hearing and heard Petitioner's testimony. He testified there was nothing in her testimony that he disagreed with. Mr. Dixon testified that he was familiar with the door in question but was not present when the incident occurred. He testified that the door was solid and heavy and may weigh as much as 400 pounds. He has worked at the Vienna facility for 17 years and to his

knowledge there have been no problems with the door in question. He opined that there was nothing defective about the door.

Following the accident, Petitioner presented to Heartland Regional Medical Center on September 15, 2017, and reported she had slammed her left hand in a metal door. She complained of pain in her left middle and left ring fingers, which she rated at 10/10. Assessment was crush injury and x-rays revealed fractures of the terminal tufts of the third and fourth fingers. Petitioner was given a prescription for Norco and instructed to follow up with Dr. Treg Brown. PX3.

On September 18, 2017, Petitioner presented to The Orthopaedic Institute of Southern Illinois and was evaluated by Physician's Assistant Tim Jennings and Dr. Steven Young. She reported a consistent history of the accident and her treatment to date. She complained of piercing pain rated at 9/10, throbbing, some numbness in the distal tips of the fingers, and radiating pain. Petitioner's x-rays were reviewed and the assessment was closed, nondisplaced fractures of the distal phalanx of both the left ring and left middle fingers. Her fingers were splinted at that time and she was instructed to remain off work until September 25, at which time she could return with a restriction of no use of the left upper extremity. PX4.

On October 10, 2017, Petitioner returned to Dr. Young and reported she was improving but her fingertips were still sensitive. She was instructed to continuing wearing her splint as needed and to start physical therapy. She was to remain on light duty, with no use of her left upper extremity. Petitioner followed up with Dr. Young on November 2, 2017, and reported continued sensitivity of the distal tips of the long and ring fingers. It was noted she had been participating in physical therapy. She stated she did not feel ready to return to full duty work, as it would require full inmate contact. She was instructed to continue with physical and occupational therapy and to remain on modified duty with no use of the left hand. She was to return in four weeks. PX4.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Sisbro, Inc. v. Industrial* Comm'n, 207 Ill.2d 193, 2013 (2003); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). If the injury coincides with these definitions and is traceable to a definite time, place, and cause, then said injury is accidental within the meaning of the Act. *Laclede Steel Co. v. Industrial Comm'n*, 6 Ill.2d 296, 300 (1955).

"In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n,* 167 Ill.2d 77,81 (1995); *Scheffler Greenhouses, Inc. v. Industrial Comm'n,* 66 Ill.2d 361, 366 (1977). That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment. *Sisbro supra.* An injury "arises out of" one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 117 Ill.2d 38, 45 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work *or* that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.*

An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he or she had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58(1989); *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 203 (2003).

In the instant case, there is no dispute that Petitioner was in the course of her employment at the time of her injury. She was in the process of relief switchover at the time of the accident, which was obviously incidental to her employment.

Respondent disputes, however, that Petitioner's injuries arose out of her employment, arguing that she was injured due to a neutral risk (doors) that the general public is exposed to. The record clearly demonstrates, however, that these prison doors are not the types of doors that the general public uses. Petitioner testified that they are heavy doors made of steel, and Respondent's own witness testified that the doors weigh approximately 400 pounds. The general public is not exposed to this type of door at all. Petitioner, on the other hand, testified that she uses these doors on a regular basis. The Arbitrator finds that this is an employment-related risk and not a risk to which the general public is exposed.

Even assuming, *arguendo*, that this was a neutral risk, the Arbitrator would still find that Petitioner sustained a work-related accident. An employee may be entitled to compensation for injury sustained from a neutral risk if he or she is exposed to that neutral risk of injury to a greater degree than the general public. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 45 (1987). That increased risk could be qualitative, such as some aspect of employment that contributes to risk, or quantitative, such as the number of times they are required to encounter the risk. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d 284, 290 (4th Dist. 2013). The sheer weight of this type of door would clearly constitute a qualitative increased risk, and the fact that Petitioner's job repeatedly exposed her to this type of door throughout her work day would constitute a quantitative increased risk.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner met her burden of proof on the issue of 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, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issue (F), and in light of Respondent's position that the issue of liability for past medical expenses stemmed from its dispute of accident, the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to her accident of September 15, 2017. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for all payments previously made to providers, including those made pursuant to Section 8(j), for which a credit is allowed. The Arbitrator finds that Respondent is liable for the following medical bills as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, and subject to prior payments.

1. Heartland Regional Medical Center	$6,128.57
2. Virtual Radiological Professionals	$ 36.00
3. Dr. Steven Young/Ortho. Institute of So. Ill.	$ 710.00
4. Real Rehab and Fitness	$1,276.00
TOTAL	**$8,150.57**

The Arbitrator notes that not all of the bills for services rendered had been invoiced as of the date of arbitration. Given the Arbitrator's findings on all issues, Respondent is liable for those bills, though they were not available at the time of arbitration.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatment that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Comm'n*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

The Arbitrator finds that Petitioner is not currently at maximum medical improvement and is in need of further care. The Arbitrator further finds that Respondent is liable for prospective medical care for Petitioner's left hand.

In support of the Arbitrator's decision relating to issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. industrial Comm'n*, 279 Ill.App.3d 1087 1090 (5th Dist. 1996).

When a claimant is disabled for a period greater than three days but less than fourteen days, compensation begins on the fourth day of temporary total disability. 820 ILCS 305/8(b).

Petitioner was unable to work for a brief period of time following her injury, from September 16, 2017, until September 21, 2017. The Arbitrator finds that Petitioner was temporarily and totally disabled for that period of time. Pursuant to Section 8(b) of the Act, Petitioner is not entitled to received TTD benefits for September 16, 17, and 18. She is entitled to benefits for September 19 through September 21, 2017, for a total of 3/7 weeks.

The parties stipulated that Petitioner's average weekly wage was $947.90. The Arbitrator finds that her temporary total disability rate is $631.93. The Arbitrator finds that Respondent is liable for 3/7 weeks of temporary total disability benefits of $270.83.

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:

The Arbitrator finds that Respondent had a reasonable basis to dispute the issue of accident. As such, Petitioner's Motion for Penalties is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debra Rohman,
Petitioner,
vs.

NO: 15 WC 06926

SOI/ Department of Financial and Professional Regulation,
Respondent.

18IWCC0709

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical, causal connection, permanent partial disability 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 7, 2018, is hereby affirmed and adopted.

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

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

NOV 21 2018

DATED:
o110118
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROHMAN, DEBRA
Employee/Petitioner

Case# **15WC006926**

SOI-DEPT OF FINANCIAL AND PROFESSIONAL REGULATION
Employer/Respondent

18IWCC0709

On 2/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2217 SHAY & ASSOCIATES
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2101 S VETERANS PARKWAY
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SPRINGFIELD, IL 62794-9255

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

FEB 7 - 2018

RO[illegible]SCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEBRA ROHMAN,
Employee/Petitioner

v.

STATE OF ILLINOIS-DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION,
Employer/Respondent

Case # **15** WC **6926**

Consolidated cases: _____

18IWCC0709

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **1/17/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/9/13**, 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.

In the year preceding the injury, Petitioner earned **$44,733.00**; the average weekly wage was **$860.25**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

The petitioner's claim for compensation is denied based on the doctrine of res judicata.

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

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

Signature of Arbitrator

2/1/18
Date

ICArbDec p. 2

FEB 7 - 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 60 year old Office Coordinator Option II, alleges she sustained an accidental injury to her left hand due to repetitive work activities that arose out of and in the course of her employment by respondent that manifested itself on 12/9/13.

On 11/19/14 petitioner proceeded to trial pursuant to Section 19(b) with respect to a claim for injuries to her left and right hands and cervical spine due to repetitive work activities that arose out of and in the course of her employment by respondent that manifested itself on 8/5/10. This was case 10 WC 34609. In his Decision dated 1/16/15, Arbitrator Gallagher found the petitioner sustained a repetitive trauma injury to her right hand arising out of and in the course of her employment by respondent that manifested itself on 8/5/10. In support of this finding the Arbitrator relied on the petitioner's testimony regarding her job duties and the non-ergonomic arrangement of her work station that was unrebutted. He noted that when petitioner was keyboarding she was required to place her hands/arms in an awkward position because the keyboard was elevated and on the same plane as the computer screen, and the computer mouse was likewise elevated and on the same place as the computer screen. He found that all doctors that examined petitioner, other than 1 of respondent's Section 12 examiners, opined that she had right carpal tunnel syndrome. He also relied more on the opinion of Dr. Fletcher in reaching this conclusion. With respect to the claim of left carpal tunnel syndrome, the arbitrator found that since this condition was not diagnosed until 10/18/13, there was no evidence that petitioner's left carpal tunnel syndrome condition manifested itself on 8/5/10. The arbitrator also found no injury to the cervical spine that arose out of and in the course of his employment by respondent that manifested itself on 8/5/10. The arbitrator found all medical treatment provided to the petitioner with respect to her right hand was reasonable and necessary. The arbitrator also found the petitioner was entitled to prospective medical treatment including the right carpal tunnel release surgery as recommended by Dr. Greatting and all reasonable and necessary treatment pertaining to the same. The petitioner appealed this decision to the Commission. In a Decision and Opinion on Review dated 2/23/16, the Commission affirmed and adopted the Decision of the Arbitrator.

Prior to the hearing on 11/19/14, on 10/7/13, petitioner was seen in follow-up with Dr. Claude Fortin after undergoing an EMG on 10/7/13. Dr. Fortin made reference to a cervical spine MRI dated 12/31/09, 6/28/11, and 10/8/12. He also made reference to the EMG study of 9/4/12 that showed a right median neuropathy at the right wrist, moderately severe and with progression since the study on 8/5/10. Dr. Fortin noted that the EMG performed 10/7/13 revealed findings consistent with bilateral median neuropathies at the wrists, mild to moderate in degree, neuropraxic in nature, without evidence of axon loss. After diagnosing bilateral carpal tunnel syndrome, Dr. Fortin noted that physical therapy had recommended an ergonomic mouse for her

computer at work to minimize aggravation of her underlying condition. Dr. Fortin recommended coverage of the ergonomic mouse for medical necessity.

On 12/9/13 petitioner presented to Dr. Greatting for evaluation of bilateral arm complaints. On petitioner's intake form, in response to the question "Does this problem interfere with or is it aggravated by her job", petitioner wrote "repetitive trauma with writing, keyboard usage and mouse usage." She indicated that she had symptoms since 8/5/10 -repetitive work trauma. Petitioner reported symptoms in both her right and left hands. She reported tingling in her right thumb, index and middle fingers, and tingling in her index finger, as well as some aching pain and a feeling of tightness in both forearms. She reported symptoms since 2010. She reported that writing and using a roller ball mouse at work aggravates her symptoms. She stated that she switched to doing some of the writing activities with her left hand and also switched to using a vertical mouse which helped some. Dr. Greatting was of the opinion that the results of the EMG/NCS showed bilateral median neuropathies at the wrist that were mild to moderate in degree. Dr. Greatting assessed bilateral carpal tunnel that accounted for the numbness and tingling in her hands and was most likely at least causing the aching pain up into her forearms. Dr. Greatting discussed various treatment options and the possibility of surgical release.

On 4/22/14 petitioner returned to Dr. Fortin. He noted that petitioner still had intermittent hand complaints, with an EMG on 10/7/13 demonstrating mild to moderate neuropraxic bilateral median neuropathies at the wrists with a distal motor latency of 4.5 left and 5.0 right. He was of the opinion that clinically petitioner's right side was worse than her left. Dr. Fortin instructed petitioner to follow-up with Dr. Fletcher, and with Dr. Greatting for median nerve decompression.

On 5/6/14 petitioner presented to Dr. David Fletcher for follow-up of her cervical radiculopathy and carpal tunnel syndrome. He noted that petitioner's essential job functions are that of a clerical worker. The date of injury was identified as 8/5/10, and petitioner described her accident as cumulative trauma disorders in the workplace during the summer of 2010. Her secondary problem was identified as pain in the left and right wrist, that began on 4/28/10, and was constant. She noted that it was accompanied by tingling and numbness, and not improving.

Petitioner did not follow-up with Dr. Greatting again until 7/7/16. Dr. Greatting noted that he last saw petitioner on 12/9/13 for bilateral carpal tunnel syndrome, and at that time it was elected that petitioner just observe her symptoms. He noted that petitioner was told that if they worsened he felt that surgery would be reasonable. Petitioner reported that she had intermittent numbness and tingling in her left hand which primarily involved the index finger but would sometimes involve the other fingers in the median nerve distribution. Dr. Greatting noted a positive Tinel's and positive compression test over her left carpal tunnel. Petitioner also

reported symptoms related to her right hand. Dr. Greatting recommended a right carpal tunnel release based on the severity of her symptoms. Petitioner never had this recommended surgery, which was her own decision.

Respondent offered into evidence the CMS Position Description and Demands of an Office Coordinator, petitioner's job. The job description indicated that petitioner used her hands for fine manipulation (typing, good finger dexterity) 6-8 hours a day.

Petitioner testified that her duties after 12/9/13 were essentially the same as they were before. Although petitioner changed to the real estate division on 2/1/12 her typing requirements and fine manipulation remained the same at 6-8 hours a day. Petitioner continued in this position in December of 2017.

Petitioner testified that on 12/9/13 when she saw Dr. Greatting, she was made aware that she had positive diagnostic findings for left carpal tunnel syndrome. Based on this opinion, petitioner selected this date as her manifestation date, the date on which both the fact of the injury to her left hand and the causal relationship of the her left hand injury to her employment would have become plainly apparent to a reasonable person.

Petitioner testified that when she filed her claim for alleged injuries to her bilateral hands on 8/5/10 she believed at that time her left hand symptoms were related to her hand writing and using the mouse with her left hand.

Petitioner filed her Application for Adjustment of Claim with respect to this claim on 3/4/15.

O. RESPONDENT ARGUES THIS CLAIM IS BARRED BY RES JUDICATA

The doctrine of res judicata bars claims that have either been litigated or could have been litigated from being litigated again. The doctrine of res judicata often comes into play when a subsequent case, similar to the case already adjudicated, is filed. The rationale behind the doctrine is that an issue or cause of action fully litigated should not be litigated again.

In the case at bar, the respondent argues that petitioner's claim that her left carpal tunnel syndrome was due to repetitive work activities that arose out of and in the course of her employment and manifested itself on 12/9/13 is a subsequent claim, identical to the claim already adjudicated on 11/19/14, and a claim that could have been litigated during the hearing on 11/19/14, and therefore should not be litigated again.

When addressing a res judicata argument, there are three factors to look at. The first factor to consider is whether there was a previous litigation in which identical claims were raised, or in which identical claims could have been raised. Petitioner previously alleged an injury to her left hand due to repetitive work activities that arose out of and in the course of her employment by respondent that manifested itself on 8/5/10. That case was

tried on 11/19/14. The arbitrator held that petitioner failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left hand due to repetitive work activities that arose out of and in the course of her employment by respondent that manifested itself on 8/5/10 because this condition was not diagnosed until 10/18/13, and there was no evidence that petitioner's left carpal tunnel syndrome condition manifested itself on 8/5/10.

Based on the arbitrator's finding with respect to the left carpal tunnel in case 10 WC 34609, the respondent argues that by 11/19/14 the petitioner had already been diagnosed with left carpal tunnel syndrome on 10/18/13, and had already seen Dr. Greatting on 12/9/13 who confirmed her diagnosis of left carpal tunnel syndrome and related it to her work duties. As a result, the arbitrator finds the petitioner had ample opportunity between her alleged manifestation date of 12/9/13 and the trial date of 11/19/14, to file a subsequent claim with respect to a repetitive injury to her left hand with a manifestation date of 12/9/13, consolidate that case with case 10 WC 34609, and try both of these claims before Arbitrator Gallagher on 11/19/14. Given that the petitioner is using a manifestation date of 12/9/13 in this claim, the arbitrator finds the petitioner knew by 12/9/13 that she had allegedly sustained a repetitive trauma injury to her left hand that arose out of and in the course of her employment by respondent. The arbitrator further finds that since the manifestation date of 12/9/13 preceded the trial on 11/19/14, this identical claim of an injury to petitioner's left hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 12/9/13 could have been raised at the trial on 11/19/14.

The second factor to consider is that the parties must be the same parties as to those who litigated the original action. In reviewing the Decision with respect to case 10 WC 34609, the arbitrator finds the parties with respect to both these cases are the same.

The third factor to consider is that the original action must have received final judgment on the merits. The arbitrator notes that the Decision of the Arbitrator was issued on 1/16/15, appealed to the Commission, and the final Decision and Opinion on Review of the Commission dated 2/23/16, affirmed and adopted the Decision of the Arbitrator, and was not reviewed. For this reason, the Arbitrator finds the original action received final judgment on the merits.

The deciding factor here seems to be the first factor, or whether or not there was a previous litigation in which identical claims were raised, or in which identical claims could have been raised. The respondent argues that since petitioner is claiming a manifestation date of 12/9/13, a date which clearly preceded the trial date in case 10 WC 34609 by nearly a year, the petitioner had sufficient time to file this claim for a left hand injury due to repetitive work activities, and consolidated this case for hearing with case 10 WC 34609. The arbitrator finds

it significant that following the trial on 11/19/14 petitioner had no further information regarding manifestation or causal connection as it relates to her alleged the left hand injury than she did before that date, given the fact that after her visit with Dr. Greatting on 12/9/13, she sought no further treatment for her left hand until 7/7/16, and at that time Dr. Greatting did not provide petitioner with any more clarity with respect to the her left hand carpal tunnel syndrome and the manifestation date of 12/9/13.

The petitioner argues that since they did not file this claim until 3/4/15, it was a timely filed claim that should be adjudicated. The arbitrator finds this argument less than persuasive given the fact that the manifestation date petitioner is alleging is a date prior to the trial date for case 10 WC 36409. Given the fact that the manifestation date of 12/9/13 petitioner is claiming in this case was nearly a year before the trial on 11/19/14; the fact that petitioner is alleging that both the fact of her alleged left hand injury and the causal relationship of the injury to her employment would have become plainly apparent to a reasonable person on 12/9/13 based on the opinions of Dr. Greatting; and the fact that petitioner had diagnostic evidence to support her left carpal tunnel as early of 10/7/13, the arbitrator finds there was a previous litigation on 11/19/14 in which this claim could have been raised, given that the petitioner's manifestation date for this claim is 12/9/13. The arbitrator further finds the fact that petitioner did not file this claim until 3/5/14, does not change the fact that the manifestation date the petitioner is claiming could have definitely been raised during the trial on 11/19/14, especially given the fact that the evidence petitioner is using to support its claim of accident and causal connection in this case, namely the EMG of 10/7/13 and the opinions of Dr. Greatting on 12/9/13, was known 11 months prior to the trial for case 10 WC 34609. Had the petitioner claimed a manifestation date after 11/19/14, these findings as to the issue of res judicata may be different, since the petitioner would be claiming a manifestation date that it claims was not known until after the trial on 11/19/14, and could not have been raised on 11/19/14.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's claim for compensation is denied based on the doctrine of res judicata. The arbitrator finds the litigation these two parties took part in on 1/17/18 presented an identical claim for left carpal tunnel syndrome that could have been raised at the trial on 11/19/14 given the fact that the manifestation date and causal connection opinion petitioner is relying on in this case (12/9/13) occurred 11 months prior to the trial in case 10 WC 34609; that the parties with respect to both these cases are the same; and that the original action received final judgment on the merits.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?
L. WERE THE 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 IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner's claim for compensation is denied based on the doctrine of res judicata, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brigid, Dowdle,
Petitioner,

vs.

NO: 14 WC 06485

South Berwyn School District #100,
Respondent.

18IWCC0710

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, causal connection, medical, permanent 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 3, 2018, is hereby affirmed and adopted.

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

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

DATED: NOV 2 1 2018
o111518
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOWDLE, BRIGID
Employee/Petitioner

Case# **14WC006485**

SOUTH BERWYN SCHOOL DISTRICT #100
Employer/Respondent

18IWCC0710

On 5/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.99% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0863 ANCEL GLINK
DAVID SULLIVAN
140 S DARBORN ST 6TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BRIGID DOWDLE
Employee/Petitioner

v.

SOUTH BERWYN SCHOOL DISTRICT #100
Employer/Respondent

Case # 14 WC 6485

18IWCC0710

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **01/29/2018** and **04/17/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 _____

18IWCC0710

FINDINGS

On **01/31/2014**, 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 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, ***married*** with dependent children.

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

Respondent ***hasnot*** 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 $ under Section 8(j) of the Act.

ORDER

BECAUSE THE PETITIONER FAILED TO PROVE THAT SHE SUSTAINED AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT, 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.

David A. Kane
Signature of Arbitrator

May 3, 2018
Date

ICArbDec p

MAY 3 - 2018

IN THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIGID DOWDLE,	)	
Petitioner,	)	
v.	)	**Case No. 14 WC 6485**
SOUTH BERWYN SD #100	)	
Respondent.	)	**18IWCC0710**

ARBITRATION DECISION – ATTACHMENT

I. FINDINGS OF FACT

On January 31, 2014, Petitioner was a full-time math teacher for South Berwyn School District #100. (T. at p. 8) She also coached volleyball and basketball at that time. (T. at p. 9) Coaching consisted of a couple of practices each season and seven games. (T. at p. 9)

On January 31, 2014, there was a student versus staff basketball game. (T. at p. 10) The Petitioner found out about the game via an e-mail from Michelle Hauer, dated January 17, 2014. (T. at p. 12 and Hauer Dep. Ex. 2) The e-mail was sent to all faculty and staff consisting of approximately 75 people. (T. at p. 31)

The e-mail discussed signing up to work at a dance that was taking place during the school day and then, among other things, asked for volunteers to play in the basketball game taking place after school in a line

that read "if you are interested in participating, please let me know". (T. at p. 14) The dance was during the day and the basketball game was to take place after regular school hours (T. at p. 16) The entry referencing a request for volunteer players was bolded in the e-mail. (T. at p. 17)

Another e-mail was sent to the Petitioner and all other faculty and staff at the school on January 29, 2014. This e-mail contained multiple topics including information about a pep assembly during the day, direction to sign up for a time slot to work during the dance and then finally another request for volunteers "interested in playing or helping" (T. at pp. 18-19 and P. Ex. 13)

Petitioner admitted that the request for volunteers in the e-mail were for players, helpers and spectators. (T. at p. 44-45)

The Petitioner admitted that the e-mail instructed teachers to sign up to work at the dance but there was no such instruction related to the basketball game. (T. at p. 43)

The Petitioner stated that she felt that her participation was a way that she could make a connection outside of school with students. (T. at p. 21) She admitted that there was no specific list that included playing basketball as a requirement. (T. at p. 21) Petitioner admitted that there were many ways to establish rapport with the students and playing in a

game was not the only way to establish rapport. (T. at pp. 34-35) Petitioner admitted in her recorded statement that participation was "not mandatory" (T. at P 38 and Respondents Exhibit 1 at p.4)

A third e-mail was sent by Ms. Hauer to the entire staff and faculty on January 30, 2014. (T. at p. 22 and Hauer Dep. Ex. 3) The e-mail specifically stated that "all are welcome to come and play or help out.) (T. at p. 23 and Hauer Dep. Ex. 3) Further, a portion of the e-mail also emphasized in capital letters that it would be a HUGE HELP; of course, if you are just interested in watching . . .please come watch, it is always a blast." (T. at p. 23 and Hauer Dep. Ex. 3)

Petitioner chose to play rather than watch and during the game jumped to get a rebound and injured her left leg. (T. at pp.23-24) Notwithstanding the fact the e-mails from Ms. Hauer went to approximately 75 faculty and staff only two or three, including the Petitioner, volunteered to play in the game. (T. at 32) Petitioner admitted that it was difficult to "have coaches come out". (T at p.32)

The Petitioner gave a transcribed recorded statement that included admissions. (T. at p. 38 and R. Ex. 1) Among the admissions was that the playing in the game "was not mandatory". (T. at p. 38 and R. Ex. 1)

Petitioner admitted that in her eleven years working for Respondent she was not aware of any staff or faculty member disciplined for not playing in a student/teacher basketball game. (T. at p. 39) She admitted that there were many ways for teachers to be more involved in school events other than playing sports. (T. at p. 40)

Petitioner admitted that playing sports with students is not a part of her job description. (T. at p. 41) Petitioner admitted that she was neither instructed to come to the game nor play in the game. It was her choice. (T. at pp. 45-46)

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATED TO:

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

To obtain compensation under the Act, a Petitioner bears the burden of showing by a preponderance of the evidence, that she has suffered a disabling injury, which arose out of and in the course of her employment. *Baggett v. IWCC*, 775 N.E. 2d 908 (2002). "In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. IWCC*, 665 N.E.2d 1084 (1995). It is not enough, however, to simply show that an injury occurred during work hours or at the place of employment. The injury must also "arise out of" the employment. *Parro v. IWCC*, 657 N.E.2d 882 (1995). The arising out of component of establishing

entitlement to benefits is primarily concerned with causal connection such that it must be shown that the injury had its origin in some risk connected with, or incident to, the employment. *Sisbro, Inc. v. IWCC*, 797 N.E.2d 665 (2003).

The Commission has noted that there are three types of risk to which an employee may be exposed: (1) risks that are distinctly associated with 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. IWCC*, 378 Ill.App.3d 113 (2007).

Further, under Section 11 of the Act, "accidental injuries incurred while participating in voluntary recreational programs, including, but not limited to ***athletic events***, parties and picnics, do not arise out of and in the course of the employment, even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program." Illinois Workers Compensation Act, 820 ILCS 305/11. *(emphasis added).*

The Arbitrator finds that on January 31, 2014, the Petitioner injured her knee while playing in a basketball game. The Arbitrator finds that the

Petitioner was not required, ordered or assigned by her employer to play in that game on that day.

While the Arbitrator acknowledges that building rapport with students outside of the classroom could be construed as activity in furtherance of the employer's interest; the evidence clearly shows that there were multiple options and opportunities other than playing in a sporting event for the Petitioner and other employees to build rapport outside of the classroom. Further, there is no evidence that suggests that choosing one method over another would incur discipline or reprimand.

Also, the Petitioner's own testimony was that she made the choice to volunteer to play in the game because it made her job "a lot easier"; indicating that this decision was her personal decision solely to benefit herself and the risk was, therefore, a personal one and not one that was distinctly associated with her employment.

The Arbitrator finds that there is no evidence that the decision whether or not to participate in any way impacted the evaluation of the Petitioner's job performance by her employer. Further, the evidence and testimony, including Petitioner's own admissions, show that she had numerous other methods by which she could build rapport with students outside of class without actually participating in this or any other physical

activity. (T. at pp. 21, 34-35) The Arbitrator finds that the choice by the Petitioner to play in this game was a personal choice and not required as part of her employment.

Further, these facts squarely fall under Section 11 of the Act, commonly referred to as "the Voluntary Recreational Exception." Petitioner admitted that the game was voluntary and the evidence and testimony proves that no one was required to participate. (T. at pp. 44-45) This was further corroborated by one of the Petitioner's supervisors and the organizer of the game, Ms. Hauer, when she testified that all of the participants were "strictly voluntary." (3/15/17 Evidence Dep. of Hauer at p. 23, lines 22-25) The Petitioner's testimony confirmed that out of 75 staff members that received the e-mails from Ms. Hauer, only 2 or 3 (including the Petitioner) participated. Petitioner was neither ordered nor assigned to participate in the game, and she testified that in her eleven years at the school, she was not aware of any ramifications to any employee for not participating.

Further, when looked at in the reflection of the dance event that was also mentioned in the e-mail, it is clear that working at the dance was not optional. There were specific instructions to sign up to work at the dance that took place during normal school hours as opposed to the references to

the basketball game that only suggested options, from merely attending and cheering, volunteering to help or play. It is very clear that none of the options for the game were mandatory and there is no evidence that attendance at the game after regular school hours was even required.

The Petitioner was not only not ordered or assigned to participate in the game, but she was not even cajoled by a co-worker to participate. The multiple e-mails gave all 75 staff and faculty members equally, multiple acceptable, suggested options for playing, helping or simply attending and cheering on the participants. None was mandatory or any more or less suggested as an option.

In Petitioner's case, playing in an after-school basketball game was clearly not within Petitioner's job duties as a math teacher and not even within her job duties as a part-time coach.

All teachers were required to be present and work at the dance according to the e-mail, but Petitioner and Ms. Hauer stated that the basketball game was voluntary and that, in fact, only 2 or 3 of 75 staff participated. As such, it is clear that Petitioner could have easily declined to play.

For these reasons the Arbitrator finds that the accident did not arise out of or in the course of the Petitioner's employment for the Respondent and is not compensable.

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

The Arbitrator finds that the accident did not arise out of or in the course of the Petitioner's employment for the Respondent and is not compensable and the Respondent is not liable for Petitioner's present condition of ill-being.

Due to the Arbitrator's findings on the issues of accident and causation, all other issues are rendered moot.

Compensation is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Koami Agbezouhlon,

Petitioner,

vs. No. 08 WC 16193

18IWCC0711

Tyson Foods, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW WITH SPECIAL FINDINGS

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

Petitioner's application for adjustment of claim alleges that on January 29, 2008, Petitioner sustained accidental work-related injuries to the neck, back and right leg as a result of "[r]epetitive shoveling." Petitioner, who was 47 years old at the time of the arbitration hearing on April 4, 2017, testified without the aid of an interpreter that he was an immigrant from Togo, a French speaking country in West Africa. Petitioner worked for Respondent from 2004, when he arrived in the United States, until late June of 2008. During his first year with Respondent, Petitioner's job was to gut carcasses. During his second year with Respondent, Petitioner's job was to push a car with carcasses. In 2006, Petitioner moved to rendering, where his job was to

"shovel meat and grease, dump them into barrel and lift them and dump them into the bin." Petitioner stated a full barrel weighed 90 to 100 pounds.

Petitioner worked in rendering at the time of the undisputed work accident. Petitioner testified that on January 29, 2008, near the end of his shift, he was shoveling grease outside in the snow when he felt a sharp pain in his low back and "couldn't walk." Petitioner reported the accident to his supervisor and received medication from the company nurse. That night, Petitioner continued to be in pain. The following day, Petitioner reported for work and advised his supervisor of the continued pain. The company nurse gave him an ice pack and Tylenol, and sent him back to his regular job. Petitioner stated he shoveled meat and grease all day, while in pain. Petitioner did not remember how many weeks he worked through the pain before Respondent sent him for treatment. The company nurse continued to give him ibuprofen, some other medication and ice packs, until one day Respondent decided to send him to a doctor. Petitioner denied ever having back pain or that kind of back pain before the accident.

Respondent initially sent Petitioner to Dr. Rhea Allen, who prescribed ibuprofen 800 and physical therapy, and referred Petitioner to Dr. Michael Dolphin. Petitioner testified he attended physical therapy for a period of time; "they" stopped it because it made the pain worse. Dr. Dolphin then sent Petitioner to a pain clinic for an injection. Petitioner received three epidural injections, but experienced no permanent relief of the pain. Dr. Dolphin discharged Petitioner from care, saying he had nothing more to offer, and released Petitioner to return to work.

In June of 2008, Petitioner attempted to return to his job in rendering. Petitioner testified he felt dizzy and could not stand. He also had pain in the low back that radiated down the right leg, as well as neck pain. Petitioner indicated the back pain had spread to the neck. Petitioner reported to the company nurse that he could not work. Petitioner stated Respondent told him to go home and seek treatment. If he felt better, he could return to work.

Regarding his further treatment, Petitioner testified that he consulted Dr. Purnendu Gupta at the University of Chicago. Dr. Gupta attributed the pain to Petitioner's scoliosis and recommended back surgery. After consulting Dr. Gupta, Petitioner consulted Dr. Rogelio Riera. Dr. Riera, in turn, referred Petitioner to Dr. Ronald Michael. Dr. Michael also recommended surgery. Additionally, Dr. Scott Glaser performed a discogram and Dr. Vasan Purighalla examined Petitioner on a referral from Dr. Lakshmi Alapati for a second opinion. When asked about Dr. Lanciloti, Petitioner stated that was his primary care provider, who referred him to another Dr. Gupta in Moline. Before Dr. Gupta in Moline returned to India, he referred Petitioner to Dr. Amanda Motto. When asked about Dr. Anseeuw, Petitioner stated that Respondent sent him to Dr. Anseeuw, who told him the "problem is not nerves." As to Dr. David Segal, Petitioner testified that Dr. Segal examined him and recommended surgery. At some point, Petitioner was granted Social Security disability benefits and Medicare.

Regarding his current condition, Petitioner testified that he has suffered from constant low back pain since 2008. The pain "spreads" to his groin area and neck, and has not improved. Petitioner receives medication from Dr. Motto or an emergency room.

The medical records in evidence show the following. A patient history questionnaire dated February 11, 2008, notes: "1/29/08, shoveling + dumping barrels (meat/guts) – all day long; c/o pain cervical area + low back area. 0 NTT into legs/arms; 0 pain into legs/arms[;] has been having pain almost 1 yr – medical dept gave Ibup + ice." On February 13, 2008, Petitioner saw Dr. Allen, who noted: "[The patient] has worked at [Respondent] for four years. Current job is flotation operator. He previously worked as a 'gutter.' His low back has really bothered him since the end of January, which he attributes to shoveling and dumping barrels of meat and guts all day long. The pain has been in his neck and his low back area, but he has not had any radiculopathy with it. He has been using over-the-counter ibuprofen a couple of tablets 2 or 3 times per day. They have had him restricted at work for the last three weeks or so." Physical examination findings were as follows: "Neck mostly has tenderness in the paraspinals and in the traps bilaterally but his range of motion is relatively well preserved. Strength, sensation, and DTRs are intact in the upper and lower extremities. He is tender over the lower lumbar spine, there is no obvious deformity. The hips appear to be a bit unlevel with right hip being a bit higher than the left." Cervical x-rays were unremarkable. The radiologist interpreted lumbar x-rays as showing "[s]ignificant curvature of the lumbar spine which is nonspecific but may be degenerative related to patient position or muscular spasm." Dr. Allen prescribed ibuprofen 800 and Skelaxin 800, ordered additional imaging studies of the lumbosacral spine, and imposed restrictions.

On February 25, 2008, Petitioner followed up, complaining of "[s]till having fair amount of pain. He is concerned because he gets a 'warm' sensation in the cervical area through his back and into his right leg, also has constant pain in his right knee. Apparently has to go up and down some steps at work, which really bothers him. Getting a headache from the neck pain." Petitioner reported working on light duty and not experiencing much relief from the medications. Physical examination was notable for subjective complaints of tenderness. Straight leg raise test was negative for radicular symptoms. Dr. Allen prescribed physical therapy, ordered an MRI to evaluate the scoliosis, and kept Petitioner on restricted duty. An MRI report dated February 25, 2008, states the following impression: "1. Mild to moderate levoconvex lumbar scoliosis. 2. Mild to borderline degree of canal stenosis at L3-L4. 3. There is evidence of a left foraminal shallow disc protrusion at L3-L4 resulting in some mild impingement upon the exiting left L3 nerve root. In addition, there is a shallow annular disc bulge encroaching upon the right exit foramina without associated nerve root compression at this level."

On March 3, 2008, Petitioner continued to complain of lumbar, neck and right knee pain, denying a work injury to the right knee. Dr. Allen noted the MRI findings. Physical examination was unchanged. Dr. Allen prescribed epidural steroid injections and kept Petitioner on restricted duty. On March 5, 2008, Dr. Timothy Miller performed an epidural steroid injection at L3-L4. On March 18, 2008, Petitioner complained to Dr. Allen of increasing pain in

the low back. He attributed the worsening low back pain to physical therapy. Physical therapy notes show Petitioner missed the first three scheduled therapy sessions, finally attending an initial evaluation on March 10, 2008. The physical therapist noted the following history: "He reports the onset of symptoms occurring initially one year ago, secondary to a shoveling incident while at work. He describes exacerbation of symptoms occurring 2/29/08, while again shoveling product at work." Petitioner rated the pain a 9/10. On March 12, 2008, Petitioner again told the physical therapist his pain was a 9/10. On March 14, 2008, physical therapy was placed on hold "per M.D.'s request today." On March 18, 2008, Dr. Allen discontinued physical therapy, refilled the Vicodin previously prescribed by Dr. Miller, kept Petitioner on restricted duty, and referred him to Dr. Dolphin, a spine surgeon.

On March 27, 2008, Petitioner consulted Dr. Dolphin, who noted the following: "[The patient] comes to our office for low back pain, localized throughout the right lower back which began after shoveling while working at [Respondent] whereby he felt a sharper pain throughout the right hip and buttock region and throughout the belt line. This pain was quite intense and now has evolved into more of a generalized deep ache in the anterior thigh on the right with associated weakness but no numbness or tingling." Petitioner rated the pain a 6-8/10, worse with activity. He reported physical therapy was discontinued after it significantly worsened his symptoms. He also reported no significant relief after an epidural steroid injection. On physical examination, Petitioner appeared in mild distress, complaining of generalized fatigue, right-sided low back pain and right thigh pain. "He ambulates with a marked antalgic gait favoring the right lower extremity and does not stand erect. He is listing to the left." Examination of the cervical spine was unremarkable. Examination of the lumbar spine was notable for "subjective weakness and achiness throughout the entire right thigh extending distally throughout the anterior knee terminating at the proximal tibia," as well as "localized tenderness throughout the right lumbosacral junction that extends laterally throughout the paraspinal musculature extending over the iliac crest." Dr. Dolphin noted that x-rays showed "significant lumbar scoliosis with approximately 3+ rotation." Dr. Dolphin generally agreed with the radiologist's reading of the MRI, also noting asymmetry of the right pedicle and right vertebral body of L5 and along the superior end plate of S1. Dr. Dolphin recommended a right-sided transforaminal epidural steroid injection at L3-L4 and a CT myelogram to evaluate the bony abnormalities at the L5-S1 disc space. He kept Petitioner on light duty.

On April 8, 2008, Dr. Miller performed a second epidural steroid injection. On April 18, 2008, Petitioner followed up with Dr. Dolphin, reporting no relief after the injection. "He continues to have severe pain throughout the right leg and thigh, worse with standing and walking, slightly improved with sitting or lying down." Petitioner also complained of dizziness, lightheadedness and severe headaches. Dr. Dolphin noted that a CT myelogram showed "minimal foraminal stenosis at L3-4, moderate spinal stenosis with foraminal narrowing at L4-5, and no significant neural pathology at L5-S1." Dr. Dolphin recommended an epidural steroid injection at L4-L5, discussed a decompression laminectomy at that level, and kept Petitioner on light duty.

On June 10, 2008, Dr. Miller performed a third epidural steroid injection. On June 19, 2008, Petitioner followed up with Dr. Dolphin, reporting no significant improvement after the injection. "He says that his right leg continues to give him pain with cramping occasionally into the calf. He says it happens even when he is sleeping. He also had a sharp pain in the right side of his back, most recently when he was operating a pump." Petitioner also complained of difficulty with activities that required his head to be in an upright position for more than 20 to 30 minutes, such as reading a book or looking at a computer. Additionally, he complained of persistent pain in the right knee. Physical examination of the spine was benign. Dr. Dolphin stated: "With respect to his low back, at this point I have nothing further to offer him. He did not really get much relief with the epidural steroid injections and as such I do not think that surgical intervention will help him. Unfortunately I have no further treatment options to offer him and as such I recommend that he follow up with Dr. Rhea Allen. Perhaps he should be placed at maximum medical improvement." Dr. Dolphin thought Petitioner's neck complaints could be related to muscular fatigue and tension headache.

On July 7, 2008, Petitioner saw Dr. Alapati with complaints of severe low back pain after a work injury. Dr. Alapati referred Petitioner to Dr. Purighalla, a neurosurgeon. On July 24, 2008, Petitioner saw Dr. Alapati and requested pain medication. Dr. Alapati prescribed Darvocet, tramadol and ibuprofen 800.

On July 31, 2008, Petitioner was treated in the emergency room for complaints of back pain, headache and weakness with severe dizziness. A CT scan of the head was negative for abnormalities in the brain.

On August 8, 2008, Petitioner saw Dr. Purighalla for a second opinion. Dr. Purighalla noted a history of "back pain radiating into the lower extremities, more so on the right than the left for several months, gradually getting worse. He stated that he injured himself at work working at [Respondent]. He says that he has to use a rake and pick up guts and throw them in the gut bin. He injured himself while doing this." Physical examination was notable for decreased lumbar range of motion because of the pain. Dr. Purighalla also noted the MRI findings. Dr. Purighalla assessed "[b]ack pain radiating to both lower extremities, the right more than the left, possibly secondary to mild to moderate degree of lumbar spinal stenosis at L3-4 level and also some degenerative changes in the disc at that level." Dr. Purighalla recommended conservative treatment, stating: "I am not seeing anything structurally abnormal to consider any surgical options."

On August 14, 2008, Petitioner saw Dr. Jeffery Jauron, reporting poorly controlled back pain despite being on cyclobenzaprine, Ultram, propoxyphene and Darvocet. Dr. Jauron prescribed Tizanidine and hydrocodone-acetaminophen, and ordered an orthopedic consult. On August 21, 2008, Petitioner followed up with Dr. Jauron, rating the pain an 8-9/10 on the medications. Dr. Jauron prescribed Prednisone.

On September 3, 2008, Petitioner returned to Dr. Dolphin, reporting "there is no light duty for him at his job. He says he is having significant difficulty with any even minimal activities of daily living. He has difficulty standing for more than 20 minutes with an increase in his right leg pain. He also has difficulty lifting his child or driving. He has been off work for 3 months and has had a second opinion. He has numerous questions today and is somewhat frustrated." Dr. Dolphin reviewed the second opinion from Dr. Purighalla and stated: "It is unfortunate at this point that I do not feel that I have anything to offer him from a surgical standpoint. I have exhausted all efforts at attempting to make his symptoms improve. We tried physical therapy, epidural steroid injections, and activity modification. I attempted to let him return to work with light duty, but he reports that this was not possible." Dr. Dolphin recommended considering a functional capacity evaluation for permanent restrictions, and declared Petitioner at maximum medical improvement.

On September 20 and December 10, 2008, Petitioner was treated in the emergency room for complaints of back pain. In the interim, on October 15, 2008, Petitioner saw Dr. Alapati for complaints of back pain.

On December 29, 2008, Petitioner consulted Dr. Brian Anseeuw about low back pain with numbness in the right leg. Dr. Anseeuw noted: "He states that he was injured on the job in January of 2008 while he worked at [Respondent]. He was shuttling and dumping heavy objects when he felt an immediate pain in his low back which radiated into the right leg and the knee." Petitioner reported that despite the treatment, "his pain has essentially been unchanged from the time of injury. *** He has difficulty sitting as well as doing his normal activities of daily living. He is now developing neck pain and also some headaches." Dr. Anseeuw recommended electrodiagnostic studies. On January 15, 2009, Petitioner continued to complain of severe pain. Dr. Anseeuw noted the electrodiagnostic studies were normal. He reviewed the MRI, reexamined Petitioner, and stated: "His workup has shown no significant abnormalities" and "his problem is not neurological and most likely he may benefit from a pain clinic."

On February 18, 2009, Petitioner consulted Dr. P. Gupta, a scoliosis and spine surgeon at the University of Chicago, complaining of "back pain, leg pain, neck pain and arm pain. He states that he has seen other physicians who have recommended surgical treatment." Petitioner rated the back and neck pain a 9/10 and reported being limited by the pain. He walked with an antalgic gait and complained of significant pain with forward bending. Dr. Gupta noted a significant genu varum of the right lower extremity and a pelvic obliquity with the right hemipelvis being elevated and an evident lumbar curve. Physical examination was otherwise benign. X-rays of the thoracolumbar spine showed "a significant pelvic obliquity and a large lumbar scoliosis." Dr. Gupta ordered MRI studies of the cervical and lumbar spine, noting: "There is a significant incidence of congenital abnormalities as well as spinal axis abnormalities with congenital malformations." Dr. Gupta took Petitioner off work. On March 4, 2009, Petitioner continued to complain of severe spinal pain. He also complained of severe headaches. This time, Petitioner ambulated with a normal gait. Physical examination was notable for "kyphosis at the lumbosacral junction on ambulation with significant pelvic obliquity." Physical

examination was otherwise benign. Dr. Gupta reviewed a CT scan, which showed "a hemivertebra in the posterior lumbar spine," a congenital abnormality. Dr. Gupta recommended a lumbar decompression and excision of the hemivertebra, and kept Petitioner off work. Petitioner then underwent further extensive imaging studies. Of significance is a CT scan report dated March 24, 2009, finding: "1. Right hemivertebra at S1 with associated degenerative changes and vertebral compression ***. 2. Mild levoscoliosis of the lumbar spine *** secondary to right S1 hemivertebra." An MRI of the cervical spine performed March 4, 2009, showed a mild central and right paracentral disc protrusion at C5-C6.

In June and July of 2009, Petitioner underwent additional several sessions of physical therapy on a referral from Dr. John Lanciloti. Petitioner demonstrated distress and reported significant disability, rating the pain a 9/10. A chart note dated July 6, 2009, states Petitioner denied any decrease in the pain after using a TENS unit for three days. The physical therapist stated: "This was essentially a last effort as interventions to this point have not yielded any kind of change in his symptoms therefore his functional level. He scored a 13 on the Back Outcome Scale. Oswestry quite high a 77%. Pain rating is very high at 9/10. Fear Avoidance Belief Questionnaire high on both scales." On November 16, 2009, Dr. Lanciloti sent Petitioner a letter stating he was moving out of the area and recommending Dr. B. Gupta or Dr. Motto as primary care providers.

In 2009 and 2010, Dr. Miller performed cervical and additional lumbar epidural steroid injections. Petitioner reported no improvement from the injections.

On November 19, 2009, Petitioner was treated in the emergency room for complaints of back pain. A CT scan of the lumbar spine performed that day showed "[m]ild degenerative changes without acute osseous injury."

On May 12, 2010, Petitioner consulted Dr. Riera, who noted: "[The patient] had an accident while at work in the year 2008. *** At present time, he is not working. The main complaint is pain in the lower back with radiation to the right leg, numbness and tingling sensation in the same leg. *** He also complains of pain along the cervical thoracic area with limitation and numbness of the left upper extremity." Dr. Riera noted that Petitioner walked with an antalgic gait. On physical examination, Petitioner complained of tenderness and pain with palpation and diagnostic maneuvers. Dr. Riera noted Petitioner's scoliosis and reviewed medical records from Dr. P. Gupta. Dr. Riera agreed that Petitioner needed surgery, referred him to Dr. Michael, a neurosurgeon, and restricted him from working. A cervical spine MRI performed May 12, 2010, showed a small central protrusion at C5-C6. A lumbar MRI, also performed May 12, 2010, was interpreted by the radiologist as showing: "1. Bulging of the L2-3 through L4-5 discs. 2. Narrowing of the foramina L2-3 through L5-S1. 3. Mild-moderate spinal stenosis, partly congenital. 4. S1 vertebral anomaly."

On May 24, 2010, Petitioner saw Dr. Michael, who noted: "[The patient] suffered a work-related injury on 1/28/08. He was shoveling and lifting heavy buckets of meat and grease,

weighing perhaps 80-100# each. He was also shoveling grease outside. He felt a sharp pain in his low back." Petitioner complained of severe low back pain, much worse than the right leg pain, and reported his condition had progressively worsened. Dr. Michael noted: "MRI of the lumbosacral spine demonstrated L3-4 worse than L4-5 disc protrusions and herniations. There is an S1 right vertebral. There is possible right L5 spondylosis. There was associated scoliosis." Dr. Michael recommended a lumbar discogram and kept Petitioner off work.

On June 29, 2010, Dr. Michael noted that Petitioner added the complaints of "neck pain, which he had at the time of the injury. He has right arm pain. He has right upper extremity numbness and tingling. He complains of weakness in the right upper extremity." Petitioner also complained about his right knee. Dr. Michael noted that "[l]umbar discogram demonstrated L3-4 pathology per Dr. Glaser." A review of Dr. Glaser's discography report shows that he noted a "greater than 7/10 concordant right lower back pain radiating into the buttock" at L3-L4. Dr. Glaser therefore believed there was moderate degeneration and posterior annular tear. However, the post-discogram CT scan showed the L3-L4 disc to be "intact and unremarkable. No obvious disk bulges, protrusions, or herniations were seen." The post-discogram CT scan report did note "significant scoliosis with spina bifida occulta deformity of the posterior elements, especially on the left" at L5-S1, as well as a developmental anomaly of the left transverse process and suspicion of partial hemivertebra in the right sacrum. Dr. Michael recommended "posterior lumbar fusion," without specifying the level(s).

Respondent obtained a utilization review. A prospective utilization review report dated September 2, 2010, denied the posterior lumbar fusion recommended by Dr. Michael, summarizing the reasons as follows: "The claimant is a 40-year-old male diagnosed with chronic back and leg pain, which have been reported to be resistant to non-operative treatment. The neurological exam and electrical studies have been noted to be normal. An MRI on 05/12/10, revealed multi-level disc protrusions and facet arthrosis with some areas of stenosis. A discogram reportedly showed pathology at L3-4. Based on the ODG, there has been no x-ray criteria (flexion-extension) revealing segmental instability, and there has been no evidence of a psychosocial screen. Without these being evident, the medical necessities of the proposed procedures have not been established at this time." A retrospective utilization review report dated September 15, 2010, denied discography as being generally unreliable in identifying pain generators.

On September 21, 2010, Petitioner complained to Dr. Michael of severe and worsening low back pain, much worse than his right leg pain. Dr. Michael was awaiting approval for the surgery. On November 2, 2010, Petitioner again voiced neck and right arm complaints in addition to the low back and right leg complaints. Dr. Michael continued to await approval for the surgery, prescribed lumbar epidural steroid injections in the interim, and kept Petitioner off work.

In a letter to Petitioner's counsel dated November 9, 2010, Dr. Miller recommended a second surgical opinion "given poor response to conservative treatment."

On March 9, 2011, Petitioner returned to Dr. Miller with complaints of persistent right leg pain. Dr. Miller did not think any further conservative treatment would help. He recommended a repeat MRI and another opinion from Dr. Millea, Dr. Chapman or Dr. Segal. Contemporaneously, Dr. Miller wrote to Petitioner's counsel, stating among other things: "The previous MRI did not suggest a strong case for surgery however, things could have changed in the interim."

On May 31, 2012, Petitioner received emergency treatment for multiple injuries he sustained in a motor vehicle collision.

On September 18, 2012, Petitioner returned to Dr. Riera, requesting a lumbosacral MRI before his appointment with Dr. Segal. Dr. Riera ordered a repeat MRI and kept Petitioner off work.

On November 13, 2012, Petitioner saw Dr. Segal, a brain and spine surgeon, on a referral from Dr. Riera. Dr. Segal noted a history of sudden onset of low back pain with injury while lifting a heavy object four years earlier. "Associated symptoms include decreased mobility, joint pain, limping, numbness in the right thigh, sexual dysfunction, spasms, tingling in the legs, weakness in the right leg & arm and numbness and tingling in the right foot." Petitioner localized his low back pain to L3-L4 on the right side, radiating down the right leg. Dr. Segal noted that Petitioner ambulated with an antalgic gait, "unable to toe-walk on the right due to pain/weakness." Dr. Segal reviewed an MRI from September of 2012, stating: "The primary finding is at L3-L4, which is very degenerative and has a herniation toward the right. There is moderate levoscoliosis of the lower lumbar spine and lumbosacral junction." Dr. Segal diagnosed "[d]iscogenic pain and right L3 radiculopathy from L3-L4 disc, by patient's history related to the work injury," and recommended fusion surgery at L3-L4. He also referenced the discogram results. Dr. Segal kept Petitioner off work.

Emergency room records from Genesis Health System show that in March of 2012, June of 2012, February of 2013, September of 2013 and May of 2014, Petitioner received emergency treatment for complaints of worsening back pain which was not responding to medication. His health insurance each time was noted to be Medicare and Medicaid.[1]

On September 9, 2013, Petitioner saw Dr. Motto, a family practitioner, and reported a flare-up of back pain during his recent trip to Africa. On May 19, 2014, Petitioner followed up after being seen in the emergency room and prescribed Ultram and Robaxin. Petitioner complained the Ultram and Robaxin were not helping at all. Dr. Motto discontinued the Robaxin, refilled hydrocodone-acetaminophen,[2] prescribed cyclobenzaprine, and ordered a pain

[1] It appears Petitioner was granted Medicare coverage sometime in 2011. Before then he was on Medicaid.

[2] Dr. Motto had been prescribing hydrocodone-acetaminophen since May of 2013. Before then, she was prescribing Tramadol, refusing Petitioner's request for Vicodin.

management consult. On June 9, 2014, Petitioner presented for an annual physical examination. Petitioner's list of active problems was as follows: abnormal electrocardiogram, backache, chest pain, cough, dermatitis, fatigue, folliculitis, headache, herniated nucleus pulposus, hyperlipidemia, lower back pain, lumbar radiculopathy, lump of skin, acute mid-back pain, and neck pain. Petitioner appeared healthy and in no acute distress. Physical examination was normal.

Dr. Purighalla testified by evidence deposition on April 30, 2012, that Petitioner was referred by Dr. Alapati for a second opinion. At the time of the examination, Dr. Purighalla did not think Petitioner required surgery.[3]

Dr. Dolphin testified by evidence deposition on April 15, 2016, that when he initially saw Petitioner, he thought Petitioner's low back pain and possibly a right-sided disc herniation at L3-L4 "would have been related to the injury." The vertebral body and pedicle asymmetry at L5 were not related to the work accident. After obtaining a CT myelogram, which showed "stenosis primarily between L3 and L4 and L4 and L5," but no herniation, Dr. Dolphin opined "none of those findings were acute so I would not attribute any of those findings directly to the work injury." Dr. Dolphin affirmed that ultimately he did not think surgery would help, since Petitioner did not get much relief from the epidural steroid injections. Dr. Dolphin opined Petitioner was at maximum medical improvement as of June 19, 2008 from the spine surgery standpoint, leaving Dr. Allen to make a final determination regarding maximum medical improvement from the occupational medicine standpoint.

When asked to comment on the medical records from Dr. Anseeuw and Dr. P. Gupta, Dr. Dolphin explained that a hemivertebra is a congenital defect where one of the vertebrae does not form completely. A hemivertebra can become symptomatic with performance of activities of daily living or no activity at all. Dr. Dolphin did not diagnose Petitioner's right S1 hemivertebra as being the source of his complaints related to the work accident. Dr. Dolphin also questioned whether the L3-L4 or L4-L5 level was the pain generator, stating: "We did not really find a pain source." Regarding Petitioner's subsequent complaints, Dr. Dolphin opined that "any complaints in 2010 would be unrelated to 2008," explaining: "[I]n 2008 we did not determine the source of his discomfort to be specifically related to any particular nerve injury or nerve compression or nerve source. ¶ My evaluation and treatment didn't help him, Dr. Anseeuw's evaluation didn't determine a nerve source for his complaints."

Dr. P. Gupta testified by evidence deposition on December 8, 2016, that he specialized in "major spinal reconstructions whether cervical, thoracic, or thoracolumbar." Dr. Gupta did not obtain a history of how Petitioner was injured because he focused on the etiology of the problem, rather than medicolegal issues. Dr. Gupta explained that a hemivertebra is a congenital abnormality that usually causes scoliosis and pelvic obliquity. After reviewing medical records from Dr. Dolphin and Dr. Anseeuw, which he did not have during his evaluation of Petitioner, Dr. Gupta testified that it is possible for a previously asymptomatic hemivertebra and pelvic

[3] The entire deposition transcript is eight pages long.

obliquity to become symptomatic as a result of repeatedly lifting and shoveling heavy loads of meat and grease. Dr. Gupta explained that a hemivertebra "also leads to this development of a curvature with a concavity, in this case on the right side, convexity on the left; and then over time, those areas are subject to increased stress and strain when bending and lifting activities are performed." Dr. Gupta opined the accident on January 29, 2008, as Petitioner described it to Dr. Dolphin and Dr. Anseeuw, "was the inciting event, the precipitating event," as "the patient was repetitively bending, lifting, and shoveling and whatnot; and that is the repetitive stress and strain on the lumbar spine, especially those heavy loads. ¶ The twisting, bending, lifting activities are known cause of stress and strain on the lumbar spine. In this particular instance, whatever load he was shoveling at that time is when he was injured and became symptomatic." Dr. Gupta also believed the strain of repetitive lifting, bending and carrying heavy loads of meat for a period of two years could have accelerated the wear and tear on the spine, in addition to causing the hemivertebra to become symptomatic. The surgery Dr. Gupta recommended was a resection of the hemivertebra to help correct the scoliosis and pelvic obliquity and to decompress a significant spinal canal stenosis. Dr. Gupta believed the proposed surgery could address Petitioner's pain, which he thought was due to significant spinal and foraminal stenosis.

Dr. Gupta disagreed Petitioner was at maximum medical improvement at the time of his evaluation, explaining: "[W]hen I met the [patient] in 2009 he still had pain, so it is hard to believe that he was at MMI as he was still having pain when I met him, and this MRI [obtained by Dr. Allen] demonstrates findings which are consistent with the MRI from the University of Chicago indicating nerve compression." Dr. Gupta continued: "So the [patient] can have leg pain due to nerve compression from the L3-4 and L4-5 area which would be in his right leg as he described to me in his posterior thigh, posterior calf, and ankle. So the stenosis is consistent with his symptoms and presentation." Dr. Gupta thought Petitioner's repeated visits to the emergency room for complaints of pain evidenced the pain was ongoing.

On cross and redirect examinations, Dr. Gupta testified that his causation opinions were based on Petitioner being asymptomatic before January 29, 2008. Dr. Gupta acknowledged a hemivertebra could become symptomatic with activities of daily living or no activity at all.

Dr. Michael testified by evidence deposition on February 21, 2017, that he diagnosed a disc protrusion with discogenic pain at L3-L4. He also noted a disc protrusion at L4-L5 and a hemivertebra at right S1 with associated scoliosis. Dr. Michael did not believe Petitioner was suffering from nerve impingement. Dr. Michael also did not think Petitioner's hemivertebra, scoliosis and pelvic obliquity caused his pain. Rather, Dr. Michael thought "[i]t's a mechanical problem. It's a problem of a mechanical structure, the disc having been damaged, and therefore, losing its functional and structural integrity." Dr. Michael maintained "it's internal disc disruption and discogenic pain that's causing the pain." Dr. Michael recommended a posterior lumbar fusion (presumably at L3-L4). Dr. Michael did not believe the hemivertebra, scoliosis and pelvic obliquity needed to be treated, stating that people with these conditions could live their entire lives pain free. Dr. Michael was very critical of Respondent's utilization review, stating it did not comport with the standard of care.

Regarding causation, Dr. Michael opined the work activities described by Petitioner could cause a back injury. When asked whether "it [was] the weight [Petitioner] was carrying for his employer that caused this pain," Dr. Michael answered in the affirmative. Dr. Michael opined the L3-L4 disc was damaged as a result of the work activities Petitioner performed on January 29, 2008. Petitioner's counsel then asked Dr. Michael's causation opinion based on a hypothetical that until January 29, 2008, Petitioner "had worked all his life without pain. And before January 29, 2008, Petitioner has a preexisting hemivertebra, scoliosis and pelvic obliquity. But despite these preexisting condition, Petitioner worked for [Respondent] without pain. ¶ [B]efore his injury *** on January 29, 2008, Petitioner had worked at least two years preceding that date, loading and shoveling between 80 to 100 pounds of grease and meat for [Respondent]. I want you to assume that for the first time on January 29, 2008 while Petitioner was lifting 80 to 100 pounds of meat and shoveling grease, he felt sharp pain in his back. Ever since that date of January 29, 2008, Petitioner has not had total relief from pain except temporarily by medication, epidural injection and therapy." Dr. Michael opined "that injury caused all of his symptoms. The mechanism is sufficient. The level, namely, L3-4, being a higher level than we typically see with, say, long-standing conditions is usually considered traumatic. In other words, the degenerative levels, the long-standing levels are lower." Dr. Michael continued: "And so absent any other knowledge of trauma, this is the only trauma I know—this is the only trauma that I have to conclude caused the symptomatology." Dr. Michael maintained the specific accident Petitioner's counsel described caused damage to the disc at L3-L4, namely, the disc "was torn—there were annular tears in the capsule as evidenced by the discogram." When asked again for his causation opinion, Dr. Michael stated: "I believe that if one looks at the history, he's fine one day; he then has this work injury, and he's no longer fine. In other words, he's symptomatic. *** Commonsense tells us that the work injury caused the symptomatology."

On cross-examination, Dr. Michael testified his causal connection opinions were based on the accuracy of Petitioner's history and the hypothetical posed by Petitioner's counsel.

The Arbitrator found Petitioner's condition of ill-being to be causally connected to the accident; *i.e.*, the condition of ill-being has not reached maximum medical improvement. For the reasons that follow, the Commission disagrees and finds that Petitioner was at maximum medical improvement as of June 19, 2008. The Commission denies temporary total disability and medical benefits after that date.

At the outset, the Commission notes that Petitioner testified to a specific accident on January 29, 2008. However, his application for adjustment of claim is for repetitive trauma. Petitioner's treaters and examiners variously noted a specific accident and repetitive trauma. In his testimony, Petitioner denied prior low back pain, which is contrary to early medical records.

The Commission further notes that over a period of nine years, Petitioner complained to his treaters of severe pain, usually rating it an 8-9/10. However, the electrodiagnostic studies were negative. Dr. Dolphin, Dr. Purighalla and Dr. Anseeuw were never able to find a pain

generator, while Dr. Michael and Dr. Segal thought the pain came from the L3-L4 level based on the discogram performed by Dr. Glaser. Dr. Michael causally connected the perceived pathology at L3-L4 based on a hypothetical of specific accident on January 29, 2008, and no prior spinal pain, which is contrary to Petitioner's application for adjustment of claim and the early histories Petitioner provided. Dr. Michael opined the specific accident Petitioner's counsel described caused damage to the disc at L3-L4; namely, the disc "was torn—there were annular tears in the capsule as evidenced by the discogram." However, the post-discogram CT scan showed the L3-L4 disc to be "intact and unremarkable. No obvious disk bulges, protrusions, or herniations were seen." Dr. Michael did not believe there was any nerve impingement. He also did not think Petitioner's hemivertebra, scoliosis and pelvic obliquity caused the pain. Dr. P. Gupta, on the other hand, thought the pain could be due to nerve compression at the L3-L4 and/or L4-L5 levels or the hemivertebra at S1. Dr. Gupta's causation opinions were also based on Petitioner being asymptomatic until January 29, 2008.

As noted, the record shows significant congenital abnormalities of the lumbar spine. Multiple imaging studies showed a congenital hemivertebra at S1 and associated scoliosis. A post-discogram CT scan showed "significant scoliosis with spina bifida occulta deformity of the posterior elements, especially on the left" at L5-S1, as well as a developmental anomaly of the left transverse process and a hemivertebra in the right sacrum. Dr. Gupta recommended a resection of the hemivertebra to help correct the scoliosis and pelvic obliquity and to decompress a significant spinal canal stenosis. Dr. Michael and Dr. Segal recommended fusion surgery at L3-L4. Dr. Michael did not think the hemivertebra, scoliosis and pelvic obliquity needed to be treated, stating that people with these conditions could live their entire lives pain free. Dr. Dolphin, Dr. Purighalla and Dr. Anseeuw did not believe any surgery would help Petitioner. It bears emphasizing that Petitioner's electrodiagnostic studies were normal and his post-discogram CT scan showed the L3-L4 disc to be "intact and unremarkable. No obvious disk bulges, protrusions, or herniations were seen." The Commission notes evidence of doctor shopping.

The Commission finds the many conflicting medical opinions fail to establish causation by a preponderance of the evidence. The Commission underscores the causation opinions in Petitioner's favor are based on Petitioner being asymptomatic until January 29, 2008, which is controverted by the early medical records. The causation opinions in Petitioner's favor also assume Petitioner was truthful and did not magnify his symptoms. However, the voluminous medical records show significant symptom magnification. Having carefully considered all the evidence before us, the Commission is persuaded by the testimony of Dr. Dolphin that Petitioner was at maximum medical improvement as of June 19, 2008.

Respondent has timely filed a request for special findings pursuant to section 19(e) of the Act and Commission Rule 7040.40(B) [*sic*], to which the Commission responds as follows:

"Interrogatory 1: When writing that he reviewed the 'record taken as a whole,' how can the Arbitrator rule on causal connection without mentioning the opinions of the back surgeon

who treated Petitioner for the first eight months following the accident?" The Commission has carefully reviewed the entire record *de novo*, including the opinions of Dr. Dolphin.

"Interrogatory 2: Is the causal connection testimony from Dr. Dolphin, who treated Petitioner during the initial eight months following the accident, more credible about Petitioner's condition at that time than Dr. Gupta, who did not first see Petitioner until more than a year after the accident and had no records from Petitioner's prior medical treatment, and Dr. Michael, who did not first see Petitioner until two years and four months after the accident and also had no records from Petitioner's prior medical treatment?" For the reasons discussed, the Commission gives greater weight to the opinions of Dr. Dolphin.

"Interrogatory 3: Where the evidence shows that Petitioner exhibited no L3-4 or L4-5 abnormalities until two years and four months after the accident, is the appropriate finding that there is no causal connection between the accident and the L3-4 and L4-5 abnormalities as of May 12, 2010, and why?" The imaging evidence is not so clear-cut, while the electrodiagnostic studies were normal. None of the findings at L3-L4 and L4-L5 were considered acute. That being the case, the Commission's decision ultimately turns on Petitioner's credibility as to the cause and severity of his pain.

"Interrogatory 4: Is the foundation and credibility of Dr. Gupta's causal connection testimony diminished when he had no records from Petitioner's medical treatment during the first year and one month after the accident, and Dr. Michael's causal connection testimony when he had no records from Petitioner's medical treatment during the two years and four months following the accident?" Dr. Gupta and Dr. Michael based their causation opinions on the chain of events. Dr. Michael also thought the L3-L4 disc was structurally damaged, which is contrary to the post-discogram CT scan. The strength of their opinions depends on Petitioner's credibility as to the cause and severity of his pain. For the reasons discussed, the Commission gives lesser weight to the causation opinions of Dr. Gupta and Dr. Michael.

"Interrogatory 5: Are temporary total disability benefits properly denied where a person is directed to return to work and there is no restriction slip or medical direction for off-work status?" The Commission has found that Petitioner was at maximum medical improvement as of June 19, 2008. The question of temporary total disability is therefore moot.[4]

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

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

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[4] Petitioner claims temporary total disability benefits beginning June 30, 2008.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence through June 19, 2008 pursuant to §§8(a) and 8.2 of the Act. The award of medical benefits after June 19, 2008, including prospective medical care, is vacated. Respondent is entitled to a credit under §8(j) of the Act for the medical benefits that have been paid, provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving this credit.

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

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

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

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

NOV 21 2018

DATED:
o-10/11/2018
SM/sk
44

Stephen Mathis

Deborah Simpson

DISSENT

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

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

AGBEZOUHLON, KOAMI
Employee/Petitioner

Case# **08WC016193**

TYSON FOODS INC
Employer/Respondent

18IWCC0711

On 8/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

5271 LEADERS LAW CENTER LLC
OWOLABI ALABA
684 W BOUGHTON RD SUITE 204
BOLINGBROOK, IL 60440

2593 GANAN & SHAPIRO PC
PAUL D DYKSTRA
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

18IWCC0711

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)

Koami Agbezouhlon
Employee/Petitioner

v.

Tyson Foods, Inc.
Employer/Respondent

Case # 08 WC 16193

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **4/4/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/29/09**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$24,544.00**; the average weekly wage was **$472.00**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's exhibit 1, with the exception of expenses incurred as a result of treatment by Dr. P. Gupta, Dr. Riera, and/or Dr. Michael, or at their referral, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Segal, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $314.67/week for 457 weeks, commencing 7/1/08 through 4/3/17, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for temporary total disability benefits that have been paid.

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

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

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

Michael K. Nowak, Arbitrator — 8/10/17 Date

ICArbDec19(b)

AUG 25 2017

FINDINGS OF FACT

Petitioner began working for Respondent in 2004. On January 29, 2008 Petitioner sustained an undisputed accident resulting to injuries to his neck and back while shoveling grease outside in the snow.

Petitioner initially saw Dr. Allen, an occupational medicine physician on referral by Respondent, on February 11, 2008. Dr. Allen recorded complaints of pain in the neck and the low back, which Petitioner associated with the January 29, 2008 accident. Petitioner underwent a lumbar MRI scan at Ramic medical imaging on February 25, 2008. The radiologist who performed the study wrote that the study showed mild to moderate lumbar scoliosis, mild to borderline L3-4 canal stenosis, a left L3-4 shallow disc protrusion resulting in mild impingement of the left L3 nerve root, and an annular bulge at L3-4 on the right.

Dr. Allen referred Petitioner to Dr. Miller for epidural steroid injections. Dr. Miller performed those injections on March 5, 2008 at L3-4, on April 3, 2008 at L3-4, and on June 10, 2008 at L4-5.

Dr. Allen also referred Petitioner to Dr. Dolphin, a spine surgeon. Dr. Dolphin initially saw Petitioner on March 27, 2008, noting Petitioner's complaints of pain in the neck and low back. Dr. Dolphin initially diagnosed Petitioner as suffering from low-back pain, degenerative disc disease with mild spinal stenosis and right-sided herniation at L3-4, and right vertebral body and pedicle asymmetry at L5. Dr. Dolphin recommended an epidural steroid injection on the right side at L3-4 and a CT myelogram of the lumbar region.

Petitioner underwent the CT myelogram of the lumbar region on April 7, 2008. The radiologist who performed the study wrote that the study showed annular bony distal ligamentum flavum hypertrophy with minimal central canal stenosis at L2-3, annular bulging of the distal ligamentum flavum hypertrophy with moderate spinal stenosis at L3-4, annular bulging of the distal ligamentum flavum hypertrophy with minimal spinal stenosis at L4-5, and an unremarkable L5-S1. The impression was lower lumbar bulging disc and ligamentum hypertrophic changes with mild to moderate spinal stenosis at L3-4 and L4-5 and no focal disc herniation, compression fracture, or gross abnormalities of the visualized nerve roots.

Petitioner returned to Dr. Dolphin on April 18, 2008. Noting the results of his CT scan and a lack of improvement with the epidural steroid injection at L3-4, Dr. Dolphin recommended an epidural steroid injection at L4-5.

On May 14, 2008 Petitioner was seen by his family physician, Dr. Alapati. Dr. Alapati was the first physician to see Petitioner since the accident other that those chosen by Respondent. Dr. Alapati ultimately referred Petitioner to Dr. Purghilla. (PX 10 p. 279)

On June 19, 2008, Dr. Dolphin noted that Petitioner had undergone the series of three epidural steroid injections without significant relief. Dr. Dolphin did not feel that Petitioner needed any further medical treatment to the low back, and did not need surgery, because of the results of the MRI scan, the CT/myelogram, and the lack of response to injections. Dr. Dolphin also felt that Petitioner did not need any further medical treatment for the neck.

Up to this point Petitioner had continued to work modified duty. On 06/30/08, Petitioner was returned to full duty with a change of duty from working a "gutter" position to being a "flotation operator" and ceased working due to back pain.

Petitioner saw Dr. Purighalla on August 8, 2008. Physical examination of petitioner showed petitioner had positive straight leg raising test on the right side and decrease range of motion secondary to back pain. (PX 4)

Dr. Purighalla assessed petitioner with cervicalgia, low back pain, pain in the limb, back pain radiating to both lower extremities, the right more than the left, possibly secondary to mild to moderate degree of lumbar spinal stenosis at L3-L4 level and some degenerative changes in the disc at that level. The plan of treatment was to try more conservative therapy in the form of continued pain medication and if that did not help, add physical therapy/chiropractic therapy. If these measures did not help, Dr. Purighalla planned to have petitioner undergo epidural steroid injections, or selective nerve blocks. Dr. Purighalla reviewed the MRI and did not see anything structurally abnormal to consider surgical options. *Id.* It appears Respondent never approved the nerve blocks suggested by Dr. Purighalla.

On August 14, 2008 Petitioner was seen by Dr. Jeffrey Jauron in the doctor's clinic.

Petitioner returned to Dr. Dolphin on September 3, 2008. After reviewing Dr. Purighalla's report, Dr. Dolphin agreed that Petitioner was not a surgical candidate. He felt that Petitioner attained maximum medical improvement and may need a functional capacity evaluation to assess work restrictions, but left the decision to Dr. Allen.

On August 21, 2008, Petitioner was seen at the Emergency unit of Genesis Hospital. Dr. Jeffery M. Jauron was listed as the admitting physician. Subsequently Petitioner was admitted at the Emergency Room of Genesis Medical Center on September 20, 2008, December 10, 2008, July 22, 2009, and November 19, 2009 with Dr. Jauron listed as the admitting physician.

On September 3, 2008 Petitioner followed up with Dr. Dolphin complaining that there was no light duty for him at his job. He said he was having significant difficulty with any even minimal activities of daily living. Petitioner had difficulty standing for more than 20 minutes with an increase in his right leg line. He also had difficulty lifting his child. Petitioner had been off work for 3months. Dr. Dolphin recommended a functional capacity evaluation to put him at permanent restrictions. (PX 3 p. 83)

On October 15, 2008 Petitioner saw Dr. Alapati complaining of severe low back pain resulting from his work place injury. (PX 10 p. 275). Petitioner stated his symptoms were getting worse. He described his pain as throbbing radiating to the buttocks, thigh and posterior leg. Petitioner could not fully extend, flex. Petitioner could not sit with comfort. His pain was worsened by bending, lifting, standing straight and sitting.

Dr. Alapati ceased practicing in the area. Petitioner credibly testified that prior to leaving the area Dr. Alapati referred him for further treatment to Dr. Lanceloti. Dr. Lanceloti, referred Petitioner to Dr. Anseeuw, a neurologist.

On December 29, 2008 Petitioner presented to Dr. Anseeuw for evaluation. (PX p. 90). Dr. Anseeuw assessed petitioner with low back pain, radicular syndrome of lower limbs. He did not "see any obvious long tracks signs." *Id.* He recommended EMG and nerve conduction units.

On January 15, 2009 Petitioner returned to Dr. Anseeuw for follow-up. (PX 5 p. 92). Dr. Anseeuw noted, "workup has been inconclusive" and that petitioner continued to complain of severe pain. He wrote: "from this, his problem is not neurological and most likely he may benefit form a pain clinic." However, Dr. Anseeuw's neurological examination showed bilateral symmetrical hyopreflexic, plantar response down, lumbar spine ROM decreased, tenderness on palpation. Orthopedic testing post tripods sign, SLR, WLR, were negative. *Id.*

Petitioner sought medical treatment with Dr. Purnendu Gupta, a back surgeon, on February 18, 2009. Dr. Gupta recorded a history of Petitioner complaining of low-back and leg pain as well as neck pain. Radiographic studies revealed significant pelvic obliquity and a large lumbar scoliosis. (PX 6, p. 602). Dr. Gupta diagnosed Petitioner with pelvic obliquity and lumbar scoliosis. *Id.* Dr. Gupta was concerned that Petitioner might have a tethered cord. Dr. Gupta noted that there was a significant incidence of congenital abnormalities as well as spinal axis abnormalities with congenital malformations. Dr. Gupta recommended MRI scans of the lumbar region and the pelvis as well as a CT scan of the lumbar region. Dr. Gupta felt that Petitioner might require a significant lumbar decompression and instrumented fusion to address the lumbosacral junction and ordered petitioner not to return to work. *Id.* at 107, 162.

On March 4, 2009 Petitioner followed up with Dr. Gupta. (Px #6 p. 606). The CT scan showed a hemivertebra in the posterior lumbar spine. Dr. Gupta was concerned Petitioner's significant hemivertebra was causing spinal stenosis with radiculopathy. He felt that Petitioner would benefit from a lumbar decompression and excision of the hemivertebra. *Id.* at 606. Dr. Gupta ordered Petitioner not to returned to work till May 6, 2009. *Id.* at 607. He further noted that Petitioner required further workup and ultimate operative intervention. *Id.*

On June 10, 2009 Petitioner underwent C6-7 interlaminar epidural steroid injection under fluoroscopic guidance by Dr. Timothy Miller at the Mississippi Valley Center Pain Management Clinic. (PX 9 p. 270). The pre-and post-operation diagnoses were right sided herniated disc at C5-6.

On November 16, 2009 Dr. Lanceloti wrote Petitioner advising he was leaving the area and recommended Petitioner follow up with Dr. Balram Gupta and/or Dr. Motto.

On May 12, 2010 Petitioner saw Dr. Rogelia Reira at the Prime Care Medical and Physical Therapy Centers. S.C. in Chicago. (PX 7, p. 702). It is unclear from the record how Petitioner came under the care of Dr. Reira. After physical examination, Dr. Riera's impression was that Petitioner had scoliosis of the thoracic spine with spinal stenosis, bulging and herniated discs of the cervical and thoracic spine. He agreed that surgical intervention was warranted, given that after two years of treatments conservative treatment had failed to improve Petitioner's condition. He ordered MRI of the spine and referred Petitioner to his clinic neurosurgeon, Dr. Ronald Michael. He also imposed no-work restriction. *Id* at 706.

The MRI dated May 12, 2010 performed at MRI Lincoln Imaging Center in Chicago showed that at L1-2, there was no herniation or foraminal narrowing. (PX 7, p. 727). At L2-3, there was normal signal with minimal diffuse and left lateral bulge causing minimal narrowing left foramen. L3-4 showed minimal-mild signal-loss/desiccation with mild diffuse and left lateral bulge causing moderate-severe narrowing left foramina, moderate on right and mild-moderate narrowing spinal canal. At L4-5 there was minimal signal-loss/desiccation and the minimal diffuse bulge causing mild-moderate right foraminal narrowing, minimal on left. And at L5-S1, there was minimal signal-loss/desiccation, moderate right foraminal narrowing. *Id.* The radiologist's impressions were: 1) bulging of the L2-3 through L4-5 discs; 2) Narrowing of the foramina L2-3 through L5-S1; 3) Mild-moderate spinal stenosis, partly congenital; 4) S1 Vertebral anomaly. *Id.* at 728.

On May 24, 2010, Petitioner saw Dr. Ronald Michael for evaluation and treatment. Petitioner provided the same history he had provided to all other physicians. (PX 7, p. 702). Petitioner told Dr. Michael that his condition since his injury had worsened. Dr. Michael diagnosed Petitioner with L3-L4 and L4-5 disc protrusions. Dr. Michael opined that since conservative measures had not improved petitioner's condition in the past two and half years, petitioner had two options: 1) continue to live with his pain or 2) consider surgery. If petitioner determined that surgery was the option, he would require a lumbar discogram to determine the nature of the pain generator. Accordingly, Dr. Michael ordered a lumbar discogram. *Id.* at 709). Dr. Michael maintained the off-work restriction. *Id* at 711.

On June 3, 2010 Petitioner underwent a discogram and post-discogram CT scan of the lumbar region performed by Dr. Scott Glaser. Dr. Glaser noted that petitioner's MRI of the lumbar spine revealed degenerative disc facet arthropathic changes at multiple levels, and at L 3-4. MRI also show disc bulge with mild impinging on exiting the left nerve root. At L4-5, there was a minor annular disc bulge. At L5-S1, there a minor disc bulge as well. There was moderate lumbar scoliosis. A myelogram revealed bulging discs at L3-4, and L4-5. A follow up CAT Scan revealed annular bulging at L3-4, annular bulging at L4-5. Follow up revealed a right hemivertebra at S1 and they describe L5-S1 as the most caudal level. X-rays revealed degenerative changes of the right hip.

Dr. Glaser noted that at the time of the discogram, Petitioner was taking tramadol. Dr. Glaser's summary indicated petitioner exhibited discogenic pain and referred somatic pain in the L3-4 level only. The L1-2, L2-3, L4-5 and L5-S1 served as control levels. (PX 7, p. 720). The post discogram CT Scan of the lumbar spine showed that at L4-5, there was a broad-based posterior disk bulge/protrusion measuring approximately 2-3mm elevating the posterior longitudinal ligament and indenting the thecal sac without significant spinal stenosis. Mild bilateral neuroforminal narrowing was seen. *Id.* at 721.

On June 29, 2010 Petitioner returned to Dr. Michael for follow-up complaining of severe low back pain, neck pain which he had since the injury, right arm pain with upper extremity numbness and tingling, and weakness in the right upper extremity. Neurological examination remained unchanged since his last visit. Dr. Michael noted Dr. Glaser's finding of L3-4 pathology. Dr. Michael review Petitioner's MRI of the lumbosacral spine, which demonstrated L3-4-disc protrusion worse than L4-5. Dr. Michael assessed petitioner with L3-4-disc protrusion with discogenic pain L3-4. Dr. Michael then opined that petitioner's care to date had been reasonable and necessary. Further, Dr. Michael opined that petitioner's condition of ill-being was causally related to the work injury of January 20, 2008. He sought approval for the posterior lumbar fusion which had

previously been recommended by Dr. Purnendu Gupta Dr. Michael maintained the off-work restriction pending surgical approval. *Id* at 716.

A September 2, 2010 utilization review concluded that the lumbar fusion was not medically necessary. The reviewer reported the physical examination and electrical studies were normal, there was no x ray evidence of segmental instability, and Petitioner had not undergone a psychosocial screening.

On September 21, 2010 Petitioner returned to Dr. Michael for follow-up complaining of severe and worsening low back pain, much worse than right leg pain. (PX 7, p. 734). On examination, Petitioner was neurological unchanged since the last visit. He had not improved whatsoever. Dr. Michael Persuasively, if somewhat venomously, refuted the conclusions of the utilization review on several grounds. His office note reflects:

> The patient cannot live with the pain. He continues to desire surgery. We continue to await approval for the posterior lumbar fusion.
>
> The patient has apparently had an electronic or virtual review of his records. He has not been seen; he has not been examined. X-rays have not been examined or reviewed. It appears to be cut-and-paste, cookie cutter sort of report. Certainly, the ODG Guidelines are irrelevant and do not apply to the practice of neurosurgery or spine surgery. Thus, this report is specious at best. Flexion and extension plain films are never required simply for discogenic pain. This is a clever ruse by the so-called impartial reviewer. There is no gross instability here. Instead, there is a disc, which has been severely damaged, and therefore lost its functional integrity. As such, it cannot perform its role, to namely evenly distribute the weight of the body whenever the patient sits, stands or walks. Flexion and extension films will likely be perfectly normal. That is, thus, meaningless. The patient has a severe disc injury which is manifested through its discogenic pain which was unequivocally proven by the gold standard four-disc [sic] condition, namely the lumbar discogram and post discogram CT. We are not discussing gross instability. The patient has a mechanical low back pain due to the internal disc disruption and discogenic pathology, namely the internal disc disruption.
>
> Another point of contention is the so-called psychosocial screen. In eighteen years of a full-time practice of neurosurgery, I have done psychosocial screens perhaps once or twice, and these, in the face of obvious, previously diagnosed schizophrenia with major medications and psychiatric follow up before and after the surgery. This patient does not have this. This is thus yet another clever ruse and attempt to obfuscate and delay diagnosis and treatment.
>
> This review is, at best disingenuous, at worst rather blatantly and intentionally deceptive. (PX 7, p. 734-35).

On November 2, 2010 Petitioner returned to Dr. Michael for follow-up. His complaints, the examination and diagnosis were all unchanged. Surgery continued to be the recommended treatment option,

but, as the surgery had not been approved by Respondent, Dr. Michael recommended lumbar epidural steroid injections for symptomatic relief while awaiting authorization for surgery.

On November 9, 2010 Petitioner underwent L3-4 interlaminar epidural steroid injections under fluoroscopic guidance. On December 29, 2010 Petitioner underwent L4-5 interlaminar epidural steroid injections under fluoroscopic guidance by Dr. Timothy Miller at the Mississippi Valley Center. The pre-and post-diagnosis were lumbar spinal stenosis. (PX 9, p. 259. 262).

There appears to have been a pretrial with the former Arbitrator with a suggestion that Petitioner be evaluated by Dr. David Segal or another spine surgeon. In any event. on March 9, 2011 Dr. Miller, who was within the initial chain of treating physicians initiated by Respondent, referred Petitioner to Dr. Segal. (PX 25, p. 5)

On September 18, 2012 Petitioner returned to Michigan Avenue Medical Associates for follow up with Dr. Michael, but he was seen by Dr. Riera. (PX 7, p. 737). Petitioner's condition was unchanged and it was noted that Petitioner was awaiting evaluation by Dr. Segal, but needed to obtain an MRI before the evaluation. Dr. Riera ordered the study. *Id.* at 740.

On November 13, 2012 Petitioner saw Dr. Segal, of Eastern Iowa Brain and Spine Surgery. (PX 12, p. 292). Petitioner described his pain radiating to the right thigh, right buttock, testicles and right groin. Symptoms were aggravated by daily activities, ascending stairs, bending, coughing, descending stairs, defecation, lifting, pushing, rolling over in bed, sitting, sneezing, standing, twisting, walking, crawling, reaching overhead, pulling and neck movement. His symptoms were relieved by lying down, and pain drugs. Associated symptoms include decreased mobility, joint pain, limping, numbness in the right thigh, sexual dysfunction, spasms, tingling in the legs, weakness in the right leg and arm, numbness and tingling in the right foot. Petitioner described that his pain started in the center of the low back and went into the right leg to behind the knee with numbness behind thigh and bottom of foot. Petitioner complained that his back pain woke him up at night. Petitioner complained that when he stood up to walk, sometimes, he cannot feel the right leg, and he must hesitate until he got some feeling back in order to avoid fall. *Id.*

Dr. Segal's review of Petitioner's systems was positive for fatigue, generalized weakness, negative for tenderness or weight loss, positive for headache, numbness, tingling in the legs; positive for back pain, decreased mobility, joint pain, limping, spasms, and weakness. Dr. Segal reviewed the MRI, and noted that the primary finding was at L3-L4 which was very degenerative, and had a herniation toward the right. There was moderate levoscoliosis of the lower lumbar spine and lumbosacral junction.

Dr. Segal opined that Petitioner's pain was coming from the disc degeneration and herniation at L3-L4. He concurred with Dr. Purdendu Gupta that fusion of L3-L4 was medically indicated because 1) Petitioner's pain had been going for 4 years and getting worse; 2) Petitioner had tried and failed all conservative treatments and 3) the findings on MRI at L3-L4 matched his pain and 4) the discogram was positive for concordant pain at L3-L4. Dr. Segal opined that there was radicular pain on the right from the foraminal stenosis from the disc herniation. (PX 12, p. 295).

Petitioner then continued pain management with Dr. Amanda Moto of Family Medicine, Eastern Avenue, Davenport, his primary care physician. (PX 13, p. 322). At the time Petitioner saw Dr. Moto, he was taking Tylenol, Nystatin and Hydrocodone. Petitioner's active problems included backache, chest pain, fatigue, herniated nucleus pulposus. Examination of the lumbar area exhibited muscle spasms and pain. *Id. at 324.* Petitioner was assessed with lumbar radiculopathy, headache and neck pain. Dr. Moto prescribed Hydrocodone 5-325 MG 4x daily, Cyclobenzaprine HCI-10MG, and a pain management consult.

At the time of trial Petitioner testified that when his pain becomes unbearable, he goes to the emergency room at Genesis or Trinity Hospital. He has been to both hospitals several times since his injury for emergency pain management.

Dr. Michael Dolphin testified by way of evidence deposition. Dr. Dolphin became Board certified in 2007, a few months prior to Petitioner's injury. (PX 11, p.4). He testified that Petitioner was referred to his office by Dr. Rhea Allen for consultation on his work-place injury at Tyson Foods. Dr. Dolphin testified that Petitioner's pain began after shoveling while working for Tyson Foods whereby he felt sharp pain throughout the right hip and buttock region and through the belt line. Dr. Dolphin testified he diagnosed Petitioner with low back pain, degenerative disc disease with mild spinal stenosis between L3 and L4, and with right-sided disc herniation. *Id.* at 7. He further testified that the low back pain and the right-sided herniation at L3-L4 were related to petitioner's work place. *Id.* However, Dr. Dolphin did not believe that the vertebra body and pedicle asymmetry of L5 and degenerative disc disease were related to the work place injury. *Id.*

Dr. Dolphin testified that he recommended right-sided transforminal epidural steroid injection to be done at L3 and L4 for relief, and a CT scan to evaluate the abnormality. *Id.* Dr. Dolphin testified that the CT myelogram showed minimal foraminal stenosis between L3 and L4, moderate spinal stenosis with foraminal narrowing at L4 and L5, but no significant nerve pathology between L5-S1. Dr. Dolphin concluded that the CT myelogram findings were not related directly to the work injury. He further testified that since the epidural injections did not help Petitioner, he felt surgical intervention was not warranted. *Id.* at 11. The last time Dr. Dolphin saw Petitioner was on September 3, 2008 at which point he recommended a functional capacity evaluation for placement of permanent restrictions. Respondent did not approve the recommended the FCE and it was never performed. Dr. Dolphin testified that he did not place petitioner at Maximum Medical Improvement on June 19, 2008.

Dr. Gupta Purnendu Gupta also testified by way of evidence deposition. Dr. Gupta evaluated Petitioner in February 2009. Dr. Gupta opined that the activity of lifting, shoveling, loads of meat and grease caused petitioner's injury, stating, "it was the inciting event, the precipitating event." (PX 21, p. 11). Dr. Gupta explained that at the time of the inciting event, Petitioner was repetitively bending and shoveling, which resulted in repetitive stress and strain on the lumbar spine. *Id.* at 24. Dr. Gupta further explained "[t]he twisting, bending, lifting activities are known cause of stress and strain on the lumbar spine. In this particular instance, whatever load he was shoveling at that time is when he was injured and became symptomatic." *Id.* at 12.

Dr. Gupta testified that when he evaluated Petitioner he was concerned with three possible diagnoses, hemivertebra, pelvic obliquity and tethered cord. Petitioner did not have tethered cord. Petitioner did have hemivertebra and pelvic obliquity. *Id.* Dr. Gupta explained that hemivertebra is a birth defect- a congenital

formation of the spine and that pelvic obliquity was a tilted pelvis which occurs because of scoliosis that results due to the hemivertebra. Dr. Gupta opined that the strain of lifting, bending, and carrying loads of 80 to 100pounds of meat could accelerate the wear and tear and cause a hemivertebra to become symptomatic. *Id.* at 13- 14.

Dr. Gupta dismissed the argument that any activity of daily living could cause a birth defect condition of hemivertebra and pelvic obliquity to become symptomatic. *Id.* at 14. He pointed our "[t]he difference is the loads that the gentleman was lifting; and, again, I would just state that whether he had hemivertebra or not, those types of loads can be very severe on the lumbar spine." *Id.* Dr. Gupta then opined Petitioner's work activity at the time of his injury exacerbated, accelerated and contributed to his injury. *Id.* at 15.

Dr. Gupta testified that based upon the findings on the MRI which demonstrated "significant spinal canal stenosis in addition to the hemivertebra, he recommended fusion decompression. Dr. Gupta testified that he recommended the resection of the hemivertebra to help correct the scoliosis and the pelvic obliquity and to decompress the spinal canal which was very narrowed at 7millimeters. *Id.* at 15-16.

Dr. Gupta further opined that the MRI examinations of Petitioner at the University of Chicago demonstrated significant spinal stenosis and foraminal stenosis which was "the source of petitioner's leg pain." *Id.* at 19-117. Dr. Gupta compared the MRI studies obtained at the University of Chicago with the MRI dated February 25, 2008 and dismissed the notion that Petitioner was at medical maximum improvement in 2008 noting "[t]he MRI presented to me demonstrates that the gentleman had spinal stenosis at L3-4 and also had stenosis at L4-5, which is consistent with the MRI that was obtained in 2009 at the University of Chicago which demonstrated significant disease and spinal canal compression." *Id.* at 17-18.

Dr. Ronald Michael, a neurosurgeon, testified by deposition as well. graduate of University of Illinois and Northwestern University. Dr. Michael has been in active practice of neurosurgery from the completion of his residency at the Northwestern University in the early 90s. (PX 22, p. 5-6). Dr. Michael first saw petitioner on referral on May 24, 2010. *Id.* at 10. The doctor indicated the referral may have been from Dr. Reira, but he did not have that noted. The history noted that Petitioner was shoveling and lifting heavy buckets of meat and grease which petitioner estimated 80 to 100 pounds each. Petitioner felt sharp pain in his low back. *Id.* at 11. Petitioner reported the injury to his supervisor and was treated with ibuprofen and ice pack. The following day, petitioner had more low back pain. Three weeks later, he was sent to a company's physician. He continued to work till June when he was dizzy, and drowsy and was sent home. *Id.* Petitioner was experiencing severe pain while sitting, standing and walking. He had right lower extremity numbness and tingling. There was right lower extremity weakness. There was no bowl or bladder incontinence. Petitioner had tried physical therapy which was terminated because it wasn't providing any additional relief. *Id.* Dr. Michael testified that he reviewed Petitioner's MRI which demonstrated L3-4 worse than L4-5 protrusions and herniations. There was a right S1hemivertebra with possibility of L5 spondylolysis and associated scoliosis. *Id.* at 12-13.

Dr. Michael diagnosed Petitioner with L3-4 and L4-5 disc protrusions and since petitioner had not improved in the two and half years since his injury, he felt conservative treatments had failed and he recommended Petitioner be evaluated for suitability for surgery. Dr. Michael ordered a discogram which he indicated was a dynamic test which stresses the disc. "It determines whether or not when a disc gets stressed,

namely, any time we're upright, it tells us if, by stressing a disc, we're able to bring on this pain condition." *Id.* at 14-15.

Dr. Michael described the difference between disc bulges and herniations as stating "[a]lmost everyone will know when a disc is bulging. Almost everyone will know when it's frankly, obviously, herniated. But the discrete point, when a bulge becomes a herniation is where differences of opinion arise. And so, it's a continuum. It's not a discrete point. There's a continuum from a bulge to a herniation." *Id.* at 13.

Dr. Michael testified that the discogram he ordered confirmed a L3-4 pathology, specifically concordant to pain. *Id.* at 16. Dr. Michael further testified that three diagnostic studies supported the diagnosis of L3-4 pathology. *Id.* Dr. Michael testified that Petitioner's work activity caused his injury. *Id.* at 17, 23.

Dr. Michael testified that what petitioner had was a mechanical problem. "It's a problem of a mechanical structure, the disc having been damaged and therefore, losing its functional and structural integrity....it's internal disc disruption and discogenic pain that is causing the pain." *Id.* at 20. Dr. Michael was firm in his opinion that Petitioner's disc was severely damaged as result of his work activity for Respondent in January of 2008. Dr. Michael testified that Petitioner "had two choices, learn to live with it, which he said he couldn't, or have surgery, namely, a lumbar fusion, a posterior lumbar fusion," which petitioner preferred. *Id.* at 22.

Unlike Dr. Purnendu Gupta, Dr. Michael did not identify scoliosis and pelvic obliquity as likely causes of Petitioner's pain because prior to the work place injury, Petitioner did not have a history of low back pain. Dr. Michael dismissed the notion that petitioner's low back problems were because of his hemivertebra or scoliosis. *Id.* at 30.

Dr. Purighalla also testified by way of deposition. Dr. Purighalla testified that at the time he saw Petitioner, on August 8, he did not feel that Petitioner needed surgery.

CONCLUSIONS

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

Petitioner had no symptoms prior to the undisputed accident. His symptoms have been present and progressing since the accident. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the accident.

Issue (O): Did Petitioner exceed his two choices of physician?

The Parties agree that Petitioner was initially seen and treated by Dr. Allen at Respondent's referral. Petitioner also came under the care of Dr. Miller and Dr. Dolphin at through Dr. Allen. The parties further agree that none of these physicians constitute a choice by Petitioner. On November 9, 2011 Dr. Miller wrote a referral for Petitioner to see Dr. Segal.

The Arbitrator finds Dr. Alapati was Petitioner's first choice of physician. Dr. Jauron constituted Petitioner's second choice. It is not lost on the Arbitrator that a number of Petitioner's encounters with Dr. Jauron appear to have been through emergency rooms beginning September 20, 2008. Even assuming arguendo

that the emergency room encounters constituted emergency treatment and would thus not count as a choice of physician, Petitioner first saw Dr. Jauron on August 14, 2008 in the doctor's clinic.

Dr. Alapati referred Petitioner to Dr. Purghalla on July 8, 2008. Further, Petitioner credibly testified that when Dr. Alapati left practice he referred Petitioner to Dr. Lanceloti. Later Dr. Lanceloti advised his patients he was no longer going to practice in the area and referred them to Dr. Balram Gupta and or Dr. Moto. When Dr. B. Gupta returned to India Petitioner continued treatment with Dr. Moto.

Petitioner testified that Dr. Balram Gupta referred him to Dr. Pornendu Gupta before leaving for India. The Arbitrator notes, however that Petitioner first saw Dr. P. Gupta on February 18, 2009, and was not referred to Dr. B. Gupta until later on November 16, 2009 and no such referral can be found in the record. The Arbitrator therefore finds Dr. P Gupta is Petitioner's third choice of physician. Petitioner also sought treatment from Dr. Riera and Dr. Michael. The Arbitrator finds these physicians are outside Petitioner's two choices of physician.

Issue (J): **Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?**

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

The Arbitrator finds the treatment Petitioner has received through the date of hearing has been both reasonable and necessary. Petitioner has exhausted conservative treatment options with no relief of his symptoms. The Arbitrator therefore further finds Petitioner is entitled to prospective medical treatment. Despite the fact that Dr. P. Gupta, Dr. Riera, and Dr. Michael are outside Petitioner's allowed choices of physician, the Arbitrator finds their opinions and testimony regarding Petitioner's required treatment to be persuasive. Although the above three physicians are outside Petitioner's permitted choices, Dr. Segal, who saw Petitioner on the referral of Dr. Miller, who was chosen by Respondent, is not.

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's exhibit 1, with the exception of expenses incurred as a result of treatment by Dr. P. Gupta, Dr. Riera, and/or Dr. Michael, or at their referral, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall further authorize and pay for prospective medical care as recommended by Dr. Segal, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): **What temporary benefits are in dispute?**

Petitioner last worked on June 30, 2008. At that point permanent restrictions had not yet been set as an FCE was recommended to determine what restrictions were appropriate. The FCE had not been authorized or performed as of the date of hearing.

Respondent shall pay Petitioner temporary total disability benefits of $314.67/week for 457 weeks, commencing July 1, 2008 through April 3, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid

18IWCC0711

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

Petitioner is not entitled to penalties or attorney fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Johnie M. Downey,

Petitioner,

vs. NO: 14WC 28250

Village of Palatine,

18IWCC0712

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(s) of accident, medical expenses, causal connection, 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 7, 2017 is hereby affirmed and adopted.

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

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

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 1 2018

Stephen J. Mathis

David L. Gore

SJM/sj
o-10/25/2018
44

DISSENT

I respectfully dissent from the Decision of the majority. The Commission affirmed and adopted the Decision of the Arbitrator who found that Petitioner's current condition of ill-being of his left shoulder was causally related to a stipulated work accident on April 3, 2014. I would have found that Petitioner did not sustain his burden of proving the work-related accident caused the current condition of ill-being and denied compensation.

Petitioner sustained a stipulated accident on April 3, 2014 when he hung out of a window in a training exercise. The record reveals that while Petitioner claimed an injury on April 3, 2014, he continued to work his normal shift until August 6, 2014, in what Petitioner testified was a "very physically demanding" job. In the interim, he posted multiple comments on Facebook noting his rigorous physical fitness program, even though he indicated he was doing it while accommodating his injury. Nevertheless, in his posts he noted that he was doing multiple pushups and pullups. In addition, on July 9, 2014, Petitioner reported to his treating chiropractor, Dr. Sleigh, that he had left-shoulder pain which he attributed to a hard workout with no mention of the April incident.

On August 1, 2014, Petitioner posted that he was looking forward to the Rugged Maniac Challenge and that he was in the best shape he had been in for two years. He competed in that competition on August 2, 2014. At arbitration, Petitioner explained that that competition involved a five-kilometer race with 22 obstacles on the course the competitors were supposed to engage. Petitioner testified that he only engaged the obstacles he felt he could do safely and simply avoided those that he did not. In his social media accounts, Petitioner proudly referred to his participation in, and completion of, the event making no mention of any self-limiting or self-protecting effort. Notably, Petitioner first sought medical treatment for his shoulder on August 6, 2014, alleging his shoulder was injured in the April incident four months earlier. Also notably, Petitioner did not report the Rugged Maniac Challenge competition to any of his medical providers or Respondent's Section 12 medical examiner.

18IWCC0712

In addition, the Arbitrator noted incorrectly that Petitioner never had any complaints about his shoulder prior to the work accident. To the contrary, on February 10, 2014, Petitioner reported to Dr. Sleigh that he hurt his shoulders and neck doing pullups.

The record before us raises serious questions about Petitioner's credibility. His lack of seeking medical attention for four months after the alleged injury, his ability to work at his very physically demanding job and continued strenuous work-outs in the interim, and his participation in the Rugged Maniac Challenge only a few days before first seeking treatment for the alleged April 4 injury cast sufficient doubt on causation in my mind to conclude Petitioner did not sustain his burden of proving the condition of ill-being of his left-shoulder was causally connected to his work accident on April 3, 2014.

I would have found that Petitioner did not prove causation, reversed the Decision of the Arbitrator, and denied compensation. Therefore, I respectfully dissent from the majority opinion.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0712

DOWNEY, JOHNIE M
Employee/Petitioner

Case# **14WC028250**

VILLAGE OF PALATINE
Employer/Respondent

On 12/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% 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:

0728 LAW OFFICES OF THOMAS W DUDA
330 W COLFAX ST
PALATINE, IL 60067

0075 POWER & CRONIN LTD
ADAM RETTBERG
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

18IWCC0712

☐ 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

Johnie M. Downey
Employee/Petitioner

Case # **14** WC **28250**

v.

Village of Palatine
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 **September 28, 2017 and November 22, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 3, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$113,763.41**; the average weekly wage was **$2,187.76**.

On the date of accident, Petitioner was **42** years of age, *married* with **3** dependent children.

Petitioner *has not* received all reasonable and necessary medical services.

Respondent through group insurance *has* in part paid some 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 for group insurance payment of **$41,722.09** under Section 8(j) of the Act, in accordance with Petitioner Exhibit 1.

ORDER

Temporary Total Disability Compensation
The Respondent shall pay to the Petitioner the sum of $1,336.91 per week for 23 5/7ths weeks of temporary, total disability benefits pursuant to Section 8(b) of the Act for the period that the Petitioner was off of work from August 22, 2014 through February 3, 2015.

Medical Benefits
The Respondent shall pay to the Petitioner the sum of $6,950.85 to reimburse him for his out-of-pocket medical expenses paid for treatment and to provide reimbursement for the unpaid medical expenses documented in Petitioner Exhibit 1, all of which have been found to be causally connected to his injury. The initial Respondent shall make these payments in accordance with the Medical Fee Schedule found in section 8.1 of the Illinois Workers' Compensation Act. The Respondent shall receive credit in the amount of $41,722.09 for group insurance payments made by the group health insurance carrier of the Respondent pursuant to 820 ILCS 305/8(j) provided it holds the Petitioner harmless from any reimbursement claims made by the group carrier.

Permanent Partial Disability; Person as a Whole
The Respondent shall pay the amount of $721.66 per week for an additional period of 80 weeks because the injury to the left shoulder sustained by the Petitioner caused a permanent partial disability to the body as a whole to the extent of 16% under section 8(d)(2) of the initial Act, in accordance with the Appellate Court Decision of *Will County Forest Preserve Dist. v. IWCC*, 2012 Ill. App. (3d) 110077WC ¶¶14-20, 970 N.E.2d 16 (3rd Dist. 2012).

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

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

David A. Kane
Signature of Arbitrator

December 7, 2017
Date

DEC 7 - 2017

IN THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

JOHNIE M. DOWNEY,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No. 14 WC 28250
	)	
VILLAGE OF PALATINE,	)	
	)	
Respondent.	)	

MEMORANDUM DECISION OF THE ARBITRATOR

The Arbitrator makes the following findings of fact on the following issues:

FINDINGS OF FACT

I. Causal Connection - F

The Respondent, Village of Palatine ("Respondent" or "Village"), admits that the Petitioner, Johnie M. Downey ("Petitioner" or "Downey"), in fact sustained an accidental injury on April 3, 2014 (Arb. Tr. 29) although it disputes that that injury led to the shoulder surgery which is the subject of this claim. However, the Arbitrator finds that the undisputed accidental injury of April 3, 2014, sustained to the Petitioner's left shoulder caused the Petitioner's need for left shoulder surgery and the permanent disability assessed in this Decision.

On April 3, 2014, Johnie Downey worked for the Village of Palatine as a firefighter/paramedic. He was first hired by the Respondent, Village of Palatine ("Respondent" or "Village"), on March 1, 2001. (Arb. Tr. 14-15) Firefighter Downey had worked for the Palatine Rural Fire Protection District; he began his employment as a firefighter for the District in August, 1999. The Petitioner had to submit to separate pre-employment physical examinations both for the Palatine Rural Fire Protection District and the Respondent before he would be hired. No problems were discovered in either examination, including no problems with his upper extremities. He had no problems in either of his shoulders. (Arb. Tr. 15-16)

Petitioner from his date of hire through April 3, 2014, performed firefighter and paramedic duties working a 24-hour shift where he would be confined to a particular station and could only leave to answer calls. His physical duties were very heavy including lifting, pulling, carrying, crawling, climbing ladders, carrying heavy tools while wearing personal protective equipment and a SCBA tank which added an additional 60-100 pounds of weight. (Arb. Tr. 16-22)

When the Petitioner came to work at the beginning of his shift on April 3, 2014, he was not noticing any pain or discomfort in either shoulder. The Petitioner is right-handed. (Arb. Tr. 22, 34) On April 3, 2014, during the course of his 24-hour shift that began at 8:00 a.m., the Petitioner was ordered to participate in a realistic training exercise practicing survival techniques while wearing full protective equipment. (Arb. Tr. 28-41; PX 12) In this exercise, the on duty firefighters were required to engage in a bailout drill and a maze drill while wearing full protective equipment. In the

bailout drill, the Petitioner was practicing getting out of a building in an emergency situation while wearing full gear weighing between 60-100 pounds. The drill is intended to reproduce a real life situation in which a firefighter would be attempting to get out of a hazardous situation by hanging outside of the building and holding onto the window sill until a ladder could be positioned under the firefighter. (Arb. Tr. 28-31) In this exercise, the Petitioner hung outside of the window and was then ordered by the training officer to push himself back up into the window into a vertical position and then drop down. While hanging outside the window and holding onto the window seal, as the Petitioner began to push himself back up into the window using his left hand, he felt a pop in his left shoulder and he felt his shoulder separate. (Arb. Tr. 31-32) This popping occurred the second time the Petitioner performed the exercise. He felt the popping, discomfort and a burning sensation in the left shoulder joint. (Arb. Tr. 33) He felt the burning sensation directly in the shoulder joint. The Petitioner immediately orally reported this event to his supervisor, Lieutenant Nathan Paulsberg (Arb. Tr. 34), and completed a written Statement of Injury which was completed on the date of the accident, April 3, 2014. (PX 2)

The Petitioner finished his shift and continued working until August 6, 2014. (Arb. Tr. 49) Before and after the undisputed accident, Petitioner was receiving chiropractic treatment at the initial Sleigh Family Chiropractic Clinic. (PX 7) He began seeing Dr. Quintin Sleigh, D.C. in September of 2012; this encounter began through a Village program in which Dr. Sleigh put on a healthy back presentation at the fire station at the request of the Respondent. (PX 7, p. 169-183; Arb. Tr. 35-41) He did not begin seeing

the chiropractor as the result of an acute low back injury and especially before April 3, 2014, there was no left shoulder injury of any kind. On April 9, 2014, the Petitioner reported to Dr. Sleigh "...that he [Downey] injured his shoulder at work doing a drill. It appears that he had a slight dislocation of the shoulder." (PX 7, p. 37) On July 15, 2014, the Petitioner complained to Dr. Sleigh that he had secondary complaints in his left trapezius and cervical region that bothered him especially after doing pull-ups. Dr. Michael A. Terry opined that these complaints were in fact evidence of a continuing problem with a torn labrum that began on April 3, 2014. (PX 11, p. 19-24) On August 8, 2014, the Petitioner reported to Dr. Sleigh that he was having his shoulder checked out from the injury incurred during the drill at work. (PX 7, p. 29) On August 25, 2014, the Petitioner complained that he had been compensating in performing his home exercises due to his left shoulder injury. (PX 7, p. 28) Petitioner continued to complain to Dr. Sleigh about his left shoulder through the remainder of 2014. (PX 7, p. 21-26)

During the period from April 3, 2014 through August 6, 2014, Petitioner's co-worker, Firefighter Shane Koeneman worked at the same station as the Petitioner both before and after April 3, 2014. As indicated earlier in this Decision, the Petitioner and Firefighter Koeneman spent 24 hours a day living, eating, socializing and sleeping at the same station. (Arb. Tr. 8-13) Firefighter Koeneman was on duty working with the Petitioner and attended the same training exercise on April 3, 2014. Before the injury, Firefighter Koeneman had not noticed the Petitioner complaining of pain in his left shoulder or icing it. Firefighter Koeneman did not physically see the injury to the Petitioner but he heard the

commotion that arose during Downey's exercise and Downey complained to him that he had injured his left shoulder. Firefighter Koeneman also noticed that the Petitioner began icing his shoulder on the day of the injury and periodically at the station afterwards up to August 22, 2014 when the Petitioner stopped working.

Although the Petitioner continued to work after his injury of April 3, 2014 through August 6, 2014, there is adequate evidence to support that he experienced pain from the April 3, 2014 injury continuously. Firstly, there are complaints to his chiropractor in April and July of 2014. (PX 7) There is the testimony of a co-worker that the Petitioner continued to ice his left shoulder. (Arb. Tr. 9-12) The history of injury given to every single medical provider cites specifically the April 3, 2014 accident and the circumstances of the accident are consistently described with each history. This includes the original injury report. (PX 2) It includes the first visit to NCH Immediate Care Center beginning on August 6, 2014. (PX 5) In that document, the NCH emergency physician reports that the Petitioner had a work-related injury four months ago. According to the occupational health doctor, the following history was taken: "Patient states he was pulling himself up and felt his left shoulder pop in and out about four months ago, still has pain." After initial conservative treatment, NCH referred the Petitioner to Dr. David M. Zoellick of the Adult & Pediatric Orthopedics, S.C. who in his encounter of August 11, 2014, reported that the patient was present for evaluation of "...a new left shoulder injury on 4/3/14 while at work. He works as a firefighter/paramedic for Palatine. While doing a rescue drill he was holding on to a window and had to pull himself back up.

He injured his arm. He did not seek any treatment for the shoulder until last week." (PX 6)

Respondent's Exhibit 1 supports the testimony of the Petitioner. Petitioner reported on April 10, 2014 that, "Ever get injured? It sucks doesn't it? Well a week ago today, I suffered an 'upper body injury' while at work and it's totally thrown a wrench into my plans." Petitioner described how it interfered with a training program that he wanted to complete. On pages 3-4, there is an internet exchange between the Petitioner and a visitor to his website about the injury. Beginning in September of 2014, the Petitioner complains of the struggle he is experiencing because he has been placed on light duty due to his shoulder. (RX 1, p. 30)

After the injury, Firefighter Koeneman testified that the Petitioner complained of pain in his left shoulder and was icing it that night. Further, Petitioner's icing activity continued through the three month period until August of 2014. (Arb. Tr. 11) Petitioner Downey iced his shoulder and complained of pain after the training exercise injury but did not engage in that behavior or make those complaints before the training exercise injury. (Arb. Tr. 10-13)

The Petitioner stopped working on August 6, 2014. On August 2, 2014, the Petitioner participated in a five K race called "Rugged Maniac." (Arb. Tr. 41-52; RX 2) The photographs posted of the participants of "Rugged Maniac" show them performing strenuous overhead activities in addition to the run itself. However, the Petitioner denied that he was able

to engage in the strenuous overhead climbing activities found in Respondent Exhibit 2 and a review of the exhibit did not reveal any photographs of the Petitioner doing anything more strenuous than sliding on his seat down an embankment with his hands in the air. (RX 2, p. 2-3) The Arbitrator would note that during this very same period between 4-3-2014 and 8-6-2014 the Petitioner worked 24 hour shifts performing the duties of firefighter/paramedic. The Petitioner admitted doing these firefighter/paramedic duties and nothing in Respondent Exhibit 2 would suggest that the activities of August 2, 2014 were more injurious to the Petitioner than his firefighting duties. The Arbitrator would further note that the Petitioner worked two shifts **AFTER** the race on August 2, 2014. It was during one of these two shifts that the Petitioner approached Deputy Chief Graciana advising him that his left shoulder had not gotten any better since the accident of April 3, 2014. He asked the Deputy Chief if he could return to the doctor. Deputy Chief Graciana said that he could and that conversation is what resulted in the visit to NCH Occupational Health on August 6, 2014. (Arb. Tr. 43-48)

Again, the Arbitrator credits the testimony of the Petitioner corroborated by the history contemporaneously given to the Respondent and the Occupational Medicine Clinic that the Petitioner continued to experience pain while performing his regular duties.

The Arbitrator finds as a matter of fact that the Petitioner sustained an injury to his left shoulder on April 3, 2014 and that the Petitioner did not sustain an injury to any part of his body including the left shoulder on August 2, 2014.

Michael Terry, M.D. (PX 11)

Dr. Michael Terry is the treating orthopedic surgeon for the Petitioner's injuries. His *curriculum vitae* reflects that he is not only an active orthopedic surgeon associated with Northwestern University Medical School but also an associate professor of orthopedic surgery with a specialty in sports medicine and shoulder surgery. He is not a regular examining physician with numerous litigation examinations in workers' compensation cases. Dr. Neal's proclivity to examine on behalf of Respondents is reflected by his testimony that 90% of his WC IME examinations are for employers.

The Petitioner and Dr. Terry had attended the same high school; the Petitioner contacted Dr. Terry through social media because an injury he sustained performing a training drill that required him to hang out of a window caused an injury to Petitioner Downey's shoulder which had not improved. (PX 11, p. 8-10)

Dr. Terry testified that he received the same history of an April 3, 2014 injury to the Petitioner as has already been documented with all of the other medical records of the medical providers who had previously seen the Petitioner. Dr. Terry expressed the unequivocal opinion that the surgery that he performed on the Petitioner's left shoulder on October 12, 2014 was caused by the shoulder injury of April 3, 2014. (PX 11, p. 23)

Dr. Terry's opinion was unequivocal and Dr. Terry was not persuaded to change his opinion by virtue of the fact that the Petitioner continued to work through August 6, 2014. In fact, Dr. Terry indicated that this is a common occurrence. In particular, Dr. Terry explained the following:

> "So a couple things on that point: I think if somebody has a SLAP here and wants to do pull-ups, we'd want them to do pull-ups. And if pull-ups hurt for the moment and they hadn't tried conservative management, we might try to hold them off of pull-ups for a bit. But I think a guy in his 40s, who's a firefighter, should be able to do pull-ups, and you would want them to be able to do pull-ups. So whether they did them that day or the next wouldn't necessarily change the structure of the injury. You know, it might be useful for them to hold off to get some information and then try to re-engage, but we don't want people quitting or giving up physical activities that they either want or need to do because of a fixable problem." (PX 11, p. 35)

M. Bryan Neal, M.D. (RX 3 & 4)

The Village ignored the opinion of the treating orthopedic surgeon and on November 20, 2014, arranged for a Section 12 examination with Dr. M. Bryan Neal. Dr. Neal's report is dated November 26, 2014 when the

Petitioner was barely one month post-surgery. Dr. Neal's written report acknowledges that at the time of his examination Firefighter Downey's left shoulder condition was not at maximum medical improvement. (RX 4, p. 12) Thus, Dr. Neal did not perform an AMA Impairment examination and rendered no AMA opinion of any kind. Dr. Neal is a board certified orthopedic surgeon in a solo orthopedic practice. (RX 3, p. 5-8) Dr. Neal sees patients three days a week but has a significant workers' compensation examination practice. 90% of Dr. Neal's IME medical examinations are in workers' compensation cases; 90% of his examinations are at the request of employers or their attorneys. (PX 11, p. 35-38) Although he does treat patients with orthopedic problems, he has constricted his practice in order to reduce medical malpractice costs; he no longer treats spinal conditions at all. (RX 3, p. 6-9)

In his report, Dr. Neal opined that Firefighter Downey's left shoulder condition requiring surgery "...is not causally related to an event of April 3, 2014... " (RX 4, p. 10) However, in his testimony under oath on January 15, 2016, Dr. Neal initially stated that the shoulder condition was not related to the April 3, 2014 event but later opined that he had no opinion as to when the SLAP tear occurred in this patient. (PX 11, p. 20-26) The Arbitrator finds these opinions not credible because the rationale described by Dr. Neal is inconsistent, not supported by the record and is based on a conclusion relating to Petitioner's complaints to his chiropractor that conflicts with the testimony of Dr. Terry, whose opinion is credited. In his report, Dr. Neal goes through a contorted analysis of work records, the records of Dr. Zoellick and his suspicions about what is contained in chiropractic records to support his conclusion. (PX 11, p. 10-12) Dr. Neal

admits that he has not seen any medical records that contradict the Petitioner's history that his left shoulder was asymptomatic before April 3, 2014. However, Dr. Neal "suspects" that the Petitioner has seen Dr. Zoellick and Dr. Pride (PCP) for left shoulder complaints. Dr. Neal then goes on to suggest that the chiropractic care performed on the Petitioner before and after April 3, 2014 might, in fact, be the source of his complaints. On page 11 of his report, Dr. Neal in the fourth full paragraph relies on records of complaints of pain in the trapezius and neck made by the Petitioner as demonstrating that these complaints do not support a shoulder condition. On that same page, Dr. Neal emphasizes that the Petitioner had "at least two prior workers' compensation claims (suggesting that he would be familiar with the workers' compensation process for a work injury)... ." (RX 4, p. 11) Dr. Neal discusses these two prior workers' compensation claims repeatedly in his report. (RX 4, p. 5, 10 and 11) As indicated, during his deposition, Dr. Neal could not identify any other event that would have caused the condition in the Petitioner's left shoulder. Dr. Neal's fixation on the Petitioner's workers' compensation experience is misplaced. The Petitioner has filed one workers' compensation claim which is the case before this Arbitrator. He did have two very minor workers' compensation injuries but never filed any workers' compensation application whatsoever.

Dr. Neal fails to take into account the Petitioner's continuing symptoms of left shoulder pain after overhead activity that began April 3, 2014 and continued through August 6, 2014. Dr. Neal was completely unaware that Petitioner's behavior was noted by co-workers and was documented in writing on social media. Most importantly, Dr. Neal did not

appreciate that a patient with a torn labrum involving the bicep tendon could very easily experience pain in his neck and trapezius muscle. Dr. Terry testified that this was a common manifestation of shoulder symptomology in an active individual. The credentials of Dr. Terry are far more impressive than those of Dr. Neal; Dr. Terry's description of his experience in treating patients with shoulder pathology is credited above that of Dr. Neal.

Based on the above facts, the Arbitrator finds that the Petitioner's accident of April 3, 2014 was the cause of the internal derangement in his left shoulder requiring the surgery performed by Dr. Terry on October 14, 2014. This is based upon the testimony of the Petitioner, the Petitioner's complaints to media mates and the consistent history he provided to each and every medical provider who rendered treatment to him.

CONCLUSIONS OF LAW

I. The Medical Services Documented in Petitioner Exhibit 1 are Reasonable, Necessary and Causally Connected to Petitioner's Injuries.

The Arbitrator concludes that given the fact that Petitioner's April 3, 2014 accident caused the necessity of the surgery performed at Northwestern University Medical Center as well as the treatment provided by Adult & Pediatric Associates are causally related to the injury. Based on the medical records from Dr. Zoellick, Dr. Terry, Northwestern University Medical Center and the testimony of Dr. Terry, the Arbitrator concludes that the itemized medical expenses found in Petitioner's Exhibit 1 are reasonable, necessary and the Respondent is ordered to make payment to the Petitioner in accordance with the Medical Fee Schedule provided in Section 8.1 of the Act.

II. Temporary Total Benefits – K

The unanimous testimony of both Dr. Terry and Dr. Neal support that the Petitioner could not return to his usual and customary occupation from August 22, 2014 when he was taken off of work by the Respondent until he returned to work on February 5, 2015. No light duty was available for the Petitioner and all physicians acknowledge that he was physically unable to perform the very heavy duties of a firefighter/paramedic. Respondent is liable to the Petitioner for temporary, total disability payments covering the period provided in the Request for Hearing – Arbitrator Exhibit 1.

III. Nature and Extent of the Injury

The surgery on the Petitioner's left shoulder was more than a simple arthroscopy and repair of a SLAP tear. Multiple structures in the left shoulder received surgical attention. During the procedure, Dr. Terry performed a SLAP debridement and repair with a biceps tenodesis. He also performed a subacromial decompression and cuff debridement during the surgery. The Petitioner complained of pain while using his left shoulder and a guarding behavior when doing anything strenuous. (Arb. Tr. 54-55) He has discomfort radiating from his left shoulder into his neck and across the shoulder (the trapezius). When he exercises, he needs to use the proper technique or he will develop a pain and ache in the joint requiring that he ice it.

Under Illinois law, the Arbitrator in assessing permanent disability is required to weigh a number of factors. These factors are provided in 820 ILCS 305/8.1b which reads in relevant part as follows:

> (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.

Based upon the following analysis applying these factors to the case at bar, the Arbitrator concludes that the Petitioner's left shoulder injury caused the permanent partial loss of use of his left shoulder and his body as a whole to the extent of 16%.

Under Section 8.1b(b)(i), the Arbitrator notes that neither party secured an impairment rating of the Petitioner. The Arbitrator therefore can give this factor little to no weight.

In Section 8.1b(b)(ii), the Arbitrator gives great weight to the occupation of the Petitioner which is a very heavy job according to the U.S. Department of Labor. The Petitioner is a firefighter/paramedic that requires intermittent, sudden but urgently necessary exertional activities in pulling fire hose, extinguishing fires, rescuing humans and rendering advanced life support to the victims of illness or trauma. This is combined with the young age of the Petitioner (he was age 42 on the date of injury) which means that he will have to endure the disability in his left shoulder for a prolonged period of time performing very heavy work. The Arbitrator gives factor 8.1b(b)(iii) great weight. Under Section 8.1b(b)(iv), the Arbitrator notes that the injury to the Petitioner did not cause the reduction

of his earning capacity at the present time. However, as the Petitioner ages with the internal derangement in his non-dominant shoulder, an impact on his future capacity is predictable. The Arbitrator gives this factor moderate weight.

Applying the factor listed in 8.1b(b)(v), the Arbitrator gives great weight to the fact that the Petitioner's injury and disability is fully corroborated by the treating medical records which demonstrate quite clearly the pathology in the left shoulder. The Arbitrator notes that the Petitioner not only sustained a tear in the anterior, superior labrum but he also had a biceps tendonitis with a frayed rotator cuff. The surgical procedure performed on October 14, 2014 was multiple. It consisted of a left shoulder rotator cuff debridement, a SLAP debridement and repair, a biceps tenodesis and a subacromial decompression. (PX 9)

Applying these criterion, the Arbitrator finds that the Petitioner sustained a permanent partial loss to the body as a whole of 16%.

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

April Bullock,

Petitioner,

vs. NO: 16WC025829

Continental Tire,

18IWCC0713

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(s) of accident, medical expenses, causal connection, 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 9, 2018 is hereby affirmed and adopted.

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

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

18IWCC0713

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $65,500.00. 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 2 1 2018
SJM/sj
o-11/1/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BULLOCK, APRIL
Employee/Petitioner

Case# **16WC025829**

CONTINENTAL TIRE
Employer/Respondent

18IWCC0713

On 4/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5623 GARY L BEMENT
5140 N ILLINOIS ST
FAIRVIEW HTS, IL 62208

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0713

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

APRIL BULLOCK
Employee/Petitioner

v.

CONTINENTAL TIRE
Employer/Respondent

Case # **16** WC **25829**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **February 7, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 14, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,864.60**; the average weekly wage was **$843.55**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay the following reasonable and necessary medical bills: Orthopaedic Center of Southern Illinois - DOS: 01-06-16 TO 08-25-16, $7,205.00 and Good Samaritan Regional Health Center - DOS: 2-25-16, $188.00; DOS: 6-13-16 TO 6-30-16, $1,933.00; DOS: 7-5-16 TO 7-25-16, $1,785.00; DOS: 8-1-16 TO8-31-16, $4,056.00; DOS: 9-2-16 TO 9-29-16, $4,416.00) Said bills shall be paid pursuant to the Medical Fee Schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$562.37/week** for **40 weeks**, commencing **January 4, 2016** through **October 10, 2016,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$506.13/week** for a further period of **50 weeks**, as provided in Section **8(d)2** of the Act, because the injuries sustained caused the **10% loss of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **December 14, 2015,** through **February 7, 2018**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Nancy Lindsay
Signature of Arbitrator

APR 9 - 2018

April 4, 2018
Date

April Bullock v. Continental Tire, 16 WC 25829

Findings of Fact and Conclusions of Law

The Arbitrator Finds:

Petitioner, a "100% Inspector" for Respondent completed an accident report on December 14, 2015, indicating that earlier in the day she was pushing a tire on the exit conveyor and felt a pop in her left bicep. She stated, "I was look at the tries [sic] and It step and went to look at back side of the tries [sic], my arm pop." She further wrote, "Went to turn the tries [sic] around and [when I did] there was a pop and my left arm." Petitioner further indicated that she went to put the tire in the line so it could go to the warehouse. No one was present/working near her when it happened. (RX 3)

An "Injury Report" was completed by Tom Stoudt, EMTP, on December 14, 2015. (PX 4). Mr. Stoudt wrote,

> [Petitioner] came to HS with [chief complaint] of pain rated 10/10 to her upper left arm. She indicates the area where she felt a 'pop' at about the midpoint between her shoulder and elbow. She also states that this area is tender to palpation. She also claims pain on movement and constant pain at 10/10. She shows no indication of suffering from pain and uses her left arm to handle and manipulate her cell phone. There is no deformity, discoloration or swelling noted." (PX 4, p. 1)

Mr. Stoudt also noted that Petitioner reported moving a tire to her left when she felt a "pop" in her upper left arm. She was give Ibuprofen and ice therapy to no effect and returned to work "duty as tolerated." She was to return on December 14, 2015 at 9:45. (PX 4)

Petitioner returned to SSM Health on December 15, 2015. She presented with pain in the medial aspect of her left upper arm, approximately located between the bicep and tricep. She had strained it "last evening" when she felt a "pop." It was still sore upon presenting. On physical examination there was no swelling or redness but "mild diffuse tenderness to palpation" was noted. Petitioner had good strength and mild discomfort with resisted flexion/extension. No deformity of muscle contour with contraction against resistance was noted. The examiner noted that Petitioner, upon observation, seemed to be using the arm quite normally. She was put on light duty for two days due to her subjective complaints before resuming full duty. (PX 4)

Petitioner returned to SSM Health on December 16, 2015, with continued pain complaints stating that "it hurts just like when it happened." She was given an appointment for the 17th and placed on duty as tolerated. (PX 4)

Petitioner returned to SSM Health on December 17, 2015 and was examined by PA-C Colon. Petitioner's subjective complaint was upper left arm pain, lateral to her biceps. Examination of her left shoulder showed no deformity. It was felt she had pain/strain of her left

bicep tendon at the intersection bilaterally. PA-C Colon recommended no use of her left arm until she could be re-evaluated on December 21, 2015. If there was persistent pain, an MRI might be appropriate to rule out a tear. (PX 4)

Petitioner returned to SSM Health on December 21, 2015 regarding her left upper extremity pain which Petitioner stated was "moving around." Dr. Byler noted that initially Petitioner's pain was in the medial upper arm and at the last visit it was in the lateral upper arm at the bicep insertion. Today, her pain was more in the posterior deltoid and up into the trapezius. Petitioner reported it hurt to externally rotate the shoulder. On physical examination Petitioner had full range of motion of her elbow and "essentially" full range of motion of her shoulder although some discomfort was noted with Apley's. She also had decreased grip but no associated pain. Petitioner was to attend Work Fit three times a week for two weeks and was given work restrictions of no lifting over two pounds and avoidance of repetitive use of her left upper extremity. She was to return in two weeks. (PX 4)

Petitioner attended Work Fit on December 22, 2015. Petitioner denied any prior medical history pertinent to her neck, shoulder and arm. She reported moving a tire on December 14th when she felt a pop in her left shoulder. She located the primary pain in the shoulder girdle. As of December 28, 2015, no improvement in her condition was noted. (PX 4)

On December 30, 2015, Petitioner presented to St. Mary's Good Samaritan Medical Group reporting that two weeks earlier, she was "lifting a tire" at work when she heard a pop in her left shoulder. (PX 2 at 1) Petitioner reported that since then she had been complaining of left shoulder pain especially when lifting her hand above her head. She had been seen by the company doctor and given light duty work and pain. Yet, her pain had persisted. On examination mild tenderness was noted. Her range of motion was limited due to pain especially when involved in abduction and rotation of the left shoulder. She was assessed with a "work related injury" and referred to an orthopedic surgeon. She was advised to use a shoulder and arm sling, continue her therapy and engage in light duty work. (PX 2)

On January 4, 2016 Petitioner returned to SSM Health. She still complained of left arm pain from her shoulder to her elbow. She denied any swelling, reported it was hard to sleep and that she wasn't taking any non-steroidal anti-inflammatory medication. It was noted that Work Fit had been focusing on her shoulder. Tenderness around her shoulder was noted. It was felt she had a biceps tendon strain. Ibuprofen was ordered and Work Fit was to focus on her bicep. If she had no improvement in two weeks, she was to be referred out. (PX 4)

Respondent's worker's compensation carrier scheduled Petitioner to be seen by Dr. Ahn, an orthopedic surgeon in Mt. Vernon. Petitioner saw Dr. Ahn on January 6, 2016. She completed a New Patient History Form in which she reported severe pain in her upper left arm associated with lifting, bending, and lying in bed. Petitioner reported injuring her arm on December 14, 2015 when she was throwing a tire weighing approximately 40 lbs. and felt a pop in her left upper arm followed by pain in the same area. There was no sign of swelling or bruising. When examined by the doctor Petitioner gave the same history of being at work and throwing a regular-sized tire when she felt a pop in her left upper arm/shoulder area. Since then she had been having pain in the same location. She denied any swelling or bruising at the time of

the injury. She had undergone some physical therapy involving only E-stim at the worksite. She had undergone no formal therapy. X-rays taken of Petitioner's left humerus showed no fracture or dislocation. On examination, diffuse tenderness was noted. The AC joint, greater tuberosity, and anterior and posterior aspects of the shoulder also caused about "7/10" discomfort but not very localized. While Petitioner was noted to initially describe her symptoms as upper arm pain she was really having mostly shoulder symptoms as the upper arm was relatively nontender with palpation. Range of motion was intact. Resistive abduction caused about "7/10" discomfort. impingement and apprehension signs were relatively minimal. Petitioner was diagnosed with a left shoulder strain and possible internal derangement. Dr. Ahn explained that the predominant symptoms she was complaining of were inflammation and strain-like and he acknowledged she was diffusely tender throughout the shoulder girdle. He felt they should begin by focusing on calming down those symptoms and Petitioner was given a cortisone injection into the subacromial space. She was also given orders for therapy and was to return in one month. If her symptoms had resolved by then then that would confirm her symptoms were related to a strain. If they persisted it was felt her complaints should be more localized as the inflammation would be decreased. If a structural abnormality was suspected at that point he would order an MRI. Petitioner was to remain on light duty with no overhead activity and a 15 lb. lifting restriction. (PX 5, dep. ex. 2)[1]

Petitioner presented for physical therapy at the Physical Rehabilitation Center in Mt. Vernon on January 13, 2016. A history of her accident was noted along with the results of her visit with Dr. Ahn. The therapist noted that Petitioner had been fired secondary to what she called a "false positive on her drug test." Petitioner reported taking an anti-inflammatory, diclofenac, that can cause a false positive. Prior to her injury Petitioner had been independent with all activities of living but since the 14th of December she has had trouble with bathing, dressing, cooking, sleeping and any lifting above her waist. The therapist's assessment was left shoulder pain following a left rotator cuff tendinopathy, left shoulder strain, and possible left internal derangement. (PX 5, dep. ex. 2)

Petitioner followed up with Dr. Ahn on February 17, 2016. On her "Pain Assessment" form she indicated moderate pain of "7/10." She also noted that when she was at physical therapy and getting a massage, it felt like something popped and did not feel right. Physical therapy did not help her pain and was stopped. Dr. Ahn noted he was seeing Petitioner in follow up for her left shoulder rotator cuff tendinopathy. Petitioner denied any improvement and the doctor explained that what happened to her in therapy did not cause any structural damage but rather was a knot being worked on. Her symptoms still seemed mostly consistent with inflammation as anywhere the doctor palpated in the AC joint, greater tuberosity, and anterior and posterior aspects of the shoulder resulted in discomfort. Range of motion was intact. Resistive abduction and impingement caused significant discomfort. Dr. Ahn's diagnosis included a possible tear. He ordered an MRI and kept her on light duty. (PX 5, dep. ex. 2)

Petitioner underwent a left shoulder MRI on February 29, 2016. The impression was: mild diffuse supraspinatus and subscapularis tendinosis but no rotator cuff tear; scarring and fibrosis of the rotator interval suspicious for chronic adhesive capsulitis; and mild chronic hypertrophic changes of the acromioclavicular joint which mildly deforms the supraspinatus

[1] A copy of the report was sent to "Dr. Apostol/Worker's Comp"

muscle. Associated shoulder impingement was to be considered along with clinical correlation. (PX 5, dep. ex. 2)

Petitioner returned to see Dr. Ahn on March 7, 2016. He told her the MRI was negative for any structural tear but showed tendinopathy of the supraspinatus and infraspinatus tendons. He recommended another injection (which she received) and ongoing light duty restrictions. (PX 5, dep. ex. 2)

Petitioner underwent more physical therapy between March 24, 2016 and April 7, 2016. She underwent a third injection with Dr. Ahn on April 18, 2016. If she had no improvement, he recommended an arthroscopic subacromial decompression and diagnostic arthroscopy. (PX 5, dep. ex. 2)

Petitioner underwent physical therapy on April 25, 2016. (PX 5, dep. ex. 2)

Dr. Ahn re-examined Petitioner on May 2, 2016. She still reported "7/10" discomfort in her shoulder and tenderness along the lateral aspect of her shoulder and medial scapular border. He offered her a diagnostic arthroscopy and possible subacromial decompression given the exhaustion of conservative treatment measures. Approval was to be obtained. She was to return in four weeks. (PX 5, dep. ex. 2)

On May 11, 2016, Petitioner underwent an Independent Medical Evaluation with Dr. George Paletta, Jr. at the request of Respondent's insurer. A written report followed. (RX 2) According to the report Petitioner informed the doctor that she would pull the tire from the waterfall to her inspection station by pulling it form the right to the left and then would "throw the tire" to the left when she finished her inspection. She told the doctor she was doing that in her usual capacity on December 14th when she "reaching back to push the ok button with the right arm when I had felt a pop in my left arm throwing the tire onto the conveyor.'" (RX 2, p. 1) Dr. Paletta wrote, "Basically what she describes is she was throwing the tire to her left using her left arm. Apparently she has to push it or throw it onto the conveyor. As she did so she felt a pop in the shoulder and noted pain in the shoulder as she then turned back to push the ok button with her right." (RX 2, p. 1) On examination, Petitioner's left shoulder was diffusely tender in the supraclavicular and infraclavicular regions as well as along the medial border of the scapula in the deltoid region. She had full range of motion and some mild pain at the end range of internal rotation in the 90/90 position. She complained of positive impingement signs with the Neer sign being more positive than the Hawkin's sign. X-rays were taken that day and the doctor reviewed an MRI non-arthrogram study of Petitioner's left shoulder. He described it as a normal study. (RX 2, p. 4) Dr. Paletta's impression was that Petitioner had left shoulder pain without any evidence of structural abnormality. He described her mechanism of injury as "relatively benign." He found no evidence of any structural abnormality or an objective explanation for Petitioner's ongoing pain complaints. He described Dr. Ahn's evaluation as very diligent, noting none of the three injections had provided Petitioner with any relief of her symptoms which he felt made Petitioner a poor candidate for surgery. Dr. Paletta described Dr. Ahn's recommended diagnostic arthroscopy as "highly unpredictable" and not indicated for Petitioner as there was nothing on the MRI scan or her physical exam that would suggest a condition that could effectively be addressed surgically. He did not feel a subacromial decompression would be helpful as the

subacromial injections had provided no relief thus suggesting that the subacromial space wasn't the source of her pain. Dr. Paletta felt Petitioner had good motion and strength objectively and her limitations appeared solely related to her subjective complaints of pain. He didn't feel she needed any restrictions or limitations. He felt the work incident did not cause any specific injury to speak of. (RX 2, p. 5)

Surgery proceeded on June 2, 2016. Petitioner underwent a left shoulder diagnostic arthroscopy, subacromial decompression, and left shoulder deep partial tear of the supraspinatus tendon converted into a full tear and double row repair with suture anchors. The pre-operative diagnosis was left shoulder subacromial impingement/possible rotator cuff tear. During that procedure Dr. Ahn noted that once debridement had been done, Petitioner had a significant deep. partial tear of the supraspinatus tendon extending all the way to the lateral margin. About 80% of the tendon fibers were compromised. A subacromial bursectomy was performed. The rotator cuff tear site was identified and converted to a full tear which he repaired with a double row of suture anchors. The post-operative diagnosis was left shoulder subacromial impingement and deep partial tear of the supraspinatus tendon. (PX 5, dep. ex. 2)

Petitioner followed up with the doctor one week later and she was progressing nicely. He recommended pendulum exercises and a return visit in six weeks. (PX 5, dep. ex. 2)

When Dr. Ahn re-examined Petitioner on July 20, 2016 she was doing well without complaints. Her pain was 5/10 and she was told to begin active and passive range of motion exercises. (PX 5, dep. ex. 2)

Petitioner returned to see Dr. Ahn on August 10, 2016. While still noting pain, she was doing well. She was progressed in her recovery regimen and told to return in four weeks. (PX 5, dep. ex. 2)

Petitioner's Application for Adjustment of Claim in this matter was filed on August 24, 2016. According to the Application, Petitioner alleged she injured herself "lifting tire." (AX 2)

Dr. Ahn re-examined Petitioner on September 12, 2016. She had full shoulder range of motion but some discomfort with resisted adduction. Aggressive strengthening was recommended. (PX 5, dep. ex. 2)

Dr. Ahn released Petitioner from care at her next visit on October 10, 2016. She was doing well, without complaints, had full range of motion, and had full strength. Her pain was "0/10." She displayed no tenderness with resisted abduction. He placed her at maximum medical improvement and released her to full activities as tolerated. She was advised to return/call if she had any further problems. (PX 5, dep. ex. 2)

Dr. Paletta performed a second Independent Medical Evaluation on January 11, 2017, and, as part of that examination, he reviewed the arthroscopic photographs from the procedure. (RX 2 at 10) At that time Dr. Paletta was of the opinion that Petitioner did have a rotator cuff tear that was not identified by any physician prior to Dr. Ahn's surgery, and further that the rotator cuff tear was not consistent with the mechanism of injury because Petitioner was not

actively lifting or doing anything in the overhead position when she reported the onset of symptoms. (RX 2, pp. 7 - 11)

Deposition of Dr. Ahn

The deposition of Dr. Ahn was taken on July 10, 2017. ((PX 5) Dr. Ahn is a board-certified Orthopedic Surgeon who practices in Mt. Vernon, Illinois at the Orthopaedic Center of Southern Illinois. He first saw Petitioner on January 6, 2016. He testified that she was referred to him by Workers' Compensation. On direct examination Dr. Ahn testified that Petitioner gave a history of "lifting" a 40 pound regular tire at work and feeling a sharp pain in her shoulder. He testified that she had persistent symptoms thereafter and underwent some physical therapy, but the symptoms did not improve. (RX 1, p. 7)

Dr. Ahn further testified that he followed up with Petitioner on February 17, 2016. The symptoms were not any better after the injection. On examination, she had diffuse tenderness throughout the shoulder girdle area. Resistive abduction and impingement signs both caused significant discomfort and physical therapy had not been helpful. He still had a working diagnosis of tendinopathy versus a tear, but felt that if symptoms did not get better with the injection therapy he would be more concerned with the structural tear. He ordered an MRI. (RX 1, p. 10)

Dr. Ahn testified that Petitioner's MRI was performed and found to be benign. There was mild diffuse supraspinatus tendon at subscapularis tendonitis. There was no evidence of a rotator cuff tear although there was scarring and fibrosis of the rotator cuff consistent with chronic adhesive capsulitis. There were hypertrophic changes of the AC joint consistent with arthritis.

Following the MRI, Dr. Ahn re-examined Petitioner in March. He testified that the clinical examination showed that range of motion was good but there were still symptoms of tenderness of about 7 out of 10 on the pain scale with resistive abduction and impingement test. He testified that he continued to have her on a lifting restriction of 15 pounds since the beginning of his care. (RX 1, p.11) His diagnosis as of the March 7, 2016 visit continued to be rotator cuff tendinopathy and he repeated an injection.

Dr. Ahn testified that he again examined Petitioner on April 13, 2016. At that time she had exactly the same symptoms and same pain level. He gave her a third and what would be the last injection. When asked the purpose of the injections, Dr. Ahn testified that his working diagnosis was tendinopathy and inflammation and he felt that the cortisone would help calm the inflammation while physical therapy would help stabilize the shoulder to get rid of the inflammation in it. (RX 1, p. 12)

Dr. Ahn testified that Petitioner returned to see him in May. Petitioner's symptoms were unchanged. Even after three rounds of injection therapy she still had a 7 out of 10 level of pain in her shoulder, mostly in the lateral aspect. The doctor felt Petitioner's symptoms were more focalized at that point, which was mostly at the rotator cuff insertion.

Dr. Ahn also testified that 80% of the time the three rounds of the injection therapy will alleviate the symptoms of mere tendinopathy; however, if it doesn't then there are two other possible explanations/concerns. One possibility is that there is chronic tendonitis which is simply not responding to injection therapy. The other possibility is that there is a structural tear that the MRI failed to detect. He felt that that was not common but when it comes to rotator cuff pathology an MRI is about 95% accurate but misses about 1 in 20. In Petitioner's case, he felt that there was a possibility that there was a tear that the MRI did not pick up. (RX 1, p.13) Dr. Ahn testified that, as a result, he recommended diagnostic arthroscopy of the left shoulder.

Dr. Ahn performed surgery on June 2, 2016. Dr. Ahn found a deep partial tear of the supraspinatus, which is the rotator cuff tendon which needed to be surgically repaired. Dr. Ahn testified that he was a little surprised to find the tear but it wasn't a complete surprise since she had failed full conservative treatment. (RX 1, p.14) He repaired the tear and performed a subacromial decompression. Following the surgery there was a general improvement in her condition. She underwent a period of physical therapy for strengthening post-operatively. His first post-op visit was June 8, 2016 which was too early to see any changes. After the physical therapy in her next visit in August, 2016 she had reduced pain in her shoulder but she had full passive range of motion and active range of motion was improving. She had some stiffness but she was doing well overall. She was then put back on a light duty restriction as of June 23, 2016 with no lifting and fine manipulation dexterity with left hand only. (RX 1, p.16) Petitioner's last visit to Dr. Ahn was on October 10, 2016. At that time her pain was substantially gone. She had manual strength at 5 out of 5 with full range of motion. He felt that she had a full recovery from the surgery. He released her from care at that time and felt that surgery had been successful. (RX 1, p.17)

Dr. Ahn was asked if he was still of the opinion that the job activity Petitioner described to him was the cause of the need for her surgery and the repair of the rotator cuff and subacromial decompression and he responded, "I'm very sure that's probably the reason." (PX 5, p. 18) He acknowledged seeing her monthly for about ten months and never being advised of any intervening accidents. He was then asked if the activity she described to him was consistent with the cause of her problem and he replied,

> Correct. I think most likely scenario is because at her age she shouldn't have that deep of severe partial tear. And usually what happens is it's tension failure. Usually heavy lifting activity on a repetitive basis then fibers start failing from the tension failure. And then when she lifted the last time, probably – analogy is this. If you have normal tense, try and grip it with your hand, you can't tear it. But if you snag on a nail and there's a little tear there, it propagates a lot easier. Just take it, rip it, and it just rips right along the lines. What happens is if you have tension failure and certain number of fibers start failing, and small partial tear is present, the next time you lift something, it's a lot easier to propagate that partial tear. So probably she did have smaller tear in the beginning from

just repetitive heavy lifting at work. And then when she lifted that tire, it just failed along the seam and just turned into big, deep partial tear at that point. (PX 5, pp. 18-19)

On cross-examination the following exchange occurred:

Q. And you took a history that she was throwing a regular-sized tire. Is that presumably what she reported to you?

A. Let me double-check. Yes.

Q. Okay. And it's that mechanism of – was that- the conditions you found, do you believe that to be a specific event that occurred on December the 14th of 2015, by way of history, that resulted in the pathology that you've described here today?

A. Like I said before, it's most likely the known- the constant repetitive lifting activity causing tension failure and then propagating that tear on that particular day, most likely. (PX 5, pp. 21 -22)

Dr. Ahn also testified that he has treated patients with similar issues in the past and he described a partial tear as "a very common – not specific trauma." He explained that a lot of times there's no specific one incident but there are times, as in this case, when the tear propagates and a particular instance can be recalled. He also added, "But frequently a partial tear, especially undersurface partial tear, a lot of times there's no specific one incident, but it's usually repetitive lifting activity." (PX 5, p. 22)

Dr. Ahn was asked about the symptoms she would have shown on clinical exam prior to the surgery that would be consistent with the injury he found and he explained that she had tenderness with resistant abduction, and tenderness gradually locally. In the beginning it seemed inflamed but her whole shoulder hurt when she initially presented to him. Then, as time went along, it settled into the anterolateral corner where the rotator cuff insertion site is located, just as she exhibited. (RX 5, p. 23)

Dr. Ahn acknowledged that all three injections were subacromial and designed to calm down her inflammation which was the working diagnosis in light of the benign MRI. When asked if the subacromial injections should have caused some relief, Dr. Ahn testified that it depends on the patient and pathology. If it is purely inflammation, he would expect it to sometimes improve with the injections. If there is a structural abnormality such as there was here, then the pain will not feel better with the injections. He further testified that with "simple inflammation" or what is called rotator tendinopathy (or irritation) about 80 percent of the time one will have relief with three rounds of injection therapy. However, if the symptoms don't get better there are the two possibilities – the persistent tendinitis, for which the next step is

arthroscopy and a subacromial decompression or the other possibility is that there is a rotator cuff tear that the MRI failed to detect and that warrants the same treatment. He explained that, regardless of what pathology Petitioner had, her next step was a diagnostic arthroscopy. (RX 1, pp 23 - .25) Dr. Ahn further testified that the fact that the injections did not provide any relief, even temporary, was that the partial tear was on the under surface, not the subacromial side. He also explained that the Cortisone effect would usually occur within the first week or so. The Lidocaine is the anesthesia and it lasts for an hour or two but that's not the "short-term" relief doctors are referring to and, in Petitioner's case, it would not have given her any relief because it would not have gone to the undersurface where the partial tear was located. The injection was on the subacromial side. (PX 5, p. 26)

Dr. Ahn was also asked about Petitioner's objective findings in her shoulder prior to surgery and he replied that she consistently had pain with resisted abduction which is a typical sign of a patient with a rotator cuff pathology. (RX 1, p. 27) Dr. Ahn further testified that it was the ongoing complaints of pain which resulted in the recommendation for the MRI study and ultimately the surgery to be performed. He testified that the bottom line is that the diagnostic arthroscopy was recommended after all conservative treatment was unsuccessful. The diagnostic arthroscopy did reveal the tear which was consistent with her complaint in her work activities, so proper treatment would be repairing at that point. (RX 1, p. 28) Dr. Ahn also testified at cross-examination that Petitioner recovered well after her surgery. He did not see that there was any substantial functional loss in terms of her right upper extremity, and of his last visits he placed no restrictions on her activities.

Additional Medical

Respondent requested that Dr. Paletta review the deposition of Dr. Ahn and he documented his findings in a report of July 17, 2017. Dr. Paletta indicated he had no reason to change his previous opinions regarding causation. He noted that Dr. Ahn agreed that the MRI scan was entirely normal. He also believed that the doctor testified that there were no objective findings on exam and Dr. Paletta felt all of Petitioner's findings were subjective with the primary one being a complaint of pain on resisted abduction of the arm. He also wrote, "Furthermore, he did not testify to a mechanism of injury different from that which I documented in my notes." While he acknowledged Dr. Ahn's testimony about false negatives with MRIs, in his own experience, it has been unusual for a well done MRI scan "to miss a high grade or a complete tear." He did not think an MRI would miss an 80% tear. Dr. Paletta further noted that he felt Dr. Ahn was suggesting in his testimony that Petitioner's injury was the culmination of a repetitive injury with final propagation of the tear. However, Dr. Paletta felt there was nothing to suggest repetitive injury as this patient had no reported symptoms of shoulder problems up until the time of the work incident. (RX 1, dep. ex. 4)

Deposition of Dr. Paletta

Dr. Paletta's deposition was taken on November 17, 2017. (RX 1) Dr. Paletta testified in his deposition that he understands the job activities of Respondent's employees, has personally been in the plant to observe the job activities, and also reviewed an in-depth job description of Petitioner's job activities. (PX 1, pp. 6-8) At the time of that examination Dr. Paletta also

personally reviewed the MRI images and found nothing of significance nor evidence of any structural abnormality in the shoulder. (PX 1, p. 10) At that time Dr. Paletta diagnosed the claimant with a left shoulder pain without evidence of structural abnormality and noted that Dr. Ahn had provided three injections that had not provided even temporary relief, therefore, she would be a poor surgical candidate. (RX 2, p. 5) Dr. Paletta noted potential issues in his report that could have been involved in the shoulder, but that the MRI has absolutely no indication that those were present. (RX 2, p. 5) Dr. Paletta felt that Petitioner had reached maximum medical improvement and was capable of returning to work full duty. (RX 2, p. 5)

Dr. Paletta saw Petitioner a second time on January 11, 2017, some seven months after her surgery. At that time he had seen the operative report where Dr. Ahn reported there was fraying of the rotator cuff and that he cleaned that up and he did a subacromial decompression. He felt there were some inconsistencies in the report as Dr. Ahn initially described the rotator cuff as showing some fraying but then eventually decided that she had a high grade tear involving about 80% of the thickness of the rotator cuff which he then converted to a complete tear and did a repair of the rotator cuff. He did agree that this is the appropriate type of surgery if there was an 80% thickness of the rotator cuff. (RX 1, p.18) When asked about visualizing the arthroscopic photos, Dr. Paletta testified that he looked at 12 photographs all of which appeared to be normal. He did see some fraying of the supraspinatus and a picture showing what appeared to be the rotator cuff after he had cleaned it up. At that time it looked much worse. Then it showed that he went ahead and took down the tear and did a repair. He felt that the pictures appeared to be inconsistent from what he described. (RX 1, pp. 18 & 19) With regard to his findings on the January 11, 2017 visit, he found that the Petitioner had some mild motion losses, particularly with regard to rotation. He decided she lacked some external rotation. With the arm up in throwing position she lacked a little bit of rotation. She still had some residual weakness at the supraspinatus. His bottom line was that she had some mild motion losses particularly of rotation and some residual weakness of the supraspinatus. She also had some mildly positive impingement signs but those were subjective and related to pain. As of that visit it was Dr. Paletta's opinion that the Petitioner could return to her regular duty as a 100% inspector given the range of motion and strength that she had and his understanding of the job duties. He also felt that she did not need any further treatment other than a home exercise program. (RX 1, p. 20)

Dr. Paletta also testified as to the job activities and the specific description of onset as being at the work station where a tire came down from the right, moved for inspection, and then while taking her left arm to move the tire to a conveyor, Petitioner felt a pop in the left shoulder. (RX 1 at 7-8) When asked about the mechanism of injury having a causative or contributing factor on the rotator cuff injury reported at the time of surgery, Dr. Paletta stated that an 80% rotator cuff tear would have been seen on an MRI scan by Dr. Ahn, the radiologist, or Dr. Paletta. None of those three physicians identified a rotator cuff tear. Dr. Paletta also questioned the intra-operative photos to some degree because they did not show any evidence of an 80% rotator cuff tear, only what was documented after the reported debridement. (RX 1, pp. 17-19) However, he acknowledged that the "bottom line was – what the pictures showed appeared to be consistent with what he described, for the most part." (RX 1, p. 19)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on February 7, 2018. The disputed issues were accident, causal connection, medical bills, temporary total disability benefits, and the nature and extent of Petitioner's injury. Petitioner was the sole witness testifying at the hearing. Respondent had a representative, Darrell Kehrer, present throughout the proceeding.

Petitioner testified that she began working for Respondent on November 29, 2010, as a 100% inspector. She was working in this position on December 14, 2015. She testified that her job involves her standing or sitting at a machine where tires are fed to her over a "waterfall" on her right side. She then pushes a button to have the tire move onto part of the machine in front of her involving rollers which spin the tire. While the tire is spinning she does a visual and manual inspection of the tires to make sure it is free of defects. After she inspects the tire she grabs the tire with her left hand, pulls it, and lifts it slightly above the roller and places it on another conveyor belt. While doing so, she reaches with her right arm slightly behind her to push a button to start the next tire cycle. The job station is depicted in Respondent's Exhibit 3, photos numbered 5, 6, and 7. Those photos show the switch panel that Petitioner testified that she would have to reach back with her right arm as well as her pulling the tire over the roller with her left arm onto the conveyor belt.

Petitioner testified that she could stand or sit while doing this position and that the photos admitted into evidence at the time of trial were accurate in depicting the work station and the activities required. (RX 3-5 through 7) After the inspection was done with the tire it would then be moved to a lower conveyor belt on her left. This action required her to put her hand inside the tire on the sidewall and roll it or push it to her left. The roller that the tire sat on was approximately the size of a soda can and Petitioner testified that all of the activities of this job were done below chest height. Petitioner testified that this job required her to use her left arm only to move the tire and while she was moving the tire she was also advancing the next tire while pushing a button with her right hand.

Petitioner testified that on December 14, 2015, she grabbed a tire with her left arm and while pulling it onto the conveyor belt she reached back with her right arm to push the button to cycle the next tire. When she did so, she felt a pop and pain in her left shoulder.

Petitioner testified that she immediately told her girlfriend who was working there and then headed to the "old hall" to tell her supervisor. Her supervisor sent her to the nurse's station and Petitioner completed an accident report. Petitioner testified that she was sent to the company doctor the next day. She was placed on light duty. Petitioner was subsequently given physical therapy at an on-site location through Work Fit. Petitioner testified that the therapy did not help.

Petitioner acknowledged that she was terminated on January 4, 2016. She was given a number to call to speak with an insurance adjuster for Sedgwick, and the adjuster sent her to see Dr. Ahn, an orthopedist.

Petitioner testified that she initially saw Dr. Ahn and followed up with him regularly thereafter. She underwent three to four weeks of physical therapy but was no better. She then had

some additional therapy and underwent three injections, from which she experienced no relief. Throughout this time period she experienced ongoing pain in the top of her shoulder down to her left elbow.

Petitioner denied any other accidents/injuries to her left shoulder.

Petitioner testified that Dr. Ahn recommended an MRI and that was done. He then recommended that she undergo a diagnostic arthroscopy which was performed on June 2, 2016.

Petitioner further testified that the surgery helped her pain and range of motion and she gradually improved after the surgery. Petitioner testified that Dr. Ahn released her from his care in October of 2016.

Petitioner was not paid any temporary total disability benefits after her termination.

Petitioner, presently, has only minor pain in her left shoulder. While she feels like she has full range of motion, she also feels her left shoulder is still weak.

Petitioner is currently employed, working for a company stacking pallets. She sometimes notices discomfort in her left shoulder when doing so and gets pain with extended overhead use. She still has some difficult sleeping on her left side and tries not to lie on that side. Petitioner felt she had substantial relief of the pain as a result of the surgery. Regarding her range of motion, Petitioner feels that she has most of her range of motion back, although she has a difficult time reaching behind her back and, sometimes, overhead. She cannot carry a purse with the strap on her left shoulder.

Petitioner testified that she no longer lifts a case of water because it hurts too much. In the "extreme cold" her shoulder hurts. She takes Tylenol and Ibuprofen as needed.

Petitioner is right hand dominant.

On cross-examination Petitioner acknowledged that she was released with no restrictions. Petitioner testified that she was honest with Dr. Paletta and that she described her work activities to him. She agreed that the pain she began having in her left shoulder on December 14, 2015 was from that one incident and not cumulative. Petitioner acknowledged being terminated over an issue with a drug test.

Near the end of the hearing Petitioner's attorney moved to amend the Application for Adjustment of Claim (AX 2) to allege that Petitioner was "moving [a] tire." The motion was allowed without objection.

The Arbitrator Concludes:

With respect to Issue (C) Did an accident occur on December 14, 2015, that arose out of and in the course of Petitioner's employment with Respondent?

Petitioner sustained an accident on December 14, 2015 that arose out of and in the course of her employment with Respondent. Petitioner consistently stated throughout the medical records and at the arbitration hearing that she felt a pop in her left upper extremity while moving a tire from right to left, as required by her job duties. No evidence was presented that Petitioner was not in the course of her employment.

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

Petitioner's current condition of ill-being in her left shoulder is causally related to her work accident of December 14, 2015. In so concluding, the Arbitrator relies upon a chain of events and the more persuasive testimony of Dr. Ahn over that of Dr. Paletta.

At the outset the Arbitrator notes that Petitioner was a very credible witness, forthright and honest in her demeanor and testimony. As evidenced by her description of the accident in the accident report she completed, Petitioner may not be the most sophisticated of individuals, yet she did an excellent job of demonstrating her mechanism of injury while describing the accident at the arbitration hearing and often, as here, actions speak louder than words and paint a very good picture for the Arbitrator. Petitioner was in an unusual position at the time of her injury, sitting and leaving back to a degree with her right arm and shoulder going back behind her to push a button on the right side. Her left arm and shoulder were moving forward and to the left away from her body while throwing a 40 lb. tire. It was an awkward position.

No evidence was presented to suggest that Petitioner had any problems with her left shoulder or arm prior to her work accident herein. Petitioner has consistently described the work events of December 14, 2015 and she experienced the abrupt onset of pain in her left shoulder/upper extremity region after that event. She has had no subsequent injuries to her left shoulder or upper extremity. There were no delays in seeking treatment after the accident or gaps in treatment.

The Arbitrator is aware of discrepancies in the record as to whether Petitioner was moving, throwing, or lifting the tire at the time of the accident. The initial accident reports indicate that Petitioner was pushing a tire to the exit conveyor when she felt a pop in the left bicep. When she originally appeared at Dr. Ahn's office she also reported moving a tire (pushing or throwing it) with her left arm when she felt pain. In opining that the accident of December 14, 2015 had a causal relationship to her shoulder injury and need for surgery, Dr. Ahn understood the mechanism of injury to be the moving of a tire. While Dr. Ahn testified on direct examination that Petitioner told him she was "lifting a tire," that is not what his records state. More importantly, and thanks to questioning from Respondent's counsel on cross-examination, he corrected himself as the following exchange shows:

> Q. And you took a history that she was throwing a regular-sized tire. Is that presumably what she reported to you?
>
> A. Let me double-check. Yes. (PX 5, p. 21)

In light thereof, and contrary to any possible assertion by Respondent, Dr. Ahn's opinions are not based upon the premise that Petitioner was lifting a tire. Petitioner admitted at trial that she was not lifting a tire.

The real crux of the causation dispute between the parties centers around whether Petitioner's rotator cuff tear corrected surgically by Dr. Ahn was caused by the work accident of December 14, 2015. The Arbitrator finds that it was.

Based upon the record of treatment after her accident, Respondent took no issue with Petitioner's care and treatment until Dr. Ahn proposed surgery. Petitioner was then examined by Dr. Paletta who felt surgery was inappropriate because Petitioner had reported absolutely no relief, even temporarily, with the 3 subacromial injections. He also felt surgery was inappropriate because nothing on the MRI suggested a problem to be addressed surgically.

Dr. Ahn testified that if a patient doesn't have improvement in symptoms after 3 injections, there are two possible explanations. The first is that the patient is suffering from persistent tendinitis. In that instance the next recommended treatment step is a diagnostic arthroscopy and subacromial decompression, which is what he recommended. The second possibility is that the patient has a rotator cuff tear missed by the MRI. It, too, warrants a diagnostic arthroscopy to find out.

Dr. Paletta testified that he didn't feel Petitioner was a good surgical candidate because the source of her pain was unclear to him when he initially examined her. He never addressed the appropriateness of proceeding with a diagnostic arthroscopy head on. He never rebutted Dr. Ahn's two-fold reasoning behind his recommendation. He never addressed/rebutted Dr. Ahn's testimony that Petitioner's lack of relief, even temporarily, to the injections was because the source of her pain was not subacromial. While he didn't think an 80% tear would be missed on an MRI, Dr. Ahn testified that it does happen in a small percentage of cases and there is nothing in the record to suggest an intervening accident or explanation for the 80% tear's existence.

Respondent, and its examining physician, Dr. Paletta, seem to feel that Dr. Ahn was of the opinion Petitioner's rotator cuff injury was caused by repetitive, cumulative trauma rather than a specific onset. That is too narrow a reading of Dr. Ahn's deposition testimony. Dr. Ahn credibly and persuasively explained that Petitioner, due to her young age, shouldn't have had such a deep severe partial tear as he saw during the diagnostic arthroscopic procedure. He further reasoned that given her job she was probably getting tension failure over time. He testified, "And then when she lifted the last time, ... So probably she did have smaller tear in the beginning from just repetitive heavy lifting at work. And then when she lifted that tire, it just failed along the seam and just turned into big, deep partial tear at that point." (PX 5, p. 19) When asked if he believed what happened on December 14, 2015 was a specific event that resulted in her shoulder pathology, he again explained that it was most likely constant repetitive lifting activity causing tension failure and then it propagated that tear on that particular day. (PX 5, pp. 21-22)While he may have felt she was experiencing asymptomatic tearing due to repetitive job duties, he never denied she had a specific onset of pain on December 14, 2015 akin to the "straw that broke the camel's back."

Of most significance to this Arbitrator is the fact that Petitioner had no problems prior thereto with respect to her shoulder, engaged in a physically demanding upper extremity job and had an acute onset of left shoulder/upper arm pain after throwing or moving a tire with her left hand/arm while at the same time reaching back with her right arm to pull another tire off a conveyor belt. Her care and treatment subsequent to that acute onset has been overseen by Respondent. It was Respondent's insurer who sent Petitioner to Dr. Ahn and it was not until the doctor was recommending surgery, that it scheduled Petitioner to be seen by another doctor. Petitioner tried therapy at Work Fit but, as Dr. Ahn later noted, it was massage-type therapy and nothing more. It did not help. She tried additional therapy ordered by Dr. Ahn and it didn't help. Dr. Ahn had her undergo three injections which did not help and Dr. Ahn explained, with the benefit of hindsight given the intra-operative findings, that her lack of relief, even temporarily with the injections, made perfect sense given the location of the tear which was completely different than the area being injected. Having tried conservative treatment measures, and remaining symptomatic throughout, Dr. Ahn reasonably recommended a diagnostic arthroscopy. The doctor also credibly explained that an MRI is only 95% accurate and it can miss a tear.

Dr. Paletta was the only doctor who appeared to question Petitioner's veracity noting he felt her subjective complaints of pain warranted no restrictions, limitations or further treatment. He felt she would not benefit from surgery because she had not even had temporary pain relief from her three injections. In the end, his reasoning was wrong as he didn't consider that her tear might be emanating from an area not being addressed by the injection. While Dr. Paletta testified that, in his experience, if one has a full thickness rotator cuff tear, the patient will, at least, get a temporary benefit of several hours from the effects of the anesthesia, (RX 1, p. 12) Petitioner did not have a full rotator cuff tear; rather, she had a partial one and, again, Dr. Ahn persuasively explained how the local anesthetic would not have altered Petitioner's pain complaints because the anesthetic would have been injected into the subacromial side and not the underneath side where Petitioner's partial tear, in actuality, was located. (PX 5, p. 26) While Dr. Paletta questioned the intra-operative photos to some degree because they did not show any evidence of an 80% rotator cuff tear until after the reported debridement, he acknowledged that the "bottom line was – what the pictures showed appeared to be consistent with what he described, for the most part." (RX 1, p. 19) The Arbitrator also finds it appropriate to give some deference to the treating physician/surgeon, Dr. Ahn, especially since he was the physician chosen to treat Petitioner in the first place.

It also cannot be overlooked that Petitioner had substantial improvement in her shoulder after the surgical repair of the rotator cuff. This fact supports Dr. Ahn's findings and surgical procedure. Further, Petitioner testified, and the records confirm, that she had consistent complaints of shoulder pain from the date of the accident through the date of her surgery. She denied, without rebuttal, any intervening incident that could have aggravated her left shoulder condition. Her treating physician, again chosen by the employer, has testified that he believed that the activity of moving the tire on the conveyor was most likely the cause of Petitioner's shoulder pain and ultimate need for surgery. His testimony, as well as the Petitioner's, is more persuasive than that of Dr. Paletta.

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?:

Petitioner is awarded the following medical bills: Orthopaedic Center of Southern Illinois - DOS: 01-06-16 TO 08-25-16, $7,205.00 and Good Samaritan Regional Health Center - DOS: 2-25-16, $188.00; DOS: 6-13-16 TO 6-30-16, $1,933.00; DOS: 7-5-16 TO 7-25-16, $1,785.00; DOS: 8-1-16 TO8-31-16, $4,056.00; DOS: 9-2-16 TO 9-29-16, $4,416.00)

The dispute regarding medical bills appears to be related to causation. In that regard, the Arbitrator incorporates by reference her findings as to accident and causal connection stated herein. Said bills shall be paid pursuant to the Medical Fee Schedule.

With respect Issue (K) What temporary benefits are in dispute?

Petitioner is entitled to temporary total disability benefits from January 4, 2016 through October 10, 2016, a period of 40 weeks. Respondent did not dispute the dates of temporary total disability, only liability for the benefits. Consistent with her liability determination set forth above, and incorporated herein by reference, TTD benefits are awarded.

With respect to Issue (L) What is the nature and extent of the injury?

As required by §8.1(b) of the Illinois Workers' Compensation Act, five factors must be considered in evaluating permanent partial disability benefits.

The first is the reported level of impairment pursuant to subsection (a). No impairment rating was provided by either party. Therefore, this factor is given no weight.

The second factor to be considered is the occupation of the injured employee. Petitioner was working as a 100% inspector while employed by the Respondent. The Petitioner was discharged from her employment with the Respondent based upon a failed drug screen. She was released by Dr. Ahn with no restrictions. Petitioner presently has a job that was identified as one that was required stacking material on pallets. Petitioner testified to some difficulty moving pallets at her new job and wasn't lifting anything heavier than a case of water. The Arbitrator gives some weight to this factor.

The third factor is the age of the employee at the time of the injury. Petitioner was 38-years-old at the time of the accident. As such, she may reasonably be expected to live and work with the effects of her injury for a reasonable time into the future. Therefore, some weight is given to this factor.

The fourth factor is the employee's earning capacity. No evidence was presented as to any impact in Petitioner's earning capacity as a result of her injury. Therefore, this factor is given no weight.

The last factor is evidence of disability as corroborated by the treating medical records. Petitioner testified that she had some difficulty moving pallets at her new job and did not lift anything heavier than a case of water. She also testified that she had a difficult time with certain movements such as reaching behind her back and had some mild pain with raising her arm overhead. Dr. Ahn testified that the Petitioner had no complaints of pain and had full range of motion, resisted abduction did not cause any tenderness, and her rotator cuff strength was 5/5. He released her to return to full activities and told her to follow-up if she had ongoing symptoms. Dr. Paletta, who saw the Petitioner four months after Dr. Ahn's last exam, found that Petitioner still had some limitations on range of motion. He found mild motion losses, particularly with regard to rotation. With the arm at the side, she lacks some rotation outward what he called external rotation. With the arm in the throwing position she lacked a little bit of rotation. She also had some residual weakness of the supraspinatus. Those findings are consistent with Petitioner's complaints at trial.

Based on the foregoing, the Arbitrator finds that the Petitioner has sustained 10 % loss of use of a body as a whole under §8(d)2 of the Act for the left shoulder pain and loss of range of motion that she complained of as a result of her accident on December 14, 2015.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Runyan,

Petitioner,

vs. NO: 15WC042337

18IWCC0714

Cunningham Children's Home,

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(s) of accident, permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 9, 2018 is hereby affirmed and adopted.

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

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

18IWCC0714

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

DATED: NOV 21 2018
SJM/sj
11/1/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUNYAN, ROBERT
Employee/Petitioner

Case# **15WC042337**

CUNNINGHAM CHILDREN'S HOME
Employer/Respondent

18IWCC0714

On 4/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT
DANVILLE, IL 61832

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

18IWCC0714

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Runyan
Employee/Petitioner

Case # **15 WC 42337**

v.

Consolidated cases: _____

Cunningham Children's Home
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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Urbana**, on **January 26, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/23/2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,600.00**; the average weekly wage was **$838.46**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

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

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

Respondent 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 **$10,839.31** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove his accident arose out of his employment with Respondent. Therefore, the Petitioner's claim for compensation is denied and no benefits are awarded.

Pursuant to the parties stipulation, Respondent paid $10,839.31 in medical bills through its group medical plan, for which Respondent is entitled a credit of pursuant to Section 8(j) of the Act. (Arb.X.1)

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

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

4/6/18
Date

ICArbDec p. 2

APR 9 - 2018

PROCEDURAL HISTORY

This matter was originally scheduled to be heard before Arbitrator Christina Hemenway (hereinafter "Arbitrator Hemenway") on January 26, 2018 in Urbana, Illinois. However, Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") covered Arbitrator Hemenway's trial call on January 26, 2018. Therefore, by agreement of both parties, this matter was tried before Arbitrator Kay and the parties agreed to have the decision rendered by Arbitrator Kay. Arbitrator Kay has examined the transcript and submitted records.

FINDINGS OF FACTS

The parties proceeded to hearing on January 26, 2018, with disputed issues as to whether the Petitioner sustained accidental injuries on October 23, 2015 that arose out of and in the course of employment, whether the Respondent is liable for unpaid medical bills, and the nature and extent of the injuries that occurred. (Arb.X.1)

The parties stipulated that Cunningham Children's Home (hereinafter "Respondent") was operating under the Illinois Workers' Compensation Act (hereinafter "Act") on October 23, 2015. (Arb.X.1) The parties stipulated that the date of the accident was October 23, 2015. (Arb.X.1) The parties also stipulated that Robert Runyan (hereinafter "Petitioner") worked for the Respondent on this date as a teacher for special education students, was 63 years of age, and that their relationship was one of employee and employer. (Arb.X.1, T.7) The parties stipulated that the Petitioner gave the Respondent timely notice pursuant to the Act. (Arb.X.1) In addition the parties stipulated that the Petitioner's current condition of ill-being is causally connected to his injury. (Arb.X.1) The stipulated average weekly wage pursuant to the Section 10 of the Act was $838.46. (Arb.X.1)

The Petitioner testified that on October 23, 2015 he was employed by Respondent as a special education teacher. (T. 7) The part of the school Petitioner worked for was operating as a day school, located in the former elementary school, in Rossville, Illinois. (T.7) On October 23, 2015 Petitioner was at school attending a required recertification by Respondent. (T.7) Although the training took place on the Respondent's premises, there were no children present that day. Petitioner testified after attending the morning training the employees were given a break before the start of the next session. (T.8) During the break the Petitioner testified that he went to the restroom. Petitioner stated that the restroom he used is locked but staff members have a key. (T.10) Petitioner described the bathroom stall as being small and a tight fit. Additionally, he said the stalls have things hanging off the stall walls, such as the toilet paper holders, making it a tight. (T.9) Petitioner testified that he did fit in the stall. (T.9)

Petitioner testified that when he went to use the restroom, on October 23, 2015, he had to sit down. (T.8) After using the restroom he said he "got out – off the toilet, put himself back together, belt on and shirt tucked in kind of thing". (T.8) Petitioner testified that he went back in the stall to flush the toilet and when he turned to step out his foot hit something or he just did not have his feet under him and he fell. (T.8) Petitioner testified that he did not see his foot hit anything but he thinks it hit the side of the toilet. (T.9) Petitioner testified that when he began to fall he was sideways to the toilet but facing the toilet. (T.11) He testified that upon falling he fell out the stall door and landed on his right shoulder and right elbow. (P.X.1) Petitioner testified that he noticed pain in his right shoulder after he fell. (T.11) Petitioner testified that he did not notice any cracks, defects, water or debris on the floor. (T.11) Petitioner has never had any issues with dizziness or fainting spells prior to October 23, 2015. (T.11) Nor has he had had any problems with his legs giving out prior to October 23, 2015. (T.11) Petitioner testified that he is right handed. (T.13)

The Petitioner reported the accident to Respondent immediately and was taken to Carle Occupational Medicine Clinic for evaluation the same day. Petitioner was evaluated by Dr. Philbert Chen (hereinafter "Dr. Chen"). While at the clinic an X-ray was taken and the Petitioner was given a follow-up appointment. (T.12) Dr. Chen assessed the Petitioner and reported a right elbow contusion and right shoulder strain with possible bicipital tendon injury. (P.X.1) On October 27, 2015 the Petitioner returned to see Dr. Chen for a follow-up visit. Due to the significant ecchymoses over the anterior shoulder and tenderness over the anterior joint line, Dr. Chen referred the Petitioner for a MRI scan of the right shoulder. (P.X.1) Petitioner was told he could "otherwise do his work, but no restraints." (P.X.1) Petitioner testified that the "work comp insurance company" denied coverage of the MRI so he ended up scheduling the MRI a couple of weeks later through his family physician. (T.12-13)

On October 27, 2015, Petitioner also completed an Employee Incident Report at Respondent's request. (R.X 1). Mrs. Barbara Miller (hereinafter "Mrs. Miller"), Petitioner's supervisor, was also present while he completed the report. Petitioner reported that when he "re-entered stall to flush, while exiting my feet became tangled and I fell through the open door." He reported landing on his right elbow, with pain into the shoulder and scraped his stomach on the locking mechanism. (R.X1) An incident analysis report was also performed by Mrs. Miller (R.X.2). In the report, Mrs. Miller noted that the Petitioner went back "to flush the toilet and must have tripped, slipped (no water involved), fell on right side through doorway(open) to stall." (R.X2) Mrs. Miller testified on the day of the trial to the aforementioned. (T.27-33)

On November 12, 2015, Petitioner was seen by Physician Assistant Debora Obrien (hereinafter "PA Obrien") at Carle Hoopeston Regional Health Center. PA Obrien evaluated the Petitioner and reported that he exhibited decreased range of motion, tenderness, pain and decreased strength. (P.X 3) She also reported that the Petitioner was unable to externally rotate his shoulder without experiencing extreme discomfort. (P.X 3) Petitioner could only elevate his arm anteriorly about 30 degrees and laterally about 70 degrees. PA Obrien reported that Petitioner had no strength at all against resistance, tenderness in the anterior joint, and no posterior pain. (P.X3) PA Obrien agreed with Dr. Chen that Petitioner needed an MRI before she would refer him to go to any physical therapy. She opined that his injury was related to the rotator cuff, and given the limited range of motion Petitioner was exhibiting, he may have a significant tear. (P.X3)

On December 3, 2015, Petitioner had an MRI performed at Carle Clinic on his right shoulder. (P.X5) The MRI revealed that Petitioner had a rotator cuff tear involving the supraspinatus and infraspinatus tendons with retraction to the level of the glenoid. (P.X 5) It also revealed diffuse muscle belly atrophy, superior migration of the humeral head, AC degenerative change, large joint effusion and anterior deltoid strain. (P.X 5) Subsequently, Petitioner was sent for evaluation by orthopedic surgeon, Dr. Robert Bane (hereinafter "Dr. Bane"), at the Carle Clinic. Petitioner first saw Dr. Bane on December 28, 2015. After reviewing the results of Petitioner's MRI, Dr. Bane recommended arthroscopic surgery. Dr. Bane noted that he did believe the tear was from the Petitioner's fall. (P.X7) On February 11, 2016, Dr. Bane performed a right shoulder arthroscopy with subacromial decompression, distal clavicle resection, and then an open repair of the rotator cuff. (P.X9) Post-operatively, Petitioner was diagnosed with a massive rotator cuff tear, impingement syndrome, and acromioclavicular joint arthritis of the right shoulder. (P.X 9) On April 4, 2016, Petitioner had a follow-up with visit with Dr. Bane. Dr. Bane released the Petitioner to return to work light duty on April 5, 2016. In addition, Dr. Bane suggested Petitioner continue the therapy three days a week for five hours a day and to return to see him in eight weeks. (P.X 7) The Petitioner told the doctor he was only taking Advil at the time for pain.

On August 5, 2016, Petitioner returned to Dr. Bane for a follow-up visit. Petitioner had completed physical therapy at this point. Dr. Bane reported the Petitioner as having good range of motion in the shoulder without pain and 4+/5 strength to resisted abduction and external rotation. Dr. Bane released the Petitioner to return to regular work duties with the exception of no physical restraints. (P.X7) Dr. Bane told him the physical restraints would be permanent limitations and although he was strong enough to do his regular job he should never participate in physical restraints. Dr. Bane instructed the Petitioner to stop formal physical therapy and just do physical therapy on his own. In addition, he opined that the Petitioner would reach MMI one year from surgery, which would be around February 11, 2017. (P.X7) Dr. Bane reported that the Petitioner would probably still have some residual weakness in his shoulder, but he was dramatically better, because he could not even lift his arm prior to surgery. (P.X7)

Petitioner returned to work full-duty, in the same job title, and with the same pay. (T.25-26) Petitioner testified that he elected to resign from work at the Respondent the following year due to unrelated medical issues. (T.14) Petitioner is currently working as a substitute teacher at Danville High School. (T.14) As it relates to the current condition of Petitioner's right shoulder, he testified that his right arm is weak and sore most nights if he has been active. (T.15) Petitioner testified he uses Tiger Balm and Tylenol to reduce discomfort as needed, but does not have any sharp pain. (T.15-16) Petitioner testified that he is no longer able to use his camper or golf. Petitioner also testified that he now has to have his son help him with woodworking. (T.17) Petitioner has also had to modify the way he plays with his grandchildren. (T.17)

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment:

The Petitioner, Robert Runyan, was one of two witnesses to testify at trial. The Arbitrator finds the overall testimony of the Petitioner to be truthful, credible and otherwise unrebutted regarding his past medical history, mechanism of injury, course of medical treatment and current subjective complaints. The Arbitrator notes that there was one discrepancy with the Petitioner's testimony regarding his five-pound job restriction. (T.14) The admitted medical records do not support this assertion. (P.X.7)

Mrs. Barbara Miller (hereinafter "Mrs. Miller") was the only witness to testify on behalf of the Respondent. Mrs. Miller, Petitioner's supervisor, testified to helping Petitioner fill out an incident analysis report on October 27, 2015. (T.29) The Arbitrator finds the overall testimony of Mrs. Miller to be truthful, credible and otherwise unrebutted regarding the limited discussion she had with the Petitioner regarding how the accident occurred, her aid with the Petitioner in filling out his report, and the report she filled out describing the accident. (T.27-33)

With respect to issue (C) whether an accident occurred that arose out of and in the course of employment with Respondent, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his accident arose out of the course of his employment. "A claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of the employment." 820 ILCS 305/2 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*,

131 Ill. 2d 478, 483, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987). Here, the Respondent only questions the "arising out of" component.

An injury 'arises out of' one's employment if it originates from a risk connected with, or incidental to, the employment, so as to create a causal connection between the employment and the accidental injury." *Brais v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 120820WC, ¶18. Therefore, "in order to determine whether the Petitioner's injury arose out of her employment, one must first categorize the risk to which he or she was exposed. Illinois recognizes three categories of risk to which an employee may be exposed: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App.3d 347, 352, 247 Ill. Dec. 333, 732 N.E.2d 49 (2000).

The Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that he was exposed to a risk distinctly associated with his employment creating a causal connection between his employment and the accidental injury. In order "for an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference the fall stemmed from a risk associated with her [his] employment." *Builders Square, Inc. v. Industrial Comm'n,* 339 Ill.App.3d 1006, 1010, 274 Ill. Dec 897,791 N.E.2d 1308. "Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work-related task which contributes to the risk of falling." *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill.App.3d 1103, 1107, 204 Ill. Dec. 354, 641 N.E.2d 578 (1994). Here, Petitioner testified that the bathroom was locked and staff members were the only ones with keys. (T.10). However, when Petitioner was asked whether there were any defects in the bathroom causing his fall he testified that he saw no cracks, defects or debris on the floor. (T.10-11) Petitioner testified that "...when he turned to step out [of the bathroom stall] my [his] foot hit something, or I just didn't have my feet under me and I fell." (T.8) The Petitioner provided no evidence that there was a condition on the premises that was a contributing cause to his fall. Accordingly, the Arbitrator finds there was no risk present that was distinctly associated with the Petitioner's employment.

The Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that he was exposed to any personal risks creating a causal connection between his employment and the accidental injury. "An injury resulting from an idiopathic fall arises out of the employment only where the employment conditions significantly contributed to the injury by increasing the risk of falling or the effects of the fall." *Stapleton v. Industrial Comm'n*, 282 Ill.App.3d 12, 16, 217 Ill.Dec.830, 668 N.E.2d15. Here, the Petitioner testified that prior to October 23, 2015 he has never had any issues with dizziness, fainting spells, or problems with his legs giving out on him. (T.11) No further evidence was provided, by the Petitioner or the Respondent, proving that the Petitioner suffered from any idiopathic health issues that could have contributed to his injury. Accordingly, the Arbitrator finds there was no personal risk present and a neutral risk analysis must be applied.

The Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that his injury resulted from a neutral risk to which he was exposed. "An injury resulting from a neutral risk, is one to which the general public is equally exposed, does not arise out of the employment." *Caterpillar Tractor Co.*, 129 Ill.2d at 59, 133 Ill.Dec. 454, 541 N.E.2d 665. Here, the Petitioner did provide testimony that the bathroom the accident occurred in was locked and only accessible by the staff members. (T.10) However, he did not provide any evidence or testimony that the bathroom or the bathroom stall was any different from the bathrooms or stalls used by the general public. The Petitioner failed to prove by a preponderance of the evidence, that the act of him using the Respondent's restroom established a greater risk to him than that faced by the general public

when using public restrooms. *Illinois Consolidated Telephone Co.*, 314 Ill.App.3d at 353, 247 Ill.Dec. 333, 732 N.E.2d 49 (200). Accordingly, the Arbitrator finds the Petitioner failed to prove by a preponderance of the evidence that his accident arose out of and in the course of his employment.

With respect to issues (J), (R) and (L) the Arbitrator finds as follows:

As a finding has been made that the Petitioner's accident did not arise out of and in the course of his employment with Respondent, the other disputed issues are moot.

Timothy Kay

Signature of Arbitrator

4-6-18
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

Shannon J. Cahill,

Petitioner,

vs. NO: 14 WC 18265

Tompkins Printing Equipment,

Respondent.

18IWCC0715

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 16, 2018, is hereby affirmed and adopted.

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

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

18IWCC0715

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 $45,000.00. 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 21 2018

o102518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

CAHILL, SHANNON J
Employee/Petitioner

Case# **14WC018265**

TOMPKINS PRINTING EQUIPMENT
Employer/Respondent

18IWCC0715

On 4/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.88% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0210 GANAN & SHAPIRO PC
RON M MARCH
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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

SHANNON J. CAHILL
Employee/Petitioner

v.

TOMPKINS PRINTING EQUIPMENT
Employer/Respondent

Case # 14 WC 18265

Consolidated cases: _____

18IWCC0715

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **February 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 11, 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 **$58,760.00**; the average weekly wage was **$1,130.00**.

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; any issue involving unpaid prior medical expenses has been deferred by stipulation of the parties.

Respondent shall be given a credit of **$155,291.45** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$155,291.45**.

Any issue with regard to Respondent's entitlement to credit under Section 8(j) of the Act has been deferred by stipulation of the parties.

ORDER

The Arbitrator finds that the Petitioner's left hip condition is causally related to the November 11, 2013 accident.

Respondent shall authorize the revision surgery involving the prior left total hip replacement as recommended by Dr. Gordon, pursuant to 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.

Signature of Arbitrator

April 12, 2018
Date

APR 16 2018

STATEMENT OF FACTS

The parties indicated prior to the hearing that the only issues in dispute for the Arbitrator to resolve are whether the Petitioner's left hip condition is causally related to the 11/11/13 accident, and if so whether he is entitled to prospective surgical treatment regarding same. The parties have stipulated that there is currently no TTD due and owing, and that the Petitioner has been fully paid for all claimed TTD with no overpayment or underpayment. Finally, the parties have stipulated that any issues that may exist regarding prior medical expenses, including credit to the Respondent, are deferred with regard to the current hearing. This includes any incurred expenses related to the left hip, which the parties have indicated will be addressed in agreement with the Arbitrator's determination on medical causation.

The Petitioner testified that he was employed by Respondent as a service technician since October 1986. His job duties involved installing and servicing graphic arts printing equipment, such as paper cutting machines, folding machines, bindery equipment and, occasionally, printing presses. The tools he used were mainly hand tools, as well as lifting/moving tools like gantries (a pulley system used for lifting heavy equipment), forklifts, pallet trucks and machine jacks. He would occasionally have to lift heavy machines and/or parts, with assistance. He testified he would perform overhead reaching to reach nuts and bolts or to place things on top of machines, and would also have to push and/or pull machines, pallet trucks and boxes. He reported constant squatting, crawling, bending, crouching, twisting and kneeling to work on, underneath and inside of machines. He would have to climb to get to upper parts of machines, sometimes with ladders and at other times by climbing on the machines themselves. Ultimately, he would have to work his body into tight or awkward spots so he would be able to work on the machines. Petitioner testified he would be on his feet for 8 to 10 hours per day. Prior to 11/11/13, Petitioner testified that he was fine and had no problems performing all of his job duties.

Petitioner testified that he had no prior treatment with regard to his left hip, left shoulder, neck or back before 11/11/13. He had undergone prior left elbow treatment in approximately 2007 involving cubital tunnel release. Following his unrestricted release from care after that surgery, he testified that he had no further treatment for that condition prior to 11/11/13.

On 11/11/13, Petitioner testified he was working at a customer's shop in the Evanston area, removing an old machine and installing a new one. While lifting an approximate 600-pound paper cutting machine, with helpers, he was injured. He testified that they were moving this by putting their hands underneath the machine and lifting with their arms. While holding the machine, they were shuffling forward and sideways to get around obstacles. After he completed the lifting, Petitioner testified that he noticed pain in his neck, left shoulder, left low back area and buttocks.

Petitioner testified he was initially seen on 11/14/13 by Dr. Simon at Occupational Health Centers/Concentra, which he indicated was Respondent's occupational health facility. Petitioner reported feeling pain in his left back and left shoulder after lifting a 600 pound machine with co-workers on 11/11/13. He denied any paresthesias, and denied any prior similar problems. Lumbar and left shoulder x-rays were within normal limits, with a note of degenerative lumbosacral facet changes. Dr. Simon diagnosed lumbar and shoulder strains, issued work restrictions and prescribed physical therapy and medications. (Px1). A pain diagram from this date indicated the lumbar pain was located in the central low back. (Px1).

Petitioner agreed he didn't specifically complain of the left hip, testifying: "I wasn't sure where the pain was actually coming from. It was pain in my lower back area and around in the buttocks." He testified that he attended the prescribed therapy and that the Respondent accommodated his restrictions until 3/12/14.

Petitioner followed up with Dr. Simon on 11/21/13, reporting ongoing shoulder pain, with tingling in the arm and elbow down to the fingers, and mild back pain (3/10) with certain movements. Exam noted tenderness of the left paraspinous muscles. Neurologic examination was normal with no indication of radicular symptoms. On 11/27/13, Petitioner noted further shoulder and back improvement with medication, therapy and light duty, with minimal occasional back pain at 1 to 2 out of 10. Restrictions, medication, therapy and home exercise were continued. (Px1).

On 12/3/13, Petitioner still noted left shoulder pain with occasional tingling into the left arm/hand, and ongoing mild 2 out of 10 back pain. Lumbar exam was essentially normal except for pain with flexion. On 12/10/13, the Petitioner's left shoulder/arm pain was worse, and a left shoulder MRI was prescribed. Petitioner's back was noted to be better, with mild occasional 2/10 pain. Otherwise, work restrictions, medication and therapy were continued. (Px1). The 12/16/13 shoulder MRI reflected a small full thickness supraspinatus tear without retraction or atrophy and mild AC joint degeneration. (Px2). On 12/17/13, the focus of Dr. Simon's report was the left shoulder, and he noted that Petitioner "states his back feels much better." Lumbar examination was normal, therapy and medication were continued, and Petitioner was referred to an orthopedic surgeon, Dr. Tu or Dr. Mercier, for his left shoulder. (Px1).

Petitioner testified that his last visit with Dr. Simon was on 12/17/13, and that he continued to have left low back pain at that time. The records from Occupational Health Center's physical therapy reflect eight visits through 12/10/13. The initial 11/14/13 visit notes complaints of left back and left shoulder pain. (Px1).

Consistent with the medical records (Px3), Petitioner testified that Dr. Mercier examined his left shoulder and performed a cortisone injection into the biceps tendon. The Petitioner had persistent symptoms on 1/9/14, and Dr. Mercier prescribed cervical MRI and left upper extremity EMG/NCV testing. (Px3). The 1/15/14 cervical MRI revealed a C5/6 disc protrusion into the left side causing moderate spinal stenosis and bilateral foraminal stenosis, and the 1/15/14 EMG/NCV was normal except for ulnar slowing at the elbow that was likely related to his prior cubital tunnel. (Px3). On 1/20/14, Dr. Mercier referred Petitioner to Dr. Elborno for cervical epidural, which appears to have been based on the MRI findings at C5/6, and light duty restrictions were continued. (Px3).

Petitioner testified that he was examined by Dr. Rosenblatt on 1/31/14 for his neck and back and continued to have left low back and buttocks area pain. Dr. Rosenblatt's report, in addition to the neck/shoulder symptoms, notes Petitioner reported low back pain that would radiate down his leg to above the knee. Lifting, standing and getting into his car exacerbated the back and arm/shoulder symptoms. Physical and neurological examination of the lumbar spine were normal. As to the back, Dr. Rosenblatt diagnosed lumbago and ordered a lumbar MRI. As to the cervical spine, the Petitioner was offered an epidural versus surgery. Based on the Petitioner wanting a more definitive resolution given his physically demanding job, a pre-operative (C5/6 fusion) CT scan was prescribed. (Px4).

Petitioner saw his primary provider Dr. Zamirowski on 2/18/14 for pre-op testing, and the doctor noted he had referred the Petitioner to Dr. Rosenblatt. Dr. Zamirowski also noted that Rosenblatt was "looking into the low back complaint the patient has developed and that work-up is not yet complete." Lumbago was included in his diagnoses. (Px5).

The 2/26/14 lumbar MRI was reported by the radiologist to be within normal limits at all levels. (Px6). A 3/3/14 thoracic MRI indicated degenerative disc changes throughout the thoracic spine with grade 2 endplate changes, as well as multiple disc herniations most prominent at T10/11 and T11/12 resulting in spinal stenosis. (Px6).

Petitioner underwent a C5/6 anterior discectomy and fusion with instrumentation on 3/12/14 with Dr. Rosenblatt. (Px7). Petitioner testified that he continued to have low back pain during post-operative follow ups with Dr. Rosenblatt. A 3/25/14 report notes complaints of low back pain into the left leg to above the knee with tingling in the buttock and posterior thigh at a 6/10 pain level, and that the lumbar MRI was completed and did not reveal any abnormalities. (Px4).

Petitioner's left upper extremity was examined by Dr. Visotsky on 4/15/14, and, noting a partial supraspinatus tear on MRI, he recommended left shoulder surgery. (Px8).

On 4/16/14, Dr. Zamirowski noted Petitioner continued to have issues with the small of the back and left hip, and he advised Petitioner to see Dr. Gleason. (Px5). Dr. Gleason's 5/12/14 report reflects a history of the November 2013 heavy lifting and twisting injury causing left low back and buttock pain into the lateral thigh to the foot. He also reported numbness and tingling in the left leg. Petitioner reported constant symptoms which had increased and were then remaining about the same, with no real improvement with the last two months with therapy. X-rays showed mild degenerative disc disease from L4 to S1 and mild to moderate bilateral hip joint disease, right greater than left, with joint space narrowing and spurring. He noted the lumbar MRI report was indicated to be essentially normal, but wanted to review the films. Dr. Gleason diagnosed left lumbar radicular syndrome, probably mechanical, and prescribed a lower extremity EMG/NCV, home exercise, weight loss, discontinuation of smoking and occasional use of over the counter medications. (Px9).

The lower extremity EMG/NCV testing was completed on 6/3/14. Dr. Rechitsky documented that Petitioner performed "ill-prepared rotational movement in the lumbar spine" on the accident date, and the next day had gradually worsening lumbalgia radiating to the left gluteal area, along with shoulder and left upper extremity complaints. Petitioner also indicated: "Since he was busy taking care of the issues of cervical radiculopathy, myelopathy, his chronic low back pain was treated with just physical therapy so far." The study was normal with no evidence of left lumbar radiculopathy, particularly in the expected L5/S1 region, and Dr. Rechitsky recommended a CT myelogram and an MRI of the pelvis and hips. (Px10).

On 6/30/14, Dr. Gleason read the lumbar MRI films to show mild degenerative disc disease, greatest at L5/S1, with minimal bulging and no evidence of stenosis. Noting Dr. Rechitsky's EMG/NCV findings, he prescribed a pelvic MRI, which on 7/15/14 was negative for fracture, sacroiliitis or avascular necrosis, but showed mild right hip degenerative joint disease. On 7/28/14, following his review of the pelvic MRI, Dr. Gleason referred the Petitioner, at his request, to Dr. Shah for a second opinion. (Px9; Px11).

On 7/25/14, Dr. Visotsky indicated he planned to perform ulnar nerve release surgeries at both the elbow and forearm, as well as removal of a foreign body or neuroma, which would be followed by left shoulder surgery at a later date. (Px8).

Petitioner saw Dr. Shah on 8/11/14. He determined that left hip x-ray showed a CAM-type femoral acetabular impingement with a convexity located at the femoral head and neck junction with sclerosis. Petitioner also had some joint space narrowing and osteophytes. He noted the same findings in the pelvic MRI, but, as had been noted by Dr. Gleason, there was difficulty with the films in assessing the labrum. There also was a chronic subcortical cyst consistent with impingement at the femoral head/neck junction with some subchondral cyst formation at the acetabulum. Diagnosing a likely labrum tear, Dr. Shah performed a left intraarticular hip injection and recommended conservative treatment. On 9/8/14, Petitioner reported the injection did not provide any significant long-term relief, and Dr. Shah prescribed a left hip MR arthrogram. (Px12).

A 9/26/14 report of Dr. Rosenblatt states that Petitioner reported right hip pain and paresthesias in the right foot, noting Dr. Shah indicated possible right hip problems. It appears this is a typo and should be left hip. (Px4).

The 10/28/14 left hip MR arthrogram impression was: 1) partially detached tear along the base of the anterosuperior labrum; 2) detached tear along the base of the anterior labrum; 3) mild left hip degenerative joint disease with areas of mild to moderate grade chondromalacia; 4) findings suggestive of CAM-type femoroacetabular impingement; and, 5) sequelae of tear of the ligamentum teres, likely complete or near complete. (Px11).

When the Petitioner returned to Dr. Shah on 11/3/14 to review the MRI, the doctor noted left hip anterior-superior and anterior labrum tear with detachment and mild arthritic change. Dr. Shah told the Petitioner that the only surgical treatment for this would include arthroscopy, labral repair versus partial labrectomy, osteoplasty, chonroplasty and acetabuloplasty, and he would recommend this if home exercises and anti-inflammatories did not help. Petitioner opted for surgery. (Px12).

On 11/21/14, Dr. Rosenblatt noted Petitioner was being evaluated for degenerative left hip disease, and Petitioner's "problem list" continued to include low back pain. The remainder of Dr. Rosenblatt's records essentially address only the left shoulder and cervical spine. (Px4).

Petitioner was examined by Dr. Puri at the Respondent's request pursuant to Section 12 of the Act on 1/26/15 with regard to the recommended left hip surgery. Petitioner reported he was moving a very heavy machine and twisting quite a bit, and developed significant soreness. He recalled complaining of left hip pain, some ulnar nerve numbness and some left shoulder and neck pain. He denied any prior history of hip pain. Dr. Puri referenced his review of the initial records of Dr. Simon. Noting that his pain was centered around the left buttock and hip, Dr. Puri opined that, based on Petitioner's history, this appeared to be causally related to the accident. He noted the pain was not in a typical location for an arthritic hip and recommended a therapeutic versus diagnostic left hip injection with a pain diary. He noted it was unclear if the left hip was the cause of his pain and disability, and that it could be lumbago. (Px20).

Following a 2/4/15 left elbow MRI, Dr. Visotsky performed surgery on the Petitioner's left upper extremity on 3/16/15, including cubital tunnel release, neurolysis, open forearm exploration, resection of neurolysis of the sensory branch and resection of a thrombosed segment of vein and scar tissue. (Px14). On 5/22/15, Dr. Visotsky prescribed left shoulder surgery. (Px8).

On 6/15/15, Petitioner noted Dr. Puri's findings. Bilateral hip injections were performed, and the Petitioner indicated he wanted to proceed with a total left hip replacement, and Dr. Shah noted that given he had severe pain, if the injection did not provide relief, he would be a candidate for hip replacement. (Px12).

Petitioner underwent left hip replacement with Dr. Shah on 7/28/15. The post-operative diagnosis was left hip osteoarthritis and osteonecrosis. The report indicated excellent reconstitution of leg length. (Px15). The Petitioner testified that this surgery was authorized by the Respondent.

In follow up with Dr. Shah on 8/17/15, Petitioner reported his hip felt better, but he remained slightly sore in his lower back and was still using a cane. However, he reported daily improvement and that the pain was mild. He was to start physical therapy for the hip and back. 8/17/15 x-ray indicated the Petitioner's leg lengths were even. On 9/14/15, Dr. Shah noted Petitioner again reported hip improvement, but that his back still hurt and his left knee had progressively worsening pain. Dr. Shah recommended a knee injection and continued therapy, and referred Petitioner back to Dr. Gleason, or to Dr. Clay, for the low back. (Px12).

On 10/9/15, Dr. Visotsky prescribed a left upper extremity EMG/NCV. (Px8).

On 10/19/15, Petitioner returned to Dr. Shah with complaints of pain mainly to the left buttock, but also progressively worsening pain in the right buttock. He felt like his left leg was longer than the right. X-ray now indicated a 3.2 mm leg length discrepancy, which Shah indicated was "fairly negligible." There was no evidence of loosening of the hardware. Dr. Shah injected the left hip, and while Petitioner indicated his low back appointment was not authorized, Dr. Shah encouraged him to follow up on seeing a back doctor for evaluation and possible injection treatment. He noted there was osteoarthritis in the right hip as well, but given no pain to the groin, he opined that conservative treatment should continue. (Px12).

Regarding the 10/20/15 upper extremity EMG/NCV with Dr. Rechitsky, Dr. Visotsky on 10/23/15 noted it showed healing at the site of the elbow surgery but persistent cervical nerve changes, and Petitioner's left shoulder remained symptomatic. (Px8).

Petitioner returned to Dr. Gleason on 11/9/15 with continued complaints of low back pain shooting down the left leg, as well as numbness, similar to what it was prior to the hip replacement, and with no improvement since then. He used a cane and reported his feelings of a leg length discrepancy. He was advised to follow up with Dr. Shah and to consider a physiatry evaluation with someone like Dr. Clay. (Px9).

On 12/14/15, Petitioner reported buttocks pain to Dr. Shah. He had completed therapy, but Dr. Shah noted he felt Petitioner's continued left knee pain was impacting his left hip rehab. He also noted that Dr. Gleason felt that the less than 3 mm leg length discrepancy should not be a cause of any trouble for Petitioner. A visit with Dr. Clay was not authorized. As to the left hip, Dr. Shah opined that Petitioner could return to full duty, but again noted he felt the left knee was significantly limiting Petitioner, that he should have a knee injection, and that he should see Dr. Clay "to help with his hip and back issues that may be compensatory." (Px12).

Petitioner saw Dr. Dotchev at the Northwest Suburban Pain Center on 1/21/16, which was indicated to be on referral from Dr. Zamirowski, and the doctor performed a left SI joint injection. Petitioner was advised that a return visit was needed, but the records from this facility to not reflect any additional visits. Dr. Dubois also performed x-rays there and determined that there was a 1.5 cm length discrepancy between the left and right legs. (Px17).

Dr. Visotsky performed left shoulder surgery on 2/11/16 involving arthroscopic subacromial decompression and rotator cuff repair, as well as open clavicle resection. (Px14)

On 2/22/16, Petitioner reported ongoing posterior buttock pain to Dr. Shah and he had a limp. Dr. Shah diagnosed left greater trochanteric bursitis, ordered a bone scan and evaluation of Petitioner's leg lengths, and injected the left hip. (Px12). The 6/3/16 bone scan showed the left hip prosthesis in position with some "moderate, not unexpected, increased activity surrounding the prosthesis in the native proximal femur and left acetabulum. (Px11). On 6/13/16, Dr. Shah noted the bone scan showed some increased uptake to the femoral stem, and diagnosed probable loosening of the hardware as a cause of pain to the thigh. He indicated that Petitioner had limited options, and after discussion indicated that the he seemed to be opting for a revision surgery of the arthroplasty. (Px12).

Petitioner was evaluated by Dr. Lieber on 6/20/16 on behalf of the Respondent (see testimony below).

On 7/26/16, Dr. Zamirowski referred Petitioner to Dr. Gordon for a hip evaluation, noting "the patient, his insurer and I would all appreciate a second opinion." (Px5). On 8/3/16, Petitioner saw Dr. Gordon with regard to the left hip, apparently also on referral from Dr. Visotsky. Dr. Gordon's testimony is outlined below, but his report noted a belief that Petitioner had suboptimal hip mechanics which could be the reason for his limp and ongoing pain. While prosthetic loosening was a possibility, Dr. Gordon believed the femoral stem was solidly fixed, and that he was a candidate for revision of the acetabular portion of the hardware to proximalize and medialize it, as well as to assess the femoral component. (Px18).

Following a 10/4/16 left shoulder CT scan, on 12/9/16, Dr. Visotsky again prescribed a left upper extremity surgery, biceps tenodesis. (Px8). The 3/20/17 operative report of Dr. Visotsky reflected a left subacromial decompression, rotator cuff repair and shoulder joint synovectomy and capsular release. (Px14).

Petitioner testified that he last saw Dr. Gordon on 8/30/17, when he injected the left hip and continued to recommend left hip revision surgery, which Petitioner wants to undergo. He last saw Dr. Visotsky on 9/22/17, and Petitioner testified the doctor continued to restrict his work activities with regard to the left upper extremity. Petitioner testified he hasn't worked for Respondent since March 2014, and was continuing to receive TTD. Since the accident date, Petitioner testified that he has had no new injuries or accidents involving the back, neck, left hip or left upper extremity.

The Petitioner testified that he currently continues to have pain in the low back, buttocks and groin areas on the left, which is the same area he says he reported originally to Dr. Simon. He takes medications for pain, including Norco and Gabapentin, and takes Ambien for sleep. These medications are prescribed by Dr. Visotsky and Dr. Kiefer, his new primary care provider. He uses a cane that he testified was prescribed by Dr. Shah. Petitioner testified he had no problems with walking prior to the 11/11/13 accident, but now has a limp/altered gait. His left hip/low back pain has worsened over time, especially with activity. He testified that the orthotic Dr. Zamirowski recommended did not provide him with relief.

On cross examination, Petitioner agreed he did not initially seek treatment after the 11/11/13 accident for three days. He agreed he reported low back and buttocks pain when he saw Dr. Simon. As to the pain diagram, Petitioner noted the low back indication was near the buttocks, and that "I wasn't sure where the pain exactly was coming from", and that he thought that indicating the low back included the buttocks area. Asked if he believed Dr. Simon's records were inaccurate if they didn't mention complaints of buttocks pain, Petitioner testified: "I may not have explained it to him exactly correctly at the time." Petitioner did not dispute Dr. Simon indicating he examined his hips and noted full range of motion without pain, and that he had a normal gait. As to whether he agreed Simon's initial report does not reference any complaints of hip symptoms, he testified "I believe they indicate the lower back area."

Petitioner agreed he also did not complain of pain into the buttocks or in the left hip when he saw Dr. Simon on 11/21/13, and didn't dispute indicating his back pain was mild, or that he didn't complain of left hip pain during hip examination. Petitioner was working light duty at this time. Petitioner testified that, if the ongoing records of Dr. Simon and Occupational Health Center physical therapy through mid-December 2013 do not reflect left hip complaints or abnormal left hip findings, he would not dispute the records. He would not dispute if the 11/27/13 report of Dr. Simon said his back was improving and doing well, though he didn't recall independently. Again, he provided the same testimony with regard to the records of physical therapy.

Petitioner did see Dr. Puri for the left hip at the Respondent's request on 1/26/15. He did not recall if he told Dr. Puri that he complained of immediate left hip pain after the accident, but had no reason to dispute this if his reported indicated same. He agreed he gave all subsequent physicians he saw a history of immediate onset of

pain after he 11/11/13 incident, and believed what he reported to Dr. Simon was low back pain. He agreed that he also reported left shoulder complaints, and that Dr. Simon prescribed a left shoulder MRI and referred him for further left shoulder treatment.

On redirect examination, Petitioner agreed that he hadn't reviewed his medical records and wasn't aware of what was contained in them and had no control over what the doctors entered into their reports, but would defer to what the doctors documented. The Petitioner testified that he's had no medical training. In his mind, his complaints of "left hip pain" involved low back pain into the buttocks. He described his current complaints to Dr. Simon, and his complaints in that area remained the same. Dr. Simon would examine him for 5 to 10 minutes, and Petitioner was not aware of exactly what body parts he was examining at any point in time or what the purpose of each exam was.

Petitioner testified he continued to have low back pain after Dr. Simon released him, and he reported the same complaints to Dr. Gleason, who referred him to Dr. Shah. The Petitioner testified he was not aware of the source or origination of his pain complaints at that time, so he couldn't say he was specifically referred for his left hip. All he could say is he reported where he had the immediate onset of pain at the time of the accident.

The parties obtained the deposition of Dr. Simon on 11/9/17. Board certified in occupational medicine and internal medicine, he testified he treated the Petitioner between 11/14/13 and 12/17/13 at Concentra (a/k/a Occupational Health Centers). He testified that Petitioner's initial complaints on 11/14/13 following the work accident were of the left low back and left shoulder. Lumbar examination findings included muscle tenderness and limited range of motion. Neurologic examination was normal, and he had a normal gait. Hip examination showed normal painless passive hip range of motion, indicating to him no abnormality causing the severe pain. Lumbar x-rays showed no bony abnormalities. Dr. Simon opined these findings indicated a back strain with no "red flags" for anything else. Dr. Simon testified that: "...at this time you could have pain when the patient is actually moving the hip, actively, because he has to activate all his muscles that can cause pain, even with a strain." He testified that he himself completed the Petitioner's 11/14/13 pain diagram. He agreed that, depending on how the injury was sustained, a person can have hip symptoms more towards the area of low back on the same side than the hip itself, but that the purpose of the hip examination is to try to rule out a hip injury. In his opinion, Petitioner's initial complaints indicated that "the injury was towards the back and not the (left) hip." Dr. Simon went on to testify that none of his other examinations indicated a left hip abnormality, and none of Petitioner's complaints were directed to the left hip. (Rx1).

On 11/21/13, Petitioner reported 3 out of 10 (3/10) left back pain, again with no neurological involvement, exacerbated by a certain movement, while hip examination was normal. On 11/27/13, Petitioner reported occasional back pain at 1/10 to 2/10 level, and that he was improved with therapy and medication and work restrictions, which Dr. Simon testified was consistent with a muscular back strain. Back and hip examinations were normal. On 12/3/13, Petitioner reported mild 2/10 back pain only with certain movements, and he was still in therapy, taking medication and had work restrictions. Again, Petitioner had no specific hip complaints, and lumbar and passive and active hip exams were normal. He was "much improved" and Dr. Simon opined "it at least means that his condition was resolving." On 12/10/13, Petitioner had had a left shoulder setback with increased pain every time he used the left arm. He continued to report 1/10 to 2/10 low back pain without radiation, and he was continuing to undergo therapy and was working within his restrictions. Hip and lumbar examinations were again normal. Dr. Simon continued to diagnose a lumbar strain, noting this was "probably residual inflammation in his lower back, but his back was much better." At the last visit of 12/17/13, Dr. Simon testified Petitioner's back was much better, and agreed he didn't indicate a specific pain level for this visit. Lumbar and hip examinations were again normal. While the report continued to indicate a lumbar strain

diagnosis, he testified: "At this point the lumbar strain was resolved." He referred Petitioner to Dr. Mercier for the left shoulder, and did not feel any referral was necessary regarding the low back. (Rx1).

On cross examination, Dr. Simon agreed he is not a surgeon, and that he has specific criteria for orthopedic referrals, including if there is a perceived need for injection or surgery. He reiterated that hip pain can be referred to the back and agreed that its possible a person with a hip problem could present with only low back pain, but that is why he would check more than one body part, and noted that most people with a hip problem would have an altered gait. Most people with a hip problem would not have pain completely localized to the back without any hip symptoms or findings on hip examination, "which is kind of what we saw in his case." Dr. Simon did not perform any additional testing of the hip beyond range of motion because the Petitioner never complained of hip pain. Back pain was elicited when Petitioner bent forward and was unable to fully flex without bending his knees. Dr. Simon acknowledged that the left low back complaints were over the left hip or the belt line area. Petitioner would be expected to have improved as he did with conservative treatments, but he agreed Petitioner continued to report 2/10 pain on 12/10/13. Dr. Simon testified that the Petitioner's back improved over the course of care in terms of both exam findings and subjective complaints. He agreed Petitioner was more concerned about his shoulder because of the pain and tingling in the left arm. While the Petitioner's pain was resolving as of 12/17/13, and he was able to fully flex while he could not do so initially, Dr. Simon agreed his back pain had not fully resolved at that point, and that he was unaware of what Petitioner's condition has been since 12/17/13. As such, he couldn't comment on the reasonableness of any post-12/17/13 treatment for the low back complaints. (Rx1).

Orthopedic surgeon Dr. Gordon testified via deposition on 1/27/17. He testified to his experience with hip conditions and arthroplasty, noting 55% of his practice addresses hip problems. He has authored papers and done presentations on the issue of hip biomechanics. His 10/17/16 narrative report was prepared after reviewing the records and reports of Dr. Shah, his partner, as well as Dr. Puri and Dr. Lieber. His recorded history indicated Petitioner had a work injury, per Dr. Shah's notes, involving a heavy lifting and twisting episode, with persistent left hip pain. He saw Petitioner on 8/3/16, about a year after his hip replacement with Dr. Shah, for a second opinion due to ongoing pain and loss of left hip function. Petitioner complained of his hip, lateral thigh and buttock, and he had a marked limp and used a cane. There was tenderness to palpation of the bones around the hip. Based on examination and review of x-rays, Petitioner had a post-surgical varus alignment and femur stem seating that resulted in a roughly 15 mm leg length inequality, with the left leg being longer. Dr. Gordon called this a "true" leg length discrepancy as opposed to a "functional" one, meaning the replacement hardware makes the left leg longer, which can cause pain and limping. He testified that anything beyond a 10 mm discrepancy starts to lead to a likelihood of symptoms. Dr. Gordon diagnosed a painful left hip arthroplasty based on suboptimal hip mechanics, which means it is outside of the optimal parameters based on the location of the ball and socket versus the mechanics on the native right side. This was due to the placement of the replacement parts, which can be challenging and is a risk of such surgery. Dr. Gordon opined that a revision surgery is indicated, including redoing the socket side versus the femur side, which he believed "could really fix a lot of these issues here." The subjective complaints were consistent with the objective findings. (Px23).

With regard to causation, Dr. Gordon noted Petitioner had undergone a hip replacement between the work accident and the time he first saw him, and so: "I don't have a full linear story here, but I guess what I can say is my opinion is that the man had a work-related injury, and my review of the record seems that it did cause a problem with his left hip that warranted a hip replacement." He opined that his symptoms on 8/3/16 were related to that hip replacement. Based on x-rays, prior to surgery, Petitioner had an "at risk hip", as the ball and socket were "a little out of round" with each other, and this was also the case in the right hip based on x-rays. A lifting and twisting load in this situation can cause the femoral head to impinge on the rim of the hip socket and cause cartilage damage and/or a labral tear to the hip, which can lead to deterioration of the hip joint. In his current

condition, Dr. Gordon opined that the Petitioner would be restricted to below medium-level duty, noting he could also have difficulty with sedentary work if he had to sit in one position for a prolonged time. He ultimately would recommend an FCE to get a definite answer. As to the opinions of Dr. Lieber, Dr. Gordon testified that, based on x-rays and bone scan, the Petitioner's hardware is solidly attached to the bone, so he disagreed that the Petitioner has a problem based on loosened implants. (Px23).

On cross-examination, Dr. Gordon agreed he only saw Petitioner once, and that he did not review any medical records other than those of Drs. Shah, Puri and Lieber. His recitation of the accident history was based on the history indicated by Shah in his initial 8/15/14 report. He agreed he did not note a causation opinion in Dr. Shah's records, and that his own opinion on causation is based on the initial hip replacement being related to the accident. Dr. Gordon testified he would expect someone with a hip injury to have hip pain and limping, but they could also have shin or knee pain. A structural injury to the hip, such as an incident causing synovial inflammation or a bone bruise, should present itself "pretty quickly" under normal circumstances. As to Petitioner's "out of round" condition with the hip ball and socket, he noted this is congenital and testified: "(T)hat's just how he is made, so he is more likely to develop a degenerative arthritis of the hip, and something like an injury to the hip could be an event that would begin the deterioration of the joint. . .", and aggravate / accelerate / exacerbate the condition, resulting in symptoms. Dr. Gordon agreed that the most common scenario in such situation would be a natural progression of the condition due to wear and tear to where it becomes symptomatic. Things that could impact an arthritic hip and cause symptoms would commonly include prolonged sitting or walking, use of stairs and even putting on one's socks and shoes. (Px23).

Dr. Gordon reiterated, regardless of Dr. Zamirowski's opinion, that post-operative x-rays and the 6/3/16 bone scan did not show any evidence of hardware loosening in the left hip. In reviewing Dr. Simon's initial 11/14/13 report, three days post-accident, Dr. Gordon agreed there was no indication of hip pain or symptoms consistent with a hip injury. He indicated the subsequent reports of 11/21/13, 11/27/13, 12/3/13 and 12/10/13, in terms of complaints and Dr. Simon's exam findings, also do not indicate evidence of hip complaints or abnormalities on exam. He testified that with a major structural hip trauma, he would expect to see complaints of limping or hip pain. He testified that Dr. Simon's records do not document findings that would indicate a left hip trauma occurred on 11/11/13, and thus based on Simon's records, he was unable to find a causal relationship between the work injury and the hip replacement. (Px23).

With regard to the proposed hip revision surgery, Dr. Gordon testified that there is no noninvasive way to make Petitioner's left leg shorter. He agreed that an orthotic trial is generally a reasonable option, but in the Petitioner's case this would just "prop up" the right leg, and the problem is his psoas muscle and hip adductor muscles would still not be in their most optimal and efficient position. An orthotic can help if the leg length discrepancy involves minimal pain, and he believed that it would be unlikely to resolve Petitioner's pain. He again opined that an alignment issue is what is causing Petitioner's pain complaints. Based on x-ray, it appears that the center of Petitioner's left hip socket is roughly 10 mm lower than the right, and the remaining 5 mm leg discrepancy is likely due to the femur portion of the prosthetic. This results in different mechanics in each hip. The soft tissues around the hip are sensitive to the amount of stretch they are under, and if the mechanics are not proper they can start causing pain. Dr. Gordon agreed the surgical recommendation relies on the veracity of Petitioner's ongoing pain complaints. He testified that a revision hip replacement is more difficult than an original surgery, with a higher ratio of failures and/or complications He anticipates 6 months of post-surgical recovery time, and that the Petitioner would be able to return to work in some capacity. (Px23).

On redirect, Dr. Gordon testified that he expected symptoms with a left hip injury could be in the groin, buttock or knee. As to whether buttock pain could be confused with low back pain, Dr. Gordon testified: "It is well-known in our business that low back pain and hip pain sometimes are very difficult to sort out. So some people

do have lower back pain that can be referred to a hip issue." He opined that a patient could present with only low back pain with a hip injury. He believes he could figure this out with his own exam, but that "sometimes it is difficult." He opined that an orthopedic surgeon would be more qualified to differentiate between hip and back pain than a general practitioner. Dr. Gleason referred Petitioner to Dr. Shah based on concern that there was a hip issue. He opined it's possible that Petitioner's back pain masked a hip injury. Again, while he could try orthotics, the optimal choice for Petitioner's condition and age would be the revision surgery. Petitioner has a similar congenital condition in the right hip but has had no known treatment for it, and Dr. Gordon testified that not everyone with a ball and socket deformity like Petitioner has ends up having hip replacement surgery. He did testify that the vast majority of people he performs hip arthroplasties on who are under age 60 have a similar genetic condition as the Petitioner. Of those patients, he couldn't say how many of them had traumatic injuries, "but it is not uncommon for someone to be asymptomatic and then sort of have some sort of incident somewhere in their life which then starts them having some symptoms." This can accelerate the need for surgery. He again testified that such an "incident" could be as trivial as tying one's shoes. (Px23).

Dr. Gordon saw the Petitioner on 8/30/17, subsequent to the deposition, and indicated that it was possible the femoral component of the prosthesis might also need to be revised depending on the findings. (Px18).

The evidence deposition of Dr. Puri was completed on 6/14/17. A board certified orthopedic surgeon specializing in reconstruction surgery, such as knee and hip replacement, examined the Petitioner at the request of Respondent on 2/10/15. Dr. Puri testified that he reviewed the medical records of Dr. Simon, Dr. Lieber, Dr. Gordon and Dr. Shah. Based on the Petitioner's history and his review of the records, Dr. Puri testified that Petitioner's left hip pain was causally connected to the 11/11/13 work accident. He testified that a person with a hip injury would complain of pain and/or weakness around the hip joint into the buttock and low back and possibly on the side of the proximal aspect of the leg to the knee. He would expect at least some symptoms to manifest within 72 hours after the accident, and in most cases certainly within a week. It would not be abnormal for the symptoms to worsen over time, or to wax and wane over time. (Px21).

With regard to the Petitioner's complaints of left low back pain to Dr. Simon on 11/14/13, Dr. Puri testified that this could represent pain from the back or the hip, and that back pain can suggest an injury to the hip. He explained that when people have hip pain or back pain, they may not articulate the origin location of the pain properly; people with hip pain can have a back problem, and people with back pain can have a hip problem. Back pain can be referred from an interarticular hip problem. While Dr. Simon found that Petitioner had full range of motion, Dr. Puri did not find this significant because hip pain can manifest in different ways. He testified Dr. Simon's 11/14 and 11/21/13 notes neither confirm nor deny that Petitioner sustained a hip injury. The notes did not confirm anything for Dr. Puri and they didn't rule anything out. However, he agreed that just looking at these two notes with no other information, "I have no way of knowing whether it was causally related." Petitioner's 11/27/13 complaints of back pain may have been indicative of an injury to the left hip. Dr. Puri acknowledged that Dr. Simon interpreted his back and hip examinations as normal, but testified that nothing in the December 2013 reports of Dr. Simon changed his opinion, as they still reference back pain. (Px21).

Dr. Puri based his causation opinion on Petitioner reporting no history of prior hip pain, and rapidly progressing hip pain after the accident. Petitioner reported moving a very heavy machine and twisting quite a bit, after which he had significant soreness. He recalled complaining of left hip pain at the time, some ulnar numbness and some left shoulder and neck pain. Dr. Puri disagreed that the Petitioner's stated history was inconsistent with the records of Occupational Health Centers, again testifying that the pain he reported on 11/14/13 could have been related to an intraarticular source of pain. He testified that he "(didn't) think the average physician is capable of a hip exam that's sensitive enough to pick up a problem." Dr. Puri testified: "So typically with a hip injury that

is significant enough to cause a chronic problem with the hip at five weeks, although you could have waxing and waning of symptoms, I would expect there would still be some objective and subjective findings." The note of mild pain with extension on 12/17/13 (Dr. Simon) could represent a problem with the hip. Again, given the ambiguity, just taking Dr. Simon's records in isolation, "I have no way of knowing what happened." Dr. Puri testified that x-rays showed Petitioner had degenerative hip joint disease, and while the origin can be traumatic in nature, it typically manifests over a period of time. An arthritic pattern, however, also can be made worse acutely by a traumatic incident to the hip. (Px21).

Following his review of the depositions of Dr. Gordon and Dr. Lieber, Dr. Puri prepared a 6/6/17 addendum report, and continued to opine that it appeared, based on Petitioner's history, that his hip condition was causally related to the 11/11/13 accident. Dr. Puri reiterated that his opinion took Dr. Simon's records into consideration, and he testified: "Stanley Simon's examination is woefully lacking." Dr. Puri agreed that his opinion relies on the Petitioner's truthfulness, including having left hip pain starting from the date of accident. (Px21).

On cross-examination, Dr. Puri testified that "unequivocally" the areas of the hip and back can be confusing in terms of diagnosis, and that multiple times in a day he has patients with hip problems that present with back pain. He again testified that it would take a trained physician to determine what is actually going on, and that this can involve diagnostic testing and/or treatment that occurs over a period of time. He sometimes consults with his spine colleagues to sort out atypical presentations in terms of the source of pain between the hip and back. He reiterated that the mechanism of injury could have caused or aggravated the Petitioner's left hip condition. Dr. Puri testified that the source of his pain had to be worked up, which is what was done per the medical records, including a diagnostic hip injection. He testified that the medical treatment performed to date has been medically necessary, and that the Petitioner could work in a light duty capacity. Dr. Puri again noted he was presented with additional evidence that led to his 6/6/17 addendum, but that none of this evidence changed his opinions. Without his own re-examination of the Petitioner, Dr. Puri agreed with the recommendation for revision of the left hip replacement based on Dr. Gordon's notes regarding the leg length issue. Dr. Puri testified that one of the goals of arthroplasty is to make the leg lengths as equal as possible, but sometimes there are anatomic issues that preclude that from happening. Dr. Puri testified: "The only way to tell whether a preexisting condition has been aggravated is to ask the patient", unless there is an acute setting where you can obtain diagnostic testing that can show an exacerbation or acute flare-up on top of a chronic process. (Px21).

Testifying on redirect exam, Dr. Puri agreed that the records of Dr. Simon indicated the Petitioner's back pain improved from November through December, and stated: "If it's going to turn into a chronic issue, meaning this turns into a chronic hip issue, it's not typical that it gets better over a six-week period. It's typical that it sort of waxes and wanes. But there are certain periods of time where someone who has severe arthritis, like we talked about before, could go through a three-month – what we call a honeymoon where they're feeling better because it's anti-inflammatory medication or physical therapy – or weather could affect pain patterns. Warm or cold weather could affect pain patterns positively or negatively. So, again, it doesn't preclude the fact that he may continue to go on to have a problem from this injury, but it certainly doesn't confirm it." (Px21).

The evidence deposition of Dr. Lieber, Respondent's Section 12 examining orthopedic surgeon, took place on 4/5/17. He examined the Petitioner on 6/20/16 and issued a narrative report (Depx2). Dr. Lieber testified he has a subspecialty in sports medicine as well as arthritis and total joint replacements. He treats and performs surgeries on hips. In addition to obtaining a verbal history from Petitioner, he reviewed the medical records from Dr. Simon, Dr. Shah, Dr. Gleason and Dr. Gordon. Petitioner reported developing left hip discomfort on 11/11/13 due to lifting a heavy piece of machinery. He noted Petitioner's complaints and exam findings. He agreed with Dr. Gordon that the Petitioner had a painful left hip replacement, a left leg that was about 1.5 cm longer than the right, a left acetabulum that was a little vertically misaligned, and that the bone scan did not

indicate a loosening of the hardware, though he noted this was not a definitive test for determining the loosening of hardware. (Rx2).

Dr. Lieber opined that there was no causal relationship between the Petitioner's current left hip complaints and the 11/11/13 accident. He testified that this opinion was based on the Petitioner's stated history, his subjective complaints, the physical examination, the medical records reviewed and his medical knowledge. He noted the records of Dr. Simon indicated that multiple examinations of the bilateral hips between 11/14/13 and 12/17/13 showed full range of motion, no pain with passive range of motion and a normal gait. He testified that at no time during this period did the Petitioner articulate complaints supporting an injury to the left hip, such as hip pain, pain with ambulation or pain with hip examination. He testified that if Petitioner sustained a hip injury on 11/11/13, the symptoms would have manifested immediately. Dr. Lieber believed the basis for the Petitioner's left hip treatment was a degenerative condition. He opined that, regardless of causation, he also did not find enough evidence to believe a revision surgery was indicated. He didn't find evidence of anything abnormal with the hip replacement, and testified that a leg length discrepancy, per se, shouldn't cause pain: "It may make you uncomfortable. You may not like it, but it shouldn't cause the pain that (Petitioner) is experiencing." If he were wrong on this, he still would first try an orthotic to see if Petitioner would do well enough that he wouldn't want to go through another surgery. He agreed with Dr. Shah's 12/15 release to full duty. (Rx2).

On cross examination, Dr. Lieber testified that 30% to 40% of his surgical practice involves the hips, including hip replacements. He testified that 99% of his Section 12 examinations are performed on behalf of employers. Dr. Lieber presumed Petitioner's leg length discrepancy was due to the hip arthroplasty. In general, such a discrepancy is significant to him if it exceeds half an inch, but any acceptable length would be one that is not symptomatic. Dr. Lieber acknowledged that arthritis can be aggravated by an injury or trauma in terms of causing an asymptomatic condition to become symptomatic, and that a lifting and twisting accident could be such a causative injury or trauma. Dr. Lieber agreed that a patient with a hip problem may present with pain in the posterior hip and/or groin and belt area, and that the onus may be on the practitioner to differentiate whether symptomatic complaints are coming from the hip or back. Dr. Lieber testified that leg length discrepancy could potentially cause pain, but could not recall the last time he saw a hip arthroplasty patient who he felt had hip pain due to such a discrepancy. If that was the case with Petitioner, he still opined that attempting an orthotic lift would help to determine whether the pain was caused by the leg length discrepancy or not. Without trying this, he testified there is no way to know if the length discrepancy is the cause of the pain. He testified: "if you gave him the lift and the pain didn't go away, then by just increasing his leg length during the procedure why would you think the pain would go away?" Dr. Lieber acknowledged that x-rays show the hip replacement "didn't recreate the normal baseline anatomy of a leg." If it were proven that the length discrepancy is causing the pain, then a revision surgery would be an option. (Rx2).

The Arbitrator notes that the parties stipulated that when a second examination was requested with Dr. Puri, the doctor at that point indicated he no longer was performing independent medical examinations, and that this was why the Respondent then had the Petitioner examined by Dr. Lieber instead. This is consistent with the testimony of Dr. Puri.

CONCLUSIONS OF LAW

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

The crux of the causation issue in this case is whether the Petitioner's symptoms and complaints from the time of his 11/11/13 work accident until his 7/28/15 left hip arthroplasty support a causal relationship of the left hip condition to the accident. Based on the preponderance of the evidence, the Arbitrator finds that the Petitioner has sustained his burden of proving this causal relationship, which resulted in the need for and performance of the left hip replacement.

In making this finding, the Arbitrator relies most significantly on Petitioner's testimony, the medical records in evidence and the opinions of Dr. Gordon and Dr. Puri.

The Arbitrator initially notes that the unrebutted evidence in this case indicates that the Petitioner was participating in lifting a very heavy piece of machinery, and while doing so attempting to maneuver the machine out of a customer's facility. The Petitioner reported injury and symptoms to multiple body parts at the time, including the left shoulder and arm and neck, which has resulted in multiple surgeries, as noted above.

To recover under the Act, an employee must show that there is a causal connection between the claimant's employment and the injury. In *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003), the Illinois Supreme Court held that "even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." The accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being." *Id.*

Much of the dispute in this case involves whether the Petitioner's complaints to Dr. Simon at Concentra/Occupational Health Centers evidenced a left hip injury contemporaneous to the accident, and whether the doctor's examination findings supported a left hip injury or condition. Multiple physicians examined and/or treated the Petitioner in this case, some of whom have testified, and different conclusions were reached.

The initial treatment records of Dr. Simon clearly reference left low back pain. Dr. Simon's records and testimony indicate that the Petitioner had no hip pain during range of motion testing of the left leg, and that Petitioner's low back complaints were significantly improved from November to December 2013. This must be tempered, however, by several facts. First, Dr. Simon appears to be a general practitioner, not an orthopedic physician or surgeon, and there is no evidence he has any specific expertise in hip injuries. Secondly, while Respondent pointed out an initial pain diagram showed central low back pain, and during cross exam Petitioner indicate he believed he put the markings on this diagram, the testimony of Dr. Simon indicated that it was Simon who actually marked this document, and apparently marked central low back pain while he also referenced complaints of left low back pain on the same date. While the Thus, Dr. Simon essentially testified that while the Petitioner did, in fact, complain of the left low back, this was not reflected on the pain diagram, which indicated the pain was in the central low back.

This causes the Arbitrator to have some question as to the reliability of the records of Dr. Simon in terms of reliance on details. The Arbitrator also notes with interest the testimony of Dr. Puri in terms of the fact that symptoms can wane during therapy, anti-inflammatory use and off work/light duty. Thus, the fact that the Petitioner reported improvement in his back pain to Dr. Simon does not, in and of itself, dictate a finding that the left low back pain condition had resolved when Dr. Simon referred him to Dr. Mercier for the left shoulder and arm condition. In fact, the records from Simon show a significant focus on the shoulder and arm versus the back pain.

The Petitioner testified that the symptoms he had at the time of the accident and his referral from Dr. Simon were the same symptoms he continued to have throughout his treatment. He agreed that he may not have specified the left buttocks to Dr. Simon, but credibly testified that he had pain in the left buttocks at the time of the accident, and that this was in the same area, to his understanding, as the left low back.

Dr. Gordon testified that a twisting or lifting injury could have caused an articular cartilage injury or labral tear to the hip requiring a hip replacement. He explained that twisting with a load could cause the femoral head to impinge the hip socket and cause cartilage damage and a labral tear which are associated with degeneration of the hip. The initial left hip/pelvic MRIs did not indicate any internal derangement, the subsequent, and more detailed, MR arthrogram did reflect actual labrum damage. While Dr. Gordon agreed that Petitioner had no specific complains of hip pain on 11/14/13, he testified that initial pain from a left hip injury could be in the groin, buttocks or knee. Dr. Gordon explained that a left hip condition could be confused with low back pain, and that low back pain and hip pain are difficulty to differentiate, even for a qualified physician. He also testified that an orthopedic surgeon would be more qualified to determine where the pain was coming from than a general physician, such as Dr. Simon, and that even he himself might have a hard time determining where such pain originated from. He testified that a person with an undiagnosed hip condition could present with only back pain, and that back pain could mask hip pain.

Respondent's own examining physician, Dr. Puri, opined that Petitioner's left hip condition was casually connected to the 11/11/13 accident. Dr. Puri did base his opinion on the Petitioner's stated history, and he agreed that he would be unable to give a causation opinion relying solely on the records of Dr. Simon without any other information. However, he also testified that nothing indicated in the records of Dr. Simon would rule out a left hip injury, including the examinations by Dr. Simon, which Dr. Puri called "woefully lacking" in terms of a full hip investigation. Nothing indicated in Dr. Simon's records changed his causation opinion, as he testified that they were ambiguous and he did not agree that the history of Petitioner experienced immediate hip pain was inconsistent with those records. Dr. Puri considered that Petitioner did not have any prior injury to his hip, and relied on the mechanism of accident and history provided to him by Petitioner. He opined that the pain reported on 11/14/13 could have been related to an intraarticular source of pain.

Dr. Puri did agree Petitioner's pain was in an atypical location for an arthritic hip, but that he had significant pain flexing both knees with extension of the back, which could represent pain emanating from an intraarticular source. Dr. Puri stated that the lack of pain on testing of bilateral hips did not preclude the fact that Petitioner may have injured his hip at the time of the accident. Dr. Puri explained that when people have hip pain or back pain, they may not articulate where the pain was located properly. Dr. Puri testified that patients will present to him daily with back pain when they actually have a left hip problem, and that it would take a trained physician via examination, diagnostic testing and further treatment to pinpoint where the pain was coming from. If a person presents with ongoing back pain, then a physician cannot rule out left hip problem without such evaluation. Dr. Puri did not find it significant that Petitioner had full range of motion of the hips because hip pain can manifest itself in different ways. Dr. Puri testified that many of his back colleagues consult with each other oftentimes consult with each other regarding atypical presentations of back and hip pain.

Dr. Simon was the first physician to examine the Petitioner, and he testified that his examinations reflected a back strain with no red flags indicating another cause for Petitioner's pain. However, he acknowledged that a patient can have hip symptoms more towards the area of the low back. While he testified that he did not believe Petitioner's symptoms were related to the hip given normal range of motion examinations, the Arbitrator notes the testimony of Dr. Puri indicating that a general doctor does not necessarily have the expertise to determine if low back pain is coming from the hip or not, and that Dr. Simon's exam findings were lacking. While Dr. Simon testified that the Petitioner's back condition had resolved as of his last visit of 12/17/13, he

acknowledged that the Petitioner probably still had residual inflammation at that time based on his ongoing complaints on examination.

It appears that Petitioner was referred by his primary provider to Dr. Rosenblatt shortly thereafter, where he complained of left low back and buttocks area pain into the leg to above knee level. Lumbar MRI was relatively benign. In the Arbitrator's view, it is reasonable to believe that the Petitioner had no prior left hip or low back problems, based on his testimony and the lack of any medical evidence to the contrary, had an incident with a very heavy lifting and twisting incident, and reported pain in the left low back/buttocks area which continued through and after the treatment ended with Dr. Simon. Clearly the Petitioner did report significant improvement with Dr. Simon through the course of his treatment as to his left low back pain, however he was undergoing therapy, taking anti-inflammatories and working light duty during this time. As noted in the testimony of Gordon, it is not easy to differentiate between a back or hip condition based on low back pain. As noted in the testimony of Dr. Puri, a person can have a "honeymoon" period of improvement with regard to an arthritic condition during such a treatment period and still not have a resolution of symptoms.

Dr. Simon also is not a surgeon, and, as noted, both Dr. Gordon and Dr. Puri indicated that a specialist would better be able to determine a hip injury than a general practitioner like Simon.

While Dr. Lieber's opinions in this case were reasonable, he also agreed that a lifting and twisting incident could have led to a previously asymptomatic arthritis condition becoming symptomatic. His opinion that the Petitioner's initial complaints to Dr. Simon did not support that a hip injury occurred on the date of accident was also a reasonable basis for defense in this hearing, however the Arbitrator finds the opinions of Dr. Puri and Dr. Gordon to be more persuasive in this case.

Dr. Gordon's testimony was persuasive regarding the fact that the Petitioner had a preexisting congenital condition in his hip sockets, and had the work accident, triggering a relatively rapid downward spiral with what began as left low back pain into a determination that the hip was responsible for Petitioner's pain and arthroplasty. The *Sisbro* case, cited above, states that the key issue in a case like this, with a preexisting degenerative condition, is whether the accident caused an aggravation or acceleration of the preexisting condition. Here, we have no evidence that the Petitioner had a prior left hip condition or similar symptoms as he developed post-accident. Additionally, the right hip involves a similar congenital condition and arthritis, but has not been indicated to be symptomatic. Given that a hip replacement surgical recommendation requires both radiographic findings supporting same, which may have preexisted Petitioner's accident in this case, as well as relevant symptoms, the fact that the accident is what appears to have created the symptoms which ultimately worsened the condition and led to surgery indicates a causal relationship exists pursuant to the meaning of *Sisbro*.

Based on the Petitioner's credible testimony and the medical opinions of Dr. Gordon and Dr. Puri, the Arbitrator finds that the Petitioner's left hip condition is causally connected to the work-related accident of 11/11/13.

The Arbitrator would also note that while the preponderance of the totality of the evidence in this case supports a causation finding in the Petitioner's favor, and that pursuant to the Act the payment of benefits by the Respondent is not an admission of liability, it is also correct that in this case both parties relied on the opinions that had been presented at the time in the Respondent's authorization of the initial left hip replacement, and the Petitioner relied on that authorization in agreeing to undergo the initial major surgery of hip arthroplasty. After reviewing all of the evidence in this case, this was a relatively close decision for the Arbitrator. However, it seems more likely to the Arbitrator that whatever injury the Petitioner received on the accident date which led him to complain of left low back pain is the same pain for which he ultimately received a left hip replacement.

The evidence here amply supports the difficulty, particularly for a layperson, in determining the origination of back and/or hip pain.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner is entitled to the left hip replacement revision surgery recommended by Dr. Gordon to address the Petitioner's leg length discrepancy. While the testimony and orthotic/shoe lift recommendation of Dr. Lieber is noted, it also appears that the worsening of the Petitioner's condition after surgery coincided with a determination of the leg length discrepancy after all initial indications post-surgery were that there was no such discrepancy. Given Dr. Gordon's testimony of how he believes there is a leg length discrepancy due to an anatomical misalignment in the left hip area, it doesn't make sense to the Arbitrator how a shoe lift would address this problem. Additionally, such an option would not help if the Petitioner were walking barefoot or without shoes. There also seems to be a question between doctors as to whether there has been any loosening of the hardware at this point. It seems to the Arbitrator that the most reasonable course here would be to allow for an attempt to revise the prior surgery. Dr. Gordon appears to be highly qualified in terms of his understanding of anatomy in the hip replacement realm.

The Respondent shall authorize the noted left hip replacement revision prescribed by Dr. Gordon pursuant to Sections 8(a) and 8.2 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

Luis Nava,
Petitioner,

18IWCC0716

vs.

NO: 16 WC 20202

Altorfer, 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, prospective medical, temporary 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. 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 March 23, 2018, is hereby affirmed and adopted.

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

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

18IWCC0716

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 $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 21 2018
o10/10/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0716

NAVA, LUIS
Employee/Petitioner

Case# **16WC020202**

16WC029431
17WC000879
17WC034552

ALTORFER, INC
Employer/Respondent

On 3/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

18IWCC0716

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Luis Nava
Employee/Petitioner
v.

Case # **16** WC **20202**

Consolidated cases: **16 WC 29431, 17 WC 879 & 17 WC 34552**

Altorfer, 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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **February 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 23, 2014,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$38,798.76**; the average weekly wage was **$746.13**.

On the date of accident, Petitioner was **59** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.**

Respondent shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of January 23, 2014, Petitioner's request for prospective medical treatment to the left knee as recommended by Dr. Phillips is denied.

Respondent shall pay for medical services **rendered during the timeframe of January 23, 2014 through January 27, 2014** 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 23, 2014 through January 27, 2014** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of January 23, 2014 through January 27, 2014** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed 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

3/20/18
Date

ICArbDec19(b)

MAR 23 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Luis Nava
Employee/Petitioner

Case # **16** WC **20202**

v.

Consolidated cases: **16 WC 29431, 17 WC 879 & 17 WC 34552**

Altorfer, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he worked for Respondent for seventeen years. Petitioner testified that he worked several different jobs while employed by Respondent, including his having worked as a painter, in prepping and in maintenance. He testified that he was laid off from his employment with Respondent on January 23, 2017.

Petitioner testified that he was first injured while working for Respondent on January 23, 2014. The Arbitrator notes that Respondent does not dispute Petitioner's accident on this particular date. (AX1). Petitioner testified that he was working in prepping and was getting down from a generator known as an "XQ350" when his right leg slipped off the unit to the ground, leaving his left leg on the fender. He testified that as his right leg slipped off the unit, he twisted his left leg. He testified that he also struck the left side of his chest on a piece of metal as he twisted. He testified that he did not experience any pain in his left knee until the next day. He testified that he reported his accident to his foreman on January 24th and that he requested medical treatment. He testified that his knee burned and was locking. He also testified that he also had some bruising to his left chest. He testified that his request for medical treatment was denied. The medical records entered into evidence at the time of arbitration, however, reflect that Petitioner presented to the emergency room at OSF St. Francis Medical Center on January 27, 2014. (PX6). Petitioner testified that his foreman accompanied him to the emergency room. He further testified that he repeatedly asked his employer in both 2014 and 2015 for approval to seek treatment of his left knee, but was denied. He testified that after January 23, 2014, he continued to work for Respondent full duty. He also denied having any issues with his left knee before this particular accident.

Petitioner testified that on August 19, 2015, he was building doors with a co-worker who was helping him put them on a pallet when his heel got caught on a mat and he dropped the door on his knees. The Arbitrator notes that Respondent does not dispute Petitioner's accident on this particular date. (AX4).

Petitioner further testified that on September 19, 2016, he was working with a co-worker to put a metal brace on a trailer when the co-worker dropped the brace and it struck his left knee. The Arbitrator notes that Respondent does not dispute Petitioner's accident on this particular date. (AX2). Petitioner testified that following this accident his left knee pain worsened due to swelling, but he also admitted that his knee was still locking up at the time of this accident.

Petitioner also testified to another alleged work accident on January 3, 2017. The Arbitrator notes that Respondent disputes Petitioner's accident on this particular date. (AX3). Petitioner testified that on January 3, 2017, he was walking to punch out for the day when his left knee gave out and he fell. He testified that upon falling, he hit his face and knees on the floor. He also testified that he injured his right shoulder when he attempted to break his fall with his right hand.

Petitioner testified that he continues to have problems with his left knee and right shoulder and wishes to purse ongoing treatment of both, including the left knee arthroscopy as recommended by Dr. Phillips. Petitioner denied having any ongoing issues regarding the chest bruise. He testified that he has not worked since being laid off by Respondent on January 23, 2017.

The Amended Application for Adjustment of Claim for 16 WC 20202 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Application for Adjustment of Claim for 16 WC 29431 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The Application for Adjustment of Claim for 17 WC 879 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The Application for Adjustment of Claim for 17 WC 34552 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4.

The Accident or Injury Investigation Forms were entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The medical records of OSF St. Francis Medical Center (1/27/14-1/3/17) were entered into evidence at the time of arbitration as Petitioner's Exhibit 6.[1] The records reflect that Petitioner was seen on January 27, 2014, at which time it was noted that he stated that he was at work, working in a factory prepping machines, when he had a ground-level fall four days ago. It was noted that Petitioner stated that he fell and the right lower extremity fell under the machine and his chest struck a piece of metal on the left upper margin of his chest, that he denied any loss of consciousness, that he denied having any head injury, and that he stated he was noticing a "soreness" sensation in his chest wall and in his right knee. It was noted that Petitioner stated that he was having pain with flexion of his right knee, that he stated he was able to stand and walk without any difficulty and that he decided to wait four days to "see if it [went] away." It was noted that Petitioner stated that he talked to a physician at his church the day before who recommended him to get a radiograph of his chest. It was noted that radiographs of Petitioner's left knee showed an abnormality of the patella which appeared to be chronic and that no acute fracture or dislocation was identified. It was noted that Petitioner's exam was unremarkable for any tenderness or swelling and that he was discharged to home. X-rays of the left knee performed on January 27, 2014 were interpreted as revealing calcific density and irregular cortex along the posterolateral margin of the lateral tibial plateau, could represent an avulsion injury; triple compartment osteoarthritic changes are present manifest by joint space narrowing and subchondral sclerosis with small marginal osteophytes, most prominent in the lateral compartment; no knee joint effusion identified; multi-partite patella. (PX6).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent x-rays of the left knee on October 7, 2016, which were interpreted as revealing redemonstration of tricompartment osteoarthritis, moderate to severe in the lateral compartment; no acutely displaced fractures identified or joint effusion; multi-partite patella again noted; minimal anterior knee soft tissue swelling could represent contusion. The records reflect that on January 3, 2017, Petitioner underwent x-rays of the right shoulder which were interpreted as revealing widened acromioclavicular joint suggestive of post-operative changes; if there is no history of right shoulder surgery, a grade 2 acromioclavicular joint separation may be possible. On January 3, 2017 Petitioner also underwent x-rays of the left knee, which were interpreted as revealing (1) no acute osseous or soft tissue abnormality demonstrated; (2) degenerative changes of the lateral

[1] Any highlighting that appears in the exhibit was not made by the Arbitrator.

compartment and patellofemoral joint, not significantly changed; (3) small suprapatellar joint effusion. (PX6).

The medical records of OSF St. Francis Medical Center (1/27/14-1/3/17) were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records were effectively duplicative of those as contained in Petitioner's Exhibit 6. (PX7; PX6).

The medical records of OSF Prompt Care were entered into evidence at the time of arbitration as Petitioner's Exhibit 8.[2] The records reflect that Petitioner was seen on January 3, 2017, at which time it was noted that he was seen for a fall. It was noted that the accident occurred 3-6 hours ago, that Petitioner's left knee gave out and that he fell while punching out of work. It was noted that Petitioner had a ground level fall, that he landed on concrete and that the points of impact were the head, left knee and right shoulder. It was noted that Petitioner had pain present in the head, left knee and right shoulder, that the pain was at a severity of 2/10, that the pain was mild and that the symptoms were aggravated by standing and use of the injured limb, ambulation and movement. The assessment was noted to be that of a sprain of the left knee, fall, left knee injury, right shoulder injury, laceration of the upper lip with complication, sprain of the right shoulder and facial contusion. Petitioner was recommended to undergo x-rays of the left knee and right shoulder. Petitioner was instructed to use an ice pack and elevation and to follow-up with an orthopedic physician if not better in 1-2 weeks. At the time of the August 20, 2017 visit, Petitioner was seen for a chief complaint of a rash on the face, arms and torso for three days. The assessment was noted to be that of poison ivy dermatitis. A "To Whom It May Concern" letter dated January 3, 2017 was issue by Dr. Luke Yang Xie indicating that Petitioner had been unable to attend work due to an injury from January 4, 2017 until January 5, 2017, that he may return to work on January 6, 2017 and that he could return to light duty. (PX8).

The medical records of OSF Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 9.[3] The records reflect that a Work Status Worksheet dated August 26, 2015 was issued, allowing Petitioner to return to work regular duty as of August 31, 2015 and modified duty as of August 26, 2015 with a 40-pound lifting limit and wearing the left-hinge brace at work through August 30, 2015. The records reflect that Petitioner was seen on August 26, 2015, at which time it was noted that Petitioner was seen in follow-up of left knee pain after a fall at work. It was noted that Petitioner's anterior knee pain had markedly improved, that he was tolerating the restrictions at work well, that he reported that he was having no mechanical symptoms and that he felt he was essentially back to his baseline knee issues that he had prior to the injury on August 19th. It was noted that Petitioner continued to follow-up for left knee pain that he had had chronically and that he reported that he was scheduled for an MRI. The assessment was noted to be that of left knee injury. It was noted that Dr. Braun thought that Petitioner's most recent injury to the left knee had healed well and that as a precaution to prevent re-injury, he was going to keep Petitioner on restrictions of 40-pound lifting and wearing the knee brace at work for the rest of the week. It was noted that starting Monday of the next week, Petitioner was to return to work without restrictions and that he was released from further follow-up. (PX9).

The records of OSF Occupational Health reflect that a Work Status Worksheet dated August 20, 2015 was issued, allowing Petitioner to return to work modified duty on August 20, 2015 with restrictions of lifting 25 pounds rarely, positional changes (sit, stand, walk) as needed for comfort, no crawling, no kneeling, rarely squatting and wearing the left knee brace at work and other times as needed. At the time of the August 20, 2015 visit, it was noted that Petitioner worked in the prep area at Altorfer and had been employed there for 17 years. It was noted that the day before about 9:45 a.m., he was building some doors for a generator and that as he and a co-worker went to lift a completed door to place on a pallet, his right heel got caught on the edge of a mat and he fell backward. It was noted that Petitioner let go of the door

[2] Any handwritten notes and/or highlighting within the exhibit was not made by the Arbitrator.
[3] Any highlighting and/or markings that appears in the exhibit were not made by the Arbitrator.

and his hands went back to catch his fall and that as he did this, the door impacted his left lower anterior thigh as well as his right anterior thigh (but mostly on the left). It was noted that Petitioner had some mild pain which persisted through the day but he worked through his shift, that he went home and went to bed and that he woke up that morning with some decreased range of motion and increased pain in the left anterior superior knee area as well as some pain in the posterior knee. The assessment was noted to be that of left knee pain/injury. Petitioner was recommended to take Ibuprofen three times a day with food until he was seen in a week. Petitioner was also placed on restrictions and was told he could try ice as well. (PX9).

The records of OSF Occupational Health reflect that Petitioner was seen by Dr. Edward Moody for an IME on July 16, 2015 for a chief complaint of left knee locking. It was noted that Petitioner stated that in January of 2014 he was working at Altorfer and was prepping a "350" and that when climbing off the unit, his right leg slipped underneath the unit, his body twisted and his chest struck a piece of metal. It was noted that the point of impact was under the left clavicle and that he also twisted the left leg. It was noted that initially Petitioner did not have any significant pain but the next day he had left anterior chest pain, which caused him to seek treatment at a local emergency department. It was noted that when taking the history, Petitioner stated that he did not have knee pain at that time but that as part of his evaluation in the emergency department, he did have left knee x-rays. It was noted that Petitioner was discharged from the emergency department and that he stated that his chest symptoms subsequently resolved without incident and that he did not have any problems with left knee pain, clicking, catching or giving way until about a month later. It was noted that Petitioner was at work, stepping over an obstacle, when his left knee gave out and that his foreman was nearby and caught him. It was noted that Petitioner did not really experience any pain with this but that since then, he had had a catching sensation in the lateral aspect of his left knee. It was noted that Petitioner localized it around the head of the left fibula and that he thought it was a "nerve" getting caught, but that he had not had any associated pain, numbness or tingling extending distally from the head of the fibula. It was noted that Petitioner noted that sometimes his knee got "stuck" and that it was most likely to happen when he had been seated for a period of time and attempted to get up. It was noted that Petitioner had to do maneuvers with his knee such as external rotation to get it to extend properly, that it had been occurring daily and that he had had one episode where he was on a ladder and had his knee briefly lock. It was noted that Petitioner had not had any giving way, that he did not have any complaints of left knee pain and that he had never sought medical attention for his mechanical knee symptoms. (PX9).

The IME report of Dr. Moody reflects that there were some apparent discrepancies regarding the history of his left knee injury, that Petitioner stated that he was not having any significant knee pain when he went to the hospital and that it appeared to be contradicted by his initial injury report and actions taken at the emergency department. It was noted that as a result of the stated injury in January 2014, Petitioner sustained a chest wall contusion which had resolved and that he also likely had a left knee contusion, also resolved. It was noted that because of the time gap between the stated date of injury and stated date of onset of left knee mechanical symptoms, Dr. Moody could not attribute those symptoms directly to the work injury but that he did think that Petitioner may very well have had a meniscus tear that was causing his left knee mechanical symptoms. It was noted that given that Petitioner was symptom-free between the time of the accident and approximately one month later, Dr. Moody could not attribute Petitioner's current left knee condition to the stated workplace accident. It was noted that it was Dr. Moody's opinion that with his mechanical left knee symptoms Petitioner should not be climbing ladders, but that otherwise he could perform full duty. It was noted that Dr. Moody recommended that Petitioner not return to ladder climbing until he had been evaluated for his left knee mechanical symptoms, that he recommended that Petitioner have MRI imaging of the left knee and that he be evaluated by an orthopedic surgeon. It was noted that Dr. Moody opined that Petitioner's chest wall injury resolved shortly after the injury of January 2014, that he was at maximum medical improvement for this and that, regarding the left knee, Petitioner was clearly not at maximum medical improvement for his left knee mechanical symptoms and may require surgical intervention to address them. (PX9).

The records of OSF Occupational Health/Dr. Moody reflect that Dr. Moody also issued a "To Whom It May Concern" Letter dated April 5, 2016, in which he indicated that he reviewed the injury report which documented that Petitioner sustained an injury on January 23, 2014 and reported it to his supervisor the following day and that the sites reported as injured included the left chest, side and twisting of the left leg. It was noted that Dr. Moody indicated that the document did not really provide any new information and was insufficient for him to reconsider his opinion on causation. It was noted that the critical issue was whether or not Petitioner had left knee mechanical symptoms or ongoing pain during the one-month interval following his emergency department visit and that in the absence of such symptoms, he could not make a causative connection between the stated injury and the meniscal tear diagnosed later. It was also noted that Dr. Moody in his addendum dated December 2, 2015 stated that either a statement from Petitioner or a co-worker documenting symptoms in that timeframe would be required for him to consider changing his opinion regarding causation and that this continued to be the case. (PX9).

The records of OSF Occupational Health/Dr. Moody further reflect that Dr. Moody issued a letter directed to Liberty Mutual Group dated December 2, 2015. It was noted that Petitioner's diagnosis was that of degenerative joint disease of the left knee; degenerative lateral meniscus tear; complex degenerative tear of the medial meniscus. It was noted that Petitioner's diagnosis for the work-related injury was that of a contusion of the left knee. It was noted that Dr. Moody opined that the extensive degenerative changes in Petitioner's left knee were not work-related and that the issue was whether the accident of January 26, 2014 caused an aggravation of the underlying condition. It was noted that Dr. Moody had noted in his initial report that Petitioner denied any left knee symptoms (in particular mechanical symptoms) prior to February 2014 and that if this was the case, it was his opinion that there was no work aggravation of his degenerative knee condition and that a month gap between injury and symptom onset was very unconvincing for establishing "work relatedness." It was noted that Petitioner's history was somewhat contradicted by emergency department records that showed he had radiographs of the knee shortly after the injury which would imply a complaint of knee pain had been made and that Dr. Moody had also reviewed a statement that a co-worker was told by Petitioner that he had ongoing pain, but that it was temporally vague and "hearsay." It was noted that Dr. Phillips stated that Petitioner had symptoms following the accident and not before, but that he did not specify how much time elapsed after the accident before symptom onset. It was noted that in order to change his opinion regarding causation, there would have to be some credible evidence that Petitioner was having knee pain or mechanical symptoms that onset with the injury and that the symptoms continued during the month following the injury and that in the absence of such evidence, Dr. Moody was disinclined to change his opinion regarding causation. It was also noted that he had not seen Petitioner since surgery and that as he had been released to full duty by his orthopedist, Dr. Moody thought that Petitioner could work without restrictions and would have regarded him to be at maximum medical improvement on November 4, 2015, the day that Dr. Phillips returned him to work. (PX9).

The records of OSF Occupational Health reflect that on September 20, 2016, Petitioner was allowed to return to modified duty of lifting a total of 20 pounds rarely, positional changes (sit/stand/walk) as needed for comfort, 15 minutes per hour max walk/stand, no crawling, no kneeling, no squatting and no operation of commercial/industrial vehicles. Included within the records of OSF Occupational Health was an interpretive report for an MRI of the left knee performed on October 28, 2015, which was interpreted as revealing (1) tricompartmental degeneration, severe at the lateral femoral tibial joint associated with extensive degenerative lateral meniscus tearing and volume loss; (2) complex degenerative tear of the posterior body and apex of the medial meniscus, grade 1-2 MCL sprain, mild to moderate suprapatellar bursal effusion with synovial proliferation, lipoma arborescens, grade 1-2 MCL sprain, distal quadriceps, medial gastrocnemius and semimembranosus tendinosis as described; (3) partial interstitial ACL tear with intrasubstance synovitis; there is valgus deformity of the knee and mild semimembranosus and lateral gastrocnemius muscle atrophy, small Baker's cyst and synovitis of the tibia fibula syndesmosis. The

History noted that Petitioner fell backwards off a trailer injuring the left leg one year ago; patient has a sensation of knee locking. (PX9).

The medical records of UPH Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner was seen on September 12, 2014 for a wellness exam and routine labs. It was noted that Petitioner stopped Simvastatin about a year ago due to muscle/joint aches. Petitioner was ordered to undergo various bloodwork and to continue his current medications. At the time of the May 26, 2016 visit, it was noted that Petitioner had been having trouble with sinus congestion and cough, among other issues. A "Task on 03/21/2014" document noted that on March 21st a comment was added regarding cancelling the order for referral to Great Plains. It was noted that the scheduler indicated that they had attempted to schedule on three different occasions (2/13, 20 and 28) with no response when they would like to see the doctor. At the time of the visit on February 11, 2014, it was noted that Petitioner was seen for a scheduled follow-up visit, that he had complaints of muscle weakness that had been reported to Dr. Mina, that he switched his cholesterol medications to see if that would help and that he had a boil on his buttocks. It was noted that as to his knee pain, Petitioner stated that he felt his nerve and muscle would "shoot out behind knee" and that he had a fall last month and went to OSF Emergency Room. It was noted that there was no erythema, swelling or pain with palpation in the left knee and that there was mild pain with external rotation of the lower leg. The assessment was noted to include, among other issues, knee pain. (PX10).

The medical records of OSF Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner was seen on February 8, 2017, at which time it was noted that he had a sling on his right arm, that certain movements hurt his right shoulder and was a throbbing pain, that he mentioned that there was no change for his left leg, that it still locked up and "came out" and that when he did therapy his leg locked up, so he was unable to do it. It was noted that in January Petitioner hurt himself again at work when he fell sideways and hurt his left knee and right shoulder when he tried to break the fall. It was noted that Petitioner was wearing a left leg brace and that he also used it when he slept, that it hurt on the posterior side of the left knee when he extended it and that when he stood all day on his feet, the pain level was 8-9. It was noted that Petitioner maintained his issues in regard to his left knee and that his right shoulder was still being waiting on to be approved for formal evaluation for worker's compensation. It was noted that Petitioner was sore, that he wore a sling and that he had non-specific numbness and tingling sensations. It was noted that Petitioner's knee examination was unchanged with continued mechanical knee issues. It was noted that Dr. Phillips stood by his recommendation of left knee surgery whenever Petitioner could sort out the other issues in regard to worker's compensation. It was noted that Dr. Phillips wanted to evaluate Petitioner's right arm prior to any surgical procedures. It was also noted that Petitioner was kept off work pending these issues. (PX11).

The records of OSF Orthopedics reflect that Petitioner underwent x-rays of the left knee on November 16, 2016, which were interpreted as revealing no acute bony changes, findings consistent with x-rays from October 2016 comparison, lateral compartment joint space narrowing and degenerative findings. At the time of the November 16, 2016 visit, it was noted that Petitioner had been last seen around the July 4th holiday with a diagnosis of significant internal derangement of the left knee. It was noted that Petitioner was planned for arthroscopic intervention and surgery because of his mechanical knee pain. It was noted that Petitioner had not gotten better and actually had taken a step for the worse, that on September 19, 2016 he had a further injury to the left knee secondary to an injury while he was working with a co-worker when a piece of metal fell and hit the anterior superior lateral aspect of his knee, causing it to twist and turn. It was noted that Petitioner felt discomfort and swelling with progressive symptoms over the next couple of hours at work and that since that time, his symptoms of mechanical knee pain had worsened. It was noted that Petitioner had catching, locking sensations, giving way and difficulty ambulating, and that he still worked with light duty restrictions. It was noted that repeat x-rays revealed lateral joint space narrowing, no acute changes from the previous films and no evidence of fracture or dislocation. It was

noted that Petitioner's diagnosis was continued with aggravated injury mechanical knee pain, left. It was noted that Petitioner was proceeding through processes to consider surgery. It was further noted that Petitioner was an outpatient arthroscopic surgical candidate with anticipated meniscus and chondral pathology, debridement lateral and medial compartments. (PX11).

The records of OSF Orthopedics reflect that Petitioner was seen on January 11, 2017, at which time it was noted that he was an ongoing patient with recommendation of left knee surgical considerations for mechanical knee pain. It was noted that the new issue was a re-injury to the left knee on January 3, 2016 [*sic*], that Petitioner was at work at the end of the day, that he was at the clock-out area and that with twisting, turning and his left knee giving way, Petitioner hit the side of his face, his right shoulder and twisted, turned and aggravated the underlying mechanical issues with the left knee. It was noted that repeat x-rays revealed some lateral compartment joint space narrowing but no acute defects and no changes from the previous studies. It was noted that Petitioner would be taken off work and that he was at a potential risk for further injury pending his surgical plans. It was noted that Petitioner was in a right shoulder sling, that Dr. Phillips had not been approved to review it at that point but that he had looked at the x-rays, which were unremarkable for acute dislocation or fractures. A "To Whom It May Concern" letter dated January 11, 2017 was issued by Dr. Phillips, indicating that Petitioner had been unable to attend work due to injury from "now until mid Feb follow up appointment" and that Petitioner could not yet return to work. At the time of the July 5, 2016 visit, it was noted that Petitioner maintained unacceptable mechanical knee pain and that he had been back to work in constant pain and needing narcotics. It was noted that Petitioner continued to have a valgus antalgic gait with joint line tenderness and decreased flexion and that he was a candidate for arthroscopy, partial medial and/or lateral meniscectomy and articular cartilage debridement as pathology would dictate. It was noted that informed consent had been obtained for elective surgery. (PX11).

The records of OSF Orthopedics reflect that Petitioner was seen on November 4, 2015, at which time it was noted that his knee was worsening, locking up and that he had unlocking sensations on the left side. It was noted that the MRI was consistent with significant mechanical issues, medial and lateral meniscus defects along with full-thickness articular cartilage loss on the lateral femorotibial joint. It was noted that Petitioner had specifically stated to Dr. Phillips that prior to the slip and fall and hyperextension twisting injury, he had not had these symptoms. It was noted that Petitioner was a candidate for arthroscopic intervention and would be a candidate for expected partial medial and lateral meniscectomies and articular cartilage debridement. It was noted that informed consent for the elective surgery had been obtained. At the time of the October 13, 2015 visit, it was noted that Petitioner was known to Dr. Phillips from a standpoint of shoulder work, which he was doing well with. It was noted that Petitioner stated that as an assembler, he was getting off a piece of equipment and slipped, that his left lower extremity was hyperextended, that he twisted and that he had significant soreness and pain. It was noted that this had happened a year and a half ago, that he was worked up at St. Francis Medical Center without a diagnosis of anything significant, that the pain continued, that he had locking and unlocking by his own history and that he had lateral discomfort. It was noted that Petitioner had significant mechanical knee pain and lateral compartment joint space narrowing. Petitioner was recommended to undergo an MRI to help define the extent of mechanical meniscus and potential loose body pathology. It was noted that Petitioner specifically denied any problems prior to the twisting incident which he described as work-related and that this was documented for his concerns. (PX11).

The records of OSF Orthopedics reflect that a work slip was issued on November 4, 2015, allowing Petitioner to return to work without restrictions on November 4, 2015. Included within the records of OSF Orthopedics was an interpretive report for x-rays of the right shoulder performed on November 2, 2005, which were interpreted as revealing expected post-operative changes without other bony defects or abnormalities. Also included within the records of OSF Orthopedics was an interpretive report for an MRI of the right shoulder performed on February 7, 2005, which was interpreted as revealing (1) full-thickness

rotator cuff tear with 2 cm of retraction and mild supraspinatus atrophy; (2) tendonitis with tenosynovitis of the long head of the biceps tendon; (3) probable coracohumeral ligament tear; coracoacromial ligament is intact; (4) mild degenerative changes of the right acromioclavicular joint. The records reflect that Petitioner also underwent x-rays of the right shoulder on January 28, 2005, which were interpreted as revealing mild degenerative changes near the insertion of the rotator cuff complex on the proximal humerus; otherwise unremarkable. (PX11).

The records of OSF Orthopedics reflect that Dr. Phillips authored a letter to Dr. Homer Pena on March 2, 2005, which noted that Petitioner was a very active 50-year-old right hand dominant painter with right shoulder problems which had developed since an injury on January 28, 2005. It was noted that Petitioner stated that he had no previous concerns, injury or specific complaints and that since that period of time he had had a significant painful arc, limited range of motion and night pain. It was noted that Petitioner was a candidate for an arthroscopic evaluation and debridement, subacromial decompression and open rotator cuff repair with possible restore patch augmentation. The records reflect that on April 11, 2005, Petitioner underwent (1) arthroscopy of the right shoulder with arthroscopic subacromial decompression and partial acromioplasty; (2) separate incision distal clavicle excision; (3) mini incision approach rotator cuff tear repair utilizing troft and bone technique for a pre-operative diagnosis of right shoulder AC joint arthropathy and impingement with rotator cuff pathology and a post-operative diagnosis of right shoulder AC joint arthropathy and impingement with rotator cuff pathology with full-thickness rotator cuff tear. (PX11).

The records of OSF Orthopedics reflect that Petitioner underwent x-rays on December 12, 2016, which were interpreted by Dr. Phillips as revealing moderate osteoarthritis in the right knee, severe osteoarthritis in the left knee; moderate loss of lateral clear space on the right, severe loss of lateral clear space on the left, nearly bone-on-bone; prominent osteophytes in all three compartments on the left knee; significant patellofemoral arthritis on the left with near complete loss of retropatellar space; significant osteophytes throughout on the left knee but no loose bodies; no fractures; no dislocations; subchondral cysts noted in the lateral femoral condyle and lateral tibia on the left knee; overall, changes consistent with severe osteoarthritis on the left knee with tricompartmental involvement and moderate osteoarthritis in the right knee. Included within the records of OSF Orthopedics was a "To Whom It May Concern" letter dated January 7, 2017, noting that Petitioner had been seen at OSF Prompt Care CFH Glen Park on January 3, 2017 and that he must wear a right arm sling until seen and cleared by orthopedics. Also included within the records of OSF Orthopedics were records related to an OSF Prompt Care visit on January 3, 2017 with Dr. Luke Yang Xie, which referenced current conditions of sprain of left knee, unspecified ligament; fall; left knee injury; right shoulder injury; laceration of upper lip with complication; sprain of right shoulder; facial contusion. (PX11).

The transcript of the deposition of Dr. Mark Phillips was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Dr. Phillips testified that he is a board-certified orthopedic surgeon and is a subspecialist dealing in knee and shoulder issues. (PX12).

Dr. Phillips testified that Petitioner was seen by his practice before 2015, specifically back in 2005 for a shoulder condition. He testified that after 2005, Petitioner first presented to him on October 13, 2015, at which time he gave a history that he was injured a year and a half before secondary to a fall at work. He testified that Petitioner stated that his left knee was twisted and that at that point, he had the initiation of symptomatology which was progressive at that time. He testified that Petitioner indicated that he was getting off a piece of equipment and slipped, that the left lower extremity was hyperextended and twisted and that he had significant soreness and pain. He testified that during the October 13, 2015 visit, Petitioner had complaints of discomfort and pain. He testified that he had the x-ray from the hospital dated January 27, 2014 and that he obtained an x-ray in their office to compliment the previous study. He testified that the studies showed some lateral compartment degenerative-type changes and some joint space narrowing on the left knee. He testified that Petitioner had normal evaluation of his hip and leg, that his knee revealed

some lateral joint line tenderness and rotational localizations and that the major ligaments were all unremarkable. He testified that his impression was that Petitioner had significant mechanical knee pain and issues that were consistent with his x-rays and physical examination and that he recommended proceeding with an MRI to help define the extent of meniscus and loose body pathology. (PX12).

Dr. Phillips testified that the MRI was performed and that he next saw Petitioner on November 4, 2015. He testified that the MRI revealed that there was some full-thickness articular cartilage loss of the lateral femorotibial joint compartment and marked volume loss in the lateral meniscus and some degenerative tearing and pseudoextrusion of portions of the meniscus and some non-specific issues, as summarized by Dr. McGee. He testified that there was also some degenerative tearing and irregularity of the medial meniscus as well. He testified that Petitioner was a candidate for arthroscopic surgical intervention. He testified that he also stated in his note that it was a work-related acute-on-chronic debilitating injury. He testified that Petitioner specifically stated to him that prior to the slip and fall and hyperextension, he had not had the symptoms that he had at that time. He also testified that given the extent of his lateral compartment arthrosis, he mentioned to Petitioner that future consideration of joint replacement may be necessary. (PX12).

Dr. Phillips testified that he next saw Petitioner on July 5, 2016, at which time he was getting worse and continued to have unacceptable mechanical knee pain, essentially the same as the evaluation in November. He testified that Petitioner had antalgic gait, joint line tenderness and decreased flexion and that x-rays were slightly worse in regard to the lateral compartment changes. He testified that he was still recommending the same arthroscopic surgery. He testified that he next saw Petitioner on November 16, 2016, at which time Petitioner was doing no better. He testified that Petitioner had had a further injury to the left knee secondary to a work-related event, that a co-worker had a piece of metal that fell and hit the anterior/superior lateral aspect of his left knee, causing it again to twist and turn another time. When asked how Petitioner described his symptoms after the September 19, 2016 accident, Dr. Phillips responded that Petitioner thought it was at that point aggravated and would have been worse. He testified that his examination findings were consistent and were diffuse joint line tenderness laterally, discomfort with flexion/extension and no ligament instability. When asked whether there were any modified duty restrictions provided to Petitioner during this visit, Dr. Phillips responded that he did not have it documented in the chart but there could have been because this would have been an issue of being able to work safely. He testified that Petitioner's diagnosis was reconfirmed and with the further reaggravation was re-emphasized as being appropriate as to his treatment course. He testified that it was his opinion that Petitioner re-aggravated his knee condition after the September 19, 2016 accident. He testified that he continued to recommend the same surgical procedure. (PX12).

Dr. Phillips testified that Petitioner next followed up on January 11, 2017, at which time his symptomatology was not significantly changed. He testified that Petitioner indicated that on January 3, 2017 he was in the clock-out area and that with a simple twist and turn, his left knee gave way. He testified that Petitioner hit the side of his face and right shoulder and that he twisted, turned and again hurt and aggravated the left knee. He testified that further x-rays were taken and no acute fractures or changes were identified. He testified that Petitioner presented with a sling on the right shoulder and that he did a cursory exam. He testified that Petitioner was not approved for him to see him in any other course besides that, and that he felt comfortable with the fact that he was not in any danger of limb or life at that point. He testified that Petitioner had proven two separate times since his initial evaluation and recommendation that his knee was a liability to him, that this time he fell and hurt other body parts and that he tried to reemphasize for him his safety and to stay off work. He testified that he continued to recommend the surgical procedure that he had initially recommended. (PX12).

Dr. Phillips testified that the last time that he saw Petitioner was on February 8, 2017 and that he was still waiting for the surgery to be authorized. He testified that he took Petitioner off work on January 11, 2017 and that Petitioner was off work when he saw him on February 8th. He testified that during that

visit, he was still recommending the surgical procedure that he initially recommended. He testified that Petitioner's diagnosis remained the same and that he had mechanical knee pathology in the left knee. (PX12).

Dr. Phillips testified that it was his understanding that Petitioner was involved in three separate incidents, the first of which was in January of 2014 when his leg hyperextended and he twisted his leg. He testified that it was an acute-on-chronic scenario, that part of Petitioner's evaluation and findings on x-ray were probably preexisting but by history and the specific fact that he had not had issues and had not sought medical or orthopedic treatment for these conditions. He testified that it was his opinion that the two subsequent injuries in September 2016 and January 2017 aggravated Petitioner's knee condition. He testified that it was his understanding that prior to the January 2014 accident Petitioner was asymptomatic and that he did not review any medical records to suggest otherwise. He testified that if Petitioner did not have any symptoms, he would not have been recommending the same surgical intervention. He testified that the medical treatment and surgery that he was recommending were causally related to the accidents that Petitioner was involved in. (PX12).

On cross examination, Dr. Phillips agreed that at the time that Petitioner first presented to him, he was more than a year and a half out from his initial injury. When asked whether he was aware what the course of treatment had been prior to his presentation, Dr. Phillips responded that he was not specifically except for what was mentioned in his report. He testified that Petitioner had mentioned on the initial evaluation the history and significant soreness that happened a year and a half ago, that he had been worked up at St. Francis Medical Center without a diagnosis of anything significant, that the pain had continued and that he had locking and unlocking by his own history. He testified that he did not review any medical records from OSF, but that he reviewed the x-ray films and report. He testified that he was not aware of any other treatment that Petitioner sought after presenting to OSF but before coming to him. (PX12).

On cross examination, Dr. Phillips agreed that the x-rays at OSF revealed no acute findings. He agreed that as he did not review the OSF records, he was not aware of what the physical examination findings were at that time. When asked whether he was made aware when Petitioner presented to him that he also had treatment related to a chest injury, Dr. Phillips responded that he recalled something to that effect but did not have any specific recollection nor did he document anything on that visit. He testified that he did not know what Petitioner's diagnosis was upon being discharged from OSF on January 27, 2014. (PX12).

On cross examination, Dr. Phillips agreed that when Petitioner presented to him on October 13, 2015, he complained of both pain and locking/unlocking in the left knee. He testified that the encounter form which made no reference to knee pain referred to the interview that Petitioner stated to one of his staff people. He testified that he could not tell why Petitioner said at that point to his staff member that he did not have any pain. He agreed that there was an inconsistency. (PX12).

On cross examination, Dr. Phillips testified that the MRI showed a significant amount of degenerative changes along with meniscus pathology. He testified that some of the characteristics of the tears had degenerative components as per Dr. McGee, and that it had to do with the configuration of the tears. He agreed that based on those findings, he recommended the arthroscopic surgery. He agreed that up through the last time that he saw Petitioner on February 8, 2017, his diagnosis and recommendation for treatment had not changed. He agreed that Petitioner had reported some worsening of his symptoms over the time that he had presented to him since October 13, 2015 and that it was to be expected given the condition of his knee and the fact that it had not gotten any better. When asked whether the incidents in September 2016 and January 2017 had changed the condition of Petitioner's left knee, Dr. Phillips responded that they could have potentially worsened it and that the symptomatology had been worse after those periods of time. He agreed that his diagnosis had not changed after either of those incidents and that

his recommendation for treatment had not changed, but that it had been "re-intensified in regard to his symptom complex." (PX12).

On cross examination, Dr. Phillips agreed that Petitioner needed the surgery before and after each of the incidents. When asked whether the January 3, 2017 incident changed the need for surgery, Dr. Phillips responded that it could have worsened it because every time there was a significant further trauma on a preexisting trauma, the damage could increase and that further tearing or articular cartilage damage could occur. He agreed that Petitioner could have had further tearing and that there was no reason to do another MRI to confirm it because it was wasting money to reconfirm pathology that required surgical intervention. He agreed that surgical intervention was recommended prior to both of these incidents. He agreed that the incident in January of 2017 involved Petitioner's knee giving out while he was walking. (PX12).

On cross examination when asked whether at any time he had considered whether Petitioner would benefit from any kind of conservative treatment, Dr. Phillips responded that they talked about anti-inflammatory medication, physical therapy and injectables and that they were all temporary measures at best in regard to mechanical issues. He testified that they also talked about activity modification, that Petitioner wanted to work and that he was "just an honest, simple guy who was afraid of consequences." He agreed that there was no guarantee given the degenerative condition of his knee that arthroscopic surgery would resolve all of Petitioner's symptoms and further testified that this was why he mentioned the total joint replacement as an alternative, which Petitioner did not want. (PX12).

On cross examination, Dr. Phillips agreed that he did not know that subsequent to the September 2016 visit Petitioner had treated with Dr. Rhode. He testified that he did not think that Petitioner reported that treatment to him when he came to him in November of 2016, nor did he remember it if he did. He agreed that he believed that Petitioner's current knee condition as well as the need for surgery was related to the initial accident in January of 2014 and that it was based on Petitioner's subjective reports that he had no prior knee problems and had continued to be symptomatic since the accident. When asked if the medical records from OSF from January 27, 2014 showed that Petitioner's exam findings for the left knee were essentially normal and whether that could or might change his opinion on causation, Dr. Phillips responded that it did not because he did not do the exam. He testified that the fact that Petitioner did not seek treatment for his knee for over a year and a half after the accident did not change his opinion on causation because of a retrospective discussion with Petitioner wherein he stated that prior to the incident he had no issues and that they began afterwards. (PX12).

On cross examination, Dr. Phillips testified that he had no record of a specific other physician referral. He testified that he did not know when Petitioner called his office to make the appointment. He agreed that Petitioner kept working full duty prior to January 11, 2017. (PX12).

On redirect, Dr. Phillips agreed that on the intake form he circled pain on the lateral portion of the knee and that this was consistent with his dictated notes. He testified that his dictation note was the official clinic evaluation and physical examination. He testified that surgery was recommended based on the clinical presentation, the history of continued symptoms, the longevity and the lack of response to non-operative measures, and that the MRI was the road map confirming pathology. When asked whether there were any acute findings on the MRI, Dr. Phillips responded that it was a difficult question because the MRI was not a temporal measurement. (PX12).

On redirect, Dr. Phillips agreed that it was his opinion that the incident in January of 2014 aggravated Petitioner's condition to a point where he was now recommending surgical intervention. He testified that if the two accidents of September 2016 and January 2017 did cause change in pathology, this was something that he could tell once he went inside arthroscopically. He testified that the joint replacement was a hugely different procedure and was usually used as a last resort. He testified that it was not indicated

at this point as the first treatment choice and that Petitioner, more importantly, did not want to have it done. (PX12).

The medical records of Orland Park Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner was seen on September 21, 2016, at which time it was noted that he was seen for a second opinion for an evaluation of a work-related left knee injury sustained on September 19, 2016. It was noted that Petitioner stated that a co-worker dropped a metal brace which impacted the anterolateral aspect of his knee, that he stated that he sustained an original injury in 2014 when he fell and twisted on his left knee and that he developed medial-sided knee pain with mechanical complaints of locking and catching. It was noted that Petitioner treated with Dr. Phillips, who performed and MRI and recommended an arthroscopy for a torn medial meniscus. It was noted that Petitioner stated that his diagnosis and treatment were denied by the company doctor and that he was returned to full duty. It was noted that Petitioner continued to be symptomatic up until his September 19, 2016 re-injury and that after that impact along the anterior aspect of his knee, he had worsened with his mechanical complaints of locking and catching. It was noted that Petitioner worked as an assembler, that he had worked for his current employer for 17 years, that he continued to work full duty and that he denied a prior left knee injury before the injury sustained in 2014. The assessment was noted to be that of knee pain. Petitioner was recommended to obtain his MRI for evaluation and to continue full duty until the MRI was evaluated. (PX13).

The records of Orland Park Orthopedics reflect that Petitioner was seen on October 9, 2016, at which time it was noted that he presented with the MRI performed on October 28, 2015. It was noted that review of the MRI demonstrated tricompartmental degenerative changes superimposed with a complex medial meniscus tear per the report. The assessment was noted to be that of knee pain and medial meniscus tear. It was noted that Petitioner continued to experience significant mechanical symptomatology to the left knee and that he had known pre-existing degenerative changes superimposed with a horizontal cleavage tear to the posterior horn of the medial meniscus. It was noted that an intraarticular steroid injection was discussed and that Petitioner was unwilling to live with his current symptoms and wished to proceed with an arthroscopic partial medial meniscectomy. It was noted that Petitioner would be issued modified light duty and that he would follow-up post-operatively. A Work Status slip was issued on October 5, 2016, allowing Petitioner to return to light work (max 20 pounds or less lift/carry; frequent at 10 pounds) and no ladders, no squatting/kneeling/crawling and no bending/stooping. (PX13).

The medical records of Unity Point Methodist/Methodist Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that on February 21, 2014, Petitioner underwent excision of an infected foreign body granuloma with non-healing wound with sinus on the right buttock. The records reflect that on January 3, 2017, Petitioner was seen in the emergency department, at which time it was noted that he had a ground-level fall at approximately 14:00. It was noted that Petitioner related clocking out from work when his knee gave out and that he broke the fall with extended arms. It was noted that Petitioner related cutting his left upper lip and denied loss of consciousness. It was noted that Petitioner related having chronic knee pain that was responsible for the ground-level fall and that he complained of right shoulder discomfort and left knee discomfort that was chronic. It was noted that Petitioner left without being seen before triage. The records further reflect that Petitioner was seen in the emergency department on October 6, 2017, at which time it was noted that he had had nine weeks of persistent cough and that he developed chest pain that evening, which prompted the visit. It was noted that Petitioner had bilateral pulmonary embolism with large clot burden and some saddle component and that he would be admitted to the ICU. (PX14).

The Motion to Consolidate was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 16.

The Wage Statement for the Dates of Accident of 1/23/14 & 1/26/14 were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Wage Statement for the Date of Accident of 9/19/16 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Wage Statement for the Date of Accident of 1/3/17 was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

The transcript of the deposition of Dr. Moody was entered into evidence at the time of arbitration as Respondent's Exhibit 4. Dr. Moody testified that he is board-certified in occupational medicine. (RX4).

Dr. Moody testified that he performed an IME on July 16, 2015. He testified that he had actually seen Petitioner in 2013 and 2008 for conditions other than the left knee. He testified that as to the history, Petitioner stated that in January of 2014 he was working at Altorfer, that he was working on a machine and that when climbing off his right leg slipped, went underneath the unit, his body twisted and his chest impacted a piece of metal. He testified that Petitioner also reported having twisted his left leg. He testified that Petitioner reported that initially he did not have any significant pain but that the following day he had left anterior chest pain and subsequently sought treatment at a local emergency department. He testified that he noted in his report that when taking Petitioner's history, he stated that he did not have the knee pain at the time but that he did review records where they performed radiographs of the left knee. He testified that Petitioner was evaluated mainly for his chest pain and discharged, and that his chest symptoms subsequently resolved. He testified that Petitioner stated that he did not have any problems with the left knee pain clicking, catching or giving way until about a month later, that at that time he was at work stepping over an obstacle when his left knee gave out and that his foreman was nearby and caught him. He testified that Petitioner stated that he really did not experience any pain with this incident but subsequent to this, had a catching sensation in the lateral aspect of his left knee. He testified that Petitioner localized this around the head of the left fibula and stated that he thought it felt like a nerve getting caught, but that he did not have any associated pain, numbness or tingling extending distally from the head of the fibula. He testified that Petitioner noted that sometimes his left knee got "stuck" and that it was most likely to happen when he had been seated for a period of time and then got up. He testified that the symptoms had been occurring daily and that he had one episode where he was on a ladder and had his knee briefly lock, but that he had not had any giving way. He testified that Petitioner did not have any complaints of left knee pain and stated that he had never sought medical attention for the mechanical knee symptoms. He further testified that he noted in his report that he re-questioned Petitioner regarding the onset of symptoms and that he stated that he did not have any catching or giving way for about a month following the injury in January of 2014. (RX4).

Dr. Moody testified that Petitioner's main complaint at the time of the IME was that of ongoing problems with mechanical symptoms of his left knee. He testified that pain was not really a prominent feature of Petitioner's report of complaints and that it was mainly the mechanical symptoms. He testified that the emergency department medical records from January 2014 did not note any mechanical symptoms related to the left knee and that he thought there was an error in the history where they referenced the right knee. He testified that as to his activities of daily living, Petitioner reported that he had no limitations on walking, that he could climb two flights of stairs without stopping and that he did not require any assistive devices or braces. He testified that Petitioner did not have any sleep interference related to his knee issues, that he was able to go to the store independently and drive without limitation, that he did not have any impairment of sitting or static standing and that he was comfortable lifting approximately 50 pounds. He testified that Petitioner did have some limitations in terms of doing snow removal and yardwork that were recommended by his cardiologist, but that he was currently working without restrictions. (RX4).

Dr. Moody testified that Petitioner's past medical history was positive for two myocardial infarctions and treatment for prostate cancer and that he had had surgery on both shoulders for recurrent dislocations. He testified that Petitioner reported that there was no current treatment for his left knee. He testified that he had access to OSF's medical records for the emergency department visit on January 27,

2014. He testified that he did not know of any other treatment between the emergency room visit and the IME that he performed. He testified that the examination of the left knee did not show any evidence of intraarticular effusion, that range of motion was full extension, that he had crepitus with passive flexion and extension of the knee joint and that there was no focal joint line tenderness, but that there was lateral compartment pain and apprehension when he performed McMurray's test. He testified that other than range of motion, the right knee was similar. He testified that his diagnosis at the time of the evaluation was left knee contusion but that he made the recommendation that there be further evaluation of Petitioner's mechanical symptoms. He testified that he also thought that Petitioner sustained a chest wall contusion. (RX4).

Dr. Moody testified that he did not think that Petitioner's mechanical symptoms were related to the work injury due to the period of time that had elapsed from the stated date of injury and the stated date of onset of the left knee mechanical symptoms. He testified that he did not believe that Petitioner required any ongoing treatment for his chest wall contusion and that he thought that the left knee needed further evaluation and an MRI. He testified that he thought that the MRI needed to be done because of the mechanical symptoms, but that he believed that the mechanical symptoms were not causally linked to the incident in January. He testified that he believed that as of July 16, 2015, Petitioner could continue working full duty with the exception that he not return to ladder climbing. (RX4).

Dr. Moody testified that after the IME, he was asked to review updated medical records for Petitioner and that he authored a supplemental report regarding follow-up questions that he received and answered on December 2, 2015. He testified that based on his review of the updated records, his diagnosis related to the current status of Petitioner's knee changed but that the diagnosis related to the injury of January did not. He testified that the new diagnosis for Petitioner's current status was that of degenerative joint disease of the left knee, degenerative lateral meniscus tear and complex degenerative tear of the medial meniscus. When asked whether he suspected back in July that Petitioner may have had a meniscus tear, Dr. Moody responded that based on Petitioner's mechanical symptoms that was his primary concern. He testified that Petitioner had some pretty severe degenerative changes in his left knee. (RX4).

Dr. Moody testified that it was still his opinion that the time latency between the accident and the onset of symptoms did not causally link the incident in January to the meniscal tear seen on the MRI and that it was based, in large part, on the history that Petitioner himself had reported to him. He testified that degenerative meniscal tears were extremely common in people with degenerative joint disease, so finding them was not a big surprise. When asked if he gave any significance to the fact that Petitioner did not treat for his knee between the emergency room visit on January 27, 2014 and when he first presented to Dr. Phillips, Dr. Moody responded that such a gap was very rare and that it was very unlikely that someone would be symptomatic and not seek medical attention somewhere over that period of time. When asked whether as of December 2015 his opinion as to Petitioner's ability to work had changed, Dr. Moody responded that he believed that Dr. Phillips after his evaluation indicated that Petitioner could work without restrictions and that he had no objection to that. (RX4).

On cross examination, Dr. Moody agreed that injured workers came to OSF Occupational Health at the direction of their employer. He testified that he occasionally saw someone who had a work-related or alleged work-related injury who wanted a second opinion or wanted to treat somewhere else other than where their employer sent them. He agreed that in many cases, the employer could "block" an injured worker from coming to OSF Occupational Health if the employer did not authorize the treatment being rendered by OSF Occupational Health. (RX4).

On cross examination, Dr. Moody agreed that the only medical records that he reviewed as of the time of the July 19, 2015 IME were the emergency room records of January 27, 2014 and the injury report. He agreed that during the initial IME, he was suspicious of a probable left meniscus tear and that it could

be consistent with the mechanical problems Petitioner was experiencing. He testified that Dr. Phillips was a competent doctor. (RX4).

On cross examination, Dr. Moody agreed that the diagnosis of a left knee contusion was based only on the history that was provided to him by Petitioner himself. He agreed that at the time of the IME in July 2015, he only provided a causation with regard to a work-related injury from January 2014. He agreed that he was not giving any causation opinion as to any subsequent injuries that Petitioner may have sustained while working for the employer. (RX4).

On cross examination, Dr. Moody testified that he was certain that he reviewed the MRI report but did not recall whether he reviewed the films. He agreed that he believed that knee pain was documented on Petitioner's initial report. He agreed that the fact that OSF did an x-ray of Petitioner's left knee implied that he was experiencing some sort of problem with the left knee. (RX4).

The transcript of the deposition of Dr. Karlsson was entered into evidence at the time of arbitration as Respondent's Exhibit 5. Dr. Karlsson testified that he is a board-certified orthopedic surgeon and that he does general orthopedic surgery. (RX5).

Dr. Karlsson testified that he examined Petitioner on December 9, 2016 for his left knee. He testified that Petitioner gave a history of having three injuries to his knee, that the most recent was on September 20, 2016, that the first injury was on January 26, 2014 and that he did not have the exact date of the second injury but said that it was days to months after the first injury. He testified that Petitioner stated that in the first injury he was coming down off a machine holding the handles, that his left leg stayed up on the fender of the machine, that his body fell downward and twisted and that he struck his chest against something and had pain in the knee and chest. He testified that the second injury was days to months later and was when Petitioner jerked his leg when trying to climb over a machine and that he stated that some months after that, he had an MRI and was told of a tear with no surgery being done. He testified that Petitioner stated that his knee continued to give him problems from the original injury in 2014 through the time when he injured his knee on September 19th or 20th of 2016, at which time he was working with another co-worker, they were lifting a 6-foot beam, the other co-worker dropped their grip on the beam and then Petitioner lost his grip. He testified that Petitioner stated that the beam fell down, hit the ground, bounced back up and struck him in the left knee, that the beam weighed about 25 pounds and was for a truck frame and that he subsequently had x-rays and saw Dr. Philips, who had previously seen him for the knee. He testified that Petitioner had seen Dr. Phillips most recently about two weeks before he examined him and that he had been told of a meniscal tear and arthritis in the knee. (RX5).

Dr. Karlsson testified that Petitioner reported subjective complaints of a constant pain in his knee and that he pointed over the lateral aspect of the knee as well as below the knee and that he also pointed to the proximal third of the calf. He testified that Petitioner told him that at times his knee would lock up and that there was also clicking, that this was unchanged from what it was prior to the third injury of September 2016 and that it had not changed in its character, severity or location in any way from sometime in 2014 to when he was seen. He testified that Petitioner reported that he was currently working and that he had restrictions of no kneeling, squatting or lifting more than 20 pounds and that he was not to climb ladders. He testified that he believed that Altorfer was accommodating the restrictions and that Petitioner did not make any complaints of being pushed beyond those limitations. (RX5).

Dr. Karlsson testified that Petitioner's motion and stability were full and were the same as the other leg, that he was tender on the outer aspect of the left knee and non-tender on the inner aspect or front of the knee, that he had some pain on the outer aspect of the kneecap and that he walked with a slight limp with trying to get off the left leg a little bit quicker. He testified that x-rays performed showed arthritis in both knees, moderate on the right side with the left side showing severe loss of clear space and almost bone-on-bone. He testified that there were prominent bone spurs throughout the left knee, that Petitioner also had

nearly complete loss of the space behind the kneecap and that there were no acute fractures, dislocations or loose bodies. He testified that there were some chronic changes with cysts that had formed beneath the joint line on both the thigh bone and shin bone on the left knee, and that those were all consistent with severe arthritis of the left knee and moderate in the right knee. He testified that both the subchondral cysts and the osteophytes were indicative of severe longstanding arthritis. (RX5).

Dr. Karlsson testified that he reviewed both the report and the actual images of the left knee MRI of October 28, 2015 and that Petitioner had an intact ACL with some high signal in the middle of it, that the PCL was intact, and that there were no displaced fragments of either the medial or lateral menisci, but that there were extensive degenerative changes throughout the back of both. He testified that there were severe tricompartmental arthritic changes with full-thickness cartilage loss on both the outer thigh bone and the outer shin bone and that there were subchondral cysts that had been seen on plain films as well. He testified that there were also bone spurs throughout the knee joint which had been seen on plain film as well, that there were no fractures or dislocations and that he felt overall it was consistent with severe degenerative change throughout the left knee, most notably in the outer or lateral joint line. (RX5).

Dr. Karlsson testified that he reviewed substantial medical records for Petitioner spanning from January 27, 2014 through October 5, 2016 and that he also saw an x-ray report dated October 7, 2016 for the left knee as well. He testified that those records documented treatment of Petitioner at the emergency room as well as with Dr. Rhode and Dr. Phillips. He testified that when he saw Petitioner on December 9, 2016 he was treating with Dr. Phillips, and that Dr. Phillips had told Petitioner of a need for surgery to the knee consisting of an arthroscopy for a meniscal tear. (RX5).

Dr. Karlsson testified that his diagnosis was that Petitioner had arthritic changes of the left knee with bone-on-bone in the lateral compartment and tricompartmental degenerative changes. He testified that the bone-on-bone changes could be the result of an acute injury, but that it was rare. He testified that if it were the result of an acute injury, one would find a large piece of cartilage seen on the MRI or a piece of cartilage and bone on the x-ray or MRI. He testified that in this case, there was no such large traumatic piece that had been knocked off. He testified that he did not agree with Dr. Phillips' recommendation for arthroscopic surgery and that he thought that there was very little likelihood of any improvement given the degree of arthritis. He testified that it would be more appropriate to treat Petitioner for his severe preexisting osteoarthritis with injections (steroid or lubricating) and possibly eventually a knee replacement. He testified that he did not think it was inevitable that Petitioner was going to need a total knee replacement, but that it was very likely and certainly more likely than not given his age and the severe nature of his arthritis. He testified that Petitioner has worse arthritis than average for his age, but that it was something that he saw on a daily basis in the office. (RX5).

Dr. Karlsson testified that he did not feel that Petitioner's left knee condition was related in any way to the injury of September 2016. He testified that this was because of the nature of the injury with something striking the knee and, more importantly, Petitioner's history given to him multiple times that he was in no way different on the day that he examined him than he was prior to that injury in September 2016. He testified that it was his opinion that the mechanism of injury that Petitioner described to him in September of 2016 could not have resulted in the condition that he had. He testified that Petitioner did not hurt in a different area and was not having any new problems whatsoever with his knee when he saw him compared to prior to the September 2016 injury. (RX5).

Dr. Karlsson testified that as of December 9, 2016, he felt that Petitioner could continue working. He testified that he did not feel that Petitioner needed restrictions at that time because the physical exam findings were that he had excellent range of motion, that he had some mild tenderness but nothing severe and that he did not appear to have any significant loss of muscle strength, so it seemed as though his limitations and disuse for the leg was fairly minimal. (RX5).

On cross examination, Dr. Karlsson agreed that in his 8-page report, he offered no opinion regarding causation as it related to the January 26, 2014 accident and testified that the single causation question that was asked of him was regarding the 2016 surgery. He agreed that his report did not offer any causation opinion with regards to an accident that Petitioner might have sustained between January of 2014 and September of 2016. (RX5).

On cross examination, Dr. Karlsson agreed that the injections that he recommended would provide temporary relief. He testified that he believed that the arthroscopy recommended by Dr. Phillips would provide temporary or possibly no relief and that he did not feel that it was likely to give any lasting benefit. He agreed that a knee or joint replacement was the kind of surgery that was used as a last resort after trying conservative treatments. He testified that a knee replacement was considered to be more invasive than an arthroscopy, and that it was more costly to perform a knee replacement. (RX5).

On cross examination, Dr. Karlsson testified that his understanding was that Petitioner was working as an assembler. He testified that he was not provided a job description for Petitioner. He testified that other than what had occurred when he had the various injuries, he did not discuss with Petitioner what his day-to-day activities were. He testified that he knew that Petitioner was carrying things at 25 pounds or more and climbing into and out of and over machinery, but that he did not go into details with him. He testified that with Petitioner's diagnosis and condition, it was his opinion that Petitioner could kneel frequently, squat frequently and climb ladders. He testified that Petitioner's lifting capabilities would depend on his overall strength and ability to lift, but that he would not place any restrictions for lifting based on his knee. (RX5).

On cross examination, Dr. Karlsson agreed that he did not review any medical records that pre-dated January 27, 2014. He testified that he did not discuss with Petitioner how his knee was before January 27, 2014. He testified that, as to the mechanism of injury on September 19, 2016, a 25-pound beam fell to the ground, bounced up and struck him in the front of the knee. He agreed that Petitioner advised him that prior to September 19, 2016, he had knee problems and that he was relating those knee problems to an accident that he was involved in in January of 2014. (RX5).

On cross examination, Dr. Karlsson testified that he did not believe that any of the pathology in Petitioner's knee was caused by the September 2016 accident. He testified that one could have something much lighter strike them in the knee that could cause pathology in the knee, but that in this case with the mechanism of injury, the weight and the findings of severe arthritis, there was nothing from that date of injury that caused Petitioner's ongoing problems to the knee. (RX5).

The 1/4/17 Written Injury/Illness Report was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report reflects that Petitioner indicated that while he was clocking out, he turned, his leg locked up and he fell down, hitting his knee and face and busting his lip. (RX6).

CONCLUSIONS OF LAW

As it pertains to 16 WC 20202 for the alleged date of accident of January 23, 2014:

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of January 23, 2014.

The timeline of Petitioner's medical treatment following his January 23, 2014 accident is undisputed. The medical records reflect that Petitioner initially sought treatment on January 27, 2014. (PX6). Despite Petitioner's testimony that he began experiencing mechanical symptoms in his knee the

day of his accident, there is no note in his records from the emergency department on January 27, 2014 of complaints of any mechanical symptoms. (*Id.*). While the records reflect that Petitioner apparently mentioned ongoing left knee pain to his primary care physician on February 11, 2014 and was provided a referral to Dr. Phillips, it appears that Petitioner never responded to Dr. Phillips' office's attempts to schedule an appointment. (PX10; PX11). The Arbitrator finds to be significant in this case that Petitioner himself reported to Dr. Moody that he did not begin experiencing any mechanical symptoms in his knee until a month after his accident, but this is contrary to Petitioner's testimony at the time of arbitration. (PX9; RX4).

The Arbitrator further finds to be significant that after January 27, 2014, there is no record of treatment until July 16, 2015, at which time Petitioner underwent a Section 12 examination with Dr. Moody. (PX9). Even though Petitioner testified that he asked his supervisor several times to get further treatment of his knee, Petitioner did not testify as to when those requests were made, nor did he call his supervisor as a witness to corroborate his testimony on this issue.

It is also undisputed that the findings on Petitioner's MRI are degenerative in nature. All of the doctors who examined Petitioner and reviewed his MRI, including Dr. Phillips, agreed as to the degenerative nature of Petitioner's MRI findings. Dr. Phillips specifically testified that there were no acute findings on Petitioner's MRI and agreed that the meniscal tearing noted was degenerative. (PX12). Dr. Karlsson also testified that the degenerative nature of Petitioner's knee was so severe that it was "bone-on-bone" and would not benefit from arthroscopic surgery. (RX5).

The Arbitrator believes that had Petitioner been experiencing mechanical symptoms to the nature and degree as alleged at the time of arbitration, he would in all likelihood have sought treatment upon obtaining the referral to Dr. Phillips from his primary care physician back in February of 2014, rather than waiting a year and a half post-accident to see Dr. Phillips in October of 2015. That said, the Arbitrator finds the opinions of Dr. Moody - particularly his opinion that he did not think that Petitioner's mechanical symptoms were related to the work injury due to the period of time that had elapsed from the stated date of injury and the stated date of onset of the left knee mechanical symptoms - to be more persuasive than those proffered by Dr. Phillips, and finds that Petitioner's ongoing symptoms in the left knee after January 27, 2014 were due to his underlying degenerative condition. As a result thereof, the Arbitrator finds that Petitioner's condition of ill-being after January 27, 2014 is not causally related to the accident of January 23, 2014.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment up through the emergency room visit on January 27, 2014 was reasonable, necessary, and causally related to the work accident of January 23, 2014. As a result thereof, Respondent shall pay the reasonable and necessary medical services as contained in Petitioner's Exhibit 16 for medical services rendered **during the timeframe of January 23, 2014 through January 27, 2014,** as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of January 23, 2014, Petitioner's request for prospective medical treatment to the left knee as recommended by Dr. Phillips is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally

related to the accident of January 23, 2014, Petitioner's request for temporary total disability benefits for the timeframe of January 23, 2017 through February 21, 2018 is hereby denied.

As it pertains to 16 WC 29431 for the alleged date of accident of September 19, 2016:

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of September 19, 2016.

Given the overwhelming testimonial evidence from Petitioner as well as all of the doctors involved that Petitioner had ongoing symptoms in his left knee prior to the September 19, 2016 accident and had been recommended to undergo surgery prior to that date of accident, the Arbitrator finds Petitioner's condition of ill-being on and after September 19, 2016 is not causally related to the accident of September 19, 2016.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of September 19, 2016, Petitioner's request for payment of reasonable and necessary medical services is hereby denied.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of September 19, 2016, Petitioner's request for prospective medical treatment to the left knee as recommended by Dr. Phillips is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of September 19, 2016, Petitioner's request for temporary total disability benefits for the timeframe of January 23, 2017 through February 21, 2018 is hereby denied.

As it pertains to 17 WC 879 for the alleged date of accident of January 3, 2017:

With respect to disputed issue (C), the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on January 3, 2017 that arose out of and in the course of his employment with Respondent.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois*

Workers' Compensation Comm'n, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21.

The Arbitrator notes that Petitioner testified that he fell on January 3, 2017 on his way to punch out for the day when his knee gave out as of result of his ongoing knee problems. The parties do not dispute that Petitioner was "in the course of" his employment at the time of the accident. The question, then, is whether the accident "arose out of" the employment. The Arbitrator notes that no allegations were made that any employment-related risk caused Petitioner's fall. In fact, it is undisputed that Petitioner's fall occurred due to his underlying left knee condition. As such, the risk to which Petitioner was exposed was personal in nature. Based the foregoing, the Arbitrator finds Petitioner's accident did not "arise out of" his employment by Respondent and was, instead, personal in nature.

As such, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on January 3, 2017 that arose out of and in the course of his employment with Respondent.

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

As it pertains to 17 WC 34552 for the alleged date of accident of August 19, 2015:

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of August 19, 2015.

Respondent does not dispute Petitioner's accident on August 19, 2015. (AX4). The question, then, is whether Petitioner's condition of ill-being after August 26, 2015 is causally related to the accident of August 19, 2015. Petitioner testified that he continued to experience symptoms in his left knee prior to his August 19, 2015 accident, and the Arbitrator notes that this is confirmed in Dr. Braun's records. (PX9). Dr. Braun's records also confirm that as of August 26, 2015, Petitioner's symptoms had returned to his pre-accident baseline. (*Id.*).

The Arbitrator finds that while Petitioner sustained a temporary aggravation of his pre-existing condition as a result of his August 19, 2015 accident, Dr. Braun's records confirm that Petitioner's condition returned to his pre-accident baseline as of August 26, 2015. (PX9). As a result thereof, the Arbitrator finds that Petitioner's condition of ill-being after August 26, 2015 is not related to the accident of August 19, 2015.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment during the timeframe of August 19, 2015 through August 26, 2015 was reasonable, necessary, and causally related to the work accident of August 19, 2015. As a result thereof, Respondent shall pay the reasonable and necessary medical services as contained in Petitioner's Exhibit 16 for medical services rendered **during the timeframe of August 19, 2015 through August 26, 2015,** as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of August 19, 2015, Petitioner's request for prospective medical treatment to the left knee as recommended by Dr. Phillips is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of August 19, 2015, Petitioner's request for temporary total disability benefits for the timeframe of January 23, 2017 through February 21, 2018 is hereby denied.

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

Luis Nava,
Petitioner,

18IWCC0717

vs.

NO: 16 WC 29431

Altorfer, 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, prospective medical, temporary 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. 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 March 23, 2018, is hereby affirmed and adopted.

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

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

18IWCC0717

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 $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 21 2018
o10/10/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0717

NAVA, LUIS
Employee/Petitioner

Case# **16WC029431**

16WC020202
17WC000879
17WC034552

ALTORFER INC
Employer/Respondent

On 3/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

18IWCC0717

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Luis Nava
Employee/Petitioner

v.

Altorfer, Inc.
Employer/Respondent

Case # **16** WC **29431**

Consolidated cases: **16 WC 20202, 17 WC 879 & 17 WC 34552**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **February 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **September 19, 2016,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$46,519.72**; the average weekly wage was **$894.61**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of September 19, 2016, Petitioner's request for prospective medical treatment to the left knee as recommended by Dr. Phillips is denied.

Respondent shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed 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.

Melinda M. Rowe-Gillman

Signature of Arbitrator

3/20/18

Date

ICArbDec19(b)

MAR 23 2018

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

Luis Nava,
Petitioner,

vs.

Altorfer, Inc.,
Respondent.

18IWCC0718

NO: 17 WC 879

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 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 23, 2018, is hereby affirmed and adopted.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
o10/10/18
DLS/rm
046

NOV 2 1 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0718

NAVA, LUIS
Employee/Petitioner

Case# **17WC000879**

16WC020202
16WC029431
17WC034552

ALTORFER INC
Employer/Respondent

On 3/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Luis Nava
Employee/Petitioner

v.

Altorfer, Inc.
Employer/Respondent

Case # 17 WC 879

Consolidated cases: 16 WC 20202, 16 WC 29431& 17 WC 34552

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **February 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 3, 2017,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$46,519.72**; the average weekly wage was **$894.61**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

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

Respondent shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

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

Melinda M. Rose Sullivan
Signature of Arbitrator

3/20/18
Date

ICArbDec19(b)

MAR 23 2018

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

Luis Nava,
Petitioner,

18IWCC0719

vs.

NO: 17 WC 34552

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 23, 2018, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 21 2018
o10/10/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0719

NAVA, LUIS
Employee/Petitioner

Case# **17WC034552**

16WC020202
16WC029431
17WC000879

ALTORFER INC
Employer/Respondent

On 3/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

18IWCC0719

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Luis Nava
Employee/Petitioner
v.

Case # **17** WC **34552**

Consolidated cases: **16 WC 20202, 16 WC 29431& 17 WC 879**

Altorfer, 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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **February 21, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 9, 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 not*** causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$46,519.72**; the average weekly wage was **$894.61**.

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

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical 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 shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to the accident of August 19, 2015, Petitioner's request for prospective medical treatment to the left knee as recommended by Dr. Phillips is denied.

Respondent shall pay for medical services **rendered during the timeframe of August 19, 2015 through August 26, 2015** 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 August 19, 2015 through August 26, 2015** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of August 19, 2015 through August 26, 2015** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall be given a credit of **$AMOUNTS TO BE DETERMINED** in medical bills through its group medical plan for which credit may be allowed 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

3/20/18
Date

ICArbDec19(b)

MAR 23 2018

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT GOODMAN,

Petitioner,

18IWCC0720

vs. NO: 17 WC 31450

STATE OF ILLINOIS – DEPARTMENT OF TRANSPORTATION,

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, 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 compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner sustained an uncontested accident on September 11, 2017 when a "skid steer" ran over his right foot. The Arbitrator awarded Petitioner 16&2/7 weeks of TTD, through the date of arbitration, $5,841.84 in medical bills, and ordered Respondent to authorize and pay for prospective treatment recommended by Dr. Khalid. The Commission agrees with the Arbitrator's decision and reasoning regarding causal connection. Accordingly, the Commission affirms and adopts those aspects of the Decision of the Arbitrator.

Petitioner testified that on November 18, 2017 and November 19, 2017. His foot was wrapped, and he only had to walk about 20 feet to his blind where he sat. He shot from his chair. He killed a doe on the 18th and a buck on the 19th. He hunted for a couple of hours each day. He got the deer out with his 4-wheeler. It has a pulley system, and Petitioner did not have to do any pulling. On cross examination, Petitioner testified that the deer he shot on the 18th was about 30 yards away. It ran maybe 6 yards after it was shot. After about ½ hour, Petitioner retrieved it with his 4-wheeler, it was right outside the blind. He tied a rope around its neck and dragged it to the house. He bent over to tie the deer. The deer he killed on the 19th was about 25 yards away. It "dropped right there." He did the same procedure with this deer that he did with the other. At no point did he lift either deer.

Jeffrey David Cariens was called by Respondent. He is a conservation police sergeant. In his job he deals with criminal, traffic, and Department of Natural Resource violations. He was asked a hypothetical consistent with Petitioner's testimony. Mr. Cariens indicated that in his experience regulating hunters and being a hunter himself, it would generally take more than two hours to "prepare, shoot, process drag out, process and then leave" but that time frame was "plausible." Bucks generally weigh 170-175 lbs and does 160-165 lbs. When he hunts he drags the deer away manually, but he has seen hunters drag one away with a 4-wheeler. "Generally, you would kneel down to tie the rope around the neck."

The Commission notes the record before us presents significant issues concerning Petitioner's credibility. He appears to have magnified his symptoms because his subjective complaints did not correspond with objective findings. In addition, his testimony was often internally inconsistent and at odds with the medical records. In light of the serious question of Petitioner's overall credibility, the Commission is not convinced of the correctness of his testimony regarding his deer hunting experience as well as his desire to hunt at all considering the level of pain he reported. Therefore, the Commission modifies the Decision of the Arbitrator to terminate temporary total disability benefits as of November 18, 2017, the first day he hunted deer after the accident.

In addition, the Commission vacates the award of current medical expenses and prospective medical treatment. Petitioner's treating doctor, Dr. Khalid placed Petitioner at maximum medical improvement as of December 7, 2017. On remand, the Commission directs the Arbitrator to award only medical expenses incurred before December 7, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $713.85 per week for a period of 9&5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of compensation for permanent disability, if any.

18IWCC0720

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay only medical expenses incurred before December 7, 2017 under §8(a) of the Act pursuant 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.

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

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

DATED: NOV 2 1 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-11/1/18
46

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

18IWCC0720

GOODMAN, ROBERT
Employee/Petitioner

Case# **17WC031450**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 3/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0656 GLASS & KOREIN LLC
MICHAEL H KOREIN
7012 W MAIN ST
BELLEVILLE, IL 62223

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

1430 CMS BREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAR 6 - 2018

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

18IWCC0720

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)

Robert Goodman
Employee/Petitioner

v.

Illinois Dept of Transportation
Employer/Respondent

Case # 17 WC 31450

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **January 4, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0720

FINDINGS

On the date of accident, **09/11/17**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,683.63**; the average weekly wage was **$1,070.77**.

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 shall be given a credit of **$7,852.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$7,852.68**.

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

ORDER

Respondent shall Petitioner temporary total disability benefits of $713.85 per week for 16-2/7 weeks commencing September 12, 2017 through January 4, 2018, as provided in Section 8(b) of the Act.
Respondent shall be given a credit for $7,852.68 in TTD.
Respondent shall pay all reasonable and necessary medical services of $5,841.84 as provided in Sections 8(a) and 8.2 of the Act all of which are identified on PX3.
Respondent shall receive credit for any medical bills previously paid.
Respondent shall pay the reasonable charges associated with further treatment recommended by Dr. Khalid, including referral to a neurologist.

The Arbitrator denies penalties pursuant to Section 19(k), 19(l) and 16 attorney fees..

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.

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

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

Edward Lee 3/2/18

Signature of Arbitrator Date

MAR 6 - 2018

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

ISSUES IN DISPUTE: Causal connection, medical bills incurred after 11/18/17, temporary total disability after 11/18/17, prospective medical treatment, penalties, and attorney's fees.

WITNESSES TESTIFYING AT TRIAL were Petitioner, Robert Goodman, and Jeffrey Cariens from the Illinois Department of Natural Resources.

THE ARBITRATOR FINDS:

At hearing, Petitioner testified that he is 51 years of age and began working for Respondent, Illinois Department of Transportation in April, 2016. Prior to his employment with the State, Petitioner worked for Environmental Management Alternatives for 17-18 years. He also served in the Marine Corp from 1984 to 1991, including infantry, special forces, and then became a weapons instructor. He then served 17 years in the Army Reserves through January, 2016, and was deployed to Iraq four times.

For the injury at issue, Petitioner testified that he was employed by Respondent as a highway maintainer. His job duties as outlined in **PX5** were admitted into evidence. Petitioner testified that his job involves a lot of standing on roadways and jumping in and out of vehicles. This was from patching roads, pothole patching, general road work, and debris clean up.

Petitioner testified that he had no problems, limitations, symptoms, or treatment to his right foot or ankle before September 11, 2017. His foot and ankle were feeling fine the morning of September 11, 2017 before he began work. He was assigned to work at the Highway 255 & 64 northbound on ramp when the outside of his right foot and ankle were run over by about a 6,000 pound skid steer. Petitioner testified that the skid steer is like a bobcat, and it had wheels as opposed to tracks. The impact of having the outside of the foot and ankle run over caused the inside or left side of his right heel to burst. As a result, Petitioner immediately sought medical treatment at Memorial Hospital in Belleville, Illinois. The hospital ordered x-rays, provided sutures to the inside of his right heel, and provided him with a wrap and crutches.

Petitioner followed up with his primary care physician, Dr. Khalid, who has since removed the sutures, ordered an MRI of the right foot/ankle, prescribed medication, prescribed a walking boot, and ordered Petitioner to remain off work through the date of hearing. Petitioner testified that he provided his off work notes to the employer. And, from the day of the accident to the present, his symptoms have stayed about the same. Namely, he has a numbness and tingling sensation around the ankle bones on the inside and outside of the ankle and then the impact area of the heel is numb. He can't put pressure on the back side of the heel. For a period of time, he was prescribed gabapentin for possible nerve damage. In December, 2017, Petitioner was referred by Dr. Khalid to a neurologist for ongoing symptoms.

Respondent terminated temporary total disability after Petitioner went deer hunting on November 18 and November 19, 2017. Petitioner admitted to having gone hunting on those

two dates for a total of four hours. While hunting, he killed two deer from a seated position, did no walking except for 20 feet from a four wheeler to the blind, did no lifting, and was on his medication. He utilized his soft wrap and crutch during the hunt. He was accompanied by four other friends, and they stayed the night at a house on private property between the two hunting excursions. Petitioner said he used a 4-wheeler to transport himself and the deer from the house to the blind and simply bent over to wrap a noose around the deers' necks and dragged them with the 4-wheeler back to the house where they were staying.

Because of Petitioner's military experience, he was intending on re-enlisting in the military and has been unable to do so as a result of the work injury. Petitioner currently takes ibuprofen for his symptoms. He is willing to treat with a neurologist on the referral of Dr. Khalid.

Petitioner removed his boot and sock at hearing and demonstrated the areas of the ankle that were still numb. There was also a noticeable bump that remains sensitive to the top of the foot where it meets the ankle. He was also observed to have residual bruising where the laceration was on the heel.

On cross-examination, Petitioner was asked whether he went to work one day in sneakers to which he responded "yes". However, on re-direct examination, Petitioner testified he was on a crutch and wearing a foot wrap when he went to work in sneakers. Petitioner was also asked on cross-examination whether he applied to Respondent for light duty or a job accommodation to which he responded "no" because he had not been released to any form of light duty. On cross examination, Petitioner testified to how he collected the deer for both kills on both days, utilizing the four wheeler and dragging them to the house with the four wheeler without any lifting, kneeling, field dressing, or putting them on a bed. He killed both deer with a shotgun. He also testified that he is currently taking Ibuprofen, 800 miligrams which makes him drowsy on occasion. On cross examination, he also testified that he could not do prolonged standing which would impact his ability to work.

Jeffrey David Cariens testified as to his job duties as a Conservation police sergeant for the Illinois Department of Natural Resources. He was presented with a hypothetical by Respondent's counsel describing the hunting Petitioner engaged in, and he did not believe Petitioner's description of the events to be unreasonable. While he said you normally kneel to put the noose around the deers' necks, he admitted on cross-examination that one can bend over at the waist as opposed to kneeling.

Petitioner offered into evidence seven exhibits. Respondent had no objection. Respondent offered into evidence two exhibits, and Petitioner had no objection. Respondent's Exhibits1 and 2 are the records of the Illinois Department of Natural Resources documenting the two kills submitted by Petitioner for November 18, 2017 and November 19, 2017.

Petitioner's Exhibit 1, the emergency room records of Memorial Hospital, demonstrates that Petitioner presented for laceration repair when his foot was run over by a skid steer while he was wearing steel-toed boots. He noted tingling to the heel **(PX1-003)**. He was noted to have a 2 cm laceration with no active bleeding **(PX1-005)**. Petitioner was noted to have tenderness to palpation along the calcaneus with the noted laceration **(PX1-007)**. Petitioner's pain intensity at

the time was 10 out of 10 **(PX1-010)**. X-rays of the right ankle noted polyarticular arthritis of the right hind foot, small calcaneal spur, heterotopic ossification of the Achilles insertion, and soft tissue defect of the posterior heel without acute osseous abnormality or fracture of the right ankle **(PX1-012)**. X-rays of the right foot demonstrated the heterotopic ossification of the Achilles insertion, the plantar calcaneal spur, type II navicular ossicle, no acute fracture, but soft tissue irregularity in the subcutaneous tissues of the heel likely corresponding to the known laceration **(PX1-014)**. Petitioner was discharged with the ability to return to work in two days and to slowly advance bearing weight as tolerated **(PX1-016)**.

Petitioner was first seen by Dr. Khalid on September 12, 2017. The history of the foot injury was recorded, and he was noted to be walking on crutches. It was also noted he was given a short course of antibiotic therapy. Petitioner reported that the right foot pain made him unable to walk without pain **(PX2-008)**. The doctor noted that his musculoskeletal system appeared normal without any problem except for the right foot on the lateral side having the laceration around the heel backward to front. The doctor believed he would need two weeks for the suture removal from the heel of the foot, prescribed pain medication, continuing use of the crutches **(PX2-009)** and ordered Petitioner to remain off work until 09/26/17 **(PX2-026)**.

Petitioner was seen in follow-up by Dr. Khalid on September 25, 2017 **(PX2-010)**. He was continuing to walk with the use of crutches and advised to continue antibiotics for two more weeks. He was noted to be able to tolerate some weight bearing but still had pain and was noted to have difficulty with ambulation **(PX2-011)**. Petitioner was kept off work and diagnosed with laceration to the heel of the right foot and right ankle strain **(PX2-028 to 30)**.

Petitioner returned to Dr. Khalid on October 9, 2017 at which time sutures of the right heel were removed. Petitioner was advised to start walking and putting weight on the foot. Petitioner's pain level was 8 out of 10. The doctor noted that he is unable to do weight bearing walking or go back to work. The Petitioner's complaints at the time were that his whole foot hurts, and he feels a severe throbbing discomfort and has to sit down and relax. He was noted to be avoiding any pain medications. On physical examination, Petitioner was noted to have pain around the dorsal aspect of the foot and the lateral border of the right foot. At that time, Dr. Khalid ordered an MRI of the foot to determine the extent of the soft tissue injury. He ordered continuation of NSAIDs and to follow up after the MRI **(PX2-013)**. Petitioner was ordered to remain off work one month until further evaluation on 11/09/17 **(PX2-031)**. Petitioner was also prescribed Neurontin, Prilosec, and Voltaren **(PX2-031)** and was again noted to have laceration of the heel of the right foot and a right ankle strain **(PX2-033)**.

On October 9, 2017, an MRI of Petitioner's right ankle was performed at Belleville Open MRI. He was noted to have a grade II osteo-chondral lesion at the medial corner of the talar dome. This was seen to be hypo-intense, and there was a focal defect in the articular cartilage overlying the lesion. Petitioner was also noted to have a Type II Os naviculare **(PX2-014 to 015)**.

On November 9, 2017, Petitioner returned to Dr. Khalid **(PX2-017 to 021)**. At this time, Dr. Khalid noted neuropathic pain around the laceration which extended proximally to the ankle above **(PX2-017)**. On physical examination, the doctor noted that the right foot medially shows palpable hyperesthesia tenderness which produces quite a bit of pain over the suture line and

proximally. Petitioner was noted to have painful weight bearing, he was started on Gabapentin, and a walking boot was ordered so Petitioner could function and walk (**PX2-018**). Petitioner was ordered to remain off work until further evaluation (**PX2-039**) and (**PX2-040**). Petitioner's nature of injury was noted to be a laceration injury and swelling of the right foot. He was prescribed Cipro, Gabapentin, Prilosec, and Ibuprofen (**PX2-040**).

On December 7, 2017, Petitioner presented to Dr. Khalid with severe neuropathic pain in the adjacent areas of the foot, and sometimes Petitioner would feel neuropathic pain traveling proximally above the ankle. He was noted to be given a special boot because he could not step in a normal shoe, and Petitioner was noted to be in such severe pain that he could not function. Petitioner's pain complaints were 6-7 out of 10 (**PX2-019**). System review reiterated the neuropathic pain in the right heel of the foot without any other physical findings. Petitioner's objective findings were noted to be quite anxious and stressful with the pain and discomfort because he wanted to go to his job and resume his normal life. On physical exam, Petitioner was noted to have localized hyperesthesia. The physical examination findings were negative but adjacent to the ankle, he had quite a bit of neurological hyperesthesia, neuropathic pain which is not fully relieved despite the Gabapentin. Dr. Khalid prescribed an oral tapering dose of steroids and referred him to a neurologist for further evaluation and management of the problems by an "expert" (**PX2-020**). Petitioner was kept off work due to the laceration injury and swelling of the right foot, with a follow-up appointment scheduled for January 2, 2018 (**PX2-041**). On January 2, 2018, Dr. Khalid prescribed continuation of Gabapentin, diagnosed him with a laceration of the heel to the right foot and neuropathy of the right foot with post traumatic disability of weight bearing (**PX2-063**).

PX3 are the bills from Belleville Open MRI, the emergency room physician from Belleville Memorial Hospital, Dr. Khalid, Memorial Hospital, and Provider Plus which provided the crutches and the boot. The statement of Belleville Open MRI demonstrates that an "insurance payment of $481.70 was paid either by Respondent or Petitioner's group health". Respondent provided no printout at hearing of any medical bills paid by the State.

PX4 is an email from Petitioner's counsel to the adjuster for Respondent asking for written basis for termination of benefits (**PX4-001**). On December 13, 2017, Respondent, through Tristar, denied the claim advising it does not appear to have arisen out of and in the course of employment with the State of Illinois (**PX4-002**). It further denied further benefits due to "additional investigation of your claim for worker's compensation benefits" without providing any written basis for denial of further benefits. A December 14, 2017 letter reiterated the denial of further benefits due to "additional investigation of your claim for worker's compensation benefits" (**PX4-003**). PX4-004 is communication between Respondent's counsel and Petitioner's counsel advising that Respondent has instructed Respondent's counsel to proceed with the 19(b) as they believe Petitioner has credibility issues regarding the extent of his disability.

PX5 is the job description for a highway maintainer. This includes an obligation to operate with a CDL class license. The job also requires performing labor related to the maintenance of roadways, including repairs, replacement and patching of concrete, bituminous and other roadway surfaces; loading and unloading of trucks; spreading of salt, gravel and asphalt;

operations during snow and ice conditions; performance of labor relating to the maintenance of roadside and right-of-way, including cutting grass, weeds, and brush; removal and disposition of trash, dead animals, and other debris along the highway.

PX 6(a) shows a bump on the medial side of Petitioner's ankle. Petitioner testified that the bump is painful to the touch. **PX6(b)** demonstrates ongoing bruising of the side and back of the foot where Petitioner's foot was run over by the skid steer.

PX7 is the Petition for Penalties & Attorney's Fees seeking penalties of $30.00 per day from December 1, 2017 through hearing, penalties of 50% pursuant to Section 19(k) and attorney's fees of 20% pursuant to Section 16.

RX1 demonstrates that Petitioner killed a doe on November 18, 2017 and reported same at approximately 6:18 pm. RX2 demonstrates Petitioner killed a buck with antlers on November 19, 2017 and reported same at approximately 3:33 pm.

CONCLUSIONS OF LAW:

The Arbitrator finds that Petitioner's current condition of ill-being, namely the ongoing neuropathic pain in his right foot and heel are causally related to the work injury of 09/11/17. Petitioner had no pre-existing problems, limitations, symptoms or treatment of his right foot or ankle before said date and has testified that his symptoms have persisted since that time. This is supported by the medical records of Memorial Hospital and Dr. Khalid. Despite negative exam findings by his family doctor, Dr. Khalid documents ongoing neuropathy and recommends referral to a neurologist for the ongoing complaints.

The Arbitrator finds that Petitioner is entitled to temporary total disability in the amount of $713.85 from September 12, 2017 through January 4, 2018 (16-2/7 weeks). The basis for this determination is Petitioner's ongoing inability to walk without use of a boot, his ongoing neuropathic pain, the positive MRI findings of a grade II osteo-chondral lesion at the medial corner of the talar dome, and the ongoing off work orders of Dr. Khalid. The Arbitrator finds it was unwise for the Petitioner to go hunting on November 18 and November 19, 2017, given his physical condition.

The Arbitrator further finds that the medical bills identified in PX 3 are reasonable, necessary and causally related to Petitioner's work injury. Respondent shall pay same in accordance with Illinois law and the fee schedule. Further, the Arbitrator finds that it is reasonable for Petitioner to be referred to a neurologist to evaluate the ongoing neuropathic symptoms of his right foot and ankle and orders Respondent to pay for continuing treatment.

The Arbitrator notes the Respondent paid benefits and offered the Petitioner light duty and also notes the Respondent was aware of Petitioner's deer hunting. Therefore, the Arbitrator finds the Respondent was not unreasonable or vexatious and accordingly denies Section19(l), 19(k) penalties and 16 attorney fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LOUIE PATRIZI,

Petitioner,

vs.

NO: 10 WC 24734

PRAIRIE STATE COMMUNITY COLLEGE,

18IWCC0721

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 "(1) Whether the 1/17/18 Decision to Reinstate Case is a void order; (2) Whether the Commission had jurisdiction to reinstate the case after 60 days; (3) Whether the 1/17/18 order is immediately appealable pursuant to Illinois Supreme Court Rule 308; (4) Whether the reinstatement was proper," and being advised of the facts and law, affirms and adopts, with the modifications noted below, the Arbitrator's January 17, 2018 Order Granting Petition to Reinstate, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings.

The Commission specifically affirms and adopts the Arbitrator's thorough recitation of the facts as contained in ¶¶ 1-20 of her Order reinstating the matter.

Respondent asserts the Arbitrator and, thereby, the Commission lacks subject matter jurisdiction. Therefore, any orders entered are void. See *Siddens v. Industrial Commission*, 304 Ill. App. 3d 506, 517, 711 N.E.2d 18 (1999) ("A judgment or order is void where it is entered by a court or agency which lacks personal jurisdiction, subject-matter jurisdiction, or the inherent power to enter the particular judgment or order, or where the order is procured by fraud."). Respondent predicates its jurisdictional argument on the 60-day time limit for filing of a Petition to Reinstate. See *Farrar v. Illinois Workers' Compensation Commission*, 2016 IL App (1st)

143129WC, ¶ 14 ("Therefore, when the Commission dismisses a workers' compensation claim for want of prosecution, the claimant has 60 days from receipt of the dismissal order to file a petition for reinstatement."). Therefore, to address the jurisdictional issue, we must determine if Petitioner's Petition to Reinstate was timely filed.

Respondent argues the matter was dismissed on July 18, 2017 and notices of dismissal were generated by the Commission on July 19, 2017. Therefore, Petitioner was required to file his Petition to Reinstate within 60 days thereafter. Accordingly, since Petitioner filed his Petition to Reinstate on November 22, 2017, beyond the 60-day limit, his Petition is barred.

Petitioner asserts his Petition to Reinstate is timely as the first notice of the dismissal received by Petitioner was on November 20, 2017. Therefore, his Petition to Reinstate was timely filed.

In advancing its argument, Respondent relies on the case of *Conley v. Industrial Commission*, 229 Ill. App. 3d 925, 594 N.E.2d 730 (1992), and claims:

> *Conley* establishes the insufficiency of simply alleging Petitioner's attorneys had not received the Notice of Case Dismissal unless the record reflects the court file contained the Notices, returned to the Commission, as proof they had not been delivered to either of Petitioner's two representatives; denial of case reinstatement was proper because the IWCC had been divested of jurisdiction by the lapse of time, with no reliable evidence otherwise, even where Petitioner's attorney represented to the Commission he never received the Notice. *Respondent's Statement of Exceptions and Supporting Brief on Review at 6-7.*

We find Respondent misapprehends the holding in *Conley*. The Court did not hold that the record must contain "Notices, returned to the Commission, as proof they had not been delivered" to an attorney who alleges that a dismissal notice was not received. Although the threshold issue in *Conley* was whether the Commission sent Petitioner's attorney the notice of dismissal and his receipt of the same, the Court found the issue waived and, thereby, did not rule on the underlying issue. In so holding, the Court noted:

> Throughout the Commission proceedings and on appeal claimant speculates as to what the Commission file may or may not contain and what the arbitrator may or may not have reviewed. The actual Commission files which the arbitrator was asked to consider and which she indicated she would review have not, however, been made a part of the record at any point in the litigation. It is clearly the duty of the party desiring to have the case reviewed to see that a complete record relating to any issues raised is filed by the Commission. (*Berry v. Industrial Comm'n (1978), 72 Ill. 2d 120, 124, 378 N.E.2d 507, 509*.) Since the record is insufficient to resolve claimant's speculative arguments, claimant has waived them for purposes of review. *Conley at 930.*

18IWCC0721

In the case at bar, there is no dispute as to the contents of the Commission's file or whether notices were sent. The question posed is- when did Petitioner's attorneys receive the November 19, 2017 dismissal notice. To that end, the *Conley* Court also stated:

> The burden of proof is on claimant to allege and prove facts justifying reinstatement. No such facts were produced before the arbitrator. Claimant initially conceded that attorney Danz was sent notice of the dismissal. While this concession was orally retracted during the hearing before the arbitrator, no evidence was ever presented by attorney Danz, either by way of testimony or affidavit, that he had not received the Commission order. *Allegations of lack of notice by someone other than the individual who would have been the recipient of the notice is not proof of that fact. Conley at 930.* (Emphasis added).

In the case at bar, the evidence shows, on July 19, 2017, Notices of Dismissal were sent to Respondent's attorney, Knell & O'Connor, and to Petitioner's co-counsels, Joseph Pigato ("Pigato") and Cullen, Haskins, Nicholson, and Menchetti, PC ("Cullen"). *Rx4, Rx5.* Petitioner filed a Petition to Reinstate on November 22, 2017. *ArbX1.*

At the reinstatement hearing before Arbitrator Mason on January 10, 2018, Jose Rivero ("Rivero"), Petitioner's attorney from Cullen's office, as an officer of the court and the individual who was the recipient of the notice, affirmatively denied that the notice was received prior to November 20, 2017. *T.24.* Furthermore, we note there is ample additional evidence to support a finding that Rivero did not receive the July 19, 2017 dismissal notice prior to November 20, 2017.

First, on August 25, 2017 over a month following the dismissal, Rivero directed an e-mail to Respondent's attorney, Bradley Knell ("Knell"), inquiring as to an agreed date for "the prove-up" and seeking confirmation that Petitioner need not appear given "the only issue is permanency which you are stipulating to." *Px2.* Later that same day, Rivero sent a second e-mail indicating Petitioner had failed to receive any disability checks since July 14, 2017 presumably due to a change in address and asking Knell to reissue the checks to Petitioner's new address which Rivero provided. *Id.* On August 31, 2017 Knell responded by stating: "I will check into this." *Id.*

Second, on November 3, 2017 Rivero filed a Section 19(b) motion along with a notice indicating he intended to appear before the Arbitrator on November 8, 2017 to seek a hearing date. *Px3.*

Third, "Respondent did not assert any jurisdictional defense" at the November 8, 2017 status call when the parties selected a hearing date of November 20, 2017. *Arbitrator's Order at #14.*

Fourth, on November 10, 2017, Knell sent Rivero an e-mail, stating in part, "I will see you on the 20th before Arbitrator Mason." *Px2.* There was no mention of the case being dismissed. In response, Rivero sent Knell an e-mail asking, "Why aren't your [*sic*] responding to me about benefits, trial, prove up? It would be helpful if you could respond to me." *Px2.*

When Rivero was eventually presented with the dismissal order by Knell at the hearing on November 20, 2017, Rivero filed a Petition to Reinstate on November 22, 2017, indicating that he received the dismissal order on November 20, 2017. *Arb. Order at #16, 17.*

The *Conley* court stated:

> Since claimant failed to establish at arbitration or before the Commission any facts suggesting his attorney of record, Warren Danz, did not receive notice of the dismissal of claimant's application for adjustment of claim, and because the record on appeal is insufficient to resolve claimant's speculative arguments on what the Commission file contains, it cannot be said that the Commission's decision denying claimant's petition to reinstate was an abuse of discretion. *Conley* at 932.

In contrast to the attorney in *Conley*, Petitioner's attorney, Rivero, affirmatively stated, in person as an officer of the court, to the Arbitrator that he received the dismissal notice on November 20, 2017.

We draw another distinction between the case at bar and *Conley*. There is no indication in *Conley* that any other activity took place regarding that case between the time it was dismissed on December 31, 1986 and when the petition for reinstatement was filed, almost six months later, on June 16, 1987. *Conley* at 926. However, in the case at bar, the evidence of the actions of both Rivero and Knell indicate that Rivero continued to operate under the impression that the case was active, and he had no knowledge that the case had been dismissed.

Regarding the notice of dismissal to Pigato, at the reinstatement hearing before Arbitrator Mason on January 10, 2018, Rivero introduced evidence that Pigato was last registered with the Attorney Registration and Disciplinary Commission (ARDC) in 2016 and was "Retired - not authorized to practice law." *Px1*. No business address was listed on the ARDC's record. We find Pigato was not acting nor could have acted as Petitioner's attorney at the time the dismissal notice was sent on July 19, 2017. *Rx4*.

Therefore, we find, as did the Arbitrator, that the evidence before us supports Rivero's representation to the Arbitrator that his initial receipt of the dismissal notice was when it was provided to him by Knell on November 20, 2017. Therefore, we find that the Petition to Reinstate was timely filed on November 22, 2017.

We note that *Conley* found that the Commission's denial of reinstatement was not an abuse of discretion and "[t]he granting or denying of the petition to reinstate rests in the sound discretion of the Commission." *Conley* at 930.

Applying standards of fairness and equity in our analysis, we reiterate the Arbitrator's finding that Rivero had no reason to believe that Knell would be seeking the dismissal of the case on July 18, 2017, given the e-mail sent by Knell on July 11, 2017 stating, "It will not be a trial. It

18IWCC0721

will be a stipulation to a perm total by me." *Px2.* The Illinois Supreme Court Rules of Professional Conduct- Rule 3.3 states, in part:

> (d) In an *ex parte* proceeding, a lawyer shall inform the tribunal of all material facts known to the lawyer that will enable the tribunal to make an informed decision, whether or not the facts are adverse. *Ill. Sup. Ct. R. Prof'l Conduct, R 3.3(d)*

When Rivero did not appear before Arbitrator Mason on July 18, 2017, Knell had an obligation to inform the Arbitrator of all the material facts including Respondent's prior stipulation that Petitioner was permanently totally disabled, and Respondent's intention not to proceed to hearing on July 18, 2017. The withholding of the material facts prevented the Arbitrator from making an informed decision regarding the dismissal of the case and formed a valid basis for her reinstatement.

Based upon our finding that Petitioner's Petition to Reinstate was timely filed, we find that the Arbitrator possessed jurisdiction to reinstate this case. We also find that Respondent filed a timely Petition for Review, and despite the Arbitrator's finding that her order was interlocutory, the Commission finds it possess jurisdiction regarding Respondent's Petition for Review. See *Pocahontas Mining Co. v. Industrial Commission*, 301 Ill. 462, 134 N.E. 160 (1922) and *Garbowicz v. Industrial Commission*, 373 Ill. 268, 26 N.E.2d 123 (1940).

For the reasons outlined above, we affirm the Arbitrator's reinstatement. However, we strike the second full paragraph on page four of the Order addressing Petitioner's second, duplicate filing. We do not need to decide that issue in our determination that this claim was properly reinstated.

Finally, we find that Petitioner's Motion to Dismiss Respondent's Review is moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Order Granting Petition to Reinstate, filed January 17, 2018, is hereby affirmed and adopted with the modifications noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

DATED: NOV 2 8 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 10/24/18
49

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

ANGEL MANCILLA, JR.,

Petitioner,

vs. NO: 11 WC 45640

ALABAMA METAL INDUSTRIES CORPORATION (AMICO),

Respondent.

18IWCC0722

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

The Commission affirms the decision of the Arbitrator, however, clarifies the date of maximum medical improvement. The Arbitrator found that Petitioner sustained a work accident on May 20, 2011 and underwent treatment with Dr. Panuska and Dr. Jimenez. However, the Commission finds the testimony and report of Dr. Hennessey persuasive in finding that Petitioner had reached maximum medical improvement for the aggravation of his underlying condition, as of August 4, 2011.

The Award of the Arbitrator is otherwise affirmed and adopted.

18IWCC0722

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 31, 2017, is hereby affirmed and adopted.

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

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

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

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

DATED: NOV 2 8 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 102418
49

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

MANCILLA, ANGEL
Employee/Petitioner

Case# **11WC045640**

12WC010092
14WC023521

ALABAMA METAL INDUSTRIES CORP
Employer/Respondent

18IWCC0722

On 3/31/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0180 LAW OFFICES OF PETER FERRACUTI
TRAVIS DUNN
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

18IWCC0722

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

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

Angel Mancilla
Employee/Petitioner

v.

Alabama Metal Industries Corp.
Employer/Respondent

Case # 11 WC 45640
Consolidated cases: 12 WC 10092 & 14 WC 23521

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **New Lenox**, on **August 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X Is Petitioner entitled to any prospective medical care?
L. ☐ 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 **May 20, 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 **$40,644.70**; the average weekly wage was **$781.62.**

On the date of accident, Petitioner was **31** 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** 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

Medical benefits

The claim for medical bills incurred for treatment rendered is denied.

Prospective Medical benefits

The claim for prospective medical treatment 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.

Christine Moy

Signature of Arbitrator
IC ArbDec19(b)

03/30/2017
Date

MAR 31 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angel Mancilla	)
Petitioner,	)
vs.	) **No. 11 WC 45640**
Alabama Metal Industries Corp.,	) (Consolidated cases: 12 WC 10092
Respondent.	) and 14 WC 23521)

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

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on August 3, 2016. The parties agree that on May 20, 2011 petitioner and respondent were operating under the provisions of the Illinois Worker's Compensation or Occupational Diseases Act; that their relationship was one of employee and employer; that petitioner had an accident that arose out of and in the course of his employment with respondent; that petitioner gave respondent notice of the accident within the time limits stated in the Act; that in the year preceding the accident petitioner earned $40,644.70, and his average weekly wage calculated pursuant to §10 was $781.62.

The matters at issue are:

1. Whether petitioner's current condition of ill-being is causally connected to the injury.
2. Whether respondent is liable for medical expense claimed in the amount of $54,046.24, of which $32,104.81 remain unpaid.
3. Whether petitioner is entitled to prospective medical treatment.

STATEMENT OF FACTS

Petitioner testified he was employed by respondent since 2005 doing the same job as "bar flipper"; which was loading bars into steel. In 2005 or 2006 he strained a muscle in his back, but recovered. Petitioner testified his back started hurting after flipping several bars on June 11, 2010. He reported the accident.

The first place petitioner obtained medical treatment after the June 11, 2010 accident was with Dr. DeForest. Dr. DeForest prescribed medication and referred petitioner to Dr. Santiago. Dr. Santiago performed a series of injections and prescribed physical therapy; neither of which relieved petitioner's problem. Therefore, Dr. Jimenez performed surgery on September 24, 2010. Petitioner testified he woke up pain free after surgery. He followed up with Dr. Jimenez once or twice. He returned to work doing the same job.

On May 20, 2011, petitioner testified he picked up a die to change and heard a pop in his back. The bottom of his spine swelled up. He reported the injury to Miguel or Omar. He was sent to Dr. Panuska by respondent for treatment. He was referred again to Dr. Santiago, this time by Dr. Panuska, for injections and physical therapy. Petitioner again saw Dr. Jimenez. He obtained another MRI.

Petitioner testified he had lost the feeling in his right calf in 2011 and 2012.

Petitioner testified that on September 18, 2013, he was helping with welding, walking backwards and tripped over a steel comb. He was sent again to see Dr. Panuska, who referred him to Dr. Santiago and then on to Dr. Jimenez.

Since 2014 he has been prescribed different medications. He regularly has pain in his back. Petitioner testified his back hurt just sitting and testifying. He continues to work on a lighter machine. He follows up with Dr. DeForest every month for prescriptions. He wants to have the surgery to fix the problem. The L5-S1 herniated disc is the same disc previously herniated.

On cross examination, petitioner testified he had pain in both legs. He claimed he had made a full recovery from his 2006 back injury. He did, however, wear a heated back brace. He claimed he has had no problems until after the 2010 incident.

Petitioner admitted he saw Dr. DeForest on May 2, 2008 for back pain; on April 22, 2008, he was put on restrictions for low back pain and strain; on March 30, 2009 he advised Dr. DeForest his pain worse in last three weeks; he was seen by Dr. DeForest on April 14, 2009, January 18, 2010, and February 1, 2010. He also told Dr. DeForest that he had back pain on and off prior to June 11, 2010.

On redirect petitioner testified he only had X-rays for the back problem in 2006. He said the pain came and went. In 2010, Dr. Deforest referred him to Dr. Santiago. In 2011 Dr. Panuska referred him to Dr. Santiago.

Medical Bills (PX.1)

Petitioner introduced the following bills totaling $54,046.24, of which $32,104.81 remain unpaid:

Associate Radiologists of Joliet $141.00
Central Illinois Radiology $638.00
Dr. Juan Jimenez $1,840.44
Dr. Juan Santiago-Palma $8,990.00
Dr. Manuel Perez $238.00
Provena St. Mary's Pain Clinic $24,472.61
Riverside Medical Center $13,886.00
St. Mary's Medical Center $3,840.19

Provena St. Mary's Medical Center Records (PX.2) and
Dr. J. Michael Panuska Records [Px.10] and
Dr. J. Michael Panuska Records up to March 11, 2015 {PX.11}

These records reflect petitioner was seen on May 17, 2006 for low back injury that occurred on May 12, 2006 after lifting bars of steel at work. The diagnosis was lumbar strain. Petitioner reported he had a back injury five to six years before with similar discomfort. (139) [10]

On May 22, 2006 petitioner returned for a recheck; physical therapy and pain medication was prescribed (138) [8]. On June 28, 2006 reportedly was doing well, was released to full duty work and discharged from care (136) [6].

On May 24, 2011, petitioner returned Dr. Panuska. He reported doing his regular job, turning a die, on May 20, 2011, when he felt a pop in lower back. He had pain in his right lower back that radiated down his right leg. He had L5-S1 surgery in 2010. Diagnosis was lumbar strain with sciatica. Therma care patches, physical therapy, and modified work were ordered. Petitioner was already on Norco, Valium, over the counter ibuprofen and Extra strength Tylenol. Dr. Panuska refilled the Norco and Valium. (133) [28]

Petitioner returned to Dr. Panuska on May 27, 2011 and continued to receive physical therapy (132) [26]. He was seen again on June 3, 2011 by Dr. Panuska, who referred him to Dr. Jimenez as Dr. Jimenez had done the previous surgery (131) [24].

Petitioner was seen again by Dr. Panuska on June 10, 2011 (131) [22], June 20, 2011 (129) [20], July 1, 2011 (127) [18] {44}, July 15, 2011 (126) [17 & 43] {43} and July 28, 2011 (125) [41] {42}.

On August 8, 2011, Dr. Panuska indicated petitioner's August 5, 2011 (sic) MRI did not show any new postsurgical changes, bud did show a new disc herniation at L1-2 (124) [39] {41}. On August 22, 2011, Dr. Panuska recommended surgery (122) [37] {39}. On September 6, 2011 petitioner was referred to Dr. Santiago for injections (120) [34] {37}.

Petitioner followed up with Dr. Panuska on September 27, 2011, October 21, 2011, November 3, 2011, November 17, 2011 and December 15, 2011.

On January 4, 2012, petitioner was seen by Dr. Panuska after seeing the "IME" doctor, who suggested an EMG (115) [47] {32}.

The EMG was performed on January 24, 2012 was reportedly suggested radiculopathy at unknown level or levels (87-91) [101-105]. Dr. Panuska did not have the EMG results when petitioner was seen by him on January 30, 2012 (114) [45] {31}. At the February 15, 2012, Dr. Panuska opined that because the EMG showed bilateral radiculopathy it suggested new injury on May 20, 2011 (113) [60] {30}.

Petitioner followed up with Dr. Panuska on February 29, 2012 and March 13, 2012.

On March 29, 2012 Dr. Panuska learned petitioner's entire claim was now being denied. Petitioner was referred to his family physician, released to return to work full duty and discharged from Dr. Panuska's care (110) [54] {27}.

Petitioner returned to Dr. Panuska on October 7, 2013 with back pain. Petitioner advised that he was having problems with a machine, walking backwards to fix it when his foot got caught and he tripped and fell twisting his back. This occurred on approximately September 27, 2013. (107) [72-73] {24}

On October 14, 2013, Dr. Panuska suggested petitioner return to Dr. Jimenez (106) [70] {23}.

Petitioner followed up with Dr. Panuska on October 21, 2013, November 6, 2013, November 11, 2013, December 16, 2013.

On December 23, 2013 petitioner returned to Dr. Panuska after obtaining an MRI. Dr. Panuska reported the new MRI showed a L5-S1 broad based posterior disc protrusion, mild central canal stenosis, bilateral recess stenosis and abutting the bilateral traversing S1 nerve root and L4-L5 disc protrusion causing mild canal stenosis and bilateral lateral recess stenosis abutting the bilateral traversing L5 nerve root. Dr. Panuska believed the findings were worse than the previous MRI. (99-101) {16-17}

Petitioner followed up with Dr. Panuska on January 6, 2014, January 13, 2014, January 20, 2014, and January 31, 2014 and February 17, 2014.

On February 28, 2014, Dr. Panuska concluded the best route for petitioner was to have surgery and discharged him from his care (93) {10}.

Dr. J. Michael Panuska Records as of March 11, 2015 {PX.11}

On March 11, 2015, petitioner returned to Dr. Panuska and reported he had seen Dr. Jimenez on March 9, 2015; Dr. Jimenez requested another MRI. {9}

On April 23, 2015, petitioner reported that he had hernia surgery on March 26, 2015 and was released from the hernia surgery to return to work on May 4, 2015. He was scheduled to have an MRI on May 1, 2015. {8}

On May 13, 2015, Dr. Panuska reported the MRI showed disc protrusion and foraminal narrowing at L4-L5 and L5-S1{7}.

Well Group Health Partners/Dr. Manuel Perez (PX.3)

Petitioner received treatment by Dr. Perez for a hernia secondary to a stab wound.

Dr. Juan Jimenez Records (PX.4)

These records begin with petitioner's visit with by Dr. Jimenez on June 27, 2011, for a low back injury, as a referral by Dr. Panuska. Petitioner related the problem to a May 20, 2011 incident at work when turning a dye. Dr. Jimenez recommended an updated MRI because of a possible displacement of lumbar disc without myelopathy. (54-55)

Petitioner was seen by the PA on August 17, 2011. The new MRI reportedly showed postoperative changes at L5-S1 with some enhancing scar tissue along the right S1 nerve root and broad disk bulge at L4-5 with mild foraminal stenosis bilaterally. He was referred to Dr. Santiago for evaluation and epidural steroid injection. (51-52)

The next visit by petitioner with Dr. Jimenez was on November 4, 2013; he reported he fell at work on September 26, 2013. H complained of back pain and lower extremity radiculitis. Another lumbar MRI was ordered. (47-49)

Petitioner returned on January 8, 2014 after obtaining an updated MRI. Dr. Jimenez believed the MRI showed lumbar disc displacement on both the L4-5 and L5-S1 level with possible L5 nerve compression at both levels. Although not optimistic, Dr. Jimenez ordered physical therapy and injections. He believed it was likely petitioner would require at L4-5 and L5-S1 TLIF (two-level fusion). (44-46)

Petitioner was seen again on February 19, 2014. He reported the physical therapy was not helping. Dr. Jimenez recommended physical therapy continue. He was referred for injections. Surgery was still being discussed as the most viable option. (40-43)

Petitioner was seen again on April 2, 2014 with same complaints. He was again referred for epidural steroid injections. (37-39)

Referral by Dr. Jimenez to Dr. Santiago (PX.5)

Dr. Jimenez referred petitioner to Dr. Santiago for ESI and pain management on April 2, 2014.

Dr. Juan Carlos Jimenez Curriculum Vitae (PX.6)

According to Dr. Juan Carlos Jimenez's curriculum vitae, he is a board certified neurosurgeon and director of Neurosciences Institute and Neurosurgery Consultants at Riverside Medical Center.

Dr. Juan Jimenez April 18, 2016 Deposition (PX.7)

Dr. Jimenez, a neurosurgeon who specializes in minimal invasive spinal surgery, testified in behalf of petitioner (P.4). Petitioner was first seen by Dr. Jimenez as an outpatient visit on September 15, 2010 (P.7). Petitioner had been seen by Dr. Santiago-Palma and his primary care doctor, Dr. DeForest (P.8). Petitioner had low back pain, right buttock pain, right posterior leg

pain extending into calf (P.8). He had undergone physical therapy and steroid injections without lasting effect (P.8).

Dr. Jimenez examination revealed a decrease pinprick on the right leg and foot at the S1 distribution, diminished right-sided Achilles' reflex and positive straight-leg raising. A review of the June 30, 2010 MRI showed a L5-S1 right paracentral disk herniation with impingement of the right S1 nerve root and some mild foraminal narrowing of L4-L5 and L5-S1. Dr. Jimenez assessment was right-sided L5-S1 disc herniation with impingement. Dr. Jimenez suggested a right-sided L5-S1 microdiscectomy. (PP.9-10)

Dr. Jimenez performed the right-sided L5-S1 microdiscectomy on September 24, 2010. The surgery was uneventful. Petitioner returned for a postoperative visit on January 3, 2011. Petitioner still had some expected right-sided numbness and had a diminished right Achilles' reflex. He was released to return to work, perform home-exercise programs and to contact the doctor if symptoms changed. On May 2, 2011, petitioner returned to Dr. Jimenez with ongoing symptoms. Petitioner was referred for physiotherapy. (PP.10-12)

On June 27, 2011, petitioner returned to Dr. Jimenez as a referral by Dr. Panuska. Petitioner reported that on May 20, 2011, he was turning over a die at work for respondent when he had immediate low back pain. He had undergone physical therapy without lasting relief. He was given a Medrol Dose Pak. Dr. Jimenez testified petitioner had been progressing until the May 20, 2011 incident and, therefore, Dr. Jimenez believed the May 20, 2011 accident caused an aggravation of petitioner's condition. An MRI was ordered. (PP.13-15)

At the August 17, 2011 visit, Dr. Jimenez reviewed both the MRI report and the actual MRI from August 4, 2011. Dr. Jimenez noted both scarring along the S1 nerve root as well as a bulge at L4-5. Dr. Jimenez believed petitioner had a new injury as well as scar tissue. Dr. Jimenez referred petitioner to Dr. Santiago for injections. (PP.15-17)

Petitioner returned to Dr. Jimenez on November 4, 2013. Petitioner had received injections by Dr. Santiago in the fall of 2011 that did not provide relief. Petitioner also gave a history of falling backwards and twisting his back on September 26, 2012 (sic). Petitioner reported he had not undergone physiotherapy since the aggravation accident of September 26, 2012 (sic) and had not had any additional injections since fall, 2011. He had undergone an EMG on January 24, 2012. He was also evaluated by Dr. Panuska. Petitioner had diminished sensation on the lateral aspect of the left and right leg and foot; a wide-based gait; a positive straight leg raising on both right and left; and lumbar tenderness with diminished range of motion of the lumbar spine. The diagnosis was displacement of lumbar intravertebral disks. Additional studies were ordered. (PP.18-20)

Petitioner was next seen by Dr. Jimenez on January 8, 2014. Dr. Jimenez noted the December 19, 2013 MRI showed degenerative changes at L4-5; a broad-based posterior disc protrusion at L4-5 abutting the L5 nerve root; and also a broad-based L5-S1 disc protrusion that encroaching and indenting the L5 nerve root. Dr. Jimenez described petitioner's condition as a continuum of petitioner's condition with a traumatic event that exacerbated his symptomology. In order to avoid surgery, due to petitioner's young age, Dr. Jimenez prescribed physiotherapy. (PP.20-22)

Petitioner returned to Dr. Jimenez on February 19, 2014 with the same findings. Dr. Jimenez recommended the same conservative care. Petitioner followed up with Dr. Jimenez on April 2, 2014 and on June 11, 2014 with similar findings. Dr. Jimenez had the same recommendations. (PP.22-25).

Petitioner returned to Dr. Jimenez on March 9, 2015 with similar, ongoing symptoms. Petitioner reported he was sent for an independent medical exam and also had a transforaminal

injection on September 25, 2014 with only slight benefit. He also advised Dr. Jimenez he was undergoing hernia surgery on March 26, 2015 Dr. Jimenez agreed with the recommendation by independent medical examiner for another MRI (PP.25-27).

Petitioner returned to Dr. Jimenez on June 8, 2015 after undergoing an MRI on May 5, 2015. Based upon his review of the MRI, Dr. Jimenez diagnosed a herniated nucleus pulposis at L5-S1 on the right. Because of the ongoing symptomology, lack of results from conservative care and the objective findings on the MRI, Dr. Jimenez recommended a redo of the L5-S1 microdiscectomy. Dr. Jimenez concluded that the occurrence of September 26, 2012 (sic) and other work-related incident of May 20, 2011 caused the lumbar disc herniation and clinical sequelae, and that all the treatment was necessitated by these injuries (PP.27-30).

On cross-examination, Dr. Jimenez explained that despite petitioner having bilateral symptoms, given petitioner's young age, Dr. Jimenez wanted to do a less invasive procedure on the right side where the majority of the symptoms were (P.32). Dr. Jimenez did not find the inconclusive January 24, 2012 EMG study to be of much benefit (PP.34-35). Petitioner remained on restricted work as of the last seen time seen by Dr. Jimenez on June 8, 2015 (PP.39-40).

Riverside Medical Center Records (PX.8)

Petitioner received epidural steroid injections by Dr. Santiago-Palma on July 7, 2010 (600-601); August 3, 2010 (578-579); and August 20, 2010 (555-556).

The records include the neurosurgical consult with Dr. Juan Jimenez on September 15, 2010, which was a referral by Dr. Juan Santiago-Palma for low back and right leg pain. Petitioner reported he had back pain starting at age 16 without a specific incident. The pain would come and go throughout the years with exercises and stretching. However, three months prior to September 15, 2010, the pain intensified. He sought treatment with Dr. DeForest, who referred him to Dr. Santiago, and then on to Dr. Jimenez. Dr. Jimenez recommended a minimally invasive right L5-S1 microdiscectomy. (334-337)

Petitioner presented to the emergency room on September 19, 2010 with back and leg pain (524-527).

The history and physical of September 21, 2010, by Dr. Mobolaji Suleiman, at the time of petitioner's admission for the surgery done by Dr. Jimenez on September 24, 2010, was that petitioner had chronic back pain since his teens which had become progressively worse since in the past few months (331-332).

Dr. Juan Jimenez reported in the operative report of September 24, 2010 that petitioner underwent a right L5-S1 microdiscectomy for a right L5-S1 disc herniation (476-477).

On August 4, 2011 petitioner had a lumbar MRI. The radiologist reported enhancing scar tissue noted at the postoperative site and along the right lateral aspect of the thecal sac, ventral to the thecal sac and partially surrounding the traversing right S1 nerve root. There was also a small residual broad-based right paracentral disk protrusion at the L5-S1 level without significant central canal stenosis, as well as stable mild bilateral foraminal narrowing at L5-S1. In addition, there was mild diffuse disk bulge at L4-L5 level with minimal encroachment. (312)

Petitioner underwent a right and left S1 neural foramen epidural steroid injection on May 2, 2012 by Dr. Santiago-Palma (296-297).

On July 10, 2012 petitioner received a caudal epidural steroid injection on July 10, 2012 by Dr. Santiago-Palma (252-253).

Petitioner seen in the emergency room on January 1, 2014 after being involved in a rear-end automobile accident. He reported his back was jarred. (102-103)

On September 25, 2014 petitioner received an epidural steroid injection bilateral at S1 neural foramen by Dr. Santiago-Palma (66-67).

Dr. Juan Santiago Palma Records (PX.9)

Petitioner completed a questionnaire on July 2, 2010 indicating the pain began on May 25, 2010 and was related to an injury that occurred between May and June, 2010 (PP.34-35).

Petitioner was first seen by Dr. Santiago-Palma on July 2, 2010 with complaints of lower back and radicular-type symptoms down the right leg. The history recorded was that petitioner was referred by Dr. DeForest for lower back and radicular type symptoms down the right leg that began on May 25, 2010 when doing repetitive strain at work. Dr. Santiago-Palma reported the June 30, 2010 MRI showed a right paracentral disc protrusion that was encroaching on the exiting right S1 nerve. (PP.55-57)

Petitioner followed up with Dr. Santiago-Palma for injections and consultation through September 14, 2010; Dr. Santiago-Palma advised he would see petitioner after he followed up with Dr. Jimenez. (66)

According to these records, the next time petitioner was seen by Dr. Santiago-Palma was on September 9, 2011. Petitioner had ongoing symptomology that was related back to petitioner's May 20, 2011 work accident. Dr. Palma recommended bilateral S1 transforaminal epidural injections. (64-65)

According to petitioner's questionnaire of September 1, 2011, he had been referred to Dr. Santiago-Palma by Dr. Jimenez (27).

According to these records, petitioner underwent epidural steroid injections and treatment by Dr. Santiago-Palma from May to August, 2012

Petitioner was next seen by Dr. Santiago-Palma on June 20, 2014. On that date, petitioner reported he was backing up, helping a co-worker with a machine, caught his foot in a [steel] comb, twisted his body and fell on September 9, 2013. (79-92)

Petitioner was seen again on August 11, 2014 (93-96) and September 8, 2014 (104-114). He received an injection on September 25, 2014 (77).

St. James Hospital Records [Actually these are Dr. DeForest's Records] (PX. 12)
Dr. DeForest's Records [PX.14]

This is a chronology of Petitioner's Exhibit 12 and Petitioner's Exhibit 14, which includes only mention of back problems or treatment.

Petitioner seen on April 22, 2008 with complaints of low back pain on the right that radiates down leg [24, 26]. On April 25, 2008 petitioner was seen for management of back pains [27]. On May 2, 2008 petitioner had a recheck of his back [25].

According to these records, petitioner was not seen again by Dr. DeForest for his back until March 30, 2009, at which time his history was that he had worsening of back pain [23]. Petitioner followed on April 14, 2009 for right lower back pain with radiculopathy [22]. Dr. DeForest ordered a lumbar MRI for the diagnosed low back pain with radiculopathy, which was not authorized (26).

On January 18, 2010 petitioner was seen by Dr. DeForest for low back pain and elbow pain (the balance of the records is illegible) [21] On February 1, 2010 petitioner's back and elbow were rechecked [20]. Petitioner had a cortisone injection into the elbow (35).

Petitioner was next seen by Dr. DeForest on June 11, 2010 for the lumbar sacral strain and right leg radiculopathy (29). According to the notes, petitioner stated "[pain started] one week ago lower back pain radiating down right leg with numbness and burning feeling with certain

movements. Did some heavy lifting at work" (34). He returned to Dr. DeForest on June 17, 2010 with persistent back pain radiating down right leg; the symptoms were present for two weeks; a lumbar MRI was ordered (28, 33). On July 1, 2010 petitioner reported no improvement; diagnosis was herniated disc at L5-S1 (27) [10,15]. Petitioner saw Dr. DeForest on September 8, 2010 for lump in abdomen (30). He was seen again for his back on September 16, 2010 (30).

Petitioner was seen by Dr. DeForest in 2012 and 2013 for carpal tunnel syndrome and a hernia only. There was no mention of treatment of the back during this period.

According to these records, petitioner next received treatment by Dr. DeForest for his back, after September 16, 2010, was on April 7, 2014. He advised Dr. DeForest that he has been unable to see the pain specialist as he was awaiting approval by worker's compensation, but needed a refill on Norco (9). Petitioner was seen on September 2, 2014 for a lumbar herniated disc (5-7). He was seen again on September 30, 2014 for a lumbar herniated disc and low back pain (3-4). He was rechecked for lumbar herniated disc on December 29, 2014 (1-2)

Dr. D. Mobolaji Suleiman /International Medicine Records (PX.13)

It appears petitioner was seen for a history and physical on September 21, 2010 for the herniated disc (10-13).

The history and physical as recorded by Dr. Suleiman at the time of petitioner's admission to Riverside Medical Center on September 24, 2010 for the L5-S1 microdiscectomy. The history recorded was petitioner had been having episodes of chronic low back pain since he was in his teens; mostly in the last few months. He provided a history that the pain was progressively worse over the last week or two. (23-25)

Petitioner was seen again on October 18, 2010 for a herniated disc and obesity (14). He was seen again on December 21, 2010 complaining of a lot of low back pain and working 10-12 hours a day that is making the pain worse (16).

Petitioner was seen by Dr. Suleiman on April 14, 2011 with a history of about three weeks earlier of having a lot of popping in lower back and has had continued lower back pain since then. He was diagnosed with a herniated disc and referred to a neurosurgeon (18).

Dr. John DeForest Note of July 8, 2013 (PX.15)

On July 8, 2012, Dr. DeForest wrote that petitioner had been off work since May 30, 2013. On July 22, 2013 petitioner was to return to Dr. DeForest for a determination as to when petitioner could return to work.

Dr. Ryon Hennessy May 4, 2016 Deposition with reports (RX.1)

At Dr. Ryon Hennessy's deposition, the following reports were admitted into evidence without objection: the December 8, 2011 reported completed after the exam of petitioner of that same date (Dep.2); the March 6, 2012 report completed after additional medical records were reviewed (Dep.3); the December 17, 2014 report completed after the exam of petitioner on December 1, 2014 (Dep. 4); the March 26, 2012 report wherein specific questions were answered (Dep.6); and the November 13, 2015 report authored after reviewing side by side MRI August 4, 2011 scan with the May 5, 2015 scan (Dep.5).

In his December 8, 2011 report, Dr. Hennessy cited to records of Dr. Jimenez that were not included in any other records admitted into evidence. (According to this report, petitioner agreed with the content, including the history contained Dr. Jimenez' records as cited by Dr. Hennessy in this report). (Dep.2)

Dr. Hennessy cited to petitioner's post op visit of October 18, 2010 wherein petitioner advised Dr. Jimenez the pain had nearly resolved and he had stopped pain medication two days before. He was released from Dr. Jimenez's care; to return on an as needed basis. (Dep.2)

On January 3, 2011, petitioner returned to Dr. Jimenez having slipped on ice and fell striking his back on a curb. He had low back and left leg pain; the left leg pain lasted two weeks. Dr. Jimenez recommended a home exercise program and released petitioner to return to work full duty. (Dep.2)

On May 2, 2011, petitioner returned to Dr. Jimenez's office and was seen by PA Joan Sullivan. At that time, petitioner advised he had continued low back pain and occasional left lower extremity radiculopathy. He had a sensation that something was moving in his low back when he would bend forward. He was tender in the bilateral sacroiliac joints. He complained of ongoing low back pain for seven months after the right L5-S1 discectomy. Physical therapy was recommended. (Dep.2)

Petitioner provided a history that on May 20, 2011, while at work and flipping a 100-pound die, when he felt a pop in his back. Petitioner continued to work, told his supervisor he had pain. He was sent to Provena St. Mary's Occupational Health Center on May 24, 2011. (Dep.2)

Dr. Hennessy believe petitioner suffered a lumbar strain in the accident of May 21, 2011 (sic). Dr. Hennessy believed the S1 radiculopathy was the temporary exacerbation of the right S1 nerve root and scar tissue from the previous surgery. Dr. Hennessy noted petitioner had symptomology of radiculopathy pain on January 3, 2011 and May 2, 2011 that pre-existed the May 20, 2011 accident. Dr. Hennessy compared the June, 2010 MRI with the August 4, 2011 and determined the only acute finding on the later MRI was the post-operative changes. Dr. Hennessy recommended petitioner undergo an EMG to determine if the condition was chronic. (Dep.2)

On March 6, 2012 Dr. Hennessy authored another report after reviewing the January 24, 2012 EMG report. Dr. Hennessy stated the EMG did not correlate with the objective findings on the MRI and failed to show the S1 right radiculopathy. Dr. Hennessy concluded petitioner had an exacerbation of his scar tissue from the fall on his back on January 3, 2011. Dr. Hennessy also believed the August 4, 2011 MRI did not show any evidence of a recurrent disc herniation or displacement. (Dep.3)

In his March 26, 2012 report, Dr. Hennessy opined that work conditioning was recommended due to the natural progression of petitioner's pre-existing degenerative disc disease, and not due to the work accident of May 21, 2011 (Dep. 6).

Dr. Hennessy authored his December 17, 2014 report after re-examining petitioner on December 1, 2014, and reviewing certain medical records. Dr. Hennessy mentions records of Dr. Panuska from May 29, 2012 and June 7, 2012 which were for treatment of a left ankle sprain after petitioner fell walking backwards. (Dep.4).

Dr. Hennessy reported that the medical records of Dr. Panuska and Dr. Jimenez provided different dates of accident in September, 2013, when petitioner fell backwards and twisted his back. The petitioner admitted he had back pain prior to the September 18, 2013 accident, but the fall had made the pain worse. Dr. Hennessy believed the fall of September 18, 2013 resulted in an exacerbation of the previous degenerative disc disease, herniation and scarring at L5-S1 level. Dr. Hennessy could not conclusively give an opinion on causality, treatment or restrictions due to the poor quality of the open MRI of December 19, 2013. (Dep. 4)

Dr. Hennessy authored his November 13, 2015 after reviewing the August 4, 2011 MRI scan side by side with the May 5, 2015 scan. Unlike the opinion of Dr. Panuska, Dr. Hennessy

did not believe there was any disc herniation causing nerve impingement at L4-L5 or L5-S1 level; only scar tissue. (Dep. 5)

Dr. Hennessy testified, after reviewing all MRI scans from 2010 to 2015, he found no progression of the petitioner's degenerative disc disease or recurrent disc herniation or left S1 impingement; only some scar tissue around the right S1 nerve root which was expected after the 2010 discectomy (PP.19-20).

Dr. Hennessy testified, after reviewing the 2015 MRI, that petitioner had an unencumbered S1 nerve root. Dr. Hennessy disagreed that petitioner required the surgery proposed by Dr. Jimenez, regardless of the cause (PP.22-23).

CONCLUSIONS OF LAW

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

F. In support of the Arbitrator's decision in regard to whether petitioner's condition of ill-being is causally related to the work injury, the Arbitrator finds the following:

Respondent does not dispute petitioner had an accident that arose out of and in the course of his employment with respondent on May 20, 2011. The evidence indicates petitioner had previously suffered a lumbar strain in a work accident of May 12, 2006 and that he had a back injury five to six years before with similar discomfort. On June 28, 2006, he reported to Dr. Panuska that he doing well, was released to full duty work and discharged from Dr. Panuska's care.

The records of petitioner's personal physician, Dr. DeForest, indicate petitioner was first seen by him on April 22, 2008 with low back pain on the right radiating down the right leg. He received treatment until May 25, 2008. On March 30, 2009, petitioner returned to Dr. DeForest on March 30, 2009, with a worsening of back pain. He was seen again on April 14, 2009, at which time a lumbar MRI was ordered due to petitioner's low back pain with radiculopathy. This was not obtained as it was not authorized by insurance.

Petitioner was seen again by Dr. DeForest in January and February, 2010 for both elbow pain and low back pain. The next time he was seen by Dr. DeForest was on June 11, 2010 for a lumbar sacral strain with right leg radiculopathy. Petitioner related the lower back pain radiating down his right leg with numbness and burning feeling started about one week prior after doing some heavy lifting at work. He received treatment by Dr. DeForest on June 17, 2010 and July 1, 2010. Dr. DeForest diagnosed a herniated disc at the L5-S1 level after the MRI was obtained.

The neurosurgical consult on September 15, 2010 with Dr. Juan Jimenez indicates petitioner had back pain starting at age 16 without a specific incident. Throughout the years, petitioner reported the pain would come and go with exercises and stretching. In the last three months, petitioner reported the pain had intensified. Dr. Jimenez performed a right-sided L5-S1 microdiscectomy on September 24, 2010.

Although the actual records of Dr. Jimenez for petitioner's post-operative visits of October 18, 2010, January 3, 2011 and May 2, 2011 were not introduced into evidence by either party, Dr. Hennessy's December 8, 2011 letter reciting Dr. Jimenez's records from those three visits, as confirmed by petitioner, provided details of petitioner's condition post-operatively prior to the claimed accident of May 20, 2011 (RX.1, Dep Ex. 2).

At the October 18, 2010 visit with Dr. Jimenez, petitioner reported the pain was nearly resolved and he had stopped taking pain medication two days before. At that time, petitioner was released from Dr. Jimenez's care; to return on an as-needed basis.

Petitioner returned to Dr. Jimenez on January 3, 2011 having slipped ice and fell striking his back on a curb. He had low back and left leg pain. (RX.1, Dep. Ex. 2)

In his testimony, Dr. Jimenez failed to mention the fall petitioner had taken prior to the January 3, 2011 post-operative visit; only testifying petitioner had some expected right-sided numbness and diminished right Achilles' reflex. Dr. Jimenez also testified petitioner returned on May 2, 2011 due to ongoing symptomology and was referred for physiotherapy. (PX. 7, pp. 10-12)

Furthermore, the April 14, 2011 records of Dr. D. Mobolaji Suleiman provides a history that petitioner felt a popping in his lower three weeks earlier and had lower back pain since. At that time, Dr. Suleiman diagnosed a herniated disc at had referred petitioner to a neurosurgeon. (PX.13, p.18)

The first treatment petitioner received after the claimed May 20, 2011 accident was on May 24, 2011 by Dr. Panuska. On that date, petitioner advised Dr. Panuska that on May 20, 2011, petitioner was doing his regular job, turning die, when he felt a pain in his back. There was no history registered by Dr. Panuska of petitioner's fall on ice before Dr. Jimenez January 3, 2011 visit; the history of popping in his back or diagnosis of herniated disc or referral to neurosurgeon, as contained in Dr. Suleiman's April 14, 2011 records; or the treatment by Dr. Jimenez on May 2, 2011 due to ongoing symptomology in the lower back.

On February 15, 2012, after reviewing the January 24, 2012 EMG that suggested bilateral radiculopathy, Dr. Panuska believed it was indicative petitioner had sustained a new injury [herniated disc] on May 20, 2011. The Arbitrator discounts Dr. Panuska's opinion as it does not appear Dr. Panuska had the records of Dr. Jimenez from January 3, 2011 and May 2, 2011 visits, or the April 14, 2011 records of Dr. Suleiman. Furthermore, both Dr. Jimenez and Dr. Hennessy did not find the EMG was of any value give the inconclusive EMG results that reportedly showed only a suggestion of radiculopathy at unknown levels.

Despite the histories of accidents/incidents found in the records of Dr. Jimenez from January 3, 2011 and May 2, 2011, and the April 14, 2011 records of Dr. Suleiman, Dr. Jimenez testified petitioner had been progressing [since the surgery of September 24, 2010] and thus the September 26, 2012 (sic) and other work-related incidents caused the lumbar disc herniation and clinical sequelae.

Dr. Hennessy believed petitioner suffered only a back strain and temporary exacerbation of the right S1 nerve root and scar tissue as a result of the work accident of May 21, 2011. Petitioner had no acute findings on the August 3, 2011 MRI other than post-operative changes.

Dr. Hennessy, who testified in behalf of respondent, in his report of March 6, 2012 concluded, petitioner had an exacerbation of his scar tissue from the fall on his back on January 3, 2011. Furthermore, Dr. Hennessey did not believe the subsequent MRI from August 4, 2011 showed any evidence of a recurrent disc herniation or displacement. (RX.1, Dep. Ex. 3)

The Arbitrator finds Dr. Hennessey's opinions to be more credible than Dr. Jimenez. Dr. Jimenez's credibility is called into question as Dr. Jimenez glossed over petitioner's fall stated in the January 3, 2011 records, ignored petitioner's ongoing symptomology as late as May 2, 2011, and apparently unaware of Dr. Suleiman's records April 14, 2011, in rendering his opinion that petitioner's incident at work on May 20, 2011 was a cause of petitioner's back problems that

require additional surgery. Clearly, the evidence shows petitioner was not progressing [since his September 24, 2010 surgery] until the May 20, 2011 accident, as claimed by Dr. Jimenez.

For these reasons, the Arbitrator finds petitioner failed to prove that the work accident of May 20, 2011 caused petitioner's ongoing back problems that necessitated any of the treatment received, or the need for future treatment.

L. In regard to whether the medical services that were provided to petitioner was reasonable and whether respondent has paid all appropriate charges for these services, the Arbitrator finds the following:

As the Arbitrator determined petitioner failed to prove the need for treatment obtained was caused by the work accident of May 20, 2011, the Arbitrator denies the claim for the medical bills incurred for this treatment.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator finds the following:

As the Arbitrator found petitioner failed to prove petitioner's ongoing back problems are the result of the May 20, 2011 work accident, the claim for prospective medical treatment is denied.

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

ANGEL MANCILLA, JR.,

Petitioner,

vs. NO: 12 WC 10092

ALABAMA METAL INDUSTRIES CORPORATION (AMICO),

Respondent.

18IWCC0723

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 31, 2017, is hereby affirmed and adopted.

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

18IWCC0723

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 2 8 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 102418
49

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

MANCILLA, ANGEL
Employee/Petitioner

Case# **12WC010092**

11WC045640
14WC023521

ALABAMA METAL INDUSTRIES CORP
Employer/Respondent

18IWCC0723

On 3/31/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICE OF PETER FERRACUTI
TRAVIS DUNN
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

18IWCC0723

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

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

Angel Mancilla
Employee/Petitioner

v.

Alabama Metal Industries Corp.
Employer/Respondent

Case # 12 WC 10092
Consolidated cases: 11 WC 45640 & 14 WC 23521

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **New Lenox**, on **August 3, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] 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 on **June 11, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,180.16**; the average weekly wage was **$753.46.**

On the date of accident, Petitioner was **30** 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** 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

Medical benefits

The claim for medical bills incurred for treatment rendered is denied.

Prospective Medical benefits

The claim for prospective medical treatment is denied

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

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

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

Christine Wong

Signature of Arbitrator
IC ArbDec19(b)

03/30/2017
Date

MAR 31 2017

 18IWCC0723

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angel Mancilla	)	
Petitioner,	)	
vs.	)	**No. 12 WC 10092**
Alabama Metal Industries Corp.	)	(Consolidated with 11 WC 45640
Respondent.	)	and 14 WC 23531)
	)	

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

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on August 3, 2016. The parties agree that on June 11, 2010 petitioner and respondent were operating under the provisions of the Illinois Worker's Compensation or Occupational Diseases Act; that their relationship was one of employee and employer; that petitioner had an accident that arose out of and in the course of his employment with respondent; that petitioner gave respondent notice of the accident within the time limits stated in the Act; that in the year preceding the accident petitioner earned $39,180.16, and his average weekly wage calculated pursuant to §10 was $753.46.

The matters at issue are:

1. Whether petitioner's current condition of ill-being is causally connected to the injury.
2. Whether respondent is liable for medical expenses claimed in the amount of $54,046.24, of which $32,104.81 remain unpaid.
3. Whether petitioner is entitled to prospective medical treatment.

STATEMENT OF FACTS

Petitioner testified he was employed by respondent since 2005 doing the same job as "bar flipper"; which was loading bars into steel. In 2005 or 2006 he strained a muscle in his back, but recovered. Petitioner testified his back started hurting after flipping several bars on June 11, 2010. He reported the accident.

The first place petitioner obtained medical treatment after the June 11, 2010 accident was with Dr. DeForest. Dr. DeForest prescribed medication and referred petitioner to Dr. Santiago. Dr. Santiago performed a series of injections and prescribed physical therapy; neither of which relieved petitioner's problem. Therefore, Dr. Jimenez performed surgery on September 24, 2010. Petitioner testified he woke up pain free after surgery. He followed up with Dr. Jimenez once or twice. He returned to work doing the same job.

On May 20, 2011, petitioner testified he picked up a die to change and heard a pop in his back. The bottom of his spine swelled up. He reported the injury to Miguel or Omar. He was sent to Dr. Panuska by respondent for treatment. He was referred again to Dr. Santiago, this time by Dr. Panuska, for injections and physical therapy. Petitioner again saw Dr. Jimenez. He obtained another MRI.

Petitioner testified he had lost the feeling in his right calf in 2011 and 2012.

Petitioner testified that on September 18, 2013, he was helping with welding, walking backwards and tripped over a steel comb. He was sent again to see Dr. Panuska, who referred him to Dr. Santiago and then on to Dr. Jimenez.

Since 2014 he has been prescribed different medications. He regularly has pain in his back. Petitioner testified his back hurt just sitting and testifying. He continues to work on a lighter machine. He follows up with Dr. DeForest every month for prescriptions. He wants to have the surgery to fix the problem. The L5-S1 herniated disc is the same disc previously herniated.

On cross examination, petitioner testified he had pain in both legs. He claimed he had made a full recovery from his 2006 back injury. He did, however, wear a heated back brace. He claimed he has had no problems until after the 2010 incident.

Petitioner admitted he saw Dr. DeForest on May 2, 2008 for back pain; on April 22, 2008, he was put on restrictions for low back pain and strain; on March 30, 2009 he advised Dr. DeForest his pain worse in last three weeks; he was seen by Dr. DeForest on April 14, 2009, January 18, 2010, and February 1, 2010. He also told Dr. DeForest that he had back pain on and off prior to June 11, 2010.

On redirect petitioner testified he only had X-rays for the back problem in 2006. He said the pain came and went. In 2010, Dr. Deforest referred him to Dr. Santiago. In 2011 Dr. Panuska referred him to Dr. Santiago.

Medical Bills (PX.1)

Petitioner introduced the following bills totaling $54,046.24, of which $32,104.81 remain unpaid:

Associate Radiologists of Joliet $141.00
Central Illinois Radiology $638.00
Dr. Juan Jimenez $1,840.44
Dr. Juan Santiago-Palma $8,990.00
Dr. Manuel Perez $238.00
Provena St. Mary's Pain Clinic $24,472.61
Riverside Medical Center $13,886.00
St. Mary's Medical Center $3,840.19

Provena St. Mary's Medical Center Records (PX.2) and
Dr. J. Michael Panuska Records [Px.10] and
Dr. J. Michael Panuska Records up to March 11, 2015 {PX.11}

These records reflect petitioner was seen on May 17, 2006 for low back injury that occurred on May 12, 2006 after lifting bars of steel at work. The diagnosis was lumbar strain. Petitioner reported he had a back injury five to six years before with similar discomfort. (139) [10]

On May 22, 2006 petitioner returned for a recheck; physical therapy and pain medication was prescribed (138) [8]. On June 28, 2006 reportedly was doing well, was released to full duty work and discharged from care (136) [6].

On May 24, 2011, petitioner returned Dr. Panuska. He reported doing his regular job, turning a die, on May 20, 2011, when he felt a pop in lower back. He had pain in his right lower back that radiated down his right leg. He had L5-S1 surgery in 2010. Diagnosis was lumbar strain with sciatica. Therma care patches, physical therapy, and modified work were ordered. Petitioner was already on Norco, Valium, over the counter ibuprofen and Extra strength Tylenol. Dr. Panuska refilled the Norco and Valium. (133) [28]

Petitioner returned to Dr. Panuska on May 27, 2011 and continued to receive physical therapy (132) [26]. He was seen again on June 3, 2011 by Dr. Panuska, who referred him to Dr. Jimenez as Dr. Jimenez had done the previous surgery (131) [24].

Petitioner was seen again by Dr. Panuska on June 10, 2011 (131) [22], June 20, 2011 (129) [20], July 1, 2011 (127) [18] {44}, July 15, 2011 (126) [17 & 43] {43} and July 28, 2011 (125) [41] {42}.

On August 8, 2011, Dr. Panuska indicated petitioner's August 5, 2011 (sic) MRI did not show any new postsurgical changes, bud did show a new disc herniation at L1-2 (124) [39] {41}. On August 22, 2011, Dr. Panuska recommended surgery (122) [37] {39}. On September 6, 2011 petitioner was referred to Dr. Santiago for injections (120) [34] {37}.

Petitioner followed up with Dr. Panuska on September 27, 2011, October 21, 2011, November 3, 2011, November 17, 2011 and December 15, 2011.

On January 4, 2012, petitioner was seen by Dr. Panuska after seeing the "IME" doctor, who suggested an EMG (115) [47] {32}.

The EMG was performed on January 24, 2012 was reportedly suggested radiculopathy at unknown level or levels (87-91) [101-105]. Dr. Panuska did not have the EMG results when petitioner was seen by him on January 30, 2012 (114) [45] {31}. At the February 15, 2012, Dr. Panuska opined that because the EMG showed bilateral radiculopathy it suggested new injury on May 20, 2011 (113) [60] {30}.

Petitioner followed up with Dr. Panuska on February 29, 2012 and March 13, 2012.

On March 29, 2012 Dr. Panuska learned petitioner's entire claim was now being denied. Petitioner was referred to his family physician, released to return to work full duty and discharged from Dr. Panuska's care (110) [54] {27}.

Petitioner returned to Dr. Panuska on October 7, 2013 with back pain. Petitioner advised that he was having problems with a machine, walking backwards to fix it when his foot got caught and he tripped and fell twisting his back. This occurred on approximately September 27, 2013. (107) [72-73] {24}

On October 14, 2013, Dr. Panuska suggested petitioner return to Dr. Jimenez (106) [70] {23}.

Petitioner followed up with Dr. Panuska on October 21, 2013, November 6, 2013, November 11, 2013, December 16, 2013.

On December 23, 2013 petitioner returned to Dr. Panuska after obtaining an MRI. Dr. Panuska reported the new MRI showed a L5-S1 broad based posterior disc protrusion, mild central canal stenosis, bilateral recess stenosis and abutting the bilateral traversing S1 nerve root and L4-L5 disc protrusion causing mild canal stenosis and bilateral lateral recess stenosis abutting the bilateral traversing L5 nerve root. Dr. Panuska believed the findings were worse than the previous MRI. (99-101) {16-17}

Petitioner followed up with Dr. Panuska on January 6, 2014, January 13, 2014, January 20, 2014, and January 31, 2014 and February 17, 2014.

On February 28, 2014, Dr. Panuska concluded the best route for petitioner was to have surgery and discharged him from his care (93) {10}.

Dr. J. Michael Panuska Records as of March 11, 2015 {PX.11}

On March 11, 2015, petitioner returned to Dr. Panuska and reported he had seen Dr. Jimenez on March 9, 2015; Dr. Jimenez requested another MRI. {9}

On April 23, 2015, petitioner reported that he had hernia surgery on March 26, 2015 and was released from the hernia surgery to return to work on May 4, 2015. He was scheduled to have an MRI on May 1, 2015. {8}

On May 13, 2015, Dr. Panuska reported the MRI showed disc protrusion and foraminal narrowing at L4-L5 and L5-S1{7}.

Well Group Health Partners/Dr. Manuel Perez (PX.3)

Petitioner received treatment by Dr. Perez for a hernia secondary to a stab wound.

Dr. Juan Jimenez Records (PX.4)

These records begin with petitioner's visit with by Dr. Jimenez on June 27, 2011, for a low back injury, as a referral by Dr. Panuska. Petitioner related the problem to a May 20, 2011 incident at work when turning a dye. Dr. Jimenez recommended an updated MRI because of a possible displacement of lumbar disc without myelopathy. (54-55)

Petitioner was seen by the PA on August 17, 2011. The new MRI reportedly showed postoperative changes at L5-S1 with some enhancing scar tissue along the right S1 nerve root and broad disk bulge at L4-5 with mild foraminal stenosis bilaterally. He was referred to Dr. Santiago for evaluation and epidural steroid injection. (51-52)

The next visit by petitioner with Dr. Jimenez was on November 4, 2013; he reported he fell at work on September 26, 2013. H complained of back pain and lower extremity radiculitis. Another lumbar MRI was ordered. (47-49)

Petitioner returned on January 8, 2014 after obtaining an updated MRI. Dr. Jimenez believed the MRI showed lumbar disc displacement on both the L4-5 and L5-S1 level with possible L5 nerve compression at both levels. Although not optimistic, Dr. Jimenez ordered physical therapy and injections. He believed it was likely petitioner would require at L4-5 and L5-S1 TLIF (two-level fusion). (44-46)

Petitioner was seen again on February 19, 2014. He reported the physical therapy was not helping. Dr. Jimenez recommended physical therapy continue. He was referred for injections. Surgery was still being discussed as the most viable option. (40-43)

Petitioner was seen again on April 2, 2014 with same complaints. He was again referred for epidural steroid injections. (37-39)

Referral by Dr. Jimenez to Dr. Santiago (PX.5)

Dr. Jimenez referred petitioner to Dr. Santiago for ESI and pain management on April 2, 2014.

Dr. Juan Carlos Jimenez Curriculum Vitae (PX.6)

According to Dr. Juan Carlos Jimenez's curriculum vitae, he is a board certified neurosurgeon and director of Neurosciences Institute and Neurosurgery Consultants at Riverside Medical Center.

Dr. Juan Jimenez April 18, 2016 Deposition (PX.7)

Dr. Jimenez, a neurosurgeon who specializes in minimal invasive spinal surgery, testified in behalf of petitioner (P.4). Petitioner was first seen by Dr. Jimenez as an outpatient visit on September 15, 2010 (P.7). Petitioner had been seen by Dr. Santiago-Palma and his primary care doctor, Dr. DeForest (P.8). Petitioner had low back pain, right buttock pain, right posterior leg

pain extending into calf (P.8). He had undergone physical therapy and steroid injections without lasting effect (P.8).

Dr. Jimenez examination revealed a decrease pinprick on the right leg and foot at the S1 distribution, diminished right-sided Achilles' reflex and positive straight-leg raising. A review of the June 30, 2010 MRI showed a L5-S1 right paracentral disk herniation with impingement of the right S1 nerve root and some mild foraminal narrowing of L4-L5 and L5-S1. Dr. Jimenez assessment was right-sided L5-S1 disc herniation with impingement. Dr. Jimenez suggested a right-sided L5-S1 microdiscectomy. (PP.9-10)

Dr. Jimenez performed the right-sided L5-S1 microdiscectomy on September 24, 2010. The surgery was uneventful. Petitioner returned for a postoperative visit on January 3, 2011. Petitioner still had some expected right-sided numbness and had a diminished right Achilles' reflex. He was released to return to work, perform home-exercise programs and to contact the doctor if symptoms changed. On May 2, 2011, petitioner returned to Dr. Jimenez with ongoing symptoms. Petitioner was referred for physiotherapy. (PP.10-12)

On June 27, 2011, petitioner returned to Dr. Jimenez as a referral by Dr. Panuska. Petitioner reported that on May 20, 2011, he was turning over a die at work for respondent when he had immediate low back pain. He had undergone physical therapy without lasting relief. He was given a Medrol Dose Pak. Dr. Jimenez testified petitioner had been progressing until the May 20, 2011 incident and, therefore, Dr. Jimenez believed the May 20, 2011 accident caused an aggravation of petitioner's condition. An MRI was ordered. (PP.13-15)

At the August 17, 2011 visit, Dr. Jimenez reviewed both the MRI report and the actual MRI from August 4, 2011. Dr. Jimenez noted both scarring along the S1 nerve root as well as a bulge at L4-5. Dr. Jimenez believed petitioner had a new injury as well as scar tissue. Dr. Jimenez referred petitioner to Dr. Santiago for injections. (PP.15-17)

Petitioner returned to Dr. Jimenez on November 4, 2013. Petitioner had received injections by Dr. Santiago in the fall of 2011 that did not provide relief. Petitioner also gave a history of falling backwards and twisting his back on September 26, 2012 (sic). Petitioner reported he had not undergone physiotherapy since the aggravation accident of September 26, 2012 (sic) and had not had any additional injections since fall, 2011. He had undergone an EMG on January 24, 2012. He was also evaluated by Dr. Panuska. Petitioner had diminished sensation on the lateral aspect of the left and right leg and foot; a wide-based gait; a positive straight leg raising on both right and left; and lumbar tenderness with diminished range of motion of the lumbar spine. The diagnosis was displacement of lumbar intravertebral disks. Additional studies were ordered. (PP.18-20)

Petitioner was next seen by Dr. Jimenez on January 8, 2014. Dr. Jimenez noted the December 19, 2013 MRI showed degenerative changes at L4-5; a broad-based posterior disc protrusion at L4-5 abutting the L5 nerve root; and also a broad-based L5-S1 disc protrusion that encroaching and indenting the L5 nerve root. Dr. Jimenez described petitioner's condition as a continuum of petitioner's condition with a traumatic event that exacerbated his symptomology. In order to avoid surgery, due to petitioner's young age, Dr. Jimenez prescribed physiotherapy. (PP.20-22)

Petitioner returned to Dr. Jimenez on February 19, 2014 with the same findings. Dr. Jimenez recommended the same conservative care. Petitioner followed up with Dr. Jimenez on April 2, 2014 and on June 11, 2014 with similar findings. Dr. Jimenez had the same recommendations. (PP.22-25).

Petitioner returned to Dr. Jimenez on March 9, 2015 with similar, ongoing symptoms. Petitioner reported he was sent for an independent medical exam and also had a transforaminal

injection on September 25, 2014 with only slight benefit. He also advised Dr. Jimenez he was undergoing hernia surgery on March 26, 2015 Dr. Jimenez agreed with the recommendation by independent medical examiner for another MRI (PP.25-27).

Petitioner returned to Dr. Jimenez on June 8, 2015 after undergoing an MRI on May 5, 2015. Based upon his review of the MRI, Dr. Jimenez diagnosed a herniated nucleus pulposis at L5-S1 on the right. Because of the ongoing symptomology, lack of results from conservative care and the objective findings on the MRI, Dr. Jimenez recommended a redo of the L5-S1 microdiscectomy. Dr. Jimenez concluded that the occurrence of September 26, 2012 (sic) and other work-related incident of May 20, 2011 caused the lumbar disc herniation and clinical sequelae, and that all the treatment was necessitated by these injuries (PP.27-30).

On cross-examination, Dr. Jimenez explained that despite petitioner having bilateral symptoms, given petitioner's young age, Dr. Jimenez wanted to do a less invasive procedure on the right side where the majority of the symptoms were (P.32). Dr. Jimenez did not find the inconclusive January 24, 2012 EMG study to be of much benefit (PP.34-35). Petitioner remained on restricted work as of the last seen time seen by Dr. Jimenez on June 8, 2015 (PP.39-40).

Riverside Medical Center Records (PX.8)

Petitioner received epidural steroid injections by Dr. Santiago-Palma on July 7, 2010 (600-601); August 3, 2010 (578-579); and August 20, 2010 (555-556).

The records include the neurosurgical consult with Dr. Juan Jimenez on September 15, 2010, which was a referral by Dr. Juan Santiago-Palma for low back and right leg pain. Petitioner reported he had back pain starting at age 16 without a specific incident. The pain would come and go throughout the years with exercises and stretching. However, three months prior to September 15, 2010, the pain intensified. He sought treatment with Dr. DeForest, who referred him to Dr. Santiago, and then on to Dr. Jimenez. Dr. Jimenez recommended a minimally invasive right L5-S1 microdiscectomy. (334-337)

Petitioner presented to the emergency room on September 19, 2010 with back and leg pain (524-527).

The history and physical of September 21, 2010, by Dr. Mobolaji Suleiman, at the time of petitioner's admission for the surgery done by Dr. Jimenez on September 24, 2010, was that petitioner had chronic back pain since his teens which had become progressively worse since in the past few months (331-332).

Dr. Juan Jimenez reported in the operative report of September 24, 2010 that petitioner underwent a right L5-S1 microdiscectomy for a right L5-S1 disc herniation (476-477).

On August 4, 2011 petitioner had a lumbar MRI. The radiologist reported enhancing scar tissue noted at the postoperative site and along the right lateral aspect of the thecal sac, ventral to the thecal sac and partially surrounding the traversing right S1 nerve root. There was also a small residual broad-based right paracentral disk protrusion at the L5-S1 level without significant central canal stenosis, as well as stable mild bilateral foraminal narrowing at L5-S1. In addition, there was mild diffuse disk bulge at L4-L5 level with minimal encroachment. (312)

Petitioner underwent a right and left S1 neural foramen epidural steroid injection on May 2, 2012 by Dr. Santiago-Palma (296-297).

On July 10, 2012 petitioner received a caudal epidural steroid injection on July 10, 2012 by Dr. Santiago-Palma (252-253).

Petitioner seen in the emergency room on January 1, 2014 after being involved in a rear-end automobile accident. He reported his back was jarred. (102-103)

On September 25, 2014 petitioner received an epidural steroid injection bilateral at S1 neural foramen by Dr. Santiago-Palma (66-67).

Dr. Juan Santiago Palma Records (PX.9)

Petitioner completed a questionnaire on July 2, 2010 indicating the pain began on May 25, 2010 and was related to an injury that occurred between May and June, 2010 (PP.34-35).

Petitioner was first seen by Dr. Santiago-Palma on July 2, 2010 with complaints of lower back and radicular-type symptoms down the right leg. The history recorded was that petitioner was referred by Dr. DeForest for lower back and radicular type symptoms down the right leg that began on May 25, 2010 when doing repetitive strain at work. Dr. Santiago-Palma reported the June 30, 2010 MRI showed a right paracentral disc protrusion that was encroaching on the exiting right S1 nerve. (PP.55-57)

Petitioner followed up with Dr. Santiago-Palma for injections and consultation through September 14, 2010; Dr. Santiago-Palma advised he would see petitioner after he followed up with Dr. Jimenez. (66)

According to these records, the next time petitioner was seen by Dr. Santiago-Palma was on September 9, 2011. Petitioner had ongoing symptomology that was related back to petitioner's May 20, 2011 work accident. Dr. Palma recommended bilateral S1 transforaminal epidural injections. (64-65)

According to petitioner's questionnaire of September 1, 2011, he had been referred to Dr. Santiago-Palma by Dr. Jimenez (27).

According to these records, petitioner underwent epidural steroid injections and treatment by Dr. Santiago-Palma from May to August, 2012

Petitioner was next seen by Dr. Santiago-Palma on June 20, 2014. On that date, petitioner reported he was backing up, helping a co-worker with a machine, caught his foot in a [steel] comb, twisted his body and fell on September 9, 2013. (79-92)

Petitioner was seen again on August 11, 2014 (93-96) and September 8, 2014 (104-114). He received an injection on September 25, 2014 (77).

St. James Hospital Records [Actually these are Dr. DeForest's Records] (PX. 12)
Dr. DeForest's Records [PX.14]

This is a chronology of Petitioner's Exhibit 12 and Petitioner's Exhibit 14, which includes only mention of back problems or treatment.

Petitioner seen on April 22, 2008 with complaints of low back pain on the right that radiates down leg [24, 26]. On April 25, 2008 petitioner was seen for management of back pains [27]. On May 2, 2008 petitioner had a recheck of his back [25].

According to these records, petitioner was not seen again by Dr. DeForest for his back until March 30, 2009, at which time his history was that he had worsening of back pain [23]. Petitioner followed on April 14, 2009 for right lower back pain with radiculopathy [22]. Dr. DeForest ordered a lumbar MRI for the diagnosed low back pain with radiculopathy, which was not authorized (26).

On January 18, 2010 petitioner was seen by Dr. DeForest for low back pain and elbow pain (the balance of the records is illegible) [21] On February 1, 2010 petitioner's back and elbow were rechecked [20]. Petitioner had a cortisone injection into the elbow (35).

Petitioner was next seen by Dr. DeForest on June 11, 2010 for the lumbar sacral strain and right leg radiculopathy (29). According to the notes, petitioner stated "[pain started] one week ago lower back pain radiating down right leg with numbness and burning feeling with certain

movements. Did some heavy lifting at work" (34). He returned to Dr. DeForest on June 17, 2010 with persistent back pain radiating down right leg; the symptoms were present for two weeks; a lumbar MRI was ordered (28, 33). On July 1, 2010 petitioner reported no improvement; diagnosis was herniated disc at L5-S1 (27) [10,15]. Petitioner saw Dr. DeForest on September 8, 2010 for lump in abdomen (30). He was seen again for his back on September 16, 2010 (30).

Petitioner was seen by Dr. DeForest in 2012 and 2013 for carpal tunnel syndrome and a hernia only. There was no mention of treatment of the back during this period.

According to these records, petitioner next received treatment by Dr. DeForest for his back, after September 16, 2010, was on April 7, 2014. He advised Dr. DeForest that he has been unable to see the pain specialist as he was awaiting approval by worker's compensation, but needed a refill on Norco (9). Petitioner was seen on September 2, 2014 for a lumbar herniated disc (5-7). He was seen again on September 30, 2014 for a lumbar herniated disc and low back pain (3-4). He was rechecked for lumbar herniated disc on December 29, 2014 (1-2)

Dr. D. Mobolaji Suleiman /International Medicine Records (PX.13)

It appears petitioner was seen for a history and physical on September 21, 2010 for the herniated disc (10-13).

The history and physical as recorded by Dr. Suleiman at the time of petitioner's admission to Riverside Medical Center on September 24, 2010 for the L5-S1 microdiscectomy. The history recorded was petitioner had been having episodes of chronic low back pain since he was in his teens; mostly in the last few months. He provided a history that the pain was progressively worse over the last week or two. (23-25)

Petitioner was seen again on October 18, 2010 for a herniated disc and obesity (14). He was seen again on December 21, 2010 complaining of a lot of low back pain and working 10-12 hours a day that is making the pain worse (16).

Petitioner was seen by Dr. Suleiman on April 14, 2011 with a history of about three weeks earlier of having a lot of popping in lower back and has had continued lower back pain since then. He was diagnosed with a herniated disc and referred to a neurosurgeon (18).

Dr. John DeForest Note of July 8, 2013 (PX.15)

On July 8, 2012, Dr. DeForest wrote that petitioner had been off work since May 30, 2013. On July 22, 2013 petitioner was to return to Dr. DeForest for a determination as to when petitioner could return to work.

Dr. Ryon Hennessy May 4, 2016 Deposition with reports (RX.1)

At Dr. Ryon Hennessy's deposition, the following reports were admitted into evidence without objection: the December 8, 2011 reported completed after the exam of petitioner of that same date (Dep.2); the March 6, 2012 report completed after additional medical records were reviewed (Dep.3); the December 17, 2014 report completed after the exam of petitioner on December 1, 2014 (Dep. 4); the March 26, 2012 report wherein specific questions were answered (Dep.6); and the November 13, 2015 report authored after reviewing side by side MRI August 4, 2011 scan with the May 5, 2015 scan (Dep.5).

In his December 8, 2011 report, Dr. Hennessy cited to records of Dr. Jimenez that were not included in any other records admitted into evidence. (According to this report, petitioner agreed with the content, including the history contained Dr. Jimenez' records as cited by Dr. Hennessy in this report). (Dep.2)

Dr. Hennessy cited to petitioner's post op visit of October 18, 2010 wherein petitioner advised Dr. Jimenez the pain had nearly resolved and he had stopped pain medication two days before. He was released from Dr. Jimenez's care; to return on an as needed basis. (Dep.2)

On January 3, 2011, petitioner returned to Dr. Jimenez having slipped on ice and fell striking his back on a curb. He had low back and left leg pain; the left leg pain lasted two weeks. Dr. Jimenez recommended a home exercise program and released petitioner to return to work full duty. (Dep.2)

On May 2, 2011, petitioner returned to Dr. Jimenez's office and was seen by PA Joan Sullivan. At that time, petitioner advised he had continued low back pain and occasional left lower extremity radiculopathy. He had a sensation that something was moving in his low back when he would bend forward. He was tender in the bilateral sacroiliac joints. He complained of ongoing low back pain for seven months after the right L5-S1 discectomy. Physical therapy was recommended. (Dep.2)

Petitioner provided a history that on May 20, 2011, while at work and flipping a 100-pound die, when he felt a pop in his back. Petitioner continued to work, told his supervisor he had pain. He was sent to Provena St. Mary's Occupational Health Center on May 24, 2011. (Dep.2)

Dr. Hennessy believe petitioner suffered a lumbar strain in the accident of May 21, 2011 (sic). Dr. Hennessy believed the S1 radiculopathy was the temporary exacerbation of the right S1 nerve root and scar tissue from the previous surgery. Dr. Hennessy noted petitioner had symptomology of radiculopathy pain on January 3, 2011 and May 2, 2011 that pre-existed the May 20, 2011 accident. Dr. Hennessy compared the June, 2010 MRI with the August 4, 2011 and determined the only acute finding on the later MRI was the post-operative changes. Dr. Hennessy recommended petitioner undergo an EMG to determine if the condition was chronic. (Dep.2)

On March 6, 2012 Dr. Hennessy authored another report after reviewing the January 24, 2012 EMG report. Dr. Hennessy stated the EMG did not correlate with the objective findings on the MRI and failed to show the S1 right radiculopathy. Dr. Hennessy concluded petitioner had an exacerbation of his scar tissue from the fall on his back on January 3, 2011. Dr. Hennessy also believed the August 4, 2011 MRI did not show any evidence of a recurrent disc herniation or displacement. (Dep.3)

In his March 26, 2012 report, Dr. Hennessy opined that work conditioning was recommended due to the natural progression of petitioner's pre-existing degenerative disc disease, and not due to the work accident of May 21, 2011 (Dep. 6).

Dr. Hennessy authored his December 17, 2014 report after re-examining petitioner on December 1, 2014, and reviewing certain medical records. Dr. Hennessy mentions records of Dr. Panuska from May 29, 2012 and June 7, 2012 which were for treatment of a left ankle sprain after petitioner fell walking backwards. (Dep.4).

Dr. Hennessy reported that the medical records of Dr. Panuska and Dr. Jimenez provided different dates of accident in September, 2013, when petitioner fell backwards and twisted his back. The petitioner admitted he had back pain prior to the September 18, 2013 accident, but the fall had made the pain worse. Dr. Hennessy believed the fall of September 18, 2013 resulted in an exacerbation of the previous degenerative disc disease, herniation and scarring at L5-S1 level. Dr. Hennessy could not conclusively give an opinion on causality, treatment or restrictions due to the poor quality of the open MRI of December 19, 2013. (Dep. 4)

Dr. Hennessy authored his November 13, 2015 after reviewing the August 4, 2011 MRI scan side by side with the May 5, 2015 scan. Unlike the opinion of Dr. Panuska, Dr. Hennessy

did not believe there was any disc herniation causing nerve impingement at L4-L5 or L5-S1 level; only scar tissue. (Dep. 5)

Dr. Hennessy testified, after reviewing all MRI scans from 2010 to 2015, he found no progression of the petitioner's degenerative disc disease or recurrent disc herniation or left S1 impingement; only some scar tissue around the right S1 nerve root which was expected after the 2010 discectomy (PP.19-20).

Dr. Hennessy testified, after reviewing the 2015 MRI, that petitioner had an unencumbered S1 nerve root. Dr. Hennessy disagreed that petitioner required the surgery proposed by Dr. Jimenez, regardless of the cause (PP.22-23).

CONCLUSIONS OF LAW

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

F. In support of the Arbitrator's decision in regard to whether petitioner's condition of ill-being is causally related to the work injury, the Arbitrator finds the following:

Respondent did not dispute petitioner had an accident that arose out of and in the course of his employment with respondent on June 11, 2010. The evidence indicates petitioner had suffered a lumbar strain in an earlier work accident of May 12, 2006 and that he had a back injury five to six years before with similar discomfort. On June 28, 2006, he reported to Dr. Panuska that he doing well and was released to full duty work and discharged from Dr. Panuska's care.

The records of petitioner's personal physician, Dr. DeForest indicate that petitioner was first seen by Dr. DeForest on April 22, 2008 with low back pain on the right radiating down the right leg. He received treatment until May 25, 2008. On March 30, 2009, petitioner returned to Dr. DeForest on March 30, 2009, with a worsening of back pain. He was seen again on April 14, 2009, at which time a lumbar MRI was ordered due to petitioner's low back pain with radiculopathy. This was not completed as it was not authorized by insurance.

Petitioner was seen again by Dr. DeForest in January and February, 2010 for both elbow pain and low back pain. The next time he was seen by Dr. DeForest was on June 11, 2010 for a lumbar sacral strain with right leg radiculopathy. Petitioner related the lower back pain radiating down his right leg with numbness and burning feeling started about one week prior after doing some heavy lifting at work. He received treatment by Dr. DeForest on June 17, 2010 and July 1, 2010. Dr. DeForest diagnosed a herniated disc at the L5-S1 level after the MRI was obtained.

The neurosurgical consult on September 15, 2010 with Dr. Juan Jimenez indicates petitioner had back pain starting at age 16 without a specific incident. Throughout the years, petitioner reported the pain would come and go with exercises and stretching. In the last three months, petitioner reported the pain had intensified. Dr. Jimenez performed a right-sided L5-S1 microdiscectomy on September 24, 2010. Although Dr. Jimenez testified in behalf of petitioner, Dr. Jimenez did not opine that the need for the September 24, 2010 surgery was necessitated by the work accident of June 11, 2010 (PX.7, pp. 29-30).

Petitioner offered no medical evidence to support his claim that the work accident of June 11, 2010 caused the back injury for which he underwent the microdiscectomy on September 24, 2010 by Dr. Jimenez. The Arbitrator notes that although petitioner testified he only had X-rays of his back prior to his claimed June 11, 2010 accident, his symptoms of lower back pain with radiculopathy was severe enough for Dr. DeForest to order an MRI on April 14, 2009, that was never obtained; not because it was not needed, but because it was not authorized by insurance.

Based upon the foregoing, the Arbitrator finds petitioner failed to prove that the claimed work accident of June 11, 2010 caused his lower back condition which necessitate the surgery of September 24, 2010, or any ongoing medical treatment, including the proposed additional surgery by Dr. Jimenez.

L. In regard to whether the medical services that were provided to petitioner was reasonable and whether respondent has paid all appropriate charges for these services, the Arbitrator finds the following:

As the Arbitrator found petitioner failed to prove that the need for the treatment obtained was caused by the work accident of June 11, 2010, the Arbitrator denies the claim for the medical bills incurred.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator finds the following:

There was no evidence to support petitioner's claim that the work accident of June 11, 2010 caused the need for the prospective medical treatment, including the claimed need for additional back surgery. The claim for prospective medical treatment is, therefore, denied.

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

ANGEL MANCILLA, JR.,

Petitioner,

vs. NO: 14 WC 23521

ALABAMA METAL INDUSTRIES CORPORATION (AMICO),

Respondent.

18IWCC0724

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

The Commission affirms the decision of the Arbitrator, however, clarifies the date of accident. In the Arbitrator's Order, the date of accident is identified as May 20, 2011. The date of accident at issue in the instant case is, in fact, September 18, 2013.

The Award of the Arbitrator is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 31, 2017, is hereby affirmed and adopted.

18IWCC0724

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 $4,181.11. 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 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 102418
49

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

MANCILLA, ANGEL
Employee/Petitioner

Case# **14WC023521**

11WC045640
12WC010092

ALABAMA METAL INDUSTRIES CORP
Employer/Respondent

18IWCC0724

On 3/31/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICE OF PETER FERRACUTI
TRAVIS DUNN
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

18IWCC0724

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

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

Angel Mancilla
Employee/Petitioner

v.

Alabama Metal Industries Corp.
Employer/Respondent

Case # 14 WC 23521
Consolidated cases: 11 WC 45640 & 12 WC 10092

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **New Lenox**, on **August 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X Is Petitioner entitled to any prospective medical care?
L. ☐ 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 **May 20, 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 **$53,733.24**; the average weekly wage was **$1,168.11.**

On the date of accident, Petitioner was **34** 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** 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

Medical benefits

Respondent shall pay medical bills incurred from St. Mary's Medical Center Clinic in the amount of $4,081.11 for treatment rendered from October 7, 2013 through February 28, 2014 pursuant to §8 and §8.2 of the Act.

Prospective Medical benefits

The claim for prospective medical treatment is denied.

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

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

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

Christine Howy

Signature of Arbitrator
IC ArbDec19(b)

03/30/2017
Date

MAR 31 2017

18IWCC0724

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angel Mancilla	)
Petitioner,	)
vs.	) **No. 14 WC 23521**
Alabama Metal Industries Corp.	) (Consolidated cases: 11 WC 45640
Respondent.	) and 12 WC 10092)

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

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on August 3, 2016. The parties agree that on September 18, 2013 petitioner and respondent were operating under the provisions of the Illinois Worker's Compensation or Occupational Diseases Act; that their relationship was one of employee and employer; that petitioner had an accident that arose out of and in the course of his employment with respondent; that petitioner gave respondent notice of the accident within the time limits stated in the Act; that in the year preceding the accident petitioner earned $53,733.24, and his average weekly wage calculated pursuant to §10 was $1,168.11.

The matters at issue are:

1. Whether petitioner's current condition of ill-being is causally connected to the injury.
2. Whether respondent is liable for medical expense claimed in the amount of $54,046.24, of which $32,104.81 remain unpaid.
3. Whether petitioner is entitled to prospective medical treatment.

STATEMENT OF FACTS

Petitioner testified he was employed by respondent since 2005 doing the same job as "bar flipper"; which was loading bars into steel. In 2005 or 2006 he strained a muscle in his back, but recovered. Petitioner testified his back started hurting after flipping several bars on June 11, 2010. He reported the accident.

The first place petitioner obtained medical treatment after the June 11, 2010 accident was with Dr. DeForest. Dr. DeForest prescribed medication and referred petitioner to Dr. Santiago. Dr. Santiago performed a series of injections and prescribed physical therapy; neither of which relieved petitioner's problem. Therefore, Dr. Jimenez performed surgery on September 24, 2010. Petitioner testified he woke up pain free after surgery. He followed up with Dr. Jimenez once or twice. He returned to work doing the same job.

On May 20, 2011, petitioner testified he picked up a die to change and heard a pop in his back. The bottom of his spine swelled up. He reported the injury to Miguel or Omar. He was sent to Dr. Panuska by respondent for treatment. He was referred again to Dr. Santiago, this time by Dr. Panuska, for injections and physical therapy. Petitioner again saw Dr. Jimenez. He obtained another MRI.

Petitioner testified he had lost the feeling in his right calf in 2011 and 2012.

Petitioner testified that on September 18, 2013, he was helping with welding, walking backwards and tripped over a steel comb. He was sent again to see Dr. Panuska, who referred him to Dr. Santiago and then on to Dr. Jimenez.

Since 2014 he has been prescribed different medications. He regularly has pain in his back. Petitioner testified his back hurt just sitting and testifying. He continues to work on a lighter machine. He follows up with Dr. DeForest every month for prescriptions. He wants to have the surgery to fix the problem. The L5-S1 herniated disc is the same disc previously herniated.

On cross examination, petitioner testified he had pain in both legs. He claimed he had made a full recovery from his 2006 back injury. He did, however, wear a heated back brace. He claimed he has had no problems until after the 2010 incident.

Petitioner admitted he saw Dr. DeForest on May 2, 2008 for back pain; on April 22, 2008, he was put on restrictions for low back pain and strain; on March 30, 2009 he advised Dr. DeForest his pain worse in last three weeks; he was seen by Dr. DeForest on April 14, 2009, January 18, 2010, and February 1, 2010. He also told Dr. DeForest that he had back pain on and off prior to June 11, 2010.

On redirect petitioner testified he only had X-rays for the back problem in 2006. He said the pain came and went. In 2010, Dr. Deforest referred him to Dr. Santiago. In 2011 Dr. Panuska referred him to Dr. Santiago.

Medical Bills (PX.1)

Petitioner introduced the following bills totaling $54,046.24, of which $32,104.81 remain unpaid:

Associate Radiologists of Joliet $141.00
Central Illinois Radiology $638.00
Dr. Juan Jimenez $1,840.44
Dr. Juan Santiago-Palma $8,990.00
Dr. Manuel Perez $238.00
Provena St. Mary's Pain Clinic $24,472.61
Riverside Medical Center $13,886.00
St. Mary's Medical Center $3,840.19

Provena St. Mary's Medical Center Records (PX.2) and
Dr. J. Michael Panuska Records [Px.10] and
Dr. J. Michael Panuska Records up to March 11, 2015 {PX.11}

These records reflect petitioner was seen on May 17, 2006 for low back injury that occurred on May 12, 2006 after lifting bars of steel at work. The diagnosis was lumbar strain. Petitioner reported he had a back injury five to six years before with similar discomfort. (139) [10]

On May 22, 2006 petitioner returned for a recheck; physical therapy and pain medication was prescribed (138) [8]. On June 28, 2006 reportedly was doing well, was released to full duty work and discharged from care (136) [6].

On May 24, 2011, petitioner returned Dr. Panuska. He reported doing his regular job, turning a die, on May 20, 2011, when he felt a pop in lower back. He had pain in his right lower back that radiated down his right leg. He had L5-S1 surgery in 2010. Diagnosis was lumbar strain with sciatica. Therma care patches, physical therapy, and modified work were ordered. Petitioner was already on Norco, Valium, over the counter ibuprofen and Extra strength Tylenol. Dr. Panuska refilled the Norco and Valium. (133) [28]

Petitioner returned to Dr. Panuska on May 27, 2011 and continued to receive physical therapy (132) [26]. He was seen again on June 3, 2011 by Dr. Panuska, who referred him to Dr. Jimenez as Dr. Jimenez had done the previous surgery (131) [24].

Petitioner was seen again by Dr. Panuska on June 10, 2011 (131) [22], June 20, 2011 (129) [20], July 1, 2011 (127) [18] {44}, July 15, 2011 (126) [17 & 43] {43} and July 28, 2011 (125) [41] {42}.

On August 8, 2011, Dr. Panuska indicated petitioner's August 5, 2011 (sic) MRI did not show any new postsurgical changes, bud did show a new disc herniation at L1-2 (124) [39] {41}. On August 22, 2011, Dr. Panuska recommended surgery (122) [37] {39}. On September 6, 2011 petitioner was referred to Dr. Santiago for injections (120) [34] {37}.

Petitioner followed up with Dr. Panuska on September 27, 2011, October 21, 2011, November 3, 2011, November 17, 2011 and December 15, 2011.

On January 4, 2012, petitioner was seen by Dr. Panuska after seeing the "IME" doctor, who suggested an EMG (115) [47] {32}.

The EMG was performed on January 24, 2012 was reportedly suggested radiculopathy at unknown level or levels (87-91) [101-105]. Dr. Panuska did not have the EMG results when petitioner was seen by him on January 30, 2012 (114) [45] {31}. At the February 15, 2012, Dr. Panuska opined that because the EMG showed bilateral radiculopathy it suggested new injury on May 20, 2011 (113) [60] {30}.

Petitioner followed up with Dr. Panuska on February 29, 2012 and March 13, 2012.

On March 29, 2012 Dr. Panuska learned petitioner's entire claim was now being denied. Petitioner was referred to his family physician, released to return to work full duty and discharged from Dr. Panuska's care (110) [54] {27}.

Petitioner returned to Dr. Panuska on October 7, 2013 with back pain. Petitioner advised that he was having problems with a machine, walking backwards to fix it when his foot got caught and he tripped and fell twisting his back. This occurred on approximately September 27, 2013. (107) [72-73] {24}

On October 14, 2013, Dr. Panuska suggested petitioner return to Dr. Jimenez (106) [70] {23}.

Petitioner followed up with Dr. Panuska on October 21, 2013, November 6, 2013, November 11, 2013, December 16, 2013.

On December 23, 2013 petitioner returned to Dr. Panuska after obtaining an MRI. Dr. Panuska reported the new MRI showed a L5-S1 broad based posterior disc protrusion, mild central canal stenosis, bilateral recess stenosis and abutting the bilateral traversing S1 nerve root and L4-L5 disc protrusion causing mild canal stenosis and bilateral lateral recess stenosis abutting the bilateral traversing L5 nerve root. Dr. Panuska believed the findings were worse than the previous MRI. (99-101) {16-17}

Petitioner followed up with Dr. Panuska on January 6, 2014, January 13, 2014, January 20, 2014, and January 31, 2014 and February 17, 2014.

On February 28, 2014, Dr. Panuska concluded the best route for petitioner was to have surgery and discharged him from his care (93) {10}.

Dr. J. Michael Panuska Records as of March 11, 2015 {PX.11}

On March 11, 2015, petitioner returned to Dr. Panuska and reported he had seen Dr. Jimenez on March 9, 2015; Dr. Jimenez requested another MRI. {9}

On April 23, 2015, petitioner reported that he had hernia surgery on March 26, 2015 and was released from the hernia surgery to return to work on May 4, 2015. He was scheduled to have an MRI on May 1, 2015. {8}

On May 13, 2015, Dr. Panuska reported the MRI showed disc protrusion and foraminal narrowing at L4-L5 and L5-S1{7}.

Well Group Health Partners/Dr. Manuel Perez (PX.3)

Petitioner received treatment by Dr. Perez for a hernia secondary to a stab wound.

Dr. Juan Jimenez Records (PX.4)

These records begin with petitioner's visit with by Dr. Jimenez on June 27, 2011, for a low back injury, as a referral by Dr. Panuska. Petitioner related the problem to a May 20, 2011 incident at work when turning a dye. Dr. Jimenez recommended an updated MRI because of a possible displacement of lumbar disc without myelopathy. (54-55)

Petitioner was seen by the PA on August 17, 2011. The new MRI reportedly showed postoperative changes at L5-S1 with some enhancing scar tissue along the right S1 nerve root and broad disk bulge at L4-5 with mild foraminal stenosis bilaterally. He was referred to Dr. Santiago for evaluation and epidural steroid injection. (51-52)

The next visit by petitioner with Dr. Jimenez was on November 4, 2013; he reported he fell at work on September 26, 2013. H complained of back pain and lower extremity radiculitis. Another lumbar MRI was ordered. (47-49)

Petitioner returned on January 8, 2014 after obtaining an updated MRI. Dr. Jimenez believed the MRI showed lumbar disc displacement on both the L4-5 and L5-S1 level with possible L5 nerve compression at both levels. Although not optimistic, Dr. Jimenez ordered physical therapy and injections. He believed it was likely petitioner would require at L4-5 and L5-S1 TLIF (two-level fusion). (44-46)

Petitioner was seen again on February 19, 2014. He reported the physical therapy was not helping. Dr. Jimenez recommended physical therapy continue. He was referred for injections. Surgery was still being discussed as the most viable option. (40-43)

Petitioner was seen again on April 2, 2014 with same complaints. He was again referred for epidural steroid injections. (37-39)

Referral by Dr. Jimenez to Dr. Santiago (PX.5)

Dr. Jimenez referred petitioner to Dr. Santiago for ESI and pain management on April 2, 2014.

Dr. Juan Carlos Jimenez Curriculum Vitae (PX.6)

According to Dr. Juan Carlos Jimenez's curriculum vitae, he is a board certified neurosurgeon and director of Neurosciences Institute and Neurosurgery Consultants at Riverside Medical Center.

Dr. Juan Jimenez April 18, 2016 Deposition (PX.7)

Dr. Jimenez, a neurosurgeon who specializes in minimal invasive spinal surgery, testified in behalf of petitioner (P.4). Petitioner was first seen by Dr. Jimenez as an outpatient visit on September 15, 2010 (P.7). Petitioner had been seen by Dr. Santiago-Palma and his primary care doctor, Dr. DeForest (P.8). Petitioner had low back pain, right buttock pain, right posterior leg

pain extending into calf (P.8). He had undergone physical therapy and steroid injections without lasting effect (P.8).

Dr. Jimenez examination revealed a decrease pinprick on the right leg and foot at the S1 distribution, diminished right-sided Achilles' reflex and positive straight-leg raising. A review of the June 30, 2010 MRI showed a L5-S1 right paracentral disk herniation with impingement of the right S1 nerve root and some mild foraminal narrowing of L4-L5 and L5-S1. Dr. Jimenez assessment was right-sided L5-S1 disc herniation with impingement. Dr. Jimenez suggested a right-sided L5-S1 microdiscectomy. (PP.9-10)

Dr. Jimenez performed the right-sided L5-S1 microdiscectomy on September 24, 2010. The surgery was uneventful. Petitioner returned for a postoperative visit on January 3, 2011. Petitioner still had some expected right-sided numbness and had a diminished right Achilles' reflex. He was released to return to work, perform home-exercise programs and to contact the doctor if symptoms changed. On May 2, 2011, petitioner returned to Dr. Jimenez with ongoing symptoms. Petitioner was referred for physiotherapy. (PP.10-12)

On June 27, 2011, petitioner returned to Dr. Jimenez as a referral by Dr. Panuska. Petitioner reported that on May 20, 2011, he was turning over a die at work for respondent when he had immediate low back pain. He had undergone physical therapy without lasting relief. He was given a Medrol Dose Pak. Dr. Jimenez testified petitioner had been progressing until the May 20, 2011 incident and, therefore, Dr. Jimenez believed the May 20, 2011 accident caused an aggravation of petitioner's condition. An MRI was ordered. (PP.13-15)

At the August 17, 2011 visit, Dr. Jimenez reviewed both the MRI report and the actual MRI from August 4, 2011. Dr. Jimenez noted both scarring along the S1 nerve root as well as a bulge at L4-5. Dr. Jimenez believed petitioner had a new injury as well as scar tissue. Dr. Jimenez referred petitioner to Dr. Santiago for injections. (PP.15-17)

Petitioner returned to Dr. Jimenez on November 4, 2013. Petitioner had received injections by Dr. Santiago in the fall of 2011 that did not provide relief. Petitioner also gave a history of falling backwards and twisting his back on September 26, 2012 (sic). Petitioner reported he had not undergone physiotherapy since the aggravation accident of September 26, 2012 (sic) and had not had any additional injections since fall, 2011. He had undergone an EMG on January 24, 2012. He was also evaluated by Dr. Panuska. Petitioner had diminished sensation on the lateral aspect of the left and right leg and foot; a wide-based gait; a positive straight leg raising on both right and left; and lumbar tenderness with diminished range of motion of the lumbar spine. The diagnosis was displacement of lumbar intravertebral disks. Additional studies were ordered. (PP.18-20)

Petitioner was next seen by Dr. Jimenez on January 8, 2014. Dr. Jimenez noted the December 19, 2013 MRI showed degenerative changes at L4-5; a broad-based posterior disc protrusion at L4-5 abutting the L5 nerve root; and also a broad-based L5-S1 disc protrusion that encroaching and indenting the L5 nerve root. Dr. Jimenez described petitioner's condition as a continuum of petitioner's condition with a traumatic event that exacerbated his symptomology. In order to avoid surgery, due to petitioner's young age, Dr. Jimenez prescribed physiotherapy. (PP.20-22)

Petitioner returned to Dr. Jimenez on February 19, 2014 with the same findings. Dr. Jimenez recommended the same conservative care. Petitioner followed up with Dr. Jimenez on April 2, 2014 and on June 11, 2014 with similar findings. Dr. Jimenez had the same recommendations. (PP.22-25).

Petitioner returned to Dr. Jimenez on March 9, 2015 with similar, ongoing symptoms. Petitioner reported he was sent for an independent medical exam and also had a transforaminal

injection on September 25, 2014 with only slight benefit. He also advised Dr. Jimenez he was undergoing hernia surgery on March 26, 2015 Dr. Jimenez agreed with the recommendation by independent medical examiner for another MRI (PP.25-27).

Petitioner returned to Dr. Jimenez on June 8, 2015 after undergoing an MRI on May 5, 2015. Based upon his review of the MRI, Dr. Jimenez diagnosed a herniated nucleus pulposis at L5-S1 on the right. Because of the ongoing symptomology, lack of results from conservative care and the objective findings on the MRI, Dr. Jimenez recommended a redo of the L5-S1 microdiscectomy. Dr. Jimenez concluded that the occurrence of September 26, 2012 (sic) and other work-related incident of May 20, 2011 caused the lumbar disc herniation and clinical sequelae, and that all the treatment was necessitated by these injuries (PP.27-30).

On cross-examination, Dr. Jimenez explained that despite petitioner having bilateral symptoms, given petitioner's young age, Dr. Jimenez wanted to do a less invasive procedure on the right side where the majority of the symptoms were (P.32). Dr. Jimenez did not find the inconclusive January 24, 2012 EMG study to be of much benefit (PP.34-35). Petitioner remained on restricted work as of the last seen time seen by Dr. Jimenez on June 8, 2015 (PP.39-40).

Riverside Medical Center Records (PX.8)

Petitioner received epidural steroid injections by Dr. Santiago-Palma on July 7, 2010 (600-601); August 3, 2010 (578-579); and August 20, 2010 (555-556).

The records include the neurosurgical consult with Dr. Juan Jimenez on September 15, 2010, which was a referral by Dr. Juan Santiago-Palma for low back and right leg pain. Petitioner reported he had back pain starting at age 16 without a specific incident. The pain would come and go throughout the years with exercises and stretching. However, three months prior to September 15, 2010, the pain intensified. He sought treatment with Dr. DeForest, who referred him to Dr. Santiago, and then on to Dr. Jimenez. Dr. Jimenez recommended a minimally invasive right L5-S1 microdiscectomy. (334-337)

Petitioner presented to the emergency room on September 19, 2010 with back and leg pain (524-527).

The history and physical of September 21, 2010, by Dr. Mobolaji Suleiman, at the time of petitioner's admission for the surgery done by Dr. Jimenez on September 24, 2010, was that petitioner had chronic back pain since his teens which had become progressively worse since in the past few months (331-332).

Dr. Juan Jimenez reported in the operative report of September 24, 2010 that petitioner underwent a right L5-S1 microdiscectomy for a right L5-S1 disc herniation (476-477).

On August 4, 2011 petitioner had a lumbar MRI. The radiologist reported enhancing scar tissue noted at the postoperative site and along the right lateral aspect of the thecal sac, ventral to the thecal sac and partially surrounding the traversing right S1 nerve root. There was also a small residual broad-based right paracentral disk protrusion at the L5-S1 level without significant central canal stenosis, as well as stable mild bilateral foraminal narrowing at L5-S1. In addition, there was mild diffuse disk bulge at L4-L5 level with minimal encroachment. (312)

Petitioner underwent a right and left S1 neural foramen epidural steroid injection on May 2, 2012 by Dr. Santiago-Palma (296-297).

On July 10, 2012 petitioner received a caudal epidural steroid injection on July 10, 2012 by Dr. Santiago-Palma (252-253).

Petitioner seen in the emergency room on January 1, 2014 after being involved in a rear-end automobile accident. He reported his back was jarred. (102-103)

On September 25, 2014 petitioner received an epidural steroid injection bilateral at S1 neural foramen by Dr. Santiago-Palma (66-67).

Dr. Juan Santiago Palma Records (PX.9)

Petitioner completed a questionnaire on July 2, 2010 indicating the pain began on May 25, 2010 and was related to an injury that occurred between May and June, 2010 (PP.34-35).

Petitioner was first seen by Dr. Santiago-Palma on July 2, 2010 with complaints of lower back and radicular-type symptoms down the right leg. The history recorded was that petitioner was referred by Dr. DeForest for lower back and radicular type symptoms down the right leg that began on May 25, 2010 when doing repetitive strain at work. Dr. Santiago-Palma reported the June 30, 2010 MRI showed a right paracentral disc protrusion that was encroaching on the exiting right S1 nerve. (PP.55-57)

Petitioner followed up with Dr. Santiago-Palma for injections and consultation through September 14, 2010; Dr. Santiago-Palma advised he would see petitioner after he followed up with Dr. Jimenez. (66)

According to these records, the next time petitioner was seen by Dr. Santiago-Palma was on September 9, 2011. Petitioner had ongoing symptomology that was related back to petitioner's May 20, 2011 work accident. Dr. Palma recommended bilateral S1 transforaminal epidural injections. (64-65)

According to petitioner's questionnaire of September 1, 2011, he had been referred to Dr. Santiago-Palma by Dr. Jimenez (27).

According to these records, petitioner underwent epidural steroid injections and treatment by Dr. Santiago-Palma from May to August, 2012

Petitioner was next seen by Dr. Santiago-Palma on June 20, 2014. On that date, petitioner reported he was backing up, helping a co-worker with a machine, caught his foot in a [steel] comb, twisted his body and fell on September 9, 2013. (79-92)

Petitioner was seen again on August 11, 2014 (93-96) and September 8, 2014 (104-114). He received an injection on September 25, 2014 (77).

St. James Hospital Records [Actually these are Dr. DeForest's Records] (PX. 12)
Dr. DeForest's Records [PX.14]

This is a chronology of Petitioner's Exhibit 12 and Petitioner's Exhibit 14, which includes only mention of back problems or treatment.

Petitioner seen on April 22, 2008 with complaints of low back pain on the right that radiates down leg [24, 26]. On April 25, 2008 petitioner was seen for management of back pains [27]. On May 2, 2008 petitioner had a recheck of his back [25].

According to these records, petitioner was not seen again by Dr. DeForest for his back until March 30, 2009, at which time his history was that he had worsening of back pain [23]. Petitioner followed on April 14, 2009 for right lower back pain with radiculopathy [22]. Dr. DeForest ordered a lumbar MRI for the diagnosed low back pain with radiculopathy, which was not authorized (26).

On January 18, 2010 petitioner was seen by Dr. DeForest for low back pain and elbow pain (the balance of the records is illegible) [21] On February 1, 2010 petitioner's back and elbow were rechecked [20]. Petitioner had a cortisone injection into the elbow (35).

Petitioner was next seen by Dr. DeForest on June 11, 2010 for the lumbar sacral strain and right leg radiculopathy (29). According to the notes, petitioner stated "[pain started] one week ago lower back pain radiating down right leg with numbness and burning feeling with certain

movements. Did some heavy lifting at work" (34). He returned to Dr. DeForest on June 17, 2010 with persistent back pain radiating down right leg; the symptoms were present for two weeks; a lumbar MRI was ordered (28, 33). On July 1, 2010 petitioner reported no improvement; diagnosis was herniated disc at L5-S1 (27) [10,15]. Petitioner saw Dr. DeForest on September 8, 2010 for lump in abdomen (30). He was seen again for his back on September 16, 2010 (30).

Petitioner was seen by Dr. DeForest in 2012 and 2013 for carpal tunnel syndrome and a hernia only. There was no mention of treatment of the back during this period.

According to these records, petitioner next received treatment by Dr. DeForest for his back, after September 16, 2010, was on April 7, 2014. He advised Dr. DeForest that he has been unable to see the pain specialist as he was awaiting approval by worker's compensation, but needed a refill on Norco (9). Petitioner was seen on September 2, 2014 for a lumbar herniated disc (5-7). He was seen again on September 30, 2014 for a lumbar herniated disc and low back pain (3-4). He was rechecked for lumbar herniated disc on December 29, 2014 (1-2)

Dr. D. Mobolaji Suleiman /International Medicine Records (PX.13)

It appears petitioner was seen for a history and physical on September 21, 2010 for the herniated disc (10-13).

The history and physical as recorded by Dr. Suleiman at the time of petitioner's admission to Riverside Medical Center on September 24, 2010 for the L5-S1 microdiscectomy. The history recorded was petitioner had been having episodes of chronic low back pain since he was in his teens; mostly in the last few months. He provided a history that the pain was progressively worse over the last week or two. (23-25)

Petitioner was seen again on October 18, 2010 for a herniated disc and obesity (14). He was seen again on December 21, 2010 complaining of a lot of low back pain and working 10-12 hours a day that is making the pain worse (16).

Petitioner was seen by Dr. Suleiman on April 14, 2011 with a history of about three weeks earlier of having a lot of popping in lower back and has had continued lower back pain since then. He was diagnosed with a herniated disc and referred to a neurosurgeon (18).

Dr. John DeForest Note of July 8, 2013 (PX.15)

On July 8, 2012, Dr. DeForest wrote that petitioner had been off work since May 30, 2013. On July 22, 2013 petitioner was to return to Dr. DeForest for a determination as to when petitioner could return to work.

Dr. Ryon Hennessy May 4, 2016 Deposition with reports (RX.1)

At Dr. Ryon Hennessy's deposition, the following reports were admitted into evidence without objection: the December 8, 2011 reported completed after the exam of petitioner of that same date (Dep.2); the March 6, 2012 report completed after additional medical records were reviewed (Dep.3); the December 17, 2014 report completed after the exam of petitioner on December 1, 2014 (Dep. 4); the March 26, 2012 report wherein specific questions were answered (Dep.6); and the November 13, 2015 report authored after reviewing side by side MRI August 4, 2011 scan with the May 5, 2015 scan (Dep.5).

In his December 8, 2011 report, Dr. Hennessy cited to records of Dr. Jimenez that were not included in any other records admitted into evidence. (According to this report, petitioner agreed with the content, including the history contained Dr. Jimenez' records as cited by Dr. Hennessy in this report). (Dep.2)

Dr. Hennessy cited to petitioner's post op visit of October 18, 2010 wherein petitioner advised Dr. Jimenez the pain had nearly resolved and he had stopped pain medication two days before. He was released from Dr. Jimenez's care; to return on an as needed basis. (Dep.2)

On January 3, 2011, petitioner returned to Dr. Jimenez having slipped on ice and fell striking his back on a curb. He had low back and left leg pain; the left leg pain lasted two weeks. Dr. Jimenez recommended a home exercise program and released petitioner to return to work full duty. (Dep.2)

On May 2, 2011, petitioner returned to Dr. Jimenez's office and was seen by PA Joan Sullivan. At that time, petitioner advised he had continued low back pain and occasional left lower extremity radiculopathy. He had a sensation that something was moving in his low back when he would bend forward. He was tender in the bilateral sacroiliac joints. He complained of ongoing low back pain for seven months after the right L5-S1 discectomy. Physical therapy was recommended. (Dep.2)

Petitioner provided a history that on May 20, 2011, while at work and flipping a 100-pound die, when he felt a pop in his back. Petitioner continued to work, told his supervisor he had pain. He was sent to Provena St. Mary's Occupational Health Center on May 24, 2011. (Dep.2)

Dr. Hennessy believe petitioner suffered a lumbar strain in the accident of May 21, 2011 (sic). Dr. Hennessy believed the S1 radiculopathy was the temporary exacerbation of the right S1 nerve root and scar tissue from the previous surgery. Dr. Hennessy noted petitioner had symptomology of radiculopathy pain on January 3, 2011 and May 2, 2011 that pre-existed the May 20, 2011 accident. Dr. Hennessy compared the June, 2010 MRI with the August 4, 2011 and determined the only acute finding on the later MRI was the post-operative changes. Dr. Hennessy recommended petitioner undergo an EMG to determine if the condition was chronic. (Dep.2)

On March 6, 2012 Dr. Hennessy authored another report after reviewing the January 24, 2012 EMG report. Dr. Hennessy stated the EMG did not correlate with the objective findings on the MRI and failed to show the S1 right radiculopathy. Dr. Hennessy concluded petitioner had an exacerbation of his scar tissue from the fall on his back on January 3, 2011. Dr. Hennessy also believed the August 4, 2011 MRI did not show any evidence of a recurrent disc herniation or displacement. (Dep.3)

In his March 26, 2012 report, Dr. Hennessy opined that work conditioning was recommended due to the natural progression of petitioner's pre-existing degenerative disc disease, and not due to the work accident of May 21, 2011 (Dep. 6).

Dr. Hennessy authored his December 17, 2014 report after re-examining petitioner on December 1, 2014, and reviewing certain medical records. Dr. Hennessy mentions records of Dr. Panuska from May 29, 2012 and June 7, 2012 which were for treatment of a left ankle sprain after petitioner fell walking backwards. (Dep.4).

Dr. Hennessy reported that the medical records of Dr. Panuska and Dr. Jimenez provided different dates of accident in September, 2013, when petitioner fell backwards and twisted his back. The petitioner admitted he had back pain prior to the September 18, 2013 accident, but the fall had made the pain worse. Dr. Hennessy believed the fall of September 18, 2013 resulted in an exacerbation of the previous degenerative disc disease, herniation and scarring at L5-S1 level. Dr. Hennessy could not conclusively give an opinion on causality, treatment or restrictions due to the poor quality of the open MRI of December 19, 2013. (Dep. 4)

Dr. Hennessy authored his November 13, 2015 after reviewing the August 4, 2011 MRI scan side by side with the May 5, 2015 scan. Unlike the opinion of Dr. Panuska, Dr. Hennessy

did not believe there was any disc herniation causing nerve impingement at L4-L5 or L5-S1 level; only scar tissue. (Dep. 5)

Dr. Hennessy testified, after reviewing all MRI scans from 2010 to 2015, he found no progression of the petitioner's degenerative disc disease or recurrent disc herniation or left S1 impingement; only some scar tissue around the right S1 nerve root which was expected after the 2010 discectomy (PP.19-20).

Dr. Hennessy testified, after reviewing the 2015 MRI, that petitioner had an unencumbered S1 nerve root. Dr. Hennessy disagreed that petitioner required the surgery proposed by Dr. Jimenez, regardless of the cause (PP.22-23).

CONCLUSIONS OF LAW

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

F. In support of the Arbitrator's decision in regard to whether petitioner's condition of ill-being is causally related to the work injury, the Arbitrator finds the following:

Respondent does not dispute petitioner was injured in an accident that occurred on or about September 18, 2013 when he was walking backwards and fell over a steel comb, twisting his back and fell. The question is whether the need for the proposed repeat laminectomy at the L5-S1 level is necessitated by the work accident of September 19, 2012.

Petitioner confirmed that in 2011 and 2012 he had lost the feeling in his right calf. Petitioner admitted to Dr. Hennessy at the time of his December 1, 2014 exam that he was having back pain prior to the fall [on September 18, 2013] (RX.1, Dep. Ex.4).

Dr. Panuska, who had treated petitioner for back problems on and off since petitioner's May 12, 2006 work-related back injury, had determined as early as August 8, 2011 that petitioner had a new disc herniation at L5-S1 level. Dr. Panuska recommended surgery as of August 22, 2011. Dr. Panuska continued to provide treatment to petitioner for the diagnosed herniated disc after August 22, 2011, until March 29, 2012 when petitioner's claim [for the May 20, 2011 accident] was denied. During that period of time, petitioner was referred to Dr. Santiago-Palma for injections. On March 29, 2012 Dr. Panuska, who had been treating petitioner as a referral from respondent, discharged petitioner to his family doctor's care.

Petitioner did not return to Dr. Panuska for back pain until October 7, 2013, at which time he provided a history of the September 27, 2013 (sic) work accident. Although Dr. Panuska reported the December 19, 2013 MRI showed evidence petitioner's condition at the L4-5 and L5-S1 was worse than the previous [August 4, 2011] MRI, Dr. Hennessy, who examined petitioner in behalf of respondent, did not believe the December 19, 2013 Open MRI was of diagnostic quality. Dr. Panuska's diagnosis remained the same after the September 19, 2013 occurrence as it had been before the claimed accident; which was a herniated disc. On May 13, 2015, Dr. Panuska made no comment as to the findings of the [May 5, 2015] MRI as compared with the previous MRIs. The diagnosis remained the same; which was herniated disc at the L5-S1 level.

Dr. Jimenez, who had provided treatment to petitioner since September, 2010, testified the need for a repeat surgery at the L5-S1 level was necessitated by the September 26, 2012 (sic) and the May 20, 2011 accidents.

Dr. Hennessey, testifying in behalf of respondent, determined petitioner had only a lumbar strain and temporary aggravation of petitioner's disc disease as a result of the work accident of September 19, 2013. Dr. Hennessey reviewed all of petitioner's lumbar MRI scans from 2010

through 2015 and concluded petitioner did not suffer any new disc herniation or progression of his degenerative disc disease as a result of the work accident of September 19, 2013 [or May 20, 2011].

Based upon the evidence, taken as a whole, the Arbitrator finds petitioner sustained only a temporary aggravation of his ongoing back problems from the work accident of September 19, 2013. The Arbitrator based this finding on the opinion of Dr. Panuska, who believed petitioner's herniated disc diagnosed as of August, 2011, required surgery; as well as the opinion of Dr. Hennessy who did not believe petitioner had a recurrent herniated disc and suffered only a temporary aggravation, with no objective findings of any permanent condition, from the work accident of September 18, 2013.

The Arbitrator did not take into consideration the opinion of Dr. Jimenez as his credibility was called into question when he failed to include the fall petitioner's took on the ice before his January 3, 2011 exam, his findings at the time of his visit with petitioner on May 2, 2011, and the failure to consider Dr. Suleiman's April 14, 2011 records. Therefore, Dr. Jimenez's opinion that petitioner's ongoing problems and need for a repeat laminectomy at the L5-S1 level was necessitated by the work accidents of September 26, 2012 (sic) and the May 20, 2011, is not supported by the other medical evidence.

L. In regard to whether the medical services that were provided to petitioner was reasonable and whether respondent has paid all appropriate charges for these services, the Arbitrator finds the following:

Petitioner submitted a total of $54,046.24, of which $32,104.81 remained unpaid, for all three of his cases. (The Arbitrator notes, included in these bills was a $1,715.00 bill from Riverside Hospital for treatment rendered on January 1, 2014 after petitioner was involved in a rear-end automobile accident.)

Based upon the evidence, the Arbitrator finds the treatment from October 7, 2013 through February 28, 2014 with Dr. Panuska at St. Mary's Medical Center Clinic, was reasonable and necessary treatment of the petitioner for the injuries sustained in the September 18, 2013 and awards these bills totaling $4,081.11 pursuant to §8 and §8.2 of the Act.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator finds the following:

The Arbitrator finds petitioner's September 18, 2013 accident caused only a temporary aggravation of petitioner's ongoing chronic back problems. Relying upon the opinion of Dr. Ryon Hennessy, the Arbitrator finds petitioner's objective findings does not support the need for further surgery. Regardless of whether petitioner requires surgery, the Arbitrator finds the need for any future treatment predated the work accident of September 18, 2013. Therefore, the claim for prospective medical treatment 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

DANIEL JAIMES,

Petitioner,

vs.

NO: 15 WC 11402

ARTOPOLIS BAKERY CAFÉ & AGORA,

18IWCC0725

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, notice, causation, medical expenses, temporary total disability, penalties, and attorney's fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the additional reasoning stated below.

The Commission affirms the Arbitrator's finding that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on February 27, 15. We also agree that the testimony of Respondent's witnesses is more credible than that of Petitioner and his sister-in-law, Magdalena Perez. However, we add the following analysis so it is clear that we considered these issues and evidence in the record.

Petitioner testified that every time he went to Cook County Hospital he explained to the personnel that his back condition was caused by the alleged work accident. *T.112 -13.* However, these medical records consistently indicate, "denies injury, trauma or heavy lifting" (3/4/15), "denies any history of injury" (3/9/15), "no recent trauma or injury" (3/16/15). We find it hard to believe that multiple medical providers, on multiple dates, would fail to record a

history of a work injury if Petitioner had informed them of such. Petitioner went to Holy Cross Hospital on March 24, 2015, and the initial records state "denies injury." When Petitioner saw Dr. Kurian in the hospital later that day, there is no mention of a work injury. It wasn't until the next day, after Petitioner was admitted to the hospital, that Dr. Mohan recorded a history of "back injury 2 weeks ago where he works with a truck ___ moving heavy objects." Based on the lack of recorded histories in the initial medical records, we don't find Petitioner credible that he told all those medical providers about any work injury.

Petitioner argues that the initial Cook County medical records include "workers compensation" as an insurer, so this proves that he told them he was injured at work. However, we do not believe these Patient Information forms and bills can be viewed that way. As evidenced by the dates on the forms, these were printed much later than the actual visits and include a Workers' Compensation policy number. But, Petitioner did not know the insurance information in the beginning. *T.46.* Maria Melidis, the acting general manager at Respondent, testified that she did not know Petitioner was claiming the he sustained a work injury on February 27th until three or four weeks later, at which point she contacted the insurance company and got a claim number. *T.165-69.* We find it most likely that this workers' compensation insurance information was added to Petitioner's medical records after his claim was filed. Therefore, the presence of this insurance information on forms that were printed at a later date is not persuasive.

We also clarify that, although the issue of causation was moot, the Arbitrator found, "Petitioner failed to introduce any medical opinion evidence to support a causal connection between his low back condition and the accident alleged." *Dec. at 10.* However, on March 30, 2015, Dr. Barnabas recorded a history of work accident on February 27, 2015, diagnosed extruded fragments of the L4-L5-S1 discs and annular tear at L4-5, and wrote, "Since the day of the accident the pain has worsened." Also, on September 24, 2015, Dr. Sokolowski wrote that Petitioner's chief complaint was lumbar pain with radiation to the left buttock and left lower extremity subsequent to a work injury on February 27, 2015. On October 7, 2016, Dr. Sokolowski wrote that Petitioner has had persistent left radicular symptoms since his work injury. Although none of Petitioner's doctors testified regarding causation, these records could be considered causation opinions. However, they are not persuasive based on Petitioner's failure to prove that he sustained an accident.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 2007, is hereby affirmed and adopted with the additional reasoning 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 28 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 10/3/18
49

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

JAIMES, DANIEL
Employee/Petitioner

Case# **15WC011402**

ARTOPOLIS BAKERY CAFÉ & AGORA
Employer/Respondent

18IWCC0725

On 4/4/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2234 CHEPOV & SCOTT LLC
MASHA A CHEPOV
5440 N CUMBERLAND AVE #150
CHICAGO, IL 60656

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

STATE OF ILLINOIS)
)SS.
COUNTY OF)

☐ 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
19(b)

Daniel Jaimes
Employee/Petitioner

Case # 15 WC 11402

v.
Artopolis Bakery Cafe & Agora
Employer/Respondent

Consolidated cases:

18IWCC0725

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Kurt A. Carlson, Arbitrator of the Commission, in the city of Chicago, on February 7, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☐ 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, 02-27-15, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $N/A; the average weekly wage was $N/A.

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

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

ORDER

Petitioner failed to prove that an accident occurred that arose out of and in the course of his employment with Respondent.

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 *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.

Signature of Arbitrator

04-04-2017
Date

APR 4 - 2017

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

Petitioner worked in the bakery and as a delivery person for Respondent. Respondent's line of business is a restaurant and bakery. Petitioner testified to making 3-8 deliveries a day depending on his schedule. Petitioner testified to using 3 different types of carts for product and delivering various items. On Friday, February 27, 2015, Petitioner testified he was making a delivery at University of Illinois Chicago. He testified to pulling a cart from the back of his truck. He stated that while holding the cart and lowering it down, he felt a sharp pain in his low back. Petitioner testified he knew this incident caused his pain and described the incident as a life changing event.

Petitioner testified the accident happened at the end of his shift on Friday, February 27, 2015. He did not report the accident that day. Petitioner testified he reported the accident to his supervisor, Iannis, on Sunday, March 1, 2015, which was the next day Petitioner was scheduled to work. Petitioner stopped working due to pain complaints. He first sought medical treatment commencing March 4, 2015 at Cook County Hospital. Petitioner testified he gave a consistent history identical to his trial testimony to medical personnel throughout his treatment for this alleged injury. During his testimony, Petitioner alleged inconsistencies documented in medical records were due to multiple errors on the part of medical personnel as well as a language barrier rather than inconsistent reporting on Petitioner's part. The Arbitrator heard testimony of multiple witnesses and has reviewed the medical records and reports in evidence. The Arbitrator does not find Petitioner's testimony credible. Petitioner's testimony is contradicted by other witnesses and the medical records.

Iannis Fregos testified. He is the morning manager for Respondent. He has no ownership interest in the company. He worked with Petitioner on a regular basis. Mr. Fregos specifically denied Petitioner reported an accident to him on Sunday, March 1, 2015. He knew Petitioner was having problems with his back and leg that week, but denied an accident was reported. He believed Petitioner was ill and recalled Petitioner had a similar problem in the past. Mr. Fregos stated he was not aware Petitioner was claiming an accident on the job until about a month later after Petitioner had been hospitalized. Mr. Fregos stated he learned Petitioner was claiming an accident on the job from Maria, who is the general manager.

Maria Melidis is the general manager for Respondent. She has no ownership interest in the business. She denied an accident claim was promptly reported by Petitioner to management. She stated that if an accident was initially reported by Petitioner following the February 27, 2015 alleged accident date, she would have promptly reported the claim to the company's carrier. She did not do so as Petitioner did not initially report the claim to her. She testified Petitioner did not report the alleged accident claim to her until a few weeks later, at which time she notified her carrier. Ms. Melidis' testimony is corroborated by an e-mail Petitioner sent her April 17, 2015 in which he acknowledged that he did not initially report this alleged accident to management. In the e-mail, Petitioner claimed he did not say anything to management initially due to "embarrassment" (RX 4).

Petitioner first sought medical treatment at Cook County Hospital on March 4, 2015. On that date, he saw Dr. Karen Cosby. Petitioner acknowledged he saw a doctor initially that was female. Contrary to his testimony, Petitioner did not give the doctor a history of the alleged work accident of February 27, 2015. Petitioner acknowledged the doctor he saw this date was female. The medical records show the attending doctor was Dr. Karen Cosby. Also, the

physician's assistant that attended to Petitioner this date was female, Alejandra Argueta. Petitioner reported the onset of lower extremity pain five days earlier. He specifically denied any injury. He reported the exacerbating factor is walking. He specifically denied suffering any injury, trauma or heavy lifting which caused his condition. Petitioner was examined and given a primary diagnosis of sciatica or piriformis inflammation. He was prescribed medication and discharged in an improved condition (RX 1).

Petitioner offered testimony of his sister-in-law, Magdalena Perez, relating to the Cook County Hospital visit of March 4, 2015. Ms. Perez testified she was with Petitioner at the hospital at the time of the March 4, 2015 visit. She testified she was in the room when the doctor examined Petitioner and heard Petitioner describe to the doctor a detailed history of the alleged work accident of February 27, 2015 in which he was allegedly lifting and injured his low back. The Arbitrator does not find Ms. Perez's testimony credible. Ms. Perez identified the doctor that examined Petitioner and to whom Petitioner provided a history as a male. Her testimony contradicted Petitioner's own testimony that he was seen by a doctor that was female this date. Further, the records of Cook County Hospital contradict Ms. Perez's statements and show Petitioner was seen by both a female doctor and physician's assistant. Further, the records contradict the testimony of Petitioner and Ms. Perez that a history of the February 27, 2015 alleged work accident was provided. It was not. Petitioner denied that he sustained any traumatic injury. He specifically denied his condition was the result of any heavy lifting episode.

Petitioner was next seen at Cook County Hospital on March 9, 2015. Petitioner was seen by a different doctor this date than he had seen originally March 4, 2015. He was again questioned regarding the history of his present illness. Once again, Petitioner specifically denied any history of injury. Petitioner was prescribed different medication. He was advised to rest and

stay off work for one week. He was advised an MRI would be considered if the pain did not resolve.

Petitioner returned to Cook County Hospital for another visit on March 16, 2015. He was seen by a different doctor in the outpatient department this date. Once again, he was questioned by this third doctor regarding the history of his present condition. Petitioner complained of lower back pain on and off for the past 2-3 weeks. He again specifically denied his condition was the result of any recent trauma or injury. He did not give a history of a work accident of February 27, 2015. He was prescribed different medications and an MRI was ordered (RX 1).

Petitioner returned to Cook County for a fourth visit a few days later on March 19, 2015. He again saw a different physician who discussed his condition with him and obtained a history. Petitioner complained of left leg pain. He admitted a similar pain on the right side the previous year. He reported previously being diagnosed with sciatica. He denied any history of traumatic injury once again. He was given instruction on medication for pain control and it was noted an MRI was scheduled (RX 1).

On March 24, 2015, Petitioner testified to developing increased pain at home. An ambulance was called and he was transported by ambulance to Holy Cross Hospital the morning of March 24, 2015. The City of Chicago Emergency Medical Services report of March 24, 2015 is in evidence (RX 2). The report shows that Petitioner gave a history of suffering from sciatica for the last month and taking prescription pain pills. Petitioner did not give a history of a February 27, 2015 work accident to emergency personnel. He denied sustaining any falls or recent traumatic injury. Petitioner stated his pain had intensified. He was transported to Holy Cross Hospital (RX 2).

Petitioner was admitted to Holy Cross Hospital on March 24, 2015 (RX 5). Petitioner gave inconsistent histories to hospital personnel. Petitioner changed his statements as to the history of his condition once it was apparent his condition was more serious and he was admitted to the hospital. Upon arrival at the hospital, Petitioner was noted by nursing staff at 9:53 a.m. that he suffered from low back pain radiating down his left leg for the past month. He denied any history of injury. When seen for a history and physical exam by Dr. Vucich at 2:27 p.m. on March 24, 2015, Petitioner gave a history of low back and left leg pain for the past month. He did not report an accident February 27, 2015 while working. Similarly, Petitioner was examined by Dr. Kurian at the hospital on March 24, 2015. Similarly, Petitioner did not give Dr. Kurian a history of an accident at work on February 27, 2015. He simply complained of back and left leg pain for more than a month. Petitioner was admitted to the hospital at 4:00 p.m. on March 24, 2015. Dr. Kurian recommended a neurology consult. Petitioner subsequently was examined by Dr. Mohan, a neurologist, during his hospital stay. Dr. Mohan dictated his report concerning his evaluation of Petitioner the night of March 25, 2015 at 8:46 p.m. Dr. Mohan notes that he obtained a history from Petitioner of back pain with a history of a back injury two weeks earlier where he works with a truck moving heavy objects. This is the first history documented in any of the medical records of an alleged work accident. It is not consistent with Petitioner's allegation of an alleged work accident about one month prior on February 27, 2015 nor is it detailed as to how the accident allegedly occurred. Petitioner was subsequently discharged from Holy Cross Hospital on February 26, 2015. He was prescribed medication and to follow up at Cook County Hospital the following Monday, which would be March 30, 2015 (RX 5).

Petitioner subsequently retained a lawyer and signed his Application for Adjustment of Claim on Saturday, March 28, 2015 (RX 9). Petitioner returned to Cook County Hospital on

Monday, March 30, 2015. Petitioner now gave a new history to personnel that his pain was precipitated by lifting heavy objects at work in a restaurant. Petitioner now also made a request for a referral to Gold Coast Orthopedics for therapy. He stated he wanted the referral as he had an appointment this same day.

Petitioner was also seen at Herron Medical Center on March 30, 2015. Petitioner now gave a detailed history of an alleged work accident on February 27, 2015, stating he was lifting a food cart and developed sudden and severe low back pain. Contrary to Petitioner's trial testimony that he promptly reported an alleged accident to management, Petitioner admitted in this medical history that he did not report the alleged accident until March 24, 2015. Petitioner was examined and diagnosed with disc abnormalities at the lower lumbar levels. He was prescribed medication and referred to a pain specialist. Contrary to Petitioner's allegations at trial, the Herron Medical Center physician noted in paragraph 11 of his treatment plan that Petitioner speaks fluent English (RX 8).

Petitioner has subsequently pursued treatment with multiple other providers which included Chicago Pain Center and Pain and Spine Institute. He eventually pursued evaluation and treatment with Dr. Sokolowski. Dr. Sokolowski has recommended low back surgery for Petitioner, which has not been performed to date.

At the request of Respondent, Petitioner has been examined by two physicians. He was evaluated by Dr. Kevin Walsh, an orthopedic surgeon, on May 28, 2015. He was examined by Dr. Andrew Zelby, a neurosurgeon, on July 25, 2016 (RX 3 and RX 7). Both doctors examined Petitioner and reviewed pertinent medical records. Both doctors concluded that Petitioner's back condition and need for treatment was unrelated to the alleged accident of February 27, 2015. The doctor's noted when Petitioner first developed complaints and sought treatment on several

occasions he specifically denied any accident or injury as the cause of his symptoms. Petitioner's history changed a month into his treatment and this revised history was inconsistent with the history Petitioner had initially provided over the course of his initial care and treatment. Dr. Zelby believed Petitioner was a candidate for microdiscectomy surgery, but stated that treatment of Petitioner's lumbar spine was not causally related to any alleged work accident.

CONCLUSIONS OF LAW

The Arbitrator finds Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment on February 27, 2015 and failed to prove his low back condition and need for medical treatment commencing March 4, 2015 is causally related to an alleged accident of February 27, 2015. The Arbitrator heard the testimony of Petitioner, Petitioner's sister-in-law, Respondent management witnesses and reviewed relevant medical records in evidence. The Arbitrator does not find Petitioner's testimony credible that he sustained accidental injuries as alleged on February 27, 2015. Petitioner's testimony is contradicted by the testimony of other witnesses and by the contemporaneous medical histories. The Arbitrator relies on the opinions of Dr. Walsh and Dr. Zelby that Petitioner's low back condition and need for medical treatment commencing in early March 2015 is unrelated to an alleged work accident of February 27, 2015. Petitioner failed to introduce any medical opinion evidence to support a causal connection between his low back condition and the accident alleged. The claim for compensation is denied. Having found that Petitioner failed to prove he sustained accidental injuries as alleged and failed to prove his condition of ill being is causally related to the accident alleged, all other issues are rendered moot.

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

Janet Kroeschel,

Petitioner,

vs.

NO: 15 WC 22310

Carlinville CUSD #1,

18IWCC0726

Respondent.

DECISION AND OPINION ON REMAND

This matter coming before the Commission on an order from the Circuit Court of Macoupin County dated December 8, 2017; the Commission being fully apprised in the premises, reverses its prior decision entered on April 3, 2017 as to the issue of accident pursuant to the directions of the circuit court order.

Procedural History

On July 21, 2016, this matter proceeded to arbitration before Arbitrator Douglas McCarthy on the following issues: 1) accident, 2) notice, 3) causal relationship, 4) medical expenses, and 5) permanent partial disability benefits. Arbitrator McCarthy issued his decision on August 9, 2016 finding Petitioner failed to prove she sustained an accident on February 19, 2015 which arose out and occurred in the course of her employment and found all other issues moot.

On September 1, 2016, Petitioner filed a timely Petition for Review before the Commission. Both parties filed briefs and presented oral arguments before the Commission on March 9, 2017. On April 3, 2017, the Commission pursuant to Section 19(e) of the Act unanimously affirmed and adopted the August 9, 2016 decision of the Arbitrator.

18IWCC0726

On April 10, 2017, Petitioner filed a timely review before the Circuit Court of Macoupin County. On December 8, 2017, the circuit court entered its order stating "The Commission decision is AGAINST the manifest weight of the evidence. Clerk to forward docket entry to attorneys of record." (Emphasis in the original). The circuit court provided no further explanation or directions in its remanding order to the Commission.

On December 20, 2017, Respondent filed a timely appeal to the Appellate Court, Fourth District. On January 24, 2018, the Appellate Court entered an order granting Appellee's (Petitioner) Motion to Dismiss and dismissed the appeal for lack of jurisdiction.

On January 25, 2018, Respondent filed a Motion for Dismissal of Review before the Commission. A hearing was conducted on June 6, 2018 before Commissioner Coppoletti in Springfield, Illinois. At the conclusion of the hearing, Commissioner Coppoletti denied Respondent's Motion citing *Noonan v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC, which holds the Commission is bound to follow the mandate of the circuit court. "Its frustration notwithstanding, the Commission could not simply ignore the circuit court's order. No matter how defective the circuit court's reasoning may have been, the Commission was charged with following the court's order, reversing the Commission and ordering it to award benefits." *Noonan* at ¶ 11.

Conclusions of Law

The Commission performed the function to which it is tasked; it weighed the competing evidence and found Petitioner failed to present sufficient evidence to prove a claim for repetitive trauma. With that said, the Commission is bound to follow the directive of the circuit court. The circuit court found the Commission's decision to be against the manifest weight of the evidence but failed to provide any reasoning, explanation, or instructions as how the Commission must now rule. As such, we do not wish to speculate regarding the circuit court's reasoning and, therefore, find as directed by the circuit court that Petitioner proved she sustained an accident which arose out of and in the course of her employment and a causal relationship exists between her current conditions of ill-being and her accident.

Given the findings made on accident and causal relationship, the Commission further finds Petitioner is entitled to medical expenses in the amount of $31,556.50 which are awarded pursuant to Sections 8 and 8.2 of the Act. Respondent is entitled to a credit for any amounts paid. The parties stipulated no temporary total disability benefits are owing. As such, no temporary total disability benefits are awarded.

Regarding nature and extent of Petitioner's permanent partial disability, pursuant to Section 8.1b of the Act, 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 the injury;

(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

The Commission weighs the factors as follows:

(i) AMA Impairment Rating - Neither party obtained an impairment rating, so no weight is assigned to this factor.

(ii) Occupation of Petitioner - Petitioner continues to work full duty as a head cook and nutrition director for Respondent. The Commission places significant weight on this factor as being indicative of reduced permanent disability.

(iii) Age of Petitioner - The Stipulation Sheet memorializes Petitioner was 49 years of age at the time her accidental injuries manifested. However, Petitioner's date of birth is September 8, 1964, and the manifestation date is February 19, 2015. Therefore, Petitioner was 50 years of age at the time her accidental injuries manifested. Petitioner has a minimal work life expectancy which will require her to manage the effects of her injury for a lesser period. The Commission finds this factor weighs in favor of reduced permanent disability.

(iv) Petitioner's Future Earning Capacity - There is no evidence of earning capacity contained in the record. The Commission places no weight on this factor.

(v) Evidence of Disability/Treating Records - Petitioner developed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. She underwent a right carpal tunnel release and release of the ulnar nerve at the right elbow on February 20, 2015. She underwent a release of the ulnar nerve at the left elbow and release of the left carpal tunnel on April 3, 2015. PX5. On her last visit with Dr. Greatting on December 21, 2015, Petitioner reported complaints of numbness and some weakness in her hands. She was working without restrictions. Dr. Greatting noted the November 5, 2015 EMG/NCV showed mild median neuropathy of the right wrist which was significantly improved; mild median neuropathy at the left wrist, mostly unchanged; no evidence of ulnar neuropathy at either elbow with resolution of the previously demonstrated right ulnar neuropathy; and no other abnormalities. Dr. Greatting opined based on the results of the EMG/NCV, he certainly did not think more surgery was indicated nor would it be helpful. Dr. Greatting opined Petitioner had reached maximum medical improvement, and she could continue working without restrictions. PX5. The Commission places significant weight on this factor as being indicative of reduced permanent disability.

Based upon the above numerated factors as well as the record taken as a whole, the Commission awards Petitioner permanent disability of 10% loss of use of the left hand, 10% loss of use of the right hand, as provided by §8(e)9 of the Act, and 10% loss of use of the left arm and 10% loss of use of the right arm, as provided by §8(e)10 of the Act.

18IWCC0726

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay the sum of $31,556.50 for reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $337.20 per week for a period of 25.3 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused the permanent loss of use of the right arm to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $337.20 per week for a period of 25.3 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused the permanent loss of use of the left arm to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $337.20 per week for a period of 19 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the permanent loss of use of the right hand to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $337.20 per week for a period of 19 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the permanent loss of use of the left hand to the extent of 10%.

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

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

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

NOV 30 2018

DATED:
LEC/maw
r10/24/18
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

VERONICA RAMIREZ,

Petitioner,

vs.

NO: 15 WC 1818

MILLENNIUM KNICKERBOCKER HOTEL,

18IWCC0727

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator concluded Petitioner sustained 17.5% loss of use of the right leg. The Commission agrees with the permanence determination but believes a more detailed explanation of the weight placed upon factors (ii), (iii), and (v) is necessary to satisfy the requirements of Section 8.1b. *820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner was a housekeeper/room attendant on the date of accident. Following her injury, Petitioner returned to that position but shortly thereafter transferred to laundry attendant. The crux of the dispute as to the significance of this fact is whether, as Petitioner asserts, she sought the transfer because of her knee complaints. Respondent argues Petitioner's credibility on why she requested the transfer was impeached by Rosa Monrel. The Commission finds Respondent's reliance on Ms. Monrel's testimony is misplaced. Ms. Monrel was asked if Petitioner told her why

she wanted the transfer, and Ms. Monrel recalled Petitioner said it would help her with taking her daughter to school. T. 61. On cross-examination, however, Ms. Monrel testified she did not remember the specific conversation and conceded she does not have a very clear memory of it at all. T. 66-67. Moreover, Petitioner testified in rebuttal and specifically denied telling Ms. Monrel the transfer was so she could take her daughter to school, and stated to the contrary, the later start time was problematic for her. Given Ms. Monrel's admittedly poor recollection of her conversation with Petitioner, the Commission finds Ms. Monrel's testimony is not persuasive.

Respondent further contends there is no evidence Petitioner could not return to her employment as a room attendant then notes, "by the petitioner's own admission, the laundry attendant position required more upper-body work than leg work." *Respondent's Statement of Exceptions*, p. 9. The upper-body focus of the laundry attendant position is a curious fact for Respondent to highlight given that it is consistent with Petitioner's transfer being predicated on easing the workload on her knee. As to the assertion there is no evidence of an inability to return to the room attendant position, the Commission finds this argument is incompatible with Dr. Westin's April 14, 2015 note. We first note Dr. Westin documented Petitioner's resumption of room attendant duties aggravated her knee: "I tried returning her to housekeeping and she did 2 days with 8 rooms a day. They then had her work full duty but it made her knee sore and even her back a little sore. An opportunity in the laundry department opened up that she took. She states the laundry job is not bothering her knee so much." PX1. The Commission further emphasizes Dr. Westin's discharge note reads, "She will do her regular activity in the laundry assignment." PX1. This is clear evidence of Petitioner's inability to return to her pre-injury room attendant position, and the Commission finds this weighs heavily in favor of increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 46 years old on the date of accident. The Commission observes Petitioner is still relatively young, has many work-years ahead of her, and will therefore have to deal with the effects of her injury for a longer period of time. The Commission finds these facts weigh in favor of increased permanence.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

After her injury, Petitioner underwent arthroscopic surgery followed by post-operative physical therapy. On April 14, 2015, Dr. Westin memorialized Petitioner's resumption of room attendant duties resulted in increased pain; documenting Petitioner had persistent soreness but full range of motion and no effusion or crepitus, Dr. Westin provided a pain medication refill and released Petitioner to work in the laundry department. PX1.

Petitioner continues to work for Respondent in the laundry department. This is a full-time position; she works eight hours per day, five days per week. Petitioner testified her knee swells and is painful every day at work; by the half-way point of her shift, her knee is starting to swell and bother her. T. 28. The doctor recommended she take Ibuprofen for the pain, and she takes that once or twice a day. T. 29. She also uses Icy Hot twice a day. T. 29. She explained she does not have to use ibuprofen or Icy Hot on days she is not working. T. 30. The Commission finds this factor indicative of increased permanence.

18IWCC0727

The Commission finds Petitioner sustained a 17.5% loss of use of the right leg pursuant to Section 8(e)12.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $531.92 per week for a period of 12 6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have credit of $6,383.90 for TTD benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $478.73 per week for a period of 37.625 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the 17.5% loss of use of the 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 $18,200.00. 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 30 2018

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC

O: 10.24.18

43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAMIREZ, VERONICA
Employee/Petitioner

Case# 15WC001818

MILLENIUM KNICKERBOCKER HOTEL
Employer/Respondent

18IWCC0727

On 10/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0233 DePAOLO ZADEIKIS & GORE
MARK A DePAOLO
309 W WASHINGTON ST SUITE 550
CHICAGO, IL 60606

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

18IWCC0727

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

Veronica Ramirez
Employee/Petitioner

v.

Millenium Knickerbocker Hotel
Employer/Respondent

Case # 15WC 01818

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **6/27/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/15/2014**, 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 $**41,489.76**; the average weekly wage was $**797.88**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent children.

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

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

Respondent is entitled to a credit of $**6,838.90** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**6,838.90**.

ORDER

Respondent shall pay Petitioner TTD benefits of $**531.92**/week for **12-6/7** weeks, for a period commencing on **11/19/2014** through **2/16/2015**, in accordance with Section 8(b) of the Act.

Respondent shall be given a credit in the amount of $**6,838.90** for TTD benefits paid to Petitioner.

Respondent shall pay Petitioner permanent partial disability benefits of $**478.73**/week for **37.63** weeks, because the injuries sustained caused a **17.5%** loss of use of the right leg, as provided in Section 8(e)12 of the Act.

Respondent shall pay benefits that have accrued since **4/14/2015**, and shall pay the remainder, if any, in weekly payments.

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

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

Signature of Arbitrator

10/9/2017
Date

OCT 11 2017

18IWCC0727

FINDINGS OF FACT

The petitioner was 46 years of age on the date of the accident, 9/15/14. She was employed as a housekeeper/room attendant by the respondent. Her duties included making beds, changing linens, vacuuming, and cleaning the tubs and showers. (Testimony of Petitioner)

On 9/15/14, the petitioner was finishing a room. She was in the process of getting down on her knees to look under the bed. She placed her hand on the bed and as she was kneeling down, her hand slipped off the bed which caused her right knee to strike the floor. In the process, she twisted the knee inward. (Testimony of Petitioner)

Over the next two days, the petitioner testified, she felt very bad, especially on the night of the accident. She could not move her right knee. It was very swollen. The petitioner testified that she went to the occupational clinic and told them what had happened. They gave her a knee brace and told her to return to light-duty work. (Testimony of Petitioner)

The records reflect that the petitioner was initially seen by Charles A. Cavallo, M.D., of Occupational Health Center of Illinois on 9/17/14. At that time, Dr. Cavallo apparently conducted a physical and diagnosed her with "Sprain Of Unspecified Site Of Knee And Leg." He dispensed prescription medication and instructed her to follow up in two days. He allowed her to return to work at modified duty. (Px #1, Record of Occupational Health Center)

The petitioner returned to Dr. Cavallo on 9/19/14. At that time, Dr. Cavallo apparently conducted a physical and diagnosed her with "Sprain Of Unspecified Site Of Knee And Leg." He allowed her to return to work at modified duty. He instructed her to follow up in four days. (Px #1, Record of Occupational Health Center)

The petitioner testified that when she went to the occupational clinic on 9/19/14, the doctor said she needed to get an MRI. He returned her to light-duty work with a knee brace. (Testimony of Petitioner)

The petitioner testified that on 10/5/14, she had MR images of her right knee taken, and then returned to the occupational clinic. On 10/6/14, she was told that they were going to send her to another kind of doctor. She saw Dr. Craig Westin on 10/21/14. (Testimony of Petitioner)

The first documented history of accident was made on 10/21/14. The handwritten history states the following: "Housekeeping Fell on flexed (R) Knee (+) pain next day swelling that night (-) prior." (Px #1, Record of Occupational Health Center)

The 10/21/14 record of orthopedic surgeon Craig Westin, M.D., confirms the handwritten history and indicates that pain in the knee is present both medially and laterally. She notices an occasional "jolt" while walking. She has symptoms most days. The MRI showed a tear of the posterior horn of the medial meniscus. The lateral meniscus is intact. The lateral patella showed low-grade chondromalacia. He further noted that the petitioner has not seen significant improvement in the last month. Dr. Westin opined that an arthroscopy is indicated. (Px #1, Record of Occupational Health Center)

The petitioner underwent the surgery at the Weiss Memorial Hospital on 11/19/14; the operating physician was Dr. Westin. Dr. Westin's pre-operative diagnosis was right knee torn medial meniscus. His post-operative diagnoses are as follow:

- Right knee torn medial meniscus;
- Hypertrophic medial synovial plica;
- Grade III chondrosis of proximal trochlea.

Dr. Westin performed the following procedures:

- Right knee arthroscopy, partial medial meniscectomy;
- Excision of medial synovial plica;
- Chondral shave debridement of proximal trochlea.

The petitioner followed up with Dr. Westin on 11/25/14. Dr. Westin prescribed physical therapy and instructed the petitioner to use a thermal compression device. (Px #2, Il. Bone & Joint; Weiss Hospital, Dr. Westin)

The petitioner attended physical therapy through February of 2015.

On 2/16/15, at the request of the respondent, the petitioner presented to orthopedic surgeon Nikhil Verma, M.D., of Midwest Orthopaedics at Rush, for a Section 12 exam. Dr. Verma reviewed all of the petitioner's medical records relative to the treatment she received for her right knee and x-rays of the knee. Dr. Verma performed a physical examination which he stated was normal and symmetric to her left knee. The petitioner reported tenderness on palpation. Dr. Verma stated that the x-rays were normal. (Rx #1)

Dr. Verma stated that the occurrence of 9/15/14, and the mechanism the petitioner described, caused the meniscal tear. Dr. Verma stated that the petitioner *did have a pre-existing condition of patellofemoral chondromalacia,* which, he opined, was contributing to the petitioner's current reported subjective complaints. Dr. Verma also stated that the *petitioner's weight was a mild factor in terms of her "slow recovery and persistent symptoms."* (Rx #1 emphasis added)

Dr. Verma stated that as of 2/16/15, the petitioner should continue the use of inflammatory medications, including Naprosyn, for four weeks, and continue work conditioning three times per week for four weeks. (Rx #1)

Dr. Verma opined that Petitioner should be able to return to work, full duty, in four weeks. He opined that the treatment that was rendered to the petitioner was reasonable and necessary and *causally related to the occurrence of 9/15/14.* Dr. Verma opined that the petitioner could return to work with restrictions, for four weeks, and then full duty. He opined that the petitioner would have no permanent limitations to her right leg based on the injury and medical procedures performed. (Rx #1, emphasis added)

On 3/3/15, the petitioner was seen by Dr. Westin. Dr. Westin noted that the petitioner was doing better; and she was still using Naprosyn. She *requested* a release to return to work, full duty. Dr. Westin's physical examination revealed trace effusion, no medial tibiofemoral pain, and mild medial patellofemoral tenderness. Dr. Westin instructed the petitioner to maintain her home exercise program. (Px #2, Record of 3/13/15, emphasis added)

The petitioner was last seen by Dr. Westin on 4/14/15. Dr. Westin released the petitioner from his care and released her to return to work, full duty. On physical examination, the petitioner had no effusion. She reported some soreness above the patella in the quadriceps tendon area. There was no crepitus and she had a full range of motion of the right knee. Dr. Westin instructed the petitioner to maintain the home exercise program despite the fact that "she does not appear too motivated to do home exercise." On this date, the petitioner told Dr. Westin that she intended to request a transfer from being a room attendant to the laundry room. Dr. Westin placed no restrictions on the petitioner's return to work. Dr. Westin's records do indicate "[s]he will do her regular activity in the laundry assignment." (Px #2, Medical record of 4/14/15)

The petitioner testified that when she returned to work her right knee was feeling "very bad." She testified that she requested the transfer to the laundry room because it was an easier job with greater use of her arms.

The petitioner testified that, presently, as she works in the laundry department for the respondent, she notices that her right knee swells up every day and hurts a lot. She notices that the knee begins to swell about 1:00 p.m. each workday. On her workdays, she takes 1-2 Ibuprofen a day for her knee pain, and applies ice twice a day to the knee. (Testimony of Petitioner)

The petitioner has not returned to Dr. Westin for treatment since 4/14/15 and has not sought any treatment from any other physicians for complaints with respect to her right knee since that date.

On cross-examination, the petitioner testified that when Dr. Westin discharged her, he did not say that she could return to a job that was less demanding than housekeeping. She has not seen Dr. Westin since 4/14/15. She has not received treatment for her right knee since 4/14/15. Since her release from care, she has worked consistently and has worked overtime hours, which she did before the accident. With regard to the "Internal Position Application," the petitioner testified that she asked someone what to write and she wrote that down on this application. The form is written in English. The petitioner knows a little bit of English. The petitioner testified that since 3/15 when she returned to work, she has not missed work due to her right knee, but has called off when she did not feel well. (Testimony of Petitioner)

The petitioner's post-occurrence wage statement, which sets forth her wages and hours from 3/2/15 through 6/5/17, shows that she consistently worked 5 to 6 days per week during that period. This statement or spreadsheet demonstrates that she worked at least 40 hours per week and often worked overtime hours; one time she worked as many as 31 overtime hours in one week. Ms. Janice Crane laid the foundation for the admission of such spreadsheet. (Rx #2, Veronica Ramirez Wage Statement, Ms. Crane's Testimony)

The respondent introduced into evidence the "Internal Position Application." The petitioner completed this application in order to transfer into the laundry room. The petitioner testified that she completed and signed the document, Respondent's Exhibit 3. Under the heading "Please list work experience related to position applying for and attach resume'," the petitioner wrote: "I like to work in the laundry washing, drying and folding towels, + duvets, changing chemical when needed. I enjoy working at a fast pace." Under the heading "Reason for Applying," the petitioner wrote: "It's an opportunity for me to try something different. I know I can get the work done." (Rx #3, Internal Position Application)

The Arbitrator notes that the petitioner did not write on the application that she was requesting this transfer due to problems with her right knee.

The respondent called Ms. Rosa Monreal as a witness. Ms. Monreal is, and was at all relevant times, the head of housekeeping for the respondent. When the petitioner requested the transfer, she was interviewed by Ms. Monreal. Ms. Monreal testified that when the petitioner requested the transfer, she stated that she wanted the position in the laundry room so that she could take her daughter to school before work. Ms. Monreal explained that as a housekeeper,the petitioner would have to start work at 8:00 a.m. However, as the laundry room attendant, she would not have to start work until 11 a.m. Ms. Monreal testified that the petitioner did not state, at any time during the interview, that she wanted the transfer because of the condition of her right knee. However, on cross-examination, Ms. Monreal had little, if any, actual recollection of the conversation. (Ms. Monreal's Testimony)

In rebuttal, the petitioner testified that on a day when she was cleaning the lobby, she saw a sign that said the respondent was looking for a laundry attendant. The petitioner asked for a transfer to the position of laundry attendant. Regarding such transfer, the petitioner did have a conversation with Ms. Monreal in Ms. Monreal's office. The petitioner denied that she mentioned her daughter's schedule as a reason for seeking such transfer. She told Ms. Monreal that she wanted to work as a laundry attendant because it is easier on her knee. When she cleans rooms, it is difficult to bend down. The petitioner further testified that she told Dr. Westin that she was moving from room attendant to laundry attendant. Dr. Westin told her that such a move was fine, and that if it was easier for her, that was good. On cross-examination, the petitioner testified that she did not ask for a note from Dr. Westin in which she would be released to the position of laundry attendant. Dr. Westin gave her a note in which he released her to her previous job. On 9/15/14, the petitioner's daughter was 16 years old and went to Phoenix Military School. (Petitioner's Testimony)

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's current condition of ill-being of her right leg is causally related to her accident of 9/15/14. In so finding, the Arbitrator relies upon the petitioner's testimony regarding the circumstances and onset of symptoms, the medical records that show she sought medical attention two days later, and the opinion by Dr. Verma that the petitioner's right knee condition was caused by the work accident. (Rx #1)

K. **WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD**

The parties have stipulated to Petitioner's lost time. Based upon the findings under causation, which are referred to, and incorporated by reference herein, the Arbitrator finds that Petitioner was temporarily and totally disabled for a period of 12-6/7 weeks, that is, from 11/19/14 to 2/16/15. The respondent is entitled to a credit in the amount of $6,838.90 for TTD benefits paid to the petitioner.

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

Pursuant to Section 8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, the following criteria are to be used in the determination of permanent partial disability:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals the petitioner was employed as a housekeeper/room attendant at the time of accident, and is currently employed as a laundry attendant for the respondent. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that the Petitioner was 46 years old at the time of the accident. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iv) of §8.1b(b), the Petitioner's future earnings capacity, the Arbitrator notes the record reveals that, post-accident, the petitioner has worked a fair number of overtime hours. However, the petitioner testified on cross that she worked overtime hours before the accident. Ms. Crane testified that as a laundry attendant, the petitioner can earn additional pay due to the biohazards of such work. Yet, Respondent's Exhibit #2 does not indicate additional biohazard pay. Therefore, the Arbitrator concludes that no quantifiable evidence was presented to indicate that the Petitioner's future earning capacity was affected by this accidental injury. The Arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the following:

At Dr. Westin's last appointment with the petitioner on 4/14/15, he wrote the following:

"Followup right knee medial meniscectomy 4 months postop. I tried returning her to housekeeping and she did 2 days with 8 rooms a day. They then had her work full duty but it made her knee sore and even her back a little sore. An opportunity in the laundry department opened up that she took. She states the laundry job is not bothering her knee so much.

On exam, the knee has no effusion. She describes some soreness above the patella in the quadriceps tendon area. No medial tibiofemoral tenderness. There is no crepitus of the knee. Range of motion is full.

IMPRESSION: Right knee medial meniscectomy.

She does not appear too motivated to do home exercises. I again reviewed this with her along with the help of Karina. I showed her how to do some core strengthening and hamstring stretching especially in view of her mid low back pain, right at the level of the tattoo in the midline with no spinous process tenderness. Leg raise is negative, so I am not concerned about neurologic symptoms. At this point, I will release her from

care. She will do her regular activity in the laundry assignment. Continue independent exercises to (sic) at least a month. Naproxen, refilled, p.r.n., Discharged from care. Follow up if problems occur. (Px #1, Record of Occupational Health Center)

Determination of permanent partial disability ("PPD") is not simply a calculation, but an evaluation of the five factors. The Arbitrator has carefully considered all five factors. By applying §8.1b and by considering the relevance and weight of all five factors, the Arbitrator finds that as a result of the 9/15/14 accident, the petitioner has sustained a permanent loss of use of her right leg to the extent of 17.5%, pursuant to Section 8(e) of the Act.

Brian T. Cronin — 10-9-2017

Brian T. Cronin
Arbitrator

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIKYYA BRIDGEMAN,

Petitioner,

vs.

NO: 12 WC 00978

SHAPIRO DEVELOPMENTAL CENTER,

18IWCC0728

Respondent.

DECISION AND OPINION ON REVIEW

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

Accident

An injury "arises out of" employment when "the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E. 2d 665 (2003). To determine whether a claimant's injury arose out of his employment, "we must first determine the type of risk to which he was exposed." *Baldwin v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 472, 478, 949 N.E.2d 1151 (2011). There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated

with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed. *Springfield Urban League v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 120219WC, ¶27, 990 N.E.2d 284. Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute v. Industrial Commission*, 314 Ill. App. 3d 149, 163, 731 N.E.2d 795 (2000). Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Commission*, 407 Ill. App. 3d 1010, 1014, 944 N.E.2d 800 (2011).

Employing a neutral risk analysis and finding Petitioner was exposed to an increased risk, the Arbitrator concluded Petitioner sustained an accidental injury arising out of her employment. Relying on *Caterpillar Tractor v. Industrial Commission*, 129 Ill. 2d 52 (1989), Respondent argues Petitioner's act of "stepp[ing] into the van at Shapiro" was no different than getting into any vehicle, and she, therefore, was not exposed to a risk to a greater degree than the general public. Resolution of this issue depends on whether the Commission concludes the maneuvers required of Petitioner to get into Respondent's van is equivalent to and indistinguishable from the normal activity of getting into a vehicle. The Commission agrees with the Arbitrator and concludes there is a significant qualitative difference.

Initially, a clear picture of Petitioner's stature is important. Petitioner is 5'3"; although Petitioner testified she believed she weighed 250 pounds on the date of the accident, the November 8, 2011 medical record evidences she actually weighed 270 pounds. PX2. This diminutive person with a Rubenesque physique was directed to drive the Unit 4 van back to the unit. To do so, she obviously had to get in the van. Significantly, Respondent's van is not a standard passenger van chassis but rather a specialized commercial vehicle. A photograph of the van establishes the distance between the ground and the bottom of the frame is 17 inches, and the door-well step is four inches higher, meaning anyone entering the van must step up 21 inches (PX8), yet Respondent's van had no hand grips or handles to assist with climbing that distance. Petitioner credibly explained when she operated Respondent's van in the past, other staff members helped her climb in. T. 33. On November 3, 2011, however, no one was available to assist her, so she had to hoist herself into the van; she testified she stepped on the door frame and was awkwardly pulling herself up and across the driver's seat when her foot slipped, and she injured her knee. Contrary to Respondent's argument, Petitioner did not, and in fact could not, simply "step into the van."

Moreover, the Commission finds there is no relevance to the fact Petitioner owned a SUV. First, Petitioner owned a sedan when the accident occurred, and it was not until some point thereafter she obtained the Durango. More importantly, though, Petitioner clearly testified her Durango had both a "very low step" and handles which she used to enter and exit the vehicle (T. 30), features Respondent's van did not have.

18IWCC0728

The Commission finds the contortions Petitioner was required to perform because Respondent's van lacked standard features constitute a qualitatively increased risk. We affirm the Arbitrator's finding that Petitioner sustained an accidental injury arising out of her employment.

Temporary Disability

The Arbitrator awarded Temporary Total Disability benefits from November 4, 2011 through March 19, 2013, and maintenance benefits from March 20, 2013 through June 12, 2017, the date of the arbitration hearing. The Commission affirms the TTD award as Petitioner reached maximum medical improvement as of March 19, 2013, her last visit with Dr. Verghese. See *Mechanical Devices v. Industrial Commission (Johnson)*, 344 Ill. App. 3d 752, 760, 800 N.E.2d 819 (2003) ("The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized. [citations omitted]."). However, for the reasons set forth below, we vacate the award of maintenance benefits.

By its own terms, the Act grants maintenance benefits only while a claimant is engaged in a rehabilitation program; if the claimant is not engaged in some type of "rehabilitation" such as physical rehabilitation, formal job training, or a self-directed job search, there is no obligation to provide maintenance. *Greaney v. Industrial Commission*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331 (2005); see also, *W.B. Olson v. Illinois Workers' Compensation Commission*, 2012 IL App (1st) 113129WC, ¶39, 981 N.E.2d 25 (An employer is obligated to pay maintenance benefits only "while a claimant is engaged in" a rehabilitation program.) It is uncontroverted that Petitioner has not and is not engaged in a vocational rehabilitation program; to the contrary, Petitioner testified she remains an employee of the State of Illinois, continuing to receive temporary disability leave benefits and accumulate pension credits, and she wishes to maintain her employment. As such, there was no vocational rehabilitation to trigger the concomitant maintenance benefits. Further, while the Commission is cognizant that Petitioner continues to see Dr. Didwania on a monthly basis for medication management, we do not find prescription monitoring rises to the level of physical rehabilitation as contemplated by Section 8(a). Therefore, the Commission finds Petitioner is not entitled to maintenance under Section 8(a) and vacates the award of maintenance benefits.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 13, 2017, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $510.61 per week for a period of 71 5/7 weeks, representing November 4, 2011 through March 19, 2013, 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 the award of maintenance benefits from March 20, 2013 through June 12, 2017 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's right knee injury pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims from any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review. *820 ILCS 305/19(f)(1)*.

DATED: NOV 30 2018

L. Elizabeth Coppoletti

LEC/mck

O: 10/3/18

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

BRIDGEMAN, MIKYYA
Employee/Petitioner

Case# **12WC000978**

SHAPIRO DEVELOPMENTAL
Employer/Respondent

18IWCC0728

On 7/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2208 CAPRON & AVGERINOS PC
STEPHEN J SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

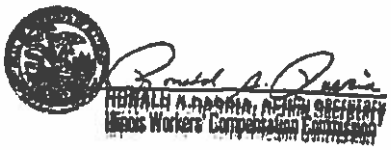
5782 ASSISTANT ATTORNEY GENERAL
KELLY KAMSTRA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

JUL 13 2017



18IWCC0728

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION
19(b)

Mikyya Bridgeman
Employee/Petitioner

v.

Shapiro Developmental
Employer/Respondent

Case # 12 WC 978

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **June 12, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 3, 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 **$39,827.84**; the average weekly wage was **$765.92**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **3** dependent children.

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

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

Respondent is entitled to a credit of **$18,818.92** under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $510.61 per week for 71-5/7 weeks commencing November 4, 2011 through March 19, 2013 as provided in Section 8(a) of the Act.
- Respondent shall pay Petitioner maintenance benefits of $510.61 per week for 220-6/7 weeks commencing March 20, 2013 through June 12, 2017 as provided in Section 8(a) of the Act.
- Respondent shall pay Petitioner the reasonable, necessary and causally related medical services incurred in the care and treatment of her right knee injury pursuant to Sections 8 and 8.2 of the Act. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims from any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Carolyn M. Doherty

Signature of Arbitrator

7/12/17

Date

JUL 13 2017

FINDINGS OF FACT

At trial, the 32 year old Petitioner testified that she was employed by the Respondent as a mental health technician. Petitioner had been so employed since 2000. Her primary job duties consisted of working with developmentally disabled individuals at the center assisting them with various activities of daily living including patient lifting, bathing, dressing and behavior control. Petitioner's duties also required her to bend and crouch while physically handling patients and performing CPR at floor level. On occasion, she would escort the residents on outings off the premises for short trips as part of her job duties. Petitioner testified that she would take patients on these off premises trips once per month and that she was only rarely the driver of the van used for the trips. Petitioner testified that prior to the subject accident, she was in good health with no medical condition to her right knee.

On November 3, 2011, Petitioner was directed to transport certain of the individuals offsite utilizing a van recently purchased by the Respondent. On this occasion, Petitioner was the driver of the van. She testified that she had driven the van on only two occasions prior to this trip. Photographs of the van in question are depicted in Petitioner's Exhibits 7 and 8. Upon returning to the facility, the Petitioner was directed to return the van back to its original parking slot located at the center. At that time, Petitioner testified she was approximately 5 foot 3 inches tall and weighed approximately 250 pounds. In order to access the driver's seat of the van, it was necessary for the Petitioner to grab the steering wheel with her left hand, the far side of the driver's seat with her right hand and position her right leg on the step all the while attempting to pull herself up into the vehicle. She testified that the step on the van was approximately 18 inches from the ground. PX 8. She described her positioning such that her torso was half way across the seat with her head facing towards the middle console. While attempting to enter the van in this fashion, her right foot slipped causing her right leg to go left and her body to turn to the right. She experienced a popping sensation and felt pain in her right knee at that time. She testified that it may have been raining that day.

Petitioner could not get out of the van alone so a supervisor called for an ambulance. Petitioner was transported to St. Mary's Hospital (P.X. 5) where a CT scan was indicative of a potential meniscal tear with cartilage irregularity noted along the central weight bearing lateral femoral condyle along the patellar apex. Petitioner was discharged and subsequently followed up with Dr. George Verghese, an orthopedic surgeon who had treated her for a previous left knee condition. (P.X. 2)

Dr. Verghese first examined the Petitioner on November 8, 2011 and prescribed an MRI and subsequently a CT arthrogram. (P.X. 2, pg. 12) She was diagnosed with knee joint pain, a varus strain and prescribed medication. Dr. Verghese noted "this condition occurred following an injury to her right knee while at work when she slipped and fell on 11/3/11." PX 2, p. 6. He recommended an MRI of the right knee and that Petitioner should remain in the knee immobilizer and kept Petitioner off work. The MRI of 11/22/11 indicated a possible meniscal tear but noted that evaluation was limited and recommended a CT arthrography for further evaluation which was prescribed by Dr. Verghese on 11/29/11. The CT showed diminished medial meniscus without evidence of a discrete tear likely related to degenerative type changes. Cartilage irregularity noted along the central weight bearing lateral femoral condyle and long the patellar apex." On 12/9/11, Dr. Verghese ordered a bone scan which showed mild degenerative uptake in the patella. At the visit of 12/22/11, Dr. Verghese prescribed physical therapy which commenced on December 22, 2011 at River Valley Physical Therapy. (P.X. 3) He also recommended an injection to the right knee after physical therapy. He noted that her claim had been denied by Workers' Comp stating "and I see no objective evidence of any other serious injury to

prevent rehabilitation." He recommended Petitioner "get on with physical therapy to rehabilitate herself." PX 2, p. 20.

On January 3, 2012, Dr. Verghese noted again that the condition occurred following a specific injury in November 2011. He noted the right knee pain continued and Petitioner was ambulating with crutches. At that visit, he noted that Petitioner was to continue with physical therapy and that if she did not significantly improve he would recommended sending Petitioner to a pain management physician noting "... since I do not have any objective musculoskeletal signs of injury." PX 2, p. 23. As of January 17, 2012, Dr. Verghese's diagnosis was noted to be chondromalacia of the right patella necessitating continued PT and home exercise. (P.X. 2, pg. 25) On 2/9/12, Dr. Verghese noted that Petitioner should continue exercises and an icing program. His exam of the right knee revealed no effusion, no tenderness from rotation, negligible pain and tenderness from patellofemoral compression, no lateral joint line tenderness and "grimaces a lot but was able to do almost 15 straight leg raises in my office." PX 2, p. 27. Petitioner was advised to continue nonsteroidal medication. Dr. Verghese then noted, "since this is not a work related injury, although she is capable of a sitting job with minimal waking on level ground only, I will give her permission to stay off work for the next 4 weeks until the next follow-up appointment." PX 2, p. 27.

On March 8, 2012, Petitioner reported that she had been doing physical therapy but could only do 20 straight leg raises and had continued difficulty with weight bearing. Dr. Verghese noted, "she is at risk of reinjury if she goes back to unprotected duties and since this is not a work related injury, and it will not help back with restricted duties at work." As of May 3, 2012, Dr. Verghese felt that her symptoms had improved and physical therapy was discontinued as her condition had plateaued. In light of the improvement and potential response, Dr. Verghese prescribed and performed injections of cortisone and local anesthetic to the knee and his office note of that date reflects he had tried everything else in an attempt to improve her condition. (P.X. 2, pg. 34) On May 3, 2012, Dr. Verghese released Petitioner to restricted duty work of no ground level work and no kneeling or squatting. PX 2, p. 76.

On June 7, 2012, Dr. Verghese noted that the knee had "much improved" since the injections. He noted that overall her condition had improved but that "I am still very guarded about the prognosis because of the extremely symptomatic suprapectoral overlay she had previously. However, she may continue with a home exercise program." Petitioner was told to follow up in 4 weeks or earlier if necessary.

As of July 5, 2012, it was noted her range of motion had not increased significantly and her knee was still painful. Petitioner reported that she could walk up to 2 miles per day before she felt sore enough to rest. Dr. Verghese felt that she had plateaued yet he would still ideally like to see an increase range of motion in her right knee. He was reluctant to initiate therapy again and felt she was a poor candidate for surgical intervention owing to her supratentoral overlay. (P.X. 2, pg. 33) As of August 6, 2012 it was noted that she was tolerating walking better but could not run and cannot kneel as is required to perform CPR as part of her job requirements. (P.X. 2, pg. 49). He noted that Petitioner appeared to be making little progress after a long rehab process and that most of her symptoms remained subjective. He recommended Petitioner undergo an FCE for a more objective status of her disability and then continue with work conditioning if appropriate. PX 2, p. 41. On October 4, 2012, Dr. Verghese issued a light duty work status of "maximum single lifting limit of 20 lbs, on an occasional basis not to exceed 2/3 of a normal 8 hour work day, and a more frequent lift and/or carry of up to 10 lbs, not to exceed 1/3 of a normal 8 hour work day." PX 2, p. 78.

On February 19, 2013, Dr. Verghese again released the Petitioner to return to work light duty with no kneeling or climbing of stairs and noted that her prognosis was guarded. (P.X. 2, pg. 84) The Petitioner was last examined by Dr. Verghese on March 19, 2013. It was noted she was diagnosed with chondromalacia in the right and left knee and was continuing to do exercises with minimal improvement. The FCE prescribed by Dr. Verghese was never performed as according to Petitioner, it was not authorized by the Respondent. (P.X.2, pg. 64). At this last visit, Dr. Verghese noted that he was unable to make an objective assessment of disability and make work recommendations without an FCE. He continued Petitioner on light duty until further recommendations on work ability could be made. PX 2, p. 65.

In addition to Dr. Verghese, the Petitioner has been periodically examined by her primary care physician, Dr. Suresh Didwania for the subject injuries. (P.X. 1) Dr. Didwania initially was responsible for the administration of her medication and thereafter would evaluate her knee in conjunction with the disability examinations required by the State of Illinois. (P.X. 9) Dr. Didwania had released the Petitioner to sedentary work only and limited her ability to climb, bend, stoop and lift. (P.X. 9)

The Petitioner testified that due to the Respondent's policy, she was not allowed to return to work until receiving a full duty release from her treating physician which never occurred. At no time did the Respondent offer her light duty work which accommodated her restrictions. Petitioner testified that she continues to be formally employed by the State of Illinois and since the accident has received non-occupational temporary disability benefits and maintained her health insurance which has paid for certain of the medical treatment as addressed herein. Petitioner continues to accrue pension credits given her employment status and she desires to return to work with the State of Illinois if at all possible.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to ("C"), did an accident occur that arose out of and in the course of Petitioner's employment by the Respondent, the Arbitrator finds the following facts:

Petitioner's primary job duties consisted of assisting disabled individuals at the Shapiro Development Center inside the facility. On rare occasions, she was asked to accompany the individuals when they left the facility to go on offsite excursions. The Respondent provided the Petitioner and her coworkers with a van for offsite transportation which is depicted in Petitioner's Exhibits 7 and 8. Petitioner testified this van had been recently purchased and she had minimal experience operating the van.

The photographs of the van as depicted in Petitioner's Exhibit 7 reveals there were no hand rails or straps which could be utilized by the Petitioner in attempting to enter the vehicle. Petitioner's Exhibit 8 confirms that the initial step up into the van was approximately 18 inches off the ground. The Petitioner is 5'3" inches tall and weighed approximately 250 pounds. According to Petitioner's testimony, she literally had to pull herself up by the steering wheel and front seat in order to access the driver's side of the vehicle. Given the configuration of the van, the Petitioner's lack of height and the maneuvers necessary for her to access the vehicle, the Arbitrator finds that she was exposed to an increased risk as compared to members of the general public. Furthermore, the Petitioner was in the act of performing her job duties in furtherance of the employer's business at the time she sustained the injury to her right knee. Accordingly, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment by the Respondent.

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 the following facts:

Immediately following the accident, the Petitioner experienced severe pain in her right knee necessitating transportation to the emergency room via ambulance. Thereafter, she came under the care of Dr. George Verghese who instituted treatment on November 8, 2011. (P.X. 2, pg. 6) On that date, he removed her from work pending diagnostic testing with a diagnosis of right knee joint pain status post trauma. Dr. Verghese's initial records reflect a fall at work resulting in injury to the right knee on November 11, 2011. The Arbitrator notes that Dr. Verghese subsequently refers to the condition as non work-related on two occasions in his records. However, given the numerous references to Petitioner's right knee injury following a 11/3/13 fall at work contained in the records, the Arbitrator attributes these comments to Dr. Verghese's knowledge that the claim had been denied and was not being treated as a work related claim by Respondent. Despite Dr. Verghese noting that Petitioner's complaints were subjective in his records, Dr. Verghese continued to regularly and consistently Petitioner until he felt her condition plateaued and ordered an FCE which was never approved. Dr. Verghese did not modify his off work recommendation until May 3, 2012 when he imposed light duty restrictions. At the last visit on March 19, 2013, he once again released her to work with light duty restrictions, recommending an FCE for further work ability determination and noting that her prognosis was guarded. (P.X. 2, pg. 66). Petitioner has not returned to Dr. Verghese or sought any additional care since March 19, 2013.

Petitioner has also undergone treatment under Dr. Didwania, her primary care physician. Dr. Didwania's first examined her on November 18, 2011 wherein it was noted she was following up for severe pain and discomfort of her right knee. The Petitioner testified that Dr. Didwania continues to treat her for the subject knee by conducting periodic examinations in completing disability confirmation reports as requested by the Respondent. (P.X. 9) The Petitioner testified that at no time subsequent to November 3, 2011 did she sustain any trauma to her right knee. The medical evidence as established herein reflects that the Petitioner has continued to treat continuously since the date of accident until the present for the right knee condition arising from the subject accident. There is no contrary medical opinion in evidence. Accordingly, the Arbitrator finds that the Petitioner's condition of ill-being is causally related to the injury.

In support of the Arbitrator's decision relating to ("J"), were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses, including out of pocket expenses, incurred in the care and treatment of her right knee injury pursuant to Sections 8 and 8.2 of the Act. PX 6. Respondent shall be given a credit for all medical benefits that have been paid by Petitioner's group insurance and Respondent shall hold Petitioner harmless from any claims from any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of the Arbitrator's decision relating to ("L"), what temporary benefits are in dispute, temporary total disability and maintenance, the Arbitrator finds the following facts:

Following the subject accident, the Petitioner came under the care of Dr. Verghese who immediately removed her from work. (P.X. 2, pg. 87) Dr. Verghese instituted a course of physical therapy and injections which resulted in slight improvement of the Petitioner's condition in her right knee. On May 3, 2012, Dr. Verghese noted that the while she had improved with physical therapy, she continued to experience pain in her right knee

and it appeared her condition had plateaued. (P.X. 2, pg. 42) At that time, he released her to return to work subject to restrictions of ground level work only and no kneeling or squatting. (P.X. 2, pg. 76) Petitioner testified that the Respondent was unable to accommodate any restrictions and would only allow her to return to work with a full duty release. Thereafter, the Petitioner continued to seek treatment with Dr. Verghese and Dr. Didwania through 2013. At no time was the Petitioner released to return to work full duty and as of the date of the hearing, Petitioner was waiting for the recommended FCE authorization to determine further restrictions or work ability, while still under light duty restrictions.

The medical evidence established that the Plaintiff was completely restricted from performing her job duties following the date of the accident through May 3, 2012 when she was released subject to light duty restrictions which were not accommodated. Petitioner was prescribed an FCE on several occasions which Dr. Verghese indicated was necessary to determine work ability as of the last visit on March 19, 2013 and the FCE has not been authorized. The evidence further established that the Respondent has not terminated the Petitioner's employment, continued her health benefits, accrual of pension credits and paid temporary disability benefits pursuant to a non-occupational injury policy. As of the date of the hearing, the Petitioner remains an employee of the Respondent and no FCE and/or vocational rehabilitation program has been offered by the Respondent based on its denial of the claim. The evidence further established that the Petitioner will remain in this status with the Respondent until such time as she is released full duty.

Accordingly, the Arbitrator finds that the Petitioner was temporarily totally disabled for the period November 4, 2011 through March 19, 2013, pending an FCE to determine further restrictions or work ability. Further, Petitioner is entitled to payment of maintenance benefits commencing March 20, 2013 through the date of hearing on June 12, 2017.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Afi Ogoubi,
Petitioner,

vs. No. 14 WC 13338

18IWCC0729

Tyson Foods, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses and prospective 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).*

Petitioner testified via a French interpreter that on March 27, 2013, she worked as a "fat picker" for Respondent Tyson Foods. Her duties included monitoring conveyor lines moving pieces of meat from which she removed fat and bones. That day, a machine had broken down. When it came back on line, a lot of meat came out. Petitioner stopped the meat with her right hand, while pulling back with her left hand, "using her neck." She felt a sudden pain in the right side of her neck. Petitioner stopped the machine and called her supervisor.

18IWCC0729

Petitioner testified she felt pain from the right side of her neck to her shoulder, down her arm, and into her right ribs and back. Her supervisor referred her to the company nurse, who gave her ice and pain pills. Although Petitioner claimed she or her employer filled out an incident report which indicated that she had radiating pain, no such report was offered into evidence. Respondent referred Petitioner to the company's doctors, who prescribed medication and four weeks of physical therapy. During this time, Petitioner continued working light duty.

Following a 7-month gap in treatment, Petitioner, who lives in Moline, IL, commenced medical treatment with doctors at Michigan Avenue Associates in Chicago. Dr. David Schafer examined her and ordered an MRI. Dr. Neeraj Jain examined her and prescribed medication. Petitioner testified that two of her doctors suggested surgery, which she now wishes to undergo. Petitioner testified she has pain in her neck which radiates to her right shoulder, goes down her arm and to her right side and back. She still works for Tyson, but experiences pain every day.

On cross-examination, Petitioner admitted she had not seen any other doctors for her condition since late 2014 or early 2015. She had no appointments scheduled for cervical spine or shoulder treatment. She was not taking prescription pain medications; only occasional ibuprofen. She admitted that the job she was performing at the time of her injury was considered a light duty position.

Petitioner expressly denied having any neck injuries, pain or treatment prior to March 27, 2013. After being shown medical records indicating she had, Petitioner admitted involvement in a 2007 car accident and acknowledged reporting cervical pain to treaters at Genesis Health Systems. However, Petitioner specifically denied being involved in a second car accident in 2008, even after being shown an EMS report which documented her complaints of neck and shoulder pain following a 30 mph rear-end accident on October 24, 2008. Petitioner was also shown a medical record showing that a cervical CT scan was ordered for her following a, "MVA, c/o posterior neck pain/stiffness." Petitioner admitted that she neglected to tell Drs. Erickson, Jain or Schafer that she had received prior treatment to her neck and shoulders.

Petitioner denied receiving a settlement from State Farm for an October 24, 2008 injury, even after being shown documents suggesting she did. Only when the Arbitrator offered Petitioner's counsel the opportunity to go off the record to talk to Petitioner, did Petitioner finally admit she had been involved in a 2008 car accident, for which she received treatment to her cervical spine and shoulder. Respondent's Exhibit D documented the treatment Petitioner received following that 2008 car accident, and included a letter from State Farm Insurance addressed to Petitioner, confirming a personal injury settlement she purportedly entered into.

The Commission finds the only injuries Petitioner proved to be causally related to her March 27, 2013 work accident were cervical, right trapezius and right shoulder sprains. In so finding, the Commission relies on the reports and conclusions of Petitioner's treaters at Respondent's Health Service Department. Those providers treated Petitioner for six months following her work accident, through September 16, 2013. Dr. Clem's diagnoses were a right trapezius and shoulder sprain. Although Petitioner did complain of cervical pain on May 6, 2013, her cervical spine range of motion on that date was normal and most of her tenderness was over her trapezius/right scapular area. Notably, Petitioner had no complaints of radiating arm pain until

she saw Dr. Schafer in April 2014, over one year after her accident. During that period and through arbitration, Petitioner missed no time from work.

On July 31, 2013, Dr. Clem found Petitioner to be at MMI; he wrote that he expected her to have no disability as a result of her work accident. Dr. Brower also found Petitioner to be at MMI when he examined her on September 16, 2013.

The Commission find the opinions of Dr. Erickson unpersuasive. At his first exam of Petitioner on June 27, 2014, Dr. Erickson recommended she undergo an anterior cervical discectomy and fusion, reporting that she suffered from bilateral C6 radiculopathy caused by a herniated cervical disc. Although Dr. Erickson opined Petitioner's radiculopathy and cervical disc were caused by her work activities, he admitted he had not reviewed or considered any of Petitioner's medical records from before or after her work accident. Instead, Dr. Erickson relied upon the history Petitioner gave to him, which omitted mention of her 2007 and 2008 auto accidents and treatment. Dr. Erickson believed Petitioner's right arm pain began suddenly after her work accident, based upon her history to him that "soon after" it, she began experiencing pain in her right arm and right-hand weakness.

Dr. Erickson's opinions were inconsistent with those of Dr. Jain. Dr. Jain did not recommend fusion surgery; only medications, physical therapy and cervical injections. And even though Dr. Erickson acknowledged an injury date of March 27, 2013, he seemed to attribute Petitioner's cervical radiculopathy to her repetitive work activities, even testifying Petitioner, "did not have a distinct accident."

The Commission finds Dr. Jain's opinions unpersuasive for similar reasons. Dr. Jain did not review Petitioner's job description or any of her medical records prior to Dr. Schafer's April 9, 2014 report. He was not made aware of Petitioner's prior cervical and shoulder injuries. He did not recommend surgery to Petitioner, and following both of his exams, he agreed with Petitioner's request to be released to full duty work. Dr. Jain's opinions are not reliable because he based them on Petitioner's incomplete and inaccurate medical history.

The Commission finds Dr. Goldberg's opinions, following his July 14, 2014 Section 12 examination support the Commission's findings that there is no causal connection between Petitioner's work accident and her radiating right arm pain, because it did not develop until over one year after her accident.

Dr. Goldberg personally reviewed Petitioner's April 9, 2014 cervical MRI and found it to be normal, with only a minimal bulge at C5-6 and no evidence of stenosis, herniation or nerve compression. Dr. Goldberg explained why he considered Petitioner's bulging C5-6 disc to be a normal variant and not pathological: it did not result in any narrowing of the neuro elements. He also explained why he did not believe Petitioner was a candidate for spine surgery: because she reported no cervical pain at his exam and because her MRI showed no neurocompression. He diagnosed Petitioner with a cervical strain.

18IWCC0729

Because the Commission finds Petitioner's cervical, right trapezius and right shoulder strains caused by her March 27, 2013 accident were completely resolved in 2013, and that her cervical problems for which she received treatment commencing in 2014 were not causally related to her work injury, the Commission reverses the Arbitrator's award of all medical expenses in 2014 and thereafter. The Commission also reverses the award of prospective medical care.

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

IT IS FURTHER ORDERED BY THE COMMISSION that the awards of medical expenses and prospective medical care are reversed.

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.

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 30 2018

o-10/03/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OGOUBI, AFI
Employee/Petitioner

Case# **14WC013338**

TYSON FOODS INC
Employer/Respondent

18IWCC0729

On 3/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5271 LEADERS LAW CENTER
OWOLABI ALABA
30 E ADAMS ST SUITE 400
CHICAGO, IL 60603

2542 BRYCE DOWNEY & LENKOV LLC
MAITAL B SAVIN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

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

Afi Ogoubi
Employee/Petitioner

v.

Tyson Foods, Inc.
Employer/Respondent

18IWCC0729

Case # 14 WC 13338

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **4/5/16**. 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 **Is Petitioner entitled to prospective medical care?**

18IWCC0729

FINDINGS

On **3/27/13**, 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 **$24,830.05**; the average weekly wage was **$551.78**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **2** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $20,558.76, as set forth in PX 5, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Erickson and Dr. Jain, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

3/10/17
Date

ICArbDec p. 2

MAR 20 2017

At the outset the Arbitrator notes that the request for hearing form indicates that nature and extent of the injury is in dispute and does not indicate that Petitioner is seeking prospective medical care. During the course of the hearing, however it became apparent that additional medical care has been recommended and that Petitioner wishes to undergo that additional treatment. The Arbitrator notes that Petitioner speaks French and testified through an interpreter.

FINDINGS OF FACT

On 3/27/13, Petitioner was employed by Respondent as a Fat Picker. Her job duties entailed removing fat from meat. There are two conveyor belts which Petitioner had to monitor. One of the conveyor belts is higher than the other. The conveyor belts carry the meat to Petitioner from her left to her right. She will pull the fat and bone from the meat and discard it to her left, as the meat continues to the right. Petitioner must simultaneously monitor the two conveyor belts. Petitioner testified she has to constantly turn her head from left to right and back to monitor the meat coming and going on the belts. This movement is done continuously during her entire shift, with the exception of lunch and break periods. If meat begins to come to her too quickly Petitioner must use her arms to hold the meat back.

On 3/27/13, a machine had been broken and was down for repair. Once the machine began working, a lot of meat came through the conveyer belt. While trying to stop the meat which was coming from her left with her hands she suddenly began experiencing pain. The pain began in her right neck and shoulder. She ultimately began experiencing symptoms down her arm as well as into her thorax, back and abdomen. There is no dispute that Petitioner reported the accident to her supervisor, who referred her to Respondent's Health Services Department.

The Arbitrator notes that Petitioner denied having any neck injuries or treatment prior to 3/27/13. However Respondent produced Records from Genesis Health System which indicate Petitioner was involved in an 11/22/07 motor vehicle accident resulting in neck pain, among other complaints as well as a 10/24/08 motor vehicle accident which resulted in neck and shoulder pain. Diagnostic studies done following those accidents were all negative. While Petitioner was somewhat evasive in testifying regarding the motor vehicle accidents it also appeared there was some degree of confusion resulting from the translation process. Significantly, there is no evidence to indicate any ongoing neck or shoulder symptoms or treatment between October of 2008 and the date of accident.

On the day of the accident Petitioner presented to Respondent's Health Services Department (HSD), complaining of right neck, trapezius and rib pain. She followed up with Dr. Gregory E. Clem in Respondent's Clinic on 4/29/13, reporting right shoulder pain. Dr. Clem assessed a right trapezius and shoulder strain, recommended medication and provided work restrictions. On 5/6/13, Petitioner presented to Dr. Jeff Brower in Respondent's Clinic, pain in the right lateral neck and trapezius. Petitioner reported pain with cervical rotation. Dr. Brower recommended medication and ordered Petitioner to begin physical therapy. Dr. Brower continued to provide the same work restrictions. On 6/17/13 Petitioner returned to Dr. Clem with complaints over the right trapezius, right scapular area and cervical spine. Dr. Clem recommended medication, physical therapy and x-rays of the cervical spine. Dr. Clem continued to provide the same work restrictions of no pulling lean off fat.

On 6/19/13 w-rays of the cervical spine and shoulder were taken and read as negative. On 7/1/13, Petitioner returned to Dr. Clem. Tenderness over the right scapular area was noted. Dr. Clem assessed right trapezius shoulder pain, much improved. Dr. Clem found Petitioner to be at MMI and did not provide work restrictions. Petitioner returned to Dr. Clem on 7/19/13 after completing a course of physical therapy and reporting right trapezius discomfort. Dr. Clem noted that Petitioner was tender over the right scapula and trapezius. Dr. Clem prescribed medication and again noted that Petitioner was at MMI.

On 8/23/13, Petitioner returned to Dr. Brower for follow up of neck and trapezius pain. Petitioner did not tolerate even moderate touch of the right paravertebral musculature or trapezius. Dr. Brower assessed chronic trapezius pain and recommended medication.

Petitioner next returned to Dr. Brower on 9/9/13 to follow up on her chronic pain. Dr. Brower noted that Petitioner had decreased cervical rotation to the left and right and that Petitioner was moderately tender over the trapezius bilaterally. Dr. Brower declared Petitioner to be at MMI and did not provide work restrictions.

On 4/9/14 Petitioner exercised her first choice of physician and presented to an Orthopedist, Dr. David Schafer of Michigan Avenue Medical Associates. Petitioner complained of pain primarily in the low neck and cervical thoracic junction. Dr. Schafer noted radiation in the trapezius and occasionally down her right arm and occasional numbness down the arm. Petitioner complained of difficulty turning her head. Dr. Schafer noted tenderness in the paraspinals. Range of motion was decreased. Spurling's sign was positive for right arm pain. Dr. Schafer assessed cervical radiculopathy and pain. Dr. Schafer recommended topical pain lotion and a cervical spine MRI and referred Petitioner to a pain specialist for a possible epidural injection series.

A 4/9/14 cervical spine MRI as read by the radiologist revealed mild multilevel degenerative bulging discs accompanied by marginal spurs; there was a "broad-based posterior disc extension greatest in the midline partially effacing ventral CSF with mild central canal narrowing" at C5-6; multilevel minor foraminal narrowing; bilobed bulging disc and marginal spurs at T1-2 with mild foraminal narrowing. (PX1 at 53-54).

On 4/17/14, Petitioner presented to Dr. Neeraj Jain of Michigan Avenue Medical Associates, reporting neck and upper back pain that radiated into her right arm. She denied any prior such complaints. Spurling's sign was positive on the right. Dr. Jain interpreted the MRI as revealing herniations at C5-6 and T1-2. Dr. Jain assessed cervical facet syndrome, cervical discogenic pain and cervical radiculopathy. Dr. Jain ordered an SSEP study as well as bilateral C3-4, C4-5 and C5-6 facet joint injections, physical therapy and pain medication. He opined that Petitioner's symptoms were directly related to the injury and that treatment had been reasonable and necessary. (PX1 at 35-38). Dr. Jain warned that delay in authorizing the prescribed treatments adversely affects outcome in terms of habituation to medication, psychological decline and affliction and decreases likelihood of symptoms resolution.

On 2/29/14 Petitioner returned to Dr. Jain for follow-up. She was not improved. She was noted to have neck and upper extremity pain, greater on the right than left. The pain was increased with any overhead activity, prolonged lifting, sitting and standing. Dr. Jain noted Petitioner has a poor sleep pattern because of pain. She had not yet started physical therapy or obtained the SSEP of the upper extremity because of an approval problem. (*Id.*, at 28)

On 6/27/14, Petitioner presented to Dr. Erickson, neurosurgeon, reporting that she experienced pain in the neck and shoulder as well as pain between the shoulder blades immediately after the accident. Shortly thereafter, she experienced pain in the right arm and weakened right grip strength. Petitioner denied significant antecedent injuries other than a 2009 work-related upper back strain. Dr. Erickson noted positive neurologic findings in the right upper extremity on exam. Dr. Erickson interpreted the MRI to show a broad central disc herniation at C5-6. SSEP testing of the upper extremity conducted that day revealed bilateral C6 radiculopathy. Dr. Erickson assessed C6 radiculopathy secondary to C5-6 disc herniation which he attributed to her work accident. Dr. Erickson prescribed continued physical therapy and anti-inflammatory medication as well as analgesic medication. Dr. Erickson felt that if Petitioner did not respond well to conservative treatments, she would undergo anterior cervical discectomy and fusion at C6-C6. (*Id.* at 22)

On 7/14/14, Petitioner was examined by Dr. Edward Goldberg pursuant to section 12 of the Act. Petitioner reported injuring her neck and shoulder on 3/27/13. She complained of neck pain and bilateral shoulder pain towards the interscapular region. He notes she denied any radicular pain in the upper extremities. Petitioner described her job duties to Dr. Goldberg and he reviewed her written job description. Dr. Goldberg also reviewed Petitioner's treatment records. Dr. Goldberg conducted a physical examination, although it does not appear he conducted a Spurling's test. (T. at 35). Dr. Goldberg deferred his diagnosis pending receipt of the cervical MRI, but tentatively diagnosed a cervical strain, which he related to the 3/27/13 alleged accident. Dr. Goldberg opined that Petitioner's treatment had been reasonable. Dr. Goldberg opined that Petitioner could return to work full duty. (RXA at 26-28).

7/25/14, Petitioner returned to Dr. Erickson, reporting continued neck pain and some paresthetic sensations in her right arm "which seem[ed] new to her." (PX1 at 17). There was mild generalized weakness of the right arm most prominent in the elbow extension. There was some lessening of pinprick acuity in the C6, C7 and C8 distributions on the right side. (*Id.*) Dr. Erickson refilled medication prescribed by Dr. Jain and planned to follow petitioner for conservative treatments pending authorization for surgery. (*Id.*, at 18)

On 7/30/14, Dr. Goldberg authored an addendum report after reviewing the 4/9/14 cervical spine MRI. Dr. Goldberg opined that the MRI was normal. He noted a minimal bulge at C5-6. He noted no evidence of stenosis, herniation or nerve compression. Dr. Goldberg diagnosed a cervical strain as a result of the 3/27/13 accident. Dr. Goldberg did not believe that Petitioner had cervical facet syndrome, discogenic pain or cervical radiculopathy. Dr. Goldberg found that the treatment up to that point had been reasonable and necessary. Dr. Goldberg opined that Petitioner did not require any further treatment. Dr. Goldberg opined that Petitioner could return to work full duty and placed her at MMI. (RXA at 29-30). The Arbitrator finds it significant that Dr. Goldberg does not mention the SSEP testing or having conducted Spurling's testing, but appears to rule out cervical radiculopathy based upon the MRI findings.

On 09/26/14, Petitioner again followed up with Dr. Erickson. Dr. Erickson noted that Petitioner "has certainly not improved during the period of time that she has been waiting to undergo surgical treatment." (PX1, at 12). Dr. Erickson concluded that "[Petitioner] remains an excellent surgical candidate who unfortunately has no good therapeutic alternatives at this point. Conservative treatment is unlikely to reverse this situation." (*Id.*)

On 10/3/14, Dr. Erickson authored a letter to Petitioner's counsel after reviewing Dr. Goldberg's report and addendum. Dr. Erickson disagrees with Dr. Goldberg's assertion that Petitioner does not have evidence of stenosis and herniation. Dr. Erickson points out the radiologist report which suggests extrusions of disc material with findings being most prominent at C5-C6 level. (PX1 at 10) He further indicates that the broad diffuse disc herniation at C5-6 correlates perfectly with neurophysiological findings on SSEP testing. While agreeing with Dr. Goldberg's notion that there was no definite evidence of clear nerve compression with MRI viewed by itself, Dr. Erickson states that it was simply misleading to imply there was no evidence of stenosis or herniation. (*Id.*, at 11) Dr. Erickson then reaffirmed Petitioner's diagnoses as cervical radiculopathy at C6 on the right side. He cited the continuous and chronic nature of Petitioner's pain which is prominently axial in nature and confined to the neck and shoulder, which he felt was a consequence of the disc herniation at C5-C6; her continued feeling of tightness around the right wrist, abnormal sensations and diminished grip on the right side; and her biceps reflex asymmetry as well as biceps weaknesses noted on her recent examinations as supportive of his diagnosis. (*Id.*, at 11) Dr. Erickson further suggested Petitioner may also be suffering from component of facet disease, facet injury, and facet change which could account for the predominance of shoulder and paraspinal neck pain. Distinguishing facet syndrome from radicular pain, Dr. Erickson stated facet syndrome does not explain Petitioner's grip weakness, reflex symmetry, or neurophysiological findings on SSEP testing. (*Id.*) He reiterated that he would not recommend further conservative treatment or injections therapy based upon the number of times that had passed since Petitioner's injury on 03/27/13. He confirmed that Petitioner had not reached maximum medical improvement and continued to recommend anterior cervical discectomy and fusion at C5-6. (*Id.*)

On 1/18/16, Dr. Goldberg authored a second addendum report after reviewing Petitioner's updated records from Michigan Avenue Medical Associates, Dr. Erickson and Dr. Jain's deposition transcripts and Petitioner's medical records from Genesis Health System relative to a motor vehicle accident. Dr. Goldberg continued to opine that Petitioner had a cervical strain from a work related accident. He noted that Petitioner's first mention of any radicular pain came over a year after Petitioner's alleged accident date. Dr. Goldberg opined that Petitioner did not require a cervical discectomy and fusion or injections. Dr. Goldberg opined that Petitioner could continue to work full duty and was at MMI as of 7/30/14. (RXA at 5)

As of the date of hearing Petitioner had not undergone surgery nor had she received any injections due to the failure of Respondent to authorize same.

At trial, Petitioner described her pain as starting at the neck, radiating to her right shoulder, down the arm and in the lower back. She testified that she is unable to bathe her kids or bend without pain. Despite Dr. Erickson's recommendation that Petitioner work only light duty, with the caveat that a light duty job itself may not be dangerous but might be impaired by Petitioner's poor grip, Petitioner has continued to work full duty. She credibly testified that as a single mother of two children she must continue to work to provide for her family.

Dr. Erickson testified via evidence deposition (PX2) He is a board certified d neurosurgeon. (*Id.* at 5) He testified consistent with his records and reports discussed above. Dr. Erickson diagnosed a cervical disc herniation at C5-6 with cervical radiculopathy affecting the C6 nerve root, which he opined was causally connected to Petitioner's accident. (*Id.* at 10-11) Dr. Erickson relied on his exam findings, diagnostic studies

and Petitioner's reports in coming to his opinion regarding causation. (*Id.* at 24) Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-6. (*Id.* at 13) Dr. Erickson opined that Petitioner's treatment had been reasonable and necessary. (*Id.* at 17)

Dr. Jain testified via evidence deposition. (PX3) He is a doctor specializing in anesthesia and pain management. (*Id.* at 5) He also testified consistent with his records and reports. He diagnosed cervical facet syndrome, cervical discogenic pain and cervical radiculopathy. (*Id.* at 8,10) Dr. Jain based his diagnoses and opinion regarding causation on the history and physical examination. (*Id.* at 11) Dr. Jain reviewed Dr. Schafer's report and the MRI. (*Id.* at 18) Dr. Jain opined that Petitioner's treatment was necessary and appropriate. (*Id.* at 13). When he last saw Petitioner Dr. Jain recommended C3-4, C4-5 facet injections, medication, physical therapy and an SSEP. (*Id.* at 15)

Dr. Goldberg testified via evidence deposition. (RXA) Dr. Goldberg is a board certified orthopedic surgeon. (*Id.* at 2) Dr. Goldberg too testified consistent with his records and reports. Dr. Goldberg testified that his review of Petitioner's cervical MRI revealed a minimal bulge—not a herniation—at C5-6. He explained that he did not observe any evidence of stenosis, herniation or nerve compression. (*Id.* at 4, 11) Dr. Goldberg explained that a bulge is a normal finding. (*Id.* at 4) Dr. Goldberg diagnosed a cervical strain. (*Id.* at 4-5, 11) Dr. Goldberg opined that there was a causal connection between the cervical strain and the accident. (*Id.* at 4) Dr. Goldberg opined treatment had been reasonable and necessary through 7/14/14. (*Id.* at 5, 11) Dr. Goldberg opined that Petitioner required no further treatment, could work full duty and had reached MMI without any permanent impairment. (*Id.* at 4-6) Dr. Goldberg explained that Petitioner was not a surgical candidate because the MRI did not reveal a herniation or nerve compression and she did not report any right arm radicular arm pain until over a year after the alleged accident. (*Id.* at 5) The Arbitrator notes he again did not address the positive SSEP results.

CONCLUSIONS

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

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

On 3/27/13 Petitioner sustained an injury while trying to hold back meat which was moving past her on a conveyor belt by using her arms and hands. The injury was reported immediately and she was provided treatment at Respondent's medical facility the same day. She treated consistently thereafter until Respondent ceased paying for medical treatment based upon the opinions of the section 12 examiner.

As time went by, Petitioner began experiencing worsening symptoms, including symptoms radiating into the upper extremities. Dr. Goldberg agreed that Petitioner sustained injuries at the time of the accident, but found that she sustained only a cervical strain and was at MMI as of 7/14/14. Petitioner's treating physicians opined that Petitioner had not yet reached MMI and required further treatment. Dr. Erickson diagnosed a cervical disc herniation at C5-6 with cervical radiculopathy affecting the C6 nerve root, which he opined was causally connected to Petitioner's accident. Dr. Erickson relied on his exam findings, diagnostic studies and Petitioner's reports in coming to his opinion regarding causation. Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-6. Dr. Jain diagnosed cervical facet syndrome, cervical discogenic pain

and cervical radiculopathy. The Arbitrator finds the opinions of Dr. Erickson and Dr. Jain more persuasive than those of Dr. Goldberg.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds did sustain an accident which arose out of and in the course of her employment with Respondent on 3/27/13 and that her current condition of ill-being is causally related to the accident.

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 (O) Is Petitioner entitled to any prospective medical care?

The treating physicians as well as Dr. Gold berg agree that the treatment received up to 7/14/14 was reasonable and necessary. Dr. Goldberg, however felt Petitioner required no treatment thereafter. Petitioner's treating physicians have opined that all of the treatment received through the date of hearing was reasonable and necessary. When he last saw Petitioner Dr. Jain recommended C3-4, C4-5 facet injections, medication, physical therapy and an SSEP. The recommended treatment was never provided because Respondent would not approve the care. Petitioner then saw Dr. Erickson on 6/27/14. An SSEP was performed that same day which revealed bilateral C6 radiculopathy. Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-6.

Based upon the foregoing and the record taken as a whole, and having previously found the opinions of Dr. Erickson and Dr. Jain more persuasive than those of Dr. Goldberg, the Arbitrator finds that Petitioner's treatment through the date of hearing has been reasonable and necessary. The Arbitrator further finds Petitioner is entitled to prospective medical treatment.

Respondent shall pay reasonable and necessary medical services of $20,558.76, as set forth in PX 5, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall further authorize and pay for prospective medical care as recommended by Dr. Erickson and Dr. Jain, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What is the nature and extent of the injury?

Petitioner has not yet reached MMI therefore this issue is not yet ripe for resolution.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Filimon Chama,

Petitioner,

18IWCC0730

vs.

NO: 16 WC 19876

Elite Staffing-Bollingbrook,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the parties herein and notice given to all parties, the Commission, after considering the issues of permanent disability, medical, prospective medical and other evidence 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 21, 2018, is hereby affirmed and adopted.

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

18IWCC0730

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 30 2018
o10/25/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0730

CHAMA, FILIMON
Employee/Petitioner

Case# **16WC019876**

ELITE STAFFING-BOLINGBROOK
Employer/Respondent

On 2/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5755 COSTA IVONE LLC
JULIO COSTA
6847 W CERMAK RD
BERWYN, IL 60402

66020 GOLDBERG SEGALLA LLC
JENNIFER B SANTORO
311 S WACKER DR SUITE 2450
CHICAGO, IL 60606

18IWCC0730

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

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

Filimon Chama
Employee/Petitioner

v.

Elite Staffing - Bolingbrook
Employer/Respondent

Case # **16** WC **19876**

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 **New Lenox**, on **January 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 Admissibility of Respondent's Proposed Exhibit 16.

FINDINGS

On the date of accident, June 7, 2016, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $16,987.36; the average weekly wage was $326.68.

On the date of accident, Petitioner was 47 years of age, *single* with no dependent children.

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

Respondent shall be given a credit of $5,060.00 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $5,060.00. *See* AX1.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner's condition of ill-being in the lumbar spine is causally related to his undisputed accident at work as opined by Dr. Salehi.

Temporary Total Disability Benefits & Prospective Medical Treatment

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 67 & 5/7th weeks, commencing September 25, 2016 through January 11, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from June 7, 2016 through January 1, 2018, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $5,060.00 for TTD benefits that have been paid.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator finds that the recommended prospective medical treatment is necessary and reasonable to alleviate Petitioner of the effects of his injury at work. Thus, the Arbitrator awards the prospective medical care in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits that remain unpaid for medical treatment pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills for treatment not certified by utilization review 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

February 26, 2018
Date

ICArbDec19(b) p 3

FEB 21 2018

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

Filimon Chama
Employee/Petitioner

v.

Elite Staffing - Bolingbrook
Employer/Respondent

Case # 16 WC 19876

Consolidated cases: N/A

FINDINGS OF FACT

The issues in dispute are causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement[1] to temporary total disability benefits from September 8, 2016 through January 11, 2018, whether he is entitled to prospective medical care in the form of a two-level lumbar fusion as ordered by Dr. Salehi, and the admissibility of Respondent's Proposed Exhibit 16. Arbitrator's Exhibit[2] ("AX") 1; Tr. at 1-10. The parties have stipulated to all other issues. *Id.*

Background

Filemon Chama (Petitioner) testified that he was employed by Elite Staffing (Respondent) and assigned to a company, Peacock, for approximately one year as a Packer. Tr. at 26. In this position, Petitioner was tasked with bringing down the pallets as well as packing and counting the boxes that went on the pallets. Tr. at 27.

On June 7, 2016, Petitioner testified that he injured his lower back while lowering a pallet. Tr. at 27. He explained that pallets weighed 20-40 pounds. *Id.*, at 28. Petitioner testified that he had not previously had injuries or accidents to his low back or received medical treatment to the low back. *Id.*, at 29. Petitioner reported the accident to his supervisor, but he was not provided with a copy of the report. Tr. at 29.

Medical Treatment

Petitioner presented to Physicians Immediate Care on June 14, 2016 as directed by the company. Tr. at 29. He went for a total of three visits and was placed on restrictions, which were accommodated. Tr. at 29-30. Petitioner testified that he stopped going because they did not take care of him the way they should have. *Id.*, at 30.

The medical records reflect that Petitioner presented at Physicians Immediate Care on June 14, 2016 reporting mid- and lower back pain since June 7, 2016 when he was injured at work "lifting and moving empty pallets then twisted causing him back pain." PX1. He also reported that he "felt like it would go away over times but it has been a week and it is still there. States he has never had back pain in the past." *Id.* Following x-rays and a physical examination, which revealed positive straight leg raise testing on the left and right sides, Petitioner was diagnosed with back pain. *Id.* Stephanie Shirkey, PA-C, a certified physician's assistant, prescribed

[1] Respondent disputes that Petitioner is entitled to temporary total disability benefits after March 1, 2014 when he was released to full duty work by Dr. Moody. AX1.

[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. Ex. _)." Citations to the arbitration hearing transcript will be denominated ("Tr. at page(s)").

medications and instructed Petitioner to apply ice and perform back exercises at least twice a day. *Id.* Additionally, Petitioner was placed on a 25-pound work restriction, which Respondent accommodated. *Id.*; Tr. at 30.

Petitioner followed up with John James, M.D. (Dr. James) at Physicians Immediate Care on June 17, 2016. PX1. He reported continued mid- and lower back pain, made worse by exertion and movement. *Id.* On physical examination, Dr. James noted diffuse tenderness of the thoracic and lumbar muscles as well as continued tenderness over the left lower lumbar sand mid-thoracic spine. *Id.* He instructed Petitioner to continue his medication and start physical therapy, three days a week for four weeks. *Id.* Additionally, Dr. James maintained Petitioner's work restrictions, but increased the lifting restriction to 15 pounds when above shoulder level. *Id.* On June 22, 2016, Petitioner returned to Physicians Immediate Care with unimproved mid and lower back pain. *Id.* Ronald Gregus, M.D. (Dr. Gregus) continued Petitioner on medications, maintained his work restrictions, and recommended that he start physical therapy. *Id.*

On June 29, 2016, Petitioner presented to Rand Medical and came under the care of Ravi Barnabas, M.D. (Dr. Barnabas. Tr. at 30; PX2. Petitioner testified that he heard of Dr. Barnabas through a friend from work. *Id.*, at 30-31. The medical records reflect Petitioner's report that he was injured at work on June 7, 2016 and "he was bringing a pallet down he felt a pain in his lower back." PX2. On physical examination, Dr. Barnabas noted a lot of spasms in the back, positive straight leg raise testing on the right at 40 degrees with decreased sensation at L5-S1, and positive straight leg raise testing on the left at 55 degrees, as well as painful heel-to-toe testing. *Id.* Dr. Barnabas ordered physical therapy and continued Petitioner's work restrictions. *Id.*

On July 5, 2016, Petitioner presented to a chiropractor, Mark Cohen, D.C. (Dr. Cohen), of Chicago Pain Center on referral from Dr. Barnabas. PX3. Following a physical examination and review of Petitioner's symptomology, Dr. Cohen placed him on a conservative treatment course of treatment consisting of electrical stimulation, ultrasound, thermal and hot to cold therapy. *Id.*

On July 14, 2016, Petitioner returned to Dr. Barnabas. PX2. He noted Petitioner's slight improvement with conservative care, then ordered an MRI of the lumbar spine. *Id.* Petitioner underwent the recommended MRI on July 26, 2016. *Id.* The interpreting radiologist noted a broad based right neural foraminal herniation with significant right neural foraminal stenosis and impingement on the exiting nerve root at the L3-4, a 2 mm right paracentral protrusion and a broad-based bulge at L4-5, and lumbar spondylosis. *Id.*

On August 1, 2016, Petitioner returned to Dr. Barnabas at Ortho Spine Surgical. PX4. After reviewing the MRI, Dr. Barnabas diagnosed Petitioner with a disc herniation, disc radiculitis, lumbar disc paracentral protrusion, lumbar spondylosis, severe right canal stenosis, and significant neuroforaminal stenosis. *Id.* He kept Petitioner on work restrictions and referred him for a neurosurgical consultation with Dr. Salehi. *Id.*

On August 5, 2016, Petitioner presented to Suneela Harsoor, M.D. (Dr. Harsoor) on referral from Dr. Barnabas. PX5. Petitioner reported a sharp and stabbing pain radiating to both lower extremities into the feet. *Id.* On physical examination, Dr. Harsoor noted positive straight leg raise testing on the right. *Id.* She noted her review of Petitioner's lumbar MRI showing right-sided disc herniation at L3-L5 with an annular tear at L5-S1 as well as facet arthropathy. *Id.* Dr. Harsoor diagnosed Petitioner with a herniated lumbar disc and chronic lumbar radiculopathy. *Id.* She then recommended an L4-L5 epidural steroid injection and kept Petitioner off work. *Id.*

On August 16, 2016, Petitioner saw Krishna Chunduri, M.D. (Dr. Chunduri) at Advanced Spine and Pain Specialists. PX6. Petitioner testified that he saw Dr. Chunduri for a second opinion regarding Dr. Harsoor's

recommended injection as referred by Dr. Barnabas. Tr. at 32-33. Dr. Chunduri noted Petitioner's report of low back pain radiating into his right lower extremity. PX6. After a physical examination and reviewing Petitioner's lumbar MRI, he also recommended a right L3-L4 epidural steroid injection. *Id.*

On September 7, 2016, Dr. Chunduri administered the recommended right L3-L4 transforaminal epidural steroid injection under fluoroscopic guidance performed at Grand Avenue Surgical Center. PX7. Petitioner testified that the injection helped a little. Tr. at 34.

On September 9, 2016, Petitioner returned to Dr. Harsoor. PX5. He testified that he did not have the transportation means to continue treatment with Dr. Chunduri so he returned to Dr. Harsoor's office as her office provided him with transportation. Tr. at 34. Petitioner explained that he did not have a car. Tr. at 34-35.

During a follow-up on September 12, 2016, Dr. Barnabas noted that Petitioner's pain was severe, and Petitioner was taken off work, and referred to Dr. Harsoor or Dr. Chunduri for a second injection. PX4. Additionally, Dr. Barnabas referred Petitioner for a neurological consultation. *Id.*

On September 27, 2016, Petitioner returned to Dr. Harsoor complaining of worsened symptoms and an inability to sleep because of the pain. PX5. Dr. Harsoor recommended a second injection. *Id.* On October 4, 2016, Petitioner underwent the recommended second right L3 and L4 transforaminal epidural steroid injection under fluoroscopic guidance performed by Dr. Harsoor. *Id.* On October 20, 2016, Petitioner noted temporary relief of his pain. *Id.* Dr. Harsoor discontinued physical therapy, which Petitioner reported worsened his pain, and referred Petitioner for a spine surgery consultation. *Id.*

On November 8, 2016, Petitioner presented to Sean Salehi, M.D. (Dr. Salehi), a neurosurgeon[3], as referred by Dr. Barnabas. PX8; Tr. at 36. Petitioner reported low back pain radiating up into the mid-back and radiating down into the bilateral lower extremities to the feet. *Id.* Following a physical examination, noting Petitioner's prior medical treatment and symptoms, and after a review of Petitioner's MRI, Dr. Salehi diagnosed Petitioner with a herniated lumbar disc at L3-4 as well as annular tears and disc disease at L4-5 and L5-S1 resulting in mechanical back pain and radicular pain. *Id.* Dr. Salehi noted that Petitioner had failed conservative medical treatment and recommended surgery in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion. *Id.* Additionally, Dr. Salehi imposed desk work restrictions including no lifting/pushing/pulling over 10 pounds, no bending/twisting over three times per hour, and alternate sitting and standing every 30-45 minutes as needed. *Id.*

In the interim, Petitioner continued chiropractic care with Dr. Cohen through November 12, 2016, noting only slight improvement. PX3; Tr. at 31.

On November 21, 2016, Petitioner returned to Dr. Barnabas for a follow-up, complaining of an increase in pain and inability to walk due to his right leg giving away. PX2. Dr. Barnabas placed Petitioner off work. *Id.*

First Section 12 Examination & Addendum Report – Dr. Kornblatt

On December 5, 2016, Petitioner presented for a medical evaluation at Respondent's request pursuant to Section 12 of the Act with Michael D. Kornblatt, M.D. (Dr. Kornblatt). RX1. Dr. Kornblatt diagnosed Petitioner with an exacerbation of preexisting multilevel lumbar degenerative disc disease and kinesiophobia. *Id.* He opined

[3] The medical records also reflect that Dr. Harsoor also referred Petitioner for a neurosurgical consultation. PX8.

that the findings on Petitioner's lumbar MRI were preexisting and degenerative. *Id.* In so concluding, he noted that Petitioner "never presented with clinical lumbar radiculopathy consistent with a clinical lumbar disc herniation and nerve root impingement. Mechanism of injury is consistent with that of a myofascial strain with exacerbation of preexisting multilevel lumbar degenerative disc disease." *Id.* Dr. Kornblatt further opined that Petitioner had not reached maximum medical improvement (MMI) and that all of the medical treatment to date had been reasonable and necessary. *Id.* He recommended Petitioner return to light duty work and begin a course of work conditioning therapy, as he was not a candidate for surgery. *Id.*

On December 15, 2016, Dr. Kornblatt authored an addendum report specifying that Petitioner could work four out of the eight hours in a work day, consistent with his light physical demand level. RX2. He also opined that Petitioner could work in a standing position, but he should alternate between standing and walking, and that Petitioner could walk four hours out of an eight hour work day. *Id.*

Continued Medical Treatment

On December 19, 2016, Petitioner presented to Dr. Thomas Dzielawski[4] at Bone & Joint Clinic for a work conditioning evaluation as referred by Dr. Barnabas after Dr. Kornblatt's Section 12 examination. PX9; RX5. Petitioner continued treatment until December 23, 2016, without improvement, and was eventually referred to his doctor for further evaluation. *Id.*

On January 25, 2017, Petitioner presented for a follow-up and Dr. Salehi noted that his pain had increased following work conditioning. PX8. Dr. Salehi suspended work conditioning, reiterated his recommendation for surgery, and kept him off work. *Id.*

Second Section 12 Examination – Dr. Kornblatt

On May 15, 2017, Petitioner presented for a second medical evaluation at Respondent's request pursuant to Section 12 of the Act with Dr. Kornblatt. RX3. Dr. Kornblatt maintained his diagnosis of Petitioner's condition, and opined that Petitioner's complaints of axial low back pain correlated with three-level lumbar degenerative disk disease, which was unrelated to the lumbosacral strain sustained as a result of the accident at work. *Id.* Dr. Kornblatt recommended that Petitioner complete an additional 10 sessions of work conditioning, followed by a functional capacity evaluation. *Id.* He further opined that Petitioner could work within the light physical demand level, which was unrelated to his work injury. *Id.*

Deposition Testimony – Dr. Kornblatt

On August 17, 2017, Respondent called Dr. Kornblatt as a witness and he provided testimony at an evidence deposition. RX4. Dr. Kornblatt testified that he is a board-certified orthopedic surgeon. RX4 at 4-5; RX4 (Dep. Ex. 1). Dr. Kornblatt testified consistent with the information contained in his reports and further explained his opinions regarding Petitioner's condition and its relatedness, if any, to his accident at work. *See generally* RX4.

Dr. Kornblatt testified that kineisiophobia is fear of movement, which highly impacts Petitioner's treatment and recover. RX4 at 9-10. He testified that Petitioner's MRI showed degenerative disc disease, which was

[4] Dr. Dzielawski's credentials as a medical doctor, doctor of osteopathic medicine, doctor of chiropractic medicine, etc. are not apparent from the records of Bone & Joint Clinic. PX9.

degenerative in nature, and that Petitioner's exacerbation was "just an onset of symptomatology attributable to a preexisting condition, whereas an aggravation is a change in the anatomy of the preexisting condition resulting in most commonly significant abnormal objective findings on examination, as well as objective findings noted on workup, such as, an X-ray or an MRI scan." *Id.*, at 11. Dr. Kornblatt opined that conservative medical treatment including "physical therapy, possibly an injection or two might be warranted with patients with Degenerative Disc Disease and exacerbation with a strain. If [Petitioner] was taking narcotics, I don't think narcotics were appropriate." *Id.*, at 11-12. Dr. Kornblatt maintained his opinion that Petitioner could work at the light physical demand level and then full duty after four weeks, including a three-week work conditioning program. *Id.*, at 12.

Dr. Kornblatt maintained the opinions reflected in his addendum report and second Section 12 examination report of May 15, 2017. RX4 at 13-14. Dr. Kornblatt noted no changes, and maintained that Petitioner should not have been taking narcotic pain medication. *Id.*, at 15-16. He also maintained his disagreement with Dr. Salehi's recommendation for surgery. *Id.*, at 17. Specifically, Dr. Kornblatt testified that "...if surgery would be performed, it had nothing to do with a strain that happened at work. But this man doesn't present with surgical indications... clinical lumbar radiculopathy... instability of his lumbar spine. ...." *Id.*, at 17-18.

On cross-examination, Dr. Kornblatt testified that he averages about 500 IME's per year, with about 400 in 2017, with approximately 98-99% of those examinations being performed for the respondent or insurance company. RX4 at 22. He acknowledged that there is no formal test for kinesiophobia, only a general orthopedic examination like the one that he performed, and the diagnosis is made on observation. *Id.*, at 23-24. Dr. Kornblatt testified that he did not see any medical records indicating that Petitioner had radiculopathy at any level. *Id.*, at 25. He did not know whether the records reflected straight leg raise testing, and he stated that "[y]ou'd have to look through the records and see[.] The point is this, you make a diagnosis based upon subjective complaints, objective findings, and workup. And my answer is that there has never been anything in the records that supported a diagnosis of a radiculopathy." *Id.*, at 26. Dr. Kornblatt maintained that "[t]here was nothing in the records that reveal that this patient ever presented with a clinical radiculopathy." *Id.*, at 27. He testified that a positive straight leg raise test, alone, does not mean that Petitioner had radiculopathy. *Id.* Dr. Kornblatt went on to disagree with the radiologist's reading of Petitioner's MRI in the following exchange on cross-examination:

> Q. Well, in conjunction with an MRI that showed significant stenosis at that level or at a different level- -
> A. What do you mean?
> Q. I'm just looking - -
> A. There's no findings of an MRI showing significant spinal stenosis at any level.
> Q. There's an MRI from - -
> A. You're not listening to what you're saying. You said significant stenosis. I'm listening to what you're saying.
> Q. And I'm just reading it off the MRI.
> A. It doesn't say.
> Q. It says significant foraminal stenosis?
> A. Well, mine doesn't, not the way I reviewed it, and mine is important. My review of the MRI scan is very important, much more important than a radiologist's.
> Q. Is it more important than the treating neurosurgeon's?
> A. Probably in this case.

RX4 at 28-29. Dr. Kornblatt maintained his opinions regarding the lack of any causal connection between Petitioner's condition of ill-being and the accident at work beyond a myofascial strain. *Id.*, at 29-32. Dr.

Kornblatt admitted that he had no information regarding Petitioner having any prior injuries or any low back complaints prior to his injury. *Id.*, at 32-33.

Continued Medical Treatment

Petitioner continued to follow-up with Dr. Salehi through September 5, 2017. PX8. Based on Petitioner's continued pain and symptomology, as well as his physical examinations, Dr. Salehi continues to recommend surgery in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion and he kept Petitioner off work. *Id.*

Utilization Review

Respondent submitted utilization reviews from Genex. RX14. The physical therapy provided from July 5, 2016 through September 13, 2016 was not certified. *Id.* The transportation charges for non-emergent transportation were not certified. *Id.* The epidural steroid injections were not certified. *Id.*

Additional Information

Petitioner testified that he wishes to proceed with the surgery recommended by Dr. Salehi because he would like to go back to work, as he is alone and has no family. Tr. at 36-37. Additionally, Petitioner testified that he continues to take pain medications and that he uses a cane and back brace, all the time, due to the pain. Tr. at 39-40.

On cross-examination, Petitioner clarified that he injured his back on line 18, bringing a pallet down from a height of nine feet. Tr. at 41-42. Specifically, Petitioner testified that he was holding the pallet with his hands, to ensure that it did not fall and make a noise, when he injured his back. *Id.* Petitioner also reaffirmed that he did not injure his back in the past or receive any related treatment. Tr. at 43. Petitioner testified that he stopped treating at Physicians Immediate Care because he felt he was not receiving adequate treatment, and that is why he presented to Dr. Barnabas, who then referred him to all subsequent treating physicians. Tr. at 44-46. When asked about a missed appointment with Dr. Salehi in August of 2016, Petitioner admitted that he did not attend the appointment because he did not have transportation. Tr. at 47. When asked whether he has pain in his legs, Petitioner testified that currently he has pain in both, although he previously experienced worse pain on the right side. Tr. at 48.

Petitioner also testified that he could work light duty for a period of time. Tr. at 50-51. Specifically, on November 8, 2016, Petitioner was placed on a 10-pound restriction by Dr. Salehi and testified that he only returned to work for a week, as Respondent wanted him to lift more weight, and Dr. Salehi and Dr. Barnabas placed him off work. *Id.* Petitioner was unable to recall the type of pain medication that he took, but produced hydrocodone-acetaminophen tablets and explained that he takes the pills once a day and uses the patches twice a day to alleviate his pain. Tr. at 51-53. Petitioner testified that he has difficulty walking and getting in and out of cars. Tr. at 57, 62-63. Lastly, Petitioner admitted that he does occasionally help an older woman in his residence sweep the building patio and helps a different woman with her child, and in exchange she provides him with food and helps him with activities he has difficulty performing. Tr. at 58-59, 60-61.

On redirect-examination, Petitioner testified that when he sweeps the patio at his residence it is usually only for about five minutes. Tr. at 63. Petitioner identified the woman who helps him as Secundina, and her daughter as Citlali. Tr. at 63-64. Petitioner testified that Secundina helps him because he is all alone, and in exchange he

helps her with Citlali, by watching her and walking her to school, which is close to their homes. Tr. at 66. Secundina lives on 24th and Pulaski, about a block from Petitioner, and he testified it takes him about 15 minutes to walk there, at his pace and with breaks. Tr. at 66-67. Additionally, Petitioner testified that sometimes Secundina also picks him up with her brother, but that he does not personally drive a vehicle. Tr. at 67. When asked whether his pain varies, Petitioner testified that treatment helps, but increased activities cause his pain to flare up. Tr. at 68. Regarding Dr. Salehi's 10-pound work restriction, Petitioner clarified that he called Dr. Salehi's office on November 16, 2016 to inform him that his pain increased, as a result of the work he was performing. Tr. at 69. At that time, Dr. Salehi recommended that he only perform seated or desk work, which Petitioner testified that Respondent did not accommodate. *Id.* Petitioner reaffirmed that Respondent wanted him to perform work outside of his restrictions, at which time Dr. Salehi placed him off work. Tr. at 70.

Petitioner reaffirmed that he saw Dr. Salehi on November 8, 2016, after he saw Dr. Chunduri and Dr. Harsoor, and underwent two injections. Tr. at 71-72. He also reaffirmed that currently he has pain in both legs, but in the past he has experienced greater pain in his right leg. Tr. at 73. Petitioner further testified that Dr. Barnabas helped him a lot and, as a result, he is pleased with the treatment he received. *Id.* Petitioner was not aware of any criminal background relative to Dr. Barnabas prior to treating with him. Tr. at 77-78.

Surveillance Video

Respondent submitted surveillance video footage taken of Petitioner. RX7-RX10. The parties stipulated that the video surveillance took place over six days, from November 15, 2017 to November 28, 2017, and represents approximately 84 minutes of actual activity, out of 53 hours and 48 minutes of attempted surveillance. Tr. at 81. Petitioner utilized a cane throughout the surveillance, but is observed in limited instances without a cane. *Id.*

Respondent's Exhibit 7 contains surveillance of Petitioner obtained on November 25, 2017, between 12:24 p.m. and 1:40 p.m. Approximately nine minutes of actual activity were obtained showing the following: Petitioner walking with a dog outside of his residence for four minutes; Petitioner entering and exiting a Gold Ford vehicle as a passenger and traveling to pick up a girl from an unknown location and then to Walgreens; and Petitioner arriving in the car back at his residence. RX7.

Respondent's Exhibits 8 and 8a contain surveillance obtained on November 19, 2017, between 6:40 a.m. and 3:00 p.m. Approximately fifteen minutes of actual activity were obtained, showing: Petitioner exiting his residence for three minutes accompanied by three children and a dog; Petitioner exiting his residence accompanied by the children and walking to a Family Dollar and then El Nopal Bakery; Petitioner, accompanied by the children walking to a bus stop then entering the bus and departing; and Petitioner arriving on the bus, exiting it, and entering a private residence. RX8-RX8a.

Respondent's Exhibits 9 and 9a contain surveillance obtained on November 18, 2017 between 6:42 a.m. and 3:00 p.m., and surveillance obtained on November 24, 2017 between 5:56 a.m. and 4:41 p.m. On November 18, 2017, approximately eight minutes of actual activity were obtained showing: a Gold Ford driven by a woman arriving at Petitioner's residence; Petitioner exiting his residence with a dog and conversing with the driver of the Gold Ford; Petitioner entering his resident and later exiting and entering the Gold Ford as a passenger; Petitioner traveling to Taqueria El Milagro in the Gold Ford, entering the restaurant and sitting at a table; Petitioner walking with a woman entering the Gold Ford traveling to a private residence; and Petitioner exiting the private residence accompanied by a woman and entering the Gold Ford and traveling to his residence. RX9-RX9a. On November 24, 2017, approximately thirteen minutes of actual activity were obtained showing:

Petitioner exiting and reentering his residence multiple times; Petitioner bending at the waist to pick up his cane; Petitioner walking to a private residence and entering; and Petitioner exiting private residence and walking to his residence. *Id.*

Respondent's Exhibits 10 and 10a contain surveillance obtained on November 15, 2017, between 6:30 a.m. and 2:45 p.m., and November 26, 2017, between 6:30 a.m. and 2:45 p.m. On November 15, 2017, approximately thirty-one minutes of actual activity were obtained showing: Petitioner exiting his residence and walking to a private residence; Petitioner exiting private residence and walking to his residence; Petitioner entering a Silver Chevrolet, as a passenger, and traveling to a private residence; and Petitioner exiting a residence and raking leaves. On November 26, 2017, approximately eight minutes of actual activity were obtained showing: Petitioner exiting and reentering his residence; Petitioner walking to a private residence, accompanied by a girl; and Petitioner opening the door of his residence to allow individuals to enter. RX10-RX10a.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work as opined by Dr. Salehi. In so concluding, the Arbitrator finds Petitioner's testimony to be credible and further finds the opinions of Dr. Salehi to be persuasive.

There is no dispute that Petitioner was asymptomatic in the low back before his accident at work. He had degenerative disc disease in the lumbar spine noted at Physicians' Immediate Care, the radiologist interpreting Petitioner's lumbar MRI, Petitioner's treating physician, Dr. Salehi, and Respondent's Section 12 examiner, Dr. Kornblatt. Petitioner had continuously worked in his full duty position for Respondent for approximately one year before his injury. Indeed, the medical records reflect that all of the physicians that rendered treatment to Petitioner, as well as Respondent's Section 12 examiner, Dr. Kornblatt, noted that Petitioner only complained of back pain after his accident at work.

"Liability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence." *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (1st Dist. 1994. "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 (1st Dist. 2003).

Petitioner's treating orthopedic surgeon, Dr. Salehi, his pain management physicians, Drs. Harsoor and Chunduri, as well as Respondent's Section 12 examiner, Dr. Kornblatt, agree that Petitioner's post-accident radiographic studies show degeneration in the lumbar spine. Dr. Kornblatt conceded that Petitioner had no prior low back symptomatology or medical treatment, but he steadfastly maintained that Petitioner's MRI should be interpreted as he opined, not as interpreted by Dr. Salehi, much less the radiologist, all of whom agreed that Petitioner had significant foraminal stenosis and annular tears. The July 26, 2016 MRI revealed a broad based

right neural foraminal herniation with significant right neural foraminal stenosis and impingement on the exiting nerve root at the L3-4, a 2 mm right paracentral protrusion and a broad-based bulge at L4-5, and lumbar spondylosis. On August 5, 2016, Dr. Harsoor noted her review of Petitioner's lumbar MRI which she also interpreted to show a right-sided disc herniation at L3-L5 with an annular tear at L5 S1 as well as facet arthropathy. On November 8, 2016, Dr. Salehi noted his review of Petitioner's lumbar MRI showing a herniated lumbar disc at L3-4 as well as annular tears and disc disease at L4-5 and L5-S1 resulting in mechanical back pain and radicular pain.

Medical opinions, whether of a treating physician or a physician retained by a Respondent for the purpose of a Section 12 examination, cannot be evaluated in a vacuum. Dr. Kornblatt's confidence in his interpretation of Petitioner's MRI is contradicted by at least three other physicians. His initial, and unchanging, opinion that Petitioner's lumbar condition is related solely to his preexisting degenerative disc disease is contradicted by objective clinical findings at Physicians Immediate Care—Respondent's occupational health facility—that Petitioner had an onset of low back pain and radiating symptoms into the lower extremities within weeks of his accident. Dr. Kornblatt also acknowledged that Petitioner was wholly asymptomatic in the low back and lower extremities before the accident at work. It is also notable that Dr. Kornblatt conducts approximately 500 medical evaluations a year for an admittedly 98-99% of respondents or insurance companies. The overwhelming agreement among the physicians examining Petitioner in this case is that he had degenerative disc disease in the lumbar spine that became symptomatic only after his accident at work. Dr. Salehi opined that Petitioner's lumbar condition was aggravated by the accident at work requiring further medical treatment including surgery, which is supported by objective clinical and diagnostic test findings since shortly after the accident. Thus, the Arbitrator accords no weight to the opinions of Dr. Kornblatt in this case, and finds the opinions of Dr. Salehi to be persuasive given the totality of the evidence in the record.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work. The medical bills submitted into evidence related to Petitioner's lumbar spine are for reasonable and necessary medical care to alleviate him of the effects of his injury at work. However, Respondent submitted utilization reviews regarding the reasonableness and necessity of certain medical treatment. The bills that were not certified by utilization review are not reasonable or necessary, and Petitioner's claim for payment of those bills is denied.

Thus, the Arbitrator awards the medical bills incurred by Petitioner for treatment 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 medical bills for treatment that was not certified by utilization review is denied.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his accident at work as opined by Dr. Salehi. Based on the totality of the record, the Arbitrator finds that the recommended medical treatment is necessary to alleviate Petitioner from the effects of his injury at work and awards the prospective medical care prescribed by Dr. Salehi in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

"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.

Petitioner claims that he is entitled to temporary total disability benefits for a disputed period beginning September 8, 2016 through January 11, 2018. As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work as opined by Dr. Salehi. Petitioner was kept off work or on work restrictions that Respondent did not or could not accommodate beginning on September 25, 2016. Thus, the Arbitrator finds that Petitioner has established his entitlement to temporary total disability benefits as claimed from September 25, 2016 through January 11, 2018.

In support of the Arbitrator's decision relating to Issue (O), admissibility of Respondent's Proposed Exhibit 16, the Arbitrator finds the following:

Respondent offered its Proposed Exhibit 16 reflecting Dr. Barnabas' criminal conviction pursuant to a guilty plea in 2002 to 57 counts of "Participating in a racketeering enterprise" in October of 1998, and asserts that it is relevant to Dr. Barnabas' truthfulness, the reliability of his testimony, and his credibility. Tr. at 17, 19, 23. Petitioner objected on the bases of hearsay, relevance, and foundation. Tr. at 18-19. Noting the age of Dr. Barnabas' conviction, the fact that Dr. Barnabas was only one of Petitioner's many treating physicians, and that Dr. Barnabas was not called as a witness by Petitioner or by Respondent as an adverse witness to testify at the hearing or at an evidence deposition, the Arbitrator overrules Petitioner's foundation objection and sustains Petitioner's relevance and hearsay objections. Respondent's Proposed Exhibit 16 will remain in the record as a rejected exhibit.

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

Willie Young,

Petitioner,

18IWCC0731

vs.

NO: 15 WC 31771

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

18IWCC0731

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 2018, 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 30 2018
o10/25/18
DLS/rm
46

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0731

YOUNG, WILLIE
Employee/Petitioner

Case# **15WC031771**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 4/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.88% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2573 MARTAY LAW OFFICE
STEPHEN R MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
ELIZABETH MEYER
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

18IWCC0731

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)

Willie Young,
Employee/Petitioner

v.

Chicago Transit Authority,
Employer/Respondent

Case # **15** WC **31771**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **January 24, 2018 & February 28, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☒ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **July 10, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was not* given to Respondent.

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

In the year preceding the injury, Petitioner earned **$68,220.88**; the average weekly wage was **$1311.94**.

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

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services. Nothing further is owed.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$500.00** for other benefits, for a total credit of **$500.00**.

ORDER

Denial of benefits

Because Petitioner did not provide timely notice of an accident and Petitioner did not prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on July 10, 2015 all claims for benefits/compensation are denied.

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

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

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

Robert M. Harris

Signature of Arbitrator

April 9, 2018
Date

ICArbDec19(b)

Willie Young v. Chicago Transit Authority

15 WC 31771

18IWCC0731

DECISION OF ARBITRATOR

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The following issues were in dispute at trial: 1) Whether Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent on July 10, 2015; 2) Whether Petitioner provided Respondent timely notice of an accident; 3) Whether Petitioner's current condition of ill-being is causally related to the injury; 4) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services; 5) Is Petitioner entitled to TTD; and 6) Is Respondent entitled to credit for any payments.

Petitioner, Willie Young, was a 42-year-old married man with one child under the age of 18 and employed by the Chicago Transit Authority on July 10, 2015 (T., p. 8). Petitioner testified he was employed by Respondent as a bus servicer and had been working in that capacity for about 7 years prior to his work-injury but worked for Respondent as a bus operator prior to that (T. pp.15-16). Petitioner has worked for Respondent for a total of about 22 years (T. p 15). Petitioner's job duties included cleaning the interior and exterior of the buses, fueling the buses and checking basic functions of the bus such as fluids, oil and antifreeze (T. p.16).

Petitioner testified that on July 10, 2015 he reported to work at about 8:00 PM (T. p.17). Petitioner went through his normal routine to get ready for work then checked his station and noted that everything was not in place for him to perform his duties (*id.*). Petitioner testified that his station did not have the antifreeze bags ready and he had to go retrieve them (T. pp.17-18). Petitioner noted that while moving a 55-60 gallon antifreeze jug, he felt something pull and get hot in his back (T. p. 18). Petitioner noted pain in the low back above the right buttocks radiating down the right leg and into the right foot (T. p.21). Petitioner testified he was injured between 9:00 and 10:30 that night (T p. 22).

On July 13, 2015 Petitioner presented to Advocate Medical Group. (PX 8). Petitioner followed-up at Advocate Medical Group on July 21, 2015 and underwent an x-ray of the lumbar spine and was advised to remain off work (PX 8). At a follow-up- on July 24, 2015 it was

recommended that Petitioner undergo an MRI of the lumbar spine, attend physical therapy, see an orthopedic surgeon and remain off work (*id.*). An MRI of the lumbar spine was completed on July 30, 2015 and showed degenerative changes most significant at L5-S1 with moderate to severe bilateral neural foraminal narrowing (*id.*).

At a follow-up appointment on July 31, 2015 Petitioner was advised to attend physical therapy and return to work light duty (PX 8). Petitioner testified that he provided the light duty note to Respondent and was advised light duty would not be accommodated (Tr. Pp.31-32). Petitioner presented back to Advocate Medical Group on August 5, 2015 and it was recommended that he remain off work (PX 8). Petitioner also started physical therapy at Physiotherapy Associates on that date (PX 7). Petitioner had a follow-up at Advocate Medical Group on August 26, 2015 and was advised to remain off work and see a pain specialist (PX 8). Petitioner presented to Dr. Ravi Kumar on September 18, 2015 and it was recommended he undergo a lumbar epidural steroid ("ESI") (PX 5). Petitioner proceeded to undergo a lumbar ESI at L5-S1 on September 30, 2015 (*id.*).

Petitioner followed-up with Advocate Medical Group on October 23, 2015 and was advised to remain off work and follow-up- with Dr. Kumar for another injection (PX 8). On November 9, 2015 Petitioner underwent another lumbar ESI at L5-S1 (PX 5). Petitioner presented back to Advocate Medical Group on December 2, 2015 and was advised to see a neurosurgeon (PX 8).

Petitioner presented to Dr. Leslie Schaffer for an examination on December 9, 2015 (PX 2 at 7). He advised Petitioner to remain off work and attend physical therapy (PX 2, p. 9). Dr. Schaffer saw Petitioner again on January 13, 2016 and recommended he remain off work (PX 2 p. 10). He also discussed the possibility of surgery and the possible need for a repeat MRI (*id.*).

Petitioner went to Advocate Medical Group again on January 20, 2016 and was advised to remain off work and continue care with pain management (PX 8). Petitioner followed-up with Dr. Schaffer on February 10, 2016 and he was advised to undergo another ESI (PX 2, p. 11). Petitioner saw Dr. Schaffer again on March 2, 2016 and was advised to attend physical therapy and undergo another ESI. Petitioner underwent a lumbar ESI at L4-5 at Trinity Hospital with Dr. Suneela Harsoor on March 25, 2016 (PX 3).

Petitioner followed-up at Advocate Medical Group on April 6, 2016 and it was recommended that he remain off work and see the neurosurgeon (PX 8). Petitioner saw Dr. Harsoor again on May 2, 2016 and attend physical therapy and remain off work (*id.*). Petitioner went back to Advocate Medical Group on May 6, 2016 and was advised to remain off work and see the neurosurgeon (*id.*).

Dr. Schaffer saw Petitioner again on June 1, 2016 and recommended Petitioner undergo a new MRI of the lumbar spine (PX 6). Petitioner underwent a new MRI of the lumbar spine on June 10, 2016 at Christ Medical Center (Px 5). Dr. Schaffer reviewed the new MRI films and concluded that the findings were consistent with Petitioner's current complaints (PX 2, pp.12-13). On June 22, 2016 Dr. Schaffer recommended Petitioner go back to the pain clinic (PX 6). Petitioner testified that he had follow-up appointments at Advocate Medical Group on June 28, 2016 and August 23, 2016 and was advised to remain off work and attend physical therapy (T. p. 37).

Petitioner presented to Dr. Ryan Trombly for a second opinion on September 6, 2016 (PX 1, p.9). Petitioner presented with back and leg complaints due to pulling a heavy drum of antifreeze (PX 1, pp.10-11). Dr. Trombly diagnosed Petitioner with lumbar radiculopathy from spinal stenosis and lumbar herniated disc (PX 1, p.11). Dr. Trombly recommended surgical decompression surgery (PX 1, pp.11-12).

On November 16, 2016 Petitioner underwent a lumbar 3, 4, 5 and sacral 1 laminectomy, medial facetectomy and foraminotomy under the care of Dr. Trombly (PX 4). Petitioner saw Dr. Trombly following the surgery on December 6, 2016 and was advised to remain off work (PX 1, p.13). At follow-up appointments on January 10, 2017 and February 21, 2017 Dr. Trombly recommended Petitioner attend physical therapy and remain off work (PX 1, pp. 13-14). On March 21, 2017 Dr. Trombly recommended continued physical therapy (PX 1, p.15).

Petitioner saw Dr. Trombly again on April 18, 2017 and he recommended Petitioner undergo a CT of the lumbar spine due to Petitioner's ongoing pain complaints (PX 1, p.16). The same recommendation was made at a follow-up on May 30, 2017 (PX 1, p.17).

On May 30, 2017 Dr. Trombly also dictated a note which he read during his deposition testimony (PX 1, pp.17-20). In the note Dr. Trombly stated Petitioner "was in good health until

an episode at which he dragged a 60-gallon jug of antifreeze for quite a distance, and shortly thereafter, was in severe pain with spasms" (PX 1, p.18). As to causation, Dr. Trombly noted that, "I feel within a reasonable degree of medical certainty that the work-related injury from July 2015 caused the lumbar disc degeneration and incapacitating back pain. Prior to that episode, the claimant had worked for the CTA for many years without chronic back pain, and this further reinforces my opinion" (PX 1, p.19).

Petitioner saw Dr. Trombly again on July 11, 2017 and August 22, 2017 and was advised he could return to work at light duty as of September 1, 2017 (PX 1, pp. 21-23). During the August 22, 2017 visit, the possibility of a fusion surgery was discussed (PX 1, p. 22).

Petitioner testified that he continues to experience muscle tightness and stiffness in his back all the time (T. p 44). He also indicated that sitting for long periods of time and walking long distances aggravates his pain (*id.*). To treat the pain, Petitioner does the stretches and exercises he learned in physical therapy (T. p 45). He is looking to continue medical care with Dr. Trombly to further treat his back pain (T. pp. 45-46).

Regarding the disputed Issue (C) Whether Petitioner suffered accidental injuries that arose out of and in the course of his employment with Respondent on July 10, 2015 and Issue (E) Whether Petitioner gave Respondent timely notice of an accident, the Arbitrator finds and concludes as follows:

It is Petitioner's burden to prove each element of his case by a preponderance of the credible evidence. It is not the burden of Respondent to disprove any issue. Rather, the burden lies with Petitioner, his testimony, character and evidence entered onto the record at the time of trial. *Rambert v. Indus. Comm'n.* 133 Ill App. 3d 895, 87 Ill. Dec. 836, 477 N.E.2d 1364, 1369 (1985).

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). "[C]laimant has the

burden of showing by a preponderance of credible evidence that his injury arose out of and in the course of employment, which requires a showing of causal connection.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. Berry v. Industrial Comm'n, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); Fickas v. Industrial Comm'n, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

On the Request for Hearing form/stipulation sheet admitted at trial, Petitioner alleges he gave timely notice at the time of the accident to a "Mr. Mendenhal", his manager. (Arb. Ex. 1). At trial, Petitioner testified he spoke to his manager, Mr. Kendall Mendenhall, on July 10, 2015. (T p. 18.) Petitioner specifically testified he reported his injury to Mr. Mendenhal. (T p. 22). However, Petitioner then went on to testify he asked Mr. Mendenhal for "help" moving the anti-freeze barrels around 9:00 or 9:15. (T p. 22-23). Petitioner further testified, in direct contradiction to this immediate prior testimony that he reported his injury to Mr. Mendenhal, that he specifically **did not** tell Mr. Mendenhal he injured his back during his shift. (T p. 23). Petitioner testified, "the antifreeze was too heavy for me to push by myself," so he asked Mr. Mendenhal for help, not that he injured his back. In fact, Petitioner testified specifically that he did not report that he injured his back. (T p. 23). Petitioner testified that he finished his shift that evening. (T p. 24). (However, it should be noted that Petitioner's treating physician Dr. Trombly testified that Petitioner told him he could not continue working that day after the accident due to severe back pain with spasms, PX 1, p. 18). Petitioner testified he did not report to work that evening (the next calendar day) because his back was still hurting. (T p. 26).

The Arbitrator notes that neither party called "Mr. Mendenhal" as a witness to offer testimony at trial. However, the Arbitrator takes as significant Petitioner's testimony that he admitted he did not tell Mendenhal that he injured his back during his shift.

The Arbitrator further notes that Petitioner called no witness to offer any testimony on his behalf.

Petitioner then testified he notified Respondent of this injury. (T p. 26). Petitioner testified he called his manager on duty, the next day, July 11, 2015, to "let him know that I wouldn't be able to come in." (T p. 26). However, Petitioner further specifically testified that he told his manager he couldn't come in because he **"was sick."** (T p. 26). Petitioner testified he was sick and **not** that he was having problems with his back or suffered a work injury (T p. 26). When asked why he said this, Petitioner testified, "I just said I was sick because we can't take days off, so the second or the third day we're off work we have to be under doctor's care." (T.p.26.) The Arbitrator emphasizes and takes specific note of the compelling fact that Petitioner explicitly testified more than once that he did **not** notify his managers of any injury to his back on July 10, 11, or 12 when he had apparently had every opportunity (and incentive) to do so The Arbitrator further notes that it is inexplicable that Petitioner failed to report his injury, especially so even when his manager was physically right next to him when Petitioner asserted he asked his manager for help at the time of the alleged injury to move the anti-freeze. Petitioner did not offer testimony that he told his manager **why** he needed help. Petitioner never offered any explanation as to why he failed to report this injury. This scenario casts serious doubts on Petitioner's credibility.

Based on the above, the Arbitrator finds and concludes Petitioner failed to prove timely notice under the Act pursuant to Section 6(C).

The Arbitrator has carefully reviewed the records admitted into evidence, including the medical records. **The Arbitrator finds and concludes these records are filled with glaring internal contradictions and inconsistencies regarding accident history, mechanism of injury** and dates on which the symptoms started or occurred. These records are therefore of very narrow and limited use and value, if any at all, in determining and resolving the disputed accident issue. Many medical notes contain entries on the very same page for the same date of service that contradict each other. Some medical notes clearly do not relate to a work accident, while others clearly do. It is also clear that these records were not proof-read. **Therefore, these records are obviously and inherently unreliable and untrustworthy. As such, they cannot and do not prove Petitioner's claims.**

This is all revealed as follows:

May 2, 2016, Dr. Harsoor: History of Present Illness: "He has been symptomatic of the last 8 months. **He reports onset of pain gradually over time.**" Employment: "The last day he worked was 07-10-15. He denies being on disability. The patient denies being on workers compensation." Plan: "5) **He is off work from 2015 July after being injured at work" (PX 8)**

November 30, 2015, Dr. Ghannam: "...herniated lumbar discs due to **repetitive injury** at the patient's place of employment." The Arbitrator notes that this is **not** a repetitive trauma claim. (PX 8)

August 17, 2015, Physiotherapy Associates, Progress Note: "Pt presents to physical therapy with c/o R-sided **LBP which has been present over the past approx. 5 weeks and was insidious in onset." (See also PX 6, identical entry in "Initial Evaluation" records dated August 5, 2015). The Arbitrator notes that "approx.. 5 weeks" past is well before July 10 and "insidious in onset" (gradual) would disqualify any claim to a specific acute trauma.**

July 31, 2015, PCP Primary Care Note: "The patient has been treated in the clinic a couple of times due to severe back pain started this month. He needs some forms to be filled for his disability and also for his job" (PX 8)

July 24, 215, PCP Primary Care Note: History of Present Illness: "Patient presents with chief complaint of Low Back Pain that has been present since July 12, 2015. **Not a job related injury.**" (PX 8)

July 14, 2015, PCP Primary Care Note: History of Present Illness: "Patient presents with chief complaint of mid back pain. **He has had pain for two weeks. Not a job related injury."** Review of Systems: "The symptoms resulted from a lifting motion, bending over motion and twisting. **The injury occurred at work. Episodes started about 4 weeks ago.**" (PX 8) These two entries obviously cancel out each other.

July 13, 2015, PCP Primary Care Note: Reason for Visit: "...patient here today for a chief complaint of Back pain X 2 days, pt request RTW." History of Present Illness: "...presenting with back pain and stiffness for two days. **Denies trauma.**" Review of Systems: The patient presents with complaints of **gradual onset of right mid back pain**..." (PX 8)

Petitioner went for treatment at Advocate Medical Group (T pp. 26-27; PX 5). The formal, typed "Report" dated September 18, 2015 written by consultant Dr. Ravi Kumar indicates, "...a chief complaint of low back pain, radiating down his right lower extremity since March 2015. The patient denies any history of trauma and his pain started gradually." (PX 5). The Arbitrator interprets this to mean Petitioner has had low back pain with right lower extremity pain that developed gradually since March 2015. Further, the doctor's hand-written notes also found in this exhibit are the basis for the formal, typed "Report", and both are consistent with each other. **The Arbitrator finds this detailed typed report very significant and assigns greatest weight and credibility to its factual reporting, which serves to severely discredit Petitioner's claims of an accidental injury. Further, as opposed to the many other medical records, there are no internal contradictions or inconsistencies in this report, which therefore greatly bolsters its credibility.**

Further, the "Pain Management Center Patient History Admission Record is a a form filled out, or at least signed by, Petitioner on September 19, 2015 (and a nurse). The form has a line labeled "Workers Compensation" – the box marked **"No"** immediately following is checked. This is nearly two months after the claimed incident. (PX 5). This indicates that Petitioner, the nurse, or both, agreed this admission was not considered a workers compensation matter more than two months after the alleged date of injury.

Respondent submitted five exhibits. Three of these were faxes of forms and medical records submitted to Sedgwick. The others are forms filled out by various treating doctors. None of these forms make mention of any work accident. In fact, Petitioner testified he did submit paper work to Sedgwick and did receive some benefits under a short term disability claim. (T. p30). Petitioner did not testify that he ever reported a work accident or a workers' compensation claim to anyone at Sedgwick or his employer.

Petitioner treated with Dr. Leslie Schaffer at Neurosurgical Professionals, Ltd. (PX 6). Dr. Shaffer first saw Petitioner on December 9, 2015 but hos hand-written notes (which are very difficult to read) make no mention of a work accident (on any date; PX 6). In fact, it is not until March 2, in a handwritten note from Dr. Schaffer, that there is any specific mention of moving ("pulling") 55 gallon drums 2 blocks and then felt pain. At the request of Petitioner's attorney, Dr. Schaffer wrote a narrative report dated April 19, 2016 (PX 6). After outlining treatment, there

is a very short discussion of causation, where Dr. Shaffer noted Petitioner's pre-existing lumbar spine condition and opined causation based on a theory of an aggravation. There is no discussion of a mechanism of injury or any injury.

In his deposition testimony, Dr. Schaffer admitted he didn't know what Petitioner's actual job title was, what his work activities were, what his job description was, and his notes had no mention of any specific injury or complaints while Petitioner was working until he was asked to prepare a causal connection letter. (PX 2, pp. 16-19). Dr. Shaffer agreed that in his treating records from December 9, 2015, January 13, 2016, and February 10, 2016 **there are no notes at all regarding any specific injury or any specific complaints about work from Petitioner** (PX 2, p. 17). Dr. Schaffer did testify, however, and somewhat disingenuously, that he and Petitioner died discuss the type of work Petitioner did and the kind of injury he had and his symptoms when they first met (PX 2, pp. 17-18). Dr. Schaffer opined causation based on a theory of aggravation of a pre-existing lumbar spine condition (PX 2, p. 14-15). The Arbitrator is not persuaded by Dr. Schaffer's testimony or opinion regarding accident or causation.

PX 4 are the records from Advocate Medical Group and Dr. Ryan Trombly, a neurosurgeon. On September 6, 2016, Petitioner saw Dr. Trombly for a neurological consultation. Dr. Trombly's notes reference this history: "Patient reports that pain started July 2015 after he pulled a 55 gallon drum of antifreeze at his place of employment. Patient felt pain immediately but did not seek medical treatment until a month later because he was unable to get out of bed due to the pain." The Arbitrator notes that this history is clearly inconsistent with Petitioner's testimony and with the treatment records entered into evidence at trial, again further supporting the finding that Petitioner is not credible. Dr. Trombly wrote a letter on the same date opining causation based on a theory of aggravation of a pre-existing condition.

At his deposition (PX 1) Dr. Trombly testified he relies on what the patient tells him and that he considers his patients to be truthful but did not make any effort to verify the truthfulness of Petitioner's claims; he "never spend time in a forensic manner going back to the incident, **especially when it is almost two years prior**." (PX 1, p. 20-21.)

Further, and very significant, in his deposition testimony, Dr. Trombly admitted that he didn't "recall" whether he had the opportunity to review any records from Dr. Schaffer or the

records from any other doctor (PX 1, p. 29). In light of a lack of history in other medical records and the fact that this alleged history was given over two years after the alleged accident when litigation was ongoing in this case, the Arbitrator is also not persuaded by Dr. Trombly's testimony or opinion regarding causation or accident. Further, since Dr. Trombly apparently did not review medical records from any other physicians, he was unbale to consider and assess all of the relevant evidence relating to the accident, mechanism of injury and reported symptoms; nor was he able to fully and properly assess Petitioner's credibility, which renders his opinion that he considers his patients to be truthful meaningless.

In summary, Petitioner's own testimony at trial was that he did not give notice to his manager of any work injury (to his back or otherwise). Petitioner offered no testimony that he gave timely notice to anyone representing Respondent. Petitioner had ample opportunity to report a work accident yet did not do so. While he did call out sick, he specifically admitted he did not tell the manager of an injury to his back either that day or the next two days he called in sick. There is no history of any work accident in the medical records immediately following the accident. While the requirements of notice under Section 6 (C) are not strictly enforced, in this case, Petitioner admitted he did not give timely notice (which also impacts on the issue of accident).

Petitioner's own testimony, combined with the lack of early history in the medical records and the numerous and significant inconsistencies and contradictions contained therein, directly leads the Arbitrator to find and conclude that notice was not prove and that Petitioner failed to prove his claim of accident, particularly in light of treating medical notes which indicate "no trauma" and/or a gradual onset of low back pain beginning in March 2015.

Therefore, the Arbitrator finds Petitioner failed to prove timely notice was provides to Respondent and failed to prove accident.

F. Is Petitioner's condition of ill-being causally related to this injury?

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of causal connection is moot.

J. & K. Are the medical bills outstanding owed by Respondent? Is Petitioner entitled to prospective medical care?

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of medical is moot.

L. What TTD benefits are owed to Petitioner?

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of TTD is moot.

N. Is Respondent entitled to any credit for payment?

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of credit is moot.

Based on the above, because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, Petitioner's claim for compensation is therefore denied.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: April 9, 2018

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KELLY COULEAS,

Petitioner,

18IWCC0732

vs. NO: 17 WC 15176

STATE OF ILLINOIS – PINCKNEYVILLE CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

It was stipulated that Petitioner sustained repetitive trauma injuries to both upper extremities engaging in her normal office activities. Petitioner had an EMG/NCV on June 27, 2007 which showed moderate sensory motor median neuropathy across the left carpal tunnel. Petitioner did not receive medical treatment at that time. Petitioner testified her symptoms worsened and an EMG/NCV taken on April 14, 2017 showed rather severe chronic bilateral sensory motor neuropathies and it was noted that the left-sided neuropathy deteriorated since 2007. There was also moderate demyelinative ulnar neuropathy across the left elbow with partial sensory axonal involvement. There was no evidence of right-sided cubital tunnel syndrome.

On August 21, 2017, Dr. Mall performed left cubital tunnel decompression/ulnar nerve transposition and left carpal tunnel release for left carpal tunnel syndrome and cubital tunnel syndrome. On February 2, 2018, Dr. Mall performed right cubital tunnel decompression and right tunnel release for right carpal tunnel syndrome and cubital tunnel syndrome.

Petitioner testified that immediately after the surgeries, her numbness resolved and she "had very little pain in" her forearm. The only issues she had currently were grip and strength. Her right palm was still tender and sore. She noticed symptoms while using a big stapler on "big wads of paper." She also noticed symptoms carrying big boxes. She used an arm brace when she had pain and a gel pad all the time at work and while driving. She took Tramadol at the end of the day because her hands were tired. Last fall she was not able to garden and picking up her grandchildren was an issue. She also noticed that when she took minutes at meetings, by the end of the day she could not grip with her right hand.

On cross examination, Petitioner testified that at the hearing she did not have any problems, but she had not done "any writing or anything like that." She did not do "too much" for her left side. She would use a brace on the left in the anticipation of using it more, such as when she saw her grandchildren. Her surgeries were in in the fall in 2017 and then in February. Her recovery had gone "pretty well." She had no numbness or tingling, but she had tenderness at the incision on the right. She had that symptom on the left as well, but it improved. Dr. Mall expected the right side to improve also, in time. She hoped to garden as the season progresses. She was not able to hunt at all the current year, but she had applied for a deer-hunting license and hoped to hunt with a shotgun that fall. She planned no additional appointments with Dr. Mall and did the exercises he taught her. She had formal physical therapy for her left side, but not the right side. Petitioner was working without restrictions and she had no reason to believe there was any issue with her job performance.

The Arbitrator awarded Petitioner 112.325 weeks of permanent partial disability benefits representing loss of the use of 15% of the right arm, 12.5% of the right hand, 12.5% of the left arm, and 10% of the left hand. In arriving at his permanent partial disability award, the Arbitrator gave no weight to the factor of diminishment of earning potential, gave moderate weight to Petitioner's testimony about continuing difficulty performing her work, and significant weight to Petitioner's ongoing complaints, right more than left. Respondent argues the award was excessive. It stresses that the Arbitrator should have given weight to the fact that Petitioner had no loss of earning potential. In addition, it notes Petitioner's speedy and successful recovery. It recommends an award of 45.80 weeks of permanent partial disability benefits representing 5% loss of the use of each hand and 5% loss of each arm. Petitioner asks for an award of 129.15 weeks of permanent partial disability benefits representing loss of 12.5% of each hand and 15% of each arm.

In awarding Petitioner greater benefits for the right-sided neuropathies than the left, the Arbitrator noted that Petitioner's complaints about her right side were greater than the left. However, the medical records are clear that the left side pathology was more severe than the right. In fact, there did not appear be any electrodiagnostic evidence of right cubital tunnel syndrome and there did not appear to be any actual diagnosis of right cubital tunnel syndrome. It should also be noted that Dr. Mall's operative reports indicate that he did not perform ulnar transposition on the right, while he did on the left. Finally, while Petitioner testified that currently she experienced greater impairment on the right side, that was the side of the more recent surgery and she agreed that Dr. Mall informed her that her right-sided symptoms should improve with time, as did the left.

18IWCC0732

In addition, Petitioner's testimony about ongoing problems does not show extreme ongoing impairment. In fact, she testified that she hoped to resume gardening and hunting with a shotgun later in the year of the hearing. In looking at the entire record before us, based on the lack of any reduction in earning potential, the greater objective evidence of pathology on the left side than the right side, the fact that the more recent surgery was on the right side, and the limited evidence of significant ongoing impairment, the Commission concludes that the award for the conditions of ill-being on Petitioner's right-side should be reduced. Accordingly, the Commission reduces the right hand award to loss of the use of 10% of the right hand, to correspond to the award for the for the left hand, and the award for the right arm is reduced to the loss of the use 10% of that arm, based on the lack of objective evidence of cubital tunnel syndrome pathology on the right side and the fact that the surgery performed on the right arm was less extensive than the surgery performed on the left arm.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $718.59 per week for a period of 2&4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $646.73 per week for a period of 97.925 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 10% of each hand, loss of the use of 10% of the right arm, and loss of the use of 12.5% of the left arm.

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

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

DATED: NOV 30 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-11/15/18
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0732

COULEAS, KELLY
Employee/Petitioner

Case# **17WC015176**

STATE OF IL/PINCKNEYVILLE C C
Employer/Respondent

On 5/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.00% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ILLINOIS ATTORNEY GENERAL
SHANNON D RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

MAY 14 2018

18IWCC0732

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Kelly Couleas
Employee/Petitioner

v.

State of IL/Pinckneyville C.C.
Employer/Respondent

Case # 17 WC 15176

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 William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 10, 2018. By stipulation, the parties agree:

On the date of accident, February 20, 2017, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $56,050.00; the average weekly wage was $1,077.88.

At the time of injury, Petitioner was 55 years of age, married, with 0 dependent child(ren).

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

Respondent shall be given a credit of $1,515.39 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,515.39. Respondent stipulated Petitioner was entitled to further TTD benefits of two and four-sevenths (2 4/7) weeks commencing August 23, 2017, through September 9, 2017.

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 TTD benefits of $718.59 per week for two and four-sevenths (2 4/7) weeks commencing August 23, 2017, through September 9, 2017.

Respondent shall pay Petitioner permanent partial disability benefits of $646.73 per week for 112.325 weeks because the injuries sustained caused the 12 1/2% loss of use of the right hand, 15% loss of use of the right arm, 10% loss of use of the left hand and 12 1/2% loss of use of the left arm, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher

May 9, 2018

William R. Gallagher, Arbitrator

Date

ICArbDecN&E p. 2

MAY 14 2018

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of February 20, 2017, and that Petitioner sustained an injury to bilateral hands, wrists, elbows and arms as a result of repetitive duties (Arbitrator's Exhibit 2). At trial, the only disputed issue was the nature and extent of permanent partial disability. Petitioner claimed she was entitled to temporary total disability benefits of four and five-sevenths (4 5/7) weeks, commencing August 23, 2017, to September 10, 2017 (through September 9, 2017) and March 1, 2018, to March 15, 2018 (through March 14, 2018). Respondent stipulated it owed temporary total disability benefits for the aforestated periods of time; however, it was determined that Respondent had not paid Petitioner temporary total disability benefits for the initial period of lost time of two and four-sevenths (2 4/7) weeks, August 23, 2017, through September 9, 2017.

Petitioner was employed by Respondent as an Executive Secretary and worked for two Assistant Wardens and one Administrative Major. Petitioner's job duties required a significant amount of repetitive use of both upper extremities. Petitioner's counsel tendered into evidence her job description and Petitioner testified that the information contained therein was accurate (Petitioner's Exhibit 9).

Petitioner was initially seen by Dr. Stevens, her family physician (his/her records were not tendered into evidence at trial). Dr. Stevens referred Petitioner to Dr. Daniel Phillips, a neurologist.

Dr. Phillips saw Petitioner on April 14, 2017, and performed EMG/nerve conduction studies on both upper extremities. The diagnostic tests were positive for severe bilateral sensory motor neuropathies across the carpal tunnels and moderate ulnar neuropathy across the left elbow. Dr. Phillips recommended Petitioner be seen by a surgeon (Petitioner's Exhibit 3).

Petitioner was subsequently evaluated by Dr. Nathan Mall, an orthopedic surgeon, on May 3, 2017. Dr. Mall reviewed the EMG/nerve conduction studies and examined Petitioner. He opined Petitioner had bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. While Dr. Mall noted Petitioner had non-work risk factors, namely, obesity and a thyroid condition, he specifically referenced Petitioner's work duties and opined that they were a factor in the development of both bilateral carpal tunnel and cubital tunnel syndromes (Petitioner's Exhibit 4).

Dr. Mall performed surgery on August 21, 2017, and the procedure consisted of a left cubital tunnel decompression and ulnar nerve transposition and a left carpal tunnel release. Following surgery, Dr. Mall ordered physical therapy and directed Petitioner to do home exercises (Petitioner's Exhibit 6).

Dr. Mall performed surgery on February 22, 2018, and the procedure consisted of a right cubital tunnel decompression and ulnar nerve decompression/transposition and a right carpal tunnel release. Following surgery, Dr. Mall again ordered physical therapy (which Petitioner did not obtain) and directed Petitioner to do home exercises (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on September 28, 2017. Dr. Williams reviewed medical records and information regarding Petitioner's job duties provided to him by Respondent. Dr. Williams agreed Petitioner had left cubital tunnel and carpal tunnel syndrome as well as right carpal tunnel syndrome. In regard to causality, Dr. Williams opined these conditions were aggravated by Petitioner's job duties (Respondent's Exhibit 4).

At trial, Petitioner testified that following the surgeries the numbness in both of her hands resolved. However, Petitioner stated she still has diminished grip strength in both of her hands. Petitioner also said she continues to have an area of tenderness in the palm of her right hand and notices it especially when she has to pick up large boxes and when she uses a big stapler in her office. Petitioner also wears a gel pad on her right elbow while at work and when driving. Petitioner is right hand dominant and does have to take minutes at various meetings at work by hand.

Conclusions of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 12 1/2% loss of use of the right hand, 15% loss of use of the right arm, 10% loss of use of the left hand and 12 1/2% loss of use of the left arm.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered into evidence an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner's job required the active and repetitive use of both upper extremities. Petitioner was able to return to work to that job; however, Petitioner has difficulties performing some of her job duties because of her conditions, especially in regard to her use of her right upper extremity. The Arbitrator gives this factor moderate weight.

Petitioner was 55 years old at the time of the accident. There was no evidence that Petitioner's age had any effect on her condition. The Arbitrator gives this factor no weight.

There was no evidence that Petitioner's injury had any effect on her future earning capacity. The Arbitrator gives this factor no weight.

Petitioner was diagnosed with bilateral cubital tunnel and carpal tunnel syndromes and surgery was required. Petitioner continues to have complaints consistent with the injuries she sustained, more so on the right than left. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelly Brent Ellis,
Petitioner,

18IWCC0733

vs.

NO: 13 WC 6834

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

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

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

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

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 30 2018
o11/1/18
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the majority's award of 22.5% MAW. I would have instead found Petitioner suffered a 15% MAW disability based on the §8.1(b) statutory factors.

Petitioner returned to full duty work on May 21, 2012 and worked in his regular position for a year and a half before the position was eliminated from Respondent's budget. Petitioner left Respondent's employment in November or December 2013 and was subsequently hired by the St. Louis Highway Department in August 2015. He still worked for the St. Louis Highway Department at the time of hearing with job duties that include repairing highways, fixing potholes and trimming trees. Petitioner testified this position involves "extreme physical labor." (Transcript at 36). Nevertheless, Petitioner is able to complete the physical aspects of his job with the aid of only over-the-counter medication.

In consideration of criterion (ii) of §8.1(b), the occupation of the employee, the Arbitrator found the tremendously physical aspect of Petitioner's new job established a greater degree of permanency. However, I would have found Petitioner's ability to return to his regular position for a substantial period of time and then transition to a more physically demanding job shows a lesser degree of permanency. Thus, in analyzing the §8.1(b) factors, as well as the record in its entirety, I would have found Petitioner established permanent partial disability of 15% MAW and modified the award accordingly. For the reasons stated above, I respectfully dissent from the Decision of the majority.

DLS/met
46

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0733

ELLIS, KELLY BRENT
Employee/Petitioner

Case# **13WC006834**

FAYETTE COUNTY
Employer/Respondent

On 11/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% 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:

0390 McGLYNN & McGLYNN
MICHAEL McGLYNN
116 S CHARLES ST
BELLEVILLE, IL 62220

0000 INMAN & FITZGIBBINS LTD
MICHAEL BANTZ
301 N NEIL ST SUITE 350
CHAMPAIGN, IL 61820

18IWCC0733

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

KELLY BRENT ELLIS
Employee/Petitioner

v.

FAYETTE COUNTY
Employer/Respondent

Case # 13 WC 06834

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 19, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,501.52**; the average weekly wage was **$913.49**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent child.

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

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

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

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of an in the course of his employment on September 29, 2011. The Arbitrator further finds that the Petitioner's cervical condition of ill-being at C5/6 is causally related to the September 29, 2011 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$608.99 per week** for **32-6/7 weeks**, commencing **October 4, 2011 through May 20, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibits 9 and 10, as provided in Sections 8(a) and 8.2 of the Act, with the exception that the Petitioner is not entitled to the expenses claimed by Phoenix Physical Therapy, as this appears to be an independent evaluation requested by the Petitioner's attorney, and does not constitute reasonable and necessary treatment under Section 8(a).

Respondent shall pay Petitioner permanent partial disability benefits of **$548.09 per week** for **112.5 weeks**, because the injuries sustained caused the **22.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **October 16, 2012** through **November 3, 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.

18IWCC0733

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 15, 2017
Date

NOV 29 2017

STATEMENT OF FACTS

Petitioner testified he worked as the Chief Deputy for Respondent's Sherriff's Department since 2006. On 9/19/11 at the end of the day, he was preparing to go on vacation and trying to tie everything up before he left. He testified that he went to get ticket books, which were in a box in his "cluttered little office," to put out for the officers to use. As he was doing so, he was moving boxes around, had the ticket box in hand, turned to go to the door and tripped over a broken drawer that was underneath his desk. His head "speared" the wall. Petitioner testified he "saw stars", it felt like electricity throughout his body, and he noticed numbness and tingling in his neck. He also noticed his head was bleeding.

Petitioner testified that the photos submitted as Px11, taken by Petitioner's wife a few weeks after the accident, fairly depict his office at the time of his injury. Petitioner indicated that photo "A" shows the drawer sticking out from the front of his desk. He testified that the drawer was about 3' to 4' wide on a 6' desk, and because it had been broken for several months to a year and would fall and drop all of his belongings out, he kept it on the floor. Photos "B" and "C" show the office door. The Petitioner testified this is the area where he fell and struck his head, but he couldn't say exactly where he hit. Photo "D" depicts how "messy and cluttered" his office was. He testified he didn't do a good job of removing clutter, but that his office was also a "catch all" room for deputies for things like evidence, radios, etc. (Px11).

No one else was in the office when the incident occurred. After he gathered himself, he put out the ticket books and went home. He had already let his wife know he had tripped and fell, and when he got home he laid down. His wife questioned him lying down with a head injury when she got home, but Petitioner wanted to see how he was after some rest. He still had neck pain the next day, but he had already paid for a vacation cruise, so he wanted to tough it out and go on the trip. His wife suggested that he report the injury to Respondent, and within a day or two, he and his wife went to see Sherriff Aaron Lay, reported the incident and completed an accident report.

Petitioner went on vacation, testifying he suffered in pain throughout the trip, but tried to have a good time. He took a lot of ibuprofen and drank liquor, and took naps when it got really bad, but testified he wasn't able to do things he normally did on cruises in the past, such as using pool slides and seeing shows. In addition to the tingling and neck pain, when he turned his head it felt like a "bone on bone catch", and he would get a stabbing pain that radiated throughout his upper body, mainly in his right arm, so he tried to avoid turning his head.

Since the fall, Petitioner testified he's had pain radiating down the right arm, as well as numbness into the right thumb, index and middle fingers. When he returned from the trip, he sought treatment with his primary

provider, Dr. Dossett, on 10/4/11. Following an MRI, the results of which sounded "a little worse than I was hoping", Dr. Dossett prescribed physical therapy, medications and ultimately referred Petitioner to a surgeon. He also had injections. None of this helped, and he in fact felt he got worse during therapy. Petitioner testified he was held off work from the Dossett visit through his surgery.

After surgery, Petitioner testified his symptoms were greatly improved, but he still had headaches and numbness and tingling in the back, shoulders and arms. He was able to return to work full duty on 5/21/12. He continued to work for Respondent for another year and a half until 12/1/13. He has been working for the St. Louis County Highway Department since August 2015, performing highway repair, potholes, tree trimming, etc. He testified it involves pretty heavy physical labor, and he is able to do it, but he takes his fair share of over-the-counter medications.

Petitioner has pain and numbness in the right arm and hand daily. In the mornings, he has considerable ache in the right shoulder and arm, and he will take an Aleve before and after work. He testified to various work duties that will trigger pain and/or headaches. He also "tightens up" with the physical labor – on good days, it is only the right side, and on other days the pain goes into the left shoulder and he sometimes gets tingling and shooting pain in the left arm as well. He testified to difficulties with handwriting, recreational activities and exercise.

Petitioner testified he didn't have any of these symptoms prior to the 9/19/11 incident at work. As to an ER visit of 7/19/11, two months before the work injury, Petitioner testified he was driving around while on duty when he started to have slight chest pains that got worse until it radiated into his neck, face and arm with vision problems, and he thought he was having a heart attack. He testified that "everything ached" - his head, neck, chest and arm - but the hospital believed it was anxiety or a migraine. He has not had a similar situation since, and he testified the symptoms were not like anything he has had with the work incident.

On cross exam, Petitioner again testified his desk drawer had been broken for months, and that both he and the maintenance man unsuccessfully tried to repair it. He decided to put the drawer under his desk because it had fallen multiple times and scattered his belongings. In order to comfortably sit at his desk, he had to position the drawer to where it would stick out from two sides of the desk. He agreed he was used to it being there and having to walk around it. He testified the Sheriff was aware of the drawer problem, and agreed that other people would access his office and put items in it.

From his testimony on cross, Petitioner went to his office around 4 or 4:30 on 9/19/11 to basically finish up things before leaving for a two week vacation, and in particular to put out the ticket books, which were generally locked up. He did testify that the Sherriff and the secretary also had keys. Again, the deputies needed the books to write tickets, and he had to mete them out or the deputies would take them all. When he fell, to the best of Petitioner's recall, he was carrying a box of ticket books.

Petitioner testified that he left town on 9/23/11, which he believed was a Friday, driving to Terre Haute, IN to catch a flight to Florida. He agreed he did go swimming and did see some late night shows, but again testified he didn't do everything he normally would have done on the cruise, and when he did he would take ibuprofen, have some drinks and go to bed.

The Arbitrator's review of the photographs of Petitioner's office (Px11) indicates a cluttered desk with paperwork, boxes stacked up on a chair and the floor in one area where the Petitioner would look if seated at the desk, and the desk drawer is depicted under the desk, sticking out several inches. The room is carpeted, and the area where the desk drawer sticks out is between the desk and two guest chairs, and is in line with the office door if one were walking parallel to the desk.

Petitioner's wife, Theresa Ellis, testified that when she came home on 9/19/11, the Petitioner was in bed and said he had a headache. He said he was getting some ticket books, tripped and fell and speared his head against a wall at work. He had a bump on his head, but he said he wanted to see how he felt before seeing a doctor. She tried to get him to avoid sleeping due to the head trauma. She testified the Petitioner also had a small area of significant bruising near the right hip, where it was dark purple. She indicated that if he was not going to see the doctor that he at least needed to report the injury, and they went in and spoke to Sherriff Lay.

They left for a prepaid, 7 day cruise with two other couples on 9/23/11, which cost about $2,000 per couple. Mrs. Ellis testified that Petitioner's injury did slow them down, and the fact he didn't feel well prevented them from doing all the activities they planned, including slides, zip lining, jet skis and excursions. She said the Petitioner pushed forward despite the pain, doing what he could and took ibuprofen, as he didn't want the other people on the trip to have a bad time because of him. When they returned to town, she accompanied Petitioner to see Dr. Dossett. Between that day and the day he had surgery, Mrs. Ellis testified the Petitioner had: "A lot of numbness, a lot of headaches. His shoulders would hurt, his neck would hurt when he would turn, things like that, and he tried therapy. It didn't work very well. He was really sore after that the next day." She had no knowledge of Petitioner ever having any similar prior problems before the incident at work.

Mrs. Ellis testified that neck surgery did help Petitioner: "He didn't have as much pain. He still had -- he still has headaches. He still has cold -- problems when it's cold outside. He has a lot of stiffness in his neck. He's got numbness in his fingers. But the pain, I think the shooting pains and everything are gone." With his current job, Mrs. Ellis testified the Petitioner is tired when he gets home from work, takes ibuprofen and sits in a chair until bedtime. They no longer do any boating or water sports. Someone else mows their lawn because it hurts his hands and neck. Handwriting causes numbness if he does it for too long. He also has problems with headaches and his neck with cold weather.

Both the Petitioner and his wife were asked about an alleged fall from a trailer at their property on Vandalia Lake, and both testified there was no such fall.

Teresa Durbin, Respondent's administrative secretary for the last 36 years, was called by the Respondent as a witness. She testified that her job includes workers' compensation claims and submitting claims to the board. She has known Petitioner for about 10 years. Ms. Durbin testified that Petitioner reported the alleged accident on 9/21/11 (Wednesday): "He said he was moving things in his office. He fell into the door with his head, and the chair arm with his side" on 9/19/11. She testified that Petitioner didn't say anything about tripping over a drawer, and that she was not aware of there being a broken drawer. When he reported the accident, Ms. Durbin testified she went and looked in his office, and she did not recall seeing any boxes.

Ms. Durbin testified that she had been in Petitioner's office during September 2011. She agreed she leaves work at 4 p.m., and no one else would have been in the office at the time of the alleged incident, around 4:30 p.m. She agreed it would be unusual for Petitioner to be at the office that late, but she had not reviewed any of Petitioner's log in/log out information.

Ms. Durbin was shown the photographs of Petitioner's office (Px11), and testified that she did not believe they were accurate as to what she saw she looked in Petitioner's office, and that there was no drawer on the floor where one is depicted in picture "A". She testified: "I actually went in and tried to determine how it could have happened, that his bruise -- that this could have happened the way he told me, so I checked everything. There was not boxes like in those pictures. I did not see anything like that. There was two chairs along the west wall that are just north of the file cabinet. The file cabinet was behind the door if you would open the door up. There

was no -- no drawer on the floor because I laid on the floor to try to determine where you would hit if you were to hit the chairs. And I know he's taller than me, I know he's bigger than me, but it just was -- I mean, I'm not an expert of any kind, but it just was not feasible the way that it supposedly happened." On redirect examination, Ms. Durbin agreed that Petitioner reported moving boxes when he was injured, and she indicated this on the Form 45, as well as that ticket books were kept in boxes.

Ms. Durbin testified that the documents contained in Rx3 are Petitioner's work records, and include documentation of all vacation, personal and sick time that was accrued and used by him in 2011 and 2012. They indicate the Petitioner was off work from 10/4/11 through 5/21/12, and he was initially paid salary until 3/1/12, when he went on FMLA. It appears that at least a portion of the time he was paid salary involved sick time, but it is unclear to the Arbitrator how much. His position was eliminated on 11/30/13 due to budget constraints. Ms. Durbin testified that she has handled probably 6 workers' compensation cases during her tenure, and she is suspicious and doesn't believe he had the accident he claims.

On cross exam, Ms. Durbin reiterated it was not routine for Petitioner to be working night hours, but it's possible he was on 9/19/11. She had no knowledge of Petitioner having a broken desk drawer, had never seen the drawer on the floor, and had never seen the drawer missing from his desk. Petitioner, the Sherriff and Ms. Durbin had keys to Petitioner's office. In this regard, she testified that it was not a problem to go into Petitioner's office at any time to get a ticket book for an officer when needed. Ms. Durbin agreed Petitioner and his wife came to the office to report his alleged injury, and she herself saw the scrape on his head and the bruise on his right side, though she believed the yellow/green color of the bruise did not appear to have occurred only two days prior. She did not recall the Petitioner going into an office to discuss the incident with the Sherriff while she spoke to Petitioner's wife. She testified that Petitioner and his wife stood at her desk while she typed the information into a Form 45.

The Form 45 states: "Tripped and fell head first into office door striking head and falling into chair hitting right side." It is undated. (Px12).

Mrs. Gay Claycomb, a dispatcher for the Respondent, testified that she went on the September 2011 cruise with Petitioner and his wife, from 9/25 (Sun.) to 10/2/11. She has known the Petitioner for 10 or more years. She testified they drove to Indianapolis and took a two hour flight from there to Florida. While on the cruise, they did socialize. They visited three islands, and their activities included going to dinner, a piano bar and drank alcohol. He didn't seem to have any difficulties swimming, driving or partying. She identified the Petitioner in the vacation photos contained in Rx2. In one, she noted he was getting dunked in the water. Ms. Claycomb did not recall Petitioner ever saying he was in pain during the trip. On the way home, he said he didn't feel good, and she admitted she didn't ask what this meant exactly. She did not recall Petitioner mentioning a work accident. The Petitioner drove back from Indiana after they flew home, and didn't ask anyone else to drive.

Respondent also called their Deputy Sherriff, Ed Durbin, to testify. He has known the Petitioner for at least 12 years, and he also went on the September 2011 Caribbean cruise with Petitioner. He testified that the Petitioner never mentioned or alluded to an accident at work. He didn't complain of any pain to his neck or arms, and he didn't appear to be in pain. They would sometimes dine together, they went drinking together at the piano bar, and swam together as well. He also identified the Petitioner in the photographs in Rx2. The Petitioner didn't have any difficulty driving that he was able to tell.

The Arbitrator's review of these pictures does not indicate anything more significant that the Petitioner standing in the ocean. In one photo the water is at about shoulder level, and in another it is around the abdomen, and a

woman appears to be attempting to dunk him into the water. He is also depicted holding a beer in one photo. (Rx2).

MEDICAL EVIDENCE

On 7/19/11, Petitioner presented to Fayette County Hospital's emergency room (ER), complaining of the spontaneous onset of nausea, headache, blurred vision, jaw pain, double vision, and right arm tingling. He also noted a "weird feeling" in his jaw and neck. A CT scan of his head was read as normal. He was diagnosed with an ocular injury, prescribed Tramadol, and he was to follow up with his primary provider if symptoms persisted. (Rx4). As to the 7/19/11 ER visit, Petitioner agreed he "probably" reported neck pain with tingling into the right arm. Mrs. Ellis recalled he called her from the hospital indicating he thought he was having a heart attack. She testified his symptoms at that time were not like his symptoms after the 9/19/11 incident.

Following the alleged accident date of 9/19/11, Petitioner initially presented to his primary provider Dr. Dossett on 10/4/11, stating that he fell at work on 9/19/11: "He was in a close room and given some chairs when he tripped and build up some momentum and fell head first into a closed a door [sic]. He felt a sudden severe electrical sensation down to his toes can be from his head." Petitioner stated that he went on a cruise with 6 people because he had already paid for it. He had a sharp pressure sensation in both sides of his neck – the left 80% of the time and the right 20% of the time. Dr. Dossett also noted he struck a chair and had a bruise above his right hip. Petitioner stated that he slept for 15 hours the day after the accident and hurt all over. He had good range of motion (ROM) in his neck but was tender between his shoulder blades with palpation at T1/2. His cervical spine was non-tender in the midline but was tender bilaterally with tense muscles. Thoracic x-rays showed age indeterminate, subtle, multilevel veterbral height loss and degenerative changes. Cervical x-rays revealed no evidence of acute fracture or subluxation, but did reveal osteopenia and multilevel degenerative change, osteophyte formation, and straightening or lordosis due to positioning or muscle strain. Dr. Dossett diagnosed a head injury with subsequent cervical and thoracic spine pain, with a possible spinal cord contusion. Petitioner was restricted from working for a week and it was noted that he would need an MRI of the cervical and thoracic areas if his symptoms persisted. (Px3, Px5).

Petitioner returned to Dr. Dossett on 10/11/11 with the same symptoms, with intermittent sharp pains radiating down the right shoulder to the elbow, as well as a continued occasional catch in his neck with very sharp pain in the center of his spine, and a constant dull ache in his thoracic spine. He was diagnosed with cervical pain with right radiculopathy, multilevel loss of vertebral heights in the thoracic spine, and a questionable compression fracture. He was restricted from work for a week and was prescribed cervical and thoracic MRIs. (Px3).

The 10/12/11 cervical MRI was read by the radiologist as showing no evidence of cervical disc herniation, but multilevel cervical spondylitic changes, most pronounced right paracentrally to laterally at C5/6. It was also noted that there was a broad based posterior osteophyte in close proximity to the right-side nerve root at C5/6, and an adjacent bulging disc, but no central canal stenosis. No neuroforaminal narrowing was noted at any other level, but there was bilateral facet hypertrophy at C4/5 and a mild disc bulge at C6/7. Thoracic MRI from the same date noted no herniation, neuroforaminal or canal stenosis, but mild multilevel disc desiccation. (Px3, Px5, Rx5).

Petitioner followed up with Dr. Dossett on 10/18/11, and he noted the thoracic MRI was completely normal, while the cervical MRI showed a bone spur and some adjacent disc narrowing, as well as borderline right sided neuroforaminal narrowing, but no disc herniations. Petitioner was referred to neurosurgeon Dr. Russell for consultation, and was held off work pending same. (Px3).

On 11/11/11, Petitioner presented to Dr. Russell at Springfield Clinic. He reported a 9/19/11 fall: "Apparently he tripped and fell back in September while at work. He had previously been scheduled for a vacation and went ahead and took his vacation and he was off work for a couple of weeks. The pain never really resolved." An intake form Petitioner completed indicated he tripped and fell head first into a door/wall. He complained of pain between his shoulder blades and down his right arm with numbness and tingling at times, and no left arm symptoms. Neurologic examination was essentially normal except for a possible area of hypesthesia over the lateral forearm. Dr. Russell opined that, clinically, he had C6 nerve root symptoms that corresponded with a sizable disc herniation at C5-6 on the right. Dr. Dossett recommended physical therapy and epidural injections, and if that failed a possible C5/6 discectomy. (Px4).

On 11/16/11, Petitioner began physical therapy at Fayette County Hospital. He reported aching pain in his neck and between the shoulder blades, as well as throbbing/aching pain and tingling in the right arm into the fingers with some numbness. It was recommended that he undergo physical therapy two to three times a week for three to four weeks. (Px5).

On 11/17/11, Petitioner requested an off-work note and a muscle relaxer from Dr. Dossett. He said that the physical therapist sent him home today because his muscles were so tight. The diagnosis was continued neck pain with radiculopathy and muscle spasms. Petitioner was prescribed ongoing therapy, Vicodin and Flexeril, and was restricted from working for two to three weeks until he followed up with Dossett or Russell. At 12/7/11 follow up, Petitioner notes excellent range of motion improvement with therapy, but no pain reduction, and his right grip was weaker than the left. Petitioner notes Dr. Russell wanted to try epidurals, and if that failed surgery would be the last resort. Dr. Dossett now diagnosed Petitioner with a herniated cervical disc. He refilled Petitioner's Vicodin and flexeril and restricted him from working for one month, or if he had marked improvement with epidural. (Px3).

Petitioner had an initial 11/16/11 therapy evaluation, noting complaints of cervical pain radiating into the right arm, stabbing cervical pain with movement, and throbbing radicular pain in the right biceps, forearm and thumb. There was significant cervical guarding, with the therapist noting he tended to rotate his whole body than just his neck. On 12/14/11 Petitioner's physical therapist noted the Petitioner had not progressed, had significantly reduced right grip strength versus the left, and had pain with daily activities. She recommended putting therapy on hold, and he was discharged shortly thereafter. (Px4).

Petitioner underwent epidural injections at C5/6 with Dr. Narla on 12/15/11 and 1/5/12. The diagnosis indicated was C5/6 broad-based osteophyte disk complex and associated right C6 radiculopathy. The 1/5/12 report diagnosis indicated "helped by previous injection to some extent." (Px3, Px6).

On 1/6/12, Petitioner went to the Fayette County ER with complaints of chest pain. He reported that he had received an injection for a pinched nerve and developed swelling on both sides of his neck, right greater than left. A chest CT scan was performed based on fullness in the supraclavicular regions, and the findings included mild axillary lymphadenopathy. He was discharged with a non-specific diagnosis, advised to continue his medications and was advised to follow up with his primary care provider. (Px5).

On 1/9/12, Dr. Dossett issued an off work note from 1/3/12 through 1/19/12, though it appears there is no progress note for either 1/3 or 1/9/12. On 1/19/12, Dr. Dossett reported that Petitioner was there mainly to review records, and noted that he had a 1/19/12 work related injury. He had undergone therapy and injections but continued to note right arm pain with numbness in the 2nd and 3rd fingers and decreased right grip. He now was complaining of similar symptoms on the left side. Dr. Dossett diagnosed chronic right upper extremity pain secondary to herniated disc. He was scheduled for a third epidural, and Petitioner noted he wanted to delay

surgery if possible. Vicodin and flexeril were prescribed, and Petitioner was restricted from working for six weeks. (Px3).

On 1/24/12, Petitioner returned to Dr. Russell. His complaints remained the same following therapy, though he felt physical therapy helped with his cervical ROM, and the injections reduced the intensity of the pain. Dr. Russell noted the right arm symptoms seemingly fit into a C6 distribution, and he had degenerative changes and osteophytes at the C5/6 level. Petitioner wished to pursue surgery, as he didn't otherwise think he would be able to return to work. (Px4).

On 2/1/12, Petitioner was cleared for cervical surgery by Dr. Dossett. (Px3).

On 2/13/12, Petitioner underwent surgery with Dr. Russell. The preoperative and postoperative diagnoses were cervical disc disease. The report noted: "The disk itself was very well collapsed with rather significant degenerative disk disease." Dr. Russell performed an anterior discectomy and interbody fusion at C5/6. (Px7).

On 2/28/12, Petitioner reported to Dr. Russell that his proximal arm pain had resolved but he still had numbness and tingling in his fingers. He was instructed to begin home exercises and to follow up in three to four weeks for X-rays. (Px4). On 3/2/12, Petitioner returned to Dr. Dossett. He indicated he no longer had severe pain in his right neck and thoracic area or stabbing pain in his right arm. He did note residual numbness in his right thumb, index, and third fingers. Dr. Dossett restricted Petitioner from working until follow up with Dr. Russell. (Px3). On 3/28/12, Dr. Russell noted Petitioner doing "tons better." X-rays showed excellent positioning of the grafts and plate and Petitioner was instructed to return in six to eight weeks. (Px4). An unsigned health status form was completed that same day, 3/28/12, in which it was indicated that Petitioner was restricted from working until April 24, 2012. (Px3).

Petitioner underwent physical therapy at Springfield Clinic on April 10, 2012 and continued through May 30, 2012. He was discharged from therapy on 5/31/12. The discharge note indicated good improvement in ROM, strength and activity tolerance, and that Petitioner had returned to work without difficulty or increased pain. He did have ongoing right wrist pain that the therapist felt needed further assessment. (Px3).

On 4/24/12, Petitioner returned to Dr. Russell, and he was doing very well. He had started therapy x-rays showed good healing with no abnormal motion. X-rays showed the hardware from the fusion and other degenerative cervical changes, including spurring at C3/4, C5/6 and C6/7. Dr. Russell noted that he planned to return the Petitioner to unrestricted work following an additional 2 to 3 weeks of therapy. He was to follow up in three months. Another unsigned health status form was completed on 4/24/12, indicating that Petitioner could return to work without restrictions on 5/21/12. (Px3, Px4).

On 6/1/12, Petitioner reported to Dr. Dossett that he was doing well with no pain and only minor numbness in the thumb and fingers. He was doing well after having returned to work for two weeks, and was very happy with the surgical results. He was otherwise to follow up with Dr. Russell. (Px3).

On June 12, 2012, Petitioner reported he was doing well and had been able to get back to work. He still had some numbness in his fingers but no longer had significant radiating arm pain. Dr. Russell indicated he could continue "bumping up" his activities, and should follow up in the fall. (Px3).

On 9/5/12, Dr. Dossett indicated Petitioner reported reduced energy and libido. His cervical disc disease was stable with the exception of residual numbness in his fingertips. (Rx3).

On 10/16/12, Petitioner told Dr. Russell that he was doing very good and that his neck felt "great." Petitioner's only complaint was numbness in his right fingers. X-rays showed grade 1 retrolisthesis of C6 over C7, similar to prior films, stable C3/4 and C6/7 disc height narrowing with posterior endplate osteophytes, and stable fusion with interval bone bridging versus 4/24/12 films. Petitioner was not given any restrictions and was discharged from care to return as needed. (Px3, Px4).

On 11/8/12, Petitioner presented to the ER at Fayette County Hospital with complaints of substernal chest pain and tingling from the left bicep to finger, an achy feeling, and he was flushed. He reported being at work when the symptoms began, and that he had similar pain one year prior. He was admitted, and then a note of Dr. Dossett from the hospital notes chest pain that had started the night before and radiated down his left arm with associated tingling. It also noted that Petitioner had neck surgery in February and had no neck pain at this time, but prior to surgery "had tingling down his right and left arms at different times." Petitioner reported being under a lot of stress at work and that he nearly lost his job a few weeks prior. Petitioner complained of chest pain going down his left arm and that he had been gassy for the past few weeks, despite being on Prontonix. He was given nitro, which resolved the arm tingling but caused a headache, medications for his depression and peptic ulcer, and it was noted that he might require a nitro pill. (Px3).

On 11/13/12, Dr. Dossett noted the ER visit and that Petitioner was there for elevated blood pressure, headaches, and chest pain. He noted the chest pain and arm numbness had resolved, but that Petitioner would be undergoing a stress test. On 12/4/12, Petitioner was to get his stress test done, and that this should rule heart problems in or out. Dr. Dossett noted complaints of persistent numbness in the same three right fingers. Dr. Dossett also noted midthoracic pain, that x-rays from the year before showed bone spurs but his MRI was negative, that the chest pain could potentially from his cervical spine disease or from heartburn, and that the thoracic pain was from arthritis or from silent reflux. The stress test appeared to indicate no abnormalities.

On 2/12/13, Petitioner met with Brian Buescher, PT, at Phoenix Physical Therapy, for a physical therapy evaluation. It is unclear how the Petitioner made his way for this evaluation, but the report is addressed to his attorney. Petitioner reported that he continued to have cervical pain, daily headaches, and numbness in his thumb, index, and long fingers. He also reported mild limitation in grip strength and fine motor skills like handwriting. Despite regular use of over-the-counter medication, he has been unable to alleviate his conditions. Mr. Beuscher opined that if Petitioner were to improve his rotator cuff strength and scapular stabilizers, this would improve his neural plasticity and his overall pain and symptoms. (Px8).

On 10/15/14, Petitioner was examined by Dr. James Stiehl at the request of the Respondent. Petitioner reported he was doing paperwork in his office on 9/19/11 when he tripped and fell to the floor, landing on his face, developing pain and stabbing in his neck and tingling in a C6 distribution. Petitioner complained of ongoing chronic neck pain, pain with weather changes, occasional migraines and daily headaches. Petitioner's further history of the accident was that he was arranging paperwork in his office, and that he also had a contusion and was bleeding from the head. He reported surgery helped with the pain, but not with the tingling and numbness. Dr. Stiehl reviewed and summarized Petitioner's medical records and performed a physical examination. (Rx1)

The exam showed unrestricted range of motion, negative Spurlings testing and intact strength, reflexes and sensation. Dr. Stiehl opined that Petitioner had chronic cervical neck pain with age related MRI findings, and that he did not believe there were verifiable neurological complaints seen in the Petitioner, and that surgery was performed for chronic cervical arthrosis. Dr. Stiehl opined that if Petitioner did in fact fall as he alleged, then he would have aggravated his degenerative condition, and that it "could have" been a temporary aggravation given no acute findings on MRI. He stated: "He did not offer evidence of radiculopathy on those early findings, and therefore that could not be attributed to the injury state. Typically, one would expect this patient to return to

normal within 3 to 4 months following such an injury. On the other hand if he had preexisting arthrosis of his cervical spine, that condition could have progressed after the above noted injury." Dr. Stiehl indicated it did not appear that Petitioner needed work restrictions other than post-surgery, and had been released to full duty as of 10/16/12. Regarding the surgery itself, Dr. Stiehl opined that the fusion surgery was "probably not" due to Petitioner's alleged fall: "He may have progressed into having numbness and tingling at some later point, but we can see for at least a period of six weeks, there were no complaints of significant radiculopathy of the upper extremities." Dr. Stiehl specifically notes that while the Petitioner told him he had numbness and tingling from the outset of his injury, this is not documented in the medical records, and this was "a substantial issue for causation in this case." He agreed that the treatment Petitioner received, including surgery, was reasonable based on Petitioner's chronic cervical condition. (Rx1).

Dr. Stiehl issued an 11/30/15 addendum report following his review of the 7/19/11 ER records from Fayette County, prior to the alleged accident. Dr. Stiehl noted Petitioner complained significant headaches and blurred vision for an ocular injury, with a normal head CT scan. He noted Petitioner also complained of moderately severe symptoms in his jaw and neck as well as right arm numbness and tingling. He also stated that Petitioner did not report any history of prior headaches. Dr. Stiehl opined that these complaints were evidence that Petitioner had a "significant" active cervical spondylosis condition prior to the accident, which was not aggravated by the accident. He also referenced the fact that Petitioner did not seek any post-accident treatment until 10/4/11. (Rx1).

Dr. Russell was deposed by the parties on 10/17/16. Dr. Russell testified that Petitioner's reported numbness and tingling symptoms appeared to be in a C6 distribution, which would correlate to a C5/6 disc herniation, and that he observed a sizable disc herniation at that level. He also was noted to have degenerative changes and osteophytes at C5/6 as well. (Px1).

On 2/13/12, Dr. Russell performed a C5/6 anterior fusion. He noted the disc was "well collapsed" with "rather significant" degenerative changes. Following surgery, Petitioner reported his arm pain was gone, but he had some ongoing numbness in the fingers. Petitioner's symptomatic relief supports that the symptoms are related to C5/6. Post-surgical x-rays showed healing and good graft positioning, and at the last visit in October 2012, Petitioner was doing well and had returned to work with no significant arm pain or unusual difficulties, with some ongoing tingling. He was to have returned to work following his discharge from therapy, likely in May 2012. Dr. Russell opined the mechanism of the alleged work injury could have caused the disc or aggravated the preexisting condition at C5/6, causing arm pain and C6 radiculopathy. He further testified that his treatment, including surgery, was necessary as a result of Petitioner's alleged work accident. (Px1).

With regard to the 7/19/11 ER records, Dr. Russell noted the diagnosis was an ocular migraine, involving a headache with vision problems, though Dr. Russell acknowledged there were complaints of tingling in his right arm at that time. He opined these symptoms were not describing a C5/6 problem, and there was no diagnosis of radiculopathy. Dr. Russell testified that Petitioner's stated history was that he had no prior cervical pain or disability. (Px1).

On cross examination, Dr. Russell couldn't determine a specific date when Petitioner returned to work, but that he had released him to full duty by 5/31/12. He agreed that in workers compensation claims it can be helpful to review all of the relevant records in determining causation. He agreed he didn't review any of Petitioner's medical records predating 9/19/11, or possibly from prior to his 11/11 initial visit. Petitioner told him that, during his two week vacation following 9/19/11, he was resting and taking pain medication. Petitioner didn't report what caused him to fall, just that he fell head first at his office, and it involved a door/wall. (Px1).

Respondent's counsel noted that a herniated disc was not specifically noted in either the cervical MRI report or the surgical report. Dr. Russell explained that a collapsed disc can have a component of disc herniation as well, and that a herniation was seen during surgery: "There's usually a combination of disc material as well as the osteophytes or the spurs, and that corresponds with the degenerative disc disease", and "This was not just a disc herniation, this was more degenerative disc disease." He agreed that such degeneration worsens over time. In response to the question, "Okay. It was degenerative disc disease rather than a disc herniation?", Dr. Russell replied, "Right." Dr. Russell also conceded that, regarding his opinions on causal connection, he relied upon what the Petitioner told him, and that he indicated that the symptoms that were consistent with C6 that he did not have prior to the fall at work. (Px1).

On re-direct, Dr. Russell opined that the disc herniation, osteophytes, and degenerative changes at C5/6 were all objective findings during surgery that corresponded to Petitioner's symptoms. The Petitioner's loss of cervical lordosis was a nonspecific finding. Dr. Russell agreed that Petitioner's degenerative C5/6 changes were preexisting, but that he performed surgery due to unrelenting arm symptoms that persisted despite conservative treatment, the worst of which were relieved by the surgery, not the degenerative condition itself: "I'm not operating to make his X-rays look better, we're trying to relieve the nerve pain." On re-cross, Dr. Russell agreed his surgical report doesn't specifically note he found a herniated disc, but that there are always disc fragments with a collapsed disc. He testified the indication that he drilled through the disc space "includes herniated fragments, that includes degenerated fragments, that includes maybe some normal disc as we clean that out." Surgery also addressed degenerative findings like osteophytes (Px1).

Primary care provider Dr. Dossett testified on 6/24/16. Dr. Dossett testified that he had been treating Petitioner since 2005. On 10/4/11, Petitioner reported a 9/19/11 injury where he was in a closed room lifting some chairs and tripped, causing him to build up some momentum as he fell forward and his head hit into a closed door. Petitioner said he felt a sudden severe electrical sensation from his head to his toes, which could be due to a pinched nerve, and a sharp pressure sensation in the bilateral neck, left greater than right, which could have been due to muscles or nerves. He diagnosed injury to the head, cervical and thoracic spines. He testified that pinching of a nerve could cause bruising and/or swelling of the nerve, or something more permanent. Cervical X-rays showed multilevel arthritis, and tight muscles / loss of lordosis that could be due to the 9/19/11 incident. Petitioner next complained of right shoulder pain into the arm, which could be radicular. Dr. Dossett opined that the arthritis was preexisting, with stenosis of the foramina, but that injury to the nerve could have caused swelling, resulting in greater squeezing of the nerves and radicular symptoms. This determination was supported, in his opinion, by the initial electrical sensation and the subsequent neck tightness and pressure sensation. Dr. Dossett testified that, per the MRI report, "the good news was there was no herniated disk, but there was a lot of arthritis, particularly at C5-6. They described a broad based posterior osteophyte, which is a big bone spur, and was resulting in some narrowing of the disk, and this bone spur was very close to where the right nerve root would exit at one of the images, producing some narrowing at the C5-6 disc area." Dr. Dossett continued Petitioner off work through the surgery, and continued to prescribe medications for him after surgery. Dr. Dossett noted he had diagnosed a herniated disc on 12/7/11, and that he was "not sure if that is technically correct." On 12/7/11, Petitioner reported weakened right grip. On 1/19/12, he reported a new complaint of similar left arm symptoms. To his knowledge, Petitioner did not have cervical complaints prior to the 9/19/11 fall, going back to when he initiated treatment in 2005. Dr. Dossett agreed that Petitioner's 2/13/12 surgery was an appropriate intervention, given Petitioner's symptoms, and that it was related to the 9/19/11 fall, but agreed he believed there was a fusion but hadn't reviewed the operative report. (Px2)

On 3/2/12, Petitioner returned to Dr. Dossett and had improved with surgery, with normal findings other than reduced sensation of his right thumb and index finger and complaints of some continued right finger numbness. By 6/1/12, Petitioner had no pain in his neck or arm and normal right grip, and he was doing well after two

weeks of regular work. Petitioner was happy with the results. On 9/5/12, Dr. Dossett noted persistent numbness in his fingertips was related to the alleged work accident, testifying that, "I would say the only complaint related to the original injury was the persistent numbness in his fingertips." Petitioner reported that Dr. Russell said the numbness should continue to improve over time. As to complaints of chest pain on 11/13/12, Dr. Dossett agreed it could be residual neck discomfort, but could be unrelated. Dr. Dossett did not review any physical therapy records. (Px2).

On cross-examination, Dr. Dossett did not believe he reviewed the 7/19/11 Fayette County ER records. He agreed that posterior headache complaints like those Petitioner made on 8/16/11 could be cervical related, but that he had a migraine on that date that was unrelated to the neck. Dr. Dossett conceded that Petitioner's cervical arthritis was degenerative and could worsen with activities of daily living. Dr. Dossett also conceded that that his only information regarding Petitioner's alleged accident were from what Petitioner had told him, and that if the facts of the alleged accident were different, it could affect his causation opinion. (Px2).

The evidence deposition of Respondent's Section 12 examining orthopedic surgeon Dr. Stiehl was taken on 3/3/16. Dr. Stiehl testified he is board certified, and for the past 7 years has a general orthopedic practice. While he has experience with a significant number of spine cases in his career, his spinal practice is a small percentage of his patients. Petitioner provided a history of doing paperwork on 9/19/11 when he tripped and fell to floor, after which he went on vacation and did not seek treatment until 10/4/11. He noted his 10/15/14 examination of Petitioner was normal, and MRI showed degenerative arthritis, most pronounced at C5-6, but no disc herniation or significant canal or foraminal stenosis: ". . . I could not prove that he had radiculopathy from my point of view." He believed Petitioner had cervical arthritis and "at some point" developed radiculopathy that led to the need for surgery. He opined that the 9/19/11 fall did not cause the condition, but that Petitioner suffered a temporary aggravation of his pre-existing degenerative arthritis on 9/19/11, and that his need for cervical surgery was not due to this incident. This was based on Petitioner not seeking immediate treatment and "there was no way of verifying his claim." (Rx1).

Following his review of Petitioner's 7/19/11 records from the Fayette County Hospital ER, which showed complaints of headaches, blurred vision, severe symptoms in his jaw and in his neck, and also right arm numbness and tingling, Dr. Stiehl revised his opinions. He testified that these records indicated a chronic right radiculopathy given the report of numbness and tingling in his right hand. The chronic arthritis was clearly preexisting, and severe enough on 7/19/11 for him to go to the ER. After the alleged injury, however, he didn't seek treatment until 10/4/11, after going on a cruise and being off work for two weeks. He didn't believe there was a significant injury on 9/19/11. He testified: "I have no evidence in the record or actually by his own admission that there had been an injury that caused a neck condition . . . Or aggravated it." Dr. Stiehl noted that Petitioner's symptoms were severe enough on 7/19/11 that he went to the emergency room, where he noted right arm numbness and tingling and had pain enough to undergo a head CT, but after the 9/19/11 incident he did not, and instead went on a cruise. Dr. Stiehl testified that cervical arthritis is a degenerative condition that worsens over time, but: "There can be conditions where we know that the cause was significantly aggravated by a neck condition, like if you're in a car wreck its extremely common to have whiplash and that can be an aggravation that can actually aggravate patients wo have arthritis." Dr. Stiehl also opined that Petitioner may have had to have the surgery that he underwent even if he did not suffer the alleged work accident. (Rx1).

On cross-examination, Dr. Stiehl agreed that he has never performed cervical surgery himself, and that he operates on knees and shoulders. He agreed that Dr. Russell would be more knowledgeable about surgical treatment, but that he is highly qualified to evaluate cervical conditions and would be equally qualified to make determinations regarding causation of cervical spine conditions. Dr. Stiehl agreed that Petitioner's cervical treatment was reasonable and necessary, including surgery, and that he did not question the Petitioner's veracity

or desire to recover. He agreed the Petitioner reported having numbness and tingling since the injury, which is significant to him, and that while he Petitioner reported an immediate electrical sensation, "I don't know what led to that." (Rx1).

Dr. Stiehl testified that he did not think that Petitioner's arthrosis was caused by the September 19, 2011 injury, but stated the he had written in his first IME report that if Petitioner had pre-existing arthrosis of his cervical spine, that condition could have progressed after the above-noted injury. His review of the MRI films showed osteophytes, but no evidence of a disc herniation. He opined that 10/5/11 cervical x-rays showed no significant changes beyond degenerative arthritis and a C5/6 osteophyte, and that the degeneration he saw was normal for Petitioner's age group. He initially testified that he did not see a loss of lordosis in cervical films, and then indicated he did not know if he did or not. He agreed the Petitioner's stated mechanism of injury could have resulted in an acute disc herniation. Dr. Stiehl conceded that Petitioner was not diagnosed with C6 root symptoms during his pre-incident 7/19/11 ER visit, but noted Petitioner had complaints of the occipital area of the head, i.e. base of skull which he would consider the neck, as well as numbness and tingling in the right upper extremity. As such, he believed this was evidence of a preexisting cervical condition, and he testified that he disagreed with the ocular diagnosis at Fayette County. Dr. Stiehl testified that he did not see any finding of a disc herniation noted in Dr. Russell's operative report. (Rx1).

On re-direct, Dr. Stiehl agreed that he changed his opinion regarding the 9/19/11 incident and progression of the preexisting condition after he reviewed the 7/19/11 ER report. His review of the MRI agreed with the radiologist's report regarding no evidence of cervical body compression forming or cervical disc herniation. Dr. Stiehl agreed that had Dr. Russell documented a herniated disc in the operative report, he would not be able to dispute it since he was not present during surgery. Had he found one during surgery, he would have reported it. (Rx1).

Petitioner presented his medical expenses as Px9 and 10. According to Arbx1, the exhibits contain a subrogation claim from the Petitioner's wife's health insurance plan totaling $60,955.85, as well as an outstanding bill from Phoenix PT totaling $194.00.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner sustained his burden of proof that he sustained accidental injuries arising out of and in the course of his employment on 9/19/11.

The Petitioner testified that he was at his office on the late afternoon of 9/19/11 to tie up some loose ends before starting his vacation. He testified that he was moving a box of ticket books when he tripped over a desk drawer he had on the floor of his office, causing him to fall headfirst into the office door.

With regard to the "in the course of" element to accident, the Petitioner testified that he was present at the Respondent's business office, and in his own office, for work activities. The activities described by Petitioner would clearly be within the course of his work duties. No evidence was presented in rebuttal, other than that regarding credibility as noted below. The Arbitrator finds the Petitioner's testimony to be credible regarding his

presence and work activities on 9/19/11, and this he has proven by the preponderance of the evidence the "in the course of" element of his accident claim.

The main thrust of Respondent's dispute is with regard to the "arising out of" element of the accident claim. As the Petitioner was the only party present, per the evidence presented, when the alleged incident occurred on 9/19/11, the only real defense the Respondent has to this claim is the argument that the Petitioner's story is not credible, and that the accident did not happen the way he said it did.

Taking Petitioner's testimony alone, he was walking in his small office, carrying a box, and tripped over a drawer that was lying on the floor because it was broken. The Arbitrator notes that while the act of walking, in and of itself, would be a neutral risk that would not be increased over and above the employment, the noted facts indicate that the employment increased the risk of injury. The photographs of the Petitioner's office support that the office was small in terms of area to walk. The Petitioners wife took the photos several weeks after the accident, apparently when they had returned from their cruise, however the Petitioner testified the photos accurately depicted what the office looked like on the accident date. The photos also support the Petitioner's testimony that the office had piles of paperwork and boxes in it. The Arbitrator believes that these factors, along with the Petitioner's testimony that he was carrying a box in that office, supports that there was an increased risk of injury which arose out of the employment.

There are three things which the Arbitrator agrees leads to questions in this case. First, Petitioner did not report the injury until 9/21/11. Secondly, Ms. Durbin's testimony is noted. She testified that when the Petitioner reported the accident, he did not indicate that he tripped over the drawer, and when she went into the office to look at how he could have tripped following his reporting, she did not see a drawer on the floor or boxes in the office. She further testified that she had no knowledge that the Petitioner's desk drawer was even broken. Third, he did not seek any medical treatment prior to or during his vacation, and thus waited over two weeks for an initial examination.

With regard to the initial question, while the Arbitrator notes this was two days after the alleged incident, it only skipped a single "work day", as the accident occurred in the late afternoon/evening of 9/19/11. This delay in reporting does not appear to be unreasonable given the Petitioner's testimony that he wanted to see if he would improve, and that he was trying to get ready for a pre-planned vacation.

While Ms. Durbin testified that Petitioner didn't say anything about tripping over a drawer, he did indicate he was moving things in the office when he fell. Her testimony that she went and looked in his office and did not recall seeing any boxes would mean that the Petitioner essentially staged the photographs of his office that were taken by his wife. The photos just do not appear to the Arbitrator to have been staged, and they depict a significantly messy and small office space. Ultimately, the Arbitrator finds the Petitioner's testimony regarding the office status to be credible. There is some question as to whether the drawer was on the floor, as Ms. Durbin testified that she laid down on the floor to look and see what the Petitioner could have tripped on. However, again, the issue with the drawer would appear to the Arbitrator to be a strange story for the Petitioner to have made up. Additionally, the Arbitrator believes that the cramped office and carrying the box when he fell would in itself be sufficient evidence that a compensable accident occurred regardless of the drawer. Tripping over the drawer would just make it even more clearly a compensable accident.

As to the treatment, it does appear that, based on the witness testimony, the Petitioner went on his vacation and enjoyed himself while engaging in a number of activities. However, at the same time, the fact that he wasn't totally disabled does not prove that he was not in pain, and it does seem reasonable to the Arbitrator that the Petitioner would have tried to enjoy a preplanned and paid for vacation with other people. The witnesses who

testified appeared credible in terms of the Petitioner not mentioning pain or that an incident occurred at work. However, the Petitioner had already reported the accident at that point, so it certainly doesn't seem that he made it up. This adds credibility to his wife's testimony that he did not want to cause the other people they were on vacation with to have a bad time because of him.

Overall, while the Respondent's dispute in this case is reasonable, the Arbitrator believes that the greater weight of the credible evidence in this case supports that the Petitioner sustained a compensable accidental injury on 9/19/11.

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

The Arbitrator finds that the Petitioner sustained his burden of proving that his cervical condition of ill-being is related to the 9/19/11 accident.

First, the Arbitrator's review of the 7/19/11 ER report reflects a completely different situation than the one Petitioner had following the 9/19/11 accident. On 7/19/11, at the ER, the Petitioner's complaints included nausea, headache, blurred vision, jaw pain, double vision, and right arm tingling. It was also noted that he had a "weird feeling in jaw and neck." He testified that this came on spontaneously while he was driving during work. The diagnosis was an ocular problem. The only films that were obtained were of the Petitioner's head. While Dr. Stichl opined that this may have been an incorrect diagnosis and that the complaints related to the cervical spine, the greater weight of the evidence does not support this speculative opinion. The complaints, while they did include the neck to some degree and the right arm, involved other complaints that clearly predominated based on the evidence in the ER records. The cervical complaints after the accident are more significant, and the accident itself involved a trauma where the Petitioner went headfirst into a door or wall, which would constitute, in the Arbitrator's view, a fairly significant trauma to the head and likely the spine. There was no trauma indicated on 7/19/11, but rather a spontaneous onset of symptoms, the greater degree of which does not appear to involve the cervical spine in any way. Dr. Russell's opinion in this regard is more persuasive to the Arbitrator, as Dr. Stiehl's opinion is more reliant on speculation.

Otherwise, there is no evidence that the Petitioner had preexisting symptoms similar to that which he had after the accident. The accident itself, as described by Petitioner, as noted, appears to be a significant trauma in that he tripped headfirst into a solid object. He tripped with enough force to cause his head to bleed, and to strike a chair resulting in a significant bruise. The mechanism of injury therefore, just by common sense, could have injured the cervical spine.

Dr. Stiehl's testimony regarding a denial of a causal relationship in this case is not persuasive to the Arbitrator. At one point, he testified: "I have no evidence in the record or actually by his own admission that there had been an injury that caused a neck condition . . . Or aggravated it." This is simply false. The Petitioner specifically reported an injury that he indicated caused his symptoms. To say there is "no evidence in the record" seems to the Arbitrator to show a level of bias on the part of Dr. Stichl in this case. Dr. Russell opined the mechanism of the injury could have caused the C5/6 disc or aggravated a preexisting condition at that level, resulting in symptoms, and that the symptoms resulted in the need for surgery. Ultimately, the Arbitrator finds the testimony of Dr. Russell supporting a causal relationship to be more persuasive than that of Dr. Stiehl.

The Arbitrator's review of the evidence indicates the Petitioner had fairly significant preexisting cervical degeneration. While Respondent argues, in part, that any cervical condition the Petitioner had was due to a preexisting condition, the case at bar calls to mind the case of *Sisbro v. Industrial Comm'n*, 207 Ill.2d 193, 797

N.E.2d 665, 278 Ill.Dec. 70 (2003). In that case, the Supreme Court reiterated the axiom: "It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." The key question is whether the work incident is a causative factor in the claimant's condition of ill-being. Here, the Arbitrator finds that the work accident of 9/19/11 was at least a causative factor in the Petitioner's development of symptoms, and resultant need for surgery.

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

Based on the Arbitrator's findings with regard to accident and causation, as noted above, as well as a review of Px9 & 10, the Arbitrator finds that the Petitioner is entitled to the expenses presented in Px9 and Px10 which are causally related to the accident. However, the Arbitrator denies the bill from Phoenix Physical Therapy. There was no evidence of a referral to this facility from any of the treating physicians, and the report is addressed to the Petitioner's attorney. Thus, this visit and report appear to be related to an independent therapy examination at the request of the Petitioner, and does not constitute reasonable and necessary treatment pursuant to Section 8(a) of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to Arbx1, the Petitioner claims he is entitled to TTD from 10/4/11 through 5/21/12.

At the time of the hearing, the Respondent indicated that the dispute with regard to TTD rests on liability for same, and there is no dispute with regard to the time period being claimed by Petitioner. Given that liability has been found in favor of the Petitioner, the Arbitrator finds that the Petitioner is entitled to TTD from 10/4/11 through 5/20/12. While Petitioner claims TTD through 5/21/12, he testified that he returned to work on that date, and this is not entitled to TTD on 5/21/12.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment rating was submitted into evidence by either party, and therefore this factor carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a deputy sheriff at the time of the accident. He returned to that position for a significant period of time before the job was eliminated by the Respondent. Thus, it does not appear from the evidence that his departure from Respondent's employ had anything to do with his injury. It does not appear that the deputy sheriff position was tremendously physical and was more of a desk job, while his current job appears to be much more physical. At the same time, evidence was not presented as to whether the Petitioner had or has other opportunities to work in a less physical position. Based on this evidence, the Arbitrator finds that this factor tends to show a somewhat greater degree of permanency than one who returns to their regular job position.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. No evidence was presented by either party with regard to the impact of the Petitioner's age on his permanent condition relative to the sequelae of the accidental injury. As such, the Arbitrator does not speculate regarding same, and this factor carries no weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that while evidence was presented that the Petitioner is working in a different and more physical job, no evidence was presented with regard to whether his future earning capacity was impacted by the work injury. Thus, this factor tends to show a lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner appears to have had a very good recovery following surgery, based on Dr. Russell's last report indicating he was doing well and that his neck felt great. The main residual complaint the Petitioner had post-surgery was ongoing numbness in his finger. While the Petitioner complains of soreness and being very tired after working at his current job on a daily basis, he was released to full duty work and has shown an ongoing capability to perform a much heavier physical job than the one he had with Respondent. In general, the Petitioner's testimony is consistent with the medical records, with a solid post-surgical recovery, and this factor carries reasonable weight in the permanency determination.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Denise Goins,

Petitioner,

vs.

Nos. 14 WC 03846
15 WC 07219

Illinois Department of Veterans' Affairs,

18IWCC0734

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, 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, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

On February 5, 2014, Petitioner filed an application for adjustment of claim, which received case No. 14 WC 03846, alleging that on October 30, 2013, she sustained accidental injuries to the hands, wrists, elbows, knees, left shoulder and person as a whole when she slipped and fell on wet floor. On March 3, 2015, Petitioner filed an application for adjustment of claim, which received case No. 15 WC 07219, alleging repetitive trauma to the hands, wrists and elbows, with the manifestation date of November 22, 2013.

Petitioner, who was 40 years old at the time of the arbitration hearing, testified that she was right hand dominant. Petitioner admitted having high blood pressure since 2006, which was controlled with medication. Petitioner denied being diabetic or a smoker. Petitioner acknowledged having symptoms in her right hand, but not the left hand, before October 30, 2013. The right hand bothered her during the day on certain days when she used it more, and the symptoms progressively became more noticeable. Petitioner mentioned the right-sided symptoms to her doctor, but was not referred to a specialist.

Petitioner further testified that she worked for Respondent since 2003. Initially, she was an executive secretary. Petitioner did not describe her job activities as an executive secretary, other than mentioning writing down meeting minutes every day. In 2012, Petitioner became a human resources associate. Her job duties included "filing, data entry, *** payroll, so a lot of computer entry, typing." She pulled files out of cabinets and boxes, sometimes needing to use force when the files were packed tightly. On Mondays, when she performed filing duties, she would "touch at least 75 to 80 file folders." On cross-examination, Petitioner clarified that was an unusually large number of folders because she had to update annual paperwork. On days when Petitioner did payroll, she mostly did data entry. Petitioner indicated she used a computer mouse with her right hand and typed on a keyboard that rested in a pull-out drawer. Petitioner stated she spent a lot of time doing data entry and looking things up, also stating she was on the computer "on and off." Doing payroll involved "constant data entry." Petitioner tried to enter payroll data daily, and closed it out every two weeks. On a typical day, she spent 30 to 45 minutes entering payroll data. Doing payroll close-out would usually take "most of the morning." On cross-examination, Petitioner clarified that typing and data entry, including payroll, took three to five hours a day. Petitioner also spent a significant amount of time on the phone, handling between five and 15 calls a day, for a total of about an hour a day.

Melanie McReynolds, Petitioner's supervisor, testified that she worked with Petitioner daily. Ms. McReynolds summarized Petitioner's job duties as follows: "60 percent of her job duties is data entry and payroll entry. The rest of the day is answering random phone calls ***, answering e-mails, staff requests." Ms. McReynolds stated Petitioner needed to process 75 to 80 folders only once a month and pull boxes of files only once or twice a year. Daily filing was "very infrequent." On the other hand, Petitioner did data entry daily.

On October 30, 2013, Petitioner slipped and fell on wet floor near the employee entrance, landing on her hands and knees. Petitioner testified she "hit the floor hard" and felt pain in her hands, knees, shoulders and wrists. She reported the accident, but stated she sustained no injury as she understood it. She did not seek immediate medical care. After the accident, Petitioner was "in pain for a couple weeks." The symptoms in the right hand became almost constant, and she developed symptoms in the left hand. Ms. McReynolds, Petitioner's supervisor, testified that Petitioner reported her fall and complained of soreness in her hands and knees. Thereafter, Petitioner would mention stiffness and soreness in her hands every so often.

On November 22, 2013, Petitioner sought treatment at Union County Hospital. The medical records from Union County Hospital show Petitioner sought emergency treatment for bilateral wrist complaints, reporting a sudden onset while at work. X-rays were unremarkable. The attending physician diagnosed wrist sprains.

Petitioner followed up with Dr. Christine Lucas for complaints of soreness in the wrists, among other things. The medical records from Dr. Lucas show that on December 12, 2013, Petitioner reporting slipping on wet floor at work and falling on her hands and knees on October 30, 2013. Regarding Petitioner's upper extremities, Dr. Lucas noted: "She states she is having a constant aching pain in her palms, forearms and going up into her elbows. She is sometimes unable to sleep on her left side due to the pain in the arm there. She freely admits to being a big fan of her smart phone playing games and doing Facebook and if she holds her phone in a certain position for any length of time her hands will start twitching and she has to switch hands. She does do a lot of data entry as part of her job especially when it is around payroll time. She needs to do 3 to 5 hours of data entry and that seems to really worsen her symptoms. At times when she is sleeping the pain will wake her from sleep. *** Her right hand would get numb and goes to sleep prior to this injury and she felt that this was likely related to her occupation and an overuse-type syndrome and she knew that eventually she would need to do something about that but it has significantly worsened this fall." Dr. Lucas noted Petitioner weighed 228 pounds. Dr. Lucas diagnosed bilateral forearm, wrist and hand paresthesias and pain, which she related to "a ground-level fall on a wet tile surface at [the patient's] workplace causing the patient to land on all 4s." Dr. Lucas recommended electrodiagnostic studies and an orthopedic consult.

On January 22, 2014, Petitioner saw Dr. Michael Davis at the Orthopaedic Institute of Southern Illinois on a referral from Dr. Lucas. Dr. Davis noted the following: "She reports that on 10/30/2013, she was at work and was attempting to walk on the floor that has had some water spilled on it ***. She slipped on the floor. Her right leg went out behind her and she reports that she fell landing directly on both knees and both wrists. She had pain, but conservatively managed it. *** She has had a gradual progression over the past several months. Her pain is now a 5 in intensity. It is generally dull, sometimes burning, but it aches if she uses her hands too much. *** She has numbness in her hands more on the left than the right and some activities including writing or using keyboard or mouse a lot seem to exacerbate her right hand symptoms." Dr. Davis noted Petitioner was 5 feet 4 inches tall and weighed 225 pounds. Physical examination was significant for a positive Finkelstein's test and tenderness to palpation in the first dorsal compartment on the right. Light touch sensation was subjectively diminished in the median nerve distribution on the right and slightly in the ulnar nerve distribution. There was tenderness to palpation in the anatomic snuffbox, more on the left than the right. Dr. Davis diagnosed bilateral carpal tunnel syndrome and a right de Quervain's tenosynovitis, and ordered electrodiagnostic studies. The electrodiagnostic studies, performed February 20, 2014, showed a moderate left and a mild right carpal tunnel syndrome. On February 26, 2014, Petitioner followed up with Dr. Davis, who prescribed splints and occupational therapy.

Dr. Davis, an orthopedic surgeon, testified by evidence deposition on August 24, 2017, that Petitioner returned on April 10, 2014, complaining of persistent symptoms in the wrists. Dr. Davis recommended a carpal tunnel release "on her more symptomatic left side." Regarding the right side, Dr. Davis thought it might improve with conservative treatment. Petitioner has not returned since.

Dr. Davis provided the following causation opinion: "I do not think that [the fall] was the sole cause [of the carpal tunnel syndrome]. I do not have electrodiagnostic studies to confirm before and after the fall, but my medical opinion would be that there was probably some component of carpal tunnel syndrome before her fall." Dr. Davis agreed the fall could have aggravated the carpal tunnel condition on the left side and the right side. Regarding the cause of the underlying carpal tunnel syndrome, Dr. Davis opined: "The described work activities are consistent with the development of [bilateral] carpal tunnel symptoms." In formulating his causation opinion, Dr. Davis relied on the history Petitioner provided to him, as well as the history noted by Dr. Lucas. Dr. Davis generally understood Petitioner's job duties to involve writing and using a keyboard or a mouse. When asked about comorbid factors, Dr. Davis acknowledged: "Her body mass index was elevated and she had a history of hypertension." Dr. Davis further acknowledged that Petitioner's gender and age could have played a role in the development of carpal tunnel syndrome.

On November 4, 2014, Dr. Anthony Sudekum, a hand and upper extremity surgeon, examined Petitioner at Respondent's request, noting the following history: "[The claimant] has a history of RIGHT carpal tunnel symptomatology predating *** October 30, 2013. [The claimant] states that on October 30, 2013 she was walking into work carrying Halloween candy and other belongings when she slipped and fell on a wet floor. She states that she landed on her bilateral palms and knees resulting in pain to her knees, hands, shoulders, back. She did not initially seek any medical evaluation or treatment for any injury related to this incident but did fill out workers compensation documents relating to this incident." Petitioner complained to Dr. Sudekum of bilateral hand and wrist symptoms, the right worse than the left. She also complained of right forearm and elbow pain, and left shoulder pain. Dr. Sudekum noted Petitioner was 5 feet 4 inches tall and weighed 225 pounds, corresponding to a BMI of 38.6. Dr. Sudekum obtained repeat electrodiagnostic studies, which were consistent with a mild right carpal tunnel syndrome and no left carpal tunnel syndrome.

Dr. Sudekum reviewed a job description from Respondent, noting the job required working on a computer. Dr. Sudekum then asked Petitioner to describe her job activities, noting: "She states that she spends approximately 80% of her workday at her desk/workstation where she performs a variety of office/clerical tasks including reading paperwork, reading documents on her computer screen, typing, keyboard entry, paperwork, filing, copying, talking on the phone, attending meetings, etc. Her job requires that she be able to type 30 words per minute. She states that she is responsible for payroll and also serves as the workers compensation coordinator for her employer."

Dr. Sudekum diagnosed a preexisting right carpal tunnel syndrome, which he opined was unrelated to the fall on October 30, 2013. Rather, Dr. Sudekum related the right carpal tunnel syndrome to "non-work related risk factors *** including female sex, her age over 37 years, obesity and hypertension and her hobbies and habits including painting, crafts, cooking, housework, scrapbooking and using smartphone for computer games and Facebook."

On June 15, 2017, Dr. Sudekum reexamined Petitioner. Petitioner gave a job history of working as a human resources associate for five years (since 2012) and, prior to that, as an executive secretary for eight years. She gave the same description of her job activities as she did during the initial section 12 examination. Petitioner also reported that since the initial section 12 examination, she had undergone a gastric bypass surgery and lost 100 pounds. She complained of persistent symptoms in the upper extremities, the right side slightly worse than the left, as well as occasional neck pain. Dr. Sudekum obtained updated electrodiagnostic studies, which showed mild bilateral carpal tunnel syndrome, worse on the right. Dr. Sudekum diagnosed mild bilateral carpal tunnel syndrome and possibly cubital tunnel syndrome or other pathologic process, such as bilateral Raynaud's syndrome (spastic vasculopathy affecting blood vessels) or cervical pathology. Dr. Sudekum opined that none of the conditions would be related to Petitioner's job activities, referencing research studies that do not support a causal relationship between clerical activities and the development or aggravation of carpal tunnel syndrome. Dr. Sudekum continued to attribute the carpal tunnel syndrome to nonwork-related risk factors. Dr. Sudekum thought surgical treatment might be appropriate, although not related to Petitioner's work for Respondent.

Dr. Sudekum testified consistently with his reports in his evidence depositions taken February 28, 2017 and September 12, 2017. Regarding the upper extremity injuries Petitioner sustained in the fall, Dr. Sudekum opined "she may have sustained mild contusions of her hands and her wrists," which resolved by the time of his initial examination.

At the time of the arbitration hearing, Petitioner was still working for Respondent in her regular job. Petitioner testified that she continued to suffer from symptoms in her hands and wrists. She noticed the symptoms more in her right hand because she used it more. Petitioner was ambivalent about having surgery, but wanted to resume treating with Dr. Davis.

Having carefully considered the record before us, the Commission gives greater weight to the opinions of Dr. Davis and finds that Petitioner proved, by a preponderance of the evidence, she sustained cumulative trauma to her hands and wrists from her job activities and her fall on October 30, 2013. The Commission therefore affirms the Arbitrator's award of medical expenses in the sum of $4,708.83, with any outstanding bills payable pursuant to the fee schedule, and prospective medical care recommended by Dr. Davis.

18IWCC0734

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2018, is hereby affirmed.

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, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

NOV 30 2018

DATED:
o-11/01/2018
SM/sk
44

Stephen Mathis

David L. Gore

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain her burden of proving that any current conditions of ill-being were caused by her work activities and denied compensation.

Petitioner alleged two separate accidents. One a fall on October 10, 2013, in which she landed on her right hand, and one a repetitive traumatic accident which caused manifestation of a condition of bilateral carpal tunnel syndrome on November 22, 2013. On review, Respondent stipulates to the fall accident on October 10, 2013, but seeks review of the alleged repetitive traumatic accident as well as causation.

Petitioner testified her work involved general clerical activities, including data entry, handling of files, and taking telephone calls. Petitioner also testified that she mostly noticed symptoms in her hands while using her cell phone to play games and accessing Facebook, which

obviously are not work-related activities. Her orthopedic surgeon, Dr. Davis, testified by deposition that all he knew about Petitioner's work activities was that it involved writing and using a keyboard or mouse. He did not know the frequency of the various functions Petitioner performed. He also did not consider the coincidence between her symptoms and her nonwork-related activities on her cell phone. Nevertheless, he opined that her work activities were consistent with development of carpal tunnel syndrome. He also opined that her fall on the right hand could have aggravated a pre-existing condition of carpal tunnel syndrome.

On the other hand, Respondent's Section 12 medical examiner, Dr. Sudekum, reviewed a description of Petitioner's job activities and interviewed her extensively about those job activities. Based on his understanding of Petitioner's job activities, Dr. Sudekum concluded that her work activities did not amount to repetitive trauma and that her bilateral carpal tunnel syndrome was not causally related to those job activities. Dr. Sudekum also noted that while Petitioner's fall could have caused a contusion and/or sprain, it was not of a sufficiently severe nature to contribute to the development of carpal tunnel syndrome. He noted that any injury sustained in that fall had resolved at the time of his Section 12 medical examination. It is also noteworthy that Petitioner did not ascribe her carpal tunnel syndrome symptoms to her fall until two weeks after the fall occurred, putting in considerable doubt any connection between the fall and her carpal tunnel symptoms.

The Arbitrator, and through its affirmation the Commission, determined that the opinions of Dr. Davis were more persuasive than those of Dr. Sudekum. I disagree with that assessment. In my opinion, Dr. Sudekum had a much better and more detailed understanding of Petitioner's work activities than did Dr. Davis. In addition, I subscribe to the general theory that normal clerical activities such as the use of a keyboard, use of a mouse, and regular and substantial hand activities are not alone sufficient to contribute to the development of carpal tunnel syndrome.

Rather, in my opinion to contribute to carpal tunnel syndrome, the activities have to involve forceful repetitive activities, significant prolonged vibration, or prolonged unnatural extension or flexion of the hands/wrists. Petitioner has not proven any of these factors. In addition, Petitioner testified that she had symptoms of carpal tunnel syndrome prior to her fall and she did not relate her symptoms to her fall for a period of weeks. Therefore, I find persuasive Dr. Sudekum's opinion that the fall did not contribute to her carpal tunnel syndrome.

Based on the persuasive opinions of Dr. Sudekum, I would have found that Petitioner did not sustain her burden of proving a repetitive traumatic accident or a causal connection between her work activities and/or fall and her carpal tunnel syndrome, reversed the Decision of the Arbitrator, and denied compensation for that condition. For these reasons, I respectfully dissent.

Deborah L. Simpson

Deborah L. Simpson

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

GOINS, DENISE
Employee/Petitioner

Case# **14WC003846**

15WC007219

DVA/ANNA VETERANS' HOME
Employer/Respondent

18IWCC0734

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPARTICK LAW OFFICES PC
ERIC KIRKPATRICK
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BELLEVILLE, IL 62226

0558 ASSISTANT ATTORNEY GENERAL
SHANNON RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 2 - 2018

Ronald A. Piccin
RONALD A. PICCIN, ACTING Secretary
Illinois Workers' Compensation Commission

18IWCC0734

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Denise Goins
Employee/Petitioner

v.

DVA/Anna Veterans' Home
Employer/Respondent

Case # **14** WC **3846**

Consolidated cases: **15 WC 7219**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **2/15/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/30/13 & 11/22/13**, 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 **$44,565.79**; the average weekly wage was **$900.00**.

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

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

Respondent shall be given a credit of **$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 if any medical bills were paid by group carrier under Section 8(j) of the Act.

ORDER

THIS ARBITRATOR FINDS PETITIONER HAS PROVEN AN ACCIDENT ON EACH CLAIM FOR THE REASONS DESCRIBED IN THE ATTACHMENT.

THIS ARBITRATOR FINDS PETITIONER HAS SUSTAINED HER BURDEN OF PROVING A CAUSAL RELATIONSHIP BETWEEN THE CARPAL TUNNEL SYNDROME AND THE ACCIDENTS. SPECIFICALLY THE ARBITRATOR FINDS THE UNDERLYING WORK ACTIVITIES TO BE AN UNDERLYING CAUSE OF THE CARPAL TUNNEL (15 WC 7219) WITH THE FALL OF OCTOBER 30,2013 (14 WC 3846) BEING AT LEAST AN AGGRAVATION OF THE PREEXISTING CONDITION OF THE RIGHT HAND AND AN AGGRAVATION OR DIRECT CAUSE OF SYMPTOMS IN THE LEFT HAND THAT NECESSITATED THE TREATMENT AS RECOMMENDED BY DR. DAVIS.

PETITIONER IS AWARDED PROSPECTIVE MEDICAL CARE AS SUGGESTED BY DR. DAVIS.

PETITIONER IS AWARDED MEDICAL EXPENSES IN THE AMOUNT OF $4,708.83. RESPONDENT IS ENTITLED TO A CREDIT FOR ANY AMOUNTS ALREADY PAID WITH ANY OUTSTANDING BILLS BEING PAID PURSUANT TO THE FEE SCHEDULE. RESPONDENT ENTITLED TO AN 8(J) CREDIT FOR ANY AMOUNTS PAID BY PETITIONER'S APPLICABLE GROUP INSURANCE CARRIER.

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

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

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

Signature of Arbitrator

3/26/18
Date

APR 2 - 2018

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

18IWCC0734

This case comes on Petition for Immediate Hearing

Petitioner filed two cases that were consolidated for hearing. Case number 14WC 3846 is for traumatic bilateral carpal tunnel. Case number 15WC 7219 alleges carpal tunnel due to repetitive trauma from work activities. It is Petitioner's position that the bilateral carpal tunnel is related to one or both in combination.

Petitioner agreed she had night time symptoms in her right hand before the fall but did not have symptoms in her left hand before the fall.

Facts of the Traumatic Accident:

Petitioner, age, 40, had worked for the Illinois Department of Veterans Affairs since 2003. She walked into the facility on a stormy and rainy day and slipped on the wet floor near the time clock. The time clock was in the hallway near the entrance used by staff or vendors. The entrance was not used by the general public.

Petitioner fell onto both outstretched hands and knees. She felt pain in her wrists up to her shoulders. She described that basically her entire body was sore from all of her weight landing as it did.

She testified she assumed the pain would ease up. She had bruises on her knees. A month later she still had pain in both knees, both wrists and shoulders. She described the pain was in the base of her hands.

She testified on direct that prior to the fall she had experienced pain and numbness in the right hand on occasion and she felt this had probably been related to her work activities. This is so stated in the medical record of Dr. Lucas who saw her after the accident. She testified her prior symptoms on the right had been some pain and numbness in the right hand at night. Her symptoms on the right worsened after the fall to the point she had pain and numbness "24/7."

She had no symptoms in the left hand before the fall. Since the fall she has had constant symptoms of numbness and tingling.

Petitioner's Job Duties:

Petitioner stated her job duties consisted of data entry, payroll and typing, 5 days per week for 37.5 hours. She also performed filing which consists of grasping/pinching files to pull them from filing cabinets. She physically grabs the files, some of which are harder to pull than others. She stated that on occasion she pulls and replaces up to 75 to 80 files per day.

She spends a great deal of time entering data into a computer. Her keyboard is right above her lap. Her elbow sets below her hands on the keyboard and mouse. Her wrists set on the edge of the desk as she uses the mouse. Her hands are extended backwards as she types. Petitioner demonstrated this to the Arbitrator.

Both hands and wrists have gotten worse since the fall. She has pain in both hands as well as numbness. In order to keep working, she stops and "shakes her hands out." She takes ibuprofen every day. Her symptoms are constant.

She testified she desires to have the treatment suggested by Dr. Davis, her treating orthopedic surgeon.

On cross-examination, Petitioner testified that she put "no injury" on the Tristar report of injury (RE3) because when that was filled out on 10/31/13, the day after the accident, she did not have any visual injuries. She said she considered herself "injured" when the pain didn't go away, and bruising developed on her knees.

She agreed she had been pregnant in 2006; that she had lost 112 pounds in a 2-year period and described she previously had been overweight her entire life.

When she was asked how the fall made her symptoms worse, she said that now she has symptoms on the right that are constant and before they were only at night. She stated again that she had no symptoms in the left hand or wrist until after the fall.

Melonie Reynolds, Petitioner's supervisor testified that only 60% of Petitioner's job is data entry and that the filing to the degree petitioner and described occasionally once per month.

Respondent disputes accident and causation and the need for surgical treatment. In order to avoid redundancy, medical will be described in the causation section of this proposed decision.

Medical evidence:

To avoid redundancy, the medical evidence will be discussed in the causation section of this decision.

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

ISSUES AND DECISION:

ACCIDENT:

Each accident will be discussed separately. This arbitrator finds Petitioner has proven accident on both claims, case number 14WC 3846 and 15WC 7219.

The traumatic accident is clear. Petitioner walked through a doorway used by employees and vendors. She fell on a wet hallway near the time clock. She landed on both hands and knees. There is no indication that this event did not happen. Petitioner's testimony is uncontradicted. Petitioner suffered an accident that arose out of and in the course of her employment. Respondents exhibit 1,2,3, and 4 outline statements consistent with Petitioner's testimony and the medical evidence contains the same history of the fall and how she landed; on her outstretched hands.

As for the work activities, this arbitrator finds those to also arise out of and in the course of her employment. They were the duties of her job. Respondents witness merely disputed the frequency and duration of the activities. The real nature of this issue on the work activities is of causation.

CAUSATION:

It is first necessary to consider the medical evidence.

Petitioner was first seen at the Union County Hospital on November 22, 2013 This note shows a history of complaints in her right and left wrists which she sustained at work. She described the "symptoms/episode began/occurred suddenly." She was given a prescription for ultram. (PE 1)

Petitioner was then seen at Rural Health, Inc.by Dr. Lucas on December 12, 2013. The history reflects she was walking on a tile floor that she did not realize was wet and fell landing on her knees and outstretched hands. The note reflects she began to have quite a bit of pain and went to the emergency department. Petitioner stated the pain got worse the first two weeks after the fall as her whole body just hurt. She had not missed any work due to the injury.

Petitioner was having constant aching pain in her palms, forearms, and into her elbows. The note describes it as a constant ache in both hands. She was sometimes unable to sleep on her left side due to pain in her arm. She stated that she sometimes played games on her cell phone and her hand would start to twitch if she held the phone for length of time and would have to switch hands.

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

Dr. Lucas noted that Petitioner did a lot of data entry at her job especially around payroll time when she does 3-5 hours of entry and that tended to worsen the symptoms.

Petitioner described that her right hand would get numb and go to sleep prior to this injury and she felt that was likely related to her occupation and overuse type syndrome. That it had significantly worsened since her fall at work.

Petitioner complained of pain in her knees but that is not a part of this petition for immediate hearing.

Dr. Lucas noted full range of motion at the wrist with tenderness profusely about the wrist. Her diagnosis was bilateral forearm wrist and hand paresthesias and pain. Dr. Lucas requested an orthopedic evaluation.

Petitioner was seen by Dr. Mike Davis, an orthopedic surgeon for the first time on January 22, 2014. Again the history was a fall on to the floor and landing directly on both knees and both wrists. She had stated she treated it conservatively and had had progression in pain over the last several months. Her pain was a 5 in intensity and generally dull but sometimes burning. It ached if she used her hands too much. The numbness in her hands was more on the left than the right and some activities including writing or using the keyboard or mouse at work seem to exacerbate her right-hand symptoms. After examination his impression was bilateral carpal tunnel syndrome with no evidence of cubital tunnel syndrome, and right wrist de Quervain's tenosynovitis. He requested an EMG/nerve conduction and allowed her to continue to work.

The EMG findings on the test of February 20, 2014 indicated moderate right and left median neuropathy at the wrist ---"carpal tunnel syndrome."

February 26, 2014 Dr. Davis noted some improvement with anti-inflammatories and he referred her to occupational therapy and the use of splints at night. He indicated that if she failed conservative treatment surgical intervention may be necessary.

On April 10, 2014 Dr. Davis noted that petitioner had been wearing her braces at night and had completed therapy but she was doing about the same. He stated that in light of her persistent symptoms she elected with carpal tunnel release on the left.

The occupation therapy progress summary dated April 10, 2014 noted petitioner subjected complaints that her right elbow and hand pain would increase with work activities on the computer. Work that required her to hold her hands in one position such as driving or performing haircare would cause cramping in her thumbs and hands.

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

Dr. Davis's deposition consisting of 37 pages was introduced as an exhibit. Dr. Davis testified that he reviewed Dr. Lucas's note of December 12, 2013 when he saw her for the first time on January 22, 2014. (Davis depo, p. 6) Dr. Davis testified that his diagnosis on that first visit was carpal tunnel syndrome in both hands as well as tendonitis of the wrist on the right. (Davis depo, p. 9)

His recommendations based on the persistence and duration of her symptoms was to proceed with carpal tunnel release on her more symptomatic LEFT HAND. His prognosis without surgery was that she would continue to be symptomatic with non-surgical treatment and with a small potential for improvement. Her prognosis after recovering from surgery was good.

With regard to her RIGHT HAND and wrist he felt that there was still the possibility for the right side to improve with non-surgical management. The left was more pressing.

On the issue of causation of the carpal tunnel and its relationship to the fall at work he did not think that it was the sole cause. He did not have electro diagnostic studies to confirm before and after the fall, but his medical opinion was that there was likely some symptom of carpal tunnel before her fall. He believed that the fall could have aggravated the underlining condition such that it necessitated the surgery that he was describing on her left side. (Davis depo, p. 14-15)

Dr. Davis was handed what he had previously reviewed, that in Dr. Lucas's medical of December 12, 2013 and asked if he it was the type of report relied on by physicians such as his self and the treatment of patients and he responded that it was. This note played a role in his formation of diagnosis and treatment. He agreed that the report indicated she did not have any left side problems prior to the fall. (Davis depo, p.16-17) Dr. Davis was then asked based on Dr. Lucas's report indicating symptoms in the right prior to the fall, whether the fall played a role in the aggravation of any pre-existing carpal tunnel syndrome on the right side he responded yes, as an aggravation of a pre-existing condition. (Davis depo, p. 18)

Dr. Davis was then asked to take into account the work activities that were described in Dr. Lucas's report of December 12, 2013 and was asked whether based from a reasonable medical certainty those work activities as described could have caused the underlying carpal syndrome. His response was that the work activities were consistent with the development of carpal tunnel syndrome on both the right and the left.

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

Respondent had petitioner evaluated three times, once by Dr. Petkovich and twice by Dr. Sudekum. Dr. Sudekum issued multiple reports.

Dr. Petkovich examined petitioner on December 12, 2014 but only for her knees which is not at issue at this time.

A very close look is taken at the evidence and testimony of Dr. Sudekum. Dr. Sudekum evaluated petitioner on November 4, 2014 and June 15, 2017. Each of his reports is 19 pages long and he had addendums to each. Dr. Sudekum evaluated petitioner one time for purposes of determining the causal relationship to the work activities and the carpal tunnel, and the second time to determine the causal relationship between the fall and the carpal tunnel.

Though Dr. Sudekum testified that his reports were not exact, the same is written in each report about the same medical evidence and information solicited from Petitioner. The paragraphs are simply put in different order. The only real exception to each report is that each denies causation for a different reason.

While repetition is not in and of itself is not unusual, in this particular case it brings Dr. Sudekum's credibility into question because of the nature of his incredible charges.

The following was brought out on cross-examination of Dr. Sudekum:

1.) The charge to the State of Illinois for the report of 2014 was $5,000.00;
2.) The charge to the State of Illinois for his report of 2017 was $5,000.00;
3.) His charge for the first the nerve conduction study he did was $1,330.00;
4.) His charge for the second nerve conduction study in 2017 was $1,548.00;
5.) He charged $2,000.00 for the deposition he did in 2014;
6.) He charged $2,000.00 for the deposition he gave again in September 2017;
7.) Dr. Sudekum sees 5 or 6 people per month for medical legal purposes and probably 2 of those are for the State of Illinois.
(RE 10, p. 20-23, 25)

The above totals $17,548.00.

This arbitrator notes nothing was asked about the charges for the two addendums.

Dr. Sudekum testified that this case took him 20 hours of work. (RE 10, p. 23)

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

While he claimed he reviewed additional records the second time, those were records from 1999 to 2005 those no additional records were set forth in the second report.

When asked what the charge to be for a one-sided carpal tunnel surgery, incredibly, the doctor testified that his charge would be $3,200.00. (RE 10, p. 24) The average for what he gets paid for a carpal tunnel surgery is $2,500.00 at least. (RE 10, p. 30)

Inquiry was then made of his income from surgery:

1.) He performs an average of carpal tunnel surgeries per week. (RE 10 p31) ($2,500.00 each = $5,000.00).
2.) Taking it a step further, he testified that he does an average of 4 or 5 surgeries per week that range in price from "a couple hundred bucks to several thousand dollars, maybe $10,000.00 being on the high end." (RE 10, p.31)

Assuming then, that Dr. Sudekum does one of the remaining "4 or 5" surgeries at $10,000, and another and does another at $5,000.00, and another at $200.00, the math for surgical income for a week comes to $20,200.00 for five surgeries. ($2,500.00 + $2,500.00 + $10,000.00 + $5,000.00 + $200.00 = $20,200.00)

The comparison is that for a claimed 20 hours medical-legal work for Denise Goins, he made $17,548.00 without taking into account the two addendums, within $3,000.00 of what he makes for 5 surgeries.

In addition to the above, Dr. Sudekum's credibility on the numbers he testified to is suspect. In reviewing his *first deposition* taken on February 28, 2017 in case number 14WC3846 the doctor testified on direct examination that he charges "$2,000.00 the first hour of deposition and then an additional $2,000.00 an hour after that." (2/28/17 Sudekum depo, p. 6)

He testified in September 2017 that he charged $2,000.00 for first deposition. If his testimony in the first deposition is to be believed, he actually charged $4,000.00 for the first deposition. The court reporter stated on page 3 of the 2/28/17 deposition that it started at 3:06 pm and finished at 4:53 – almost two hours.

Dr. Sudekum opined the carpal tunnel was not caused by the administrative duties or the fall at work. Though two depositions were taken, the testimony solicited was essentially the same.

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

On page 40 of his deposition he was asked "if this injury was not caused by an acute trauma, is there any additional testing for things of that nature that you would have done for Ms. Goins that you did not do?" The answer was "no."

It is then interesting that when he saw her the second time he chose to perform yet another nerve conduction study at a charge of over $1,500.00 as stated above.

During cross examination he testified that 80% of the folks that he sees for medical legal purposes are at the request of the employers or insurance companies or their lawyers.

He also agreed on cross examination that there were no records he reviewed from 1999 to indicate that there were any symptoms noted regarding either of her hands until the note of December 12, 2013 which gave a history of some prior issues on the right side.

As will be explained below, this Arbitrator finds in Petitioner's favor with regard to causation for the bilateral carpal tunnel syndrome as follows:

Left carpal tunnel syndrome;

This Arbitrator finds that the condition of Petitioner's left hand to be related to the traumatic accident of October 30, 2013. (14WC3846) It is significant that prior to the fall, Petitioner had no complaints or symptoms with regard to her left hand. There were no medical records to suggest that Petitioner had any symptoms in her left hand prior to the fall. Dr. Davis testified that there was a causal relationship. He testified that he did not have a nerve conduction study prior to the fall but opined that if there were such preexisting findings they were aggravated by the fall and the recommendation for the surgery was necessitated by the fall.

Right carpal tunnel syndrome;

This Arbitrator finds that the condition of Petitioner's right hand is related to both the repetitive aspects of her work activities and the fall suffered at work. Petitioner testified, and it is uncontradicted that before her fall she had symptoms of pain and numbness in her right hand on occasion but only at night time. She testified that after the fall her symptoms became progressively worse. Her symptoms became constant and progressively painful.

Dr. Davis opined that the Petitioner's work activities might or could have caused the symptoms of carpal tunnel in her right hand. He also testified that the symptoms failed to respond to physical therapy and that the fall at work aggravated her condition.

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

PROSPECTIVE MEDICAL CARE:

Dr. Davis suggested surgery on the left hand. This was the worse of the two hands. His prognosis without surgery was that with conservative treatment and physical therapy having failed, she would not see relief over time. He believed that with surgery her prognosis was good.

Petitioner testified that her condition in the left hand has progressively worsened. She testified that she desires to have the treatment suggested by Dr. Davis.

MEDICAL BILLS:

It is first noted that Dr. Sudekum testified the treatment that Petitioner had received prior to his first examination of her in 2014 was reasonable.

Petitioner submitted medical bills totaling $4,708.83 of which $641.00 remained outstanding. In light of the findings on causation and accident, this arbitrator awards the same to be paid in accordance with the fee schedule. Respondent is entitled to an 8j credit for any bills paid by Petitioner's 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

Bessie Joy Kaufhold,

Petitioner,

vs. NO: 13WC022871

Grand & Ashland Tap Inc. d/b/a
Grandbar and the Illinois State Treasurer as ex-officio
Custodian of the Injured Workers'
Benefit Fund,

18IWCC0735

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and the Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issue(s) of causal connection, benefit rates, wage calculations, permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 30, 2018 is hereby affirmed and adopted.

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

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

18IWCC0735

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 30 2018
SJM/sj
o-11/15/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAUFHOLD, BESSIE JOY
Employee/Petitioner

Case# **13WC022871**

GRAND & ASHLAND TAP INC D/B/A GRANDBAR AND THE ILLINOIS STATE TREASURER AS CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0735

On 5/30/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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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

Bessie Joy Kaufhold
Employee/Petitioner

v.

Grand & Ashland Tap, Inc. d/b/a Grandbar and the Illinois State Treasurer as custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **13WC22871**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the City of **Chicago**, County of **Cook**, on **October 2, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 16, 2013**, Respondent-Employer ***was*** operating under and subject to the provisions of the Act.

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

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-Employer.

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

In the year preceding the injury, Petitioner's average weekly wage was **$1,212.96.**

On the date of accident, Petitioner was **41** years of age, married with 0 dependent child.

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

Respondent-Employer ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent-Employer is not awarded any credit for TTD, TPD, maintenance, or for other benefits.

Respondent-Employer is not entitled to a credit under Section 8(j) of the Act.

ORDER

Temporary Total Disability
Respondent-Employer shall pay Petitioner temporary total disability benefits of **$808.64**/week for **23** weeks, commencing March 17, 2013 through August 24, 2013, as provided in Section 8(b) of the Act.

Medical benefits
Respondent-Employer shall pay the medical bills for the reasonable and necessary medical services, which total **$30,734.25**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Permanent Partial Disability with 8.1b language (For injuries after 9/1/11)

Respondent-Employer shall pay Petitioner **$712.55**/week for **175** weeks as Petitioner sustained permanent partial disability to the extent of **35%** loss of use of a person as a whole, pursuant to §8(d)2 of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This finding is hereby entered as to the Fund to the extent permitted and allowed under §4(d) of the Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Employer-Respondent's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

5/30/18
Date

MAY 30 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ATTACHMENT TO ARBITRATION DECISION

Bessie Joy Kaufhold
Employee/Petitioner

18IWCC0735

v.

Case No. 13 WC 22871

Grand & Ashland Tap, Inc. d/b/a Grandbar
and the Illinois State Treasurer as Ex-Officio
Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act (the "Act") by the Petitioner-Employee, Bessie Joy Kaufhold, ("Petitioner") and sought relief from the Respondent-Employer, Grand & Ashland Tap, Inc., ("Grandbar") and the Illinois State Treasurer as custodian of the State of Illinois, Injured Workers' Benefit Fund, ("IWBF").

On October 2, 2017, a trial was held and proofs were closed before Arbitrator Brian T. Cronin in Chicago, Illinois. Attorney Jose Rivero represented the Petitioner. The Illinois Attorney General's office represented the IWBF. Respondent-Employer was not present; however, they were represented by counsel, Scott Barber, who only made a brief statement and did not present a defense. Petitioner entered into evidence a certification from the National Council on Compensation Insurance showing that Respondent-Employer was not insured at the time of the injury. [Px.19].

A. **Summary of Petitioner's Testimony at Trial**

On March 16, 2013, Petitioner was 41 years old, married with no dependent children. [Ax.1]. Petitioner was married at the time of the incident; however, her divorce had not yet been finalized. Transcript of Proceedings (hereinafter "T.") 82. Petitioner's highest level of completed education is 12th Grade; however, Petitioner took additional courses at Elgin Community College in electronics, although she never received an associate's degree. [Px.16 and T. 63]. Petitioner did have CDL training at Star Truck Driving School, apprenticeship as a journeyman lineman through Electricians Local 9, and training/licensure as a mortgage broker, although that licensure has lapsed. [T. 63].

Grandbar is owned by Betty Stokes, Petitioner's aunt, and managed by Gene Stokes, Petitioner's cousin. [T. 45]. Grandbar had approximately seven plus employees working the night of the accident and served alcoholic beverages to the public. [T. 56].

Petitioner worked for Grandbar as a cocktail waitress, but was unsure when she had started working there. [T. 55-56]. Petitioner found out about the job through her family and never signed an employment contract. [T. 54]. While working at Grandbar, Gene Stoke acted as Petitioner's boss and would discipline her with regard to getting there early, requesting time off, and moving faster. [T. 12-13]. Petitioner worked from 9:00 p.m. to 4:00 a.m. on Fridays, and from 9:00 p.m. to 5:00 a.m. on Saturdays. [T. 9]. While Petitioner stated she was paid in cash at the end of every night, she could not recall how much her pay rate was, even when presented with her tax returns. [T. 10-12]. Moreover, Petitioner never received a W-2 from Grandbar. [T. 60]. Petitioner identified, as Petitioner's Exhibits 25 and 26, her tax returns for the years 2012 and 2013. [T. 11]. Additionally, Petitioner testified that Grandbar served alcohol, and had sharp

cutting tools and refrigerators. [T. 13]. Petitioner never received any training by Grandbar. [T. 58].

On March 16, 2013, at approximately 3:00 a.m., while Petitioner was working as a cocktail waitress, she approached two customers, a husband and a wife, the latter identified as Vanessa Suarez. [T. 16]. Petitioner asked if they wanted a shot to go with their drinks as the bar would be closing soon. *Id.* They declined, so Petitioner moved past these two customers to the bar where she attempted to get the attention of the bartender, Zita. *Id.* At that time, Vanessa Suarez took a pint glass, broke it on Petitioner's head, and ran it down Petitioner's nose, cheek, and neck. [T. 19]. Initially, Petitioner did not feel pain, but instant wetness. [T. 18]. Petitioner asked the bartender the following: "did this f---ing bitch just throw a drink on me?" *Id.* [Letters deleted.] The bartender responded that Petitioner was bleeding. Petitioner touched her face and saw that there was blood everywhere. [T. 18-19]. Petitioner offered into evidence photographs of Petitioner's face as Exhibit 17. [T. 20]. Petitioner testified that she felt light-headed and fell to the floor. [T. 22].

After Petitioner had been injured, the bartender's husband's friend, a chef, pressed a dirty bar towel to Petitioner's face to stop the bleeding. [T. 23]. After using the restroom with the assistance of others and having a cigarette, Petitioner got into the ambulance with the help of the paramedics. [T. 26-28]. When the paramedic removed the towel, Petitioner felt pain in the left side of her head, temple, and face. [T. 28]. Gene Stokes got in the ambulance and briefly spoke with Petitioner. *Id.* Petitioner asked Gene if he was coming with her. *Id.* Gene responded that he was not, but that he loved her. *Id.*

Petitioner did not return to work for Respondent-Employer after this injury.

B. **Summary of Petitioner's Medical Treatment Based Upon Petitioner's Testimony and Medical Records**

Petitioner was taken to Northwestern Memorial HealthCare on March 16, 2013. [Px.5]. Petitioner was treated for a 4-cm. laceration across her left cheek that was deep. Petitioner had an additional 1-cm. deep laceration above her left eyebrow and a third laceration that was thin, shallow 1.5-cm. and across bridge of Petitioner's nose. Petitioner complained of a headache and had CT scans of her face and brain taken. [Px.5].

The CT scan of Petitioner's face revealed, in pertinent part, that she did not have an acute facial fracture, but rather a large vertical laceration involving the soft tissues overlying the left check extending inferolaterally to the level of the mid left lower mandible, as well as a smaller vertical laceration more posteriorly in the soft tissues overlying the left lateral face, and lastly, a small amount of air overlying the anterior left aspect of the maxillary alveolus that may reflect an additional lactation. [Px.5].

The CT scan of the Petitioner's brain showed no acute intracranial hemorrhage and mild swelling in the extracranial soft tissues overlying the left supraorbital region. Petitioner was discharged later that day. The records of Northwestern Memorial Hospital also indicate that Petitioner had been previously treated for anxiety. [Px.5].

Petitioner was treated at Northwestern Maxillofacial Surgeons, P.C. for her lacerations. [Px.7]. There, Petitioner's lacerations were cleaned and stitched up. On March 22, 2013, Petitioner's sutures were removed and Petitioner returned to Northwestern Maxillofacial Surgeons, P.C. for follow-up visits. Petitioner was told to see her primary care physician/neurologist regarding head trauma and to wait five months before undergoing scar revision surgery. [Px.7].

On April 8, 2013, Petitioner saw her primary care physician Gloria F. Millare, M.D. [Px.8]. Petitioner complained of pain in her face, blinding headaches, tingling and numbness in her left lower jaw, problems with concentration and memory, nightmares, and crying spells. After examining Petitioner, Dr. Millare diagnosed with multiple deep lacerations, head injury with persistent headaches, and post-traumatic stress disorder. Dr. Millare advised Petitioner to take off from work for approximately two months while undergoing treatment and to follow up with plastic surgeon. [Px.8].

On April 25, 2013, Anthony Geroulis, M.D, a plastic surgeon from North Shore Center for Cosmetic Surgery, examined Petitioner and found that her scar appeared to be smooth and level, but that in other areas, the scar appeared to be irregular and not level. [Px10]. He opined that a future scar revision would have to be evaluated further down the line since it takes a good year for a scar to mature. [Px10].

Post-accident, Petitioner saw Karen Lake, LCSW, of Associates in Psychiatry & Coun., on April 18, 2013. [Px1]. Pre-accident, and since 2003, Petitioner had been seeing Karen Lake, LCSW, for therapy for anxiety, depression, and sleep problems. [Px.1, Px.13]. In fact, Petitioner stated she was depressed prior to the accident due to a number of factors. [T. 73-74]. However, Petitioner testified she could not recall how long she had going to therapy prior to the accident or how frequently she had been receiving such therapy. [T. 72-73].

After the accident, Petitioner made numerous complaints to Karen Lake, LCSW including, significant headaches, bad dreams, anxiety, stress, exhaustion, and low self-esteem. [Px.2, Px.3, Px.4]. Petitioner stated that she was also having difficult time concentrating, recalling certain memories, and recalling words. [Px.2, Px.3, Px.4].

Petitioner also began treating with Bindu Gandhiraj, M.D., a psychiatrist, prior to this accident as well. [T. 73]. Petitioner testified that prior to the accident, she saw Dr. Gandhiraj "usually quarterly or twice a year." Id. However, she could not recall when she started seeing Dr. Gandhiraj, but did recall that it was for her condition following the deaths of loved ones and a divorce. [T. 73-74]. While not all of Petitioner's records from past psychiatric treatment were provided, the records due indicate that Dr. Gandhiraj saw Petitioner prior to the accident on January 26, 2013 and February 8, 2013.

On January 26, 2013, Dr. Gandhiraj listed her problems as Major Depressive Affective Disorder, Recurrent Episode Moderate Degree, and Anxiety State, Unspecified. [Px1]. Dr. Gandhiraj also prescribed Klonopin, Lexapro, and Wellbutrin. [Px.1]

On February 8, 2013, which was five weeks before the accident, Dr. Gandhiraj wrote, in the Client Report section of the Clinician Progress Note, the following:

> "Client is a 41 year old female. Client was seen at the office for individual therapy. Client reports feeling anxious, some low mood. Feeling overwhelmed. Client reports that she often "feels like crying." She reports feeling lonely. She is not sleeping well and is waking up frequently. Client reports that she has been having some medical issues lately. She reports that she has been having severe financial issues. She reports that her house has been ordered into foreclosure. She also reports that her divorce is still pending. Plus, now she has to find a new attorney because her current attorney is no longer working her case. Client reports that she still wishes husband did not want a divorce. Client reports that relationship with daughter is showing some improvements. Daughter is being more pleasant while talking with client. Client reports that overall her job is good and she is happy to have a job. However, she reports that there are a lot of work stressors." [Px.1]

After the accident, Petitioner continued to see Dr. Gandhiraj and made new complaints of recurrent nightmares and crying spells; however, Dr. Gandhiraj's course of treatment largely stayed the course; he continued to prescribe similar medication for Petitioner. [Px.2, Px.3, Px.4]. Petitioner also testified that she continues to see Dr. Gandhiraj today and is in the process of setting up another appointment. [T. 80].

On May 3, 2013 and June 3, 2013, Petitioner saw Todd Gephart, M.D., at Northwest Health Care Associates - East Dundee. [Px.11]. Petitioner complained of headaches, disorientation, memory lapses, visual changes, and numbness of the face, and fatigue. A CT scan of Petitioner's brain was negative for intracranial bleed. Petitioner was told to follow up for a neuropsychological evaluation. Dr. Gephart referred Petitioner to Alan G. Shephard, M.D., who examined her and referred her to Beth Borosh, Ph.D. [Px.11].

On September 18 and 19, 2013, Petitioner underwent an evaluation at Northwestern Memorial HealthCare. [Px.6]. D. Mark Courtney, M.D., and Kory Gebhardt, M.D., examined Petitioner's head. The MRI of the brain was found to be unremarkable. Petitioner complained of continued intermittent headaches, difficulty with concentration and focus, work finding difficulties, memory difficulty, sleep disruptions, and increased daytime tiredness. Dr. Courtney, the attending physician, offered the following impression:

> "not totally clear if this is true post concussive syndrome. based on near constant every day HA and duration this seems unlikely. may be some component of post traumatic syndrome of somatic manifestation of anxiety/depression." [Px.6].

On October 15, 2013, Beth Borosh, Ph.D., of Neuropsychology Assessment and Wellness, LLC, conducted a neuropsychological evaluation of Petitioner. [Px.13]. After taking a

history that indicated Petitioner had been seeing a therapist since 2003, and administering various tests, Dr. Borosh found that Petitioner had mild to moderate processing speed impairment and mild naming impairment, and relative weakness in sustained attention, working memory, verbal reasoning, and mental flexibility. [Px.13]. While Dr. Borosh determined Petitioner's profile demonstrates depression, "there is an indication of an element of exaggeration of complaints or a 'cry for help.'" She opined that her clinical profile reveals marked elevations across several scales that suggest the presence of significant distress likely associated with a traumatic event. Ultimately, Dr. Borosh found that Petitioner suffered mild to moderate frontal networks dysfunction and a mild nonspecific naming impairment for which the "differential for this type of profile is quite broad; however, Petitioner's profile likely reflects both post concussive syndrome and psychiatric etiologies." [Px.13].

On June 5, 2014, Petitioner underwent Active FX/Deep FX/ CO2 Resurfacing Surgery for her facial disfiguration. [Px.12].

On November 21, 2014 and December 1, 2014, at the request of Petitioner's counsel, Petitioner presented to Kathy Borchardt, Psy.D., for an independent neuropsychological evaluation. [Px.15]. At that time, Petitioner complained of residual cognitive impairments from her head injury, including word-retrieval deficits, difficulty with sustained concentration, short-term/working memory impairments, and gaps in her autobiographical memory. [Px.15]. After taking a work history and noting that Petitioner had returned to work a month earlier, Dr. Borchardt administered a series of tests to Petitioner. Dr. Borchardt stated the results should be interpreted with caution since there is "significant variability." Dr. Borchardt opined that Petitioner's FSIQ of 80 was an underrepresentation of her true abilities since Petitioner reported that she was an A-B student in college, earned credits toward a college degree, and held a

mortgage broker's license. Dr. Borchardt then wrote: "It is highly probable that her apparent cognitive processing deficits and word-retrieval impairments likely resulted from her traumatic brain injury and depressed her FSIQ score during this neuropsychological evaluation." Dr. Borchardt determined that Petitioner had mild cognitive deficits and was likely to need work-related accommodations upon a return to work. Additionally, Petitioner needed supportive psychotherapy to assist Petitioner with her PTSD and anxiety. Lastly, Petitioner should consider speech therapy to address her significant word-retrieval deficits. [Px.15].

On April 16, 2015, James F. Boyd, M.S., C.R.C., conducted a vocational evaluation of Petitioner. [Px.16]. Petitioner told Mr. Boyd that she periodically worked at a friend's window and door company. At that time, Petitioner's job consisted of replying to emails and scheduling appointments. He wrote that she never worked more than four to six hours. Mr. Boyd found that Petitioner would have difficulty maintaining any level or type of competitive employment at that time. Mr. Boyd stated that vocational test results indicated relative strength in reading comprehension, math computation, auditory comprehension, and keyboarding. However, Mr. Boyd stated that Petitioner's below average visual-motor speed, excessive error rates, inconsistent attention to detail and poor visual problem solving are not compatible with the requirements of any full or part-time jobs in the competitive labor market. [Px.16].

Petitioner testified that because of the incident she has a difficult time sleeping and is continually stressed and anxious. [T. 36]. Petitioner also states that she gets blinding headaches. [T. 43].

Petitioner testified that she was off of work until May 10, 2016. [T. 34]. At that time, Petitioner began working for McHenry County Glass and Mirror. [T.35].

At trial, Arbitrator Cronin viewed Petitioner's scars from approximately six feet away and described the longer scar as a three to four-inch scar running from Petitioner's left eye to jaw and narrowing. [T. 39, 41]. The Arbitrator also observed Petitioner's scars on both her clavicle and nose. [T. 41]. In addition, Petitioner offered into evidence photographs her injuries. [Px.17A, Px.17B].

Petitioner testified that due to the nerve damage from her accidental injury, she experiences pain on the left and right sides of her face. [T. 43] The scars still itch and she has massive, blinding headaches, for which she takes Tylenol turns the lights down low. [T. 43]

II. CONCLUSIONS OF LAW

With respect to issue (A), whether Respondent was operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator finds as follows:

The Arbitrator finds that the Respondent was operating under and subject to the Illinois Workers' Compensation Act as Petitioner's testified that Respondent used sharp cutting tools (820 ILCS 305/3(8)), sold alcoholic beverages for the public for consumption on its premises (820 ILCS 305/3(12)), and operated equipment powered by electricity (820 ILCS 305/3(15). (T. 13).

With respect to issue (B), was there and employer and employee relationship, the Arbitrator finds as follows:

Petitioner testified that Respondent's owners, Betty and Gene Stokes, hired her. (T. 9). Gene paid her at the end of each night and had the capacity to discipline her for arriving late and not working fast enough. (T. 10, 13). Petitioner's testimony is unrebutted. Accordingly, the Arbitrator finds that Respondent controlled Petitioner's work to the degree that an employer and employee relationship existed.

With respect to issue (C) and (D) whether an accident occurred that arose out of her employment with the Respondent and what is the date of accident, the Arbitrator finds as follows:

Petitioner testified that she suffered injuries to her head and face on March 16 ,2013 when she was attacked with a glass by a patron of the Respondent's bar while she was attempting to place a drink order with the bartender. (T. 15-21). The Arbitrator finds that Petitioner's testimony is corroborated by the treating records and consequently finds that on March 16, 2013, Petitioner sustained an accident that arose out of and in the course of her employment by Respondent.

With respect to issue (E), whether timely notice was provided to the Respondent, the Arbitrator finds as follows:

Petitioner testified that Gene Stokes entered the ambulance with her when she was being transported from the scene of the accident to the hospital. (T. 28-29). Furthermore, Petitioner read into the record a text message sent to her by Betty Stokes wherein Respondent admitted to having been informed of the incident by "Hector" the day after the accident. (T. 50). Accordingly, the Arbitrator finds that timely notice was provided to Respondent of the accident sustained by Petitioner.

With respect to issue (F), is Petitioner's condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner offered photographs of the lacerations to her head, face and neck shortly after the accident. [Px.17A]. Petitioner also offered more recent photographs of the lacerations to her head and face. [Px.17B]. The Arbitrator find that the injuries to Petitioner's head, face and neck that he observed at trial are consistent with the photographs displayed in Px.17B.

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

Joseph Ficek,

Petitioner,

vs.
Home Depot,

NO: 13WC 29548

Respondent.

18IWCC0736

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and proper notice given, the Commission, after considering the issue(s) of causal connection, temporary disability, permanent 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 March 8, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

18IWCC0736

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,200.00. 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.

NOV 30 2018

DATED:
SJM/sj
o-11/15/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FICEK, JOSEPH
Employee/Petitioner

Case# **13WC029548**

18IWCC0736

HOME DEPOT
Employer/Respondent

On 3/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1747 SEIDMAN MARGULIA & FAIRMAN
NIKITAS FUDUKOS
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

4136 ADELSON TESTAN & BRUNDO
MARCY E BENNETT
125 S WACKER DR SUITE 1717
CHICAGO, IL 60606

18IWCC0736

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

Joseph Ficek,
Employee/Petitioner

v.

Home Depot,
Employer/Respondent

Case # **13** WC **29548**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **January 29, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **February 8, 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 **$30,218.76**; the average weekly wage was **$581.13**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$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 a causal connection exists between his current condition of ill-being and the accident (except as noted below) no medical benefits or TTD benefits are awarded.

Respondent shall pay Petitioner compensation of $310.88/week for 10 weeks, because the injuries sustained caused serious and permanent disfigurement of the left arm and left foot, as provided in Section 8(c) of the Act. These are the specific injuries to which causation is found and for which compensation is payable.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert M. Harris

Robert M. Harris, Arbitrator

March 8, 2018
Date

MAR 8 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION OF ARBITRATOR

Joseph Ficek,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 13WC29548
	)	
Home Depot,	)	
	)	
Respondent.	)	

STATEMENT OF FACTS

Petitioner Joseph Ficek testified he currently works for Respondent Home Depot and has been working there since approximately 2012. Petitioner testified he was working at the Home Depot on February 8, 2013, at which point his job title was "Pro Account Salesperson." Petitioner's job duties include working with contractors and builders determining materials needed for projects. On occasion, he goes out on the sales floor. (Tx 12-14)

Petitioner testified that on February 8, 2013 he was injured at work. Petitioner was on the sales floor helping a customer and checking stock when he got up on a ladder. While attempting to walk down from the ladder Petitioner turned and his foot hit the side of the ladder and he fell down three steps of the ladder. Petitioner testified he was approximate 3 ½ to 4 feet off the ground when he tripped on the ladder scraping his left arm and left foot. (Tx 14-19)

Petitioner testified that he drafted an accident report. (PX 14/Tx 19-20).

Petitioner testified that he sought medical treatment for his ankle anywhere from 3 to 6 weeks after his alleged fall. Upon clarification, the petitioner testified that March 25, 2013 was the first time he sought medical treatment. The petitioner was seen at Stroger Hospital on March 25, 2013. Petitioner testified that his arm and wrist area had healed without problem prior to his first visit. Petitioner testified that his foot began to become "ulcerated," and the skin was breaking and opening up, which made him worry there may have been an infection. Petitioner testified the "ulcer" was getting larger so he went to the doctor. (Tx 21-24)

Cook County Health/Stroger Hospital medical records show the petitioner was seen on March 25, 2013. (PX 1). The medical record indicates Petitioner had a history of deep vein thrombosis with pulmonary embolism in February 2007, deep vein thrombosis 1992 after trauma. At the time of his first visit on March 25, 2013, Petitioner complained of left leg redness and pain.

The medical record indicates on examination, sharp areas of erythema on the left leg with mildly increasing local temps. Petitioner was diagnosed with possible cellulitis eczema with superimposed cellulitis. Petitioner was prescribed ointment and told to follow-up in one week. **The medical record does not indicate any open wound, laceration, or ulceration on Petitioner's left ankle. Medical record further does not indicate any trauma or fall Petitioenr suffered. (PX 1, pg. 453).**

Petitioner testified he suffered from deep vein thrombosis in his left leg prior to the date of injury. As a result, Petitioner was taking Coumadin at the time of injury. Medical records further indicate Petitioner will be a lifelong Coumadin recipient due to a history of deep vein thrombosis. (PX 1, pg. 440).

Petitioner testified he followed up at Stroger Hospital on April 1, 2013 and saw a dermatology specialist on the same day. Medical records indicate Petitioner had an ulcer on the left lateral lower extremity. **This is the first notation of ulceration on the ankle.** There is no mention of cause of ulceration or trauma. (PX 1, pg. 431,440).

Petitioner testified he followed up with a vascular surgeon on April 19, 2013. Medical records demonstrate the petitioner was seen at Stroger Hospital again and was again noted to have a small superficial ulceration on the left lateral malleus. At this point, Petitioner was diagnosed with venous insufficiency and a small venous ulceration, healing. **There is no mention in the medical record of injury or trauma to petitioner's left ankle.** (PX 1, pg. 423).

Petitioner testified he continued to receive wound care at Stroger Hospital through September 10 of 2013. Petitioner was seen at Stroger Hospital on the following dates: May 7, 2013 (PX 1, pg. 402), May 14, 2013 (PX 1, pg. 389), June 3, 2013 (PX 1), July 9, 2013 (PX 1, pg. 349).

Petitioner was seen in Stroger Hospital on July 26, 2013. **This is a first medical record where Petitioner claims he fell at work.** In this record, Petitioner indicates he fell at work in March 2013. (PX 1, pg. 339).

Petitioner was seen at Stroger Hospital on August 27, 2013. At that time he indicated he fell from a ladder in February 2013. It was noted Petitioner had a healed ulceration of the left ankle. Petitioner was given a strap for compression and medication and told to follow up in two weeks. The records note Petitioner requested time off for work, however the doctor indicated it would be inappropriate as there was no clear endpoint with venous stasis disease and it would take time to resolve. The doctor indicated the patient was offered a note for light duty work at which point he became agitated and vocally upset. He (Petitioner) refused a light duty note and stated that he'd follow up with his primary care for continued application for Worker's Compensation. (PX 1, pg. 321-322).

Petitioner testified he saw Dr. Ali at Chicago Heart Association on September 9, 2013. During this visit, Petitioner told the physician he sustained an injury at work about a week prior. There was no noted edema in the extremities. The doctor noted chronic venous stasis changes seen in the left ankle. There was no ulceration or inflammation of the skin noted and no edema of

the ankle joint. The doctor noted full range of motion of the left ankle. Patient was diagnosed with: chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity, hemorrhagic disorder due to intrinsic circulating anticoagulants antibodies inhibitors, and venous peripheral insufficiency. The doctor noted the ankle pain was most probably chronic neuropathic pain and advised the petitioner to continue anticoagulation. The doctor noted chronic venous insufficiency was due to chronic DVT. The doctor recommended compression stockings and follow up with his primary care physician. (PX 2).

Petitioner testified he followed up with Dr. Ahmed on September 21, 2013. Petitioner's Exhibit 3 shows Petitioner saw Dr. Ahmed on September 21, 2013 at which time he indicated he needed a primary care doctor. At this time, Petitioner indicated he could not bear weight on the left foot. (PX 3, pg 007). Handwritten notes from Dr. Ahmed are mostly illegible.

On September 22, 2013, Petitioner was admitted to St. Mary of Nazareth Hospital. Medical records indicate the petitioner had history of DVT approximately 18 years ago after an incident and a repeat DVT in 2007 at which time he was noted to have pulmonary embolism. The left lower extremity was noted to have blue/purple discoloration and some skin thickening centrally which extends towards posterior leg. Minimal swelling was noted in the left ankle. It was noted the skin was intact and there were no open wounds. (PX 10).

Petitioner was seen by Dr. Vais on September 24, 2013 at St. Mary of Nazareth Hospital. The MRI was reviewed and showed increased T2 signal in the bone marrow of the fifth metatarsal. It was noted there is mild erythema and induration of the extremities. Petitioner was diagnosed with left ankle cellulitis on a background of chronic stasis dermatitis. Possible osteomyelitis of the left fifth metatarsal, which is somewhat unusual given the fact that his pain is mostly on the lateral malleus, and chronic venous insufficiency with a history of an ulcer healed about a month ago. (PX 7, pg. 30).

On September 27, 2013 Petitioner was again seen by Dr. Ahmed. It was noted that the ulcer of the left ankle had resolved. Petitioner's discharge diagnosis was contact dermatitis and painful left ankle. Petitioner had received consult by an infectious disease, orthopedic surgery and podiatry. (PX 7, pg. 23). Petitioner was discharged.

Petitioner testified he was told to stay off work and let his foot heal. Petitioner testified he was told to be off work from September through December.

Petitioner was seen by Metro Infectious Disease Consultants on October 18, 2013. It was noted there was improvement in Petitioner's left ankle and no evidence of active infection. He was recommended to finish his prescribed medication then no further antibiotics. Petitioner was diagnosed with venous stasis dermatitis, with history of deep vein thrombosis. Petitioner was recommended referral to a vein clinic. (PX 3, pg. 14).

Dr. Joba testified via deposition. (PX 6). Dr. Joba testified he is a doctor of podiatric medicine and at the time of the first visit with Petitioner he was a practicing podiatrist for four years. The doctor noted Petitioner was complaining of pain in his left ankle, with some erythema.

Dr. Joba last saw Petitioner in November 2014. Dr. Joba's ultimate diagnosis was edema pain and venous insufficiency. Dr. Joba clarified the venous insufficiency means the arteries and veins responsible for moving blood are not working properly and not taking blood to and from the heart correctly. Due to this insufficiency, blood starts circulating and pooling in lower extremities causing swelling and pain. Dr. Joba testified the venous insufficiency is related to the pain and swelling the claimant had on November 4, 2014. Dr. Joba further clarified there are several causes of venous insufficiency and risk factors including chronic standing, smoking, and trauma. Dr. Joba further testified he does not know the exact cause of claimant's venous insufficiency. Dr. Joba testified based on claimant's history, the fact that he had a history of deep vein thrombosis, the fact that he's a smoker, and the fact that he might be standing for extended period of times can all cause venous insufficiency. The doctor noted venous insufficiency is usually a chronic condition.

On cross-examination, Dr. Joba noted Petitioner's diagnosis of edema, venous insufficiency, pain in limb are all conditions commonly seen in a patient who has a history of deep vein thrombosis and is a cigarette smoker. Further, venous stasis is another diagnosis commonly seen in persons with history of deep vein thrombosis. Dr. Joba testified it is common for ulcers to develop in the area where venous stasis occurs as well as common for ulcers to develop in the area of the lateral malleus. Dr. Joba confirmed the lateral malleus is the area Petitioner is complaining of ulcers in this case. Dr. Joba finally testified that venous stasis can cause nerve pain. (PX 6).

Petitioner was seen by Dr. Ahmed on November 23, 2013 (PX 3). Petitioner testified at this time that the doctor ordered petitioner to return to work.

Petitioner testified he was examined by Dr. Ernest Chiodo in February 2014 at the request of Respondent. Dr. Chiodo testified via deposition (RX 1). Dr. Chiodo testified regarding his significant and voluminous curriculum vitae as well as his extensive experience. Dr. Chiodo testified that he examined Petitioner and reviewed significant medical records as well as imaging studies (the actual films) in anticipation of his report and addendum reports. Dr. Chiodo testified Petitioner provided a history of falling off a four-step ladder, causing injury to the ulnar aspect of his left wrist, and the lateral malleus of the ankle. Dr. Chiodo testified this history was not consistent with any medical records.

On examination, Dr. Chiodo noted a brownish discoloration of claimant's left ankle with no current ulceration or laceration of the left ankle. Dr. Chiodo further noted there was no scar consistent with laceration, no swelling, normal gait, and normal blood flow (but he still noted venous stasis). Dr. Chiodo testified regarding venous stasis indicating it is a condition where blood does not properly flow back through the venous system causing problems like ulcers. Dr. Chiodo testified Petitioner has a history of deep vein thrombosis in the left leg. Dr. Chiodo noted the findings on his exam were consistent with venous stasis involving the left leg consistent with the known history of two DVT and resultant pulmonary embolism because of DVT of the left leg. Dr. Chiodo diagnosed Petitioner with left leg venous stasis with skin discoloration due to left venous stasis and venous stasis ulcer of the left lower extremity because of prior history of deep venous thrombosis. Dr. Chiodo noted these were chronic conditions and these conditions pre-existed any fall at work that may have occurred on February 8, 2013. Dr. Chiodo opined Petitioner was suffering from diabetes.

When asked about Petitioner's current condition of ill being, Dr. Chiodo indicated a fall at work with claimed laceration would not explain burning pain in his extremity. Dr. Chiodo clarified that nerve pain is not related to any fall at work and could not provide a mechanism given the circumstances in this case where laceration of the skin of the lateral malleus would cause him to have this type of nerve pain. Dr. Chiodo opined there is no pathophysiological mechanism that would explain nerve pain like this. Dr. Chiodo testified regarding the cause of the current condition of claimant's venous stasis that Petitioner's past history of deep venous thrombosis is the basis for Petitioner's condition.

Dr. Chiodo was asked about the claimed laceration from February 2013 whether that was a cause of the venous stasis or ulcerations. Dr. Chiodo testified that whether or not there was a laceration in February 2013 did not impact or cause Petitioner's current condition of ill being. **Dr. Chiodo testified he based his opinions on the fact that the March 25, 2013 medical record from Stroger Hospital did not show any laceration, ulceration or open wound of the left ankle. Dr. Chiodo explained that if there was a laceration in February 2013 it had fully healed by March 25 of 2013. Dr. Chiodo testified that if there was later an ulceration, which medical records show only after March 2013, it was not caused by any potential fall or injury at work.**

Dr. Chiodo testified clearly that venous stasis is in no way related to the claimant's work at the Home Depot. The doctor found the petitioner to be at MMI prior to March 25, 2013 due to the fact that there was no ulceration or laceration to the petitioner's left ankle on his March 25, 2013 visit.

On cross-examination, Dr. Chiodo further clarified that he was not testifying whether or not there was a laceration in February 2013; however, if there was, it had fully healed and resolved by March 25, 2013 due to the medical records from that date (not indicating any such laceration).

Petitioner testified he still presently has tingling and the movement is not the same as his right ankle. Petitioner testified he continues to take medication and he is still working today. Petitioner testified he is not as mobile as he used to be. Petitioner testified that the ulcers on his left ankle took three to four years to close up, which is not supported by the medical records. (Tx 36-39)

Petitioner's left and right ankles were examined at the trial setting. Petitioner's left ankle showed a dark area with a bruise on it. Petitioner's right ankle and leg were viewed for comparison and noted to have discoloration/darkened areas on the skin. (Tx 40-42)

Petitioner testified on cross-examination that Coumadin does not cause bruises. Petitioner testified that he drafted the report indicating there was internal bleeding on the arm and a scratch on the left foot on the date of injury. Petitioner testified that he scratched his left arm but on the report only indicated internal bleeding and no scratching. Petitioner further confirmed that the report he drafted did not discuss any blood being drawn from the ankle or arm. (Tx 44-50). Petitioner could not explain why he did not identify a laceration or bloody ankle in his drafted witness statement.

Petitioner testified he has not seen a doctor in 2 ½ years. Petitioner testified the last time he saw a doctor, he was told to follow up but he did not follow up with such a physician. Petitioner further clarified the medication he is presently on is in no way related to this claimed accident. Petitioner is not currently taking any pain medication, rather only Coumadin for his pre-existing deep vein thrombosis. (Tx 51-54)

Petitioner testified that he is working in a full duty capacity, with no work restrictions. Petitioner testified that he goes to Stroger Hospital approximately once a month for anticoagulants. Petitioner further testified that he has communication issues with his physicians, nurses, and physical therapist. Petitioner was unable to recall the names of the doctors, physical therapists or and nurses with whom he had communication issues.

Petitioner testified he always felt like he was rushed in his doctors' appointments. Petitioner felt the doctors and physicians were taking full advantage of his insurance. Petitioner further testified that the medical records for his treatment could or may be incorrect, but gave no specific examples. Petitioner had a language problem with his physicians, but he never made note of it to his attorney. Petitioner testified he hired an attorney for his workers' compensation case in September 2013. (Tx 54-62)

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (C), WHETHER AN ACCIDENT OCCURRED ARISING OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT ON FEBRUARY 8, 2013, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOW:

It is Petitioner's burden to prove each element of his case by a preponderance of the credible evidence. It is not the burden of Respondent to disprove any issue. Rather, the burden lies with Petitioner, his testimony, character and evidence entered onto the record at the time of trial. *Rambert v. Indus. Comm'n.* 133 Ill App. 3d 895, 87 Ill. Dec. 836, 477 N.E.2d 1364, 1369 (1985).

An accident arises out of employment if the employee was performing acts instructed by the employer, or acts which the employee might reasonably be expected to perform. *Nabisco Brands v. Indus. Comm'n (Prendergast),* 266 Ill. App. 3d 1103, 1106, 204 Ill. Dec. 354, 357, 641 N.E.2d 578, 581 (1994).

Petitioner testified that he was helping a customer, climbing up a ladder on February 8, 2013 when he fell from the ladder scraping his left forearm and left ankle. Petitioner offered no medical evidence which described what specific injury may have resulted from this accident on February 8, 2013; however, Petitioner's unrebutted testimony provides sufficient evidence to demonstrate that an accident took place on February 8, 2013.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (F), WHETHER PETITIONER PROVED A CAUSAL RELATIONSHIP EXISTS BETWEEN THE ACCIDENT SUSTAINED AND HIS CURRENT CONDITION OF ILL-BEING, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

In a workers' compensation case, the claimant has the burden of proving, by a preponderance of the evidence, some causal relation between the employment the claimed injury and current condition of ill being. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63, 541 N.E.2d 665, 669, 133 Ill. Dec. 454 (1989).

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). "[C]laimant has the burden of showing by a preponderance of credible evidence that his injury arose out of and in the course of employment, which requires a showing of causal connection.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. Berry v. Industrial Comm'n, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); Fickas v. Industrial Comm'n, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

It is the Commission's function to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill. 2d 1, 4, 31 Ill. Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 590 N.E. 2d 78, 82 (1992).

As indicated *supra*, Petitioner bears the burden of proving each element of his case by a preponderance of credible evidence. *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470 (4th Dist. 1987). In order to meet this burden, a Petitioner must "produce competent evidence of objective conditions and symptoms to support [a] claim." *Nunn* at 477. Where a claimant has a pre-existing condition, whether it is aggravated or accelerated is a question of fact for the Commission. *Caterpillar Tractor Co. v. Indus. Comm'n*, 92 Ill. 2d 30, 36-37 (1982). Furthermore, in questions involving causation, the parties need not necessarily submit a medical opinion in order to prove causation. **However, "where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that the claimant's work activities caused the condition complained of."** *Nunn* at 507, citing to *Interlake Steel Co. v. Indus. Comm'n*, 136 Ill. App. 3d 740 (1985). In this case, the Arbitrator finds that "the question is one within the knowledge of experts only and not within the common knowledge of laypersons." Based upon the evidence submitted by the parties, the Arbitrator finds that the evidence submitted by Petitioner is not sufficient to prove that it is more probable than not

that his current condition of ill-being is related to the February 8, 2013 accident. Respondent's evidence is more credible and weighty than Petitioner's evidence.

Regarding the conflicting expert medical testimony which ultimately decides this case, all expert testimony, whether scientific or not, must have an adequate foundation in order to be admissible. An adequate foundation must be laid establishing that the information upon which the expert bases his opinion is reliable.

It is fundamental and elementary that an expert's opinion is only as valid (as to weight and credibility) as the basis and reason for the opinion. An expert must give some reason for his opinion.

The Arbitrator has been presented with divergent medical opinion evidence regarding the causal relationship between Petitioner's condition of ill-being and his accident. It is within the purview of the Commission to accord the proper weight to these conflicting opinions.

The Illinois Supreme Court has held that the weight accorded an expert's opinion must be measured by the facts supporting the opinion and the reason given for the opinions. If the expert's opinion lacks a factual basis, the opinion deserves little weight. An expert's opinion cannot be based solely on guess, surmise or conjecture. *Doser v. Savage Manufacturing and Sales, Inc.*, 142 Ill. 2d 176, 195-196 (1990).

While it is true that expert testimony couched in terms of probabilities or possibilities based on assumed facts is admissible, this rule does not lessen the need for a reasonable degree of certainty. *Brown v. Chicago Northwestern Transportation Co.*, 162 Ill. App. 3rd 926, 037-38 (Ill. App. 1st Dist.1987). The *Brown* Court held that, "...the doctor's response, **'It's possible'**, to a question concerning the necessity of surgery in the future was **"too speculative"** to support an award for future medical expenses. *Brown*, 161 Ill. App. 3rd at 938. Similarly in this case, Dr. Joba's opinions couched in terms of mere "possibility" are not grounded in a reasonable degree of certainty and are "too speculative" to support his opinions regarding causation.

Additional case law supports the finding and conclusion that Dr. Joba's opinions are too speculative. The Appellate Court, Industrial Commission Division, has held that a physician's opinion that "Repeated bending **may well have** caused her condition of ill-being..." **was equivocal with regard to causation.** *McRae v. Industrial Comm'n*, 285 Ill. App. 3rd 448, 451-453, 674 N.E. 2d 512, 515-516 (Ill. App. 5th Dist. 1996). The Court emphasized that **the physician "could not say repeated bending at work did in fact cause the injury..."** *McRae*, 285 Ill. App. 3rd at 453. Very significantly, the Appellate Court further held that, "...the Commission was not required to accept this equivocal and ambiguous opinion as undeniable truth that claimant's condition was indeed caused by repeated bending and lifting at work. Moreover, the Commission was at liberty to discount the credibility of this statement because it was made 14 months after claimant's alleged injury." *Ibid.*

Lastly, and also very significant, the *McRae* **Court also held that implicit in the physician's expert opinion that claimant's work "may well have" caused her condition of ill-being, "is that claimant's work may well <u>not</u> have caused the condition."** *Id.*, at 516.

The McRae case is directly on point. It's holdings directly attack the weight and credibility of Dr. Joba's "equivocal and ambiguous" opinions on causation, which also were offered some 25 months after Petitioner's injury.

Petitioner claims his current condition of ill being, including venous insufficiency causing venous stasis and venous stasis ulcers of the left leg, are related to his work accident of February 8, 2013. To support his claim, Petitioner offered his testimony, along with medical records and deposition of Dr. Joba, records of Dr. Ahmed, records from Dr. Vias, Stroger Hospital records and St. Mary of Nazareth records. Respondent offered medical reports and the deposition testimony of its examining expert Dr. Ernest Chiodo.

It is undisputed that Petitioner has a longstanding history of deep vein thrombosis to his left leg, clearly unrelated to and pre-dating this claim. Petitioner has been participating in anticoagulation therapy for several years and the evidence shows he will likely have to continue this treatment for the rest of his life.

The evidence reveals that Petitioner offered no medical records outlining any trauma to his left ankle for more than 7 weeks. Petitioner was seen at Stroger Hospital on February 19, 2013 for his follow-up anticoagulation treatment, yet, inexplicably, there is no mention of any ankle laceration, pain or injury seen in those records. (PX 1, pg. 468).

Petitioner was seen again on March 19, 2013 at Stroger Hospital for another round of anticoagulant treatment and again he inexplicably did not complain of any issues with his ankle or forearm nor are any such injuries noted in these records. (PX 1, pg. 463).

The first office visit record discussing his left ankle was on March 25, 2013 at Cook County Hospital. The records from this office visit and physical examination indicate Petitioner complained of ankle pain and erythema (redness), with no laceration, open wound or ulceration noted or indicated at that time. Inexplicably, there is also no mention of any work injury or trauma during this office visit. (PX 1, pg 453). Medical records do not mention any work injury until July 26, 2013, at which point the hospital indicated Petitioner fell in March and developed an ulcer. (PX 1, pg 339).

Petitioner sought treatment with a vascular specialist in August of 2013 who noted a healed ulceration to the left ankle. The vascular surgeon indicated that Petitioner requested an off work slip which was denied, due to the chronic nature of the disease and there being no formal endpoint for venous stasis. Petitioner then became agitated and vocally upset with the vascular surgeon when a light duty work slip was offered. (PX 1, pg. 321).

Petitioner's treating podiatrist, Dr. Joba, testified via deposition that Petitioner suffered from edema pain and venous insufficiency. (PX 6) Dr. Joba first saw Petitioner on September 23, 2013 (PX 6, p. 09). Dr. Joba testified that Petitioner complained of pain in the left ankle, he had some erythema and he had an injury at work about six months prior (PX 6, p. 010). Dr. Joba testified that **"It's <u>possible</u> that Petitioner had a laceration that had healed"** (PX 6, p. 010). X-rays taken on that date only indicated some swelling, which "**could be** from chronic venous problem." (PX 6, pp. 011-12). Dr. Joba's impression was only "history of DVT and some cellulitis

(infection) of the left ankle." (PX 6, p. 012). Dr. Joba was **unable** to offer an opinion "I cannot offer specifically") regarding where the bacteria (causing the cellulitis) came from. (PX 6, p. 015). Dr. Joba could not answer these causation questions because he admitted that he was not involved in the Petitioner's treatment during this six-month period (PX 6, p. 013).

Dr. Joba next saw Petitioner on September 25, 2013 (PX 6, p. 016). The MRI showed "some kind of a reading that suggested something wrong with the fifth metatarsal." (PX 6, p. 017).

Dr. Joba next saw Petitioner on September 26, 2013 (PX 6, p. 018). The impression was "cellulitis/dermatitis." (PX 6, p. 018). A new left foot MRI showed findings that could be due to normal variation or a remote trauma and some degenerative changes. (PX 6, p. 018-019). Tests showed negative DVT.

Dr. Joba next saw Petitioner on November 4, 2013 (PX 6, p. 019-020). The impression was pain and swelling of the left ankle, and he later modified that testimony to indicate "edema, pain, and venous insufficiency." (PX 6, p. 023). . (PX 6, p. 020). There was no cellulitis present (PX 6, p. 022-023). Dr. Joba testified Petitioner had told him that he had pain and swelling since his fall at work (PX 6, pp. 020-021).

Dr. Joba was asked what caused the venous insufficiency. Dr. Joba answered; there are a lot of risk factors that can cause venous insufficiency, for example, chronic standing, smoking, if the valves in the veins do not work properly. Trauma can cause venous insufficiency too. (PX 6, p. 024). History of infection "can happen." (PX 6, pp. 024-025),

Significantly, when asked to offer an opinion as to what caused Petitioner's venous insufficiency, Dr. Joba stated he "wouldn't know exactly" because different risk factors can cause the insufficiency. (PX 6, p. 025).

Upon further questioning as to whether Petitioner's trauma to his left ankle could have been a factor to this venous insufficiency, Dr. Joba **first** indicated that venous insufficiency is usually a chronic condition (indicating he was clearly reluctant to indicate that trauma could have caused his venous insufficiency) and then Dr. Joba eventually testified that stated that venous insufficiency **"could"** be caused by trauma. (PX 6, p. 027).

On cross-examination, Dr. Joba clarified that venous insufficiency and venous stasis commonly occur in persons with DVT, and ulcers commonly occur in limbs with venous stasis. Dr. Joba further clarified that it is common for venous stasis ulcers to occur in the area of the lateral malleus. (PX 6, p. 031-032). Finally, Dr. Joba confirmed that the chronic condition of venous stasis can possibly cause nerve pain. (PX 6, pp. 034-035).

Dr. Joba testified that the only two conditions that were consistent with infection when he examined Petitioner were tissue redness and pain, which are the same conditions consistent with venous stasis (PX 6, pp. 034-035).

Significantly, Dr. Joba testified that he did not review any medical records from March to June of 2013 (PX 6, p. 036). This places Dr. Joba at a distinct disadvantage in

relation to Dr. Chiodo, as Dr. Chiodo did review these records and he made important and considerable use of them at his deposition as a basis in formulating his expert opinions. This factor adds great weight to Dr. Chiodo's opinions.

Petitioner's treating medical records, including from Dr. Ahmed and Dr. Vais **do not indicate** Petitioner's injury at work on February 8, 2013 caused his condition of venous stasis, venous insufficiency or ulcers of the left lower extremity.

Petitioner's treating medical records, including from Dr. Ahmed and Dr. Vais **do not offer an opinion** that Petitioner's injury at work on February 8, 2013 caused his condition of venous stasis, venous insufficiency or ulcers of the left lower extremity.

Therefore, based on a thorough review of the applicable case law and the facts, the Arbitrator finds and concludes that Dr. Joba's opinions merit very little weight and credibility, are discounted and do not support a finding of causation. The Arbitrator resolves the conflicts found in the expert medical evidence opinions in favor of Dr. Chiodo.

On the other hand, the Arbitrator affords and assigns greater weight and credibility to the opinions of Respondent's examining expert Dr. Chiodo. Beyond the very relevant and significant fact that Dr. Chiodo reviewed more medical records than Dr. Joba (thereby making him more informed) Dr. Chiodo is objectively far better qualified and credentialed as an expert in the medical, scientific and (significantly) forensic fields than Dr. Joba (who is only a podiatrist with only four years of practice experience) to offer causation opinions. The Arbitrator highlights that Dr. Chiodo has the following relevant credentials (not considering his M.S, in Threat Response, MBA and law degrees): Doctor of Medicine, Master of Public Health, Master of Science in Biomedical Engineering and Master of Science in Occupational and Environmental Health Sciences. Dr. Chiodo has also completed his class work at Oxford towards his degree of Master of Science in Evidence Based Medicine. He is also specialty resident-trained in Diagnostic Radiology and Internal Medicine. Dr. Chiodo is triple-board certified in Internal Medicine, Occupational Medicine, and Public Health and General Preventative Medicine. Dr. Chiodo is a Certified Industrial Hygienist, Graduate Toxicologist and epidemiologist. Lastly, Dr. Chiodo has been specially trained to determine causation due to an environmental or occupational exposure or circumstance.

Dr. Chiodo testified regarding Petitioner's venous stasis, venous insufficiency and ulceration of the left ankle (Resp. Ex. No. 1). Dr. Chiodo testified that Petitioner's condition of ill being including venous stasis, venous insufficiency and ulceration of the left ankle are not related to his claimed work injury of February 8, 2013. Dr. Chiodo testified that he would not opine whether there was an injury on February 8, 2013, as he did not have any medical records to identify an injury, but that even if there were an injury, **it had resolved prior to the March 25, 2013 visit to Stroger Hospital. Dr. Chiodo explained in detail that the March 25, 2013 medical record from Stroger Hospital showed detailed examination of Petitioner demonstrated left lower extremity sharp area of erythema, and that the record in no way implied or stated any ulcer, laceration or open wound existed on that date.** (Resp. Ex. 1, pp. 21-23).

Dr. Chiodo offered other explanations for the venous stasis and venous insufficiency but noted that there was no relation between a claimed wound in February to Petitioner's current condition. Dr. Chiodo indicated that the claimed injury of a laceration/open wound suffered in February was completely resolved by March 25, 2013, and any subsequent treatment was unrelated to the work for Respondent.

Dr. Chiodo opined that Petitioner's nerve pain condition is a peripheral neuropathy "in my opinion most likely to diabetes mellitus", an opinion based on Petitioner's history of pain in his lower extremities. Resp. Ex. 1, pp.21-23. Dr. Chiodo opined that that nerve pain is not related to the fall but rather "the explanation is to a high likelihood is diabetes mellitus." Resp. Ex. 1, pp.22-23.

Dr. Chiodo testified and explained that Petitioner's condition of venous stasis is related to his past history of two deep venous thrombosis. Resp. Ex. 1, p. 24.

Dr. Kyoto also testified that it is his opinion that Petitioner did not have cellulitis in his lower extremity any time after the work accident of 2013. This is based on his evaluation and workup in the medical records. Dr. Chiodo further testified that there was nothing records it was consistent with Petitioner having a venous stasis. The records of Cook County Hospital are not consistent with any laceration causing the problem because it was no laceration of the skin. If there was a laceration of skin causing cellulitis you would expect there to be a continued laceration. So clearly anything to happen to work even if there was a laceration that didn't cause a problem because it healed if you did have a laceration and had healed by the date of the accident of February 25, 2013. Dr. Kyoto further noted that an ulceration is not a laceration. They look completely different and that's consistent with venous stasis. You would not typically see an ulceration with cellulitis.

Dr. Chiodo further testified that as of March 25, 2013 Petitioner did not present with anything consistent with a work-related injury. Further, at no time in the records that he reviewed did Petitioner present with anything consistent with a work-related injury. Dr. Chiodo further testified that the records from Cook County Hospital for March 25, 2013 do not indicate any sign of any laceration on the skin. Dr. Chiodo reviewed these records at his deposition. Under review of systems the records indicated sharp areas of erythma on the left leg with mild increase in local temperature but there was no indication of any laceration or indication of any ulceration. That would've been a significant finding that would have been recorded in the records. Nowhere in the records does Dr. Chiodo find the word ulcer or laceration. Dr. Chiodo again confirmed that Petitioner's venous stasis has nothing to do with his claimed work incident. The venous stasis is related to the to the prior deep venous thrombosis. The eventual venous ulcers also are related to the venous stasis and the DVT.

Dr. Chiodo testified that the records indicate that if Petitioner did have any abrasion or laceration of the skin over the left malleolus it had clearly healed by March 25, 2013 as his records do not indicate any such condition being present. Dr. Chiodo also agreed that Petitioner did develop an ulcer as indicated in the Cook County Hospital records dated April 1, 2013. This means that Petitioner clearly developed ulcers well after the claimed injury so he developed this after they saw him in March 25, 2013. And an ulcer could develop pretty rapidly. Dr. Chiodo also confirmed

that the ulcer which appeared on or about April 1 again has nothing to do with the February work injury.

Dr. Chiodo questioned how does Petitioner have a problem due to laceration of his ankle at work but then he is no manifestation of any ulceration or laceration March 25 then he claims that April 1 is the manifestation of his work condition which Dr. Chiodo indicated does not flow. Dr. Chiodo then again confirmed that the Cook County Hospital records do not indicate that the physicians diagnosed cellulitis on March 25 but rather it was part of his differential diagnosis. Petitioner never had cellulitis based upon the medical records. Petitioner never had osteomyelitis based upon the medical records and imaging studies.

Dr. Chiodo testified that to an absolute certainty the ulceration later on had nothing to do with work because he didn't have any abrasion, any laceration or any ulceration of the skin when he was seen on March 25, 2013. So anything that may or may not have happened with that letter had nothing to do with his later problems.

Dr. Joba's testimony relied on hypothetical situations wherein Petitioner suffered a trauma and an open wound. But Dr. Joba testified that he did not review medical records for the period between February and March of 2013. Significantly, Dr. Joba did not review any medical records which demonstrated any open wound or injury following the claimed work injury in February 2013.

There are no medical records which show an open wound to Petitioner's left ankle following the accident. Medical records from March 25, 2013 at Cook County Hospital show no laceration, ulceration or open wound. Due to this lack of evidence, Petitioner failed to prove causation and any injury Petitioner may have suffered to his left ankle on February 8, 2013 has not been proven and has long since resolved.

Petitioner has not met his burden of proof by a preponderance of the credible evidence. Petitioner's own treating podiatrist did not provide credible causation opinions with a proper foundation. None of the treating physicians were able to provide causation opinions sufficient to outweigh Dr. Chiodo's clear and decisive opinions, based on a thorough review of the medcial redcords, pacing him at a distinct advantage . As such, the Arbitrator finds Dr. Chiodo's medical opinions more persuasive, and finds that the petitioner's current condition of ill being is unrelated to petitioner's work accident of February 8, 2013.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (J), WHETHER THE MEDICAL SERVICES PROVIDED WERE REASONABLE AND NECESSARY AND WHETHER RESPONDENT HAS PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

"[T]he employer shall provide and pay for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited,

however, to that which is necessary to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a).

Petitioner has not proven that his condition of ill-being as of his March 25, 2013 visits to Cook County Hospital is related to his work accident of February 8, 2013. Petitioner did not submit any bills for payment between February 8, 2013 and March 25, 2013. The Arbitrator finds that Petitioner's condition had resolved prior to March 25, 2013 and any treatment from that day forth is not related to his work injury. As the bills from March 25, 2013 forward were not necessary to cure or relieve the effects of the accidental injury, the submitted bills are not awarded.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (K), WHETHER TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

To be entitled to a temporary total disability award under the Act, an injured employee must provide not only that he or she did not work but also that he or she could not work. *Lukasik v. Indus. Com. of Ill.*, 124 Ill. App. 3d 609, 614, 80 Ill. Dec. 416, 419, 465 N.E.2d 528, 531 (1984).

Petitioner has failed to meet his burden of proving that his condition of ill-being from March 25, 2013 forward is causally related to his work accident. Petitioner submitted no off works slips for the period between February 8, 2013 and March 25, 2013. Any work restrictions imposed beyond March 25, 2013 are unrelated to claimant's work accident and therefore not compensable. TTD for the claimed period of September 22, 2013 through December 3, 2013 is denied.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING THE NATURE AND EXTENT OF PETITIONER'S INJURY, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Petitioner sustained an accident at work on February 8, 2013. Petitioner testified that he scraped/cut his forearm and his left ankle. Therese are the only injuries for which causation is found and therefore the only injuries regarding which permanency shall be awarded.

The Arbitrator viewed Petitioner's injuries. Regarding the scrapes/cuts to Petitioner's forearm and left ankle, the Arbitrator awards 10 weeks of compensation for serious and permanent disfigurement pursuant to Section 8(c) of the Act.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: March 8, 2018