STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MORGAN HUDSON as Executor or Administrator of the Estate of Glenna Romaniszak,

Petitioner,

vs. NO: 14 WC 11547

STATE OF ILLINOIS, DEPARTMENT OF CORRECTIONS,

Respondent.

19IWCC0594

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent disability, and being advised of the facts and law, provides additional discussion as set forth below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms and adopts the Arbitrator's finding that Decedent had not reached maximum medical improvement prior to her death. We write separately to clarify the law regarding the benefits to which an estate is entitled.

Although an employee's death "extinguishe[s] all payments falling due after [the employee's] death," an administrator of the claimant's estate may recover for "those payments accrued to the date of death." *Bell v. Illinois Workers' Compensation Commission*, 2015 IL App (4th) 140028WC, ¶ 21, 32 N.E.3d 704, quoting *Republic Steel Corp. v. Industrial Commission*, 26 Ill. 2d 32, 46, 185 N.E.2d 877 (1962). To be clear, an estate's recovery is limited to benefits accrued from the date the decedent reached maximum medical improvement through his or her death. As such, assuming *arguendo*, Decedent had reached maximum medical improvement prior to her death as argued by Petitioner, the estate would only be entitled to permanent partial disability benefits from April 11, 2017, the date she allegedly reached maximum medical improvement, through May 3, 2017, her date of death, *i.e.*, 3 2/7 weeks at $797.50 per week. In

19IWCC0594

addition, because there cannot be a simultaneous finding that Decedent's condition was both temporary and permanent, the TTD[1] benefits claimed for that same period would necessarily be vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2018, as amended above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that all Temporary Total Disability benefits be paid through May 3, 2017, Decedent's date of death.

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.

DATED: NOV - 1 2019

L. Elizabeth Coppoletti

LEC/mck

O: 9/11/19

43

Stephen Mathis

D. Douglas McCarthy

1 The Commission observes Petitioner alleged, and Respondent stipulated, Decedent was temporarily and totally disabled through her demise on May 3, 2017. This position is incompatible with Petitioner's simultaneous assertion that Decedent reached maximum medical improvement prior to her death.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORGAN HUDSON AS EXCUTOR OR ADMINISTRATOR OF THE ESTATE OF GLENNA ROMANISZAK
Employee/Petitioner

Case# **14WC011547**

19IWCC0594

STATE OF ILLINOIS/DEPARTMENT OF CORRECTIONS/DIXON
Employer/Respondent

On 8/14/2018, 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 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

0452 PIGNATELLI & ASSOCIATES
102 E ROUTE 30
ROCK FALLS, IL 61071

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

4971 ASSISTANT ATTORNEY GENERAL
BRETT KOLDITZ
500 SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MANAGEMENT SVCS
BUREAU OF RISK MGMT
PO BOX 19208
SPRINGFIELD, IL 62794

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

AUG 14 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Morgan Hudson as Executor or Administrator of the Estate of Glenna Romaniszak
Employee/Petitioner

Case # **14** WC **11547**

v.

State of Illinois / Department of Corrections / Dixon
Employer/Respondent

19IWCC0594

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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Ottawa**, on **July 25, 2018**. By stipulation, the parties agree:

On the date of accident, **December 12, 2012**, 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 $**69,117.00**, and the average weekly wage was $**1,329.17**.

At the time of injury, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**155,456.42** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings of fact and conclusions of law, and attaches those findings and conclusions to this document.

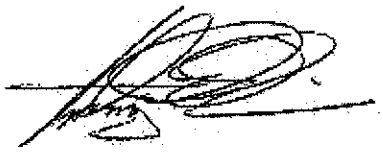
ORDER

Petitioner's claim for Permanent Disability benefits is denied.

No benefits are awarded herein.

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

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



Signature of Arbitrator

August 10, 2018
Date

AUG 14 2018

FINDINGS OF FACT

Petitioner was a nurse at Respondent's Dixon Correctional Center. On December 12, 2012, she stepped into a pothole on the prison grounds and twisted her right ankle. She presented to Katherine Shaw Bethea hospital on the same day and was diagnosed with an ankle sprain and taken off-work. She continued complaining of pain and numbness in her lower right extremity and was referred for an EMG and an MRI. The EMG was normal, but the MRI revealed a partial tear of the anterior talofibular ligament. Petitioner treated with a brace, crutches, and physical therapy. On April 30, 2013, she was diagnosed with complex regional pain syndrome. On May 1, Petitioner presented to Medical Pain Management Services and underwent a right lumbar sympathetic block injection. On August 13, Dr. Minore at MPMS recommended a spinal cord stimulator trial. Petitioner continued to see Dr. Minore for refills of pain medication until February 24, 2015. On that date, Dr. Minore implanted a spinal cord stimulator, but removed it on February 27. On March 13, he recommended an intrathecal pump trial. On September 7, 2016, Petitioner received another lumbar injection. Petitioner continued to see Dr. Minore every three-to-four months. On April 11, 2017, Petitioner returned to MPMS with 7-8/10 pain complaints in her right leg. She obtained a prescription refill and a plan to "follow up in three months or sooner if needed." On May 3, 2017, Petitioner passed away from unrelated causes.

CONCLUSIONS OF LAW

While Temporary Total Disability and medical benefits had accrued to Petitioner before her passing, Permanent Partial Disability benefits had not accrued as she had not yet reached Maximum Medical Improvement before her passing. Illinois courts have resolved this issue and have determined what benefits are owed to a deceased Petitioner's estate or dependents.

In *Nationwide Bank,* the Petitioner filed an Application, but died prior to reaching Maximum Medical Improvement or his claim being heard. *Nationwide Bank & Office Mgmt. v. Indus. Comm'n*, 361 Ill. App. 3d 207, 212, 836 N.E.2d 120, 125 (2005). The case was continued by his widow, who was awarded Temporary Total Disability and medical benefits, but not Permanent Partial Disability benefits. Id. The period of Temporary Total Disability was from the date of accident to the date of death. Id.

In *Republic Steel,* the Petitioner filed an Application and had a hearing regarding his claim. *Republic Steel Corp. v. Indus. Comm'n*, 26 Ill. 2d 32, 47, 185 N.E.2d 877 (1962). The arbitrator found no causal connection and denied benefits. Id. On appeal, the Commission found causal connection and awarded benefits. Id. While the case was on appeal to the circuit court, Petitioner died, and the state Supreme Court allowed the administratrix "to collect the payments accrued up to the date of death." Id. In *Republic Steel,* the court summarized its prior holding in *Central Illinois Light* by saying, "we held the award was personal to the deceased employee and that his death extinguished all payments falling due after his death, and permitted the administrator to recover only for those payments accrued to the date of death." Id at 885.

In *Bell,* the Petitioner died after reaching Maximum Medical Improvement. *Bell v. Illinois Workers' Comp. Comm'n*, 2015 IL App (1st) 140028WC, 32 N.E.3d 704. The parties stipulated that Petitioner suffered a work-related accident on January 30, 2008. Id. She filed an Application on

March 18, 2009. Id. Her treating doctor declared her at Maximum Medical Improvement as of August 27, 2008. Id. On September 23, 2008, Respondent's IME physician concurred that she had reached Maximum Medical Improvement with regard to her work-related injury. Id. On August 19, 2010, she died of unrelated causes. Id. The case was continued by her estate and went to a hearing on June 25, 2012. Id. The arbitrator awarded Temporary Total Disability and medical, but not Permanent Partial Disability. Id. The Commission affirmed, and the circuit court affirmed, but the appellate court reversed and remanded the case to the Commission with instructions to determine what Permanent Partial Disability benefits accrued prior to Petitioner's death. Id.

In *Electro-Motive,* the Petitioner filed an Application but died of unrelated causes before a hearing could be held, and it was not noted if he reached Maximum Medical Improvement before passing away. *Electro-Motive Div. v. Indus. Comm'n*, 250 Ill. App. 3d 432, 433, 621 N.E.2d 145, 146 (1993). The case was continued by Petitioner's dependents. Id. The arbitrator awarded medical, Temporary Total Disability, and Permanent Partial Disability. Id. The Commission affirmed and Respondent did not appeal. Id. Instead, the Respondent paid only a portion of the award, which caused the Petitioner to file a petition for penalties. Id. The Commission awarded penalties, and the Respondent appealed that decision. The appellate court decision in this case is silent on whether Petitioner reached Maximum Medical Improvement before passing away. Id.

The facts at issue here are most like those in *Nationwide Bank,* where the Petitioner died prior to the hearing and was awarded Temporary Total Disability and medical benefits, but not Permanent Partial Disability. In that case, as here, Temporary Total Disability is owed from the date of accident to the date of death. In *Republic Steel* and *Bell,* the Petitioner reached Maximum Medical Improvement before passing away, and so Permanent Partial Disability was appropriate. Those are not the facts in this case. In *Electro-Motive,* Permanent Partial Disability was awarded, but the record is silent on the Maximum Medical Improvement status of the Petitioner and therefore cannot be relied on to determine if Permanent Partial Disability is owed here.

Therefore, as Petitioner did not reach Maximum Medical Improvement before passing away, she cannot be entitled to Permanent Partial Disability benefits.

Petitioner's claim for Permanent Partial Disability benefits is, therefore, denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marc Hodge,

Petitioner,

vs. NO: 14 WC 25124

State of Illinois/Dept. of Corrections,

Respondent.

19IWCC0595

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below, finding that Petitioner sustained his burden of proving that his bilateral carpal tunnel syndromes arose out of and in the course of his employment with Respondent.

I. FINDINGS OF FACT

A. Background

Petitioner was hired by Respondent as a Correctional Officer in 1994. From 2010 to 2014 he served as Senior Public Service Administrator Warden. As a Warden, Petitioner worked four days per week. He performed inspections and tours, made written entries into logbooks, typed disciplinary reports, transfer requests and did other paperwork, and oversaw 2,400 inmates and 500 employees. He estimated that he spent 6-7 hours keyboarding daily. The angle of the keyboard necessitated that Petitioner lift his hands to type. He drafted written responses to 50-100 inmate request slips per day, many of which were healthcare related, and Petitioner made notes. Petitioner also had an assigned state vehicle which he drove to and from his residence to work, as well as to training locations in different cities.

In May of 2011 Petitioner noticed he was having issues with his hands. However, he did not seek medical attention until 2012, when he testified that he underwent cortisone injections. At some point, Petitioner testified that he was diagnosed with arthritis in his hands bilaterally.

While still serving in his capacity as a Warden in early 2014, Petitioner noticed an onset of hand pain and occasional tingling. He reported his symptoms to his then-Commander Mike Atchison as well as Deputy Director Ty Bates.

In March of 2014, Petitioner transitioned to the Internal Security Investigator II position, where he worked 5 days per week until late 2016 returning to a 4-day work week. In this position, Petitioner investigates alleged employee malfeasance, and offender and potential parolee violations of the Illinois Compliance statutes. He estimates spending between 7 and 8 hours of each shift typing. He does not have a secretary and works 37.5 hours per week. He described this job as being more sedentary than his duties as a Warden, with more writing and typing.

B. Medical Treatment

On March 21, 2014, Petitioner presented to Dr. Robert Bond at Deaconess Clinic with complaints of bilateral wrist pain and swelling for 6 months, which was gradually worsening. Petitioner also complained of bilateral wrist pain. Dr. Bond found signs of carpal tunnel symptoms. Petitioner was diagnosed with deQuervain's tenosynovitis and carpal tunnel syndrome. In the interim, Petitioner was tasked with shooting firearms 5 times per year: once per quarter as well as during an annual recertification.

In June of 2014, Petitioner noticed increased issues with his hands. On or about June 16, 2014, Petitioner was at the shooting range and noticed some hand issues with the recoil after every shot. At that time he informed his boss, Deputy Commander Larry Sims, and completed a Notice of Injury report on June 17, 2014. An Employer's First Report of Injury form was completed on June 18, 2014. Petitioner testified that when he was not at work, he did not have a lot of noticeable hand issues.

On July 16, 2014, Petitioner presented to Wabash General Hospital with bilateral wrist pain. X-rays led to a diagnosis of mild arthrosis bilaterally of the radioscaphoid by Dr. Leskosky. Physicians Assistant Tori Barnes noted the onset was 2 years prior, right worse than left. The pain was increasing over the past 6 months and radiated to the right shoulder and left elbow. Pain was aggravated by wrist movement and shooting a firearm. It was noted that Petitioner had engaged in extensive typing, writing and repetitive motion. Petitioner also complained of bilateral numbness at the base of his thumbs, index and middle fingers, as well as nocturnal awakening and pain. Petitioner was diagnosed with deQuervain's tenosynovitis, which is suspected to be secondary to carpal tunnel syndrome, but more symptomatic due to compensating factors.

An EMG was performed by Dr. Whitacre on August 21, 2014 and revealed moderate right upper extremity median mononeuropathy and left upper extremity mild to moderate median mononeuropathy. Signs of deQuervain's tenosynovitis were also noted.

On August 29, 2014, Tori Barnes, PA-C reviewed the EMG and found bilateral moderate median nerve compression consistent with carpal tunnel syndrome. A deQuervain's injection was performed on the right which provided mild thumb relief, but had no effect on Petitioner's wrists. Petitioner was referred for surgical evaluation and diagnosed with carpal tunnel syndrome.

On September 15, 2014 Petitioner presented to orthopedic surgeon Dr. Justin Miller, and he informed Dr. Miller that his pain was most prominent after doing a lot of writing and typing. The pain was mostly located in his index and middle fingers. He was again diagnosed with carpal tunnel syndrome and agreed to undergo surgical intervention.

Petitioner underwent a right carpal tunnel release surgery with Dr. Miller on September 25, 2014 and a left carpal tunnel release surgery was performed by Dr. Miller October 28, 2014. The surgeries eventually reduced Petitioner's pain and tingling while resting and not working. However, he still suffered residual left-hand numbness and occasional tingling and burning in his thumbs when typing (although his symptoms were reduced post-surgery). Petitioner and Dr. Miller also discussed a left wrist fusion.

On December 23, 2014, Petitioner indicated that he was doing well and his symptoms were much improved. He also informed Dr. Miller that he had seen a wrist specialist who had recommended a fusion of some bones in the wrist joint.

Dr. Miller eventually referred Petitioner to Dr. Marburger, a hand specialist, for arthritic concerns. On or about April 6, 2015, Petitioner complained to Dr. Marburger of problems gripping, writing and typing due to numbness, tingling, pain and swelling in his wrists bilaterally. Petitioner was diagnosed with bilateral scaphoid lunate advanced collapse in the wrists. Injections were performed.

On September 2, 2015, Petitioner followed up with Dr. Marburger for his bilateral wrist pain. A four corner partial right wrist arthrodesis surgery was agreed upon, and performed on September 24, 2015. Petitioner followed up post-operatively over the following months and progressed well post-surgically.

On February 26, 2016, Petitioner presented to Dr. Marburger for his left wrist pain. An injection was performed. On July 13, 2016, Petitioner returned to discuss definitive management and agreed upon a left wrist four corner arthrodesis surgery, which was performed on August 19, 2016. Petitioner testified that post-surgically the stability in his wrists bilaterally improved.

C. Respondent's Section 12 Examination & Deposition Testimony – Dr. Sudekum

Dr. Sudekum testified via deposition on February 4, 2016. He is a board-certified hand and upper extremity specialist. He estimated that he treats a couple hundred carpal tunnel syndrome patients annually, less than half of whom eventually require surgery. He treats 30 to 40 deQuervain's patients annually, one third of whom require surgery. Dr. Sudekum performed a Section 12 examination on Petitioner at Respondent's request on October 21, 2014. He took hand x-rays which revealed findings consistent with osteoarthritis of both hands and wrists, as well as evidence of arthritic changes in the left thumb basilar joint. He testified that neither Petitioner's

physical exam nor nerve conduction study revealed any evidence of carpal or cubital tunnel syndrome. His first examination report specifies that a left upper extremity nerve conduction study revealed normal results. In his addendum, Dr. Sudekum stated that he personally performed the nerve conduction study referenced in his first report. However, the specific results of this study were not provided by Dr. Sudekum and are not contained in the record; only his conclusion that the results were normal. Moreover, Dr. Sudekum relied on a Harvard study, a "very large European study" and a study performed at the Mayo Clinic and published in the Journal of the American Medical Association, all of which indicated that typing, keyboarding and clerical work shared no correlation in increasing the likelihood of carpal tunnel syndrome. Dr. Sudekum did note, however, that Respondent failed to provide him with the August 2014 EMG report. In an addendum report dated April 10, 2015, Dr. Sudekum noted that he had received additional medical records related to Mr. Hodge's treatment spanning from March 20002 through December of 2014. Again, Dr. Sudekum noted the absence of an EMG report.

Dr. Sudekum reviewed medical records dating back to March of 2002. He noted findings of lumbar osteoarthritis in 2005, neck pain and right ear pain in 2009, and left buttocks and lower extremity pain in 2013. Dr. Sudekum reviewed treatment records from treating physician Dr. Bond dating back to April 12, 2008. Throughout these records Dr. Sudekum noted that Dr. Bond routinely found no indications of carpal tunnel symptoms or peripheral neuropathy through October 30, 2012. Neurological physical exams were also benign. On March 21, 2014, Dr. Bond evaluated Petitioner for bilateral wrist pain ongoing for 6 months and diagnosed deQuervain's tenosynovitis and carpal tunnel syndrome. Dr. Sudekum testified that Petitioner informed him that his hand symptoms began in 2006 or 2007.

Dr. Sudekum diagnosed Petitioner with bilateral hand and wrist osteoarthritis, opining that this was the cause of Petitioner's wrist pain and paresthesia. He stated that osteoarthritis is a degenerative process of the cartilage in the joints. He acknowledged that the condition can develop after trauma, but also noted Petitioner's comorbid factors of age, morbid obesity and hypertension. Dr. Sudekum also noted that the pain and swelling symptoms Petitioner initially complained about were atypical of carpal tunnel syndrome. He testified that wrist pain is much more likely to be a symptom of osteoarthritis and carpal tunnel does not cause swelling. Dr. Sudekum testified that arthritis, however, does cause swelling, along with pain at the base of the thumb. He also noted that a fusion in the wrist is the end-stage treatment for severe osteoarthritis.

Dr. Sudekum also did not believe that Petitioner suffered from deQuervain's tendinitis, as an injection did not improve his symptoms, leading Dr. Sudekum to the conclusion that Petitioner suffered from arthritis of the carpal bones in the radial wrist area. Dr. Sudekum believed Petitioner's arthritis to be systemic, as his Section 12 evaluation reports noted a history of lumbar osteoarthritis after a 2005 motor vehicle accident, chronic right knee arthritis in April 2008, right elbow pain in August 2009, and neck pain and stiffness in January 2010. He testified that osteoarthritis of the hands and wrists causes inflammation in and around the area directly adjacent to the median nerve and carpal tunnel, which can cause a secondary carpal tunnel syndrome.

Dr. Sudekum opined that Petitioner's job duties did not cause or aggravate his osteoarthritis. Moreover, since Dr. Sudekum believed carpal tunnel syndrome was an incorrect

diagnosis, he opined that the left carpal tunnel release was unnecessary[1]. He also opined that Petitioner's job change did not affect his arthritic condition to produce swelling that would suggest carpal tunnel syndrome because his new job duties as an Investigator would not cause pathological change. On direct examination, Dr. Sudekum testified that the hand movements Petitioner performed at work were benign. (Sudekum Dep. 33). He testified that hands are made to move repetitively and frequently through the course of a regular day, adding that not moving is potentially more problematic than moving. *Id.* Dr. Sudekum further testified that "carpal tunnel syndromes typically don't occur with movement, they occur when the hand is not moving. That's why [carpal tunnel] symptoms [are] almost always more common at night when the hand is immobile." *Id.* On cross examination Dr. Sudekum reinforced his opinion. When asked if he was suggesting that not moving the hand could cause carpal tunnel syndrome, he replied "Absolutely." *Id.* at 41. He provided an example, stating that many people assume a fetal posture with their wrists when they sleep, and holding this position for an hour or more can cause nerve pinching and carpal tunnel symptoms. *Id.* Dr. Sudekum indicated carpal tunnel symptoms can also occur when the wrist is immobilized and the nerve is pinched while gripping a steering wheel while driving, talking on the phone or sitting with a remote in your hand. *Id.*

D. Deposition Testimony – Dr. Miller

On March 18, 2016, Petitioner's surgeon, Dr. Miller, testified via deposition. He stated that Petitioner was initially seen by one of his Physician's Assistants who diagnosed carpal tunnel syndrome and eventually referred Petitioner to Dr. Miller for surgical evaluation. Dr. Miller noted that Petitioner's wrist and thumb pain was not specific to carpal tunnel syndrome, but the numbness in his index and middle fingers was. He also noted that Petitioner was slightly overweight, which he did not initially feel contributed to Petitioner's condition. Upon further questioning, Dr. Miller noted that Petitioner's Body Mass Index of 40.3 rendered him morbidly obese, which could cause nerve compression and ultimately contribute to the development of carpal tunnel syndrome. He also agreed that hypertension was a comorbid factor in the development of carpal tunnel syndrome. Based on these factors, Dr. Miller changed his testimony and agreed that it was possible something outside of work could have caused Petitioner's carpal tunnel syndrome. However, Dr. Miller also noted the likelihood that Petitioner's morbidly obese and osteoarthritic conditions had been around for quite some time.

Dr. Miller noted that the EMG revealed carpal tunnel syndrome bilaterally and did not give any indications of the presence of cervical radiculopathy. He did not address Petitioner's extensive arthritis, although he denounced the idea that arthritis could lead to the development of carpal tunnel syndrome.[2] Dr. Miller did not review Petitioner's x-rays, but acknowledged that, hypothetically, if they showed moderate to severe arthrosis, it would indicate mid-road to end-stage osteoarthritis.

Petitioner informed Dr. Miller that shooting a firearm, extensive typing, writing and

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[1] Dr. Sudekum declined to speak to the validity of a right CTS diagnosis, as Petitioner had already undergone surgery prior to the Section 12 exam.

[2] Dr. Miller indicated that *significant* swelling from osteoarthritis (which could cause nerve compression) could contribute to carpal tunnel symptoms (which is a compression neuropathy), but he did not believe that osteoarthritis itself would elicit Petitioner's numbness and tingling.

repetitive motions all increased his symptoms. Eventually, Dr. Miller performed bilateral carpal tunnel releases on Petitioner. Petitioner recovered well after his right carpal tunnel release, and his numbness and tingling improved. After a left carpal tunnel release Petitioner did well, but he acknowledged that he still had numbness and tingling albeit improved compared to pre-surgery symptoms. Dr. Miller testified that these improvements confirmed the pre-operative bilateral carpal tunnel diagnoses.

Petitioner summarized his job duties to Dr. Miller as being mostly clerical. However, Dr. Miller was unaware of the frequency, intensity and duration of said duties. Nevertheless, when provided with a hypothetical of Petitioner having no comorbid conditions which would contribute to carpal tunnel, and a job requiring 3-4 hours daily of typing, writing and filing, Dr. Miller opined that these factors could lead to the development or exacerbation of symptoms consistent with carpal tunnel syndrome.

Dr. Miller admitted that he was not board-certified when he treated Petitioner. He did not interpret the EMG himself, as he relies on the evaluation of the neurologist. Dr. Miller acknowledged that a hand specialist who treats several hundred carpal tunnel patients annually and performs 50 to 100 carpal tunnel releases annually would have a better understanding of the condition. However, he also acknowledged the potential bias a physician may have if said physician has earned well over a million dollars performing independent medical examinations for a particular employer.

E. Current Condition

At the time of arbitration, Petitioner still had numbness and tingling, although the extent varied based on his daily activities. Petitioner is not a smoker and has not been diagnosed with diabetes. He does take medication for hypertension, however. He has also been diagnosed with osteoarthritis in the wrists. He stands 5'8" and weighs 265 pounds. His weight did not fluctuate much over the 10 years prior to arbitration.

II. CONCLUSIONS OF LAW

A. Accident/Causal Connection

In light of the totality of the record, the Commission finds that Petitioner has established that he sustained a compensable injury at work caused, in part, by repetitive trauma as claimed. In so concluding, the Commission notes that Petitioner gave uncontroverted testimony regarding his job-related duties throughout his employment with Respondent. He testified that he then transitioned to a more hand-intensive position with Respondent which included shooting firearms at regular intervals. Petitioner's testimony in this regard is uncontroverted. Petitioner also gave unrebutted testimony that his carpal tunnel syndrome symptoms developed only after performing the duties related to his new position, which is corroborated by the medical records. The medical records also reflect a diagnosis of bilateral carpal tunnel syndrome only after engaging in the aforementioned work-related duties.

The facts must be closely examined in repetitive-injury cases to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006). Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66. The Illinois Supreme Court went on to highlight its *Peoria County* decision stating that "[t]o deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill. 2d at 66 (citing *Peoria County*, 115 Ill. 2d at 529-30).

It has long been held 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 (1982). In addition, an employer takes its employee as it finds him. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-206 (2003). In cases where "... an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." Sisbro, 207 Ill. 2d at 205.

Petitioner has a history of osteoarthritis, which has never been denied. Petitioner himself informed Respondent's Section 12 examiner, Dr. Sudekum of his history of hand issues dating back to 2006 or 2007. However, the specific symptoms related to carpal tunnel syndrome were not present until 2014 and Petitioner testified that the pain he experienced in 2014 was different than that of 2006. Dr. Sudekum's Section 12 report confirms the lack of peripheral neuropathy or carpal tunnel symptoms prior to March 21, 2014 when Dr. Bond diagnosed Petitioner with deQuervain's tenosynovitis and carpal tunnel syndrome. The Commission also notes Petitioner's subjective complaints of carpal tunnel symptoms in 2014, including bilateral numbness in his index and middle fingers. Dr. Miller testified that Petitioner's bilateral numbness in his fingers was specific to carpal tunnel syndrome. Objectively, an EMG performed on August 21, 2014 led to a diagnosis of bilateral carpal tunnel syndrome. Petitioner acknowledged hand pain as far back as 2006, yet his condition did not require surgery until 2014, after changing jobs and increasing his hand-intensive work activities, including firearm shooting. Although Petitioner may have had osteoarthritis prior to 2014, he was not diagnosed with carpal tunnel syndrome until 2014. Petitioner was also able to work without any carpal tunnel-related treatment until after the accident date, when his symptoms began increasing.

The Commission notes that the Arbitrator found Petitioner to be less-than-forthright, pointing out that Petitioner admitted to having hand issues in 2011 but refused to characterize it as "symptom-related issues." Petitioner underwent cortisone injections in 2012, and on December 23, 2014 he mentioned to Dr. Miller that he had seen a wrist specialist who recommended a fusion. The Arbitrator questioned why these records were excluded from the record. The Arbitrator also noted that Petitioner testified to reporting his symptoms to Respondent in 2014, but did not address the fact that he reported his declining wrist problems in May of 2011.

The Commission finds no reason to question Petitioner's credibility as the Arbitrator did. To the contrary, if Petitioner were engaging in some deception it seems unlikely that he would have volunteered his 2011 hand symptoms and 2012 treatment particularly in the absence of such

records. Petitioner also offered testimony of hand pain dating back to 2006 despite a lack of such medical evidence being presented at arbitration. He also volunteered such information to Respondent's Section 12 examiner. Moreover, several medical records from 2011 and 2012 not submitted by either party at the hearing were, in fact, provided to Respondent's Section 12 examiner, Dr. Sudekum. Based on Dr. Sudekum's review of these records there was no indication that anything contrary to Petitioner's testimony was ongoing during that period.

The Commission also evaluates the persuasiveness of the physicians' opinions differently than the Arbitrator who found the testimony of Dr. Miller to be unconvincing. The Arbitrator noted concessions made by Dr. Miller during his cross examination. The Commission recognizes the sum of Dr. Miller's testimony to be less problematic than did the Arbitrator. Dr. Miller indicated through testimony that significant swelling from osteoarthritis could contribute to carpal tunnel symptoms, but he did not believe that osteoarthritis itself would elicit Petitioner's numbness and tingling. Most contemporaneous to Petitioner's initial carpal tunnel complaints and diagnosis, x-rays revealed only mild arthrosis bilaterally of the radioscaphoid. Thus, the Commission finds objective medical evidence that Petitioner did not suffer from significant osteoarthritic swelling at the time his carpal tunnel symptoms arose as posited at the time of Dr. Miller's cross-examination. Notwithstanding, where "... an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Sisbro*, 207 Ill. 2d at 205; see also *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36-37 (1982) ("The claimant's injury need not be the sole factor that aggravates a preexisting condition, so long as it is a factor that contributes to the disability."). Thus, even if, *arguendo*, there was evidence of significant osteoarthritic swelling contributing to Petitioner's carpal tunnel syndrome, it would not sever causal connection to Petitioner's employment.

Pertaining to Dr. Miller's deferral to a hand specialist and his limited knowledge of the frequency, intensity and duration of Petitioner's job duties, the Commission finds that these factors do not supersede the fact that Petitioner had no carpal tunnel symptoms causing the need for medical treatment that prevented him from performing his job duties prior to the accident date. Petitioner was diagnosed with bilateral carpal tunnel syndrome causing a breakdown in his physical condition such that he required invasive medical treatment due to increasing symptomatology contemporaneous to the accident date and his execution of constant hand-intensive activities. Specifically, as a Warden from 2010 to March 2014 Petitioner typed on a keyboard set to a higher position necessitating that he raise his hands at an angle to type. Although he changed jobs in 2014, the ergonomic position of his hands while typing did not change. Petitioner's increasing symptoms are documented in the medical records and reflect an aggravation of his condition due to the increase in hand-intensive work activity and firearm shooting.

Moreover, the Commission finds the causation opinion of Dr. Sudekum to be less than persuasive in this case. "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 (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607 (2003)). The Court went on to specify that such opinions are "only as valid as the reasons for the opinion." *Id.* (citing *Kleiss v. Cassida*, 297 Ill. App. 3d 165, 174 (1998)). Dr. Sudekum posits that flexed wrists, gripping a steering wheel, talking on the phone and holding a remote can pinch the nerve and trigger carpal tunnel

symptoms, and opines that repetitive hand movements—including typing with your wrists at an angle for approximately 7 hours daily—would not contribute to the development of carpal tunnel syndrome. In so concluding, he references various studies without specific citation and which are not included at the time of his deposition or offered at the arbitration hearing. Additionally, the Commission notes that Dr. Sudekum's opinion was formed without the benefit of the August 2014 EMG report, which led to a diagnosis of carpal tunnel syndrome by Dr. Miller, along with indications of the same diagnosis by Dr. Whitacre and Tori Barnes, PA-C. Given the foregoing, the opinions of Dr. Sudekum are conclusory and not persuasive in light of the chain of events.

Next, the Commission addresses the Arbitrator's doubts surrounding the bilateral carpal tunnel diagnosis itself. The Arbitrator questioned Petitioner's diagnoses pointing to both Dr. Miller and Dr. Sudekum's testimony that Petitioner's complaints along his radial arms, right shoulder and left elbow were unrelated to carpal tunnel syndrome. The Arbitrator also noted Dr. Miller's testimony that he did not notice any median nerve flattening during surgery and that Petitioner underwent bilateral carpal tunnel releases, but still had continued complaints and had to undergo additional surgery. The Arbitrator found these facts to suggest Petitioner suffered from osteoarthritis rather than carpal tunnel syndrome. Dr. Miller testified that the numbness in Petitioner's index and middle fingers was specific to carpal tunnel syndrome. Moreover, objective medical evidence, particularly Petitioner's EMG test results, taken with contemporaneous clinical findings throughout treatment supports the conclusion that Petitioner suffered from bilateral carpal tunnel syndrome. The Commission also finds it prudent to clarify Dr. Miller's testimony regarding visual evidence of median nerve flattening or the lack thereof. Dr. Miller testified that he did not notice said flattening during surgery, but he also testified that he would not expect to be able to visualize flattening in mild to moderate cases of carpal tunnel syndrome such as Petitioner's case whereas he would in severe cases. Thus, the Commission finds that the evidence establishes that Petitioner suffered from bilateral carpal tunnel syndrome not merely osteoarthritis.

Lastly, the Commission notes that the medical records reflect Petitioner's much improved symptoms subsequent to his bilateral carpal tunnel releases on December 23, 2014. During his final visit with Dr. Miller, Petitioner still had some occasional bilateral burning and tingling in his thumbs. However, as indicated at his deposition, Dr. Miller testified that wrist and thumb pain are not specific to carpal tunnel syndrome. Furthermore, based on subsequent medical records and treatment, the Commission notes an increased likelihood that Petitioner's symptoms subsequent to December 2014 were related to his osteoarthritis rather than carpal tunnel syndrome.

The Commission recognizes the similar, yet different, symptomatology related to carpal tunnel syndrome and osteoarthritis. However, having one condition does not negate the presence of the other and the Commission rejects the notion in this case that Petitioner suffered from either carpal tunnel syndrome or osteoarthritis finding that the evidence establishes that Petitioner suffered from both conditions, one being degenerative/genetic (osteoarthritis) and the other being work-related (carpal tunnel syndrome).

Thus, the Commission, herein, reverses the Arbitrator's denial of accident and causal connection and finds that Petitioner has met his burden of proof for the same.

B. Medical Expenses

Respondent's denial of liability for medical care is based on its belief that Petitioner failed to sustain his burden of proof regarding accident and causal connection. Having herein reversed the Arbitrator's ruling and found accident and causal connection, the Commission now analyzes the reasonableness and necessity of Petitioner's medical care. The medical bills submitted into evidence are for treatment rendered by Dr. Miller, and referenced above, for reasonable and necessary treatment to alleviate Petitioner from the effects of his work-related bilateral carpal tunnel syndrome condition. Thus, the Commission finds that Respondent shall be liable for all unpaid portions of the medical bills generated by Dr. Miller in relation to Petitioner's bilateral carpal tunnel syndromes pursuant to Sections 8(a) and 8.2 of the Act.

C. Permanent Partial Disability

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

Id. Considering these factors in light of the evidence submitted at arbitration, the Commission addresses the factors delineated in the Act for determining permanent disability.

With regard to subsection (i) of § 8.1b(b), the Commission notes that no AMA impairment rating was offered by either party. Therefore, the Commission assigns no weight to this factor.

With regard to subsection (ii) of § 8.1b(b), the occupation of the employee, the Commission notes that Petitioner was employed as an Internal Security Investigator II, which he indicated was a relatively sedentary position requiring extensive writing and typing. Petitioner returned to full duty work and was still employed in this capacity at the time of arbitration. Thus, the Commission assigns moderate weight to this factor.

With regard to subsection (iii) of § 8.1b(b), the Commission notes the parties' stipulation that Petitioner was 44 years old at the time of the accident. Given Petitioner's younger age, it will require him to manage the effects of his injury for a longer period of work remaining in his career. Thus, the Commission assigns significant weight to this factor.

With regard to subsection (iv) of § 8.1b(b), the future earning capacity of the employee, the Commission notes there was no evidence offered regarding any change in Petitioner's future earning capacity. Petitioner was able to return to work after the accident. Thus, the Commission assigns some weight to this factor.

With regard to subsection (v) of § 8.1b(b), evidence of disability corroborated by the treating medical records, the Commission notes that Petitioner developed bilateral carpal tunnel syndromes, which were ultimately treated with surgical intervention. Petitioner subsequently reported marked improvement in his symptoms and there is no evidence that he returned for follow-up treatment after December 23, 2014. Thus, the Commission assigns significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Commission finds that Petitioner has established permanent partial disability to the extent of a 12.5% loss of use of his dominant right hand and a 10% loss of use of his non-dominant left hand pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner has met his burden of proof in relation to accident and his current condition of ill-being being causally connected to his work accident suffered on June 17, 2014.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 (*maximum rate*) per week for a total period of 42.75 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused a 12.5% loss of use of Petitioner's right hand (23.75 weeks) and a 10% loss of use of Petitioner's left hand (19 weeks).

191WCC0595

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical bills related to the care provided by Dr. Miller for Petitioner's bilateral carpal tunnel conditions pursuant to Sections 8(a) and 8.2 of the Act.

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

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

Pursuant to section 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 - 1 2019
o: 9/12/19
BNF/wde
45

Barbara N. Flores

Marc Parker

Dissent

I respectfully dissent from the Decision of the majority. I would have affirmed and adopted the well-reasoned Decision of the Arbitrator who found that Petitioner did not sustain his burden of proving that his alleged current conditions of bilateral carpal tunnel syndrome, deQuervain's syndrome, or osteoarthritis were caused by his work activities and denied compensation.

Petitioner was a warden for Respondent from 2010 to 2014 and then an Internal Investigation Officer from 2014 to the present. He alleged repetitive keyboarding extensive writing, and shooting firearms as the cause of the conditions of ill-being of his hands/wrists. Petitioner relies on the testimony of his treating surgeon, Dr. Miller. However, Dr. Miller's testimony concerning causation was equivocal at best. He only had 2 & ½ years of experience as a doctor when he treated Petitioner, he agreed that he would defer to the opinions of a hand specialist who had more experience treating carpal tunnel syndrome, he acknowledged that he did not have a good understanding of the frequency, duration, or intensity of the activities which Petitioner alleged caused his conditions of ill-being, and he conceded that the cause of his ailments could have been factors other than Petitioner's work activities.

On the other hand, Respondent's Section 12 medical examiner, Dr. Sudekum, had a better understanding of Petitioner's work activities, noted that his osteoarthritis was degenerative in nature, and that osteoarthritis could have resulted in swelling and pain which could mimic symptoms of carpal tunnel syndrome. I believe the Arbitrator was correct in finding the opinions of Dr. Sudekum more persuasive than those of Dr. Miller.

In addition, the Arbitrator was understandably skeptical that Petitioner even had carpal tunnel syndrome. Besides the symptoms associated with Petitioner's arthritis noted above, he exhibited other symptoms which were not typical of carpal tunnel syndrome, an EMG/NCV found no evidence of carpal tunnel syndrome, and Dr. Miller, acknowledged that he found no flattening of the nerves intraoperatively. Finally, it is important to note that Petitioner's symptoms were not relieved by the surgeries. As a result, Dr. Miller referred him to Dr. Marburger, who performed surgery fusing Petitioner's wrists to treat his osteoarthritis.

The Arbitrator began her analysis by describing Petitioner as "not an altogether forthright witness," noting inconsistencies between his testimony and the medical record. She also noted that he testified to treatment for his hands as early as 2011 and that he mentioned to Dr. Miller that a wrist-specialist had recommended fusion surgery prior to Dr. Miller's treatment. The Arbitrator correctly found that the failure of Petitioner to submit prior treating records into evidence implies that those records would not have been beneficial to his claim.

Based on the entire record before us, I would have affirmed and adopted the well-reasoned Decision of the Arbitrator who found that Petitioner did not sustain his burden of proving an accident or a causal connection between his work activities and his conditions of ill-being and denied compensation. For these reasons, I respectfully dissent.

DLS/dw
O-9/12/19
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Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HODGE, MARC
Employee/Petitioner

Case# **14WC025124**

DEPT OF CORRECTIONS/ST OF IL
Employer/Respondent

19IWCC0595

On 5/15/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE KEITH SHORT
1355 N BLUFF RD
UNITS C-D
COLLINSVILLE, IL 62234

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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 15 2018

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marc Hodge
Employee/Petitioner

v.

Department of Corrections/State of Illinois
Employer/Respondent

Case # **14** WC **25124**

Consolidated cases: **N/A**

19IWCC0595

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 15, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 19IWCC0595

On **6/17/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**85,782**; the average weekly wage was $**1,649.65**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**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 general credit for any medical bills it may have paid through its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on June 17, 2014 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his hands and wrists is causally related to the injury or his job duties 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.

Nancy Lindsey
Signature of Arbitrator

May 10, 2018
Date

MAY 15 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner alleges that he suffered repetitive trauma to his bilateral hands due to his job duties for Respondent with a manifestation date of June 17, 2014. The issues in dispute are accident, causation, notice, medical bills, and nature and extent.

The Arbitration finds:

Petitioner has been employed by Respondent since 1994. From 2010 to 2014 he served as the Warden at Lawrence Correctional Center. Since 2014 Petitioner has been working as an Internal Security Investigator II for Respondent.

On March 21, 2014, Petitioner presented to Dr. Robert Bond at Deaconess Clinic complaining of bilateral wrist pain and swelling for the past six months. (PX3). It was noted that Petitioner had been diagnosed with hypertension. (PX3). Both of Petitioner's thumbs hurt and Petitioner had signs and symptoms of carpal tunnel syndrome. (PX3). Dr. Bond gave Petitioner splints and referred him to an orthopedic surgeon. (PX3).

On June 17, 2014, Petitioner filled out an Employee's Notice of Injury form. (RX 6). On it, Petitioner indicated his date of injury was June 17, 2014 and that his injury stemmed from increased repetitive motion from his job duties. He claimed injuries to both hands and his right elbow (RX6). Petitioner also indicated that he had reported the injury to his supervisor on June 17, 2014. (RX6). Petitioner wrote:

> Over the past six years I have been an Investigations Lieutenant, Assistant Warden and Warden. I have written and typed numerous reports in facility investigations. As the AWO and Warden I completed thousands typed and written repots [sic] such as transfer request, reclassifications, grievance response, special reports, requisitions and purchase orders, checks, drop-slips, vote sheets, SSC reviews, reviews of rosters, assignment changes, TA approvals, time restorations and revocation, labor issues. Notifications of absence, OT slips, OT reports, monthly indicator reports, audits, evaluations, special acknowledgement memorandums, wardens bulletins, daily use of OTS, Email, client server applications to name a few. This was done on a daily basis as I started in facility Investigations in 1996 and became a manager in 2009 and now I am Internal Security Investigator. (RX 6)

Under "Additional Details" Petitioner wrote:

> As a manager, with the agency a large portion of the paperwork process was dated required more paper generated

> work. A large amount of written documentation was completed due to the lack of technology the agency worked within. The Agency has begun to update some of it's [sic] computer applications that may cut down on repetitive action and processing of paper documents in the future. I did report my declining health (wrist) problems around May of 2011 to then Deputy Director Ty. J. Bates. (RX 6)

A First Report of Injury was completed on June 18, 2014. (RX 1)

Petitioner signed his Application for Adjustment of Claim herein on July 9, 2014. (AX 2)

On July 16, 2014, Petitioner presented to Tori Barnes, PA, at Wabash General Hospital. (PX2). Petitioner complained of bilateral wrist pain (radial portion and right greater than left). Petitioner described the pain as radiating to the right shoulder and left elbow. Petitioner stated that his pain had begun two years earlier and that his pain level was a seven on his right hand and four on his left hand. Petitioner indicated there was no injury and the pain was aggravated by activity involving wrist movement and progression of the day as well as firearm shooting. Petitioner stated his job involved extensive typing, writing, and repetitive motions and that it had worsened in the last six months. Petitioner had tried bracing a couple months prior per his primary care physician with no improvement. Petitioner's x-rays were reviewed and described as showing osteoarthritis. On physical examination, Tinels testing was negative. Mild swelling was noted over the scapholunate on the left. It was suspected Petitioner had deQuervain's with concern for carpal tunnel syndrome, even though the PA was unable to elicit these symptoms on exam. Petitioner was given oral steroids, told to wear a wrist brace while sleeping, and scheduled for an EMG. (PX2).

On July 16, 2014, and at the request of Mr. Barnes, Petitioner underwent x-rays of his left wrist which showed arthrosis of the radial-scaphoid and scaphoid-multangular articulations. (PX2). Petitioner also underwent x-rays of his right wrist which showed arthrosis of the radioscaphoid and scaphoid-multangular articulations and no acute pathology. (PX2).

On August 21, 2014, Petitioner underwent a nerve conduction study (NCS) at Tri-State Orthopedics. (PX5). It was noted Petitioner had signs and symptoms for carpal tunnel syndrome that had been worsening over the past 18 months. (PX4). The NCS revealed evidence of moderate right upper extremity median mononeuropathy across the wrist and evidence of mild-moderate left upper extremity median mononueropathy across the wrist. (PX5).

Petitioner followed up with PA-C. Barnes on August 29, 2014. (PX2). It was noted that Petitioner had bilateral wrist pain and right deQuervain's, intermittent and ongoing for two years, without specific injury. (PX2). Petitioner indicated the wrist splints helped slightly, but he still woke up at night and had constant numbness. Petitioner also reported increased pain in his right thumb and he requested an injection which was given. Ms. Barnes reviewed the EMG noting that it showed bilateral moderate median nerve compression, consistent with carpal tunnel syndrome. (PX2). Petitioner was referred for surgical evaluation. (PX2).

On September 15, 2014, Petitioner presented to Dr. Justin Miller at Wabash General Hospital. (PX2). Petitioner, who was right hand dominant, complained of bilateral wrist pain and

indicated he noticed pain after a lot of writing and typing. (PX2). Petitioner was assessed with bilateral carpal tunnel syndrome and was scheduled for surgery. (PX2).

On September 25, 2014, Petitioner underwent a right wrist open carpal tunnel release. (PX2).

On October 7, 2014 a Supervisor's Report of Injury or Illness was completed. Supervisor Sims stated that Petitioner told him he was having trouble with his wrists and that it was ongoing from his time at Lawrenceville. (RX 7)

On October 16, 2014, Petitioner followed up with Ms. Barnes. (PX2). Petitioner was doing well, his incisions had healed, and his numbness and tingling had improved. (PX2). His sutures were removed and Petitioner was scheduled for surgery for the left wrist. (PX2).

On October 21, 2014, Petitioner underwent a Section 12 examination with Dr. Anthony Sudekum at Missouri Hand Center. (RX3). Dr. Sudekum reviewed Petitioner's medical records. (RX3). Pertinent past diagnoses included hypertension and arthritis. (RX3). Petitioner indicated he had undergone right carpal tunnel surgery three weeks prior to this exam. (RX3). Petitioner indicated his right wrist paresthesia and pain had improved, but not completely resolved. (RX3). He complained of continued numbness and tingling, pain, soreness, and thumb pain. (RX3). X-rays were taken of Petitioner's bilateral wrists and hands which showed significant osteoarthritic changes. (RX3). Dr. Sudekum performed a left upper extremity nerve conduction study, which was normal. (RX3). There was no evidence of carpal tunnel syndrome, cubital tunnel syndrome, median neuropathy, ulnar neuropathy, or any peripheral neuropathy. (RX3). All values were well within normal limits. (RX3).

In his report, Dr. Sudekum discussed his analysis of Petitioner's positions with Respondent. (RX3). Petitioner had advised him that all of his positions involved a variety of different administrative and clerical tasks including meeting and talking with inmates/staff, handling/reading files, talking on the phone, paperwork, writing, and keyboarding. (RX3). Petitioner indicated he was a warden from 2010 to 2014 and performed paperwork/wrote for three to five hours a day. (RX3). He was currently an investigator and had been in that position for approximately 10 months. (RX3). He indicated he spent four to five hours a day writing or typing in his new position. (RX3).

Dr. Sudekum diagnosed Petitioner with significant chronic osteoarthritis of both hands and wrists. (RX3). Dr. Sudekum stated this diagnosis was consistent with Petitioner's subjective symptoms, findings on physical examination, and imaging studies. (RX3). Dr. Sudekum indicated all of the hand and wrist symptoms noted in his medical records could be the result of Petitioner's osteoarthritis. (RX3). He further stated that individuals who suffer from significant chronic inflammatory degenerative osteoarthritis like Petitioner, may develop secondary carpal tunnel syndrome/symptoms and/or tendinitis symptoms due to the proximity of the inflammatory/degenerative effects of the underlying primary condition, osteoarthritis, to the nearby tendons and the nerves in the hands and wrists. (RX3). This type of secondary effect of degenerative arthritis may be more common when the arthritic condition is relatively widespread and more generalized, as it was with Petitioner. (RX3). Based on his review of all of the

information, Dr. Sudekum opined Petitioner did not sustain any injury to either of his upper extremities due to his work activities for Respondent. (RX3). Dr. Sudekum further opined that Petitioner's bilateral wrist and hand osteoarthritis was not caused or aggravated by Petitioner's job duties for Respondent. (RX3). Dr. Sudekum indicated Petitioner was capable of working full duty without restriction. (RX3).

On October 28, 2014, Petitioner underwent a left wrist open carpal tunnel release. (PX2).

On November 4, 2014, Petitioner followed up with Dr. Miller. (PX2). Petitioner indicated he still had some numbness and tingling in his left hand, but he had noticed improvement. (PX2).

On November 11, 2014, Petitioner returned to Dr. Miller. (PX2). Petitioner indicated he was doing well and his numbness and tingling were better. (PX2). Petitioner had full range of motion in all fingers and his incision sites were well-healed. (PX2). Petitioner was to follow up in four weeks. (PX2).

On December 23, 2014, Petitioner followed up with Dr. Miller. (PX2). Petitioner indicated he had been seen by a wrist specialist who recommended a fusion. He was noticing occasional tingling and burning in his thumbs when he was typing but was much better than before his surgery. Petitioner was released to return in three months and referred to a hand specialist in Evansville, Indiana. (PX2).

On April 4, 2015, Petitioner presented to Dr. Ross Marburger at the Hand Center of Evansville. (PX4). Petitioner indicated his carpal tunnel surgeries improved his numbness and tingling, but he still had problems with gripping, pain, and swelling. (PX4). X-rays of Petitioner's wrists were taken which showed SLAC wrist stage II, early stage III on the left, and stage II on the right. (PX4). There were no acute findings. (PX4). Petitioner was diagnosed with bilateral schapholunate advanced collapse, SLAC wrists. (PX4). Petitioner was given an injection in both wrists. (PX4).

On April 10, 2015, Dr. Sudekum issued an addendum to his Section 12 report. (RX4). Dr. Sudekum reviewed additional medical records. (RX4). These medical records included Petitioner's diagnosis of L-spine osteoarthritis in 2005 and records from Dr. Miller from 2014 regarding Petitioner's treatment for his bilateral hands and wrists, including the carpal tunnel operative reports. (RX4). Dr. Sudekum stated it was important that Petitioner had continued complaints of pain and paresthesia in both hands and wrists even after undergoing carpal tunnel surgeries and that was, most likely, due to his underlying significant chronic osteoarthritic pathology affecting both hands and wrists and those symptoms will not improve or resolve until Petitioner underwent effective treatment for his chronic hand and wrist arthritic conditions. (RX4). These records confirmed and reinforced Dr. Sudekum's diagnosis of significant chronic/non-traumatic osteoarthritis of the bilateral hands and wrists. (RX4). The new records did not change Dr. Sudekum's opinion regarding the causation or work relatedness of Petitioner's hand/wrists conditions.

On April 20, 2015, Petitioner followed up with Dr. Marburger. (PX4). Petitioner indicated his wrists had improved after the injections. (PX4). Petitioner was told to return as needed. (PX4).

Petitioner underwent no further medical treatment between April 20, 2015 and September 2, 2015.

On September 2, 2015, Petitioner returned to Dr. Marburger complaining of bilateral wrist pain. (PX4). Different treatment options were discussed and Petitioner indicated he wished to proceed with definitive management. (PX4). Dr. Marburger recommended a right wrist four corner arthrodesis. (PX4).

On September 24, 2015, Petitioner underwent surgical intervention including a four corner partial wrist arthrodesis, right wrist for Petitioner's advanced state III scapholunate, advanced collapse arthritis of the right wrist. (PX4).

On October 7, 2015, Petitioner had a post-op appointment with Dr. Marburger. (PX4). X-rays showed stable alignment. (PX4). Petitioner was to return in two weeks for early cast change and exam. (PX4).

On October 21, 2015, Petitioner followed up with Dr. Marburger. (PX4). No problems were noted. (PX4).

On November 6, 2015, Petitioner returned to Dr. Marburger. (PX4). Petitioner was doing well and was to return in two weeks for pin removal. (PX4).

On November 20, 2015, Petitioner followed up with Dr. Marburger. (PX4). Petitioner was doing well. (PX4). X-rays showed hardware and fusion was stable, and successful union of the intervals of the four corners. (PX4). Petitioner was fitted for a custom orthotic and told to work on finger range of motion and gentle wrist range of motion. (PX4).

On December 4, 2015, Petitioner followed up with Dr. Marburger. (PX4). Petitioner was doing well and was to begin hand therapy. (PX4). Petitioner underwent a physical therapy assessment. (PX4).

On February 26, 2016, Petitioner returned to Dr. Marburger. (PX4). Petitioner indicated his right wrist was progressing and he was at full activity, but complained of left wrist pain. (PX4). Petitioner was given a left wrist injection under fluoroscopy. (PX4).

On July 13, 2016, Petitioner followed up with Dr. Marburger complaining of left wrist pain. (PX4). Petitioner wanted to discuss definitive management. (PX4). Petitioner had done well with four corner arthrodesis of the right wrist and wished to proceed with same for his left wrist to treat his symptomatic osteoarthritis. (PX4).

On August 10, 2016, Petitioner had a pre-op visit with Dr. Marburger. (PX4).

On August 19, 2016, Petitioner underwent surgical intervention including a four-corner arthrodesis of his left wrist due to his stage III SLAC wrist arthritis. (PX4).

On August 29, 2016, Petitioner had a post-op appointment with Dr. Marburger. (PX4). Petitioner was doing well. (PX4). Petitioner's sutures were removed and he was to return in three weeks. (PX4).

On September 19, 2016, Petitioner followed up with Dr. Marburger. (PX4). Petitioner had no significant problems and was doing well. (PX4). X-rays showed stable alignment of hardware and fusion. (PX4).

On October 10, 2016, Petitioner followed up with Dr. Marburger. (PX4). Petitioner was doing well. (PX4). X-rays showed hardware and fusion was stable, and successful union of the intervals of the four corners. (PX4). Petitioner was fitted for a custom orthotic. (PX4).

On November 11, 2016, Petitioner returned to Dr. Marburger. (PX4). X-rays showed successful consolidation of the four corner arthrodesis. (PX4). It was noted Petitioner had undergone this surgery on his right wrist and knew how to get this mobilized as much as possible. (PX4). Petitioner was released to return as needed and told to call if there were any problems. (PX4).

Deposition of Dr. Sudekum

Dr. Sudekum testified via evidence deposition taken on February 4, 2016. (RX5). Dr. Sudekum testified he is a board-certified hand and upper extremity specialist. (RX5, tr. 5-6). He holds two different board certifications in both surgery of the upper extremity and plastic/reconstructive surgery. He also holds a Special Certificate of Added Qualification for Surgery of the Hand. (RX5, tr. 6). Dr. Sudekum testified his practice involves the evaluation and treatment, mainly surgical, of the upper extremity. (RX5, tr. 6). He primarily focuses on the upper extremity from the elbow to fingertips. (RX5, tr. 6). Dr. Sudekum testified he also performs IMEs which makes up approximately five percent of his practice. (RX5, tr. 7).

Dr. Sudekum testified he examined Petitioner on October 21, 2014 and reviewed medical records. (RX5, tr. 10-11). Dr. Sudekum took x-rays of Petitioner's hands and wrists which revealed findings consistent with osteoarthritis of both hands and wrists. (RX5, pg. 12). There was also evidence of arthritic changes in the left thumb basilar joint. (RX5, tr. 12). Dr. Sudekum performed a physical examination with findings of tenderness to the bilateral dorsal wrists, postivie scaphoid shift tests, positive Finkelstein's test in the region of the STT joint, negative over the deQuarvain's tendons, bilateral radial wrist pain, decreased thumb range of motion, decreased bilateral wrist general range of motion, and decreased bilateral elbow general range of motion. (RX5, tr. 12-13). Dr. Sudekum testified he also performed a nerve conduction study on Petitioner's left side which was completely normal. (RX5, tr. 14). There was no evidence of carpal tunnel syndrome, cubital tunnel syndrome, median neuropathy, ulnar neuropathy, or any peripheral neuropathy. (RX5, tr. 14). All results were well within normal limits, they were not borderline. (RX5, tr. 14).

Dr. Sudekum testified that he asked Petitioner about the onset of his symptoms, and Petitioner indicated they first began in 2006 or 2007. (RX5, tr. 14). Dr. Sudekum testified this was inconsistent with the medical records he reviewed, one of which indicated Petitioner had symptoms for six months, another which indicated Petitioner had symptoms for two years. (RX5,

tr. 13-4-15). Petitioner described his job to Dr. Sudekum. (RX5, tr. 15). Petitioner indicated he worked for Lawrence Correctional Center since 1994 and was a correctional officer for about 15 years. (RX5, tr. 16). Petitioner was then an assistant warden in 2009 and warden from 2010 to 2014. (RX5, tr. 16). Petitioner indicated he was currently a Southern Region Investigator for the Department of Corrections and had been in that position for approximately 10 months. (RX5, tr. 16). Petitioner felt his job duties of paperwork and keyboarding could have contributed to his upper extremity conditions. (RX5, tr. 16). Petitioner indicated he spent as much as five hours a day typing and he thought that contributed to his symptoms. (RX5, tr. 17).

Dr. Sudekum further testified that he diagnosed Petitioner with bilateral hand and wrist osteoarthritis. (RX5, tr. 17). He did not see any objective evidence for a diagnosis of carpal tunnel syndrome on the right side, but did not get to see Petitioner before the surgery had been performed. (RX5, tr. 17). Dr. Sudekum testified he definitely did not think Petitioner was suffering from carpal tunnel syndrome on the left side as he had a completely normal nerve conduction study. (RX5, tr. 18). Dr. Sudekum testified that Petitioner's symptoms of wrist pain and paresthesia was caused by his osteoarthritis as opposed to carpal tunnel syndrome. (RX5, tr. 18). Dr. Sudekum also testified he did not think Petitioner had deQuervain's syndrome, but that his pain was due to arthritis. (RX5, tr. 19). He felt that this was further evidenced by the fact that Petitioner did not improve after the steroid injection. (RX5, tr. 19).

Dr. Sudekum testified that osteoarthritis is a condition whereby there is abnormal wear on the articular surfaces of the joints. (RX5, tr. 20). It is a degenerative process of the cartilage of those joints; it is primarily determined genetically. RX5, tr. 20). He explained that it is possible to get osteoarthritis from a significant traumatic injury, such as a fracture, but it is mostly determined genetically. (RX5, tr. 20-21). Dr. Sudekum testified Petitioner's medical records showed he had arthritis in his right knee, right elbow, neck, and low back, which he would consider a systemic condition. (RX5, tr. 21). Dr. Sudekum also testified Petitioner had comorbid factors that could predispose him to the development of carpal tunnel syndrome or deQuervain's including his age, the fact Petitioner is morbidly obese with a BMI of 40.3, and his diagnoses of hypertension and osteoarthritis. (RX5, tr. 22). Dr. Sudekum testified that there is a three times greater chance of developing carpal tunnel syndrome in people whose BMI is over 30. (RX5, tr. 22). He also explained that hypertension causes fluid retention and peripheral edema which can contribute to the development of carpal tunnel syndrome by increasing the fluid accumulation around the nerve, compressing the nerve as a matter of that phenomenon and that osteoarthritis of the hands and wrists causes inflammation in and around the area directly adjacent to the median nerve and the carpal tunnel and that can cause a secondary carpal tunnel syndrome. (XRX, tr. 22-23).

Dr. Sudekum testified that the symptoms Petitioner was complaining of when he first sought treatment for his wrists and hands were not the typical presentation of carpal tunnel syndrome. (RX5, tr. 23). Dr. Sudekum explained that Petitioner's main complaints of pain and swelling were not the typical complaint. (RX5, tr. 23-24). He further testified that Petitioner also complained of numbness, which is a symptom of carpal tunnel syndrome, but that appeared to be an "afterthought in the records." (RX5, tr. 24). The doctor testified that wrist pain is much more likely a description of arthritis and that carpal tunnel syndrome does not cause swelling, but arthritis does. (RX5, tr. 24). Dr. Sudekum also pointed out that Petitioner indicated both thumbs hurt at the base of the thumb which would not be a symptom of carpal tunnel syndrome, but it was

a symptom of arthritis. (RX5, tr. 24). Dr. Sudekum testified it is normal for there to by signs and symptoms of carpal tunnel syndrome with arthritis, as arthritis can cause a secondary neuropathy. (RX5, tr. 24-25). Dr. Sudekum testified Petitioner's presentation of symptoms was more consistent with arthritis. (RX5, tr. 25-26).

Dr. Sudekum testified he has visited multiple facilities of the Illinois Department of Corrections, performed various job activities, and spoken to different employees to understand what their job duties entail. (RX5, tr. 28-30). Petitioner did not indicate to Dr. Sudekum that he related his hand and wrist conditions to his job duties as a correctional officer or lieutenant. (RX5, tr. 31). Dr. Sudekum testified Petitioner's job duties with Respondent did not cause or aggravate his osteoarthritis or any bilateral hand and wrist conditions he was diagnosed with. (RX5, tr. 31). Furthermore, he felt Petitioner's job duties did not make any difference with respect to the development, progression, or need for treatment of any of those conditions. (RX5, tr. 32). He also felt that Petitioner's job duties do not rise to the level of causing injury to the hands and wrists as the job duties performed are benign with respect to potential causation of those conditions. (RX5, tr. 33). Dr. Sudekum testified the hands are made to move and are made to do so repetitively and frequently throughout the course of the regular human day. (RX5, tr. 33). He added that not moving is potentially more problematic than moving and carpal tunnel syndrome typically does not occur with movement, but when the hand is not moving. (RX5, tr. 33).

Dr. Sudekum testified the relationship between keyboarding and carpal tunnel syndrome has been fairly heavily studied in the medical studies and literature. (RX5, tr. 34). There have been several studies, including a well-known one out of Harvard, that has concluded that typing and keyboarding do not play a role in the development or progression of carpal tunnel syndrome. (RX5, tr. 34).

Dr. Sudekum testified a fusion in the wrist is an end stage treatment for severe osteoarthritis of those carpal joints. (RX5, tr. 38). He is reluctant to perform wrist fusions as it has a high complication rate and can cause loss of motion and strength. (RX5, tr. 38). Dr. Sudekum testified he would not recommend that treatment for Petitioner and would, instead, recommend conservative treatment for quite a while before considering a fusion. (RX5, tr. 38).

Dr. Sudekum testified Petitioner was at maximum medical improvement (MMI) and could work full duty without restrictions. (RX5, tr. 36-37).

On cross-examination, Dr. Sudekum testified not moving your hand can cause carpal tunnel syndrome because, when the wrist is not moving, the nerve gets pinched a little bit, which a person will feel after a while. (RX5, tr. 40-41). Dr. Sudekum testified he has performed multiple IMEs for the state of Illinois and there were hundreds where he found that carpal tunnel syndrome was related to a position's job duties. (RX5, tr. 43-44). Dr. Sudekum testified if a position was similar to one as in this case, though, he probably would not have found that to be related. (RX5, tr. 44). Dr. Sudekum testified if would be highly unusual for carpal tunnel syndrome to be caused by typing for four or five hours a day. (RX5, tr. 47).

Dr. Sudekum testified he personally performed a nerve conduction study on Petitioner at the time of his examination. (RX5, tr. 54). Dr. Sudekum testified he does not perform an EMG

unless he thinks there is an unusual type of condition. (RX5, tr. 54). In that case, he will send the person to a neurologist for the EMG. (RX5, tr. 54-55). Dr. Sudekum testified an EMG is not needed for garden variety conditions and is a more invasive study than a nerve conduction study. (RX5, tr. 57-58).

Dr. Sudekum testified he disagreed with the treating doctor's diagnosis of carpal tunnel syndrome, but agreed with the diagnosis of arthritis, which all doctors in this case had diagnosed Petitioner with. (RX5, tr. 59-62). Dr. Sudekum testified he thought the left carpal tunnel release was unnecessary. (RX5, tr. 62). Dr. Sudekum testified Petitioner's change in jobs did not affect his arthritic condition to produce the swelling suggestive of carpal tunnel syndrome as that type of activity would not cause a pathologic change. (RX5, tr. 65-66). In fact, movement is encouraged of people with arthritis. (RX5, tr. 66). Dr. Sudekum testified Petitioner may have experienced symptoms while performing benign activities, but that is not going to cause a pathological change. (RX5, tr. 67). Simply experiencing pain does not mean there is a progression of the underlying disease. (RX5, tr. 73). Dr. Sudekum testified Petitioner's subjective complaints and the objective findings were all consistent with osteoarthritis of the wrists and hands. (RX5, tr. 69-70).

Dr. Miller's Deposition

Dr. Justin Miller testified via evidence deposition on March 18, 2016. (PX1). Dr. Miller testified he is board certified in orthopedic surgery. (PX1, tr. 6). He is a general orthopedist. (PX1, tr. 6). Dr. Miller testified he has been practicing as an orthopedic surgeon for two and a half years. (PX1, tr. 7). Dr. Miller testified Petitioner treated with a PA who had diagnosed him with carpal tunnel syndrome and referred Petitioner to him for surgical evaluation. (PX1, tr. 7-8). Dr. Miller testified Petitioner complained of wrist and thumb pain, burning, and numbness and tingling in his wrists. (PX1, tr. 9). Dr. Miller testified that Petitioner's presenting wrist and thumb pain was not specific to carpal tunnel syndrome, but the numbness in the index finger and middle finger was. (PX1, tr. 9). He also acknowledged that he didn't actually examine Petitioner on July 16th. Dr. Miller testified Petitioner does not have diabetes or thyroid malfunction, is not a smoker, and is slightly overweight, but he did not feel that same was contributory. (PX1, tr. 9-10).

Dr. Miller testified Petitioner underwent conservative care, including bracing for about two months. (PX1, tr. 11). Dr. Miller testified the EMG studies showed carpal tunnel syndrome in Petitioner's hands. (PX1, tr. 12-13). Dr. Miller testified Petitioner's complaints were consistent with carpal tunnel syndrome; however, he admitted he did not address Petitioner's "extensive arthritis" as Petitioner indicated he was seeing a hand specialist for that. (PX1, tr. 15). Dr. Miller testified that he did not feel arthritis would cause carpal tunnel syndrome. (PX1, tr. 15).

Dr. Miller testified Petitioner told him that shooting a firearm, extensive typing, writing, and repetitive motions caused an increase in his symptoms. (PX1, tr. 16). Dr. Miller was not aware if Petitioner had any hobbies and did not ask him that. (PX1, tr. 16). Dr. Miller testified he offered surgical intervention as Petitioner had failed conservative care. (PX1, tr. 17). Dr. Miller testified Petitioner did well after his right carpal tunnel release and that Petitioner's numbness and tingling had improved. (PX1, tr. 18). He acknowledged seeing no flattening of the nerve during the procedure. (PX 1, tr. 18) Dr. Miller testified Petitioner then underwent a left carpal tunnel release.

(PX1, tr. 20). Petitioner did well, he indicated he had continued numbness and tingling, but was better than pre-surgery. (PX1, tr. 22).

Dr. Miller testified he last saw Petitioner on December 23, 2014. (PX1, tr. 22). At that time he felt Petitioner was at maximum medical improvement (MMI) and could return to work without restriction. (PX1, tr. 24). Petitioner indicated he was doing well, but asked for a referral to a hand specialist for a fusion in his wrists and treatment of arthritis. (PX1, tr. 22-23). Dr. Miller testified he has not seen Petitioner since December 2014 and told him to return if he had any problems. (PX1, tr. 24).

Dr. Miller testified he was not offering an opinion regarding the etiology of Petitioner's arthritis condition or whether or not it was work-related as he did not treat Petitioner for that. (PX1, tr. 23).

Dr. Miller was asked a hypothetical question to which he replied that if Petitioner had a job involving three to four hours of daily typing, writing, filing, using a computer (or more) and that "since he took on this position that requires all of this office type hand use" he saw an increase or development of symptoms consistent with carpal tunnel syndrome, that could have caused it. (PX 1, tr.25)

Dr. Miller testified he could not ascribe Petitioner's carpal tunnel syndrome to any other cause outside of his work. (PX1, tr. 25). Dr. Miller testified he took a history from Petitioner regarding his job duties that included frequent writing, typing, and repetitive motion of the hands over the last six months. (PX1, tr. 25). Dr. Miller testified he is not aware of any correlation between wrist arthritis and carpal tunnel syndrome. (PX1, tr. 27). Dr. Miller testified the surgeries he performed improved Petitioner's numbness and tingling, but did not address Petitioner's wrist pain. (PX1, tr. 28). Dr. Miller testified Petitioner indicated his job duties involved extensive typing and writing and he felt there could be some exacerbation of his symptoms based on that. (PX1, tr. 48).

On cross-examination, Dr. Miller admitted that he was not board certified when he was treating Petitioner. (PX1, tr. 32). Dr. Miller also testified he did not have a Certificate of Added Qualification for the Hand and Upper Extremity Surgery, either. (PX1, tr. 32). Dr. Miller testified when he receives an EMG, he relies heavily on the evaluation by the neurologist and does not interpret the raw data himself. (PX1, tr. 33).

Dr. Miller testified when Petitioner was first seen by a PA, he complained of pain and swelling, which are not typical complaints of carpal tunnel syndrome. (PX1, tr. 33-34). Swelling is a symptom of osteoarthritis, though. (PX1, tr. 34). Dr. Miller testified swelling could result in positive Tinel's and Phalen's tests. (PX1, tr. 35). Dr. Miller testified swelling from osteoarthritis could contribute to carpal tunnel syndrome, but he did believe there was a direct correlation between the two. (PX1, tr. 36). Dr. Miller admitted carpal tunnel syndrome is a compression neuropathy, so swelling from osteoarthritis can cause nerve compression. (PX1, tr. 36-37). Therefore, if there is swelling from osteoarthritis, it can cause or contribute to the development of a compression neuropathy. (PX1, tr. 37). Dr. Miller testified he did not review Petitioner's x-rays,

but if they showed moderate to severe arthrosis, it would indicate mid-road to end-stage osteoarthritis. (PX1, tr. 37).

Dr. Miller testified the job description Petitioner gave him was mostly clerical. (PX1, tr. 38). Dr. Miller admitted he did not know the frequency, duration, or the intensity of those job duties when he performed them. (PX1, tr. 38).

Dr. Miller testified he referred Petitioner to a hand specialist for further evaluation regarding his arthritis. (PX1, tr. 42). He thought a fusion was extreme for someone of Petitioner's age, so that is why he referred him to a specialist to make that determination. (PX1, tr. 42). He did not know what the outcome of that referral was. (PX1, tr. 42).

Dr. Miller testified Petitioner had no comorbidities that would cause or aggravate carpal tunnel syndrome. (PX1, tr. 42). Dr. Miller testified he was not aware of any direct correlation between age and carpal tunnel syndrome. (PX1, tr. 42). Dr. Miller admitted Petitioner's BMI of 40.3 and being morbidly obese could contribute to the development of carpal tunnel syndrome because it is compression neuropathy and obesity can cause compression of the nerve. (PX1, tr. 43), Dr. Miller further admitted hypertension was a comorbid factor in the development of carpal tunnel syndrome. (PX1, tr. 44). Dr. Miller then changed his testimony and agreed that it was possible that something outside of work could have caused Petitioner's carpal tunnel syndrome. (PX1, tr. 44).

Dr. Miller admitted that a physician who is a hand specialist treating a couple hundred patients with carpal tunnel syndrome a year, who does his own nerve conduction studies and evaluates the results of those, and who has visited various department of Corrections facilities would have a better understanding of the condition and the treatment of the condition than he would. (PX1, tr. 45-46).

Dr. Miller didn't know when Petitioner began working for the State of Illinois. (PX 1, tr. 48)

Dr. Miller testified osteoarthritis is a progressive condition, and if the swelling of osteoarthritis is worsening, that could also correlate to a worsening of the carpal tunnel syndrome or create a carpal tunnel syndrome. (PX1, tr. 50). He further testified carpal tunnel syndrome is a cumulative condition, so if Petitioner had been obese and had osteoarthritis for a long time, it could potentially cause or contribute to the development of his carpal tunnel syndrome. (PX1, tr. 51). Dr. Miller also testified that he felt Petitioner was telling him his current job duties involved extensive typing and writing and he felt those could "exacerbate his symptoms." Dr. Miller acknowledged that symptoms do not necessarily correlate with progression of any underlying disease. (PX 1, tr. 51-52)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 15, 2018. Russell Goins was present as Respondent's representative. The disputed issues were accident, notice, causal connection,

medical bills, and the nature and extent of any injury. Petitioner was the sole witness testifying at the hearing.

Petitioner testified he has been employed with the Department of Corrections since 1994. His current title is Internal Security Investigator II. His job duties include investigating assigned cases of alleged employee malfeasance, and offender, employee, parolee potential violations of Illinois Compliance statutes and the Illinois Correctional Unified Code. He has been in this position for four years, since March 2014. From 2010 to 2014, he was the Senior Public Service Administration Warden at Lawrence Correctional Center.

Petitioner testified he is not a smoker and does not have diabetes. He has been diagnosed with high blood pressure and takes medication for same. He does not have a thyroid condition. He currently weighs 265 pounds and is five feet eight inches tall. His weight has not fluctuated much in the last 10 years.

Petitioner testified he was promoted to Warden in 2011. At that time, he did not have any injuries to his hands, but he did have "symptom-related issues with his hands." He did not seek treatment for his hands until 2012, at which time he believed that he underwent some cortisone injections. Petitioner testified that "at some point," he was diagnosed with arthritis in his hands.

Petitioner testified his job changed in 2014 and he noticed the onset of a lot of pain ("deadening") in his hands. He experienced tingling occasionally and it took longer during the day to get them "adjusted" to the job he needed to do. Petitioner testified after his job change in 2014, he had to take statements and write them and then type them in report form. He estimated he spent 70 to 80 percent of his day writing or typing. Petitioner testified a typical work week was 8:30 a.m. to 4 p.m. five days a week. He later switched to a four day shift from 7 a.m. to 5 p.m. He works 37.5 hours a week. Petitioner denied having anyone assist him with reports or writing.

Petitioner testified that before he changed jobs in 2014 he had to fire a weapon. Then in 2014 he had to start firing a weapon quarterly and certify annually (that is, fire a weapon five times a year). Petitioner also testified that he does not hunt or have hobbies of firing a weapon outside of work. Petitioner testified his only hobbies are playing with his children who are in athletic activities. On cross-examination, Petitioner testified that he does fish and that could be considered a hobby.

Petitioner testified that when he started noticing problems with his hands, his boss was Larry Sims. Petitioner testified that he believed he spoke to Mr. Sims regarding the problems with his hands in June of 2014. He filled out a workers' compensation packet and injury form. Petitioner also testified that in 2014 while he was at the shooting range, he was having difficulty qualifying because the recoil was causing problems with his hands. Petitioner testified that he spoke to the range instructor who thought his problem maybe had something to do with his technique but he noticed that every time Petitioner went to fire his weapon he squinted his eyes. When the instructor asked what was going on, Petitioner told him that the recoil was causing some issues with his hands. As a result, Petitioner, when he got into work the next day, wrote the incident report and verbally advised his supervisor (Mr. Sims) of the incident. That occurred in June of 2014.

Petitioner was also asked about a conversation with "Mike." He explained that when he was ending his tenure as warden and his hand problems "started again" his commander was Mike Atchison and the deputy director was Ty Bates. He reported this to both of them as he was doing quite a bit of paperwork at the time. This would have occurred in the first three months of 2014 before Petitioner switched positions.

Petitioner testified that while he was a warden in 2014 his job activities varied. He did inspections, tours, paperwork, and oversaw 2,400 offenders and approximately 500 employees. While making tours, there would be logbooks at certain locations that he would make notations in. He would make hand notations in each logbook and also documented the notation in his note pad. He would then type up his notations. Petitioner's paperwork also included inmate transfers and disciplinary reports. Petitioner testified he spent six or seven hours a day typing. Petitioner testified he sat parallel to his work space and the keyboard in the warden's office required him to kind of lift his hands when he typed. Petitioner testified during his time as warden, he was assigned a state vehicle. He drove it to and from work, trainings, and meetings. He did a lot of writing. Petitioner had an executive secretary.

Petitioner testified when his job changed in March 2014, his hands and the "emphasis on the firearms" worsened. Petitioner testified his job became more sedentary, there was more writing and typing. Petitioner testified he spent seven to eight hours a day typing daily. Petitioner testified he does not have an assistant in this position.

Petitioner testified he began treating with Dr. Miller who performed bilateral hand surgeries but Petitioner continued to have residual numbness in his left hand. Dr. Miller then referred him to Dr. Marburger for the arthritic concerns in his wrist. He ultimately underwent wrist fusions. Petitioner testified that, altogether, he has undergone surgeries for his hands and missed approximately one week of work for each surgery. He is not making a claim for TTD. He returned to work after each surgery.

Petitioner testified his hands did not bother him as much when he was away from work, but he did occasionally drop things like a glass or his mother's cookie jar. Petitioner testified that after his surgeries he was able to sleep because his hands were not hurting. The surgeries improved his pain and tingling in his hands. Petitioner testified he is currently working with no restrictions. He does still experience some numbness and tingling, occasionally.

On cross-examination, Petitioner testified he is currently 48 years old and was 44 years old when he filed his claim. He has been diagnosed with hypertension and takes prescription medication to control it. He has also been diagnosed with osteoarthritis.

Petitioner was asked if he recalled telling Dr. Sudekum that he first began experiencing symptoms in his hands in 2006 or 2007 and he replied, "That's possible." He testified he believed the symptoms he was experiencing in his hands at that time was due to his job duties because all he did was work. He could not recall if he told Dr. Sudekum he spent five hours a day typing.

Petitioner testified he currently works four days a week. He can take up to an hour lunch break. Petitioner testified he typed 70 to 80 percent of his day both when he worked a five day

work week and a four day work week. He testified that when he stated he typed six to seven hours a day, he was referring to when he works a 10 hour work day.

Petitioner testified that as warden, his job duties were varied and there were times he would not be typing and writing. The notations he made in his note pad while doing tours would be short and simple notations. Petitioner testified there would be intermittent rest between times he would have to write. Petitioner testified the state vehicle he was assigned was a car, not a work truck or large van. The car was an automatic, not a manual.

Petitioner testified that he first saw Dr. Miller in June 2014, approximately three months after he became an Internal Investigator. Petitioner testified he switched to the four day work schedule in late 2016 or 2017, so he was still working a five day work week in 2014 and worked a five day work week all through 2014, working seven and a half hours a day.

Petitioner testified he was released from care for his carpal tunnel surgeries in December of 2014, and that he did not believe he ever returned to Dr. Miller with complaints regarding those surgeries. Petitioner testified he is not currently undergoing any physical therapy for his hands or wrists. He does not take any prescription medication. He takes over-the-counter medication occasionally when they hurt. Petitioner is not required to wear any kind of brace or protective device and can perform his job satisfactorily. Petitioner has undergone a performance evaluation since his return to work and it was good. He is currently working full duty without restrictions.

On re-direct examination Petitioner testified that when he was in internal affairs and a lieutenant, he was typing and writing a lot of reports and that when he first began experiencing symptoms in his hands. However, when asked what changed in 2014 causing him to go to the doctor he replied, "Again, I had never experienced the pain that I experienced when I qualified at the range in May – or, excuse me, March, because I really never shot in regards to the warden's position so once I had that incident on the shooting range, you know, I was hurting." Petitioner believed that occurred in late March of 2014 because in order to assume the new position and carry a firearm he had to be certified and when he went to the range for the certification he was having a lot of pain scoring the required percentage. He believed that occurred in the last week of March of 2014.

RX 2 is the CMS job description for an Internal Security Investigation II. It describes the essential functions of the job. No ergonomic analysis was included.

RX 9 is the job description for a warden.

The Arbitrator concludes:

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

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

Petitioner failed to prove he sustained an accident on June 17, 2014 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his hands/wrists, including bilateral carpal tunnel syndrome, osteoarthritis, and deQuervain's syndrome, is causally related to his injury or his employment duties for Respondent.

At the outset the Arbitrator notes that Petitioner was not an altogether forthright witness, being vague with certain aspects of his testimony, especially as to prior problems with his hands. Most significantly, Petitioner was asked about issues with his hands in 2011. He testified that he didn't have an injury at that time and wasn't "going to define it" but he was having "symptom-related issues" with his hands. He also testified that he sought medical treatment in 2012 and underwent some injections. Those records were not included in the record. Petitioner also mentioned to Dr. Miller during their December 23, 2014 visit that he had seen a wrist specialist who had recommended a fusion. Nothing in the record identifies who provided the treatment in 2012 or who the wrist specialist was that Petitioner had seen before December 23, 2014. Thus, Respondent would not have had access to these records. Petitioner's failure to include them in the record or adequately address the nature of the treatment and what was going on during those times suggests to the Arbitrator that the information contained in the records may have been detrimental to Petitioner's case herein. The Arbitrator cannot overlook the fact that when Petitioner reported his alleged injury on June 17, 2014 he specifically indicated that he had reported "his declining health (wrist) problems" around May of 2011 to then Deputy Director Ty. J. Bates. (RX 6) Petitioner also did not address the reporting in May of 2011, testifying only that he spoke to Deputy Director Bates about problems in early 2014.

In support of his claim, Petitioner relies upon the testimony of his treating physician and surgeon, Dr. Miller. Dr. Miller made significant concessions on cross-examination that undermined his opinions, an opinion based on a hypothetical posed to him and which was not based upon all pertinent facts in the record. More importantly, Dr. Miller stated he would defer to a hand specialist who treated more patients per year for carpal tunnel syndrome, did his own nerve conduction studies and evaluated them, and who had visited various departments within the Corrections facilities. Dr. Miller was not board certified during the time he treated Petitioner and had only two and one-half years of experience. Dr. Miller also lacked a great amount of detail regarding Petitioner's job duties for Respondent. Dr. Miller admitted that he did not know the frequency, duration, or the intensity of those job duties when he performed them. Dr. Miller's testimony was also, at times, contradictory as when he initially testified that osteoarthritis would not cause carpal tunnel syndrome but then agreed, on cross-examination, that carpal tunnel syndrome is a compression neuropathy and that osteoarthritis can cause swelling which, in turn, can cause nerve compression. Dr. Miller also lacked knowledge and familiarity with Petitioner's treatment for his hands going back to 2011. He was also unaware of Petitioner's chronology of difficulties going back to 2011 and what had happened in early 2014 after taking on a new position and needing to qualify with his firearm. Finally, Dr. Miller also acknowledged that while Petitioner was telling him his current job duties involved extensive typing and writing and the doctor felt those activities could exacerbate Petitioner's symptoms, he also agreed that the symptoms themselves would not necessarily correlate with progression of an underlying disease.

Based upon the foregoing, the Arbitrator did not find Dr. Miller's opinions persuasive.

The Arbitrator also has some doubt as to whether Petitioner even had bilateral carpal tunnel syndrome. The earliest medical records entered into evidence indicate Petitioner's chief complaint when seen by Dr. Bonds was his thumbs along with bilateral wrist pain and swelling. Petitioner then presented to PA-C Barnes who noted deQuervain's symptoms but no positive examination findings for carpal tunnel syndrome. Petitioner's complaints at that time also included the radial side of the arms, the right shoulder and left elbow. Both Dr. Miller and Dr. Sudekum testified those were not symptoms of carpal tunnel syndrome. Dr. Miller acknowledged there was no flattening of the median nerve noted during Petitioner's surgery. It is evident from the medical records that Petitioner suffered from significant hand and wrist osteoarthritis as he was diagnosed with same based on objective imaging studies by PA-C. Barnes, Dr. Marburger and Dr. Sudekum. Dr. Miller also indicated Petitioner had osteoarthritis, but did not handle that part of his treatment. The Arbitrator also takes note that Petitioner underwent carpal tunnel releases for both wrists, but had continued complaints and had to undergo additional surgery. This is consistent with Dr. Sudekum's testimony that Petitioner's symptoms and issues regarding his hands and wrists were due to his osteoarthritis, not carpal tunnel syndrome.

Petitioner has alleged that he has sustained work-related injuries to his hands due to typing, extensive writing, and firearms shooting. Petitioner is right hand dominant. As such, it is difficult to see how his activities of handwriting could cause or aggravate carpal tunnel syndrome in the left hand. It further appears that the alleged problems with handwriting and typing may have manifested themselves in May of 2011 when problems were reported to Deputy Director Bates. Petitioner, through his testimony at arbitration, indicated that when he reported his problems in May of 2014 he did so because of issues he was having at the range while trying to qualify with his firearm. Interestingly, he failed to mention anything about firearm shooting when reporting the alleged injury. (RX 6) Additionally, Dr. Sudekum testified, without rebuttal, as to numerous studies that have found typing and keyboarding do not play a role in the development or progression of carpal tunnel syndrome.

Dr. Sudekum testified that Petitioner's osteoarthritis is a degenerative progressive condition unrelated to Petitioner's job duties. Petitioner did not provide any causation opinion regarding his osteoarthritis and job duties. In fact, Dr. Miller specifically testified that he was not opinion on Petitioner's osteoarthritis. It is well established that a claimant must present medical opinion evidence that his work duties caused or contributed to the repetitive injury alleged in order to recover under the Act. As such, the Arbitrator finds Petitioner failed to prove that his osteoarthritis was related to his job duties. Similarly, Petitioner failed to prove that his deQuervain's syndrome was related to his job duties.

Based upon the foregoing, the Arbitrator concludes that Petitioner failed to prove that his injuries arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally related to the alleged injury. Petitioner's claim for benefits is denied and all other issues are moot.

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

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

Issue (L) What is the nature and extent of the injury?

Given the Arbitrator's determination as to liability Issues (E), (J) and (L) are moot. Petitioner's claim is denied and no benefits are awarded.

****

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

SAMUEL WHITE,

Petitioner,

vs. NO: 14 WC 014858

RICH TOWNSHIP HIGH SCHOOL # 227,

Respondent.

19IWCC0596

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability, wage differential, and nature and extent of disability, and being advised of the facts and law, affirms the Decision of the Arbitrator with the addition of further analysis concerning the denial of wage differential award pursuant to Section 8(d)1 of The Act.

Petitioner was a part-time employee of Respondent working as a police liaison officer at a school when he sustained an injury to his right shoulder and neck on April 15, 2014. He fell while struggling with a student and injured his right shoulder and cervical spine. Petitioner is right hand dominant.

While treating for the right shoulder Petitioner had continued neck pain. Both the right shoulder and cervical spine injuries are causally related to the work accident. Petitioner's primary employment was as a police sergeant with the City of Harvey Police Department. Petitioner has not returned to employment since the work accident.

Petitioner's treating physician and Respondent's Section 12 examiner concur that Petitioner is not able to return to police work and is restricted to sedentary activities. Petitioner's work restrictions are permanent.

19IWCC0596

Petitioner acknowledged that he has not looked for any jobs since the work accident. Petitioner admits that he received a job offer from Respondent on May 10, 2018 offering a job paying $25.00 per hour for a 20 hours of work per week. Respondent maintains that this offer of employment was followed by a subsequent offer made to Petitioner that increased the hours of work to 25 per week. It is not disputed that the employment offered was sedentary in nature and fell within Petitioner's permanent restrictions. The work offered involved monitoring surveillance cameras onsite at the school. Petitioner declined the offered employment.

On July 17, 2018 a Vocational Analysis Assessment/Labor Market Survey Report was prepared. The report concluded that given Petitioner's work history, transferable skills, and physical restrictions, alternative gainful employment opportunities do exist in his community but the rate of pay was significantly less than Petitioner's average weekly wage of $2,004.99 prior to the work accident.

The parties stipulated that Petitioner was entitled to temporary total disability payments commencing April 16, 2014 through May 13, 2018. The parties further stipulated to temporary partial disability payments from May 14, 2018 through October 15, 2018. Additionally, the parties stipulated that there was a partial outstanding balance due to Dr. Piska with a date of service of October 16, 2015 that is owed by Respondent. The Commission finds that this balance of $1290.00 shall be paid by Respondent directly to Dr. Piska

The Commission finds that the Arbitrator correctly found that Petitioner sustained a 50% loss of use of the person as a whole pursuant to Section 8(d)(2) rather than find, as urged by Petitioner, that he is entitled to wage differential benefits pursuant to Section 8(d)(1) of The Act.

The Commission finds the decision of the Appellate Court in *Euclid Beverage Co. v. Illinois Workers' Comp. Commission* 2019 IL App (2d) 180090WC instructive on this issue and bears several factual similarities to the instant case. To qualify for wage differential benefits, a claimant must prove (1) a partial incapacity that prevents claimant from pursuing his usual and customary line of employment and (2) an impairment of earnings. The purpose of a wage differential award is to compensate an injured worker for his reduced earning capacity. Petitioner in the present case fulfilled the initial criteria of incapacity but failed to demonstrate the requisite impairment of earnings to qualify for wage differential benefits pursuant to Section 8(d)(1) of the Act.

As was the situation in *Euclid* the Commission finds that Petitioner abandoned the labor market on April 15, 2014 and failed to prove his earnings capability. Petitioner testified that he did not look for any jobs, nor had he applied for any jobs. Petitioner did not request vocational rehabilitation from Respondent nor did he perform any independent job search. Petitioner did not contact the City of Harvey Police Department seeking employment when he was determined to be at MMI.

In light of the foregoing factors the Commission affirms the Arbitrator's award of 50% loss of the use of the person as a whole for Petitioner's right shoulder and cervical injuries.

19IWCC0596

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 7, 2019, is hereby affirmed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits for 212 5/7 weeks commencing April 16, 2014 through May 13, 2018, that being the stipulated period of total temporary incapacity to work, under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $721.66 per week for a period of 250 weeks, commencing May 14, 2018 through October 15, 2018 in a lump sum and weekly benefits thereafter because the injuries sustained caused the loss of use of 50% of the person as a whole, as provided in Section 8 (d)2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner reasonable and necessary medical expenses in the sum of $1,290.00 directly to Dr. Jalaja Piska, Advanced Pain Specialists, pursuant to the Medical Fee Schedule, and pursuant to Sections 8(a) and 8.2 of the Act.

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 be given a credit of $285,471.61 for temporary total disability benefits paid, $20,500.60 for temporary partial disability payments paid and $88,667.57 under Section 8(j) of the Act.

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

DATED: NOV - 4 2019
SJM/msb
o:9/11/19
44

Stephen Mathis

Douglas McCarthy

L Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHITE, SAMUEL
Employee/Petitioner

Case# **14WC014858**

19IWCC0596

RICH TOWNSHIP HIGH SCHOOL #227
Employer/Respondent

On 1/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

2337 INMAN & FITZGIBBONS LTD
KRISTIN THOMAS
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

19IWCC0596

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

Samuel White
Employee/Petitioner

v.

Rich Township High School District #227
Employer/Respondent

Case # **14** WC **14858**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **October 15, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ 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 **Amount of 8(d)(1) benefits**

FINDINGS 19IWCC0596

On **April 14, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**104,259.48**; the average weekly wage was $**2,004.99**.

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 $**285,471.61** for TTD, $**20,500.60** for TPD, $**0.00** for maintenance, and $**88,667.57** for other benefits, for a total credit of $**394,639.78**.

Respondent is entitled to a credit of $**88,667.57** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $**285,471.61** for temporary total disability benefits and $**20,500.60** for temporary partial disability benefits paid.

Respondent shall pay for the **reasonable and necessary medical services** set forth below, directly to the providers, pursuant to the Medical Fee Schedule, and Sections 8(a) and 8.2 of the Act:

1. Dr. Jalaja Piska $1290.00 Advanced Pain Specialists

Respondent shall pay Petitioner permanent partial disability benefits of $**721.66**/week for **250** weeks, because the injuries sustained caused the **50**% 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

01/07/19
Date

ICArbDec p. 2

JAN 7 - 2019

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on October 15, 2018 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator Kay.

STATEMENT OF FACTS

The parties proceeded to hearing on October 15, 2018. The parties disputed whether Rich Township School District #227 (hereinafter "Respondent") is liable for unpaid medical bills, the nature and extent of the injuries Mr. Samuel White (hereinafter "Petitioner") incurred from his accident on April 15, 2014 while employed for Respondent, and whether §8(d)(1) benefits should be awarded. (Arb.X1)

The parties stipulated that the Respondent was operating under the Act on April 15, 2014. (Arb.X1) The parties stipulated that the date of the accident was April 15, 2014, Petitioner and Respondent had a relationship of employer and employee, notice of the accident was given within the time limits stated in the Act, there was a causal connection between Petitioner's current condition of ill-being and his injury, and the average weekly wage pursuant to Section 10 of the Act was $2004.99. (Arb.X1) Petitioner was 48 years of age on the date of the accident, married and had 0 dependent children. The parties stipulated that Respondent paid $285,471.61 in TTD, $20,500.60 in TPD and $88,667.57 in other benefits for which credit is allowed under §8(j) of the Act. (Arb.X1)

Petitioner testified that he was employed as a Sergeant for the City of Harvey in September of 1995, while also working for Respondent as a police liaison officer since 1998. His job duties for Respondent included assisting the Office of the Dean, escorting students from the Dean of Counselors Office, breaking up fights, providing security at functions for the school, scheduling other officers to work and completing payroll. Petitioner testified that he worked 25 to 30 hours per week at $30.00 per hour. Petitioner testified that on April 15, 2014, there was a fight in the gym amongst some special education students. Petitioner broke up the fight and escorted the students back to the Deans Office. One of the students was escorted off campus, but she returned, and Petitioner had to take her into custody. While taking the student into custody, Petitioner and the student fell to the ground. Petitioner injured his right arm during the fall. Petitioner testified that he could not lift his right arm in result.

The parties stipulate, and the Petitioner testified, that he provided notice to the Respondent and was seen on April 15, 2014 for medical attention at Ingles Memorial Hospital (hereinafter "Ingles"). (Arb.X1, P.X1) The medical records indicate that Petitioner presented with complaints of pain to his right shoulder and elbow after falling to the ground resulting in the inability to lift his arm. (P.X1) Ingles diagnosed Petitioner with a shoulder and elbow contusion with an elbow laceration. (P.X1) Ingles noted that there was no evidence of a fracture or dislocation. (P.X1)

On April 28, 2014, Petitioner returned to Ingalls and had an MRI performed on his right shoulder. The MRI revealed a focal full thickness tear in the distal supraspinatus tendon without evidence of tendon retraction (P.X2, p.84). Ingalls referred the Petitioner to see Dr. Daniel Weber (hereinafter "Dr. Weber") at Integrity Orthopedics. On May 7, 2014, Petitioner saw Dr. Weber and indicated his pain was in the posterior lateral neck, trapezius area on the right, and right lateral neck; anterior aspect of the right shoulder, lateral aspect of the right shoulder in superior aspect of the right shoulder; as well as lateral aspect of the right upper arm. (P.X2) Petitioner further indicated he had neck pain, joint pain and stiffness in joint. The doctor's assessment was that Petitioner had a right rotator cuff tear, and recommended Petitioner proceed with right shoulder arthroscopy given his findings on the MRI. (P.X2) Dr. Weber also restricted Petitioner to light-duty work.

On May 22, 2014, Dr. Weber performed right shoulder arthroscopy for a rotator cuff repair and a subacromial decompression on Petitioner (P.X2, p. 87). The postoperative diagnosis was right shoulder rotator cuff tear. It was noted the tear was essentially 90% thickness on the bursal side of the cuff. (P.X2) On May 30, 2014, Petitioner returned to Dr. Weber who recommended physical therapy, Norco and Percocet. Dr. Weber also authorized Petitioner off work (P.X2, p.7). On July 2, 2014, Petitioner returned to Dr. Weber with less pain complaints but issues with stiffness in his shoulder. Dr. Weber advised Petitioner to continue physical therapy and maintain his work restrictions. (P.X2)

On August 6, 2014, Petitioner returned to Dr. Weber noting an increase in pain in his shoulder. Dr. Weber recommended Petitioner continue physical therapy and modified work restrictions. (P.X2) On September 17, 2014, Petitioner returned to Dr. Weber and reported that although his shoulder was better he still was experiencing some soreness. Dr. Weber recommended he continue PT and his restricted his work duties. (P.X2) On November 19, 2014, Petitioner returned to Dr. Weber and complained of pain in his shoulder still. Dr. Weber administered a cortisone injection and recommended he continue PT. (P.X2)

On December 9, 2014, Petitioner was seen by Dr. Khalid Baig (hereinafter "Dr. Baig"), his family physician. Petitioner complained of neck pain. Dr. Baig recommended a cervical X-Ray and prescribed Voltaren for is neck pain. (P.X3) The X-ray revealed straightening of the cervical spine consistent with muscle spasm, rudimentary left cervical rib at C7, calcifications in the projection of the left carotid artery suggesting arteriosclerotic plaque. The x-ray was otherwise negative. (P.X 3)

On December 19, 2014, Petitioner returned to see Dr. Weber complaining of returning pain and tingling. Dr. Weber opined that his rotator cuff tear was stable. Petitioner was prescribed Neurontin and Skelaxin to take for pain. (P.X2) Dr. Weber recommended that Petitioner continue with his home exercise program and restricted work duties. (P.X2) On December 23, 2014, Petitioner had an ultrasound taken of his neck that revealed no hemodynamically significant stenosis in the internal carotid arteries. (P.X3)

On January 7, 2015, Petitioner returned for a follow-up with Dr. Baig. Petitioner complained of pain in the left side of his neck with tingling in his left shoulder. The doctor reviewed his x-ray of the cervical spine, which shows rudimentary C7 rib and he had surgery on his right shoulder. He did not report a history of accident for the neck pain. Physical therapy for his neck was ordered. (P.X3) In addition, Petitioner was given a note to stay off of work until orthopedics released him to go back to work. (P.X3)

On February 9, 2015, Petitioner underwent an MRI arthrogram at Ingalls. The MRI arthrogram revealed a partial thickness articular surface tear in the distal supraspinatus tendon, post-operative changes in the right shoulder, a SLAP tear and rupture of the long head of the biceps tendon (P.X2, p. 86). On February 10, 2015, Petitioner was seen Dr. Baig. Petitioner complained of some neck discomfort which resulted in Dr. Baig ordering a cervical MRI. (P.X3)

On February 12, 2015, Petitioner had the MRI at AMG-Sykes. The MRI revealed mild paracentral disc protrusion at C3-C4 with left foraminal narrowing. (P.X3) On February 13, 2015, Petitioner was seen by Dr. Weber to review his upper extremity MRI. Dr. Weber opined that the MRI demonstrated the repair was intact. Dr. Weber recommended that Petitioner undergo physical therapy to help regain his strength. (P.X2)

On February 13, 2015, Petitioner was examined by Dr. William Vitello (hereinafter "Dr. Vitello") at Chicago Orthopaedics, at the request of the Respondent. Dr. Vitello opined that Petitioner's right shoulder injury and the need for surgery were related to the work incident. Dr. Vitello also opined that clinically,

Petitioner has signs of possible failure of the rotator cuff repair or re-rupture as well as continued right shoulder impingement. Dr. Vitello agreed with Dr. Weber's recommendation for the need of a MRI arthrogram (R.X4).

On February 28, 2015, Petitioner underwent a second cervical MRI which revealed degenerative disc disease at the C5-6 level causing mild to moderate spinal canal stenosis. The court had normal signal and caliber. (P.X 4)

On March 12, 2015, Respondent obtained an addendum report from Dr. Vitello who confirmed that Petitioner's condition was work related and that his persistent post-traumatic changes in the distal supraspinatus tendon were consistent with a partial thickness tear from the original injury and surgery. He opined that Petitioner was not at MMI and concurred with additional physical therapy and a steroid injection (R.X5).

On March 19, 2015, Petitioner returned for a follow-up with Dr. Baig. Petitioner was complaining of neck pain which had gotten better previously but was getting worse and radiating to the left shoulder. Petitioner also complained of painful neck movements on the left side. Dr. Baig referred Petitioner to an orthopedic physician (P.X3).

On March 25, 2015, Petitioner was seen by Dr. Anil Kesani (hereinafter "Dr. Kesani") of Southland Orthopedics. Dr. Kesani reviewed the cervical MRI and diagnosed Petitioner with brachial neuritis or radiculitis and cervical spondylosis. Dr. Kesani recommended physical therapy, Naproxen and Gabapentin (P.X4).

On March 27, 2015, Petitioner returned for a follow-up with Dr. Weber. Dr. Weber gave Petitioner a right shoulder steroid injection that day prior to proceeding with therapy. (P.X2) On May 6, 2015, Dr. Weber re-examined Petitioner and recommended an arthroscopy with rotator cuff repair due to Petitioner's continued complaints of pain that limited his function. (PX2) On May 20, 2015, Petitioner returned for a follow-up with Dr. Kesani. Petitioner complained of neck pains. Petitioner was referred to a pain management specialist, Dr. Jalaja Piska (hereinafter "Dr. Piska") at Advance Pain Specialists, to see if Petitioner was a candidate for spinal injections. He was instructed to continue with his daily home exercises and taking Naproxen. He was to return on an as-needed basis. (P.X4)

On May 28, 2015, Petitioner was seen by Dr. Piska. Petitioner was diagnosed with acute muscle stiffness of neck, brachial neuritis, cervicalgia, displacement of cervical intervertebral disc without myelopathy, cervical disc degeneration, pain in shoulder joint and sprain of rotator cuff capsule. The doctor reviewed the MRI and explained that Petitioner's current condition was irritation/inflammation of facet joints, secondary to cervical facet joint syndrome. The doctor recommended cervical facet joint injection. (P.X5) On June 3, 2015, Petitioner was re-examined by Dr. Vitello who concurred with the need for the right shoulder arthroscopy recommended by Dr. Weber (RX6). On June 11, 2015, Petitioner returned to Dr. Piska and was given a Medrol Dosepak. Dr. Piska recommended a cervical epidural injection after Petitioner's shoulder surgery (P.X5).

On June 25, 2015, Dr. Weber performed a right shoulder arthroscopy with debridement and release and removal of adhesions from the subacromial space on Petitioner (P.X2). On August 14, 2015, Petitioner returned to Dr. Weber stating that his shoulder was starting to become painful again. Petitioner was noted to still have restriction of motion for which Dr. Weber recommended continuing physical therapy. He continued Petitioner on restricted work duties (P.X2). On September 11, 2015, Petitioner returned to Dr. Weber, who administered another cortisone injection and kept Petitioner on restricted work duties (P.X2).

On October 15, 2015, Petitioner returned to Dr. Piska still complaining of neck pain. Dr. Piska recommended small fiber testing for his cervical plexus study (PX5). On October 16, 2015, Petitioner had the

small fiber testing performed. On October 29, 2015, Dr. Piska reviewed the small fiber testing with Petitioner and recommended a cervical MRI (P.X5).

On November 25, 2015, Petitioner returned to Dr. Weber complaining about his shoulder being sore over the past several days. Dr. Weber discussed the possibility of a distal clavicle excision (P.X2). On December 4, 2015, Petitioner was examined again by Dr. Vitello. Dr. Vitello opined that it did not appear that a resection of the distal clavicle was performed during the second operation and that this could be the cause of Petitioner's current pain and delayed recovery. Dr. Vitello concurred that a right shoulder arthroscopy with AC joint resection was an appropriate procedure (RX7).

On December 23, 2015, Petitioner returned to Dr. Weber with the same complaints. Dr. Weber administered the epidural steroid injection and continued Petitioner on his work restrictions (P.X2). On January 15, 2016, Petitioner returned to Dr. Weber advising the shot helped for about 10 days following which he became symptomatic again. Dr. Weber recommended a right distal clavicle excision (P.X2).

On February 4, 2016, Petitioner underwent a right shoulder distal clavicle excision (P.X2 p.93). Following the surgery, Petitioner returned to Dr. Weber for several visits. The postoperative diagnosis was internal derangement and arthrosis of the right shoulder acromioclavicular joint. (P.X2)

Petitioner's last visit with Dr. Weber was on June 3, 2016, at which time Petitioner noted that he was still having complaints of pain in his right shoulder. Dr. Weber released Petitioner to modified work only. He stated that clerical work would be appropriate which would involve no lifting of the right upper extremity. Dr. Weber did not recommend any additional treatment to Petitioner's right shoulder, but recommended Petitioner continue with his pain management physician for his cervical spine (P.X2).

On June 27, 2016, Petitioner returned to Dr. Piska complaining of chronic pain in his neck and shoulder. Dr. Piska diagnosed Petitioner with brachial neuritis or radiculitis, cervicalgia, degeneration of cervical intervertebral disc, displacement of cervical intervertebral disc, muscle spasm and occipital neuralgia. Dr. Piska recommended small sensory fiber testing followed by either a cervical epidural or facet joint median branch blocks (P.X5).

On September 16, 2016, Petitioner returned to Dr. Piska for a small fiber testing (PX.5, p. 21). On September 29, 2016, Petitioner returned to Dr. Piska still complaining of neck pain and pain in his left shoulder worse than on his right. Dr. Piska recommended a cervical MRI and EMG/NCV (P.X5, p. 22-25). The medical records reflect that Petitioner was seen again by Dr. Piska on October 16, 2016 for additional small fiber testing. (P.X 5, p. 22). On November 4, 2016, an MRI of Petitioner's cervical spine was obtained, which revealed straightening of the usual cervical lordotic curvature, and minimal disc degenerative disease at C4-5. (P.X 5)

On November 21, 2016, Petitioner returned to Dr. Piska who recommended physical therapy and then a possible epidural steroid injection. Dr. Piska also opined that the small fiber testing was positive for a C8 radiculopathy (P.X5). On January 16, 2017, Petitioner returned to Dr. Piska who recommended cervical facet joint/facet joint medial branch blocks (P.X5).

On March 2, 2017, another MRI of the cervical spine was obtained which revealed: 1) C3-4 left posterior lobe lateral disc osteophyte complex causing left and moderate narrowing of left foreman. No dramatic change since previous study; 2) complete opacification left maxillary sinus. (P.X5)

On March 17, 2017, an NCV/EMG was obtained which revealed an abnormal study. There was electrodiagnostic evidence consistent with, but not diagnostic for, a C5-6 radiculopathy on the left. There were prolonged latencies that could be attributed to Kuehl extremities. The correlation with the MRI of the cervical spine was advised. (P.X5)

On June 23, 2017, Petitioner was re-examined by Dr. Payne who reviewed the MRI and EMG. Dr. Payne concurred with the cervical epidural steroid injections and stated that after two or three such epidurals, if there was no positive response an FCE would be appropriate. He opined that Petitioner was not a surgical candidate and could do restricted work. Dr. Payne related all of Petitioner's complaints to the work injury. (R.X9)

On August 21, 2017, Petitioner treated with Dr. Piska. He reported he had 100% relief after the injection, but currently had only 50% pain relief. Petitioner also now complained of pain in the right elbow. Petitioner was referred to Dr. Sweeney for a surgical consultation on the neck. He was to continue his home exercise program and was given work restrictions of no lifting more than 20 pounds. (P.X 5)

On September 7, 2017, Petitioner was examined by Dr. Patrick Sweeney (hereinafter "Dr. Sweeney") at Minimally Invasive Spine Specialists. Petitioner reported that he had right upper extremity pain after 20-30 minutes of use. He rated his pain 8/10 in severity. Petitioner reported that he had not been taking any pain medications since his first injection as they caused GI issues and provided little benefit. The doctor reviewed the MRI studies and diagnosed Petitioner with cervical radiculitis, and facet syndrome at C3-6. Dr. Sweeney felt Petitioner did not have a surgical problem and recommended he follow up with Dr. Piska and consider facet blocks. (P.X 7)

On February 13, 2018, Petitioner underwent an FCE at ATI Physical Therapy at the request of Dr. Piska. It was noted that Petitioner's occupational physical demand level of a police officer was medium, and he demonstrated the physical demand level of heavy. Petitioner's capabilities met the level stated by DOT. The FCE was determined to be valid (P.X 5, pp. 74-79).

On March 1, 2018, Petitioner followed up with Dr. Piska. Petitioner rated his neck pain 3/10 and his shoulder pain 2/10. Petitioner reported tingling in both hands and forearm on the right side. It was noted he had an EMG of bilateral upper extremities in the past, which was positive for cervical radiculopathy at left C5-6 but did not mention any carpal tunnel syndrome. According to the FCE, Petitioner was capable and met the level by DOT, and he had mild moderate range of motion limitations. The doctor recommended Petitioner return to Dr. Sweeney for further evaluation before Dr. Piska considered Petitioner at MMI. (P.X 5)

On March 22, 2018, Petitioner returned to see Dr. Sweeney. Petitioner had undergone a series of 3 injections with Dr. Piska that provided 50-60% relief for a period of 2-3 days. He complained of left sided neck pain with radiation into the left shoulder with associated numbness and tingling, as well as increase complaints of numbness and tingling to both hands and most recently the right wrist inform regions. He rated his pain 5/10. He was not taking any pain medication. The doctor opined based on physical examination, cervical MRI and EMG, Petitioner was not a surgical candidate despite having significant ongoing pain without diagnosis. The doctor opined he did not feel Petitioner could return to police duty work with his current level of pain. Dr. Sweeney opined Petitioner had facet syndrome, advised he was at MMI but may need facet injections and RFL in the future. Dr. Sweeney would defer and hand over care to Dr. Piska. (P.X 7)

On April 9, 2018, Petitioner returned to Dr. Piska still complaining of tingling which had gotten worse in both of his hands and forearm. He stated the right side of his arm was now going numb. The cervical exam

revealed increased pain when going to the left side and with neck flexion. There was pain with lateral flexion to the left. Dr. Piska informed Petitioner his condition was an irritation/inflammation of the joint secondary to cervical facet joints. Dr. Piska recommended a cervical facet joint medial branch block (P.X6, p. 6).

On April 27, 2018, Petitioner was seen by Dr. Timothy Payne for an IME examination. Dr. Payne diagnosed Petitioner with a cervical strain and cervical spondylosis. He noted no inconsistencies in Petitioner's history. Dr. Payne also diagnosed injuries to Petitioner's right rotator cuff which had become chronic. He stated that Petitioner's current cause of symptomatology was ongoing pain, aggravated atrophy and nerve pain documented on an EMG. His opinion had not changed since his last report and he advised that Petitioner's condition has become chronic as it had been four years since his work accident. Dr. Payne advised Petitioner had reached MMI and further treatment would not improve his function. He said Petitioner may require some medication to help manage his pain, and that the cervical facet joint/facet medial branch blocks were "worth a try to see if we can control his pain...". Dr. Payne further opined that if Petitioner did not elect to undergo this treatment, he was at MMI and not in need of any further treatment. Dr. Payne opined that Petitioner was not able to perform full-duty activities per his restrictions. In addition, Dr. Payne opined that Petitioner could perform sedentary activities, including avoiding overhead lifting, no lifting above 5 pounds, and sit, stand, walk as tolerated. (R.X11)

Petitioner testified that he spoke with Mrs. Julie Grohn (hereinafter "Mrs. Grohn"), the Director of Human Resources from Rich Township High School District on May 10, 2018. Petitioner's attorney stipulated that he spoke with Julie Grohn on May 11, 2018. A job offer was made for a position with Respondent as a Police Liaison, working 20 hours per week, and paying Petitioner $25.00 per hour. This job accommodated Petitioner's work restrictions given by Dr. Payne. Specifically, the position entailed Petitioner sitting at a security desk and monitoring the cameras positioned around the school. Petitioner further testified that he rejected this job offer and refused to return to Respondent. (R.X13)

On August 24, 2018, Petitioner received another job offer through a letter from Respondent. This letter offered Petitioner a position as a Police Liaison, working 25 hours a week, and earning $25.00 per hour. (R.X2) The letter requested that Petitioner return to work or provide Respondent with documentation showing what prevented him from returning to work before August 27, 2018. (R.X2) Petitioner testified that he received this letter and still did not return to work for Respondent.

Petitioner further testified that he elected not to return to work regarding either job offer, nor has he looked for any jobs. He testified that he has not spoken with anyone from the City of Harvey to return to work.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment:

The Petitioner, Mr. Samuel White, was the only witness to testify at trial. The Arbitrator finds the overall testimony of Petitioner to be truthful, credible and otherwise unrebutted regarding his past medical history, mechanism of injury, course of medical treatment and current subjective complaints.

With respect to issue (J), whether the Respondent paid for all appropriate charges for all reasonable and necessary medical services, 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 the medical services provided to the Petitioner were reasonable and necessary to cure his condition of ill-being causally connected to his accident on April 15, 2014. Having determined that the petitioner's condition of ill being is relative to his work injury, the Arbitrator awards all medical bills submitted for that condition in accordance with Section 8(a) and Section 8.2 of the Illinois Workers' Compensation Act. The Respondent is liable for payment of any such medical expenses pursuant to the medical fee schedule and/or contract that the Respondent may have had with the specific providers of care.

The parties stipulated that the Respondent was operating under the Act on April 15, 2014, that the date of the accident was April 15, 2014, Petitioner and Respondent had a relationship of employer and employee, notice of the accident was given within the time limits stated in the Act, and that there was a causal connection between Petitioner's current condition of ill-being and his injury. The parties stipulated that all medical bills were paid by Respondent except for one outstanding bill owed to Dr. Piska for a visit and services that occurred on October 16, 2016. (P.X9, P.X5, Arb.X1) On October 16, 2016, Petitioner was seen by Dr. Piska for small fiber testing. (P.X5 p.26) The medical records indicate that Petitioner tolerated the procedure well and had no complaints. A follow-up was scheduled to discuss the results of the testing. (P.X5) The fees incurred for this visit was $1290.00. (P.X9, Arb.X1) The Arbitrator finds that this charge is causally related to the injuries which are the subject of this claim and orders the Respondent to pay the submitted outstanding bill directly to the providers pursuant to Sections 8(a) and 8.2 of the Act and fee schedule.

With respect to issue (L), what is the Nature and Extent of the injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. Petitioner is seeking a wage differential under Section 8(d)(1) of the Act. In accordance to Section 8(d)(1) of the Act, a Petitioner is entitled to a wage differential "if after the accidental injury has been sustained, the employee as a result thereof becomes 1) partial incapacitated from pursuing his usual and customary line of employment and 2) an impairment of earnings." 820 ILCS 305/8(d)(1).

On February 13, 2018, Petitioner underwent an FCE at ATI Physical Therapy at the request of Dr. Piska. It was noted that Petitioner's occupational physical demand level of a security/ police officer was medium, and he demonstrated the physical demand level of heavy. Petitioner's capabilities met the level stated by DOT. It was noted that the FCE was valid. (P.X 5, p. 74-79).

On April 27, 2018, Petitioner was seen by Dr. Timothy Payne for an IME examination. Dr. Payne diagnosed Petitioner with a cervical strain and cervical spondylosis. He noted no inconsistencies in Petitioner's history. Dr. Payne advised that Petitioner had reached MMI and further treatment would not improve his function. Dr. Payne opined that Petitioner was not able to perform full-duty activities per his restrictions. In addition, Dr. Payne opined that Petitioner could perform sedentary activities, including avoiding overhead lifting, no lifting above 5 pounds, and sit, stand, walk as tolerated. (R.X11)

Petitioner testified that he spoke with Mrs. Grohn, the Director of Human Resources from Rich Township High School District on May 10, 2018. Petitioner's attorney also stipulated that he spoke with Julie Grohn on May 11, 2018. Mrs. Grohn made a job offer to Petitioner for a position with Respondent as a Police Liaison, working 20 hours per week, and paying Petitioner $25.00 per hour. The job entailed Petitioner sitting at

a security desk and monitoring the cameras positioned around the school. During cross examination, Petitioner testified that he was made aware that the job accommodated his work restrictions given by Dr. Payne. Petitioner further testified that he rejected this job offer and refused to return to Respondent. (R.X 13) The Arbitrator notes that Petitioner provided no additional testimony as to why he rejected this position within his job restrictions.

On August 24, 2018, Petitioner received another job offer from Respondent in a letter. This letter offered Petitioner a position as a Police Liaison, working 25 hours a week, and earning $25.00 per hour. (R.X2) The letter requested Petitioner return to work or provide Respondent with documentation showing what prevented him from returning to work before August 27, 2018. (R.X2) Petitioner testified that he received this letter and still did not return to work for Respondent.

The Arbitrator finds that Petitioner refused to return to work based on a job offer made by Respondent, where he would be earning the same $25.00 per hour wage after the accident that he was earning prior to the accident. (R.X12) The Arbitrator notes that the position was within the Petitioner's job restrictions and the Petitioner testified to being aware of this. Petitioner testified that he did not attempt to look for any jobs, apply for any jobs or contact The City of Harvey to return to work once he reached maximum medical improvement. According to Petitioner's testimony he never participated in vocational rehabilitation, attempted to obtain his own vocational expert or job placement services, nor did Petitioner demonstrate any other efforts to assist in obtaining gainful employment within his restrictions. The Arbitrator finds that no effort was made by Petitioner to determine whether he could be employed in any capacity once his treating physician put him at maximum medical improvement. Respondent offered a job within Petitioner's restrictions, which Petitioner testified he refused. The Arbitrator finds that Petitioner failed to meet his burden of proof regarding his entitlement to wage differential benefits.

The Arbtirator finds that the Petitioner is entitled to permanent partial disability benefits under Section 8(d)(2) on a person as a whole basis. On March 22, 2018, Petitioner saw Dr. Sweeney who opined he had reached MMI. (P.X7) Additionally, on April 27, 2018, Petitioner was seen by Dr. Timothy Payne, who noted that Petitioner had reached MMI. (R.X11) Therefore, the claim for any permanent partial disability is ripe for adjudication.

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the Section §8.1b of the Illinois Workers' Compensation Act. Here, the accident occurred on April 15, 2014, making section §8.1b applicable.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party offered into evidence a permanent partial disability impairment report and/or opinion as defined by this Section of the Act. Therefore, the Arbitrator gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the record reflects that the Petitioner was employed as a Sergeant for the City of Harvey while also working for Respondent as a police liaison officer at the time of the accident. Petitioner testified that his job duties for Respondent included assisting the office of the Dean, escorting students from the Dean of Counselors office, breaking up fights, providing security at functions for the school, scheduling other officers to work and completing payroll. Petitioner did not return to work for the Respondent following his injury on April 15, 2014. On March 22, 2018, Petitioner saw Dr. Sweeney who opined that he did not feel Petitioner could return to police duty work with his current level of pain. Dr. Sweeney opined further that Petitioner had facet syndrome and advised that he was at MMI. (P.X7) On April 27, 2018, Petitioner was seen by Dr. Payne for an IME examination. Dr. Payne opined that Petitioner could perform sedentary activities, including avoiding overhead lifting, no lifting above 5

pounds, and sit, stand, walk as tolerated. (R.X 11) Petitioner testified that on May 10, 2018, the Director of Human Resources for Respondent, presented him with a job offer. The job was for a Police Liaison position, involving viewing security cameras, was for 5 days a week, 4 hours per day at $25.00 an hour, and accommodated Petitioner's work restrictions given by Dr. Payne. Petitioner further testified that he rejected this job offer and refused to return to Respondent. (RX 13) The Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. (Arb.x1) The Petitioner's permanent partial disability with regard to his injuries resulting from the April 15, 2014 accident will be something he has to live with for an extended period of time much longer than that of an older individual. Petitioner testified that as he sat there at trial on October 15, 2018, he was still experiencing pain and had a constant crook in his neck on the left side, if he is upright or driving too long he has increasing pain and his shoulder goes numb. Additionally, Petitioner testified that he is right handed and lacks full strength in his right arm, his right-hand tingles and his right upper bicep is smaller than his left. Therefore, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earning capacity, the Arbitrator notes that Petitioner testified that he is not working at the current time. Petitioner testified that on May 10, 2018, Mrs. Grohn the HR representative from Respondent, offered him a position within his work restrictions and for the same pay he made prior to the injury. Petitioner further testified that he rejected this job offer and refused to return to Respondent. (R.X13) Additionally, Petitioner testified that on August 24, 2018 Respondent contacted him again with a job offer for a sedentary position. Petitioner testified that he responded to the offer and requested an appointment but never received an appointment. Furthermore, Petitioner testified that he elected not to return to work regarding either job offer, nor has he looked for any jobs. He testified that he has not spoken with anyone from the City of Harvey to return to work. Petitioner testified that he is not currently working and has not looked for any employment. Therefore, the Arbitrator gives 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 had an undisputed injury on April 15, 2014 for which the parties stipulate, and the Petitioner testified, that he provided notice to Respondent and was seen on April 15, 2014 for medical attention at Ingles Memorial Hospital (hereinafter "Ingles"). (Arb.X1, P.X1) On April 28, 2014, Petitioner returned to Ingalls and had an MRI performed on his right shoulder. The MRI revealed a focal full thickness tear in the distal supraspinatus tendon without evidence of tendon retraction (P.X2, p84). On May 22, 2014, Dr. Weber performed right shoulder arthroscopy for a rotator cuff repair and a subacromial decompression on Petitioner (P.X2, p87). The postoperative diagnosis was right shoulder rotator cuff tear. On June 25, 2015, Dr. Weber performed a right shoulder arthroscopy with debridement and release and removal of adhesions from the subacromial space on Petitioner (P.X2). Additionally, on February 4, 2016, Petitioner underwent a right shoulder distal clavicle excision (P.X2, p. 93). Petitioner's last visit with Dr. Weber was on June 3, 2016 at which time Petitioner noted that he was still having complaints of pain in his right shoulder. Dr. Weber released Petitioner to modified work only. He stated that clerical work would be appropriate which would involve no lifting of the right upper extremity. Dr. Weber did not recommend any additional treatment to Petitioner's right shoulder, but recommended Petitioner continue with his pain management physician for his cervical spine (P.X2). On September 7, 2017, Petitioner was examined by Dr. Sweeney, and after review of the MRI studies, diagnosed Petitioner with cervical radiculitis, and facet syndrome at C3-6.

On March 22, 2018, Petitioner returned to see Dr. Sweeney. The doctor opined based on physical examination, cervical MRI and EMG, Petitioner was not a surgical candidate despite having significant ongoing pain without diagnosis. The doctor opined he did not feel Petitioner could return to police duty work with his current level of pain. Dr. Sweeney opined Petitioner had facet syndrome, advised he was at MMI but may need

facet injections and RFL in the future. Dr. Sweeney would defer and hand over care to Dr. Piska. (P.X 7) On April 9, 2018, Petitioner returned to Dr. Piska still complaining of tingling which had gotten worse in both of his hands and forearm. Dr. Piska recommended a cervical facet joint medial branch block (P.X6, p. 6). On April 27, 2018, Petitioner was seen by Dr. Timothy Payne for an IME examination. Dr. Payne diagnosed Petitioner with a cervical strain and cervical spondylosis. He noted no inconsistencies in Petitioner's history. Dr. Payne also diagnosed injuries to Petitioner's right rotator cuff which had become chronic. He stated that Petitioner's current cause of symptomatology was ongoing pain, aggravated atrophy and nerve pain documented on an EMG. His opinion had not changed since his last report and he advised that Petitioner's condition has become chronic as it had been four years since his work accident. Dr. Payne advised Petitioner had reached MMI and further treatment would not improve his function. Dr. Payne further opined that if Petitioner did not elect to undergo this treatment, he was at MMI and not in need of any further treatment.

At trial, Petitioner testified that he has a constant crook in his neck and that the level of pain is around three although it does go up to a seven or eight. He testified this is in the left side of his neck and that he sometimes gets numbness in his left shoulder. With respect to his right shoulder, Petitioner testified he is at less than 100% strength, his arm "pops", and that he has numbness and tingling in his right hand. He also testified that his right arm is smaller than the left arm. It is further noted that Petitioner is not taking any pain medications and he does not have any future medical appointments scheduled. The Arbitrator concludes that the evidence demonstrates that the Petitioner sustained permanent partial disability regarding his complaints of pain and places significant weight on the aforementioned factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 50% of a man as a whole pursuant to §8(d)2 of the Act.

Signature of Arbitrator

01/07/19

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John J. Galvin,

Petitioner,

vs. No. 17 WC 16850

F.H. Paschen,

Respondent.

19IWCC0597

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision with respect to the issues of admissibility of surveillance videos, wage calculations, medical expenses and credit for the medical bills paid.

Regarding surveillance videos, the Commission finds all surveillance footage admissible. Petitioner did not dispute he is the individual in the surveillance videos. Foundation was laid for each of the videos, and there was no dispute as to the dates and locations of the surveillance. Accordingly, the surveillance videos are admissible. See *People ex rel. Sherman v. Cryns*, 327 Ill. App. 3d 753, 760-61 (2002). Any concerns over missing or "cherry-picked" footage go to

19IWCC0597

the weight, rather than admissibility. See *People v. Taylor*, 2011 IL 110067. In deciding the parties' cross-petitions for review, the Commission has considered all surveillance footage and the opinions of Dr. Hutchinson that rely on the footage.

Regarding wage calculations, the Commission includes required ("critical") overtime, yielding an average weekly wage of $1,606.46.

Lastly, as there is a dispute as to outstanding medical bills balances and credit, the Commission awards the medical bills in evidence pursuant to sections 8(a) and 8.2 of the Act, subject to credit for the amounts paid.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 21, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,070.97 per week for a period of 25 3/7 weeks, from June 28, 2017 through November 19, 2017, and from March 7, 2018 through April 8, 2018, those being the periods of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills in evidence pursuant to §§8(a) and 8.2 of the Act. Respondent shall be given §8(j) credit for the amounts paid by its group health insurance, provided that Respondent holds Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving this credit. Respondent shall also be given credit for the medical payments made by its workers' compensation carrier.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for further treatment recommended by Dr. Nicholson, pursuant to §§8(a) and 8.2 of the Act.

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

19IWCC0597

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 - 5 2019
o-09/11/2019
SM/sk
44

Stephen Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with all aspects of the Majority's decision other than the award of temporary total disability benefits. I find Petitioner is not entitled to temporary total disability benefits. Therefore, I respectfully dissent.

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). I believe the evidence shows Petitioner was able to work. The video footage clearly evidences Petitioner was capable of working and was, in fact, working. Moreover, Petitioner testified he returned to work for Respondent at his full-duty capacity for a period of time. Petitioner testified he subsequently worked for several other employers and was working as of the date of hearing. I would vacate the award of temporary total disability benefits as Petitioner failed to prove his entitlement to the same.

L. Elizabeth Coppoletti

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

GALVIN, JOHN
Employee/Petitioner

Case# **17WC016850**

F H PASCHEN
Employer/Respondent

19IWCC0597

On 8/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0146 CRONIN PETERS & COOK
PATRICIA CRONIN COOK
221 N LASALLE ST SUITE 1454
CHICAGO, IL 60601

1120 BRADY CONNOLLY & MASUDA PC
NICOLE WIZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK 19IWCC0597

☐ 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 GALVIN,
Employee/Petitioner

v.

F.H. PASCHEN,
Employer/Respondent

Case # **17** WC **16850**

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **3/14/18, 5/10/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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, SECTION 8(A) MEDICAL TREATMENT**

19IWCC0597

FINDINGS

On the date of accident, **5/15/17**, 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 **$78,712.00**; the average weekly wage was **$1,513.69**.

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

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services. Respondent shall be given a credit 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 **$3,483.45** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits from **June 28, 2017** through **November 19, 2017**, and from **March 7, 2018** through **April 8, 2018**, for a total of **25-3/7** weeks.

Respondent shall pay reasonable and necessary medical services of totaling the gross amount of **$12,241.67**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of **$3,483.45** 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 approve the recommended shoulder and cervical treatment as outlined by Dr. Nicolson, including any and all incidental care thereto. In so finding, the Arbitrator finds that Petitioner's claim for vocational rehabilitation at this time is premature as he has not yet reached maximum medical improvement and thereby finds this issue ***moot***.

Petitioner's request 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

8-20-2018
Date

AUG 21 2018

FINDINGS OF FACT

John Glavin ("Petitioner") alleged injuries arising out of and in the course of his employment with FH Paschen ("Respondent") on 5/15/17. Ax1-2. By agreement of the parties, this matter proceeded to arbitration on 3/15/18 and again on 5/10/18. In dispute were the issues of causal connection, liability for unpaid medical bills, temporary total disability, vocational rehabilitation and prospective medical care. The following is a recitation of the facts adduced at trial.

On the date of the accident, Petitioner said he worked at the Washington/Wabash project taking gondolas up to the mezzanine level and taking garbage out. Prior to this date, he had no medical treatment for the neck, ribs, right shoulder or upper back. Petitioner testified that while working, he stepped on small skinny conduits and his feet flew out and he fell on his back. He grabbed onto a fence and fell onto concrete. Petitioner described the conduit as long skinny pipes, 1 inch in diameter. Petitioner said several carpenters were present at the time of the fall. Petitioner got himself up and said he noticed his right arm was hurting right away. Petitioner said he then reported the incident right away to Danny Cooper and Nick. The next day, he made an accident report. On cross, Petitioner clarified that he is claiming a slipping injury and that this occurred around 2:30pm. Prior to this date, he was able to perform work without difficulty and he had no medical condition that affected his ability to do his job.

Petitioner testified that no one advised him to seek treatment. That night, Petitioner iced his arm, took Tylenol or Advil and slept. The next day and night, Petitioner said he noticed his ribs hurt and he was having a hard time breathing, laughing, coughing and sneezing. He got up for work and his wife helped him put his shirt on. Petitioner then went to the ER.

Petitioner presented Ingalls Memorial Hospital on May 16, 2017. Petitioner reported slipping on a pipe, falling backwards and having injury to the right shoulder, left ribs, neck and upper back. Petitioner was given a diagnosis of a shoulder sprain, rib pain and inter-coastal pain. X-rays of the chest showed no acute findings. X-rays of the right shoulder showed fragmentation of the right AC joint which was described as indicative of chronic changes. Petitioner was discharged and was advised to follow up with his primary care physician. Although Petitioner attempted to see his own doctor, he was unable to get an appointment for at least a week.

On May 17, 2017, Petitioner went into work but in light of his injury, Petitioner was asked to undergo further evaluation. On May 18, 2017, Concentra released Petitioner to both "no medical restrictions" and "to work no lifting over 15lbs no overhead work." Petitioner subsequently returned to work at the employer within the light duty restrictions provided by Concentra on May 18th.

On May 24, 2017, Petitioner returned to Concentra for an examination. Petitioner reported injury to the right shoulder, right side of the neck, upper back, left ribs and now left elbow. Petitioner reported he slipped and fell onto his upper back when he stepped on a piece of pipe on May 15, 2017. Petitioner was unsure if he grabbed anything in the fall. Petitioner reported pain radiating to the right arm and right elbow along with a decrease of range of motion and numbness in the arm. He reported pain in the right shoulder at 8/10, pain in the neck at 5/10, pain in the left ribs at 6/10 and pain in the upper back at 5/10. The diagnosis provided was right shoulder strain and contusion of the left back wall of the thorax. A prescription was written for Tramadol and physical therapy. Petitioner was restricted from using his right arm at that time.

On 5/25, Petitioner followed up with Concentra. He began physical therapy and was to continue work restrictions. Petitioner testified they had him in charge of dumping garbage. He recalled it was very rainy, that he did a lot of grout mixing that involved 40-55-gallon buckets, mixing with a mixer and that it involved the use

of his right arm. Petitioner said that he also did clean up in the mezzanine area, was lifting gondolas and dumping garbage, which he said involved the use of his right arm. Petitioner also said during this time he had to unwire and rewire fences to let things in and out of the job site and that the panels were 8 x 12 in size. He said that this too involved him reaching above shoulder level.

Petitioner testified that in May 2017, he recalled doing yardwork, stating that he and his family filled and potted 50 plants. He said it was an annual event the family does for his wife's birthday. He recalled his daughters and their boyfriends helped. Petitioner said he performed cutting hedges, picking weeds, fertilization and pumping the pool.

Petitioner recalled using a battery-operated hedger. When he was shown Px5, Petitioner said it was like the hedger he used that day. He said that he used his right arm for the triggering and that right arm was "along for the ride," while his left arm did most of the work and led. Petitioner also did sweeping using a push broom, explaining that he was pulling it and dragging it. Petitioner also used a back-pack blower. Shown Px6, he said his daughters helped him put it on his back. He said one does not use your arms, you just turn your body and the triggers are right there. On cross, Petitioner admitted that it was him in the surveillance videos.

Petitioner said that during this time, as he continued to work, he noticed that his ribs were getting better, the neck was getting worse, that he was having headaches, he noticed electrical shooting pains between the shoulder blades, that he could not sleep in his bed and that his shoulder was getting worse. Petitioner said he kept working because he thought it was a sprain and that it was going to go away. At home, Petitioner used ice, heat and modified his activities. He recalled he had a lot of help from his daughters and wife.

After the holiday weekend, on Tuesday, May 30, 2017, Petitioner followed up with Concentra. At that time, Petitioner reported a pain level of 8/10 with pain in the right anterior shoulder and left lateral shoulder and right posterior shoulder. Petitioner was diagnosed with a contusion of the left back wall of the thorax and a right shoulder strain. Work restrictions were modified to lifting up to 15 lbs. occasionally, pushing and pulling 20 lbs. occasionally, no reaching above the shoulders and no reaching above the head. Petitioner was also restricted from using power/impact vibratory tools with the right upper extremity.

Petitioner continued to work at the employer with restricted light duty accommodations through June 6, 2017. During that time, Petitioner participated in physical therapy at Concentra.

On June 7, 2017, Petitioner returned to Concentra. He reported his pain in the shoulder at 8/10. He also described mild numbness in the right fourth and fifth fingers with radiating pain from the right elbow. The diagnosis remained strain of the right shoulder and contusion of the left back wall of the thorax. The physician at that time allowed Petitioner to return to full duty work and discharged him from physical therapy citing video surveillance.

Petitioner worked at a full duty until June 22, 2017. While Petitioner was fully employed through June 22, 2017, Petitioner only worked through June 15, 2017. From June 16, 2017 through June 22, 2017, Petitioner went on vacation to Mexico. The weekend of June 16, 2017 through June 18, 2017 constituted a CTA shut-down, or "critical overtime" weekend for the project.

Petitioner returned to work on June 22, 2017 and was laid off. According to Petitioner, the lay-off was because of reduction in the workforce.

On June 28, 2017, Petitioner went for a second opinion with Dr. Nicholson at Midwest Orthopedics at Rush. Px12. At that visit, Petitioner reported to Dr. Nicholson he slipped on pipes and fell backwards onto the upper part of his back. Petitioner displayed 90° of active elevation and 55° of active external rotation with the elbow at the side. Petitioner had significant tenderness to palpation of the AC joint. Petitioner displayed positive Hawkin's-Kennedy and Near impingement tests. He reported numbness in the ring and pinkie finger. X-rays were obtained of the right shoulder and cervical spine. Dr. Nicholson read the right shoulder x-ray to have no evidence of glenohumeral osteoarthritis, no acromiohumeral distance narrowing and no fracture, dislocation or boney abnormalities. Dr. Nicholson read the cervical x-ray to show foraminal stenosis at C4-5 and C5-6. Dr. Nicholson recommended a right shoulder MRI and cervical spine MRI. He diagnosed Petitioner with right shoulder pain and cervical stenosis. Petitioner was at that time taken off work completely at that time.

On July 13, 2017, Petitioner underwent an MRI of the right shoulder. The radiologist reported a suspected complete full thickness tear of the supraspinatus tendon with retraction on the background of severe tendinosis. The radiologist also reported severe tendinosis of the infraspinatus, subscapularis and biceps tendon. In addition, there was a reported under-surface strain on the infraspinatus tendon and early osteoarthritic changes of the AC joint with large osteophytes.

On July 13, 2017, Petitioner also underwent an MRI of the cervical spine. The radiologist impression indicated curvature and slight reversal of cervical lordosis with minimal degenerative anterolisthesis of C3 on C4 and T1 on T2 with minimal retrolisthesis of C5 on C6 and C6 on C7. There was evidence of multi-level degenerative changes prominent at C4-5 through C6-7 levels and moderate spinal canals narrowing at C5-6 and C6-7 with indentation of the spinal cord without signal abnormality. There was also evidence of moderate bilateral foraminal narrowing at C2-3, moderate to severe bilateral foraminal narrowing at C3-4, moderate right foraminal narrowing at C4-5, severe right and moderate left foraminal narrowing at C5-6 and severe bilateral foraminal narrowing at C6-7.

On July 14, 2017, Petitioner followed up with Dr. Nicholson for both the cervical and right shoulder. For the shoulder, Dr. Nicholson diagnosed a small to medium sized full thickness tear of the rotator cuff in the anterior aspect of the supraspinatus with acute inflammation in the subacromial bursa and a little in the anterior subdeltoid bursa with an encroaching acromial morphology. According to Dr. Nicholson, Petitioner had suffered an acute rotator cuff tear matching with Petitioner's mechanism of injury, the pain in his shoulder and the physical examination findings. Dr. Nicholson recommended right rotator cuff repair and subacromial decompression. No therapy was recommended for the shoulder.

For the cervical spine, Dr. Nicholson recommended Petitioner see a cervical spine specialist for further intervention. Dr. Nicholson opined Petitioner had exacerbated a cervical spine condition as a result of the fall and ordered physical therapy. Petitioner was kept off work at that time.

Petitioner began a course of physical therapy at Integrity Physical Therapy beginning July 19, 2017, initially for the cervical spine. Px13. At that first visit, Petitioner reported 7/10 pain in the neck and stiffness. Petitioner reported a very difficult time performing daily activities other than work since the accident. He reported problems with self-care, grooming and home tasks.

On July 20, 2017, at therapy, Petitioner's primary complaint was neck pain and headaches. Petitioner advised he was unable to turn his head and would have to turn his shoulders completely towards what he was attempting to see. Petitioner stated he was unable to perform yardwork and home projects as he was prior to the injury.

On his third therapy visit, on July 25, 2017, Petitioner stated he mostly remained at home resting. He stated avoiding overhead reaching and lifting anything greater than 15 lbs. He continued to require help to do physically exerting tasks such as yardwork, shopping, cooking, laundry and housecleaning. He stated it was painful to bend over the sink to wash his face and brush his teeth.

By July 27, 2017, Petitioner's primary complaints were neck pain and dwindling headaches. Px13. Petitioner took over the counter medications for pain and did home stretches and exercises. Petitioner reported driving less due to continued pain and difficulty turning and bending his neck and head. He reported increased pain when lifting the right arm to wash and comb his hair and dress himself.

By August 1, 2017, Petitioner reported the pain made him unable to cook, grill and mingle during a party at his house. Px13. More specifically, manipulation of yard tools and chair, grill utensils and food platters in backyard cooler was very painful. Petitioner reported pain with sleeping. He also has difficulty driving with difficulty turning his neck. Lifting of the right upper extremity to do home tasks was painful. On August 3, 2017, Petitioner had no headache complaints. Petitioner stated taking breaks in between activities and that walking the dog increased his pain. On August 8, 2017, Petitioner reiterated issues with lifting bags, cooking, driving, cleaning, prepping a grill, and walking his dogs.

Petitioner returned to Dr. Nicholson on August 23, 2017 for evaluation. Px14. Examination showed significant improvements in Petitioner's physical exam, specifically noting an improvement from 90 degrees on active side elevation up to 140 degrees. Dr. Nicholson noted Petitioner had greatly improved with time, activity modification and physical therapy.

In therapy on August 29, 2017, Petitioner told therapists he had an inability to lift his upper extremity above shoulder level and could not place his arm outside of a car window if in a passenger seat. Petitioner reported difficulty starting a lawnmower and having to use a lawn service.

On August 30, 2017, Petitioner underwent an Section 12 exam with Dr. Hutchinson. Rx3. Petitioner confirmed he fell backwards square on his back, landing neither on his left or right shoulder. Dr. Hutchinson examined medical treatment records from Ingalls, Concentra, Dr. Nicholson, films and surveillance video. Dr. Hutchinson provided a diagnosis of multilevel degenerative in the cervical spine. Dr. Hutchinson opined Petitioner sustained a temporary exacerbation of the pre-existing cervical condition as a result of the fall. According to Dr. Hutchinson, the treatment Petitioner received up to three months after the injury date was reasonable and necessary. No additional treatment was recommended for the cervical spine. As for the right shoulder, Dr. Hutchinson found no evidence of a causally related shoulder diagnosis. According to Dr. Hutchinson, there was no objective evidence to support a causal relation between the pathology on the diagnostics and the mechanism of injury or Petitioner's physical exam. Findings on the initial x-rays and MRIs were chronic in nature. Further, the act of falling simply on one's back is not consistent with causing a rotator cuff tear.

At therapy on August 31, 2017, Petitioner continued to complain of pain and difficulty with elevation of the right upper extremity when conducting chores, cooking, grooming and driving. Px1. The last date of therapy is September 21, 2017. Petitioner, at that time, still reported having a pain level that was still having a debilitating and negative effect on the quality of his life. Px13. Petitioner was given work restrictions.

Petitioner testified he then began looking for work and eventually secured work within his restrictions. Petitioner agreed he worked from November 20, 2017 through March 6, 2018 and again from April 9, 2018

onward. Ax2. Petitioner confirmed he was able to secure alternate employment with Hugh-Henry Construction. This work began on December 1, 2017 and went through December 29, 2017. Petitioner also found work for K&S Engineering which took place a few days in December and a few days in January. In addition, Petitioner worked for Case Foundations from January 11, 2018 through March 8, 2018. Petitioner testified that he did not advise all of his employers when he returned to work in the winter of 2017 about his injury and pending restrictions.

Regarding physical therapy, Petitioner recalled he was doing chores to tolerance and stated that in prior years, his daughters would not have helped. He also recalled he was doing home exercise during this time. Petitioner currently notices that his fingers still go numb, that he has ongoing neck symptoms, that he still has shoulder problems and he cannot handle weight above the shoulder.

On cross, Petitioner said as a Steward, he is does labor duties but also handles issues with money and hours. Petitioner said that if offered overtime, he is the first in line to be offered it but did not recall refusing overtime prior to the date of accident. He further testified that post-accident, he did not recall being offered and refusing overtime hours

Petitioner said his duties included using a jack hammer, a concrete chipper and a wheel barrel. After the accident, Petitioner said he never used a jackhammer or chipper again. He recalled using a shovel to scoop garbage, dust and small stuff.

Petitioner testified that he returned to work from December 2017 thru part of March 2018. During this time, he recalled he used a shovel and maybe used a wheel barrel. He also carried materials like a level, tape measure, wood and metal bolts.

Dan Erickson ("Erickson") testified on behalf of Respondent. Erickson is the construction superintendent responsible for coordinating field activities on site. Erickson worked the Washington/Wabash project starting in October 2015 thru June 2017. Erickson confirmed Petitioner worked as a laborer/union steward, responsible for ensuring that all other laborers are up to date on dues and that they are all union employees. Regarding injuries, Erickson said that either he or the foreman takes a report if one occurs. Erickson testified that Dan Cooper, foreman at the time, did not report any accidents to him. He said the policy is to report immediately and this is conveyed in orientation and daily tool box talks on safety. Erickson acknowledged that Petitioner called him the following day after the alleged incident and told him he (Petitioner) had an injury. Regarding overtime, Erickson said that laborers could refuse overtime, that Petitioner had declined overtime in the past. He said that Petitioner was always offered overtime first.

Regarding the shutdown, Erickson said that 50 hour shut downs are considered critical to the job. Erickson said Petitioner knew of the shutdown quite a few weeks or maybe a month before it was scheduled, and that Petitioner did not tell him of any vacation until the week prior to the scheduled vacation.

Erickson was shown Rx11 and confirmed that the reason for Petitioner's separation notice was that Petitioner did not work the critical week. On cross, Erickson testified that it would not have been Petitioner's job to stay late and close down a job and that Petitioner had been offered and refused overtime in the past but that they were expected to stay and work critical weekends.

Adam Dreger ("Dreger") testified on behalf of Respondent that he was a private investigator working for Photofax. He was hired by Respondent to document certain activity by Petitioner. Dreger testified that Rx5 was his report from surveillance dates 5/20, 5/21 and 5/29. He testified that Rx6 was the video clips pertaining

to his surveillance. Dreger testified initially that there was no issue with his recording equipment, that he did not alter or edit the footage filmed on those days, that he uploads his footage to Google Drive and that only he and his video person have access to that. He said that on 5/20 the camera was not running all day and that he took descriptive film every 30 minutes for 10 seconds. On cross, however, Dreger admitted that a supervisor can revise a report. Dreger was shown a portion of his video for 5/29 and was asked how the footage skipped how dirt got onto Petitioner's shoulder. Dreger could not explain why the footage skipped this, saying that in his actual film it should not skip. He then testified that the film in fact jumps that they just take the best clips. Dreger explained that the video department puts the film together, that it is in fact edited and that he could not state that Rx6 captured everything he was doing. Dreger was shown an additional clip where the film appears to be missing from 1:43 to 1:45. Dreger could not explain why this was missing or what occurred, stating he may have stopped the camera or someone was out of view. Based upon the totality of the testimony presented and the objection lodged, the Arbitrator sustained Petitioner's objections and rejected Rx6 as to Dreger's portion based on lack of foundation and rejected Rx5 based Respondent's failure to properly establish that it was a business record and further finding that the document is a record prepared for litigation.

Kevin Kennedy ("Kennedy") also testified on behalf of Respondent. He testified that he is a private investigator and conducted surveillance for Respondent on 5/27/17 and 5/28/17. Kennedy testified that every 30 minutes a 10 second clip is taking and that when filming someone, the camera stays except to maybe change SD cards. He testified that if someone is visualized you are to keep filming them. He then creates a report using a template. He reviews film while creating the report. He conducted surveillance on 5/27 and 5/28. Kennedy said his report is accurate because he reviewed it but was not aware of another person being able to edit it. Kennedy said that where he did not always film it may have been because Petitioner was in and out of view. Kennedy testified that there were no discrepancies between the video and the report and that no edits were made. On cross, Kennedy said he would have to look at the video to explain why 16 seconds of film were missing for 5/28, that around 1:09 four minutes were missing but that it may be because Petitioner went out of view, that at 1:23 he could not recall why the film did not show how Petitioner got the backpack blower off.

On 5/10/18, arbitration was continued, and, on that date, Matthew Morgan was called to testify on behalf of Respondent. Morgan testified he worked for Photo Fax as an investigator and that he was assigned to Petitioner to surveille him. Morgan said he does not keep the camera running all the time where the claimant is out of view. Morgan confirmed that Rx8a and Rx10a were copies of the video of dates of surveillance he conducted. Morgan explained that once he concludes filming, he uploads his SD card to a laptop and downloads to Google Drive. He did not edit the film and was not aware of anyone else who may have edited it. As to Rx7, Morgan confirmed that it was his December report and that there were no edits to it. As to Rx9, Morgan confirmed that he was agent 1 in that report and that it too was not edited. Morgan then described his filming Petitioner taking a train, commuting and working downtown and at his residence in December 2017 and January 2018. On cross, Morgan testified that Joe Pierce would have the final say on any edits to film. Morgan said he chose the pictures in Rx7 and Rx9. As to Rx8a, he would have uploaded it on 12/22. As to Rx10a, he would have uploaded it 1/26/18. Scott Walker would be in charge of any final video for Rx8a and Rx10a, but Morgan would have no way of knowing whether Scott Walker changed it. As to Rx7 and Rx9, the Arbitrator sustained Petitioner's hearsay objection and rejected Morgan's portions of that exhibit.

Jeff Elkins ("Elkins") testified for Respondent that he also worked for Photofax and conducted surveillance in this matter. Elkins said that the film is turned off when starting to drive or if a person is out of view. Elkins confirmed the procedure of descriptive filming. Elkins was shown Rx7 and confirmed his portion of the written report. He said no edits were made. Elkins was shown Rx8b and confirmed that his video was shot 12/21 and that he uploaded it after shooting. He had no reason to believe that it was inaccurate or edited.

The Arbitrator rejected Rx7 on the same basis as made previously with Morgan. As to Rx8a, no objection was noted during the course of trial.

Petitioner was then recalled. He said that after his injury he gave notice during break time. he was not allowed to fill out his own accident report and relied on his bosses to do that. He testified that he told his employer in early January of his vacation and that he also gave informal notice by putting it down in a calendar. He said that at the time he put it down on the calendar he had no idea of an impending shut down. Petitioner was shown Rx11 and said that when he signed it, only lay off was marked and refusal was not. There were also no comments on it at the time he signed it. He said after his injury he was released to work to his tolerance and that is what he attempted to do. Petitioner noted that surveillance began 5 days after his date of accident. Petitioner was shown pictures of the surveillance film and Petitioner noticed he used his left more. Petitioner clarified as to some of the activities depicted in the video, stating that the hammer drill is not a jackhammer or a chipper; that working a drill rig was considered light duty and that shaft work involved primarily coordinating using two hands. Petitioner said he applied to multiple jobs and currently does flagging for McHugh.

Petitioner testified that his work from December 2017 to March 2018 was the same or easier than the light duty work he had done for Respondent. After his work injury, Petitioner said he worked at a much slower pace, lifted much less weight and worked primarily with his left hand instead of his right.

At the time of hearing, Petitioner still had symptoms in his neck including aching and tightness. He still had symptoms in his right fingers. The fingers go numb every day. Galvin still had symptoms in his right shoulder and arm, including the inability to handle any weight above his head. At some point his ribs had gotten better and the headaches went away, but he still had the neck and shoulder pain. Galvin wanted to continue his treatment for his neck and shoulder. He still wanted to have the surgery on his right shoulder.

As a result of his work injury, Petitioner alleged he incurred many medical bills, some of which were paid by Respondent. At the time of hearing, there were outstanding bills with Dr. Nicholson and Integrity Physical Therapy. The Ingalls Memorial ER bill had been paid by group insurance Blue Cross Blue Shield.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner testified at trial and the Arbitrator finds that Petitioner was credible, candid and forthright regarding the circumstances of his injury, his course of medical treatment, his attempts to return to work, work abilities and subjective belief of his current condition of ill-being. The Arbitrator finds Petitioner credible as to his rebuttal testimony regarding the video surveillance. Similarly, the Arbitrator finds the testimonies of the surveillance witnesses to be generally credible in their recollection as to the processes and procedures regarding the collection, submission and editing of certain video. The Arbitrator finds Respondent's witness, Erickson, to be generally credible insofar as how work is organized although as it relates to the factual dispute that he was unaware of a reported accident or that Petitioner had previously scheduled vacation.

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. Petitioner alleges he suffered injuries to his right shoulder, neck and radicular symptoms down the right arm into the fingers as a result of the fall. For the foregoing reasons, the Arbitrator finds and concludes

that Petitioner has proven by a preponderance of the evidence that Petitioner's right arm, right shoulder and neck/cervical injuries are causally related to his work accident.

Petitioner credibly testified that prior to the date of accident, he had no injuries, symptoms or treatment relative to the shoulder and neck/cervical area. Petitioner testified that his right shoulder hurt immediately after he fell. He also testified that he iced the right shoulder that night and slept in a lazy boy chair because he was unable to sleep in a bed. The next morning, he was unable to put on his shirt and presented to the ER.

Petitioner timely sought medical care with Ingalls Memorial ER on 5/16/17, where he complained of pain to the right shoulder, left ribs, neck, and upper back. Px9. On physical exam, Petitioner was "unable to abduct the right shoulder." Providers noted traumatic right shoulder pain and Petitioner was diagnosed with a sprain of the right shoulder joint. Petitioner was given medications and taken off of work.

Similarly, at the company clinic, Concentra, on 5/24/17, Petitioner timely and consistently again complained of pain to the right shoulder, neck, left ribs, and upper back. Px11. Physical exam revealed tenderness in the supraspinatus muscle and in the anterior and superior shoulder. He was diagnosed with a strain of the right shoulder and was prescribed Tramadol and physical therapy for the right shoulder. The company clinic released him for modified work with no use of the right upper extremity. When he began therapy at the company clinic on May 30, 2017, the initial physical exam recorded a positive Hawkins-Kennedy test, a positive Painful Arc Sign, Flexion to 92 degrees and Abduction to 100 degrees on the right, compared to both at 150 degrees on the left. Although he was released for full duty work by the company clinic on 6/7/17, he continued to have a positive physical exam and a diagnosis of right shoulder strain. Px11. Petitioner likewise testified that he was not improved at the time of his full duty release. Petitioner eventually saw Dr. Hutchinson at the request of Respondent at the time he had first begun physical therapy for the right shoulder.

On 6/28/17, Petitioner saw his own doctor, Dr. Nicholson, a shoulder specialist at Midwest Orthopaedics at Rush, and complained of pain in the right shoulder and neck with radicular symptoms. Px12, Px14. Exam likewise showed positive Hawkins-Kennedy test, a positive Neer impingement sign and numbness in the ring and pinky fingers. There was reduced strength and range of motion. Dr. Nicholson prescribed a right shoulder MRI and cervical spine MRI and took Petitioner off work. Eventually, MRI of the right shoulder showed a small to medium size full-thickness rotator cuff tear in the anterior aspect of the supraspinatus with acute inflammation in the subacromial bursa and a little bit in the anterior subdeltoid bursa. Dr. Nicholson opined and concluded at that time that the findings on MRI showed an acute RC tear consistent with Petitioner's mechanism of injury, pain in the shoulder and exam. The doctor recommended surgery. The doctor similarly testified that the mechanism of a fall with unexpected force applied to the upper body was consistent for an acute RC tear, immediate pain and dysfunction.

Dr. Nicholson opined Petitioner's rotator cuff tear was an acute tear because the MRI revealed a ragged, retracted tear with significant inflammation within the glenohumeral joint, within the bursa and around the area of the tear and it was accompanied by an acute diminution of function. Px14. He explained a degenerative tear would have more of a thin edge to the tear with no inflammation in and around the shoulder, and it would not be accompanied by an acute diminution of function.

Dr. Nicholson dismissed that a direct trauma to the right shoulder is required to cause a tear in the right supraspinatus, explaining that a forceful impact to the upper back can cause the shoulder joint to move in such a way as to cause a tear in the supraspinatus. A fall would cause acceleration and deceleration resulting in direct muscle action and indirect muscle action, all of which can cause the tear. Whether Petitioner fell onto his back or onto his right shoulder would not change Dr. Nicholson's opinion.

Regarding the medical opinions submitted by Respondent in this case as it relates to the right shoulder, the Arbitrator assigns little weight to those opinions for several reasons. Rx3. First, Dr. Hutchinson relied on video surveillance that ultimately was excluded at trial. Second, Dr. Hutchinson based his conclusions on speculation that Petitioner was likely performing activities beyond his stated capabilities and further speculated on Petitioner's activities ultimately not observed in any of the videos reviewed. Third, Dr. Hutchinson's opinion that Petitioner's rotator cuff tear was degenerative and not aggravated by any work fall is based on unpersuasive reasoning that he expected a cleaner tear in a younger patient. This conclusion was not supported by any further evidence or testimony. Fourth, Dr. Hutchinson admitted that he ignored the history Petitioner gave. Rx3:129. Finally, Dr. Hutchinson's testimony at times was unclear and evasive on often basic interrogatories regarding the medical treatment in this case, thereby leading the Arbitrator to conclude that Dr. Hutchinson's testimony is not credible and that he was otherwise uncooperative. For example, when asked about the examination at the ER, the doctor testified that some of the exam was "incomplete," and suggesting that the notations by the doctors could have been "comments" made by Petitioner. The doctor provided no basis for the conclusion that the exam was otherwise incomplete and provided no basis for the conclusion that findings are comments. Rx3:70-75. In conclusion, the Arbitrator assigns little weight to the opinions of Dr. Hutchinson and instead adopts and relies on the medical opinions of Dr. Nicholson.

As it relates to the cervical spine injuries, the Arbitrator likewise finds Petitioner's condition of ill-being in the cervical spine related to his work accident. Again, Petitioner had no prior evidence of medical treatment or injury to the cervical spine. In addition, Dr. Hutchinson surmised that Petitioner's fall likely exacerbated or aggravated his pre-existing multi-level spine pathology and that despite stating the fall also led to a temporary exacerbation, the doctor also concluded that it was possible that some disc disease or foraminal impingement was advanced to some degree. It is well settled that so long as the work accident was a causative factor, compensation should not be denied. Given Dr. Hutchinson's equivocal opinions and the fact that Petitioner experienced a change in condition as it related to the neck/cervical spine immediately after the fall, the Arbitrator concludes Petitioner's neck/cervical spine is causally related to the accident.

The Arbitrator has also considered and weighed the video surveillance and related testimonial evidence as it relates to the issue of causation. Having considered same, the Arbitrator does not find such surveillance fatal to Petitioner's claim for compensation. The video that was admitted into evidence shows Petitioner commuting to work, doing home exercise to his arm while on his bike commuting downtown, and performing work activities to his tolerance as authorized by his treating physician, Dr. Nicholson. As to the work activities performed, the Arbitrator finds Petitioner's testimony persuasive in highlighting the fact that Petitioner can be observed using mostly the left arm for dominant activities while the right arm appears to be assistive in nature. In this regard, it is evident from the video that Petitioner is favoring the injured right arm. The mere fact that Petitioner is seen working is not evidence of a break in causal connection where Petitioner attempted to work within light duty restrictions that Respondent otherwise would not or could not accommodate. Similarly, the Arbitrator does not find Petitioner's pre-planned vacation as fatal to the issue of causation. Petitioner credibly testified that his vacation was pre-planned and that he had informed his employer long before and again shortly before the scheduled vacation. The Arbitrator is not persuaded by Erickson that Petitioner simply took time off without previously letting anyone know.

Based on record as a whole, the Arbitrator concludes that Petitioner's right shoulder condition of ill-being is causally related to his undisputed fall at work on May 15, 2017.

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 found in favor of Petitioner on the issue of causation, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the medical services that were provided to him were both reasonable and necessary, and further that Respondent has not yet paid all appropriate charges for same. The evidence shows that Respondent made payments for some but not all medical treatment in this case. Rx1, Rx8. Respondent ceased payments in August 2017 pursuant to the conclusions of Dr. Hutchinson's initial Section 12 evaluation. Rx2.

The evidence established that Petitioner's treatment with Ingalls Memorial Hospital, Concentra, Dr. Nicholson, and Integrity Physical Therapy was reasonably required to diagnose, relieve or cure his medical condition. Respondent offered no evidence to dispute that the treatment Galvin has received to date was medically necessary. In fact, its Section 12 doctor agreed that Petitioner suffered from shoulder pathology and that certain treatment was necessary. Rather, it disputed that the treatment was causally related to Galvin's work injury. Because the Arbitrator has concluded that Petitioner's conditions of ill-being are causally related to his fall at work on May 15, 2017, the Arbitrator further concludes that the medically necessary treatment he received for those causally related conditions are also causally related and should be paid by Respondent pursuant to the Medical Fee Schedule.

At trial, Petitioner submitted his calculations as to charges, payments and balances owed. Ax1, Px8. Petitioner alleges charges from Ingalls Memorial Hospital, Integrity PT and Midwest Orthopaedics at Rush (Nicholson). Px8. In regard to Ingalls, the Arbitrator finds such treatment reasonable and necessary and further finds that the outstanding charges correlate to and are corroborated by a corresponding medical record. The Arbitrator awards the Ingalls bill in gross in the amount of **$3,483.45**, subject to Sections 8(a) and 8.2. Against this award, Respondent is entitled to a credit under Section 8(j) in the amount of **$3,483.45** for BCBS payments made toward this bill. Ax2, Px10. In regard to Integrity PT, the Arbitrator finds such treatment reasonable and necessary and further finds that the outstanding charges correlate to and are corroborated by a corresponding medical record. The Arbitrator awards the Integrity bill in gross in the amount of **$3,392.22**, subject to Sections 8(a) and 8.2. Against this award, Respondent is entitled to a credit for workers' compensation insurance payments made toward this bill. Ax2, Px13. In regard to Midwest Ortho, the Arbitrator finds such treatment reasonable and necessary and further finds that the outstanding charges correlate to and are corroborated by a corresponding medical record. The Arbitrator awards the Midwest Ortho bill in gross in the amount of **$5,365.00**, subject to Sections 8(a) and 8.2. Against this award, Respondent is entitled to a credit for workers' compensation insurance payments made toward this bill. Px8, Px12, Rx1.

In summary, the Arbitrator concludes that Respondent shall pay reasonable and necessary medical services of **$12,241.67**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of **$3,483.45** 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) ***Is Petitioner entitled to any prospective medical care?***
ISSUE (O) ***Other: Vocational rehabilitation; Section 8(a) medical treatment***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the issue of causation, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to prospective medical care pursuant to Section 8(a) for his causally related right shoulder, neck and radicular symptoms.

Dr. Nicholson prescribed a right rotator cuff surgery which would include an arthroscopic rotator cuff repair and subacromial decompression. Px12, Px14:16. He also recommended a work-up by a cervical spine specialist. Dr. Hutchinson agreed with Dr. Nicholson that Galvin had a rotator cuff tear that required surgical repair. Rx3. Dr. Hutchinson also agreed that Galvin should have had a work up and treatment for two to three months for the neck. Thus, the dispute over prospective medical care is one based on liability and the evidence shows that the parties agree Petitioner's conditions have not yet stabilized.

Petitioner wants to have the rotator cuff surgery prescribed by Dr. Nicholson and he still wants to see neck specialist. Because the Arbitrator concluded that Petitioner's conditions of ill-being, including the right shoulder and neck, are causally related to his fall at work on May 15, 2017, the Arbitrator further concludes that Petitioner is entitled to medically necessary prospective medical treatment, including the prescribed right rotator cuff surgery and the work-up and treatment by a cervical spine specialist. Respondent shall authorize and approve the recommended shoulder and cervical treatment as outlined by Dr. Nicolson, including any and all incidental care thereto. In so finding, the Arbitrator finds that Petitioner's claim for vocational rehabilitation at this time is premature as he has not yet reached maximum medical improvement and thereby finds this issue moot.

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. At trial, the parties disputed the issue of earnings and average weekly wage. Ax1-2. Specifically, the dispute is over whether Petitioner's earning and resultant average weekly wage should include overtime earnings. Stated simply, Petitioner alleged that he was required to work overtime while Respondent alleged via the testimony of Erickson that Petitioner was usually offered overtime first but was free to reject it. Petitioner testified that in the 52 weeks prior to the date of incident he worked overtime hours 60% of the weeks that he worked during that period. Petitioner testified that he would have to work overtime hours on occasion dependent on the kind of work being performed, such as pouring concrete.

Section 10 of the Act excludes overtime pay from the average weekly wage calculation. Overtime includes "those hours in excess of an employee's regular weekly hours of employment that he or she is not required to work as a condition of his or her employment or which are not part of a set number of hours consistently worked each week." *Airborne Express, Inc. v. IL Workers' Comp. Comm'n*, 372 Ill. App. 3d 549, 554, 865 N.E.2d 979 (1st Dist. 2007). To prove that the hours a claimant worked were part of his regular hours of employment, a claimant must present evidence that "he was required to work overtime as a condition of his employment or that he consistently worked a set number of overtime hours each week." *Edward Don Co. v. Indus. Comm'n*, 344 Ill. App. 3d 643, 657, 801 N.E.2d 18 (1st Dist. 2003); *Freesen, Inc. v. Indus. Comm'n*, 348 Ill. App. 3d 1035, 1042, 811 N.E.2d 322 (4th Dist. 2004). Evidence that demonstrates that a claimant worked "an irregular number of overtime hours" is insufficient to support a finding that overtime pay is part of the claimant's regular hours of employment. Airborne Express, Inc., 372 Ill. App. 3d at 554. In addition, "merely working overtime on a regular, voluntary basis [is insufficient] to include the overtime hours worked in the calculation of an employee's average weekly wage. " *Id.* at 555. To hold otherwise would be to render § 10 of the Act "meaningless." *Id.*

Here, Petitioner failed to show any evidence that he was required to work overtime as a condition of his employment; instead merely concluding that he had to work overtime without further explanation. In addition, Petitioner failed to show that he consistently worked a set number of hours of overtime each week. Specifically, Petitioner's documentary evidence showed that Petitioner worked overtime in 31 out of the 52

weeks in the year preceding his injury, there no explanation as to how those overtime hours were consistent in days, weeks and/or number of hours. Petitioner merely stated he worked overtime *on occasion*. Finally, Petitioner also did not show that such overtime hours were part of his regular hours of employment. Therefore, the Arbitrator concludes that Petitioner's earnings were **$78,712.00** resulting in an average weekly wage of **$1,513.69**.

ISSUE (L) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to payment of temporary total disability benefits ("TTD") from June 28, 2017 through November 19, 2017, and from March 7, 2018 through April 8, 2018, for a total of 25-3/7 weeks. During these periods Petitioner was either off work on Dr. Nicholson's order or released with work restrictions that Respondent did not accommodate.

The full duty release by Concentra, the company clinic, is accorded no weight as it was made based on a conclusion of video surveillance tendered to his then treating physician, who released Petitioner full duty on that basis and recommended an IME. Px11. In support thereof, the Arbitrator has already concluded that the video surveillance admitted into evidence is not fatal to Petitioner's claim and that Petitioner persuasively explained that use of his injured arm was as an assist and that such use was within his applicable restrictions.

The Arbitrator also accords little weight to the Section 12 doctor's release on August 30, 2017, as it is based solely on his causal opinion, which the Arbitrator has declined to adopt. The Arbitrator relies instead on the off-work orders and light duty release of Dr. Nicholson. Based on Dr. Nicholson's orders, the Arbitrator concludes that Petitioner is entitled to TTD from **June 28, 2017** through **November 19, 2017**, and from **March 7, 2018** through **April 8, 2018**, for a total of **25-3/7** weeks.

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. The Arbitrator has reviewed the record as a whole and the arguments made for and against Petitioner's request for penalties and fees and concludes that penalties and fees are not warranted in this case. Ax1-2, Px15, Rx2. As Respondent correctly points out, part of the basis of its denial for further benefits were the opinions of Dr. Hutchinson and its surveillance of Petitioner. While the Arbitrator ultimately declined to adopt the opinions of Dr. Hutchinson in this case, Dr. Hutchinson's opinion that Petitioner's rotator cuff pathology was degenerative in nature not aggravated by a work injury is not an unreasonable basis for denying a claim. Further, Respondent was entitled to conduct and rely on video surveillance of Petitioner in support of the defense of its claim.

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

Nekia Alexander,

Petitioner,

vs. NO. 17 WC 34407

Walgreens,

19IWCC0598

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 medical expenses, prospective medical care, 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 April 1, 2019 is hereby affirmed and adopted.

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

19IWCC0598

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 - 5 2019

DATED:
SJM/sj
o-10/29/19
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

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

ALEXANDER, NEKIA
Employee/Petitioner

Case# **17WC034407**

WALGREENS
Employer/Respondent

19IWCC0598

On 4/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE PC
DAVID GALANTI
PO BOX 99
E ALTON, IL 62924

0180 EVANS & DIXON LLC
MICHAEL A KARR
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

19IWCC0598

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nekia Alexander
Employee/Petitioner

Case # 17 WC 34407

v.

Consolidated cases: n/a

Walgreens
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 Collinsville, on February 27, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

19IWCC0598

On the date of accident, April 27, 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 $34,098.77; the average weekly wage was $681.98.

On the date of accident, Petitioner was 35 years of age, married with 5 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 $12,989.90 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $12,989.90.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the disc replacement surgery recommended by Dr. Matthew Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $454.65 per week for 80 3/7 weeks commencing April 27, 2017, through November 26, 2017, and March 16, 2018, through February 27, 2019, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher

William R. Gallagher, Arbitrator
ICArbDec19(b)

March 29, 2019
Date

APR 1 - 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on April 27, 2017. According to the Application, "Petitioner was packing a order" and sustained an injury to the "MAW" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical as well as prospective medical treatment. In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits for 80 3/7 weeks commencing April 27, 2017, through November 26, 2017, and March 16, 2018, through February 27, 2019 (the date of trial). The prospective medical treatment sought by Petitioner is disc replacement surgery as recommended by Dr. Matthew Gornet. Respondent disputed liability on the basis of accident and causal relationship (Petitioner's Exhibit 1).

Petitioner testified that on April 27, 2017, she was packing various items in a box. Petitioner used a tape dispenser on the top of the box and, when she reached across her body with her right arm, Petitioner experienced an onset of pain in her low back on the left side. At trial, Petitioner demonstrated how she sustained the accident. Petitioner had her left arm outstretched in front of her with her left hand on the top of the box and then pulled the tape dispenser with her right hand. Petitioner said she reported the accident to Respondent immediately after it occurred.

Petitioner sought medical treatment on April 27, 2017, and was evaluated by Tara Helfrich, a Nurse Practitioner associated with Dr. Anthony Truong. According to NP Helfrich's record of that date, Petitioner was taping a tote at waist level and when she pulled her right arm back, she experienced a sudden sharp pain in her right mid lateral back. NP Helfrich prescribed medication and ordered x-rays. X-rays of Petitioner's thoracic and lumbar spine were obtained which were normal (Petitioner's Exhibit 1).

Dr. Truong saw Petitioner on May 8, 2017, and diagnosed Petitioner with mid and low back pain. He opined Petitioner sustained a muscular strain/sprain and kept her on medication. He noted that if Petitioner's condition did not improve, he would order physical therapy and an MRI scan (Petitioner's Exhibit 1).

Dr. Truong subsequently saw Petitioner on June 2, 2017, and Petitioner's condition had not improved. Dr. Truong ordered physical therapy (Petitioner's Exhibit 1).

Petitioner received physical therapy from June 2, 2017, through November 1, 2017. When initially seen on June 2, 2017, Petitioner stated she was packing a box for shipment, and when she reached across the box to apply the tape, she twisted to the right and experienced sharp burning pain in the middle of her low back (Petitioner's Exhibit 2).

Petitioner continued to be treated by Dr. Truong. When Dr. Truong saw Petitioner on September 15, 2017, he ordered an MRI scan (Petitioner's Exhibit 1).

The MRI was performed on October 13, 2017. According to the radiologist, Petitioner complained of low back and left leg pain and the MRI revealed a protrusion on the left at L4-L5 and neuroforaminal narrowing at L4-L5 and L5-S1 (Petitioner's Exhibit 6).

When Dr. Truong saw Petitioner on November 3, 2017, he reviewed the MRI and opined it revealed degenerative changes and a small disc protrusion. He recommended Petitioner continue physical therapy, but noted Petitioner had an appointment with a neurosurgeon (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. David Raskas, an orthopedic surgeon, on October 17, 2017. According to his report of that date, Petitioner's job duties consisted of lifting totes off of a conveyor belt, removing items from and packing the items in boxes. Petitioner "noticed symptoms" on April 27, 2017. At the time of the examination, Petitioner had received approximately 16 weeks of physical therapy, but still had low back pain and occasional neck pain (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Raskas' findings on examination were benign, but Petitioner did complain of low back pain/discomfort on the extremes of flexion and extension. Dr. Raskas reviewed the MRI of October 13, 2017, and opined it revealed the L5-S1 disc was dehydrated, but he did not see a definite herniation. He noted that there might be a slight disruption in the posterior annulus to the left side of the midline, but the scan was not of good enough quality for him to make that diagnosis. Dr. Raskas noted there was no evidence of nerve root compression. Dr. Raskas opined Petitioner's condition was not work-related and noted there was not a specific injury, but that Petitioner just had an onset of symptoms while at work. He also opined Petitioner had received too much physical therapy, but opined Petitioner might benefit from some epidural steroid injections (Respondent's Exhibit 1; Deposition Exhibit 2).

Petitioner was subsequently seen by Dr. Matthew Gornet, an orthopedic surgeon, on December 16, 2017. At that time, Petitioner advised Dr. Gornet she sustained an injury on April 27, 2017, while lifting totes from different lines and twisted when she put tape over a box. Petitioner also informed Dr. Gornet she had prior back injuries 2014 and 2016, but her symptoms were not severe enough to warrant an MRI. Petitioner complained of neck and low back pain with the low back pain in both sides, but predominantly the left buttock and left anterolateral calf. Dr. Gornet reviewed the MRI of October 13, 2017, and noted it was of moderate/poor quality, but that it did reveal a left sided disc herniation at L4-L5 and, to a lesser extent, at L5-S1. Dr. Gornet referred Petitioner to Dr. Helen Blake for steroid injections and indicated he would obtain MRIs of both the cervical and lumbar spine (Petitioner's Exhibit 3).

Dr. Blake saw Petitioner on January 9, 2018, and administered an epidural steroid injection on the left at L4-L5. Dr. Blake again saw Petitioner on January 30, 2018, and administered an epidural steroid injection on the left at L5-S1 (Petitioner's Exhibit 7). At trial, Petitioner testified the injections only worsened her symptoms.

Petitioner contacted Dr. Gornet's office by telephone on February 12, 2018. At that time, Petitioner advised she was having increased low back pain which radiated to her left hip and left

buttock. Petitioner's medications were changed and she was advised to follow up if her symptoms worsened (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Gornet on February 22, 2018. Because of Petitioner's neck symptoms, Dr. Gornet ordered an MRI of Petitioner's cervical spine which was performed that same day (Petitioner's Exhibit 3).

The radiologist who performed the cervical MRI opined the scan revealed a central disc herniation at C3-C4 as well as smaller protrusions/herniations at C4-C5 and C5-C6 (Petitioner's Exhibit 6). Dr. Gornet reviewed the MRI and his reading of the study was consistent with that of the radiologist (Petitioner's Exhibit 3).

Because of Petitioner's low back symptoms, Dr. Gornet ordered CT discograms at L4-L5 and L5-S1, as well as an MRI spectroscopy at L3-L4, L4-L5 and L5-S1. He also ordered another MRI with high resolution (Petitioner's Exhibit 3).

The CT discogram and MRI spectroscopy were performed on April 6, 2018. The studies revealed annular tears at L4-L5 and L5-S1 as well as painful chemicals at L5-S1 (Petitioner's Exhibits 3 and 5).

Dr. Gornet saw Petitioner on April 21, 2018, and reviewed the diagnostic studies. He again opined a high resolution MRI of the lumbar spine was indicated. If it revealed left sided pathology at L4-L5, he opined Petitioner should have disc replacement surgery at L4-L5 and L5-S1 (Petitioner's Exhibit 3).

A high resolution MRI scan of Petitioner's lumbar spine was performed on May 3, 2018. According to the radiologist, it revealed a right sided disc protrusion at L5-S1 and a left sided disc protrusion at L4-L5 (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on May 3, 2018, and reviewed the MRI that was performed that day. Dr. Gornet reaffirmed his recommendation Petitioner undergo disc replacement surgery at L4-L5 and L5-S1. When Dr. Gornet subsequently saw Petitioner on August 16, 2018, he again recommended Petitioner have disc replacement surgery (Petitioner's Exhibit 3).

Dr. Gornet was deposed on December 20, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Gornet testified he recommended disc replacement surgery at L4-L5 and L5-S1. In regard to causality, Dr. Gornet stated Petitioner's symptoms were related to the accident of April 27, 2017, and that Petitioner sustained a new disc injury as well as an aggravation of pre-existing disc degeneration and pathology (Petitioner's Exhibit 4; pp 10-11).

On cross-examination, Dr. Gornet was questioned about Petitioner's initial low back complaints being on the right side. Dr. Gornet testified Petitioner had pain referable to both sides, but that it was predominantly on the left with radiation into the left buttock and left anterolateral calf (Petitioner's Exhibit 4; p 16).

Dr. Raskas was deposed on February 6, 2019, and his deposition testimony was received into evidence at trial. In regard to the accident of April 27, 2017, Dr. Raskas noted the history Petitioner gave to her primary care physician was that she was taping a tote at the waist level, pulled her right arm and experienced a sudden sharp pain in the right midlateral back. Dr. Raskas noted Petitioner had informed him that she had experienced low back symptoms while lifting boxes and this was a different history than the one Petitioner gave to her primary treating physician (Respondent's Exhibit 1; pp 11-13).

In regard to causality, Dr. Raskas testified that neither of the preceding activities would cause an injury to the lumbar spine. Dr. Raskas opined Petitioner's pulling her right arm while taping a box caused her to feel a sharp pain in the right midlateral back, but not in the lumbosacral junction area. In regard to whether Petitioner required further treatment, Dr. Raskas testified Petitioner might benefit from some epidural injections and facet blocks, but that disc replacement surgery was not indicated. He also stated Petitioner had work/activity restrictions, but that they were not related to the accident of April 27, 2017 (Respondent's Exhibit 1; pp 19-21).

On cross-examination, Dr. Raskas agreed that twisting at the waist while pulling on tape could put increased pressure on the discs in the lumbar spine. However, he also stated that he did not see how pulling on tape with an arm would produce a disc injury (Respondent's Exhibit 1; p 27).

At trial, Petitioner testified Dr. Gornet has continued to impose light duty work restrictions. Respondent provided Petitioner with light duty work from late November, 2017, until March 16, 2018. Petitioner has not worked since that time. Petitioner stated she has continued to have low back pain as well as aching and throbbing. Petitioner's activities at home are extremely limited and she wants to proceed with the surgery recommended by Dr. Gornet. In regard to her prior back symptoms, Petitioner testified she went to Urgent Care, received some muscle relaxers and that her back symptoms resolved within three days.

Antoinette Goodwin, Petitioner's mother, testified for Petitioner at trial. She confirmed Petitioner's day-to-day activities are extremely limited and Petitioner is no longer physically active.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of her employment by Respondent on April 27, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the circumstances of the accident of April 27, 2017, was unrebutted.

Petitioner reported the accident to Respondent immediately after its occurrence and sought medical treatment that same day.

Petitioner provided a consistent history of the accident of April 27, 2017, to the medical providers who treated her.

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of April 27, 2017.

In support of this conclusion the Arbitrator notes the following:

While Petitioner apparently experienced prior low back symptoms, Petitioner's testimony that the symptoms resolved after just a few days was unrebutted. Further, none of the medical records regarding Petitioner's prior back symptoms were tendered into evidence at trial.

The fact that Petitioner initially complained of low back pain with right sided symptoms and subsequently had primarily left sided symptoms is not of any great significance. As noted herein, Dr. Gornet testified Petitioner had pain referable to both sides, but that it was predominantly on the left side.

When Petitioner pulled on the tape, she sustained a "twisting" injury to her low back. Dr. Gornet testified there was a causal relationship between the accident of April 27, 2017, and Petitioner's low back condition. Respondent's Section 12 examiner, Dr. Raskas, agreed the "twisting" could put increased pressure on the discs in the lumbar spine.

Given the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. Raskas in regard to causality.

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 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the disc replacement surgery recommended by Dr. Matthew Gornet.

In support of this conclusion the Arbitrator notes the following:

Dr. Gornet ordered extensive diagnostic tests and initially treated Petitioner's condition conservatively ordering epidural steroid injections. Petitioner did not respond well to the injections and Dr. Gornet ultimately opined Petitioner should undergo disc replacement surgery at L4-L5 and L5-S1.

While Dr. Raskas opined disc replacement surgery was not appropriate, he stated Petitioner needed additional medical treatment including epidural steroid injections. Dr. Raskas evaluated Petitioner prior to her undergoing epidural steroid injections and when deposed, he was apparently unaware of the fact that Petitioner had received epidural steroid injections and that they did not produce any relief of her symptoms.

In view of the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. Raskas in regard to Petitioner's need for prospective medical treatment.

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 for 80 3/7 weeks, commencing April 27, 2017, through November 26, 2017, and March 16, 2018, through February 27, 2019.

In support of this conclusion the Arbitrator notes the following:

Petitioner was under active medical treatment and was either authorized to be off work or on light duty. Respondent did provide light duty work to Petitioner from November 27, 2017, through March 15, 2018, but not thereafter.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

OMAR CORRAL,

Petitioner,

19IWCC0599

vs.

NO: 15 WC 31299

LEVY RESTAURANTS,

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, medical expenses, temporary total disability, and "TPD benefits," and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causation as explained below. However, we attach the Decision of the Arbitrator, which is made a part hereof, for the Statement of Facts with the modifications noted 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 views the evidence differently and finds Petitioner's testimony credible. We further find that the opinion of Respondent's Section 12 examiner, Dr. Mather, is not persuasive regarding causation.

We first address the initial medical records from Northwestern Hospital on September 18, 2015. *Px1.* The Nursing Assessment, by Vanessa Woroszylo, lists "Pain: LLE." The "Nursing Narrative" indicates Petitioner complained of pain to the left lower back radiating to the left thigh. In another section, it states "Radiation Location: Upper leg, left." Although the notes of Dr. Keith Hemmet include references to "R sided low back pain that radiates down right leg" and "minimal ttp R lower back, paraspinal," these are inconsistent with the complaints noted in the nursing assessment. Petitioner testified that after his accident, he had low back pain that went down both legs but it was mostly in the left leg. *T.12-13, 28.* We find his testimony to be consistent with the

complaints documented in subsequent medical records and also with the notes of Vanessa Woroszylo. We resolve the discrepancy in the initial medical records by noting several facts that might explain said discrepancies. First, it is possible that Dr. Hemmet focused on Petitioner's right side because Petitioner also had right leg symptoms. This would also be consistent with Petitioner's testimony. Second, it is possible that Dr. Hemmet's references to the "right" leg and back are simply clerical errors. Third, the triage notes indicate that an interpreter was requested for assistance since Petitioner spoke Spanish. However, Dr. Hemmet's record does not indicate whether an interpreter was actually used during his examination. This could be a possible source of confusion as well. Regardless, we do not believe that this discrepancy in the initial emergency room records reflects negatively on Petitioner's credibility.

We next address the question of when Petitioner's left thigh symptoms began. When Petitioner followed up with Northwestern Corporate Health, on September 21, 2015, Dr. Edelstein recorded complaints of pain in Petitioner's low back since the accident and tingling in his left leg. This record states, "He claims he was given a shot of something in the left thigh for the pain which he thinks caused the tingling." We find that the emergency room records on September 18th, do indicate Petitioner was given a Toradol injection in his left thigh. On September 25, 2015, Dr. Cullen at Northwestern, noted there was "no radiation of pain, but lateral circumferential tingling lateral thigh." By September 29th, Dr. Cullen wrote, "Still localized lumbar pain, and L lateral thigh pain."

Dr. Mather based his opinion, in part, on his belief that Petitioner's left thigh symptoms did not start until a month after the accident. On September 15, 2016, Dr. Mather wrote:

> It is noted that when [Petitioner] saw me today, he stated that the pain in the left thigh started approx. 1 month after the injury, indicating that his medical verbal history is not consistent with the medical records.

We note that it appears Dr. Mather chose to believe whatever facts placed Petitioner in the worst possible light. Dr. Mather did not believe that Petitioner had initial left leg symptoms because one of the emergency room records, which was inconsistent with the others, indicated Petitioner had right leg symptoms. However, when Petitioner allegedly told Dr. Mather that his left thigh symptoms did not begin until a month after the accident, Dr. Mather chose to believe that history and ignored the written medical records indicating Petitioner did, in fact, complain of left thigh symptoms within days of his accident. Dr. Mather then relied on his belief that the left thigh symptoms did not begin until a month later as a basis of his opinion that this was not causally related to Petitioner's work accident.

Dr. Mather also opined, "it is clear that he is not telling me the truth regarding his intake of Lyrica. Given that, I do not find that his complaints are likewise credible." *Rx2-DepX2.* Dr. Mather came to this conclusion because Petitioner allegedly told him that he had been taking Lyrica twice per day for nine months. However, Dr. Mather's review of the Illinois Prescription State Monitoring website on September 15, 2016, only showed that Petitioner filled prescriptions for 60 tablets on November 24, 2015; 60 tablets on April 19, 2016; and 90 tablets on June 23, 2016. This would be a total of 210 pills. Dr. Mather testified that Petitioner would have had to obtain 540 pills if he had been taking Lyrica twice a day for nine months and, since the records do not show he received that many, Petitioner is "not credible" and "not telling the truth." *Rx2 at 22, 26, 42, 53.*

We find that there is another credible explanation for this discrepancy, which is that Dr. Shah gave Lyrica samples to Petitioner during the periods when it was being denied by the workers' compensation insurance carrier. On February 4, 2016, Dr. Laich reported that Lyrica helped Petitioner's back pain but he ran out of medication. Dr. Shah's February 16, 2016, record states that Petitioner was given "one box of Lyrica samples." On March 8, 2016, Dr. Shah noted that Lyrica was still not approved by insurance and that Petitioner requested more Lyrica samples. On April 19, 2016, Dr. Shah noted that Petitioner has been getting Lyrica samples which helps his pain.

We find that the Lyrica samples Petitioner was given could account for much of the discrepancy between quantities shown on the Illinois Prescription Monitoring website and what Petitioner actually took during that 9-month period. Since it does not appear Dr. Mather was aware that Petitioner was being given Lyrica samples, we find his opinion that Petitioner was "not credible" and "not telling the truth" to be unsupported by the evidence.

Dr. Mather found that Petitioner's left thigh numbness and tingling was due to meralgia paresthetica related to Petitioner's obesity. However, we find that none of Petitioner's treating medical professionals made that diagnosis and, instead, documented that Petitioner's symptoms were consistent with radicular pain.

Dr. Mather testified that Petitioner's medical records showed Petitioner had no symptoms radiating below his knee but when Petitioner saw Dr. Shah on November 24, 2015, "all of a sudden he started having pain going all the way down in the ankle in a positive straight leg raise maneuver at 30 degrees, which no one else had found." *Rx2 at 15.* This is not accurate. The November 20, 2015, physical therapy record noted pain down the left lower extremity to the knee but that, "In the mornings, he continues to have pain down to plantar surface of his foot." Even earlier, on November 5, 2015, Dr. Laich noted that colder temperatures cause Petitioner's left lower extremity symptoms to travel below the knee but, in warmer climates, the sensation stays in the thigh. Therefore, we find Dr. Mather's opinion to be based on an inaccurate interpretation of the medical records.

Dr. Mather further testified that based on his review of the medical records, Petitioner's examinations were all normal objectively and that if Petitioner really was having symptoms from a disc herniation, he would have had a "positive straight leg raise maneuver along the way somewhere. We didn't see that." *Rx2 at 15.*

This is not accurate. On October 2, 2015, Dr. Laich found a positive FABER test bilaterally, weak hip abductors/flexors/knee extension, and decreased left L4 sensation. Petitioner had a negative right-side straight-leg-raise test but it was positive on the left at 30 degrees with low back, buttock, and leg pain above the knee. *Px3.* We note that this is consistent with Dr. Shah's November 24, 2015, finding of a positive left-side straight-leg-raise test above the knee at 30 degrees.

Dr. Mather testified that if Petitioner had radiculopathy then his "left knee reflex would have been absent and he had a completely normal knee reflex." *Rx2 at 11.* However, contrary to Dr. Mather's statement, at the October 2, 2015 examination, Dr. Laich noted that all of Petitioner's reflexes were normal ("2"), except the left patella reflex, which was a "1."

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Dr. Mather testified that Petitioner did have a disc protrusion on the left at L4-5 but it was "very small" and "calcified" so he did not feel that it was contributing to any of Petitioner's symptoms. *Rx2 at 17.* However, we do not find Dr. Mather's opinion persuasive. The October 15, 2015 MRI report states that Petitioner had "complete effacement of the left lateral recess" at L4-5. We find that this pre-existing disc protrusion was aggravated and became symptomatic as a result of Petitioner's fall at work.

Based on all of the evidence, we find Petitioner sustained injuries to his lumbar spine at L3-4 and L4-5 as identified on the October 15, 2015 MRI.

Medical Expenses

Our decision regarding causation notwithstanding, we find it premature to determine whether the surgery recommended by Dr. Sergey Neckrysh on February 1, 2018, is reasonable, necessary, and causally related. We note that Dr. Laich had recommended an EMG/NCV on November 23, 2016, but this was not approved by insurance. *Px3.* Therefore, we award the EMG/NCV along with attendant follow up care with Dr. Laich.

We also award the following medical expenses, under Section 8(a) of the Act, subject to the fee schedule in Section 8.2 of the Act:

Dr. Laich	$ 294.00
Swedish Covenant Hospital	4,701.96
ATI	12,449.81
Academic Spine Consultants	750.00
Niles Open MRI	3,569.00
Total	$21,764.77

Temporary Total Disability (TTD)

The parties stipulated that Petitioner's average weekly wage (AWW) in the year preceding his accident was $457.00. We find Petitioner is entitled to TTD from September 19, 2015 through September 22, 2015 and October 2, 2015 through April 1, 2016. The parties stipulated that Respondent is entitled to a credit of $8,627.14 for payments already made for these periods. We find that Petitioner is entitled to an additional 6 weeks of TTD from January 3, 2017 through February 19, 2017. Respondent's restaurant closed on January 2, 2017, so Petitioner's 20-pound lifting restrictions as prescribed by Dr. Laich could not be accommodated. *Px3.* Petitioner then obtained a new job at Tiny Tavern on February 20, 2017, which ended his entitlement to TTD benefits.

The parties stipulated that Petitioner was married with three dependent children at the time of his accident. Based on Petitioner's AWW of $457.00, he is entitled to the statutory minimum temporary total disability rate of $330.00 per week. Petitioner is entitled to a total of 32-5/7 weeks of TTD (9/19/15 through 9/22/15; 10/2/15 through 4/1/16; and 1/3/17 through 2/19/17).

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Temporary Partial Disability (TPD)

We find that Petitioner is entitled to TPD benefits from April 2, 2016 through January 2, 2017. Respondent paid TPD benefits through October 21, 2016, (Rx1) and is entitled to a credit of $8,438.56 for those payments. *Rx5.*

We find Petitioner is entitled to an additional 10-3/7 weeks of TPD from October 22, 2016 through January 2, 2017, when Respondent closed the restaurant. Respondent seemed to imply at the hearing that Petitioner's reduced hours were not due to his work restrictions but, rather, because business was slowing down at Respondent. We find there is no evidence of this and Petitioner directly contradicted that claim. *T.29.* The parties stipulated to the hours that Petitioner worked during this period. *T.30; Rx4.*

We find that Petitioner earned $2,037.20 during the disputed 10-3/7 weeks, which averages to $195.34 per week. *Rx4.* Pursuant to Section 8(a) of the Act, Petitioner is entitled to two-thirds of the difference between the amount he was able to earn in the full performance of his duties (in this case calculated using his AWW) and the amount he actually earned, calculated as: ($457.00 - $195.34) x 2/3 = $174.44 per week. Therefore, Petitioner is entitled to $174.44 per week in TPD benefits for 10-3/7 weeks from October 22, 2016 through January 2, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is entitled to, and Respondent has paid, $8,627.14 for temporary total disability payments already made under §8(b) of the Act for the relevant periods through April 1, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to, and Respondent has paid, $8,438.56 for temporary partial disability benefits under §8(a) of the Act for the period from April 2, 2016 through October 21, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $174.44 per week for a period of 10-3/7 weeks, from October 22, 2016 through January 2, 2017, that being an additional period of temporary partial disability under §8(a), 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 shall pay to the Petitioner the sum of $330.00 per week for a period of 6 weeks, from January 3, 2017 through February 19, 2017, that being an additional 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 $21,764.77 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for prospective medical treatment including an EMG/NCV as prescribed by Dr. Laich, along with all attendant follow up care, 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 $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 5 - 2019

Maria E. Portela

Thomas J. Tyrrell

L. Elizabeth Coppoletti

SE/
O: 9/10/19
49

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

CORRAL, OMAR
Employee/Petitioner

Case# **15WC031299**

19IWCC0599

LEVY RESTAURANTS
Employer/Respondent

On 5/30/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5882 HERRERA LAW CENTER
JOEL HERRERA
4252 N CICERO AVE
CHICAGO, IL 60641

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Omar Corral
Employee/Petitioner

v.

Levy Restaurants
Employer/Respondent

Case # **15WC 31299**

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 **David Kane** , Arbitrator of the Commission, in the city of **Chicago**, on **May 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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, **9/18/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,777.00**; the average weekly wage was $**457.00**

On the date of accident, Petitioner was **32** 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 $**8,795.14** for TTD, $**6,856.28** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**15,651.42**.

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

ORDER

The Arbitrator finds Petitioner entitled to $330.00 per week for six weeks of temporary total disability, through October 31, 2015 only. Claim for further TTD or any TPD is denied.

Petitioner's claim for any further medical bills is denied.

Respondent shall have a credit of $13,671.42 in overpaid TTD and TPD, toward any further benefits due.

Prospective medical care including surgery 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.

David A. Kane
Signature of Arbitrator

May 30, 2018
Date

ICArbDec19(b)

MAY 30 2018

Omar Corral Hernandez v. Levy Restaurants
15 WC 31299

19IWCC0599

Statement of Facts

Petitioner was hired by Respondent as a prep cook on July 23, 2015. He worked an average of 38.58 hours per week. (Resp.Ex.#5) On September 18, 2015 while working at the Bar Toma location he slipped and fell while carrying a tray, landing on his low back. He testified he felt pain in his low back and down both legs, left worse than right. He was taken to Northwestern Memorial's emergency room, where he was examined and he testified he received an injection to the left leg. He was referred to Northwestern Corporate Health, where he was seen on three occasions and then discontinued care to seek treatment with Dr. Laich on referral from his attorney.

Petitioner first saw Dr. Laich October 2, 2015; he was taken off all work duties, sent for a MRI, and was referred to Dr. Shah for epidural steroid injections. Petitioner testified these offered only short term relief. Dr. Laich recommended surgery, which Petitioner elected not to have at the time.

Petitioner was released to light duty April 2, 2016 by Dr. Laich. He testified he continued in his cooking duties for Respondent, on his feet, but was given fewer hours by Respondent. Petitioner had in fact been released to work 18 hours per week by Dr. Laich, and was paid differential benefits by Respondent. (Resp.Ex.#1) On July 7, 2016 Dr. Laich had removed any hourly limitations on Petitioner's work and

cleared him to no lifting over 20 lbs. Petitioner By January 5, 2017, Petitioner reported to Dr. Laich he had been working full duty for Respondent until the Bar Toma location closed January 2, 2017. (Pet.Ex.#3)

Petitioner testified he worked for three to four months as a cook for the Tiny Tavern but quit when they wanted full time hours from him which he did not feel he could work. He also worked as a cook for Harry Caray's. In the fall of 2017 Petitioner began working as a driver for Lyft, which continues to date. Petitioner testified this allows him to set his own hours and work fewer as sitting is painful for him.

He continued in physical therapy until June, 2016. He decided on surgery. He last saw Dr. Laich in April, 2017 at which time the doctor told him he could no longer see him until surgery was approved.

On referral from his attorney Petitioner saw Dr. Neckrysh January 18, 2018. The doctor ordered a new MRI and prescribed low back surgery. Petitioner denied having or seeing him for neck pain.

Petitioner testified he currently has pain, it limits his activities, and he wishes to have surgery.

Northwestern's emergency room record reflects Petitioner was seen with the aid of a Spanish interpreter on September 18, 2015. The nurse's assessment reflects a history that Petitioner fell forward with left lower back pain radiating to his left thigh. The "HPI" shows a

history of fall "on back," with right sided pain down the right leg. X-rays showed disc space narrowing at L3-4. The diagnosis was "acute low back pain." (Pet.Ex.#1)

Petitioner was seen at Northwestern Corporate Health September 21, 2015 reporting continued low back pain and tingling in his left thigh which Petitioner related to an injection he had received at the hospital. Petitioner reported weakness in the left leg but admitted he had been able to "walk and do everything that he normally does, albeit with pain." The pain did not radiate down his leg. He had full range of motion, normal strength and sensation. He was diagnosed with a contusion and due to reported pain was given work restrictions of seated work with no lifting over 5 lbs.

Petitioner returned September 25, 2015 reporting continued low back pain and continued tingling in the left thigh where he had received the injection. A CT scan was ordered and he was limited to four hour work shifts. Petitioner returned September 29, advising his attorney was referring him to another doctor. (Pet.Ex.#2)

Petitioner saw Dr. Laich October 2, 2015 with a report of the fall onto his low back, with pain in his low back and a "weird sleep feeling" in his left lateral and anterior thigh. He took Petitioner off all work. A MRI was ordered. (Pet.Ex.#3)

Petitioner underwent a MRI October 15, 2015, read as showing mild disc space narrowing and degeneration with a small diffuse bulge and

effacement to the right at L3-4, mild narrowing to the left at that level, with mild disc space narrowing and degeneration with a small bulge to the left at L4-5, and degeneration at L5-S1. (Pet.Ex.#4)

Dr. Laich diagnosed herniated discs at L3-4 and L4-5. He referred Petitioner for therapy and to Dr. Shah for epidurals. Petitioner reported improvement with the first injection and that pain no longer radiated below the knee, but that he had continued low back pain, as of December 17, 2015. Petitioner reported "new" right sided pain February 4, 2016. Dr. Laich discussed low back surgery at this time. (Pet.Ex.#3)

Petitioner reported he was "much improved" with therapy and the one injection, as of March 3, 2016. Weight loss, therapy and home exercises with a goal of returning to work were discussed. (Id.)

Petitioner returned to work for Respondent April 3, 2016. He reported increased bilateral low back pain and thigh numbness but no left leg pain, "resolved even with work" and with "symptoms improved overall" per Dr. Laich's records. Weight loss was urged. Petitioner was allowed to continue working 18 hours per week. (Id.)

Petitioner reported continued low back pain, "difficult but making it." May 26, 2016. He continued on Lyrica. Naproxen was added and therapy was continued. (Id.)

By July 7, 2016 Petitioner had completed therapy. He continued on Lyrica. He had "stable" low back pain and left anterior thigh numbness. Petitioner advised that he was deferring surgery and having his restrictions made permanent. By this time he was allowed to lift up to 20 lbs. Continued weight loss was urged. (Id.)

Petitioner returned to Dr. Laich October 6, 2016 with continued low back pain, left thigh numbness, and now a "burning and needles" feeling after standing for three to five hours. He now wished surgery. A new MRI was ordered and he was directed to return to therapy. By November 23, 2016 Petitioner reported he was working full duty three days per week, based on a full duty release from an IME. Dr. Laich ordered therapy and an EMG. (Id.)

Petitioner saw Dr. Laich January 5, 2017 reporting he had been working full duty but his workplace had now closed. He was noted to be obese. He now reported low back pain radiating to his left knee. Petitioner was directed to find work within his restrictions, to continue weight loss and exercises, and to return in three months. (Id.)

Petitioner last saw Dr. Laich April 6, 2017 at which time he reported consistent low back pain to his left knee. He was noted to be working part time as a cook. Petitioner was directed to continue therapy at home and to return as needed. (Id.)

At trial Petitioner claimed Dr. Laich stopped seeing him as surgery had not been approved. Petitioner did not receive any medical care for the next nine months.

Petitioner testified he was referred to Dr. Neckrysh's office by his attorney. He saw a physician's assistant in that office on January 18, 2018. He reported a slip and fall at work back on September 18, 2015, landing on his low back and now for the first time also reporting he had hit his head. He reported left sided low back and left leg pain as well as a three month history of neck pain. A new MRI was ordered. (Pet.Ex.#7)

Petitioner was seen by Dr. Neckrysh February 1, 2018, reporting low back pain radiating down his left leg to his foot. Dr. Neckrysh reviewed the MRI as showing a herniated disc to the left at L4-5 with significant stenosis at that level, along with a bulge causing stenosis at L3-4. Dr. Neckrysh recommended a laminectomy, facetectomy and foraminotomy at those levels. (Id.)

At Respondent's request Petitioner was examined by Dr. Mather September 15, 2016. Dr. Mather was deposed on April 27 and July 20, 2017. Petitioner provided him a history of falling on his buttocks at work on September 18, 2015. At the time of Dr. Mather's exam Petitioner reported low back pain and tingling in his left thigh only. He walked without difficulty, reported pain to both sides of his low back but had normal flexion and extension, and normal strength. The left thigh numbness was in the distribution of the lateral femoral

cutaneous nerve, consistent with meralgia paraesthetica, a condition resulting from an obese abdomen overhanging and stretching the nerve. (Resp.Ex.#2)

Dr. Mather did not find any lumbar injury causing or contributing to that nerve pain. He noted a fall with landing on the low back as described by Petitioner would have resulted in damage to the L2-3 disc, which Petitioner did not have. He noted a completely normal left knee reflex, belying any lumbar cause. Petitioner had no atrophy, normal reflexes, negative straight leg raise, and only a report of increased low back pain with simultaneous hip and knee flexion which Dr. Mather could not explain at all. Dr. Mather noted similar pain reports with other maneuvers which he likewise could not explain, and noted Petitioner also reported pain when he was "not stressing the back at all." (Id.)

In reviewing the medical records Dr. Mather noted Petitioner had reported pain all the way down the left leg to Dr. Shah, however denied such to Dr. Mather. Dr. Mather reviewed the MRI himself as showing only a disc protrusion to the left at L4-5, deemed small and calcified, thus "there for years." He did not feel that in any way caused or contributed to Petitioner's symptoms. He diagnosed a lumbar strain. He cleared Petitioner to return to work full duty. He would have recommended six weeks of light duty with no lifting over 15 lbs only.

He did not find the lumbar steroid injections necessary or warranted by the American Pain Society guidelines.

Petitioner had reported to Dr. Mather ongoing Lyrica usage, taking two per day for nine months. Dr. Mather's check of the Illinois Prescription State Monitoring website showed Petitioner had not filled a prescription since June 22, 2016. The website showed Petitioner had only received 150 pills total, and not the 540 which 9 months at two per day would have represented. (Id., also Resp.Ex.#3)

He diagnosed Petitioner with a lumbar strain. (Id.)

Neither treating physician testified in this matter. Neither Dr. Laich nor Dr. Neckrysh provided a causal connection opinion relating the low back condition, need for care or need for surgery to the work injury.

Conclusions of Law

Regarding F) is Petitioner's current condition of ill being causally related to the injury, the Arbitrator finds the following:

A Petitioner bears the burden of proving every element of his claim by a preponderance of the evidence; Baldwin v. Illinois Workers' Compensation Commission, 409 Ill.App.3d 472, 949 N.E.2d 1151 (2011). It is for the arbitrator and Commission to assess credibility of the witnesses; O'Dette v. Industrial Commission, 79 Ill.2d 249, 403 N.E.2d 221 (1980); Hosteny v. Illinois Workers' Compensation Commission, 387 Ill.App.3d 665, 928 N.E.2d 474 (2009).

The Arbitrator begins by noting multiple consistencies between what Petitioner is now claiming at trial and what he provided at various points to his treating and evaluating physicians. At trial Petitioner testified to a low back injury with consistent left leg pain, unrelieved by treatment including epidural steroid injections. The earliest medical reflects report of *right leg pain* which Petitioner never testified to at trial, and left thigh numbness which Petitioner related to an injection he received at the hospital. He denied ever having any radiating pain below the left knee to Dr. Mather, although reported such to Dr. Shah. He reported he was "much improved" from injections to Dr. Laich. He told Dr. Mather he had been taking two Lyrica per day for nine months as of his exam September 15, 2016, yet had only received 150 pills and had last filled a monthly prescription in June of that year. He denied hitting his head to the emergency room, to Dr. Laich and to Dr. Shah, yet reported such to Dr. Neckrysh's office along with neck pain he denied at trial.

A claimant must produce competent evidence of objective conditions and that the work accident caused the condition and disability. While medical testimony as to causation is not necessarily required, where the question is within the knowledge of experts that testimony is required to show the claimant's injury caused the condition complained of; Nunn v. Industrial Commission, 157 Ill.App.3d 470 (1987).

Dr. Laich found pathology at L3-4 and L4-5 for which he ordered surgery, without ever opining such was caused or aggravated by the fall at work. Petitioner claimed the doctor stopped seeing him in April, 2017 as that surgery had not been approved, however the doctor's records reflect Petitioner was actually stable at that time, and being discharged to follow up as needed. Petitioner did not return to Dr. Laich and did not seek further medical care for over nine months.

Dr. Neckrysh made findings of worsening pathology at L3-4 and L4-5, without opining such was work related or explaining the change in pathology between the first and second MRI's.

Dr. Mather was the only physician who testified in this matter and the only physician who addressed what Petitioner's work injury was. His exam was negative for more than a low back strain. He related Petitioner's left thigh numbness complaint to obesity, which had been consistently noted by Dr. Laich and which was completely unrelated to any work injury. He reviewed the MRI as showing non operable, pre-existing pathology unrelated to the fall at work.

For the foregoing reasons the Arbitrator finds Petitioner sustained a low back strain only.

Regarding J) were the medical services provided to Petitioner reasonable and necessary, the Arbitrator finds the following:

At trial Petitioner sought payment of Dr. Laich's charges of January 5 and April 6, 2017, Swedish Covenant for physical therapy and injections January through June, 2016, ATI for physical therapy April 12 through June 13, 2017, Academic Spine for Dr. Neckrysh's charges in January and February, 2018 and Niles Open MRI for the testing ordered by Dr. Neckrysh January 23, 2018.

Having relied upon Dr. Mather's findings and conclusions, which included that Petitioner had suffered a low back strain, did not require injections and was at maximum medical improvement by the time of his exam September 15, 2016, Respondent's liability for these charges is denied.

Regarding K) prospective medical, the Arbitrator finds the following:

Prospective medical care including surgery is denied.

Regarding L) what temporary total and temporary partial pay is due, the Arbitrator finds the following:

At trial Petitioner sought award of temporary total disability for periods September 19 – 22, 2015, October 2, 2015 – April 1, 2016, and January 3 – February 19, 2017 for a total of 33 3/7's weeks. Petitioner first received light duty restrictions from Northwestern Corporate Health September 21, 2015 and was not taken off work duties until October 2, 2015. He was released to light duty April 1,

2016, effective April 2, 2016 and per his testimony returned to work light duty for Respondent. Dr. Mather had opined Petitioner would only have required work restrictions for a period of six weeks following the work injury of September 18, 2015, thus through approximately October 31, 2015. Petitioner is therefore awarded six weeks of temporary total disability.

Petitioner also sought award of temporary partial pay for a period of April 2, 2016 through January 2, 2017. Having found Petitioner capable of full duty by that time, in reliance on Dr. Mather's opinions, no temporary partial pay is due.

Regarding N) what credit is due Respondent, the Arbitrator finds the following:

Petitioner is found entitled to $330.00 (the applicable minimum rate) in TTD for six weeks, thus $1,980.00. Respondent paid a total of $15,651.42 in temporary partial and temporary total disability to Petitioner (Resp.Ex.#1). Respondent therefore has a credit of $13,671.42 toward any further benefits found due.

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)
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pamela Frasco,

Petitioner,

vs. NO: 15 WC 8076

Cook County Clerk of the Circuit Court,

Respondent.

19IWCC0600

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice provided to all parties, the Commission, after considering the issues of temporary total disability benefits, medical benefits, penalties and attorneys' fees and being advised of the facts and the law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof with changes noted 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 (1980).

Temporary Total Disability Benefits

"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). The Commission notes both Dr. Moss and Dr. Cole agreed Petitioner required additional surgery. Therefore, Petitioner's condition has not stabilized, and she has not reached maximum medical improvement. The

Commission affirms the Arbitrator's finding that Respondent is liable for temporary total disability benefits from February 11, 2015 through August 21, 2018, the date of the arbitration hearing, a period of 184 weeks. The Commission strikes the language ordering Respondent to pay an underpayment of $3,429.95 from February 11, 2015 through June 12, 2018 and June 13, 2018 through August 21, 2018, as this language is redundant. The Commission strikes the language on page 22 and page 28 of the Decision awarding ongoing temporary total disability benefits past the date of arbitration. See *Weyer v. Illinois Workers' Compensation Commission*, 387 Ill. App. 3d 297, 307, 900 N.E.2d 360 (2008) citing *R.D. Masonry, Inc.*, 215 Ill. 2d at 408. ("Each section 19(b) proceeding is a separate and proceeding, limited to a determination of temporary total disability up to the date of hearing, and each 19(b) decision is a separate and appealable order"). This case is remanded to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation. The Commission affirms the credit to Respondent for $118,230.60 paid in temporary total disability benefits.

Medical Benefits

The Commission affirms the Arbitrator's finding that the medical services provided to Petitioner were reasonable, necessary and causally related to the February 10, 2015 accidental injury and Respondent is liable for same. The parties stipulated Respondent paid $77,042.93 in medical expenses, and Respondent is entitled to credit for that amount.

Prospective Medical Care

The Commission strikes the language on page 22 of the Decision ordering Respondent to immediately authorize the second opinion prescribed by treating Dr. Moss. The Commission notes at oral arguments the parties stipulated Petitioner underwent the right knee surgery previously recommended by Dr. Cole.

Penalties and Attorneys' Fees

The Commission finds the offer of light-duty work was not a valid job offer as it failed to accommodate all of Petitioner's restrictions. Dr. Cole released Petitioner to a seated job and further stated "There would need to be some provision to get her to and from a desk job without a lot of walking in order to do this safely and realistically. I do not know if it is realistic for her to conduct the duties of a desk job with her continued narcotic use as ideally she would be off narcotics in the workplace." RX1. Mr. Ringfelt testified an accommodation could be made for sedentary work only. T.152. Moreover, Mr. Ringfelt testified Petitioner would not be allowed to return to work if she used narcotic medication (T. 161) which is consistent with Dr. Cole's opinion. The Commission notes despite not being accommodated, Petitioner attempted to return to work on July 3, 2018, but was unable to do so as her reinstatement documents had not been processed by Respondent. T. 160. The Commission also notes temporary total disability benefits were paid only through June 12, 2018 despite the fact a job-offer, valid or not, was not extended until July 3, 2018.

As such, the Commission affirms the Arbitrator's awarding of penalties pursuant to Sections 19(l) and (k) of the Act and attorneys' fees pursuant to Section 16.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's October 11, 2018 decision is affirmed with changes stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $699.20 per week for a period of 184 weeks, representing February 11, 2015 through August 21, 2018, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable, necessary and causally related medical expenses pursuant to §8(a) of the Act and subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for prospective medical care including, but not limited to, right knee surgery recommended by Dr. Cole, pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $3,496.00 as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $2,100.00 as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for Petitioner legal fees in the amount of $1,119.20 as provided in §16 of the Act; the balance of attorneys' fees to be paid by Petitioner to her attorney.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $118,230.60 in temporary total disability benefits and $77,042.93 in medical expenses.

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

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

There is no bond for removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 6 - 2019
LEC/maw
o09/11/19
43

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Stephen J. Mathis
Stephen J. Mathis

D. Douglas McCarthy
D. Douglas McCarthy

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

FRASCO, PAMELA
Employee/Petitioner

Case# **15WC008076**

COOK COUNTY CLERK OF THE CIRCUIT COURT
Employer/Respondent

19IWCC0600

On 10/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4703 LAW OFFICE OF SCOTT B SHAPIRO
218 N JEFFERSON ST
SUITE 401
CHICAGO, IL 60661

0132 COOK COUNTY STATE'S ATTORNEY
MARRENA VANHORN
500 RICHARD J DALEY CENTER
CHICAGO, IL 60602

19IWCC0600

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)

PAMELA FRASCO,
Employee/Petitioner

v.

COOK COUNTY CLERK OF THE CIRCUIT COURT,
Employer/Respondent

Case # **15** WC **8076**

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 **August 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Return to work, light duty, unpaid TTD, unpaid medical benefits**

FINDINGS

On the date of accident, **February 10, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**54,537.60**; the average weekly wage was $**1,048.80**.

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

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

Respondent shall be given a credit of $**118,230.86** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**118,230.86**.

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

ORDER:

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent stipulated on the record that it has paid all known reasonable and necessary medical bills and shall further pay any and all unpaid medical bills submitted by Petitioner as found in its exhibits admitted into evidence at trial.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**699.20**/week for a period of **184** weeks, commencing **February 11, 2015** through **August 21, 2018**, date of hearing, as provided in Section 8(b) of the Act. Respondent shall be liable for continuing and ongoing temporary total disability benefits subsequent to the date of hearing as Petitioner has not reached MMI and is completely unable to work. Respondent shall be awarded credit of $**118,230.86** for paid temporary total disability benefits for the period of February 11, 2015 through June 12, 2018. Respondent shall pay Petitioner additional underpaid TTD to Petitioner for the period of February 11, 2015 through June 12, 2018 being a total of $3,429.94. Respondent shall further pay Petitioner the sum of $6,992.00 in unpaid TTD benefits, for the period of June 13, 2018 through August 21, 2018 or 10 weeks.

Penalties

Respondent shall pay to Petitioner penalties of $**1,119.20** as provided in Section 16 of the Act; $**3,496.00**, as provided in Section 19(k) of the Act; and $**2,100.00**, as provided in Section 19(l) of the Act.

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

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

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

Robert M. Harris

Signature of Arbitrator

October 11, 2018

ICArbDec19(b)

OCT 11 2018

MEMORANDUM OF DECISION OF ARBITRATOR

PAMELA FRASCO v. COOK COUNTY CLERK OF THE CIRCUIT COURT
IWCC No.: 15 WC 8076

STATEMENT OF FACTS

Petitioner, Pamela Frasco (hereinafter "Petitioner"), worked at the Maywood courthouse in Maywood, Illinois, as a court room clerk for Respondent, Cook County Circuit (hereinafter "Respondent"). Petitioner testified on February 10, 2015 she was in her normal state of health (T p. 20). Petitioner did not have any prior medical issues, in particular did not have any issues with her right leg or her lower back. (T p. 21) Petitioner lived approximately 5 minutes from the Maywood courthouse, and this was her usual and customary work location for approximately 19 years. (T pp. 21- 22).

Petitioner testified that on February 10, 2018, at approximately 11:30 a.m., she was performing her normal duties in courtroom 103 as a court clerk on the bench next to the judge. Petitioner was administering orders and paperwork to attorneys after the judge provides his orders and passes them to her. Petitioner testified she went to step down to go to the front of the court room. While stepping down the stair from the bench, Petitioner's heel became caught in the open hole at the base of the flagpole, causing her to fall to the ground. (T p. 22, PX 15). Petitioner testified that immediately after she fell, she suffered a cut on her head, cuts on her legs, and she could not stand up due to the pain in her right knee and low back. The Sheriff helped her get up and assisted her to a chair. Petitioner noticed immediate swelling in her right knee. (T p. 26). Petitioner testified by that evening the pain in her low back became much worse (T p. 27).

After her fall, the Sheriff took Petitioner upstairs in a wheelchair, and she reported her accident to the clerk's office. The Sheriffs took an immediate statement and completed an accident report, along with having Petitioner sign a medical request release form. After completing the

accident report, Petitioner called a friend to come and pick her up. (T pp. 27-28, PX 12).

Petitioner testified her friend picked her up from the accident location and she went immediately to Gottlieb Memorial Hospital emergency room. (T p. 30). At Gottlieb Memorial emergency room the attending physicians took X-rays, administered pain medication, and performed a CT scan. The emergency room physicians advised Petitioner to remain off work until she followed with an orthopedic surgeon, and referred her for an orthopedic consultation with Dr. Ryon Hennessy. (Tp. 31, PX 1 and 11).

Petitioner first saw Dr. Hennessy on February 13, 2015. Dr. Hennessy authorized Petitioner to remain off work at that time. (T p. 31, PX 1). Dr. Hennessy prescribed an MRI for her right knee and low back, physical therapy, and pain medication. Petitioner continued to treat with doctor Hennessy who eventually prescribed a total knee replacement surgery for her right knee. (T pp. 30-33). Respondent delayed the surgery and sent Petitioner for a Section 12 examination ("IME") Dr. Brian Cole at Midwest Orthopedics at Rush. This examination took place on April 13, 2015.

After Petitioner attended the IME she returned to see Dr. Hennessy. Due to the continued pain in Petitioner's low back, Dr. Hennessy prescribed an MRI and EMG. (PX 1). Dr. Hennessy again prescribed surgery on or about August 3, 2015. Dr. Hennessy again recommended a total knee replacement. (T p. 34, PX 1). Respondent, however, citing Dr. Cole's opinion, would only authorize injections and arthroscopic surgery.

Thereafter, Petitioner sought a second opinion with Dr. Brian Moss. Petitioner first saw Dr. Moss on August 10, 2015. (T p. 35). Dr. Moss concurred with Dr. Hennessy and prescribed a total knee replacement. Again, however, Respondent denied the prescribed surgery because the IME recommended, prior to the surgery being performed, cortisone injections. (T p. 37). Despite Dr. Moss's prescription for surgery, Respondent required Dr. Moss to only follow Dr. Cole's

opinion regarding medical treatment. During this time Dr. Moss continued to restrict Petitioner completely from work. (PX 3). Petitioner continued to remain off work throughout the course of injections, and physical therapy at ATI Physical Therapy.

Due to Petitioner's low back pain, Dr. Moss referred Petitioner to a Dr. Sajaad Murtaza, a pain management specialist. (PX 5). Dr. Moss also prescribed and referred Petitioner for an examination with an orthopedic back surgeon, Dr. Avi Bernstein. Both Dr. Murtaza and Dr. Bernstein related Petitioner's low back injuries to her work-related accident. (PX 5 and 8).

Petitioner continued to have pain in her low back and more significantly in her right knee. Dr. Moss prescribed surgery again. Respondent, in response, obtained another IME with Dr. Cole on November 14, 2016. (T pp. 37-39, RX 1). In the meantime, Dr. Moss ordered Petitioner to remain restricted completely from work. (T p. 39-40). Respondent continued to pay temporary total disability benefits.

Eventually, Petitioner underwent her first knee surgery June 6, 2016. Subsequent to the surgery Petitioner developed serious postsurgical complications. Petitioner developed blood clots and scar tissue adhesions. (PX 8). Due to the scar tissue adhesions and blood clots Petitioner underwent cortisone injections in August of 2016, as well as manipulation of the knee under sedation with Dr. Moss. Due to the blood clots she sought medical attention at Rush Copley Emergency Room and was required to follow up with her family physicians in order to monitor the clotting and provide medications. (T pp. 45-46, PX 8).

In November 2017, Respondent obtained yet another IME with Dr. Cole, at which time Dr. Cole recommended further care, but advised Petitioner she could work "sedentary duty." Despite Dr. Moss's recommendation Petitioner remain totally off work, Petitioner reported to work because Respondent terminated TTD benefits. Respondent advised and allowed Petitioner to

report to the Maywood courthouse. Petitioner presented for work at that time, signed in and was placed at a desk. Petitioner testified despite the sedentary work, her knee swelled so large that she could barely even move it. Petitioner then reported to her supervisor's office who looked at her leg, and agreed she was in too much pain and advised her to go home. (T p. 41). Respondent then resumed paying temporary total disability benefits. Petitioner testified she returned to see Dr. Moss after her attempted return to work in November 2016. Dr. Moss again completely restricted Petitioner from any work, and again recommended the knee replacement that he and Dr. Hennessy had previously prescribed. (T pp. 41-42).

Eventually, Respondent authorized the total knee replacement which Petitioner's treating physicians and Dr. Cole recommended. Petitioner underwent the total knee replacement July 18, 2017. (T p. 47, PX 3, RX 1). Subsequent to her total knee replacement Dr. Moss continued to restrict Petitioner completely from work. Respondent continued to pay bi-weekly TTD benefits during this time in the amount $699.60 per week. (T p. 48, RX 3).

Petitioner again developed complications and Dr. Moss prescribed another knee surgery. Respondent yet again obtained another IME with Dr. Cole in November 2017 (RX 1).

Respondent also obtained an IME with Dr. Howard Konowitz, a pain management specialist, which took place on February 28, 2018, due to Petitioner's continued use of narcotic pain medications. Petitioner continued taking medications for her blood clot issue at that time. (RX 2). Both Dr. Konowitz and Dr. Cole concurred that Petitioner needed to continue the use of pain medications. (RX 1, 2). Dr. Konowitz opined the use of pain medications was reasonable, necessary, and related to Petitioner's work-related accident. Dr. Konowitz opined that although the use of these pain medications was not ideal, it was necessary until her knee condition could be addressed further orthopedically.

Thereafter, Respondent obtained yet another, third IME with Dr. Cole on May 7, 2018. (T pp. 37-39, RX 1). Dr. Cole agreed with Dr. Moss. (T p. 50, RX 1). Dr. Cole recommended a specific surgery, an arthroscopic lysis of adhesions, manipulation under anesthesia, and a posterior capsular release and a suprapatellar pouch release. (RX 1). Dr. Cole also opined Petitioner could return to work in a "sedentary" capacity; however, Dr. Cole specifically stated Petitioner required the use of continued narcotic pain medication. Regarding Petitioner's work ability, Dr. Cole opined "she is capable of a seated job only given her level of stiffness and difficulty ambulating today." Dr. Cole specifically opined, under Number 12, on page 3 of his report that Petitioner was capable of only seated work given her level of pain, stiffness, and difficulty ambulating. Dr. Cole opined Petitioner required accommodations to get her to and from a desk job with minimal walking in order to work safely and realistically. (RX 1). Dr. Cole did not believe it was realistic for Petitioner to work with the continued use of narcotic medications, and this was also a safety concern in the work place. Petitioner testified that she has "huge" problems ambulating at all. (T p. 44).

Petitioner also provided testimony regarding Dr. Cole's examination. Petitioner testified Dr. Cole also advised her that she would require a certain type of specialist to address her knee condition. (T p. 140).

After seeing Dr. Cole, Petitioner returned to Dr. Moss. Dr. Moss continued to restrict or completely take Petitioner off work. Petitioner testified Dr. Moss also reviewed the IME report from Dr. Cole. (T p. 51). Dr. Moss stated the specific surgery Dr. Cole recommended was something outside of Dr. Moss's scope of practice, and therefore Dr. Moss referred Petitioner for a second opinion to review said surgical recommendations. (RX 10, 3, T pp. 51-52).

After the May 7, 2018, IME Petitioner testified that she did not receive any formal notice

from Respondent to return to work. Petitioner testified she also did not receive any payment from workers' compensation until approximately May 29, 2018 when she was paid $3,495.00, which was TTD withheld by Respondent after the IME report was issued. Petitioner testified after May 29, 2018 she did not receive any further payment. Petitioner also testified she did not receive any contact from her employer to return to work during that time period. (T pp. 55-58.).

Petitioner testified that on June 19, 2018 she was contacted by her attorney who informed Petitioner he received a request from Respondent that she report to work on the 9th floor of 50 W. Washington, the Richard J. Daley Center. Respondent made this request despite her treating physician's continued authorization to remain off work. Respondent made no mention of any specific job accommodations it would make, and repeatedly just stated to Petitioner's attorney that she had to report to that location. (T. pp. 55-57, PX 4, RX 10, 13). After receiving the instruction to return to work, Petitioner began contacting Respondent's Human Resources to determine what if any accommodations would be made for her due to her inability to ambulate, as stated by her treating physician and Dr. Cole. (T pp. 58 – 61, RX 6).

Due to her concern in attempting to return to work, Petitioner testified she first contacted Jim D'Archangelis who works for Respondent's Human Resources department. D'Archangelis spoke to her on June 20, 2018 at approximately 10:00 a.m. (T. pp. 58-61). Petitioner spoke to him by telephone. Petitioner informed him that no one directly from the County had contacted her, she was reporting to work because she was not receiving any pay and was advised to report to work at 50 W. Washington. Petitioner testified D'Archangelis had no knowledge of her situation whatsoever. He instructed Petitioner to contact Labor Relations. (T pp. 60-62). On June 21, 2018, Petitioner testified she called D 'Archangelis again because Respondent's representatives still had not contacted her to advise what if any accommodations would be made per Dr. Cole's opinion.

D'Archangelis stated that he would send out an email right away and did not provide her any further instructions. (T 62, RX 6). He instructed Petitioner someone would get back to her; however, she testified nobody contacted her again at that time. (T pp. 63-65).

After speaking to D'Archangelis, and not receiving any responses, Petitioner called Mike Mikula, who was the head of labor relations. Petitioner contacted Mikula because she did not receive any response from Respondent as to how she was to attempt to go to work and what accommodations were going to be made for her. Upon speaking with Mikula, he also stated he did not have any instructions or any knowledge of her situation. Mikula did not offer any instructions with regard to her return to work. (T. pp. 66-67). Petitioner was advised to speak to Lauren Raymond. After speaking to Mikula, Petitioner, tried to speak to Raymond. Petitioner testified she did not know what Raymond's position was, however Mikula told her to contact Raymond so she did so. (T. pp. 66-67). Petitioner attempted to contact Raymond on Monday, June 25, 2018. Petitioner called her office and was told she was unavailable but left a message. Raymond did not call Petitioner back. The next day, June 26, 2018, Petitioner called Raymond twice. (T pp. 68-72). Petitioner again did not receive a call back and she called again that day. Petitioner insisted on speaking to Raymond and spoke to a secretary who took down her name and number and had Petitioner leave another voicemail message. (T pp. 68-70).

On Wednesday June 27, 2018, at approximately 10:30 a.m., Petitioner testified she finally received a call back from Raymond. Raymond contacted her and asked what she wanted and Petitioner stated that she had been trying to attempt to return to work and needed to know what if any accommodations were going to be made. Petitioner questioned what and where she was supposed to report to work, and what type of job she was being provided. Petitioner advised she was quite concerned about going to the Daley Center due to her inability to ambulate. (T pp. 69-

72). Petitioner testified Raymond responded that she also knew absolutely nothing about what Petitioner was telling her and stated she did not want to talk to Petitioner at all. Raymond instructed Petitioner to talk to her attorney. Raymond did not offer any information regarding a return to work or accommodations to be made. Petitioner testified she informed Raymond despite her treating physician keeping her off work, she was following instructions of Dr. Cole and her employer. Petitioner again expressed concerns about her inability to ambulate. Petitioner testified she informed Raymond she was also taking oxycodone and Norco at the time. Both medications were authorized and found to be reasonable by both IMEs. The conversation ended at that time.

Thereafter, Raymond contacted Petitioner again on the same day. Petitioner testified that Raymond apologized for being rude in their prior conversation and discussed accommodations, and admitted she knew nothing about any of the accommodations which were supposed to be provided. (T pp. 72-75). Petitioner informed her that getting to the Daley Center was almost impossible because she was unable to walk any distances. Petitioner explained to Raymond that it is very difficult for her to move around. Petitioner testified that in her second conversation with Raymond, Raymond asked where she worked and Petitioner explained to her that she worked at the Maywood location for 20 years. (T pp. 73-74). Raymond informed Petitioner that she had the power to reinstate her at the Maywood location remotely, that Petitioner did not have to report to the Daley Center as instructed by Respondent previously. Raymond and Petitioner agreed Petitioner would report to work on July 3, 2018, because she had therapy and a doctor's appointment with Dr. Moss prior to July 3, 2018.

Raymond explained she would send reinstatement paperwork to the agreed work location before July 3, 2018. Petitioner reminded Raymond and advised of her concerns in reporting because the same situation occurred one year ago, the return to work failed because of her knee

condition, and that her knee was far worse at this point. (T p. 76).

Despite this Petitioner's treating physician stating she should remain off work, and due to her financial situation, Petitioner made a good theft faith effort to return to work on Tuesday, July 3, 2018. Petitioner reported to the clerk's office at the Maywood court house on said date. (T pp. 73-76). Petitioner testified she swiped in with her security card and reported to her supervisor Richard Ringfelt. Upon presenting to Ringfelt's office, Petitioner testified Ringfelt had no idea why she was there, had not received any notice she would be reporting for work, and that he could not reassign her to any position at all without the reinstatement paperwork. (T pp. 77-78). Petitioner informed Ringfelt about the conversation with Raymond, when Raymond instructed her to report to work on July 3, 2018 and advised the reinstatement paperwork would be there and she was sending the documents the previous Friday. (T pp. 77-78). Petitioner testified after swiping in at approximately 8:30 a.m., she eventually saw Ringfelt. Petitioner testified she sat in his office and talked with him. By 10:00 a.m. no reinstatement paperwork had arrived.

Petitioner testified her physical condition on July 3, 2018 was "terrible." (T pp. 77-79). Petitioner testified she was, and is, in a great deal of pain on a daily basis, and the pain is chronic all day and all night. Petitioner testified that her pain extended from her tailbone down throughout her right leg all the way to her toes on her right foot. (T pp. 79-83). On July 3, 2018, Petitioner's right knee was extremely painful and continued to swell while she was waiting at her employer's office. Petitioner testified the only way to relieve the pain at that point is too elevate her leg, take the prescribed narcotics, and put ice on her leg. Petitioner testified that she has to also frequently change positions. (T pp. 79-80). Petitioner testified that she tried ice packs, pain patches and has become addicted to pain medications. (T p. 80-81). Due to her pain, Petitioner testified that she signed out at 10 o'clock requesting sick pay.

Petitioner further testified between July 3, 2018, and the date of trial, she still had not received any pay. Petitioner testified her pain and condition had become much worse. Where she used to be able to perform limited bending with her knee, now she could now barely bend her knee at all. (T pp. 80-81). Petitioner testified that her physical condition declined greatly and she received no pay from workers' compensation other than the check that was issued to her for $3,495.00 in the end of May, although she did receive pay from her employer for one half hours for reporting to work on July 3, 2018. Petitioner also testified she was still waiting to have the prescribed surgery. Petitioner was following the instructions of all treating physician and Dr. Cole. Dr. Moss could not perform specific surgery Dr. Cole had recommended. Petitioner testified she was actively seeking surgeons to be able to perform the complex surgery as recommended to her by her treating physicians and Dr. Cole. (T pp. 80-85).

On cross-examination Petitioner testified she uses a cane or sometimes a walker when needed. Petitioner testified she takes it with her to certain locations or if she is afraid she may have to walk any great distances, an activity she avoids at all costs. Petitioner testified when she presented to the Commission for trial, she only used a cane because her friend dropped her off outside the front door. Petitioner testified the cane alleviates the pressure on her right side, and allows her to be less weight bearing on her right side. Petitioner testified that she is able to drive a car, although there were periods of time where she was unable to drive. (T pp. 87-89). Specifically, she did not drive after her knee replacement and the other surgeries to her leg. Petitioner also testified that does not use public transportation and in order for her to report to work on a daily basis she would require transportation. (T pp. 90-96). Petitioner testified when she does drive it is usually to Jewel to get food which is right around the corner from her home. Petitioner testified when she does drive she makes sure she does not take any pain medication. She also drives to

physical therapy, but she does not take pain medications prior to driving to physical therapy. (T pp. 90-100). She takes narcotics every day but she tries not to take them and tries to replace the narcotics with laying on the couch with her leg up with an ice pack. She does this about 10:30 a.m. At about 1 p.m. everyday she puts heat on her leg as well to try to stay away from as much oxycodone and Norco as possible because she feels she's addicted. Petitioner said that 85% week she spends at home. Petitioner testified she also has increased pain in her back and it is difficult for her to bend and she tries to keep it loose by bending as much as possible. (T pp. 100-102).

Upon presenting to Ringfelt's office on July 3 Petitioner presented him with her restrictions to make sure he knew what her restrictions were and what accommodations were required. He took a copy of the restrictions. (T pp. 108-109, RX 10). Petitioner provided Ringfelt with her restrictions to remain off work, and her condition was worse than last time she attempted to return to work at Respondent's request in 2017. (T p. 110).

Respondent asked Petitioner whether she was familiar with a Request For Return From A Leave Of Absence form, Respondent's Exhibit #11. Petitioner testified she was not familiar with that form. Respondent asked if Petitioner if she provided the form to Ringfelt. Petitioner said that she did not and could not because she had never seen that document before trial.

Petitioner testified that she was unable to work once she reported because there was no reinstatement paperwork and her supervisor informed her he could not give her job until she was reinstated back to work with that documentation. Petitioner again admitted that she left at approximately 10:00 a.m., because she had to take pain medications and was in a great deal of pain at that time. (T pp. 114- 120).

Petitioner testified the reason she did not drive a car often was because her use opioids and narcotics on a daily basis makes her very impaired. (T pp. 124 -126). Upon questioning by the

Arbitrator, Petitioner testified she cut back on her pain medications as best she could, and has always followed treating physicians' prescriptions for medication and mobility.

Petitioner again testified she was never informed of the type of job she was to report to, only to report to the Daley Center. She received no information in terms of what type of job she was being assigned. Petitioner's employer did not inform her of where to park or if there would be any accommodations due to her limited ability to walk and ambulate. Petitioner's attorney on multiple occasions, via email, also requested Respondent advise as to what type of accommodations would be made per Dr. Cole's recommendations, and also advised despite said recommendations, Dr. Moss continued to restrict Petitioner completely from work. (T pp. 29-132, RX 6).

Petitioner contacted D'Archangelis because she was not provided with any information or documentation as to any accommodations to assist her limited walking ability. Petitioner testified she contacted him because it was her understanding he was one of the directors of Human Resources. (T pp. 131-133). Petitioner was very concerned regarding her ability to ambulate between any potential parking facilities to the Daily Center at 50 W. Washington. (T pp. 133-134). Specifically, if she drove, there is no parking anywhere near the Daily Center, that would limit her need walk. Respondent's representatives again provided no answers as to how she could limit her walking as Dr. Cole prescribed. (T pp. 133-134).

Petitioner continued her requests for information and accommodations to Raymond of Human Resources. Petitioner testified Raymond had no idea where she worked. Raymond had no idea what was Petitioner's actual position. Raymond also confirmed Petitioner should report directly to Maywood. Petitioner still had no idea how she was going to ambulate herself from the door to the alleged sedentary positions. Petitioner testified she was afraid not to report to work

because she did not want lose her job, Respondent terminated her TTD benefits and would not release her sick pay or vacation pay. Petitioner testified as of May 29, 2018, after a pretrial had been conducted that there was an agreement TTD benefits would be paid and she only received back pay. She had not been paid for any time in June. Petitioner testified prior to her continued attempts to reach Respondent's representatives, and prior to her conversation with Raymond she had not received any other contact from her employer regarding sedentary work or any offers regarding light-duty. (T pp. 138-140).

Respondent called Richard Ringfelt as a witness, who is Respondent's chief deputy clerk. His duties were to oversee the day-to-day operations and is the manager of approximately 60 employees. (T pp. 143). Ringfelt testified he was familiar with the status form from her treating doctor, Dr. Moss. (See, RX 10). Ringfelt testified it stated she should not be working, and specifically should not be working while on narcotics or driving while on narcotics. (T pp. 146-147). Ringfelt also testified the work status form stated unable to work pending surgery. (T pp. 147-148). Ringfelt would normally pass this type of document along to Labor Relations and Human Resources who would direct him what to do and he passed the work status form along via email or fax to Raymond. Petitioner's knee was swollen at the time and Petitioner advised him she was going to have to take medication but did not want to take that medication at work. (T pp. 150). Ringfelt testified prior to her presenting to his office that day he was unaware of any of her restrictions, or of her work status at all. Ringfelt also testified the reinstatement form listed Petitioner's restrictions as sedentary work only, and this document was sent to him Lauren Raymond (T p. 152; RX 11). He testified this document arrived at his office at approximately 10:15 a.m., on July 3, 2018, but was unsure of the exact time, or how he received it. By the time he received the document, Petitioner had already signed out from work due to pain.

Ringfelt confirmed Petitioner's position as a Circuit Court clerk would fall under his purview. He confirmed Petitioner signed in at approximately 8:30 a.m. on July 3, 2018. He admitted that he takes all his directives regarding people returning to work from Human Resources and from Labor Relations. He admitted nobody from Labor Relations or Human Resource ever contacted him regarding Petitioner's return to work or regarding the restrictions, nor had anyone advised him of any accommodations she required. He testified that Respondent's Exhibit #11, the Request For Return From A Leave of Absence form, was necessary for him to reinstate an employee to return to work. He admitted Human Resources and Labor Relations would have to reinstate her and that he would follow their directive contained on the form. Ringfelt admitted he did not receive this document until later in the day on July 3, 2018 and could not provide Petitioner with any work until the form was received. (T pp. 156-158). He confirmed that he had no reason at all to disbelieve Petitioner's work abilities and need for accommodations, and did not doubt the veracity of her complaints. He testified that between the time she checked in to work, at approximately checked into work 8:30 a.m., and the time she checked out at approximately 10:00 a.m., there was nothing for her to do. (T pp. 156-158). He testified that she signed out due to being in a great deal of pain, which he also confirmed he believed. He further admitted that he does not allow employees to knowingly attend work while on narcotics. (T p. 161). He admitted it is against the County's regulations. The Arbitrator questioned Ringfelt regarding the patient's status forms and return to work forms. (T pp. 161-165). Ringfelt was unclear as to the timing of the receipt of all of the forms and how he could have provided the form to Raymond or how Raymond could have provided her sedentary return to work instruction, as he had only received it from Petitioner the morning of July 3, 2018. He was not sure as to the timing of the receipt of Respondent's Exhibit #10 or Respondent's Exhibit #12. He testified that he sent the work status

form to Raymond later on in the day.

Respondent called Lauren Raymond as a witness. Raymond is Chief Deputy General Counsel for Human Resources (T p. 166). She testified her job is to coordinate all litigation for the County Clerk's office, and she is responsible for administering leaves of absence and providing counsel on employment and labor matters and reinstating employees. Raymond testified she was familiar with Petitioner and vaguely recalled on June 21, 2018, at approximately 11:47 a.m., she was contacted to forward a request to return to work document regarding Petitioner. Raymond stated she was unsure whether she received this request. (T p. 167). Raymond testified on June 27, 2018, she received a telephone call from Petitioner. Petitioner stated to her that she had "some mobility issues and that she would need to be seated and she had some problems as it relates to mobility." (T p. 169). Raymond testified that she told Petitioner she had not seen all her restrictions, only what Risk Management gave her, which was portions of a medical report, and based on what she saw, she could accommodate her and to report to work. (T p. 169). She confirmed Petitioner expressed concern to her regarding her restrictions and accommodations to be made. Petitioner advised her that going to the Daily Center would be very difficult due to her inability to walk. (T p. 169). Raymond then testified she advised Petitioner she could just report directly to "District 4," the Maywood courthouse, and she would reinstate her remotely. Raymond said this is normally outside of their practice but she was willing to do it in this particular case. (T pp.167-170). Raymond testified that she believed the conversation took place on Wednesday. She inquired whether petitioner would report to work, and due to doctors' appointments it was agreed that she would report to work on July 3, 2018, in Maywood. Raymond did discuss Petitioner's situation with Ringfelt as he was in charge of all the Maywood employees. She contacted Ringfelt and had numerous conversations with him regarding Petitioner.

Raymond testified she told Ringfelt to expect Petitioner to return to work, had reviewed her restrictions, and to expect documentation to be sent regarding Petitioner's return to work. (T pp. 172-178). Ringfelt denied ever having any knowledge of Petitioner's return to work. Raymond confirmed subsequently Ringfelt emailed and called her regarding Petitioner on July 3, 2018. By the time she returned his call Petitioner had already left work. (T pp. 173 -176) Raymond testified she is not familiar with independent medical examination reports or treating physician reports so she was unaware there was more than one medical report. She again confirmed that she based her filling out the Return to Work From Leave of Absence form, Respondent's Ex. # 11, on a portion of the IME report, and from a conversation with someone in Michael McFarland, who is not in risk management. (T pp. 175-177).

Raymond agreed she was in charge of administering employees return to work in determining whether or not accommodations could be made for people were injured and otherwise disabled. (Tp. 179). She agreed it was important to know a person's job duties in order to return people to work. She agreed despite the importance of job duties, she did not know Petitioner's job duties. (T pp. 180-181). She agreed she did not know Petitioner's job title. She agreed she would also confirm with her superior prior to making a decision about whether a person could be reinstated or not. She testified it was important to know a person's job duties to return a person to work, and to know their restrictions, and it was reasonable for a person attempting to return to work to contact various people in Human Resources to determine what accommodations were being made. (T pp. 178-183). Raymond could not recall whether or not she had spoken to her on June 27, 2018, or another day. She agreed she could not remember whether or not she was ever contacted to buy Mr. Ringfelt prior to June 27, 2018. (T pp. 187-189). She agreed she was unable to recall whether or not she was emailed or otherwise contacted by Petitioner in the days preceding

June 27, 2018. (T pp. 185-189). She was not sure she received any voicemails from Petitioner, and further testified she did not feel is important to listen to her voicemails from people attempting to return to work. (T pp. 182-185). Raymond did not recall whether or not petitioner had attempted to contact her return to work despite it being her position to return people to work. (T p. 180). She agreed her first recollection of speaking to Petitioner was on June 27, 2018. She could not recall what Petitioner's restrictions were at trial, despite testifying that she had knowledge of the restrictions, and had numerous conversations regarding Petitioner with other Respondent representatives. Specifically, she stated that risk management provided her with restrictions. She believed an adjuster, Michael McFarlane, provided the restrictions. She then agreed she was not sure if he was the adjuster, or it may have been a different adjuster at the time, a lady. She went on to admit she was not sure who contacted her and provided the information regarding Petitioner's injury related restrictions. (T pp. 187-189). She did not know what restrictions she reviewed. (T p. 190). She did not know what portion of what medical report was provided to her. (Transcript p. 193-194). Raymond agreed, when questioned regarding what type of position she was providing to Petitioner, that all she knew was it was to be a sedentary position only. She testified that she could not recall the entire report she reviewed, or if she reviewed an entire report, and whether there was any information regarding Petitioner's ability to ambulate or restrictions in that regard. (T p. 196). Despite not knowing this information, she still made a decision Petitioner could perform sedentary work and wrote this on the leave of absence form on July 3, 2018. (T pp. 196-200). She confirmed she could not recall when she provided the reinstatement form to Ringfelt.

Respondent called three surveillance witnesses who provided testimony and reviewed video surveillance of Petitioner taken on July 6 through July 8, 2018. (T pp. 214- 281). All three witnesses admitted to seeing Petitioner in her yard. All three witnesses testified Petitioner could

be seen slowly ambulating around her yard, and walking with a limp. All three witnesses admitted Petitioner only walked very small distance, and only lifted very small objects.

CONCLUSIONS OF LAW

C) Regarding the disputed issue whether an accident occurred that arose out of the and in the course of Petitioner's employment with Respondent on February 10, 2015, the Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes, first, that Petitioner was a very credible witness and accordingly places great weight and significance on her testimony.

Next, the Arbitrator finds and concludes Petitioner prove she sustained accidental injuries arising out of and in the course of her employment with Respondent on February 10, 2015. Petitioner presented unrebutted testimony that on February 10, 2015, she was working next to the judge in courtroom 103. On that date, at approximately 11:30 a.m., Petitioner was working in courtroom 103 performing her normal duties as court clerk next to the judge in the criminal courtroom. Petitioner testified she was on the bench providing orders to the attorneys from the judge. Petitioner testified she stepped down from the bench area to go to the front of the courtroom. As she stepped down off of the stair to the bench, her heel became caught in the open hole at the base of the courtroom flagpole, and caused her to fall to the ground. (T p. 22; PX 15). Petitioner testified the fall caused immediate swelling in her leg and pain in her back. Clearly, Petitioner was engaged in the scope and course of her employment when her heel caught in an open hole at the base of the flagpole, causing injury due to exposure to an increased risk of employment risk of a nature to which the general public was not exposed.

D) Regarding the disputed issue what was the date of accident, the Arbitrator finds and concludes:

Based upon Petitioner's unrebutted testimony, the Arbitrator finds the date of accident was February 10, 2015. There is no evidence to the contrary.

F) Regarding the disputed issue whether Petitioner's current condition of ill-being is causally related to the agreed accidental injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes Petitioner's current condition of ill-being is directly causally related to the accident of February 10, 2015. Respondent presented not a shred of evidence, let alone medical evidence, to rebut Petitioner's treating physicians' medical opinions regarding causation of Petitioner's condition. Even Respondent's two Section `12 expert medical examiners agree with Petitioner on the issue of causation.

The emergency room records from immediately after the accident provide a consistent history of accident. Petitioner's treating orthopedic physicians, Dr. Ryon Hennessy, Dr. Brian Moss, Dr. Avi Bernstein, and her pain management physician, Dr. Sarjaad Murtaza all opine that Petitioner's current knee, low back and blood clot conditions of ill-being are all causally related to the injury.

In addition to Petitioner's treating physician's opinions, again, Respondent's own Section 12 IME opinions from orthopedic physician Dr. Brian Cole, of Midwest Orthopedics and Dr. Howard Konowitz, a pain management expert, all agree that Petitioner's condition is causally related to her February 10, 2015 accident.

The Arbitrator finds and concludes, based upon Petitioner's unrebutted testimony, the unrebutted medical opinions of Petitioner's multiple treating physicians, and the opinions of Respondent's two Section 12 examining experts, the Arbitrator finds Petitioner's current condition of ill-being is causally related to her February 10, 2015, work-related accident.

Further, the Arbitrator finds and concludes that Respondent's surveillance evidence has nearly no value regarding this disputed issue.

J) Regarding the disputed issue whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical care, the Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes all of the medical services provided to Petitioner were reasonable, necessary and causally related to the accidental injury. Once again, Respondent presented not a shred of medical evidence to dispute the reasonableness and necessity of Petitioner's medical treatment. The Arbitrator emphasizes Respondent submitted no Utilization Review reports to address this disputed issue. In fact, Respondent admitted and stipulated it paid for, and would continue to pay for, medical care incurred by Petitioner. In addition, not only did Respondent's Section 12 examining experts concur with Petitioner's treating physicians regarding this issue, but Respondent's examining expert Dr. Cole recommended additional and ongoing medical care and treatment, more specifically, additional surgery, for Petitioner's work-related knee condition. Therefore, the Arbitrator finds and concludes the medical care provided to Petitioner was all reasonable and necessary and related to Petitioner's compensable work accident and injury. **The Arbitrator specifically finds and concludes that the opinions and recommendations of Petitioner's treating physicians' shall be afforded greater weight and credibility than those of Respondent's examining experts, to the extent that any such opinions offered by Respondent's examining experts conflict or disagree with those opinions and recommendations of Petitioner's treating physicians.**

Therefore, the Arbitrator orders Respondent to immediately authorize and approve any and all medical care and treatment as prescribed only by Petitioner's treating physicians.

The Arbitrator further finds and concludes Respondent is liable for all medical bills for treatment incurred to date. Respondent provided no evidence to rebut or refute the medical treatment provide by or charges incurred by Petitioner's treating physicians. In fact, Respondent stipulated on the record that it would pay any and all medical bills incurred, and would pay any other bills to be submitted. (T p. 11).

The Arbitrator finds, and orders Respondent to pay, pursuant to the Commission Medical Fee Schedule, all outstanding medical bills for Petitioner's treatment owed to Dr. Avi Bernstein/The Spine Center, Dr. Ryon Hennessy/Orthopedic Specialists, Gottleib Memorial Hospital, North Park Medical Group, Dr. Brian Moss/Orthopedic Associates, Dr. Sajaad Murtaza, West Suburban Family Practice Associates, and ATI Physical Therapy. These bills are found in Petitioner's Exhibits admitted into evidence as numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 16. Respondent shall be given credit for any and all bills previously paid prior to the hearing. The parties stipulated Respondent had paid $77,042.93 through the date of trial.

K) Regarding the disputed issue whether Petitioner is entitled to prospective medical care, the Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes Respondent is liable for Petitioner's prospective medical care. As noted previously, the Arbitrator specifically finds and concludes the opinions of Petitioner's treating physicians carry greater weight and credibility than the opinions of Respondent's examining expert Dr. Cole. Respondent offered no evidence to rebut or refute the medical opinions of Petitioner's treating orthopedic physician, Dr. Moss. In fact, Dr. Cole concurred with Petitioner's need for ongoing medical care. Dr. Moss and Dr. Cole both agreed Petitioner requires additional surgery. Dr. Moss opined that the type of surgery Petitioner required was outside his scope of practice, and he therefore recommended Petitioner obtain a second

opinion regarding the type of surgery she would require going forward. As of the date of trial, Respondent had not authorized this referral for a second opinion provided by Dr. Moss. **The Arbitrator finds and concludes there was no reasonable basis for Respondent to deny or delay authorization for this medical referral.** The Arbitrator orders Respondent to immediately approve, pay for and immediately authorize the second opinion prescribed by Dr. Moss, as well as all further medical care related to Petitioner's work-related injuries.

L) Regarding the disputed issue of what temporary benefits are in dispute the Arbitrator finds and concludes as follows:

The Arbitrator finds Respondent liable for TTD benefits for the period of February 11, 2015, through August 21, 2018, the date of trial, being a period of **184 weeks ($128,652.20 or 184 X $699.20 = $128,652.80)** as well as ongoing TTD benefits subsequent to trial (as Petitioner has been taken completely off work and is currently unable to work pending surgery). Respondent stipulated it paid TTD benefits from February 11, 2015, through June 12, 2018, totaling 174 weeks Respondent, however, stipulated it paid a total of $118,230.86 – which is **not** the full 174 weeks (174 X $699.20 = $121,660.80). This period represents the period for which Respondent did not dispute Petitioner's entitlement to temporary total disability benefits. Respondent stipulated it paid a total $118,230.86. **Petitioner's TTD rate is $699.20 ($1,048.80 div. by 2 X 3 = $699.20).** Based on the TTD rate, and the aforementioned awarded TTD dates which total 184 weeks, **the Arbitrator finds Respondent should have paid $128,652.80 (184 X $699.20). The Arbitrator therefore finds Respondent underpaid Petitioner and owes Petitioner the amount of $10,421.34 ($128,652.20 - $118,230.86 = $10, 421.34** and orders Respondent to pay the underpaid TTD amount of $10,421.34.

The issue presented at this hearing is whether Petitioner was able to work after June 12, 2018, which was the last date Respondent paid TTD benefits and whether Respondent properly provided a bona fide light duty job offer. Petitioner claims she is entitled to TTD benefits for the periods of February 11, 2015, through August 21, 2018, the date of trial, representing a total of 184 weeks, and ongoing benefits due to her ongoing temporary total disability. Respondent alleges Petitioner was capable of returning to work in a sedentary capacity, and bases this on its IME opinion of Dr. Cole. (RX 1). Petitioner's treating physicians continued to advise and opine that she was unable to work due to her injuries, and was also unable to work or drive while using narcotic pain medications. Respondent's pain management physician, Dr. Konowitz, in his March 22, 2018, report opined Petitioner's use of narcotics for pain was reasonable, and she should maintain sedentary restrictions, and should also continue to treat orthopedically to address the issues with her right knee. (RX 2). Dr. Konowitz opined Petitioner's back and right knee conditions required further care, and recommended she continue treatment with her treating physicians to address her orthopedic needs and to address her continued use of narcotic pain medication.

In his May 7, 2018 report, Dr. Cole noted that he previously assessed Petitioner's conditions on November 27, 2017, noting the July 2017 total knee replacement which subsequently caused Petitioner to develop blood clots in the right calf. (RX 1). Of note is the fact that Respondent elected not to introduce Dr. Cole's prior IME reports. Dr. Cole, in his May 7, 2018 report, in the "Summary of Discussion, Recommendations, and Plan" section, opined Petitioner's condition required arthroscopic lysis of adhesions, manipulation under anesthesia, and a posterior capsular release and a suprapatellar pouch release. Dr. Cole stated in his report that this surgery was "more than warranted." Dr. Cole stated other consideration must be made for additional

treatment, and Petitioner would require a hematologist to be present and involved for the best practices in her complex medical scenario. Dr. Cole also opined that his opinion is provisional as to MMI, but also stated his opinions could change based on the intraoperative findings which would be unique to her. Dr. Cole also opined that all treatment to date was reasonable, necessary, appropriate, and causally related to the work-related accident.

Dr. Cole went on to provide opinions related to her ongoing use of narcotics. Dr. Cole opined that Petitioner's continued use of narcotics was necessary, and that pain management should be continued by a pain management physician. Dr. Cole noted Petitioner's current functional abilities were poor due to her continued level of stiffness.

Dr. Cole also addressed Petitioner's ability to work. Dr. Cole specifically opined, under number 12, on page 3 of his report, Petitioner was capable of only seated work given her level of pain, stiffness, and difficulty ambulating. Dr. Cole further opined Petitioner required provisions to get her to and from a desk job with minimal walking in order to work safely and realistically. Dr. Cole was clearly concerned for Petitioner's medical safety in this particular case. Dr. Cole further opined he did not believe it was realistic to work with the continued use of narcotic medications, and this was also a safety concern in the work place.

Petitioner also provided testimony regarding Dr. Cole's examination. Petitioner testified Dr. Cole also advised her that she would require a certain type of specialist to address her knee condition. Respondent offered no evidence to rebut Petitioner's testimony in this regard. Petitioner testified she never received any further recommendation as to what type of doctor he discussed with her, and she was actively trying to find a doctor to further evaluate her serious medical condition.

On June 29, 2018, Dr. Moss reviewed Dr. Cole's report, Dr. Moss, in his report Dr. Moss stated that the procedures recommended by Dr. Cole were outside his scope of practice, and therefore he recommended a second opinion for Petitioner regarding Dr. Cole's opinions and the surgery he recommended. Dr. Moss also stated in his report of June 29, 2018, that Petitioner was still not medically able to work, and the estimated duration of total disability was dependent on surgery (PX 3, 4, RX 10, RX 13). Dr. Moss also opined Petitioner still required narcotics, should not be driving or working while on narcotics, in addition to requiring a second opinion to review Dr. Cole's recommendations. (Id.). Dr. Moss continually from the outset of Petitioner's treatment recommended a knee replacement. Respondent continually refused to authorize said treatment, and continually authorized alternative procedures, which did not help Petitioner. Dr. Moss continually restricted Petitioner completely from work. Respondent continually ignored this restriction at the behest of Dr. Cole's opinions. Despite Dr. Moss's opinions, Respondent also refused to recognize that even if Petitioner could return to sedentary duty prescribed by Dr. Cole, certain accommodations must be made due to her inability to walk and ambulate. To ignore this was callous, reckless and jeopardized Petitioner's medical condition and health. Respondent's representatives could not even confirm if they actually read the full recommendations for accommodations provided by Dr. Cole, or whether they reviewed Dr. Moss's reports until Petitioner presented Dr. Moss's restrictions on July 3, 2018.

Respondent's position is it offered Petitioner sedentary work based on Dr. Cole's opinion. The Arbitrator finds the light duty/sedentary offer disingenuous at best. Respondent offered into evidence a chain of emails in an attempt to prove Petitioner was not compliant with its sedentary job offer. (RX 6). Respondent also offered testimony from several witnesses that Petitioner was able to return to work, or that she was non-compliant in making a good faith effort to return to

work. Petitioner testified that despite her doctor's recommendation and opinion that she was unable to work, she did attempt to return to work on July 3, 2018.

The Arbitrator finds Respondent's witnesses were not credible. In particular, Lauren Raymond, who is Chief Deputy Counsel for Human Resources, and in charge of returning employees to work, provided contradictory and non-credible testimony as to what if any of Petitioner's restrictions she reviewed. She testified it was reasonable for Petitioner to inquire about what accommodations could be made. She admitted she had no idea when she provided the release to return to work forms to Petitioner's supervisor, Mr. Ringfelt. Ringfelt denied having ever heard from Raymond prior to Petitioner presenting to his office.

In addition, Respondent's own Exhibit #6, completely refutes its position regarding its alleged light duty/sedentary work offer to Petitioner. The Arbitrator notes the emails began on or about June 12, 2018, between the parties' respective counsel, and the adjusters in the matter. On said date Respondent stated TTD had been issued. Petitioner admitted she received one payment after May 22, 2018 but it was only for benefits due through June 12, 2018. Respondent did not provide, as evidenced in the email chain, any description regarding accommodations to be made to Petitioner at that time, only a copy of the IME report. Further, Respondent did not even provide a job offer to Petitioner until June 19, 2018. Thereafter it is clear, based on Petitioner's credible testimony, Petitioner and her attorney attempted to obtain clarification due to the serious concerns for her health and inability to walk.

The Arbitrator finds and concludes Petitioner was more credible than Respondent's witnesses. The Arbitrator finds and concludes Petitioner was unable to work and adopts Dr. Moss's opinions, treatment recommendations and his restrictions, which were consistently provided by Dr. Moss from the outset of his treatment of Petitioner. These opinions, along with

Petitioner's testimony regarding her continued pain, are more credible than the opinion of Dr. Cole, who also incidentally confirmed the veracity of Petitioner's complaints. The Arbitrator finds and concludes Petitioner continued to be temporarily and totally disabled from June 12, 2018, forward, and finds she is still temporarily and totally disabled as of the August 21, 2018 date of hearing.

M) Regarding the disputed issue whether penalties or fees be imposed upon Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes Respondent is liable for penalties and fees pursuant to Sections 19(k), 19(l) and Section 16. The Arbitrator finds Respondent's actions were unreasonable, vexatious, and instituted only for the purposes of delay. Respondent's actions in this case were clearly objectively unreasonable, callous and jeopardized Petitioner's medical condition, health and safety. The Arbitrator finds and concludes Respondent's failure to pay TTD benefits was clearly unreasonable and not based on any objective or justifiable basis. Respondent's alleged light duty/sedentary job offer ignored the restrictions imposed by its own IME expert examiner. Respondent's actions subjected Petitioner to great risks to her health, as its own IME expert examiner expressed concerns that it would.

The Arbitrator awards Petitioner penalties under Section 19(k) in the amount of 50% of the 10 weeks of unpaid TTD benefits (June 12, 2018 thru August 21, 2018) or the sum of $3,496.00 (5 weeks X $699.20 = $3,496). The Arbitrator orders Respondent to pay this amount to Petitioner pursuant to Section 19(k).

The Arbitrator finds Respondent is also liable for penalties pursuant to Section 19(l) in the amount of $30.00 per day for the amount of time said benefits were withheld. Respondent

unjustifiably did not pay for the period of June 13, 2018 through August 21, 2018, a period of 70 days. **Respondent shall pay Petitioner a total of $2,100.00 pursuant to Section 19(l).**

In addition, the Arbitrator awards Petitioner penalties for attorney's fees pursuant to **Section 16 in the amount of $1,119.20, being 20% of $5,596.00** (the amount of the total penalties awarded). The Arbitrator orders Respondent to pay Petitioner this $5,596.00 amount.

O) In relation to issue Other: Return to work, light duty, unpaid TTD and unpaid medical benefits, the Arbitrator finds as follows:

For the reasons set forth in the prior Sections, the Arbitrator finds Petitioner could not work light duty, and Respondent failed to properly provide Petitioner with accommodations to return to work. Further, the Arbitrator finds Respondent's IME opinion regarding sedentary work less credible than that of the treating physician, Dr. Moss.

Regarding unpaid TTD, the Arbitrator orders Respondent to pay TTD benefits from June 12, 2018 through the date of trial, and finds Petitioner continues to be temporarily and totally disabled as a result of her work related accident. The Arbitrator orders Respondent to continue to pay Petitioner TTD benefits until her treating physicians opine she can return to work.

The Arbitrator, for reasons set forth above, also orders Respondent to pay any and all unpaid medical benefits. The Arbitrator orders Respondent to pay future medical benefits consistent with the recommendations of Petitioner's treating physicians.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: October 11, 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DWIGHT DAVIS,

Petitioner,

vs.

NO: 15 WC 38201

19IWCC0601

JOY GLOBAL,

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 occupational disease, causation and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On page 12, in the second paragraph under "Issue C", the Arbitrator's Decision states:

The Arbitrator finds it significant that four doctors read the 9.9.15 chest x-ray and three of the four found it to be negative for CWP. Additionally, one of those three doctors, Dr. Youseff, was a neutral examiner as he was not asked by either party herein to read the film.

The Commission modifies the Arbitrator's Decision on page 12, in the second paragraph under "Issue C" to state as follows:

The Arbitrator finds it significant that five doctors read the September 9, 2015 chest x-ray (Drs. Castle, Meyers, Smith, Istanbouly (who relied in part on Dr. Smith's B-readings of the x-ray) and Dr. Youssef) and three out of the five found it to be negative for coal workers' pneumoconiosis. Additionally, one of these

19IWCC0601

doctors, Dr. Youssef, was a neutral examiner as he was not asked by either party to read the film.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 9, 2018 is hereby modified as stated herein and otherwise affirmed and adopted.

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

The 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 6 - 2019

Maria E. Portela

Kathryn A. Doerries

Thomas J. Tyrrell

MEP/dmm
O:100819
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAVIS, DWIGHT
Employee/Petitioner

Case# **15WC038201**

19IWCC0601

JOY GLOBAL
Employer/Respondent

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:

5236 CULLEY FEIST KUPPART & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

19IWCC0601

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

DWIGHT DAVIS
Employee/Petitioner

v.

JOY GLOBAL
Employer/Respondent

Case # **15** WC **38201**

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, Illinois**, on **February 8, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did a disease occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d) -(f) of the Occupational Disease Act**

FINDINGS

On **March 2, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***was*** last exposed to coal dust and fumes arising out of and in the course of employment with Respondent; however, he failed to prove he has an occupational disease as a result of said exposure.

Timely notice of the alleged exposure ***was*** given to Respondent.

In the year preceding the injury, Petitioner earned $**69,631.64** ; the average weekly wage was $**1,339.07**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

Petitioner's current condition of ill-being ***is not*** causally related to his exposure/employment with Respondent.

ORDER

Petitioner failed to prove he has an occupational disease as a result of an occupational exposure. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

April 5, 2018
Date

APR 9 - 2018

DWIGHT DAVIS V. JOY GLOBAL, 15 WC 38201

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

On July 23, 2009, Petitioner underwent bare metal stenting of the critical proximal left anterior descending artery (LAD). (RX 5)

Petitioner was seen at the Orthopedic Center of Southern Illinois on June 4, 2010. At that time Petitioner was complaining of both low back pain as well as neck/parascapular pain. (RX 8, pp. 220-224). Petitioner underwent an anterior cervical discectomy, epidural decompression and foraminotomies bilaterally at C4-5 and C5-6 as well as C6-7 with inter-body fusion of C4-5, C5-6 and C6-7 on July 20, 2010. This was performed by Dr. Kovalsky with no complications. (RX 8, pp. 198-203).

Petitioner was seen at the Orthopedic Center on November 3, 2010. He was still having some pain, numbness and tingling in the right upper extremity. He was allowed to go back to work full duty two weeks from that appointment. (RX 8, p. 191).

Petitioner returned to the Orthopedic Center on February 2, 2011 regarding his neck, reporting that he was feeling wonderful. The doctor gave Petitioner the "okay" to go back to the gym for cardio and light lifting. (RX 8, p. 187)

Petitioner was again seen at the Orthopedic Center of Southern Illinois on July 7, 2011, with continued pain complaints in his neck radiating down into the right upper extremity. (RX 8, p. 81). Petitioner was seen on July 20, 2011. He was working full time as a heavy equipment operator and had complaints of lower back pain with radiation into his buttocks and leg. He was having difficulty walking more than two blocks. He also continued to have right sided neck pain. (RX 8, p. 177). Petitioner returned to see Dr. Kovalsky on August 17, 2011. He was still having neck pain and low back pain with radiation. He was working full-time. He reported that he would like to work for another two to three years if possible. He wanted to continue working and to avoid surgery until he retired. He was referred to physical therapy to learn a home maintenance exercise program. (Respondent's Exhibit No. 8, p. 167).

Petitioner met with the occupational therapist on August 22, 2011 regarding his lumbar disc disease. Petitioner had sustained a compression fracture twenty years earlier and had been experiencing low back pain and pain down his right leg ever since. In the last six months or so he had also noticed increasing pain down his left leg. Both legs reportedly experienced numbness and tingling as well as sharp pains going down to his toes. His pain was rated as 5-6/10 in just his low back and described as a dull achiness. It was at its worst when lifting/squatting and described as a "10" and sharp. At its best, it was 5/10 when resting and taking his pain medication. Petitioner was currently working full duty, working on heavy equipment, sitting for long periods of time on a computer and lifting equipment, crawling and squatting. He had previously undergone two heart attacks for which he had stents put in and a two-level fusion in his neck. Petitioner reported waking up two to three times per night secondary to his back pain. His balance was good. He was starting to limp a little bit on his left lower extremity but had not noticed any decrease in strength. He could currently stand for about ten minutes before sitting secondary to low back pain and could walk for

about fifteen minutes before needing to sit. If he sits for more than ten minutes he needs to get up and move around secondary to increased back pain. No reference was made to any exertional complaints by history or as part of the testing. (RX 8, pp. 164 – 166)

Petitioner was seen at the Orthopedic Center on November 22, 2011, for his left knee which he had twisted when he fell at home. X-rays revealed that Petitioner had advanced left knee medial compartment osteoarthritis. Petitioner would continue to treat with Dr. Freehill for his left knee in 2012. (RX 8, p. 157).

Petitioner was examined by Dr. Kovalsky on May 17, 2012, complaining of increasing lower back pain and neck pain. He discussed with Dr. Kovalsky the possibility of disability. Due to his severe cervical problems and lumbar problems, he most likely qualified for disability, especially because of his intolerance to pain medication. (RX 8). Dr. Kovalsky did not feel that Petitioner was a candidate for surgery and recommended that he try to work as long as he could and once he got to the point where he could not tolerate it he should consider disability. (RX 8, p. 148). Petitioner saw Dr. Kovalsky on September 19, 2012, for follow up regarding his back pain. At that time Petitioner reported that working was getting to be a bigger struggle. He also had problems riding in a car for more than two to three hours. (RX 8, p. 137). Petitioner was seen on September 12, 2013, for bilateral knee pain. He wanted to proceed with injection therapy. He rated his pain as a 10. (RX 8, pp. 118-119).

Petitioner underwent stenting of the mid-LAD on October 25, 2012. (RX5).

Medical records of Family Medical Center were admitted into evidence. Petitioner was seen on October 14, 2013, for a general physical. He did not have any chest pain or dyspnea at that time. He reported that he was fatigued and did not sleep well due to back and neck pain. On physical examination of the chest, his lungs were clear to auscultation and percussion. (RX 6, pp. 60-61, PX 1)

Petitioner underwent a cervical spine MRI, without contrast, on October 28, 2013. (PX 1)

Petitioner returned to the Orthopedic Center on January 21, 2014. He continued to rate his bilateral knee pain as a 10. Petitioner would continue to see Dr. Freehill throughout 2014. (RX 8, pp. 55 - 110, 112)

Petitioner's last day at Respondent's mine was March 2, 2014.

Petitioner was seen by Dr. Fozard at Family Medical Center (FMC) on March 25, 2014, for a history and physical for surgery. A review of all systems was negative. On examination Petitioner's lungs were clear to auscultation and percussion. (RX 6, pp. 50-51, PX 1)

On April 2, 2014, Petitioner underwent a lumbar hemilaminectomy with foraminotomy and medial facetectomy at L3-4, L4-5, and L5-S1. (RX7)

Petitioner underwent another pre-op chest x-ray on September 16, 2014 which revealed stable granulomatous calcifications and mild cardiomegaly. There was no acute cardiopulmonary process and no change from March 25, 2014. (RX. 6, pp. 43-44)

Petitioner was seen at FMC on September 17, 2014, for a history and physical examination prior to low back surgery. At that time Petitioner reported no complaints other than chronic low back pain. Physical examination of the chest was clear to auscultation and percussion. Petitioner was cleared for surgery. (RX 6, pp. 34-36, PX 1)

On September 24, 2012 Petitioner completed an MRI Safety Screening. It asked about any breathing problems and Petitioner denied same. (RX 8, p. 128)

On September 22, 2014, Petitioner had a L2-3 hemilaminectomy with medial facetectomy and foraminotomy. (RX7)

Petitioner was seen again at FMC on December 4, 2014, for surgical clearance for an upcoming left knee replacement. Petitioner denied any shortness of breath or chest pain. His review of systems respiratory was negative for cough, dyspnea or frequent wheezing. Physical examination respiratory showed a normal respiratory rate and pattern with no distress. (RX 6, pp. 24-26, PX 1)

On December 8, 2014, Petitioner underwent a total left knee replacement. Petitioner continued to see Dr. Freehill for his left knee condition through January 22, 2015. (RX 8, pp. 75-76)

From February through May of 2015 Petitioner treated with Dr. Freehill for his right knee. (RX 8, pp. 30 – 43)

In May of 2015 Petitioner returned to see Dr. Freehill regarding his right knee. She recommended arthroscopic surgery. (RX 8, p. 30)

Petitioner was seen again at FMC on May 19, 2015, for a pre-surgery physical for right knee arthroscopy. Petitioner reported chronic right knee pain with a torn meniscus. He had no other complaints and was doing well at that time. Physical examination of his chest was clear to auscultation and percussion. He was deemed medically stable for right knee arthroscopy pending completion of cardiac stress test and evaluation by his cardiologist. (RX 6, pp. 21-23, PX 1)

Petitioner underwent a right knee arthroscopy, right knee arthroscopic partial medial meniscectomy and right knee arthroscopic patellar chrondroplasty on June 3, 2015. (RX 8, pp. 15-18) Petitioner followed up with Dr. Freehill on July 14, 2015. (RX 8, p. 9)

On September 1, 2015 Petitioner saw Dr. Freehill regarding his right knee which was reportedly not doing well. Petitioner wished to try a brace and they discussed surgery; however, Petitioner was not ready to proceed. (RX 8, p. 6)

On September 9, 2015 Dr. Hisham Youssef interpreted a chest x-ray taken that day for purposes of looking for black lung. He saw no active cardiopulmonary disease, evidence of a prior anterior cervical fusion and benign chronic changes (tiny benign calcified granuloma of the left mid lung zone). (RX 4)

On September 26, 2015, Petitioner underwent a posterior cervical fusion at C6-7. (RX7)

On October 12, 2015, and at the request of Petitioner's attorney, Dr. Henry K. Smith performed a Pneumoconiosis Chest Film Interpretation of the 9/9/15 chest x-ray. Dr. Smith is a board-certified radiologist who also holds a Certificate as a NIOSH Pneumoconiosis B-Reader. Dr. Smith's impression of the chest film was of simple coal workers' pneumoconiosis, with small opacities, primary p, secondary q, with all lung zones involved bilaterally, profusion 1/1. Dr. Smith graded the film quality as a quality 1. (PX 3,4)

On October 22, 2015, Petitioner returned to the Orthopedic Center reporting he was doing really well with regard to his right knee and his pain was low. He did not want any further treatment regarding his knees at that time. (RX 8, p. 3).

Medical records of the St. Louis Heart Center were admitted into evidence. Dr. Ronald A. Weiss issued a consultation report dated November 4, 2015. In a history obtained from Petitioner. Petitioner denied any anginal type chest pain. Petitioner did note some dyspnea on exertion which he attributed to being out of shape. Petitioner had chronic back discomfort from a previous injury with residual right leg numbness and discomfort. He also reported excessive daytime fatigue due to poor sleep, secondary to back and leg discomfort. Petitioner's past medical history was significant for stenting of the critical proximal LAD on July 23, 2009. It was further noted that he also underwent a stenting of the mid LAD on October 25, 2012. Dr. Weiss indicated that Petitioner suffered from progressive exertional dyspnea, suspect secondary to weight gain and aerobic deconditioning. Dr. Weiss also noted that Petitioner had significant pain. (RX 5, pp. 19-21).

Petitioner signed his Application for Adjustment of Claim herein on November 6, 2015. (AX 2)

On December 29, 2015, Dr. Suhail Istanbouly examined Petitioner at the request of Petitioner's attorney. Thereafter, he authored a report outlining the test results, diagnosis, and his opinions. (PX2, Exhibit 2). Dr. Istanbouly reported that Petitioner was a 63 years old male with exertional dyspnea. Dr. Istanbouly noted that Petitioner was dyspneic walking for half a block to one block. Dr. Istanbouly noted that Petitioner had been coughing on a daily basis for years. The cough was described as mild to moderate in intensity and triggered by physical activity. The cough was productive of mild light yellow sputum, one to two teaspoonful per day. Petitioner reported no wheezing or chest pain. Petitioner reported no history of asthma or COPD in the past. Petitioner has never smoked in the past.

Dr. Istanbouly obtained Petitioner's occupational history. (PX2, Exhibit 2). He noted that Petitioner had worked as a coal miner for a total of 40 years with his last month of coal mining career being in March, 2014. For the 10 years prior to retirement Petitioner worked for Joy, which was a coal mine equipment manufacturing company. Petitioner installed and repaired equipment in the coal mine underground averaging six hours per day for five to six days per week with significant coal dust exposure. Prior to that he had done multiple jobs in the coal mines, all of them underground.

Dr. Istanbouly reported that Petitioner's spirometry testing was within normal limits. (PX2, Exhibit 2). Dr. Istanbouly personally reviewed the chest x-ray from Ferrell Hospital which was obtained on September 9, 2015 which he noted had been read as positive by Dr. Henry Smith, a B-reader. Dr. Istanbouly ultimately assessed Petitioner with simple coal workers'

pneumoconiosis, which seemed to be "mild and in its early stages due to [a] normal spirometry test." (PX 2, dep. ex. 2) He advised Petitioner to avoid further coal dust inhalation and to avoid going back into the mines to avoid any further lung damage.

On February 9, 2016 Petitioner underwent pulmonary function testing at Methodist Hospital in Henderson, Kentucky. It was interpreted as showing normal diffusion capacity. (RX 3)

On February 27, 2016, and at the request of Respondent, Dr. Christopher A. Meyer, a board-certified radiologist and B-Reader, read an x-ray of Petitioner's chest taken on September 9, 2015. He noted the film to be of quality 3, under-inflated, and mottled. He found no evidence of coal workers' pneumoconiosis. He did see calcified granuloma in the left mid lung but no small round, small irregular or large opacities. Dr. Meyer further noted that he had reviewed a narrative summary and B-reading form completed by Dr. Henry K. Smith and disagreed with his reported findings of primary opacities of size "p" with profusion of 1/1. Petitioner's lungs were clear. (RX 1, dep. ex. B)

Petitioner returned to see Dr. Weiss at the St. Louis Hear Center on April 21, 2016. Petitioner reported that he remained active. On that date he denied dyspnea on exertion. The examination of the chest revealed the lungs to be clear to auscultation. According to a Nuclear Cardiology Report, Petitioner had a fixed inferoposterior wall defect consistent with a prior infarction. (RX 5, pp. 3-8).

Deposition of Dr. Christopher A. Meyer (5/6/16)

On May 6, 2016, Dr. Christopher A. Meyer testified via evidence deposition at Respondent's request. (RX1). Dr. Meyer testified that he is a board-certified Radiologist who has a B-reading certificate. Dr. Meyer testified that he currently works as the Vice Chair of Finance and Business Development and professor of diagnostic radiology at the University of Wisconsin Hospital and Clinics in Madison, Wisconsin. Dr. Meyer testified at length regarding his extensive experience in his field. (RX 1, pp. 1 – 22, 40 - 41) He is currently involved in the rewriting of the B-reading syllabus. (RX 1, p. 43)

Dr. Meyer further testified that a B-reader is presented with a chest x-ray and a very specific form that has been developed for use by the B-reader to evaluate the chest x-ray for the presence or absence of occupational lung disease. The B-reader evaluates the quality of the film, describes any limitations of the x-ray and then proceeds to both classify the examination on the parenchymal abnormalities and determine whether there are any small nodular opacities or any linear opacities and give them a letter score based upon their size and appearance. Dr. Meyer further explained the significance of the letter scoring and what each letter represents. He explained that CWP is typically found in the upper zone of the lungs. The final component of the reading is to determine the extent of the lung involvement or "profusion" and that is probably the most difficult component of the classification system for most radiologists. It ranges from "0/0" which is normal to "3/+" which is the most abnormal. The radiologist then looks for large opacities and categorize them along with looking for miscellaneous findings. Dr. Meyer also described the differences in positioning for chest x-rays and the difference between analog films

and digital films. Dr. Meyer testified that digital films are now being accepted for purposes of CWP. (RX 2, pp. 23 – 26)

Dr. Meyer further testified that when one looks at a lung on x-ray the air is black and the tissue will be a little whiter or gray. The small opacities seen by the B-reader are markings in the lung and can be nodular, linear or irregular. "P" is the smallest while "R" is the largest of the round/nodular opacities. "S", "T", and U" are for irregular opacities with "S" being the smallest and "U" the largest. The doctor also explained that film quality is important as chest x-rays that are underexposed are extremely white and have a tendency to artificially increase the look of the opacities and if the x-ray is too dark, it can artificially make the small opacities disappear. Additionally, if there is mottle on the exam, it can make the film look grainy and a "little polka dot" look to it which can simulate small opacities. If the film is underexposed it can accentuate the pulmonary vasculature and that can be mistaken for a nodule or an opacity. The vascular can also be accentuated if the patient doesn't take a deep enough breath when the film is taken. (RX 26 – 29)

Dr. Meyer testified that certain opacity types are connected to certain occupational lung diseases. Silicosis and CWP are characteristically described by small round opacities whereas pulmonary fibrosis diseases, like asbestosis, would be described by small linear or small irregular opacities. In a B-reading, one identifies both the primary opacity (the numerator) and the secondary opacity (the denominator). (RX 2, pp. 29 -31)

Dr. Meyer also testified that the hardest definition for all B-readers is probably the profusion grade which is where one tries to define the density of the small opacities in the lung. Normal is "0". A profusion value of "1" indicated a mild amount of disease. The numerator of a profusion value implies what the reader thinks the value is while the denominator implies the other closest value. In other words, a "0/1" would mean that the x-ray is normal but it might be just a little bit mildly abnormal. If it's a "1/0" one is saying that it's closest to a positive reading but the next closest is a normal reading. (RX 2, pp. 31 – 33)

Dr. Meyer also testified regarding the extensive program one undergoes to become a B-reader. (RX 2, pp. 33 – 40.)

Dr. Meyer testified that he reviewed a PA and lateral chest x-ray of Petitioner dated September 9, 2015. (RX1). Dr. Meyer testified that the film was of diagnostic quality but was a quality 3 film. Dr. Meyer testified that it was his impression that there were no radiographic findings of coal workers' pneumoconiosis on that film. (RX 1, pp. 42 – 44)

On cross-examination, Dr. Meyer testified regarding his charges for services. He also testified that he does about 30 to 40 B-readings per week. The disease primarily occurs in the upper lobes and can extend down; however, he has not seen it begin in the lower lobes, per literature. The doctor agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown that they actually had the condition pathologically. Dr. Meyer also agreed that it was fair to say

that experts with similar credentials may disagree on the reading of chest films, especially those in Category 1 of pneumoconiosis. (RX 1, pp. 44 – 64)

Additional Medical

Petitioner underwent a chest x-ray on July 7, 2016 due to a history of back pain radiating into his chest and left arm. The impression was no acute cardiopulmonary process. (RX 6, p. 18, PX 1)

Petitioner was seen at FMC on July 11, 2016, for a check-up. He reported being seen in the emergency room the previous week with blood pressure over 200. His cardiac work-up was negative. His review of systems respiratory was negative for any chest pain or dyspnea. Physical examination of chest showed the lungs were clear to auscultation and percussion. (RX. 6, pp. 15-17, PX 1)

Petitioner was seen at FMC on September 13, 2016, for a pre-op history and physical examination for upcoming back surgery. His review of systems respiratory revealed no dyspnea. Physical examination of the respiratory system showed the lungs were clear to auscultation and percussion. He was deemed medically stable for surgery. (RX 6, pp. 11-14, PX 1)

On October 12, 2016, and at the request of Respondent, Dr. James Castle issued a records review regarding Petitioner. (RX 2, dep. ex. C) As part of the records review, Dr. Castle, a B-Reader, reviewed a chest x-ray dated September 9, 2015. He found no parenchymal abnormalities consistent with pneumoconiosis on the film. He did not feel Petitioner had radiographic evidence of CWP. He noted prior chest x-rays and reports interpreted as not showing evidence of CWP with only Dr. Smith finding evidence of minimal, simple pneumoconiosis. He further stated that Petitioner had entirely normal pulmonary or ventilatory function without any evidence of obstruction, restriction, or diffusion abnormality. He concluded his report noting that it was his opinion within a reasonable degree of medical certainty that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust.

Deposition of Dr. Istanbouly (3/29/17)

On March 29, 2017, Dr. Istanbouly testified via evidence deposition at Petitioner's request. (PX2). Dr. Istanbouly testified that he is board certified in critical care medicine and pulmonary medicine. He is presently engaged in a solo practice focused on pulmonary issues. Dr. Istanbouly testified that he does black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. He is also the director of the Intensive Care Unit at Carbondale Memorial Hospital and that he has been the director of the Intensive Care Unit at Herrin Hospital. (PX 2, pp. 1- 7)

Dr. Istanbouly testified that he evaluated Petitioner on December 29, 2015 at the request of Petitioner's attorneys. (PX2, p. 7.) Dr. Istanbouly testified that he took a detailed history from Petitioner, performed a physical examination and reviewed the pulmonary function testing and the chest x-ray undergone before the examination. He then issued a written report.

Dr. Istanbouly testified that Petitioner was referred for possible CWP so he began his examination by obtaining an occupational history. (PX 2, pp. 8-9) Dr. Istanbouly testified that the pertinent aspects of Petitioner's history were that Petitioner was 63 years old, he reported complaints of dyspnea on exertion. Dr. Istanbouly testified that Petitioner was dyspneic walking for half a block to one block. Dr. Istanbouly testified that Petitioner had been coughing on a daily basis for years. The cough was described as mild to moderate in intensity and triggered by physical activity and was productive of mild light yellow sputum, one to two teaspoonful per day. Dr. Istanbouly testified that Petitioner reported no wheezing or chest pain and that Petitioner reported no history of asthma or COPD in the past. Dr. Istanbouly testified that Petitioner had never smoked in the past. (PX 2, pp. 9 -12)

Dr. Istanbouly testified that it is not unusual for miners with simple coal workers' pneumoconiosis to be asymptomatic. He testified that if the miner was symptomatic they could have chronic cough, sputum production and shortness of breath mainly on exertion. (PX2). Dr. Istanbouly testified that on physical examination Petitioner's chest was within normal limits, which wasn't unusual. Dr. Istanbouly explained that a person does not have to have abnormalities on a physical exam of the chest in order to have simple coal workers' pneumoconiosis. Dr. Istanbouly testified the pulmonary function studies Petitioner performed were within normal limits. Dr. Istanbouly testified that normal pulmonary function studies are consistent in patients with category 1 pneumoconiosis. He also testified that patients can have shortness of breath and have normal pulmonary function.

Dr. Istanbouly testified that he personally reviewed Petitioner's chest x-ray which was taken on September 9, 2015. (PX2). Dr. Istanbouly testified that you do not have to be a B-reader in order to diagnose someone with pneumoconiosis. Dr. Istanbouly explained that the B-reading program was developed mainly for the profusion rating on x-rays. (PX 2, pp. 12, 23-24)

Dr. Istanbouly testified that coal workers' pneumoconiosis is caused by the inhalation of coal dust that causes irritation and inflammation that will ultimately end up forming a tiny scar. Dr. Istanbouly testified that the condition causes scarring and a form of emphysema to occur. Dr. Istanbouly agreed that not every miner exposed to coal dust gets CWP. Dr. Istanbouly testified that the scar tissue is permanent, and cannot carry on the function of normal, healthy lung tissue. Dr. Istanbouly testified that if a patient has coal workers' pneumoconiosis they have an impairment of the function of the lung, at least at the site of the scarring and emphysema. Dr. Istanbouly advised that coal workers' pneumoconiosis is a chronic disease with no cure. (PX 2, pp. 13-15)

Dr. Istanbouly testified that, based upon on a reasonable degree of medical certainty, Petitioner's coal workers' pneumoconiosis was caused by his numerous years of exposure to coal dust working as a coal miner for Respondent. Dr. Istanbouly testified that, based on the information he had available, Petitioner had clinically significant pulmonary impairment because of his exertional dyspnea. Dr. Istanbouly testified that Petitioner should not have additional exposure to coal dust without endangering his health, because additional exposure would increase the likelihood of additional progression of the disease. He also testified that the daily cough and sputum was consistent with chronic bronchitis which Petitioner has and was, in his opinion, caused by long-term coal exposure. (PX 2, p. 17)

On cross-examination Dr. Istanbouly acknowledged only seeing Petitioner one time. He did not know just how many exams he had done for various attorneys but he believed it was between five and seven per month. He has never done an exam for a coal company. (PX 2, pp. 17-18)

Dr. Istanbouly acknowledged that he reviewed no outside medical records although he had a medication list for Petitioner. (PX 2, pp. 18-20)

Dr. Istanbouly agreed that conditions other than pulmonary disease can cause dyspnea such as congestive heart failure. (PX 2, pp. 20-21) He agreed that Petitioner's exam showed no signs of respiratory disease. He acknowledged that Petitioner didn't tell him he left the mine due to breathing problems or that he was having any difficulty performing his job duties for Respondent due to breathing issues. His FVC was normal as was his FEV. (PX 2, p. 22)

Dr. Istanbouly acknowledged that the only diagnosis for Petitioner listed in his report was that of CWP. He didn't recall the quality of the chest x-ray film but assumed it was good. He also agreed that CWP cannot be diagnosed by symptoms. (PX 2, p. 25) Dr. Istanbouly agreed that an individual could have a 40-year history of underground coal mining with symptoms of dyspnea and exertion and not have CWP; however, in Petitioner's case he had the positive x-ray. When asked if he would have made the diagnosis had the x-ray been negative, the doctor replied, "I cannot exclude that possibility, honestly speaking, but the cause would be stronger if you have a positive x-ray, but still that possibility cannot be excluded even with negative x-ray." (PX 2, p. 26)

On redirect examination the doctor agreed that he did not believe he reviewed any outside medical records pertaining to Petitioner. (PX 2)

Deposition of Dr. James Castle (6/7/17)

On June 7, 2017, Dr. James R. Castle testified via evidence deposition on behalf of Respondent. (RX2). Dr. Castle testified that he is a pulmonologist who is board certified in internal medicine with a subspecialty in pulmonology. Dr. Castle testified that he had a practice in Roanoke, VA for thirty years, beginning in 1977. Dr. Castle testified that in the course of his practice he saw patients with all different types of chest disease. Dr. Castle testified that he semi-retired in 2007, but he continues to do medicolegal types of exams and records reviews. (RX 2, pp. 1 -21) Dr. Castle testified that he is also a B reader, and that he had reviewed medical records and films regarding Petitioner. (RX2, pp. 22 -44). Dr. Castle testified that it was his opinion, within a reasonable degree of medical certainty, that Petitioner does not have any pulmonary disease or impairment as a result of his occupational exposure. (RX 2, pp. 45-48)

On cross-examination Dr. Castle conceded that he had never met, spoken to, taken a history from, or physically examined the Petitioner. Dr. Castle also agreed that he did not have the charts or notes from any of the physicians that personally evaluated the Petitioner, so he does not know what questions were posed to Petitioner or what answers were obtained.

Dr. Castle testified that there is a possibility that similarly qualified physicians can, and do, disagree as to the findings on chest x-rays. (RX2) Dr. Castle agreed that such disagreement is more common in the lower categories of pneumoconiosis, for example 0/1 and 1/0. Dr. Castle testified that the only possible cause of coal workers' pneumoconiosis is exposure to coal dust, and that there is no cure for that condition.

Dr. Castle testified that the scarring and fibrosis that occurs in the lungs from pneumoconiosis is irreversible and permanent. Dr. Castle agreed that the scarring and fibrosis is an alteration of the lung tissue, and is also an alteration of the function of the involved lung tissue. Dr. Castle further agreed that the condition of pneumoconiosis can progress absent further coal dust exposure. Dr. Castle acknowledged that there are contradictory opinions as to whether or not there is a "safe" level of coal dust exposure, but even exposure to the alleged "safe" levels of coal dust are still causing some workers to develop pneumoconiosis.

On cross-examination, Dr. Castle testified that an individual could have coal workers' pneumoconiosis and not know it because most people that have it are asymptomatic. On cross-examination Dr. Castle agreed that a patient can still have shortness of breath despite having normal PFTs. Dr. Castle further stated that having a normal PFT does not mean that the lungs are not damaged, it simply means that lung function is normal. Dr. Castle testified that it was even possible to have a normal PFT after a portion, or a lobe, of a patient's lung has been removed. Dr. Castle testified that spirometry is a measure of the function of the entire pulmonary system rather than a measure of focal areas or impairments of the lung. (RX 2, pp. 48-68)

Additional Medical Treatment

Petitioner was seen for follow up visit at FMC on June 16, 2017. It was noted that he had experienced a myocardial infarction in October 2016. He had a stent placed and went through cardio rehab. He had no dyspnea at this visit. Physical examination of the chest showed the lungs were clear to auscultation and percussion. Petitioner was to continue his medications and return in 3 -4 months (RX 6, pp. 7-10, PX 1)

Petitioner was seen for follow up visit at FMC on October 16, 2017, primarily for hypertension and GERD. He had no dyspnea. Physical examination of the respiratory system showed the chest was clear to auscultation and percussion. (RX 6, pp. 2-6)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on February 8, 2018. Petitioner was the sole witness testifying at the hearing. The issues in disputes were accident, causal causation, nature and extent and Sections 1(d), 1(e) and 1(f) of the Occupational Disease Act.

Petitioner testified that he is 65 years old and lives at 4717 Starling Road, Tamaroa, Illinois. He has been married to Diana Davis for 47 years. He has a high school education. Petitioner testified that he spent approximately 30 years working in the coal mines and the last 8 years of his employment for Respondent herein working on equipment in the coal mines. Petitioner testified that while working as a coal miner and for Respondent he was regularly

exposed to coal dust and smoke from welding fumes. March 2, 2014, was Petitioner's last day of exposure to coal dust. On that date he was 62 years old and was working for Respondent at the Prairie State coal mine. On March 2, 2014, his job classification was "smart services". Petitioner was underground in the coal mine working on a continuous mining machine and was exposed to coal dust. He quit his employment on that date because he was having problems walking and was short of breath. Petitioner could not physically do his job because of his breathing and walking. He also decided to have his knee replaced and did not return to work after the knee replacement.

Petitioner testified that his first job was at Norge from 1971 to 1974. In 1974 he went to work for Zeigler Coal Company at their Murdock Mine #5 until 1988. In 1990 he went to work for Zeigler Coal Company at their Spartan Mine, where he worked until 1997. From 1997 to 1998 he worked at Metro East working on locomotives. In 1998 he went to work for Zeigler Coal Company at their #11 mine where he worked until 2005. Petitioner then worked for about 6 months for a trash company and then went to work for Stamler, which was bought out by Respondent, and worked there until he quit in 2014.

Petitioner testified to various job duties that he performed while working as a coal miner. He testified that he worked as a general inside laborer, a timberman, ran a loading machine, ran a roof bolter, was a scoop operator, was a mine examiner and an electrician. For Respondent he was a repairman/welder. He worked as "smart services" for the last year of his employment. While working for Respondent he was regularly exposed to coal dust. Petitioner testified that all of his job duties required heavy manual labor on a regular basis.

Petitioner testified that his work caused him breathing problems, and that he still has breathing problems as a result. Petitioner testified that he began to notice the breathing problems during his last year working for Respondent. Petitioner testified he would notice that he would become short of breath while carrying tools and parts to work on the machines. He was required to use a sledge hammer and huge tools to work on the machines and that would cause him breathing problems. Petitioner testified that he would have to walk out of the mines ever so often for safety reasons. The walk would be from five to ten miles and the walking out would cause him severe breathing problems. He would have to stop and take breaks very often when walking out.

Petitioner testified he can currently only walk for one block before noticing a change in his breathing. Petitioner testified that he can only climb one flight of stairs before he would start breathing hard. Petitioner testified that his breathing problems affect his activities of daily life as well. Petitioner testified that when going to the mall or taking the grandchildren out he cannot walk very far before having to stop and rest. He cannot do anything in the cold weather or hot weather because it "takes his breath". He mows his own yard with a riding mower. When weed eating his yard Petitioner has to do it on days that are not too hot and he has to take breaks. Petitioner testified that he used to bird and rabbit hunt but he cannot do so anymore because he cannot do the walking.

Petitioner testified that he could not physically do his last job for Respondent because of "the walking or carrying or any of it. I couldn't do it".

Petitioner testified that his treating doctor is Dr. John Fozard. Petitioner testified that he is not currently taking any breathing medication. He also testified that he is a lifetime non-smoker. In addition to his breathing problems Petitioner has had three heart attacks, four stent placements, three back operations and one knee replacement.

The Arbitrator concludes:

ISSUE (C), DID AN OCCUPATIONAL DISEASE 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?:

Petitioner has failed to prove that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Arbitrator finds the B-readings by Drs. Meyer and Castle to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer to be insightful, informative and persuasive. His background and experience in radiology, B-reading and coal workers' pneumoconiosis is impressive and beyond that of Petitioner's physician, Dr. Istanbouly. Dr. Smith was not deposed. Dr. Meyer's and Dr. Castle's testimony remain unrebutted by Dr. Smith. Dr. Meyer testified to the training received in the B-reading course. Dr. Istanbouly does not have that training. Drs. Meyer and Castle are both B-readers and have been re-certified as same numerous times.

The Arbitrator finds it significant that four doctors read the 9.9.15 chest x-ray and three of the four found it to be negative for CWP. Additionally, one of those three doctors, Dr. Youseff, was a neutral examiner as he was not asked by either party herein to read the film.

The Arbitrator further notes that Dr. Istanbouly did not review any outside medical records pertaining to Petitioner's medical care over the years. Petitioner represented to Dr. Istanbouly that he left the mine due to breathing difficulties. While Petitioner testified that he was having breathing difficulties when he left his employment with Respondent, the medical records from that time period record stable dyspnea on exertion in a pre-surgical consultation with his cardiologist on March 31, 2014. Furthermore, when Petitioner was examined at the St. Louis Heart Center on 11.5.15 he attributed his dyspnea on exertion to being out of shape. He did not attribute any of his symptoms to his work as a coal miner. It appears most apparent that the reason Petitioner left his work with Respondent was to undergo surgery on his low back. The medical records document years of ongoing treatment for his neck, back and knees both during, and subsequent to, his employment with Respondent. Medical records subsequent to his leaving Respondent, separate and apart from the examination he attended as part of his claim herein, document only one complaint of dyspnea on exertion which was when Petitioner told Dr. Weiss he attributed it to weight gain and deconditioning. Prior to undergoing an MRI on September 24, 2012 Petitioner completed a safety screening questionnaire in which he specifically denied any breathing problems. This contradicts his testimony at arbitration in which he testified that he had been having breathing problems while in the mine. The Arbitrator gives more weight to the medical entries and histories than to Petitioner's arbitration testimony as the latter may have been motivated to support his claim and is uncorroborated.

The Arbitrator further notes that Dr. Istanbouly's opinions regarding Petitioner's mild CWP were based upon, in part, Dr. Smith's B-readings of the September 9, 2015 chest x-ray, a reading done at the request of Petitioner's attorney. Dr. Istanbouly was not provided with all of the chest film interpretations for the September 9, 2015 chest x-ray (from which there were four) which would have allowed for a potentially more unbiased analysis by him. Dr. Istanbouly is not a B-reader. He saw Petitioner only one time, after Petitioner had filed his Application for Adjustment of Claim herein, and at the request of Petitioner's attorney. He acknowledged that Petitioner's CWP was mild and that his pulmonary studies were normal. Pulmonary function testing on February 9, 2016 was normal. While a coal miner may have CWP despite normal chest x-rays and pulmonary studies, it is also true that not all coal miners develop CWP. In this instance, Petitioner failed to prove by a preponderance of the evidence, that he has coal workers' pneumoconiosis.

Petitioner also failed to prove by a preponderance of the evidence that his current condition of ill-being was causally connected to any exposure.

Petitioner further failed to prove by a preponderance of the evidence that he suffered a timely disablement under Section 1(f) of the Occupational Diseases Act. In order to prevail in this matter Petitioner must prove he became disabled within two years of leaving the mine. Dr. Youseff's reading was negative as was Dr. Meyers. Only Dr. Smith, Petitioner's B-reader, found it be positive. However, the Arbitrator finds Dr. Smith's B-reading less persuasive in light of three other doctors finding it to be negative. By reference, the Arbitrator further incorporates her discussion above regarding whether Petitioner had CWP.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Stephanie Matlock,

Petitioner,

19IWCC0602

vs.

NO: 15 WC 030798

State of IL / Choate Mental Health,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 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.

19IWCC0602

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)(l) of the Act, claims against the State of Illinois are not subject to judicial review.

DATED: NOV 6 - 2019

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MEP/ypv
049

Maria E. Portela

Thomas J. Tyrrell

Kathryn Doerries

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

MATLOCK, STEPHANIE
Employee/Petitioner

Case# **15WC030798**

16WC004246
16WC002296
16WC036410
16WC036411

ST OF IL/CHOATE MENTAL HEALTH
Employer/Respondent

19IWCC0602

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:

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
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1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

APR 2 - 2018

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

19IWCC0602

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)

Stephanie Matlock
Employee/Petitioner

v.

State of Illinois/Choate Mental Health
Employer/Respondent

Case # **15** WC **30798**

Consolidated cases: **16 WC 04246**
16 WC 02296
16 WC 36410
16 WC 36411

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0602

FINDINGS

On the date of accident, **9/4/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**51,477.74**; the average weekly wage was $**989.96**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.

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

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

Respondent ***is*** entitled to a 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's current condition of ill-being in her low back is causally related to her September 4, 2015 accident.

Respondent shall pay the medical bills outlined in Petitioner's Group Exhibit 1 and incurred between September 4, 2015 and November 28, 2015 pursuant to the Medical Fee Schedule and Sections 8(a) and 8.2 of the Act. Respondent is entitled to a general credit for any medical bills paid by it or its group medical plan for which credit is allowed under Section 8(j) of the Act and shall hold Petitioner harmless from liability for same. The parties stipulated that the medical bills could be paid directly to the providers.

Prospective medical care is denied as it is being more appropriately addressed in Case #16 WC 02296. Temporary total disability benefits are also denied as they are being more appropriately addressed in Case # 16 WC 36411.

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

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

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

Nancy Lindsay
Signature of Arbitrator

3/23/18
Date

APR 2 - 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner is employed as a security therapy aide for Respondent, Choate Mental Health and Development Center. Petitioner has five applications for adjustment of claim pending against Respondent. All five claims involve alleged injuries to Petitioner's knees, low back and neck and they were consolidated at the time of arbitration with the parties understanding that separate decisions would issue. The parties further stipulated that this 19(b) hearing was solely limited to Petitioner's alleged low back condition and that all issues regarding injuries to other body parts were being reserved. Therefore, the Arbitrator's findings and conclusions only address the alleged low back claim. None of Petitioner's five accidents against Respondent are disputed. The focus of the dispute is causal connection and Petitioner's need for prospective medical care.

The Arbitrator finds:

On June 30, 2013, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. (RX1). Petitioner indicated that on June 29, 2013, she was knocked down while assisting with a hostile patient and landed on the edge of a dresser. (RX1). Petitioner indicated she injured the bridge of her nose, left buttock, right upper arm, lower arm/hand, and left and right knees. (RX1). Respondent does not dispute that this accident occurred. (AX 5)

On March 10, 2014, Petitioner presented to Dr. Lori Moyers at Cape Family Practice to establish herself as a patient. (RX20). It was noted Petitioner was a heavy every day smoker and had previously undergone removal of her thyroid. (RX20).

On April 8, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner was seen for low thyroid levels and complained of right hip pain. (RX20). Petitioner was given an injection into her hip. (RX20).

On May 13, 2014, Petitioner returned to Dr. Moyers. (RX20). Petitioner complained of swelling all over and pain in her feet. (RX20). Petitioner was given a fatigue panel. (RX20).

On June 10, 2014, Petitioner saw Dr. Moyers. (RX20). Petitioner complained of shortness of breath, increased stress, and bilateral knee pain. (RX20). Petitioner requested a steroid shot, but declined it as it was out of network. (RX20). Petitioner was scheduled for an EKG and stress test. (RX20).

On July 9, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner complained of chronic back pain on lower left side. Petitioner indicated it had started about a year earlier and had gotten worse. Petitioner also indicated her back actually "went out" approximately five months earlier. Petitioner did not mention any accident or injury with regard to her back. It was noted Petitioner had a history of syringomyelia. A lumbar spine x-ray was ordered and Petitioner was prescribed physical therapy.

On August 11, 2014, Petitioner returned to Dr. Moyers. Petitioner indicated she had undergone the L-spine x-ray, but had not started the physical therapy yet due to her schedule. Petitioner also complained of left foot pain. Petitioner was referred to another doctor for her foot. (RX20).

On September 8, 2014, Petitioner followed up with Dr. Moyers. Petitioner complained of fatigue, abdominal pain, joint/muscle pain, and anxiety. (RX20).

On October 10, 2014, Petitioner returned to Dr. Moyers. Petitioner complained of fatigue, thyroid issues, joint/muscle aches, and anxiety. It was noted Petitioner had multiple trigger points. (RX20).

On November 11, 2014, Petitioner saw Dr. Moyers. Petitioner complained the prescription Savella caused nausea and had not helped her pain at all. (RX20).

On January 16, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of low thyroid levels and a rash all over her body. (RX20).

On June 4, 2015, Petitioner returned to Dr. Moyers for her thyroid. Petitioner returned on June 15, 2015 complaining of congestion and sinus pressure. (RX20).

On July 15, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of continued allergy symptoms and weight gain. (RX20).

Petitioner was involved in an undisputed work accident on September 4, 2015. (AX 1)

On September 8, 2015, Petitioner returned to Dr. Moyers. Petitioner complained of a spot on her left foot and low energy/fatigue. (RX20).

On September 9, 2015, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. Petitioner indicated that on September 4, 2015, she was knocked down twice by an aggressive patient. Petitioner indicated she injured her lower back, upper back, and both knees. (RX4).

On September 10, 2015, Petitioner presented to Work Care regarding her 9/4/15 accident. At that time she was complaining of pain in her low back, neck, bilateral knees, and left foot. Petitioner indicated she was in a patient altercation and was thrown to the floor two times. During the altercations she began dry heaving and vomiting. Petitioner indicated her primary problem was her neck; her secondary problem was her low back. It was noted Petitioner was previously diagnosed with syringomyleia and fibromyalgia. Petitioner indicated her primary care physician did not take work comp. Petitioner complained of constant aching pain in her back aggravated by use and relieved by rest. X-rays were described as unremarkable with no degenerative findings. Petitioner was diagnosed with a cervical spine radiculopathy and strain, thoracic spine strain, lumbar spine strain, and bilateral knee contusions. Petitioner was prescribed medication and physical therapy and taken off work through September 11, 2015 to be followed by sedentary work restrictions as of September 12, 2015 Petitioner was also referred for a neurology consult for a

"pre-existing spinal condition." FNP-BC Dena Kommer addressed causation stating, "The cause of this problem is related to work activities. The objective findings are consistent with the history of a work-related etiology. Work activities have aggravated an underlying pre-existing condition." (PX3)

Petitioner testified, without rebuttal, that Respondent could not accommodate her work restrictions/light duty and she remained off work.

On September 17, 2015, Petitioner returned to Work Care and reported she was no better. Petitioner indicated her primary problem was her neck and that she had burning down into her shoulders. She also had bilateral knee pain and muscle spasms in her lumbar area. Diagnoses and recommendations remained the same. She was referred to Dr. Hayward. (PX3).

On September 16, 2015 Petitioner signed her Application for Adjustment of Claim in case #15 WC 30798 alleging injuries to her body as a whole and bilateral knees due to an accident on September 4, 2015 when she was attacked by a resident. (AX 2)

On September 17, 2015, Petitioner underwent x-rays of her left knee. The findings were normal with mild osteoarthritic changes noted. Petitioner also underwent x-rays of her right knee. The findings were normal with minimal osteoarthritic changes noted. Additionally, Petitioner underwent x-rays of her lumbar spine. The findings showed normal curvature and alignment maintained except for mild right convex curvature centered near L1/2, mild loss of disc height from L3/4 through L5/S1, and mild lumbar facet arthropathy present. There was no fracture or subluxation identified, sacral arcuate lines intact, and soft tissues were unremarkable. Petitioner also underwent x-rays of her thoracic spine. The findings showed no compression fracture or subluxation. Finally, Petitioner underwent x-rays of her cervical spine. The findings were normal. (PX3).

Petitioner completed a questionnaire for Dr. Thalman's office on September 24, 2015 regarding her September 4, 2015 accident. Dr. Thalman is a chiropractor. (PX 6; AX 12)

As ordered by Work Care, Petitioner presented to physical therapy at Mid America Rehab on September 29, 2015. Petitioner reported trying to break up a fight between patients earlier in September and being injured in the process. She had undergone x-rays but no other tests. Her complaints included pain in the neck, upper back, mid back, low back and down her left leg. She reported some occasional arm and leg pain and burning into the shoulder blade region and both legs. She also reported numbness and tingling down her legs at times. The therapist described Petitioner's level of pain as moderate to severe and documented an antalgic gait along with decreased range of motion. Petitioner was to be seen three times a week for four weeks. (PX 2)

Petitioner attended therapy as instructed. At the October 7, 2015 session Petitioner requested that she not have to lay on the treatment table as it bothered her. She reported increased pain down her left leg when side bending to the right. She was unable to tolerate "ther-ex:" secondary to increasing pain. She also reported that she was always having to change positions to relieve her pain which was admittedly "getting to her." (PX 2)

On October 8, 2015, Petitioner followed up at Work Care. Petitioner indicated her primary concern was her lumbar spine, followed by her cervical spine and knees. Petitioner described both as aching and unrelenting. Petitioner also reported that walking increased her symptoms in all areas and she was experiencing a radiculopathy that would come and go. Petitioner indicated she had an appointment pending with Dr. Hayward for her spine, although she had concerns about seeing him. According to the notes, the MRI was on hold per the case manager until after Petitioner's exam with Dr. Hayward. It was noted Petitioner refused to see the doctor who diagnosed her with syringomelia. Petitioner indicated that physical therapy was not helping much. It was noted symptom magnification was present but her attitude and effort were felt to be "fair." Restricted duty was continued. (PX 3)

On October 12, 2015, Petitioner presented to Dr. Franklin Hayward at Heartland Spine Institute. Petitioner provided the doctor with a detailed account of her work accident in September and her medical care since the accident and told the doctor that she was undergoing therapy with no relief. Petitioner also described her current symptoms as new, and told the doctor about a work injury two and one-half years earlier when she fell on her left buttock while confronting an aggressive resident. She also recalled a neck injury when a resident pushed her head into a wall but couldn't recall the date. There was also an incident when her right thumb was bent backwards and an incident when she fell to her knees during an altercation but she couldn't recall those dates of injury. Petitioner denied any history of back surgery and explained she had seen Dr. Stahley for tremors. Petitioner complained of low back pain, weakness all over, dizziness, balance difficulty, nausea, headache, numbness in her feet, and numbness and tingling in the 4th and 5th fingers of the right hand, all of which began after the accident. Petitioner felt the accident had worsened her tremors. Dr. Hayward ordered MRIs of Petitioner's cervical and lumbar spine and continued Petitioner's restrictions. He referred Petitioner back to Dr. Stahley and/or her family doctor for her tremors. (PX5).

Petitioner returned for physical therapy on October 14, 2015 having last attended on October 7, 2015. Petitioner was reporting continued pain down her left leg all the way to the ankle. She was still waiting for the MRI to be scheduled. (PX 3)

Petitioner attended physical therapy on October 16, 2015 reporting some slight subjective improvement that day but also having tremors in her upper back and a "grabbing" sensation in her left low back along with sharp pain when trying to sit straight. (PX 3)

Petitioner again attended physical therapy on October 19, 2015 reporting increased pain that day and over the weekend (associated with increased standing). Petitioner attempted more therapy at this visit. (PX 3)

As of October 22, and October 26, 2015 Petitioner was still having trouble with some aspects of therapy and her MRI was still pending. As of October 28, 2015 her MRI was finally being scheduled. (PX 3)

On November 2, 2015, Petitioner underwent an MRI of her lumbar spine. The impressions were: 1) minor degenerative disc disease, disc bulges cause minor foraminal stenoses at L3/4 and L4/5, left L3 nerve root contacts the disc bulge near the foramen, and could be a source of pain; 2)

no lumbar spine central canal stenosis; 3) benign hemangioma in the T10 vertebra; and 4) LLQ borderline nodes vs mild mesenteric lymphadenitis. Petitioner also underwent a cervical spine MRI. The impressions were: 1) c-spine straightening may be due to positioning or muscle spasm; 2) minor cervical disc bulges, no cord compression or central canal stenosis; 3) tiny hydromelia, syrinx at C7/T1; 4) moderate left foraminal stenosis at C6/7; 5) benign hemangioma in the T4 vertebra; and 6) S/P thyroidectomy. (PX5).

Petitioner attended physical therapy on November 4, 2015 reporting she had undergone the MRI but was unaware of the results. Sitting and bending were still bothering her and she had an ongoing antalgic gait and difficulty walking. It was recommended that she continue physical therapy three times a week. (PX 3)

On November 6, 2015, Petitioner returned to Work Care. Petitioner indicated her neck pain was 7 out of 10, her back pain was 7 out of 10, and her bilateral knee pain was 7 out of 10. She was also noted to be depressed. Her condition was again noted to be related to her work activities. Petitioner's prescriptions were refilled and she was to start an exercise program. (PX3).

On November 9, 2015, Petitioner followed up with Dr. Hayward. Petitioner continued to complain of back and leg pain that the doctor described as being in a non-dermatomal distribution. Petitioner also reported she was not improving and asked the doctor to refer her to a neurologist to facilitate a neurology consultation as part of her claim. Dr. Hayward explained that he felt she needed to follow up with Dr. Stahley regarding her chronic condition and that she might need to do that under her own health insurance. On examination, Dr. Hayward stated that Petitioner's motor strength was intact. He further noted Petitioner had Waddell's testing, three out of five. Dr. Hayward reviewed Petitioner's MRIs which showed age appropriate mild degenerative changes and a bulge at L3/4 which was making contact with her L3 nerve root; however, he felt Petitioner had no L3 radiculopathy as her leg pain was all posterior and radiating down to the leg and foot which he could not explain. Petitioner also had clearly reproducible pain to palpation of her lumbar and cervical spines with the lumbar region being more tender. Petitioner was diagnosed with myofascial muscle pain. Dr. Hayward also noted Petitioner's history of fibromyalgia and syringomyelia and felt that might be the cause of her myofascial pain. Dr. Hayward saw no evidence to suggest radiculopathy. Dr. Hayward noted that whether the tremors were related to her work accident was an issue for Dr. Stahley to address. Dr. Hayward also noted that there were no surgical indications and, while he released Petitioner from his care without any restrictions due to the absence of any physical limitations, he did recommend a referral to an occupational medicine doctor for further treatment of her condition given that there was no acute surgical indication. (PX5).

According to the November 19, 2015 physical therapy discharge note, Petitioner had been discharged from further care in light of Dr. Hayward's release to return to work. Petitioner had last undergone therapy on November 4, 2015. (PX 3)

On November 29, 2015, Petitioner sustained another accident while working for Respondent. Petitioner filled out a Worker's Compensation Employee's Notice of Injury form (d/a: 11/29/15). Petitioner indicated she was attempting to restrain an aggressive patient. Petitioner

indicated she injured her left wrist/hand, right hand, bilateral forearms, neck, and back. (RX7). Respondent does not dispute that this accident occurred. (AX 3)

On November 30, 2015, Petitioner returned to Dr. Moyers, her primary care doctor. Petitioner complained of chronic low back pain and indicated she was attacked by a patient on November 29, 2015. She made no mention of the September 4, 2015 accident. Petitioner indicated she had seen a neurosurgeon who did not feel she needed surgery and released her back to work. Petitioner indicated she was then attacked again on the 29th while on light duty and had pain radiating down her left leg into her foot. It was noted Petitioner had had C-spine and L-spine MRIs. Petitioner was diagnosed with C-spine and T-spine sprains and disc degeneration in her lumbar region. Petitioner was prescribed physical therapy. (RX20).

On December 7, 2015, Petitioner returned to Work Care regarding her September 4, 2015 accident. Petitioner indicated her back pain, neck pain, and bilateral knee pain was a 7 out of 10 and that she had sustained a new accident at work that was being handled by another provider so she requested a release from the previous injury. Petitioner was discharged at her request. (PX3).

On December 10, 2015, Petitioner presented to Dr. Matthew Gornet at The Orthopedic Center of St. Louis. Petitioner complained of low back pain and neck pain. Petitioner indicated her problem began on September 4, 2015 after she was involved in an altercation with an aggressive patient. Petitioner indicated she did have some spinal pain and chiropractic care in 2004, but no intervening treatment since that time. Petitioner was diagnosed with: a disc injury at L3/4; disc injury, annular tear, and herniation at L5/S1; and disc injury at C6/7. Dr. Gornet noted that he felt Petitioner had, at a minimum, suffered an aggravation/re-aggravation of her "work injury." Dr. Gornet put treatment for the neck on hold while Petitioner treated for the low back. Dr. Gornet recommended a steroid injection at L5/S1 and physical therapy. A new cervical MRI was ordered. Petitioner was taken off of work. (PX 8)

On December 15, 2015, Petitioner followed up with Dr. Moyers regarding her lower back. Petitioner indicated she was treating with Dr. Gornet and was scheduled to undergo injections in her lower back. Petitioner reported that her left hip pain was continuing and was radiating down to her left knee and foot. Petitioner requested a referral to a mental health specialist for anxiety and insomnia. Petitioner was to remain off work per Dr. Gornet and was referred to Brad Robison. (RX20)

On January 13, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 2296 alleging injuries to her neck, back, bilateral hands and arms, and body as a whole as a result of an accident on November 29, 2015 described as an "altercation with patient/aggravation." (AX 4)

On January 14, 2016, Petitioner underwent a left L5/S1 epidural steroid injection by Dr. Kaylea Boutwell. (PX9)

On February 1, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 004246 alleging injuries to her bilateral knees, left buttock, right arm, back, and body as a whole as a result of an accident on June 29, 2013. (AX 6)

On February 29, 2016, Petitioner underwent an MRI of her cervical spine without contrast. The impressions were: 1) central-left foraminal broad-based protrusion at C6/7 measuring up to 3.5 mm in the left foramen, resulting in moderate left foraminal stenosis; 2) central broad-based protrusions at the C3/4, C4/5 and C5/6 levels; and 3) 1-1.5 mm maximal diameter cervical cord syrinx focally at the C7/T1 disc level. (PX11).

That same day, Petitioner followed up with Dr. Gornet. Dr. Gornet reviewed Petitioner's cervical MRI noting that it showed Petitioner had a fragment of disc on the left side at C6/7, subtle changes on the right side at C5/6 and C6/7, and central disc protrusions at C3/4, C4/5, and C5/6. Dr. Gornet also stated in his notes that Petitioner had a foraminal herniation at L3/4 on the left and recommended a transforaminal steroid injection. He again noted that Petitioner's symptoms related to an accident on September 4, 2015. If that did not help, a CT discogram and MRI spectroscopy would be next. Petitioner was given work restrictions fo "office work only" on a trial basis. (PX8).

On March 16, 2016, Petitioner underwent a transforaminal steroid injection under fluoroscopic guidance at L3/4 left with facet block at L3/4 left. Petitioner tolerated the procedure well. (PX12; PX 8).

On May 9, 2016, Petitioner followed up with Dr. Gornet. Petitioner indicated the injection gave her a month of relief, but she had continued symptoms and pain. Dr. Gornet recommended an MRI spectroscopy and CT discogram. Petitioner's work restrictions were continued and her prescriptions refilled. (PX8)

On May 10, 2016, and at Respondent's request, Petitioner underwent a Section 12 examination by Dr. David Robson at Comprehensive Spine Care. Petitioner gave a history of being attacked by a patient at work on September 4, 2015, injuring her neck and back. Dr. Robson also reviewed an accident report from November 29, 2015 indicating Petitioner was injured by an aggressive patient. Petitioner gave no history of prior treatment for her neck or back, but when interviewed, did recall a remote history of low back treatment with a chiropractor in 2011. Dr. Robson reviewed medical records including those from physical therapy, Dr. Moyers, Dr. Gornet, injection reports, and imaging studies. Dr. Robson diagnosed Petitioner with mild degenerative changes of the lumbar spine, mild disc bulging at L5/S1, mild degenerative changes at the cervical spine, and syringomyelia at C7/T1. Dr. Robson opined physical therapy was warranted for a flare-up of low back pain, but further treatment was not reasonable or necessary as Petitioner had a known history of chronic lower back and neck problems. Dr. Robson further opined the September 4, 2015 and November 29, 2015 injuries caused a temporary aggravation of her pre-existing neck and lower back complaints, but Petitioner was at MMI and could return to work without restrictions. (RX16)

On June 16, 2016, Petitioner presented to Dr. Eugene Kostiuk at Clay Medical Center. Petitioner complained of anxiety, depression, and difficulty sleeping. Petitioner was diagnosed with post-traumatic stress disorder and counseling was recommended. (PX13)

On June 28, 2016, Petitioner underwent a discogram with x-ray interpretation at L3/4, L4/5, and L5/S1 with facet block left at L3/4, L4/5, and L5/S1. The summary indicated: non-provocative

disc at L4/5; minimally provocative disc at L3/4 for back pain, some butt pain; and L5/S1 severely provocative of concordant back pain. (PX14)

On July 26, 2016, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) broad based or bilobed disc herniation on L3/4, larger on the left, extending towards the foramina, also worse on the left, without central stenosis; and 2) smaller central protrusion at L5/S1 without significant impression upon the dura. (PX11)

On July 26, 2016, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed the MRI spectroscopy and CT discogram, noting Petitioner had a non-provocative disc at L4-5, minimally provocative disc at L3-4 and a severely provocative disc at L5-S1 on the discogram; however, the MRI spectroscopy did not detect any reading at L5-S1. There was a large central annular tear at L5-S1. Dr. Gornet also reviewed Dr. Robson's IME report and noted his explanations of it to Petitioner. He pointed out that Dr. Robson apparently felt Petitioner had sustained temporary aggravations of her pre-existing neck and low back complaints in relation to her 9/4/15 and 11/29/15 accidents. Dr. Gornet explained to Petitioner that while she did candidly acknowledge a history of pre-existing complaints in her spine there was no indication that her level of complaints or severity was anywhere near the level of her current ones. He further noted that Dr. Robson did not have the opportunity to review the CT discogram report and visualize the central annular tear as well as the reproduction of symptoms at L5-S1. As her adjacent levels for the most part were "fairly clean" and she had failed conservative care, to date, Dr. Gornet recommended Petitioner undergo an anterior lumbar fusion. Her work restrictions remained unchanged. (PX8).

Petitioner resumed full duty work for Respondent in July of 2016.

Deposition of Dr. Gornet

Dr. Matthew Gornet testified via evidence deposition on September 15, 2016. (PX15). Dr. Gornet testified he is an orthopedic surgeon whose practice is devoted to spine surgery. (PX15, p. 4). He performs research, clinical trials, and treats patients. (PX15, p. 4-5). Dr. Gornet testified Petitioner first saw him on December 10, 2015. (PX15, p. 6). She acknowledged a history of some prior low back/neck pain. (PX15, p. 7). Dr. Gornet testified he reviewed imaging studies of Petitioner's lumbar and cervical spine. (PX15, p. 7-8). Dr. Gornet diagnosed Petitioner with a disc injury at L3/4; a disc injury, annular tear and herniation at L5/S1; and a disc injury at C6/7. (PX15, p. 9). Conservative care of injections and physical therapy was recommended, as well as new imaging studies. (PX15, p. 9). Dr. Gornet testified it was his understanding Petitioner had had a couple work injuries and it was impossible to tell which findings were objectively caused by which accident when looking at x-rays, MRIs, or other films. (PX15, p. 10).

Dr. Gornet testified that Petitioner only received temporary relief from the injection. (PX15, p. 11). Petitioner then underwent an MRI spectroscopy and CT discogram and he then recommended to undergo an anterior lumbar fusion at L5/S1. (PX15, p. 12-14). Dr. Gornet opined Petitioner's work injury of September 24, 2015 aggravated her underlying condition and the November 29, 2015 injury aggravated it further. (PX15, p. 15-16) As he explained it:

> . . . [T]his is a woman who may have had some mild disc degeneration prior to this. She does have a history of low back pain dating back several years. That being said, there is no indication that she had a significant major problem that she does today. Therefore, almost de facto we can state that her condition is one that is ongoing, and in her overall health status this condition is relatively new and dates to approximately September of 2015.
>
> Now, that being said, what I believe happened is, is that this woman has some preexisting disc degeneration. Disc degeneration is a normal part of life and can be relatively asymptomatic, but it does weaken the disc. She's in an altercation, she has applied mechanical load which injures the disc and it causes a tear.
>
> I believe November 29th aggravated that further, making her more symptomatic, and at this point in time, she continues to be symptomatic. We can say as a matter of course that this is not a temporary condition, because the patient's symptoms have never returned back to baseline prior to the injury. (PX 15, pp. 15-16)

On cross-examination, Dr. Gornet admitted that he did not review any medical records outside of his own and the IME report. (PX15, p. 18). He further explained that Petitioner's syringomyelia refers to some mild fluid contained within her spinal cord. It usually does not progress except in very rare circumstances. He did not feel it had anything to do with her current complaints. (PX 15, pp. 18-19) Dr. Gornet testified he compared the MRIs of Petitioner's cervical and lumbar spine taken November 2, 2015 to the ones he had done. (PX15, p. 19-20). He testified the more recent MRIs did not show newer pathology, just a more accurate definition of the pathology present. (PX15, p. 20). There was no major progression. (PX15, p. 20). Dr. Gornet testified myofascial muscle pain is a subjective complaint. (PX15, p. 21). Dr. Gornet agreed Petitioner gave him a history of spine pain and chiropractic care in 2004, but did not recall any intervening treatment since that time. (PX15, p. 22). Dr. Gornet testified if that was inaccurate, and there was a "significant event" that was near that time frame it could possibly change his opinion and he would evaluate any new information. However, Petitioner clearly detailed to him that she felt she had spinal problems in the past. (PX15, p. 23)

Dr. Gornet testified he did not have Dr. Hayward's medical records and was unaware Dr. Hayward found three out of five Waddell's testing. (PX15, p. 24). Dr. Gornet testified Waddell's testing is a way to evaluate inorganic or other findings in patients that is associated with non-necessarily physiologic presentations of low back pain and can be used to determine if there is the possibility of symptom magnification. (PX15, p. 25). Dr. Gornet testified a three out of five would be a moderately positive Waddell's sign. However, he did not detect any functional overlays during his exams with Petitioner. (PX15, pp. 25-26)

Dr. Gornet testified he has put any treatment for Petitioner's neck on hold at this point in hopes that treating the low back would alleviate Petitioner's complaints. (PX15, p. 26-27). Petitioner has not undergone any injections for her neck and there is no surgical recommendation at this time. (PX15, p. 27)

Dr. Gornet testified his causation opinion is based upon the history Petitioner gave him regarding the injuries, her medical history she told him, and the records he had for review. (PX15, p. 28). Dr. Gornet admitted that if the history Petitioner gave him regarding her prior back complaints and treatment was inaccurate, it could change his opinion. (PX15, p. 28)

Dr. Gornet testified that he is relating Petitioner's need for surgery to both the September 4, 2015 and November 29, 2015 accidents. (PX15, p. 28). Dr. Gornet testified that there were no structural changes in Petitioner's spine in comparing the two MRIs. (PX15, p. 28). Dr. Gornet agreed that a herniation on an MRI cannot be dated. (PX15, p. 29)

Additional Medical Treatment

On October 6, 2016, Petitioner followed up with Dr. Gornet. Petitioner complained of continued low back pain. Dr. Gornet continued to recommend an anterior lumbar fusion at L5/S1 and refilled Petitioner's prescriptions. (PX8).

Deposition of Dr. Robson

Dr. Robson testified via evidence deposition on October 24, 2016. (RX18). Dr. Robson testified he is a board certified orthopedic spine surgeon who treats conditions of the cervical, thoracic, and lumbar spine. (RX18, p. 4-5). Dr. Robson testified he performed an IME on Petitioner on May 10, 2016. (RX18, p. 7). He reviewed Petitioner's medical records which showed Petitioner had lower back complaints prior to September 4, 2015. (RX18, p. 8). Specifically, Petitioner had treated with Dr. Moyers on July 9, 2014 complaining of chronic back pain and indicated her back had previously gone out five months prior. (RX18, p. 8). Dr. Robson testified this was inconsistent with the history Petitioner gave on his Patient Questionnaire where she denied any pre-existing problems prior to September 2015. (RX18, p. 9). Also, Dr. Robson testified that when he asked her directly about any prior treatment, she indicated she had some chiropractic care in 2011, but did not mention any problems or treatment in 2014. (RX18, p. 8)

Dr. Robson testified he reviewed the films of Petitioner's cervical and lumbar spine MRIs done on November 2, 2015. (RX18, p. 9). He did not see any significant herniation or protrusion lateralizing in Petitioner's neck. (RX18, p. 9). With regard to the lumbar spine, he thought she had some loss of disc height at L3/4 and L5/S1, but did not see any significant foraminal stenosis at either level. (RX18, p. 10). There was some minimal bulging at L5/S1. (RX18, p. 10). Dr. Robson testified he did not diagnose an annular tear at L5/S1. (RX18, p. 10). Dr. Robson testified he pulled up the films of Petitioner's lumbar spine MRI just prior to being deposed and re-examined them. (RX18, p. 10). While Dr. Gornet noted an annular tear at L5/S1 on axial image 12, Dr. Robson disagreed as there was no high intensity zone or a white spot or a bright lesion that would denote an annular tear. (RX18, p. 10)

Dr. Robson testified he took a history from Petitioner regarding the September 4, 2015 and November 29, 2015 injuries and performed a physical examination. (RX18, p. 11). On physical examination, Dr. Robson testified Petitioner's examination was normal, except some decreased range of motion of the cervical spine. (RX18, p. 11-12). Petitioner's lumbar spine showed normal gait and normal neurological testing. (RX18, p. 12)

Dr. Robson testified Petitioner had previously been diagnosed with fibromyalgia which is purported to cause cervical and lumbar spine problems and often time physical therapy and trigger point injections are required. (RX18, p. 12). Petitioner's medical records indicate she had previously undergone physical therapy and trigger point injections prior to September 4, 2015. (RX18, p. 12).

Dr. Robson diagnosed Petitioner with a cervical strain and lumbar strain, based on his review of the medical records, the history taken from Petitioner, and the physical examination he performed on her. (RX18, p. 12-13). He did not believe Petitioner required any additional treatment, opined she was at MMI, and could return to work without restriction. (RX18, p. 13-14).

On cross-examination, Dr. Robson testified he had not seen the results of Petitioner's CT discogram. (RX18, p. 15). Dr. Robson testified he does not perform discograms even though he is trained to do it because he is not a big believer in that test. (RX18, p. 16). Dr. Robson testified patients are supposed to be blinded as to what levels are being tested, but it depends on who is performing it. (RX18, p. 17).

Dr. Robson testified he did not see any signs of malingering or Waddell's signs in his examination, but Petitioner was inconsistent as far as forthcoming with her past medical history. (RX18, p. 18). Dr. Robson testified Petitioner indicated on the Patient Questionnaire she filled out that she had not had any prior problems with her back before her 2015 injury. (RX18, p. 18-19). He said this was inconsistent with what was in Dr. Gornet's notes and Dr. Moyer's notes. 9RX18, p. 18-19). He testified this was also inconsistent with what Petitioner told him about receiving chiropractic care in 2011. (RX18, p. 19). Dr. Robson testified Petitioner did not tell him that she had a previous injury on June 29, 2013. (RX18, p. 21). Dr. Robson testified he had no criticism of her care and treatment up to date. (RX18, p. 22).

Additional Medical Treatment

On October 29, 2016, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form for an accident occurring that day. Petitioner indicated that on October 24, 2016, she was jerked around while trying to break up a fight between three aggressive patients. (RX 10) Respondent does not dispute that this accident occurred. (AX 7)

On October 30, 2016, Petitioner filled out a Workers' Compensation Employee's Notice of Injury form regarding an accident that occurred that day. Petitioner indicated she was thrown over the back of a couch with a patient while trying to stop his violent behavior. Petitioner indicated she injured her hips, left leg, and had whole spine pain. (RX13). Respondent does not dispute that this accident occurred. (AX 9)

On November 21, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 0036410 alleging injuries to her back, neck, and body as a whole as result of an accident on October 24, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 8)

On November 21, 2016 Petitioner also signed her Application for Adjustment of Claim in case #16 WC 0036411 alleging injuries to her back, neck, and body as a whole as result of an accident on October 30, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 10)

On November 23, 2016, Petitioner returned to Dr. Gornet. Petitioner indicated she was in two new altercations on October 24, 2016 and October 30, 2016. Petitioner indicated she felt she had aggravated her underlying back condition and injured her neck and shoulders. Dr. Gornet recommended observation and indicated if Petitioner's symptoms continued to be elevated, he would recommend new imaging studies to see if there is a new disc injury. Petitioner was taken off work. Dr. Gornet noted, "At a minimum, these new injuries have aggravated her underlying conditions in her cervical and lumbar spines." (PX8).

On January 9, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet described Petitioner as being "clinically worse." He recommended a new MRI, but indicated unless it was dramatically changed, he would move forward with the anterior lumbar fusion at L5/S1. (PX8)

On March 23, 2017, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) L3/4 and L4/5 annular disc bulges with superimposed left foraminal protrusions at both levels resulting in moderate left greater than right foraminal stenosis but no central canal stenosis; and 2) left paracentral focal protrusion at L5/S1 resulting in dural displacement and contact with the traversing left S1 root sleeve but no definite central canal or foraminal stenosis. (PX11)

On March 23, 2017, Petitioner returned to Dr. Gornet, regarding her with-related injuries, including new altercations of 10/24/16 and 10/30/16 as well as her original injury of 9/4/15. He noted that the MRI did not show any dramatic changes. The options of a lumbar fusion and a disc replacement at L5/S1 were discussed. (PX8)

On April 27, 2017, Petitioner underwent another Section 12 examination with Dr. Robson. Petitioner gave a history of a new injury on October 30, 2016 when she was in another patient altercation. Petitioner complained of low back pain radiating down into her left leg and foot. Dr. Robson reviewed accident reports, medical records, and imaging studies, including MRIs of Petitioner's lumbar spine from November 2, 2015, September 26, 2016, and March 23, 2017. Dr. Robson's assessment was mild disc desiccation at L3/4 and L4/5 and diffuse disc bulging asymmetric to the left at L5/S1. Dr. Robson noted Petitioner had previous low back complaints in 2014 for which she treated and took pain medication. Dr. Robson opined there was no causal relationship between Petitioner's current condition and the reported accident, and that her current condition was related to her pre-existing condition. Dr. Robson opined that he did not believe surgical intervention was medically necessary. He further opined Petitioner was at MMI and could return to work without restrictions. (RX17)

On May 11, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet continued to recommend a disc replacement at L5/S1. (PX8)

Second Deposition of Dr. Robson

Dr. Robson testified again via evidence deposition on July 27, 2017. (RX19). Dr. Robson testified he performed a second IME on Petitioner on April 27, 2017. (RX19, p. 7). Dr. Robson testified that he reviewed medical records and performed a physical examination. (RX19, p. 7). Dr. Robson reviewed MRI films of Petitioner's lumbar spine from November 2, 2015, July 26, 2016, and March 23, 2017. (RX19, p. 9). Dr. Robson testified he compared all three lumbar spine MRI films. (RX19, p. 10). The March 23, 2017 MRI showed some mild loss of disc height between her third and fourth lumbar, her fourth and fifth lumbar, and L5/S1. (RX19, p. 10). There was a small asymmetric disc bulge to the left at L5/S, and, in comparison to the two previous MRIs, Dr. Robson felt it was unchanged or maybe even slightly better. (RX19, p. 10). The size of the disc bulge did not appear as large. (RX19, p. 10).

Dr. Robson testified that Petitioner indicated to him that she was injured at work when she was breaking up a fight between two patients on October 30, 2016. (RX19, p. 11). Petitioner said this increased her back pain. (RX19, p. 11). Dr. Robson performed a physical examination of Petitioner which was normal, except some limited range of motion in forward flexion. (RX19, p.11). Dr. Robson testified there were no structural changes between Petitioner's lumbar MRIs taken in 2016 and March 23, 2017. (RX19, p. 11).

Dr. Robson diagnosed Petitioner with mild dehydration of the disc between her third and fourth lumbar and her fourth and fifth lumbar vertebra and a diffuse disc bulge asymmetric to the left at L5/S1. (RX19, p. 12). Dr. Robson testified this diagnosis was not related to the October 30, 2016 work injury. (RX19, p. 12). Dr. Robson testified Petitioner did not need any further treatment related to the October 30, 2016 injury and that she was at MMI. (RX19, p. 13). Dr. Robson testified he personally would not perform the recommended surgery. (RX19, p. 13). He further testified that he could not attribute the need for same to an October 30, 2016 injury. (RX19, p. 13). Dr. Robson explained that he would personally not do the surgery because the only positive test that came back was the discogram which has subjective components to it. (RX19, p. 14). The imaging studies did not demonstrate instability, and while there was some pathology, he did not see it in what he would offer surgical intervention to. (RX19, p. 14). Dr. Robson testified the medical literature is replete with evidence that discograms are not completely objective studies. (RX19, p. 14).

On cross-examination, Dr. Robson testified Petitioner had pre-existing lumbar complaints, referring to medical records he reviewed from 2014. (RX19, p. 17-18). Dr. Robson agreed that Petitioner had not been recommended to see a spine specialist prior to September 2015 in the medical records he reviewed. (RX19, p. 19). Dr. Robson testified he did not review Dr. Hayward's records or records from Work Care and that if Dr. Hayward's records contained more information about the September 4, 2015 accident he would have liked to have reviewed it. (RX19, p. 20-21).

Dr. Robson testified only a minority of spine surgeons and specialists in the medical community use CT discograms. (RX19, p.21-22). Dr. Robson testified he did not find an annular tear on Petitioner's lumbar spine MRIs. (RX19, p. 22). Dr. Robson testified he thought the disc protrusion at L5/S1 was actually smaller on Petitioner's March 23, 2017 MRI. (RX19, p. 23).

Dr. Robson testified that a patient altercation where a person was jostled around and thrown to the ground, such as the ones Petitioner had been involved in, can be the type of mechanism of injury that can cause a disc injury in the lumbar spine. (RX19, p. 24). He also testified that kind of altercation could hypothetically aggravate a pre-existing lumbar condition. (RX19, p. 24).

Dr. Robson testified that the symptoms Petitioner complained of are the type that tend to wax and wane. (RX19, p. 25). Dr. Robson testified that there were no structural changes in Petitioner's lumbar spine after the October 30, 2016 injury, which both the radiologist and Dr. Gornet agreed with. (RX19, p. 25). Dr. Robson was asked if Petitioner's symptoms have ever returned to a baseline or pre-injury status and he replied:

> Well, it's really hard to tell. She's had the same low back and left-sided symptoms since 2014, so I can't tell which – symptoms like that tend to wax and wane. I don't know what impact this injury on October 30th of 2016 had. It certainly didn't change the structures of her lumbar spine as [we] all agree to. (RX 19, p. 25)

Dr. Robson testified it would be rare to see a person have symptoms aggravated without seeing a change on MRI. (RX19, p. 25-26). These types of symptoms tend to wax and wane in patients and they will experience flare-ups from time to time. (RX19, p. 26). Dr. Robson further testified that he had no record of the 10/24/16 accident and he wasn't sure if he had Dr. Gornet's 11.23.16 note. However, he took no issue with Dr. Gornet's records indicating Petitioner's symptoms increased after the two October of 2016 accidents. (RX 19, pp. 27-28) Dr. Robson testified that surgery is not always the solution for someone who has failed conservative care. (RX19, p. 30). In his practice, he would try to talk to Petitioner about living with her condition rather than face the risk of a complication. (RX19, p. 30). He does not believe the risk outweighs the potential rewards should she undergo surgery. (RX19, p. 31).

Dr. Robson testified that when treating a patient, one considers MRI findings, physical exam findings, and patient symptoms. (RX19, p. 32). Dr. Robson also testified that symptoms have a good subjective component to them, especially in a litigated case, whereas objective findings tend to be standard. (RX19, p. 32).

Additional Medical Treatment

On August 17, 2017, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed Dr. Robson's IME report with Petitioner. Dr. Gornet reiterated his recommendation of a disc replacement at L5/S1. Her work restrictions remained unchanged. (PX8)

On December 14, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet indicated Petitioner's exam was unchanged and there were no new issues, Dr. Gornet again recommended a disc replacement at L5/S1 and possible fusion, if needed. She remained temporarily totally disabled. (PX8)

The Arbitration Hearing

Petitioner's case against Respondent proceeded to arbitration on January 25, 2018 pursuant to a 19(b) Petition she had filed. The disputed issues were causal connection, medical bills, temporary total disability benefits and prospective medical care. Petitioner was the sole witness testifying at the hearing. Respondent's representative at the hearing was Cathy Kennedy. At the commencement of the proceeding, Petitioner's attorney moved, without objection, to amend the Application for Adjustment of Claim in case #15 WC 30798 (D/A: 9.4.15) to include alleged injuries to the neck and back.

Petitioner testified she is currently employed with Respondent as a Security Therapy Aide I. She works with the criminally insane and it is her job to keep everyone safe and help monitor patients. She also has to intervene if patients become aggressive.

Petitioner testified that she was injured on September 4, 2015 when she tried to stop a patient from charging another patient. Petitioner testified she "got hit like a linebacker" and flew backwards on the floor and injured her back, knees, and neck. (See also RX 4.) Petitioner testified her primary care doctor did not take work comp, so she went to Work Care. Petitioner testified she was given work restrictions that could not be accommodated, so she was taken off of work and paid extended benefits. Petitioner then saw Dr. Hayward. She underwent an MRI and he released her back to work sometime in November of 2015.

Petitioner further testified that on November 29, 2015, she was trying to hold the leg of a patient who had attacked another patient and she was jostled around, inflaming her lower back. (See RX 7.) Petitioner testified she began treating with Dr. Gornet and was taken off of work. Petitioner testified that Dr. Gornet has also given her restrictions, at times, but has never released her to full duty since she began treating with him. She has undergone multiple imaging studies and has had injections. Petitioner testified she underwent an IME with Dr. Robson and after receiving his report she was advised she needed to go back to work on a full duty basis.

Petitioner testified that she did return to full duty work and on October 24, 2016, she was trying to hold back a patient from attacking another patient who was jumping over her back, and she was "getting landed on" while the patient was trying to pummel another patient. She injured her back and it made her foot numb that day. (See also RX 10.) Then on October 30, 2016, she grabbed a patient's arm to prevent him from throwing a punch, which pulled her over a couch. She landed in the crack of the couch holding him while he was fighting, injuring her back and neck. (See RX 13) Petitioner testified that after that accident Dr. Gornet said "that was enough" and he took her completely off of work.

Petitioner testified that she had a prior work accident in June of 2013 when she was trying to restrain a patient and was standing on a bed. She dropped down, hitting her buttocks on the edge of the nightstand, and kind of "cranked this way" with the weight of her body and hurt her back. (RX 1) Petitioner testified that she sought very little medical treatment for this although she thought she may have seen her doctor in 2014 for some residual pain but she didn't "deal with it." Petitioner also testified that her primary care doctor's records indicate she had some back pain in 2014 and she explained that those complaints were referable to her 2013 accident. She did not seek any other treatment then this and did not miss any work due to this injury. Petitioner testified she

did not believe that the 2013 accident was in any way responsible for the symptoms that she has now.

Petitioner testified that prior to September 4, 2015 she was doing well with regard to her low back. She was going to the gym twice a day, biking, and running two miles a day after work. She testified she cannot do those things now. She testified Dr. Gornet is recommending lower back surgery which she would like to undergo as she is tired of the pain.

Petitioner testified after her second IME with Dr. Robson, she received notification that she would no longer be receiving workers' compensation benefits. Petitioner testified that she did not tell Dr. Robson about having low back issues prior to September of 2015 because she thought it was different than her 2004 diagnosis of fibromyalgia. To her fibromyalgia referred to muscular aches whereas "back pain" referred to her spine. Petitioner also testified she did not mention the 2013 injury and 2014 treatment to Dr. Robson because she had "let it go" and it did not cause her any more grief.

On cross-examination, Petitioner testified that when her workers' compensation benefits were terminated, she went on a non-occupational leave and has been receiving benefits through non-occ since that time. Petitioner further testified she still has her group insurance through her employment. Petitioner testified that she has not undergone the recommended surgery through her group insurance because she wants Dr. Gornet to perform the surgery. Petitioner admitted that she has not asked if Dr. Gornet accepts her insurance and that she is just waiting to see how this plays out. If she were to lose her workers' compensation case, she would still pursue having the surgery done through her group insurance.

Petitioner testified she did not miss any time from work for her 2013 injury nor did she admit any medical records indicating she treated for her back in 2013 into evidence. Petitioner testified after the September 2015 injury, Dr. Hayward released her to return to work full duty on November 12, 2015, but she did not return until November 24, 2015 because she was shocked he had released her.

Petitioner testified the November 29, 2015 injury occurred five days after she had returned to work full duty. At that time, Petitioner was bumped from day shift to evening shift by a more senior employee. Petitioner admitted that she was upset that she was bumped to evening shift.

Petitioner testified she was off of work until July of 2016 when she returned to work full duty. She was working full duty at the time of the October 24, 2016 injury and continued to work full duty until the October 30, 2016 injury.

Petitioner testified that she is not currently working and does not have any kind of employment. When asked if she makes and sells jewelry online, she admitted that she did have a "hobby" of that. Petitioner testified she makes coin rings using a little mandrill, which she uses to pound on the coin.

Petitioner testified she smokes one pack of cigarettes a day and has been counseled regarding same. She has been diagnosed with fibromyalgia. Petitioner testified she underwent chiropractic care for her back in 2004, but could not remember if she did so in 2011.

Petitioner testified she is not using any kind of brace or protective device. She takes over-the-counter medication pretty much daily. Workers' compensation refused to pay for one medication she was prescribed and another medication bothered her stomach. She is not currently undergoing physical therapy.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in her low back is causally related to her September 4, 2015 work accident. In so concluding, the Arbitrator relies upon a chain of events and the more persuasive opinions of Dr. Gornet over those of Dr. Robson.

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 902 N.E.2d 1269, 1273 (5d Dist. 2009). When a pre-existing condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] 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." *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 864 N.E.2d 266, 272-273 (5th Dist. 2007).

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, 672 (Ill. 2003). [Emphasis original]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1st Dist. 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (Ill. 1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977). The Supreme Court's decision in *Sisbro, Inc.* highlighted that even though a workers' compensation claimant has a pre-existing condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003).

Petitioner has filed five claims against Respondent for injuries to her low back, neck and knees. Respondent has not disputed any of the accidents.

Petitioner's first accident was on June 29, 2013. Petitioner testified that she sought very little medical care as a result thereof. Medical records appear to corroborate that although Dr. Moyer's office note of June 9, 2014 notes chronic back pain on Petitioner's lower left side "for about a year." This would be consistent with her June 29, 2013 work accident. Dr. Moyer ordered an x-ray and physical therapy but Petitioner never underwent any therapy because of her schedule. Thus, she underwent no treatment for her low back and continued to work full duty for Respondent for another fourteen months before having to seek medical treatment after an undisputed work accident on September 4, 2015 (the subject of the instant claim).

At the center of the causation dispute in this case is Respondent's position, and Dr. Robson's belief, that Petitioner's need for treatment as proposed by Dr. Gornet stems from a chronic pre-existing low back condition made apparent on July 19, 2014, as opposed to any/all of the four subsequent very hostile and physical assaults on Petitioner while working. The Arbitrator doesn't agree with Respondent's position or the opinion of its examining doctor. July 9, 2014 is the first mention in the records of any low back issues. Petitioner did not even mention an injury to her back on the June 30, 2013 Notice of Injury form. While there is a reference in some of the medical histories to chiropractic care in 2004 no records were introduced to further set forth the nature of this treatment and, more significantly, Petitioner underwent no further treatment for her back for over ten years. Nothing in the record herein suggests that Petitioner had a diagnosed and treated chronic low back condition before July 9, 2014. The Arbitrator views the reference to "chronic" back pain in the July 9, 2014 medical office note as distinguishing Petitioner's complaints from an acute problem. While the doctor ordered some physical therapy and an x-ray, the therapy was not undertaken, no formal diagnosis for her back followed, and, most significantly, Petitioner continued to treat with Dr. Moyers for another fourteen months or so with no further mention of back pain or complaints or treatment to her back. The Arbitrator sees a distinct difference between vague references to fatigue and joint/muscle aches and pain and the very specific complaints Petitioner voiced on September 10, 2015 at Work Care and thereafter. Respondent produced no evidence of extensive back treatment pre-dating September 4, 2015. In light of the above, the Arbitrator does not find Petitioner's denial of prior back problems in Dr. Robson's questionnaire to be intentionally deceitful or misleading. Petitioner had been working full duty before September 4, 2015 and engaged in all activities of life, including hobbies and sports. Under these circumstances the Arbitrator finds it reasonable to infer from Petitioner's denial of prior problems that, in her mind, she wasn't having "problems." Petitioner was an exceedingly credible witness.

Contrary to Dr. Robson's opinions and Respondent's position, everything changed for Petitioner on September 4, 2015. She has never really returned to her level of activity pre-September 4, 2015. While she has returned to full duty work periodically since that accident she has not been asymptomatic and she ended up being involved in additional accidents. Petitioner's treatment after that date was initially managed by Respondent. She was sent to Work Care and, in turn, to Dr. Hayward. Medical personnel at Work Care opined that Petitioner's condition was related to her work activities/accident, that objective findings were consistent with a work-related etiology and that work activities had aggravated an underlying pre-existing condition for which a neurology consultation was recommended.

Work Care referred Petitioner to Dr. Hayward who acknowledged that Petitioner had a bulging disc at L3-4 on the left side which was contacting the nerve. He released her from his care because he didn't feel she needed surgery, not because she was at maximum medical improvement. A referral to an occupational medicine doctor for further treatment was recommended. While he saw no reason she couldn't return to work, it is interesting that just five days prior to the final visit with Dr. Hayward, Petitioner attended physical therapy and was noted to have limited lumbar AROM secondary to pain and the inability to perform normal activities secondary to lumbar and lower extremity radicular pain. She demonstrated an antalgic gait and difficulty walking. It was recommended that she continue with physical therapy; however, that wasn't done because Dr. Hayward released her to return to work. Dr. Hayward's records (PX 5) don't include copies of the therapy records. His office note of November 9, 2015 doesn't discuss them. As such, it ia unclear to the Arbitrator if he knew what was going on in therapy, including Petitioner's limitations. In light of the foregoing, as well as Dr. Hayward's belief that Petitioner should follow up with occupational medicine and the therapist's recommendation for additional therapy, the Arbitrator finds Petitioner remained symptomatic when discharged by the doctor and not yet at maximum medical improvement.

Against this backdrop Respondent sent Petitioner back to work and, unfortunately, she sustained another accident on November 29, 2015. The Arbitrator found Petitioner to be a very credible witness and her reluctance to return to work after being discharged by Dr. Hayward, along with her disappointment about being switched to a different shift, does not negate her credibility.

In his deposition, Dr. Robson admitted that Petitioner's accidents resulted in a change of her work status and her symptoms. (RX18, p.20; RX19, p.25-26) He admitted that Petitioner consistently complained of pain following her work accidents. *Id.* at 26. He testified that he had no basis to dispute Dr. Gornet's records indicating the fact that Petitioner's symptoms increased after being involved in those incidents, and he admitted that Petitioner showed no signs of symptom magnification or malingering. *Id.* at 28-29, 32. He acknowledged that Petitioner's discogram demonstrated a severely provocative disc at L5 to S1. *Id.* at 21. He further admitted that annular tears could produce Petitioner's lumbar spine symptoms. *Id.* at 22. He acknowledged that, although he failed to appreciate Petitioner's annular tear, the radiologist who performed Petitioner's MRI of March 23, 2017, Dr. Ruyle, documented an annular tear visible at the apex of the protrusion at L5-S1. *Id.* at 22-23. When asked whether he agreed with Dr. Ruyle's interpretation, Dr. Robson stated, "I agree." *Id.* at 23. He further admitted that Petitioner's work accidents were a mechanism of injury consistent with her current pathology and symptoms, and significantly, that these incidents could aggravate Petitioner's pre-existing condition. *Id.* at 24. He also acknowledged that he did not possess any imaging studies for comparison prior to Petitioner's work injuries to say that Petitioner's lumbar spine herniations were definitively pre-existing. *Id.* at 20. Significantly, he acknowledged that Petitioner required no treatment for eleven (11) months prior to her work injury in September of 2015. (RX18, p.20) Even though he diagnosed Petitioner with simply a "strain," he admitted that Petitioner's symptoms had been unresolved and persistent since her work injuries. (RX19, p.26) Dr. Robson never addressed the cumulative effect of Petitioner's last four accidents, he did not comment on the October 24, 2016 accident whatsoever, he did not address the issue of "aggravation," and he failed to review all pertinent medical records (Hayward and Work Care) as part of his examination review and report. Dr. Robson also testified that Petitioner has had the same low back and left-sided symptoms since 2014 (RX 19, p. 25).

That's incorrect as records from 2014 don't indicate any left lower extremity issues emanating from Petitioner's low back; however, the same cannot be said after September 4, 2015 as medical records indicate lower extremity complaints. For these reasons, the Arbitrator is not persuaded by his opinion.

In contrast, Dr. Gornet opined that Petitioner has a disc injury at L3-L4 and a disc injury, annular tear and herniation at L5-S1. He causally related these conditions to her September 4, 2015 accident. His opinion as to causation is supported by the objective diagnostic studies and the circumstantial evidence. Dr. Gornet noted that Petitioner suffers from minimal to degeneration, which is supported by the evidence and the findings of Work Care and Dr. Hayward. (PX3, 9/10/15; PX5, 11/9/15; PX8, 12/10/15) Dr. Gornet's diagnosis of an L5-S1 annular tear with herniations was confirmed by the objective imaging studies and the discogram procedure. (PX11; PX12; PX14) Dr. Gornet also noted that Petitioner's complaints markedly increased and have been unabated since her injuries, leading him to credibly conclude that Petitioner's work assaults aggravated and caused her current condition of ill-being. (PX15, p.15-16) The Arbitrator, therefore, finds his opinion persuasive and finds that Petitioner met her burden of proof in establishing that her current condition of ill-being in her low back is related to her work accident herein. The Arbitrator does not find Dr. Gornet's opinions less persuasive given the fact he did not personally review outside medical records on Petitioner and may not have known about Petitioner's problems in 2013 and 2014. He was questioned at length by both parties during his deposition and adequately addressed issues regarding pre-existing issues.

Dr. Gornet has premised his surgical recommendation on this accident and her subsequent one of November 29, 2015. While Petitioner has had three subsequent undisputed accidents to her low back, the Arbitrator does not view them as intervening accidents severe enough to sever ongoing causation. Petitioner had evidence of a bulging disc at L3-4 after this accident. She has never returned to her pre-September 4, 2015 level of activity nor has she been asymptomatic. After the November 29, 2015 accident she continued to be diagnosed with a disc injury at that level. As such, and in accordance with current Illinois law, the accident of September 4, 2015 has remained a cause of her current low back condition.

A causal connection between one's work duties and an injured condition may be established by chain of events including the workers' compensation claimant's ability to perform duties before the date of accident and the inability to perform same duties following the date of accident. *Darling v. Indus. Comm'n of Illinois*, 176 Ill. App. 3d 186, 530 N.E.2d 1135 (1st Dist. 1988). Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n,* 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724 (4th Dist. 1994); *International Harvester v. Industrial Comm'n,* 93 Ill.2d 59, 442 N.E.2d 908 (Ill. 1982). In the instant case, the record establishes that Petitioner had no difficulty working prior to her work injuries. Dr. Robson admitted same during his deposition testimony. In fact, he made significant concessions and admissions that confirming that the circumstantial evidence rests squarely in Petitioner's favor.

With regard to a chain of events, Petitioner was able to work full duty prior to September 4, 2015 and had not sought treatment for any low back complaints for approximately fourteen months before. She has been symptomatic since September 4, 2015 and, while returning to work

periodically to full duty and/or light duty (and sometimes contra to her treating doctor's orders) has remained symptomatic and been involved in additional accidents. Physical therapy and injections have not helped. She has yet to return to baseline.

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 entitled to recover reasonable medical expenses that are causally related to the September 4, 2015 accident. Respondent's dispute as to medical bills was based upon liability. Consistent with her causation determination set forth above (and incorporated herein by reference), Petitioner is awarded those medical bills incurred by her between September 4, 2015 and November 28, 2015 subject to the Medical Fee Schedule. Respondent shall receive credit for any bills previously paid by it, including any paid by its group medical plan for which credit is allowed under Section 8(j) of the Act. Any bills incurred after the November 29, 2015 accident are more appropriately awarded in connection with that claim.

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

Prospective medical care is denied in this case as it has been awarded in Case # 16 WC 02296.

Petitioner was able to work full duty prior to September 4, 2015 and had not sought treatment for any low back complaints for approximately fourteen months before. She has been symptomatic since September 4, 2015 and, while returning to full or light duty work periodically (and sometimes contra to her treating doctor's orders) has remained symptomatic and been involved in additional accidents. Physical therapy and injections have not helped. She has yet to return to baseline. Additional treatment is in order. While Petitioner's current condition in her low back is causally connected to the accident herein, the Arbitrator finds it significant that Dr. Gornet originally recommended surgery after Petitioner's November 29, 2015 accident (which is the subject of case #16 WC 02296). As such, the Arbitrator finds it to be the more appropriate case in which to award prospective care.

Issue (L): What temporary benefits are in dispute? (TTD)

Petitioner's claim for temporary total disability benefits is denied with regard to this case and is addressed in claim #16 WC 36411 as it was after that accident (October 30, 2016) that Petitioner was taken completely off work.

****

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

Stephanie Matlock,

Petitioner,

19IWCC0603

vs. NO: 16 WC 002296

State of IL / Choate Mental Health,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 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.

19IWCC0603

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)(l) of the Act, claims against the State of Illinois are not subject to judicial review.

DATED: NOV 6 - 2019

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MEP/ypv
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Maria E. Portela

Thomas J. Tyrrell

Kathryn Doerries

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

MATLOCK, STEPHANIE
Employee/Petitioner

Case# **16WC002296**

15WC030798
16WC004246
16WC036410
16WC036411

ST OF IL/CHOATE MENTAL HEALTH
Employer/Respondent

19IWCC0603

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:

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

APR 2 - 2018

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

19IWCC0603

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

STEPHANIE MATLOCK
Employee/Petitioner

v.

STATE OF ILLINOIS, CHOATE MENTAL HEALTH
Employer/Respondent

Case # **16** WC **02296**

Consolidated cases: **15 WC 30798**
16 WC 04246
16 WC 36410
16 WC 36411

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville,** on **January 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury? (lumbar spine only)
G. [ ] What were Petitioner's earnings?
H. [ ] What 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, **November 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 year preceding the injury, Petitioner earned **$51,477.74**; the average weekly wage was **$989.96**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services related to the care and treatment of Petitioner's lumbar spine since November 29, 2015 as further set forth in Petitioner's Exhibit 1 and subject to the Medical Fee Schedule and as provided in § 8(a) and § 8.2 of the Act. Respondent shall have credit for any amounts previously paid by it or its group medical plan and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit. The parties stipulated that Respondent could pay the medical providers directly.

Respondent shall authorize and pay for the treatment recommended by Dr. Gornet, including, but not limited to low back disc replacement surgery at L5-S1 and, if necessary, a fusion.

Respondent's claim for temporary total disability benefits is denied as it is more appropriately awarded in Case #16 WC 36411.

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

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

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

Nancy Lindsay
Signature of Arbitrator

3/23/18
Date

APR 2 - 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner is employed as a security therapy aide for Respondent, Choate Mental Health and Development Center. Petitioner has five applications for adjustment of claim pending against Respondent. All five claims involve alleged injuries to Petitioner's knees, low back and neck and they were consolidated at the time of arbitration with the parties understanding that separate decisions would issue. The parties further stipulated that this 19(b) hearing was solely limited to Petitioner's alleged low back condition and that all issues regarding injuries to other body parts were being reserved. Therefore, the Arbitrator's findings and conclusions only address the the alleged low back claim. None of Petitioner's five accidents against Respondent are disputed. The focus of the dispute is causal connection and Petitioner's need for prospective medical care.

The Arbitrator finds:

On June 30, 2013, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. (RX1). Petitioner indicated that on June 29, 2013, she was knocked down while assisting with a hostile patient and landed on the edge of a dresser. (RX1). Petitioner indicated she injured the bridge of her nose, left buttock, right upper arm, lower arm/hand, and left and right knees. (RX1). Respondent does not dispute that this accident occurred. (AX 5)

On March 10, 2014, Petitioner presented to Dr. Lori Moyers at Cape Family Practice to establish herself as a patient. (RX20). It was noted Petitioner was a heavy every day smoker and had previously undergone removal of her thyroid. (RX20).

On April 8, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner was seen for low thyroid levels and complained of right hip pain. (RX20). Petitioner was given an injection into her hip. (RX20).

On May 13, 2014, Petitioner returned to Dr. Moyers. (RX20). Petitioner complained of swelling all over and pain in her feet. (RX20). Petitioner was given a fatigue panel. (RX20).

On June 10, 2014, Petitioner saw Dr. Moyers. (RX20). Petitioner complained of shortness of breath, increased stress, and bilateral knee pain. (RX20). Petitioner requested a steroid shot, but declined it as it was out of network. (RX20). Petitioner was scheduled for an EKG and stress test. (RX20).

On July 9, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner complained of chronic back pain on lower left side. Petitioner indicated it had started about a year earlier and had gotten worse. Petitioner also indicated her back actually "went out" approximately five months earlier. Petitioner did not mention any accident or injury with regard to her back. It was noted Petitioner had a history of syringomyelia. A lumbar spine x-ray was ordered and Petitioner was prescribed physical therapy.

On August 11, 2014, Petitioner returned to Dr. Moyers. Petitioner indicated she had undergone the L-spine x-ray, but had not started the physical therapy yet due to her schedule. Petitioner also complained of left foot pain. Petitioner was referred to another doctor for her foot. (RX20).

On September 8, 2014, Petitioner followed up with Dr. Moyers. Petitioner complained of fatigue, abdominal pain, joint/muscle pain, and anxiety. (RX20).

On October 10, 2014, Petitioner returned to Dr. Moyers. Petitioner complained of fatigue, thyroid issues, joint/muscle aches, and anxiety. It was noted Petitioner had multiple trigger points. (RX20).

On November 11, 2014, Petitioner saw Dr. Moyers. Petitioner complained the prescription Savella caused nausea and had not helped her pain at all. (RX20).

On January 16, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of low thyroid levels and a rash all over her body. (RX20).

On June 4, 2015, Petitioner returned to Dr. Moyers for her thyroid. Petitioner returned on June 15, 2015 complaining of congestion and sinus pressure. (RX20).

On July 15, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of continued allergy symptoms and weight gain. (RX20).

Petitioner was involved in an undisputed work accident on September 4, 2015. (AX 1)

On September 8, 2015, Petitioner returned to Dr. Moyers. Petitioner complained of a spot on her left foot and low energy/fatigue. (RX20).

On September 9, 2015, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. Petitioner indicated that on September 4, 2015, she was knocked down twice by an aggressive patient. Petitioner indicated she injured her lower back, upper back, and both knees. (RX4).

On September 10, 2015, Petitioner presented to Work Care regarding her 9/4/15 accident. At that time she was complaining of pain in her low back, neck, bilateral knees, and left foot. Petitioner indicated she was in a patient altercation and was thrown to the floor two times. During the altercations she began dry heaving and vomiting. Petitioner indicated her primary problem was her neck; her secondary problem was her low back. It was noted Petitioner was previously diagnosed with syringomyleia and fibromyalgia. Petitioner indicated her primary care physician did not take work comp. Petitioner complained of constant aching pain in her back aggravated by use and relieved by rest. X-rays were described as unremarkable with no degenerative findings. Petitioner was diagnosed with a cervical spine radiculopathy and strain, thoracic spine strain, lumbar spine strain, and bilateral knee contusions. Petitioner was prescribed medication and physical therapy and taken off work through September 11, 2015 to be followed by sedentary work restrictions as of September 12, 2015 Petitioner was also referred for a neurology consult for a

"pre-existing spinal condition." FNP-BC Dena Kommer addressed causation stating, "The cause of this problem is related to work activities. The objective findings are consistent with the history of a work-related etiology. Work activities have aggravated an underlying pre-existing condition." (PX3)

Petitioner testified, without rebuttal, that Respondent could not accommodate her work restrictions/light duty and she remained off work.

On September 17, 2015, Petitioner returned to Work Care and reported she was no better. Petitioner indicated her primary problem was her neck and that she had burning down into her shoulders. She also had bilateral knee pain and muscle spasms in her lumbar area. Diagnoses and recommendations remained the same. She was referred to Dr. Hayward. (PX3).

On September 16, 2015 Petitioner signed her Application for Adjustment of Claim in case #15 WC 30798 alleging injuries to her body as a whole and bilateral knees due to an accident on September 4, 2015 when she was attacked by a resident. (AX 2)

On September 17, 2015, Petitioner underwent x-rays of her left knee. The findings were normal with mild osteoarthritic changes noted. Petitioner also underwent x-rays of her right knee. The findings were normal with minimal osteoarthritic changes noted. Additionally, Petitioner underwent x-rays of her lumbar spine. The findings showed normal curvature and alignment maintained except for mild right convex curvature centered near L1/2, mild loss of disc height from L3/4 through L5/S1, and mild lumbar facet arthropathy present. There was no fracture or subluxation identified, sacral arcuate lines intact, and soft tissues were unremarkable. Petitioner also underwent x-rays of her thoracic spine. The findings showed no compression fracture or subluxation. Finally, Petitioner underwent x-rays of her cervical spine. The findings were normal. (PX3).

Petitioner completed a questionnaire for Dr. Thalman's office on September 24, 2015 regarding her September 4, 2015 accident. Dr. Thalman is a chiropractor. (PX 6; AX 12)

As ordered by Work Care, Petitioner presented to physical therapy at Mid America Rehab on September 29, 2015. Petitioner reported trying to break up a fight between patients earlier in September and being injured in the process. She had undergone x-rays but no other tests. Her complaints included pain in the neck, upper back, mid back, low back and down her left leg. She reported some occasional arm and leg pain and burning into the shoulder blade region and both legs. She also reported numbness and tingling down her legs at times. The therapist described Petitioner's level of pain as moderate to severe and documented an antalgic gait along with decreased range of motion. Petitioner was to be seen three times a week for four weeks. (PX 2)

Petitioner attended therapy as instructed. At the October 7, 2015 session Petitioner requested that she not have to lay on the treatment table as it bothered her. She reported increased pain down her left leg when side bending to the right. She was unable to tolerate "ther-ex:" secondary to increasing pain. She also reported that she was always having to change positions to relieve her pain which was admittedly "getting to her." (PX 2)

On October 8, 2015, Petitioner followed up at Work Care. Petitioner indicated her primary concern was her lumbar spine, followed by her cervical spine and knees. Petitioner described both as aching and unrelenting. Petitioner also reported that walking increased her symptoms in all areas and she was experiencing a radiculopathy that would come and go. Petitioner indicated she had an appointment pending with Dr. Hayward for her spine, although she had concerns about seeing him. According to the notes, the MRI was on hold per the case manager until after Petitioner's exam with Dr. Hayward. It was noted Petitioner refused to see the doctor who diagnosed her with syringomelia. Petitioner indicated that physical therapy was not helping much. It was noted symptom magnification was present but her attitude and effort were felt to be "fair." Restricted duty was continued. (PX 3)

On October 12, 2015, Petitioner presented to Dr. Franklin Hayward at Heartland Spine Institute. Petitioner provided the doctor with a detailed account of her work accident in September and her medical care since the accident and told the doctor that she was undergoing therapy with no relief. Petitioner also described her current symptoms as new, and told the doctor about a work injury two and one-half years earlier when she fell on her left buttock while confronting an aggressive resident. She also recalled a neck injury when a resident pushed her head into a wall but couldn't recall the date. There was also an incident when her right thumb was bent backwards and an incident when she fell to her knees during an altercation but she couldn't recall those dates of injury. Petitioner denied any history of back surgery and explained she had seen Dr. Stahley for tremors. Petitioner complained of low back pain, weakness all over, dizziness, balance difficulty, nausea, headache, numbness in her feet, and numbness and tingling in the 4th and 5th fingers of the right hand, all of which began after the accident. Petitioner felt the accident had worsened her tremors. Dr. Hayward ordered MRIs of Petitioner's cervical and lumbar spine and continued Petitioner's restrictions. He referred Petitioner back to Dr. Stahley and/or her family doctor for her tremors. (PX5).

Petitioner returned for physical therapy on October 14, 2015 having last attended on October 7, 2015. Petitioner was reporting continued pain down her left leg all the way to the ankle. She was still waiting for the MRI to be scheduled. (PX 3)

Petitioner attended physical therapy on October 16, 2015 reporting some slight subjective improvement that day but also having tremors in her upper back and a "grabbing" sensation in her left low back along with sharp pain when trying to sit straight. (PX 3)

Petitioner again attended physical therapy on October 19, 2015 reporting increased pain that day and over the weekend (associated with increased standing). Petitioner attempted more therapy at this visit. (PX 3)

As of October 22, and October 26, 2015 Petitioner was still having trouble with some aspects of therapy and her MRI was still pending. As of October 28, 2015 her MRI was finally being scheduled. (PX 3)

On November 2, 2015, Petitioner underwent an MRI of her lumbar spine. The impressions were: 1) minor degenerative disc disease, disc bulges cause minor foraminal stenoses at L3/4 and L4/5, left L3 nerve root contacts the disc bulge near the foramen, and could be a source of pain; 2)

no lumbar spine central canal stenosis; 3) benign hemangioma in the T10 vertebra; and 4) LLQ borderline nodes vs mild mesenteric lymphadenitis. Petitioner also underwent a cervical spine MRI. The impressions were: 1) c-spine straightening may be due to positioning or muscle spasm; 2) minor cervical disc bulges, no cord compression or central canal stenosis; 3) tiny hydromelia, syrinx at C7/T1; 4) moderate left foraminal stenosis at C6/7; 5) benign hemangioma in the T4 vertebra; and 6) S/P thyroidectomy. (PX5).

Petitioner attended physical therapy on November 4, 2015 reporting she had undergone the MRI but was unaware of the results. Sitting and bending were still bothering her and she had an ongoing antalgic gait and difficulty walking. It was recommended that she continue physical therapy three times a week. (PX 3)

On November 6, 2015, Petitioner returned to Work Care. Petitioner indicated her neck pain was 7 out of 10, her back pain was 7 out of 10, and her bilateral knee pain was 7 out of 10. She was also noted to be depressed. Her condition was again noted to be related to her work activities. Petitioner's prescriptions were refilled and she was to start an exercise program. (PX3).

On November 9, 2015, Petitioner followed up with Dr. Hayward. Petitioner continued to complain of back and leg pain that the doctor described as being in a non-dermatomal distribution. Petitioner also reported she was not improving and asked the doctor to refer her to a neurologist to facilitate a neurology consultation as part of her claim. Dr. Hayward explained that he felt she needed to follow up with Dr. Stahley regarding her chronic condition and that she might need to do that under her own health insurance. On examination, Dr. Hayward stated that Petitioner's motor strength was intact. He further noted Petitioner had Waddell's testing, three out of five. Dr. Hayward reviewed Petitioner's MRIs which showed age appropriate mild degenerative changes and a bulge at L3/4 which was making contact with her L3 nerve root; however, he felt Petitioner had no L3 radiculopathy as her leg pain was all posterior and radiating down to the leg and foot which he could not explain. Petitioner also had clearly reproducible pain to palpation of her lumbar and cervical spines with the lumbar region being more tender. Petitioner was diagnosed with myofascial muscle pain. Dr. Hayward also noted Petitioner's history of fibromyalgia and syringomyelia and felt that might be the cause of her myofascial pain. Dr. Hayward saw no evidence to suggest radiculopathy. Dr. Hayward noted that whether the tremors were related to her work accident was an issue for Dr. Stahley to address. Dr. Hayward also noted that there were no surgical indications and, while he released Petitioner from his care without any restrictions due to the absence of any physical limitations, he did recommend a referral to an occupational medicine doctor for further treatment of her condition given that there was no acute surgical indication. (PX5).

According to the November 19, 2015 physical therapy discharge note, Petitioner had been discharged from further care in light of Dr. Hayward's release to return to work. Petitioner had last undergone therapy on November 4, 2015. (PX 3)

On November 29, 2015, Petitioner sustained another accident while working for Respondent. Petitioner filled out a Worker's Compensation Employee's Notice of Injury form (d/a: 11/29/15). Petitioner indicated she was attempting to restrain an aggressive patient. Petitioner

indicated she injured her left wrist/hand, right hand, bilateral forearms, neck, and back. (RX7). Respondent does not dispute that this accident occurred. (AX 3)

On November 30, 2015, Petitioner returned to Dr. Moyers, her primary care doctor. Petitioner complained of chronic low back pain and indicated she was attacked by a patient on November 29, 2015. She made no mention of the September 4, 2015 accident. Petitioner indicated she had seen a neurosurgeon who did not feel she needed surgery and released her back to work. Petitioner indicated she was then attacked again on the 29th while on light duty and had pain radiating down her left leg into her foot. It was noted Petitioner had had C-spine and L-spine MRIs. Petitioner was diagnosed with C-spine and T-spine sprains and disc degeneration in her lumbar region. Petitioner was prescribed physical therapy. (RX20).

On December 7, 2015, Petitioner returned to Work Care regarding her September 4, 2015 accident. Petitioner indicated her back pain, neck pain, and bilateral knee pain was a 7 out of 10 and that she had sustained a new accident at work that was being handled by another provider so she requested a release from the previous injury. Petitioner was discharged at her request. (PX3).

On December 10, 2015, Petitioner presented to Dr. Matthew Gornet at The Orthopedic Center of St. Louis. Petitioner complained of low back pain and neck pain. Petitioner indicated her problem began on September 4, 2015 after she was involved in an altercation with an aggressive patient. Petitioner indicated she did have some spinal pain and chiropractic care in 2004, but no intervening treatment since that time. Petitioner was diagnosed with: a disc injury at L3/4; disc injury, annular tear, and herniation at L5/S1; and disc injury at C6/7. Dr. Gornet noted that he felt Petitioner had, at a minimum, suffered an aggravation/re-aggravation of her "work injury." Dr. Gornet put treatment for the neck on hold while Petitioner treated for the low back. Dr. Gornet recommended a steroid injection at L5/S1 and physical therapy. A new cervical MRI was ordered. Petitioner was taken off of work. (PX 8)

On December 15, 2015, Petitioner followed up with Dr. Moyers regarding her lower back. Petitioner indicated she was treating with Dr. Gornet and was scheduled to undergo injections in her lower back. Petitioner reported that her left hip pain was continuing and was radiating down to her left knee and foot. Petitioner requested a referral to a mental health specialist for anxiety and insomnia. Petitioner was to remain off work per Dr. Gornet and was referred to Brad Robison. (RX20)

On January 13, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 2296 alleging injuries to her neck, back, bilateral hands and arms, and body as a whole as a result of an accident on November 29, 2015 described as an "altercation with patient/aggravation." (AX 4)

On January 14, 2016, Petitioner underwent a left L5/S1 epidural steroid injection by Dr. Kaylea Boutwell. (PX9)

On February 1, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 004246 alleging injuries to her bilateral knees, left buttock, right arm, back, and body as a whole as a result of an accident on June 29, 2013. (AX 6)

On February 29, 2016, Petitioner underwent an MRI of her cervical spine without contrast. The impressions were: 1) central-left foraminal broad-based protrusion at C6/7 measuring up to 3.5 mm in the left foramen, resulting in moderate left foraminal stenosis; 2) central broad-based protrusions at the C3/4, C4/5 and C5/6 levels; and 3) 1-1.5 mm maximal diameter cervical cord syrinx focally at the C7/T1 disc level. (PX11).

That same day, Petitioner followed up with Dr. Gornet. Dr. Gornet reviewed Petitioner's cervical MRI noting that it showed Petitioner had a fragment of disc on the left side at C6/7, subtle changes on the right side at C5/6 and C6/7, and central disc protrusions at C3/4, C4/5, and C5/6. Dr. Gornet also stated in his notes that Petitioner had a foraminal herniation at L3/4 on the left and recommended a transforaminal steroid injection. He again noted that Petitioner's symptoms related to an accident on September 4, 2015. If that did not help, a CT discogram and MRI spectroscopy would be next. Petitioner was given work restrictions fo "office work only" on a trial basis. (PX8).

On March 16, 2016, Petitioner underwent a transforaminal steroid injection under fluoroscopic guidance at L3/4 left with facet block at L3/4 left. Petitioner tolerated the procedure well. (PX12; PX 8).

On May 9, 2016, Petitioner followed up with Dr. Gornet. Petitioner indicated the injection gave her a month of relief, but she had continued symptoms and pain. Dr. Gornet recommended an MRI spectroscopy and CT discogram. Petitioner's work restrictions were continued and her prescriptions refilled. (PX8)

On May 10, 2016, and at Respondent's request, Petitioner underwent a Section 12 examination by Dr. David Robson at Comprehensive Spine Care. Petitioner gave a history of being attacked by a patient at work on September 4, 2015, injuring her neck and back. Dr. Robson also reviewed an accident report from November 29, 2015 indicating Petitioner was injured by an aggressive patient. Petitioner gave no history of prior treatment for her neck or back, but when interviewed, did recall a remote history of low back treatment with a chiropractor in 2011. Dr. Robson reviewed medical records including those from physical therapy, Dr. Moyers, Dr. Gornet, injection reports, and imaging studies. Dr. Robson diagnosed Petitioner with mild degenerative changes of the lumbar spine, mild disc bulging at L5/S1, mild degenerative changes at the cervical spine, and syringomyelia at C7/T1. Dr. Robson opined physical therapy was warranted for a flare-up of low back pain, but further treatment was not reasonable or necessary as Petitioner had a known history of chronic lower back and neck problems. Dr. Robson further opined the September 4, 2015 and November 29, 2015 injuries caused a temporary aggravation of her pre-existing neck and lower back complaints, but Petitioner was at MMI and could return to work without restrictions. (RX16)

On June 16, 2016, Petitioner presented to Dr. Eugene Kostiuk at Clay Medical Center. Petitioner complained of anxiety, depression, and difficulty sleeping. Petitioner was diagnosed with post-traumatic stress disorder and counseling was recommended. (PX13)

On June 28, 2016, Petitioner underwent a discogram with x-ray interpretation at L3/4, L4/5, and L5/S1 with facet block left at L3/4, L4/5, and L5/S1. The summary indicated: non-provocative

disc at L4/5; minimally provocative disc at L3/4 for back pain, some butt pain; and L5/S1 severely provocative of concordant back pain. (PX14)

On July 26, 2016, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) broad based or bilobed disc herniation on L3/4, larger on the left, extending towards the foramina, also worse on the left, without central stenosis; and 2) smaller central protrusion at L5/S1 without significant impression upon the dura. (PX11)

On July 26, 2016, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed the MRI spectroscopy and CT discogram, noting Petitioner had a non-provocative disc at L4-5, minimally provocative disc at L3-4 and a severely provocative disc at L5-S1 on the discogram; however, the MRI spectroscopy did not detect any reading at L5-S1. There was a large central annular tear at L5-S1. Dr. Gornet also reviewed Dr. Robson's IME report and noted his explanations of it to Petitioner. He pointed out that Dr. Robson apparently felt Petitioner had sustained temporary aggravations of her pre-existing neck and low back complaints in relation to her 9/4/15 and 11/29/15 accidents. Dr. Gornet explained to Petitioner that while she did candidly acknowledge a history of pre-existing complaints in her spine there was no indication that her level of complaints or severity was anywhere near the level of her current ones. He further noted that Dr. Robson did not have the opportunity to review the CT discogram report and visualize the central annular tear as well as the reproduction of symptoms at L5-S1. As her adjacent levels for the most part were "fairly clean" and she had failed conservative care, to date, Dr. Gornet recommended Petitioner undergo an anterior lumbar fusion. Her work restrictions remained unchanged. (PX8).

Petitioner resumed full duty work for Respondent in July of 2016.

Deposition of Dr. Gornet

Dr. Matthew Gornet testified via evidence deposition on September 15, 2016. (PX15). Dr. Gornet testified he is an orthopedic surgeon whose practice is devoted to spine surgery. (PX15, p. 4). He performs research, clinical trials, and treats patients. (PX15, p. 4-5). Dr. Gornet testified Petitioner first saw him on December 10, 2015. (PX15, p. 6). She acknowledged a history of some prior low back/neck pain. (PX15, p. 7). Dr. Gornet testified he reviewed imaging studies of Petitioner's lumbar and cervical spine. (PX15, p. 7-8). Dr. Gornet diagnosed Petitioner with a disc injury at L3/4; a disc injury, annular tear and herniation at L5/S1; and a disc injury at C6/7. (PX15, p. 9). Conservative care of injections and physical therapy was recommended, as well as new imaging studies. (PX15, p. 9). Dr. Gornet testified it was his understanding Petitioner had had a couple work injuries and it was impossible to tell which findings were objectively caused by which accident when looking at x-rays, MRIs, or other films. (PX15, p. 10).

Dr. Gornet testified that Petitioner only received temporary relief from the injection. (PX15, p. 11). Petitioner then underwent an MRI spectroscopy and CT discogram and he then recommended to undergo an anterior lumbar fusion at L5/S1. (PX15, p. 12-14). Dr. Gornet opined Petitioner's work injury of September 24, 2015 aggravated her underlying condition and the November 29, 2015 injury aggravated it further. (PX15, p. 15-16) As he explained it:

> . . . [T]his is a woman who may have had some mild disc degeneration prior to this. She does have a history of low back pain dating back several years. That being said, there is no indication that she had a significant major problem that she does today. Therefore, almost de facto we can state that her condition is one that is ongoing, and in her overall health status this condition is relatively new and dates to approximately September of 2015.
>
> Now, that being said, what I believe happened is, is that this woman has some preexisting disc degeneration. Disc degeneration is a normal part of life and can be relatively asymptomatic, but it does weaken the disc. She's in an altercation, she has applied mechanical load which injures the disc and it causes a tear.
>
> I believe November 29th aggravated that further, making her more symptomatic, and at this point in time, she continues to be symptomatic. We can say as a matter of course that this is not a temporary condition, because the patient's symptoms have never returned back to baseline prior to the injury. (PX 15, pp. 15-16)

On cross-examination, Dr. Gornet admitted that he did not review any medical records outside of his own and the IME report. (PX15, p. 18). He further explained that Petitioner's syringomyelia refers to some mild fluid contained within her spinal cord. It usually does not progress except in very rare circumstances. He did not feel it had anything to do with her current complaints. (PX 15, pp. 18-19) Dr. Gornet testified he compared the MRIs of Petitioner's cervical and lumbar spine taken November 2, 2015 to the ones he had done. (PX15, p. 19-20). He testified the more recent MRIs did not show newer pathology, just a more accurate definition of the pathology present. (PX15, p. 20). There was no major progression. (PX15, p. 20). Dr. Gornet testified myofascial muscle pain is a subjective complaint. (PX15, p. 21). Dr. Gornet agreed Petitioner gave him a history of spine pain and chiropractic care in 2004, but did not recall any intervening treatment since that time. (PX15, p. 22). Dr. Gornet testified if that was inaccurate, and there was a "significant event" that was near that time frame it could possibly change his opinion and he would evaluate any new information. However, Petitioner clearly detailed to him that she felt she had spinal problems in the past. (PX15, p. 23)

Dr. Gornet testified he did not have Dr. Hayward's medical records and was unaware Dr. Hayward found three out of five Waddell's testing. (PX15, p. 24). Dr. Gornet testified Waddell's testing is a way to evaluate inorganic or other findings in patients that is associated with non-necessarily physiologic presentations of low back pain and can be used to determine if there is the possibility of symptom magnification. (PX15, p. 25). Dr. Gornet testified a three out of five would be a moderately positive Waddell's sign. However, he did not detect any functional overlays during his exams with Petitioner. (PX15, pp. 25-26)

Dr. Gornet testified he has put any treatment for Petitioner's neck on hold at this point in hopes that treating the low back would alleviate Petitioner's complaints. (PX15, p. 26-27). Petitioner has not undergone any injections for her neck and there is no surgical recommendation at this time. (PX15, p. 27)

Dr. Gornet testified his causation opinion is based upon the history Petitioner gave him regarding the injuries, her medical history she told him, and the records he had for review. (PX15, p. 28). Dr. Gornet admitted that if the history Petitioner gave him regarding her prior back complaints and treatment was inaccurate, it could change his opinion. (PX15, p. 28)

Dr. Gornet testified that he is relating Petitioner's need for surgery to both the September 4, 2015 and November 29, 2015 accidents. (PX15, p. 28). Dr. Gornet testified that there were no structural changes in Petitioner's spine in comparing the two MRIs. (PX15, p. 28). Dr. Gornet agreed that a herniation on an MRI cannot be dated. (PX15, p. 29)

Additional Medical Treatment

On October 6, 2016, Petitioner followed up with Dr. Gornet. Petitioner complained of continued low back pain. Dr. Gornet continued to recommend an anterior lumbar fusion at L5/S1 and refilled Petitioner's prescriptions. (PX8).

Deposition of Dr. Robson

Dr. Robson testified via evidence deposition on October 24, 2016. (RX18). Dr. Robson testified he is a board certified orthopedic spine surgeon who treats conditions of the cervical, thoracic, and lumbar spine. (RX18, p. 4-5). Dr. Robson testified he performed an IME on Petitioner on May 10, 2016. (RX18, p. 7). He reviewed Petitioner's medical records which showed Petitioner had lower back complaints prior to September 4, 2015. (RX18, p. 8). Specifically, Petitioner had treated with Dr. Moyers on July 9, 2014 complaining of chronic back pain and indicated her back had previously gone out five months prior. (RX18, p. 8). Dr. Robson testified this was inconsistent with the history Petitioner gave on his Patient Questionnaire where she denied any pre-existing problems prior to September 2015. (RX18, p. 9). Also, Dr. Robson testified that when he asked her directly about any prior treatment, she indicated she had some chiropractic care in 2011, but did not mention any problems or treatment in 2014. (RX18, p. 8)

Dr. Robson testified he reviewed the films of Petitioner's cervical and lumbar spine MRIs done on November 2, 2015. (RX18, p. 9). He did not see any significant herniation or protrusion lateralizing in Petitioner's neck. (RX18, p. 9). With regard to the lumbar spine, he thought she had some loss of disc height at L3/4 and L5/S1, but did not see any significant foraminal stenosis at either level. (RX18, p. 10). There was some minimal bulging at L5/S1. (RX18, p. 10). Dr. Robson testified he did not diagnose an annular tear at L5/S1. (RX18, p. 10). Dr. Robson testified he pulled up the films of Petitioner's lumbar spine MRI just prior to being deposed and re-examined them. (RX18, p. 10). While Dr. Gornet noted an annular tear at L5/S1 on axial image 12, Dr. Robson disagreed as there was no high intensity zone or a white spot or a bright lesion that would denote an annular tear. (RX18, p. 10)

Dr. Robson testified he took a history from Petitioner regarding the September 4, 2015 and November 29, 2015 injuries and performed a physical examination. (RX18, p. 11). On physical examination, Dr. Robson testified Petitioner's examination was normal, except some decreased range of motion of the cervical spine. (RX18, p. 11-12). Petitioner's lumbar spine showed normal gait and normal neurological testing. (RX18, p. 12)

Dr. Robson testified Petitioner had previously been diagnosed with fibromyalgia which is purported to cause cervical and lumbar spine problems and often time physical therapy and trigger point injections are required. (RX18, p. 12). Petitioner's medical records indicate she had previously undergone physical therapy and trigger point injections prior to September 4, 2015. (RX18, p. 12).

Dr. Robson diagnosed Petitioner with a cervical strain and lumbar strain, based on his review of the medical records, the history taken from Petitioner, and the physical examination he performed on her. (RX18, p. 12-13). He did not believe Petitioner required any additional treatment, opined she was at MMI, and could return to work without restriction. (RX18, p. 13-14).

On cross-examination, Dr. Robson testified he had not seen the results of Petitioner's CT discogram. (RX18, p. 15). Dr. Robson testified he does not perform discograms even though he is trained to do it because he is not a big believer in that test. (RX18, p. 16). Dr. Robson testified patients are supposed to be blinded as to what levels are being tested, but it depends on who is performing it. (RX18, p. 17).

Dr. Robson testified he did not see any signs of malingering or Waddell's signs in his examination, but Petitioner was inconsistent as far as forthcoming with her past medical history. (RX18, p. 18). Dr. Robson testified Petitioner indicated on the Patient Questionnaire she filled out that she had not had any prior problems with her back before her 2015 injury. (RX18, p. 18-19). He said this was inconsistent with what was in Dr. Gornet's notes and Dr. Moyer's notes. 9RX18, p. 18-19). He testified this was also inconsistent with what Petitioner told him about receiving chiropractic care in 2011. (RX18, p. 19). Dr. Robson testified Petitioner did not tell him that she had a previous injury on June 29, 2013. (RX18, p. 21). Dr. Robson testified he had no criticism of her care and treatment up to date. (RX18, p. 22).

Additional Medical Treatment

On October 29, 2016, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form for an accident occurring that day. Petitioner indicated that on October 24, 2016, she was jerked around while trying to break up a fight between three aggressive patients. (RX 10) Respondent does not dispute that this accident occurred. (AX 7)

On October 30, 2016, Petitioner filled out a Workers' Compensation Employee's Notice of Injury form regarding an accident that occurred that day. Petitioner indicated she was thrown over the back of a couch with a patient while trying to stop his violent behavior. Petitioner indicated she injured her hips, left leg, and had whole spine pain. (RX13). Respondent does not dispute that this accident occurred. (AX 9)

On November 21, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 0036410 alleging injuries to her back, neck, and body as a whole as result of an accident on October 24, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 8)

On November 21, 2016 Petitioner also signed her Application for Adjustment of Claim in case #16 WC 0036411 alleging injuries to her back, neck, and body as a whole as result of an accident on October 30, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 10)

On November 23, 2016, Petitioner returned to Dr. Gornet. Petitioner indicated she was in two new altercations on October 24, 2016 and October 30, 2016. Petitioner indicated she felt she had aggravated her underlying back condition and injured her neck and shoulders. Dr. Gornet recommended observation and indicated if Petitioner's symptoms continued to be elevated, he would recommend new imaging studies to see if there is a new disc injury. Petitioner was taken off work. Dr. Gornet noted, "At a minimum, these new injuries have aggravated her underlying conditions in her cervical and lumbar spines." (PX8).

On January 9, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet described Petitioner as being "clinically worse." He recommended a new MRI, but indicated unless it was dramatically changed, he would move forward with the anterior lumbar fusion at L5/S1. (PX8)

On March 23, 2017, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) L3/4 and L4/5 annular disc bulges with superimposed left foraminal protrusions at both levels resulting in moderate left greater than right foraminal stenosis but no central canal stenosis; and 2) left paracentral focal protrusion at L5/S1 resulting in dural displacement and contact with the traversing left S1 root sleeve but no definite central canal or foraminal stenosis. (PX11)

On March 23, 2017, Petitioner returned to Dr. Gornet, regarding her with-related injuries, including new altercations of 10/24/16 and 10/30/16 as well as her original injury of 9/4/15. He noted that the MRI did not show any dramatic changes. The options of a lumbar fusion and a disc replacement at L5/S1 were discussed. (PX8)

On April 27, 2017, Petitioner underwent another Section 12 examination with Dr. Robson. Petitioner gave a history of a new injury on October 30, 2016 when she was in another patient altercation. Petitioner complained of low back pain radiating down into her left leg and foot. Dr. Robson reviewed accident reports, medical records, and imaging studies, including MRIs of Petitioner's lumbar spine from November 2, 2015, September 26, 2016, and March 23, 2017. Dr. Robson's assessment was mild disc desiccation at L3/4 and L4/5 and diffuse disc bulging asymmetric to the left at L5/S1. Dr. Robson noted Petitioner had previous low back complaints in 2014 for which she treated and took pain medication. Dr. Robson opined there was no causal relationship between Petitioner's current condition and the reported accident, and that her current condition was related to her pre-existing condition. Dr. Robson opined that he did not believe surgical intervention was medically necessary. He further opined Petitioner was at MMI and could return to work without restrictions. (RX17)

On May 11, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet continued to recommend a disc replacement at L5/S1. (PX8)

Second Deposition of Dr. Robson

Dr. Robson testified again via evidence deposition on July 27, 2017. (RX19). Dr. Robson testified he performed a second IME on Petitioner on April 27, 2017. (RX19, p. 7). Dr. Robson testified that he reviewed medical records and performed a physical examination. (RX19, p. 7). Dr. Robson reviewed MRI films of Petitioner's lumbar spine from November 2, 2015, July 26, 2016, and March 23, 2017. (RX19, p. 9). Dr. Robson testified he compared all three lumbar spine MRI films. (RX19, p. 10). The March 23, 2017 MRI showed some mild loss of disc height between her third and fourth lumbar, her fourth and fifth lumbar, and L5/S1. (RX19, p. 10). There was a small asymmetric disc bulge to the left at L5/S, and, in comparison to the two previous MRIs, Dr. Robson felt it was unchanged or maybe even slightly better. (RX19, p. 10). The size of the disc bulge did not appear as large. (RX19, p. 10).

Dr. Robson testified that Petitioner indicated to him that she was injured at work when she was breaking up a fight between two patients on October 30, 2016. (RX19, p. 11). Petitioner said this increased her back pain. (RX19, p. 11). Dr. Robson performed a physical examination of Petitioner which was normal, except some limited range of motion in forward flexion. (RX19, p.11). Dr. Robson testified there were no structural changes between Petitioner's lumbar MRIs taken in 2016 and March 23, 2017. (RX19, p. 11).

Dr. Robson diagnosed Petitioner with mild dehydration of the disc between her third and fourth lumbar and her fourth and fifth lumbar vertebra and a diffuse disc bulge asymmetric to the left at L5/S1. (RX19, p. 12). Dr. Robson testified this diagnosis was not related to the October 30, 2016 work injury. (RX19, p. 12). Dr. Robson testified Petitioner did not need any further treatment related to the October 30, 2016 injury and that she was at MMI. (RX19, p. 13). Dr. Robson testified he personally would not perform the recommended surgery. (RX19, p. 13). He further testified that he could not attribute the need for same to an October 30, 2016 injury. (RX19, p. 13). Dr. Robson explained that he would personally not do the surgery because the only positive test that came back was the discogram which has subjective components to it. (RX19, p. 14). The imaging studies did not demonstrate instability, and while there was some pathology, he did not see it in what he would offer surgical intervention to. (RX19, p. 14). Dr. Robson testified the medical literature is replete with evidence that discograms are not completely objective studies. (RX19, p. 14).

On cross-examination, Dr. Robson testified Petitioner had pre-existing lumbar complaints, referring to medical records he reviewed from 2014. (RX19, p. 17-18). Dr. Robson agreed that Petitioner had not been recommended to see a spine specialist prior to September 2015 in the medical records he reviewed. (RX19, p. 19). Dr. Robson testified he did not review Dr. Hayward's records or records from Work Care and that if Dr. Hayward's records contained more information about the September 4, 2015 accident he would have liked to have reviewed it. (RX19, p. 20-21).

Dr. Robson testified only a minority of spine surgeons and specialists in the medical community use CT discograms. (RX19, p.21-22). Dr. Robson testified he did not find an annular tear on Petitioner's lumbar spine MRIs. (RX19, p. 22). Dr. Robson testified he thought the disc protrusion at L5/S1 was actually smaller on Petitioner's March 23, 2017 MRI. (RX19, p. 23).

Dr. Robson testified that a patient altercation where a person was jostled around and thrown to the ground, such as the ones Petitioner had been involved in, can be the type of mechanism of injury that can cause a disc injury in the lumbar spine. (RX19, p. 24). He also testified that kind of altercation could hypothetically aggravate a pre-existing lumbar condition. (RX19, p. 24).

Dr. Robson testified that the symptoms Petitioner complained of are the type that tend to wax and wane. (RX19, p. 25). Dr. Robson testified that there were no structural changes in Petitioner's lumbar spine after the October 30, 2016 injury, which both the radiologist and Dr. Gornet agreed with. (RX19, p. 25). Dr. Robson was asked if Petitioner's symptoms have ever returned to a baseline or pre-injury status and he replied:

> Well, it's really hard to tell. She's had the same low back and left-sided symptoms since 2014, so I can't tell which – symptoms like that tend to wax and wane. I don't know what impact this injury on October 30th of 2016 had. It certainly didn't change the structures of her lumbar spine as [we] all agree to. (RX 19, p. 25)

Dr. Robson testified it would be rare to see a person have symptoms aggravated without seeing a change on MRI. (RX19, p. 25-26). These types of symptoms tend to wax and wane in patients and they will experience flare-ups from time to time. (RX19, p. 26). Dr. Robson further testified that he had no record of the 10/24/16 accident and he wasn't sure if he had Dr. Gornet's 11.23.16 note. However, he took no issue with Dr. Gornet's records indicating Petitioner's symptoms increased after the two October of 2016 accidents. (RX 19, pp. 27-28) Dr. Robson testified that surgery is not always the solution for someone who has failed conservative care. (RX19, p. 30). In his practice, he would try to talk to Petitioner about living with her condition rather than face the risk of a complication. (RX19, p. 30). He does not believe the risk outweighs the potential rewards should she undergo surgery. (RX19, p. 31).

Dr. Robson testified that when treating a patient, one considers MRI findings, physical exam findings, and patient symptoms. (RX19, p. 32). Dr. Robson also testified that symptoms have a good subjective component to them, especially in a litigated case, whereas objective findings tend to be standard. (RX19, p. 32).

Additional Medical Treatment

On August 17, 2017, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed Dr. Robson's IME report with Petitioner. Dr. Gornet reiterated his recommendation of a disc replacement at L5/S1. Her work restrictions remained unchanged. (PX8)

On December 14, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet indicated Petitioner's exam was unchanged and there were no new issues, Dr. Gornet again recommended a disc replacement at L5/S1 and possible fusion, if needed. She remained temporarily totally disabled. (PX8)

The Arbitration Hearing

Petitioner's case against Respondent proceeded to arbitration on January 25, 2018 pursuant to a 19(b) Petition she had filed. The disputed issues were causal connection, medical bills, temporary total disability benefits and prospective medical care. Petitioner was the sole witness testifying at the hearing. Respondent's representative at the hearing was Cathy Kennedy. At the commencement of the proceeding, Petitioner's attorney moved, without objection, to amend the Application for Adjustment of Claim in case #15 WC 30798 (D/A: 9.4.15) to include alleged injuries to the neck and back.

Petitioner testified she is currently employed with Respondent as a Security Therapy Aide I. She works with the criminally insane and it is her job to keep everyone safe and help monitor patients. She also has to intervene if patients become aggressive.

Petitioner testified that she was injured on September 4, 2015 when she tried to stop a patient from charging another patient. Petitioner testified she "got hit like a linebacker" and flew backwards on the floor and injured her back, knees, and neck. (See also RX 4.) Petitioner testified her primary care doctor did not take work comp, so she went to Work Care. Petitioner testified she was given work restrictions that could not be accommodated, so she was taken off of work and paid extended benefits. Petitioner then saw Dr. Hayward. She underwent an MRI and he released her back to work sometime in November of 2015.

Petitioner further testified that on November 29, 2015, she was trying to hold the leg of a patient who had attacked another patient and she was jostled around, inflaming her lower back. (See RX 7.) Petitioner testified she began treating with Dr. Gornet and was taken off of work. Petitioner testified that Dr. Gornet has also given her restrictions, at times, but has never released her to full duty since she began treating with him. She has undergone multiple imaging studies and has had injections. Petitioner testified she underwent an IME with Dr. Robson and after receiving his report she was advised she needed to go back to work on a full duty basis.

Petitioner testified that she did return to full duty work and on October 24, 2016, she was trying to hold back a patient from attacking another patient who was jumping over her back, and she was "getting landed on" while the patient was trying to pummel another patient. She injured her back and it made her foot numb that day. (See also RX 10.) Then on October 30, 2016, she grabbed a patient's arm to prevent him from throwing a punch, which pulled her over a couch. She landed in the crack of the couch holding him while he was fighting, injuring her back and neck. (See RX 13) Petitioner testified that after that accident Dr. Gornet said "that was enough" and he took her completely off of work.

Petitioner testified that she had a prior work accident in June of 2013 when she was trying to restrain a patient and was standing on a bed. She dropped down, hitting her buttocks on the edge of the nightstand, and kind of "cranked this way" with the weight of her body and hurt her back. (RX 1) Petitioner testified that she sought very little medical treatment for this although she thought she may have seen her doctor in 2014 for some residual pain but she didn't "deal with it." Petitioner also testified that her primary care doctor's records indicate she had some back pain in 2014 and she explained that those complaints were referable to her 2013 accident. She did not seek any other treatment then this and did not miss any work due to this injury. Petitioner testified she

did not believe that the 2013 accident was in any way responsible for the symptoms that she has now.

Petitioner testified that prior to September 4, 2015 she was doing well with regard to her low back. She was going to the gym twice a day, biking, and running two miles a day after work. She testified she cannot do those things now. She testified Dr. Gornet is recommending lower back surgery which she would like to undergo as she is tired of the pain.

Petitioner testified after her second IME with Dr. Robson, she received notification that she would no longer be receiving workers' compensation benefits. Petitioner testified that she did not tell Dr. Robson about having low back issues prior to September of 2015 because she thought it was different than her 2004 diagnosis of fibromyalgia. To her fibromyalgia referred to muscular aches whereas "back pain" referred to her spine. Petitioner also testified she did not mention the 2013 injury and 2014 treatment to Dr. Robson because she had "let it go" and it did not cause her any more grief.

On cross-examination, Petitioner testified that when her workers' compensation benefits were terminated, she went on a non-occupational leave and has been receiving benefits through non-occ since that time. Petitioner further testified she still has her group insurance through her employment. Petitioner testified that she has not undergone the recommended surgery through her group insurance because she wants Dr. Gornet to perform the surgery. Petitioner admitted that she has not asked if Dr. Gornet accepts her insurance and that she is just waiting to see how this plays out. If she were to lose her workers' compensation case, she would still pursue having the surgery done through her group insurance.

Petitioner testified she did not miss any time from work for her 2013 injury nor did she admit any medical records indicating she treated for her back in 2013 into evidence. Petitioner testified after the September 2015 injury, Dr. Hayward released her to return to work full duty on November 12, 2015, but she did not return until November 24, 2015 because she was shocked he had released her.

Petitioner testified the November 29, 2015 injury occurred five days after she had returned to work full duty. At that time, Petitioner was bumped from day shift to evening shift by a more senior employee. Petitioner admitted that she was upset that she was bumped to evening shift.

Petitioner testified she was off of work until July of 2016 when she returned to work full duty. She was working full duty at the time of the October 24, 2016 injury and continued to work full duty until the October 30, 2016 injury.

Petitioner testified that she is not currently working and does not have any kind of employment. When asked if she makes and sells jewelry online, she admitted that she did have a "hobby" of that. Petitioner testified she makes coin rings using a little mandrill, which she uses to pound on the coin.

Petitioner testified she smokes one pack of cigarettes a day and has been counseled regarding same. She has been diagnosed with fibromyalgia. Petitioner testified she underwent chiropractic care for her back in 2004, but could not remember if she did so in 2011.

Petitioner testified she is not using any kind of brace or protective device. She takes over-the-counter medication pretty much daily. Workers' compensation refused to pay for one medication she was prescribed and another medication bothered her stomach. She is not currently undergoing physical therapy.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in her low back is causally related to her November 29, 2015 work accident. In so concluding, the Arbitrator relies upon the more persuasive opinions of Dr. Gornet over those of Dr. Robson.

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 902 N.E.2d 1269, 1273 (5d Dist. 2009). When a pre-existing condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] 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." *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 864 N.E.2d 266, 272-273 (5th Dist. 2007).

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, 672 (Ill. 2003). [Emphasis original]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1st Dist. 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (Ill. 1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977). The Supreme Court's decision in *Sisbro, Inc.* highlighted that even though a workers' compensation claimant has a pre-existing condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003).

Petitioner has filed five claims against Respondent for injuries to her low back, neck and knees. Respondent has not disputed any of the accidents.

Petitioner's first accident was on June 29, 2013. Petitioner testified that she sought very little medical care as a result thereof. Medical records appear to corroborate that although Dr. Moyer's office note of June 9, 2014 notes chronic back pain on Petitioner's lower left side "for about a year" which would be consistent with her June 29, 2013 work accident. Dr. Moyer ordered an x-ray and physical therapy but Petitioner never underwent any therapy because of her schedule. Thus, she underwent no treatment for her low back and continued to work full duty for Respondent for another fourteen months before having to seek medical treatment after an undisputed work accident on September 4, 2015.

At the center of the causation dispute in this case is Respondent's position, and Dr. Robson's belief, that Petitioner's need for treatment as proposed by Dr. Gornet stems from a chronic pre-existing low back condition made apparent on July 19, 2014, as opposed to any/all of the four subsequent very hostile and physical assaults on Petitioner while working. The Arbitrator doesn't agree with Respondent's position or the opinion of its examining doctor. July 9, 2014 is the first mention in the records of any low back issues. Petitioner did not even mention an injury to her back on the June 30, 2013 Notice of Injury form. While there is a reference in some of the medical histories to chiropractic care in 2004 no records were introduced to further set forth the nature of this treatment and, more significantly, Petitioner underwent no further treatment for her back for over ten years. Nothing in the record herein suggests that Petitioner had a diagnosed and treated chronic low back condition before July 9, 2014. The Arbitrator views the reference to "chronic" back pain in the July 9, 2014 medical office note as distinguishing Petitioner's complaints from an acute problem. While the doctor ordered some physical therapy and an x-ray, the therapy was not undertaken, no formal diagnosis for her back followed, and, most significantly, Petitioner continued to treat with Dr. Moyers for another fourteen months or so with no further mention of back pain or complaints or treatment to her back. The Arbitrator sees a distinct difference between vague references to fatigue and joint/muscle aches and pain and the very specific complaints Petitioner voiced on September 10, 2015 at Work Care and thereafter. Respondent produced no evidence of extensive back treatment pre-dating September 4, 2015. In light of the above, the Arbitrator does not find Petitioner's denial of prior back problems in Dr. Robson's questionnaire to be intentionally deceitful or misleading. Petitioner had been working full duty before September 4, 2015 and engaged in all activities of life, including hobbies and sports. Under these circumstances the Arbitrator finds it reasonable to infer from Petitioner's denial of prior problems that, in her mind, she wasn't having "problems." Petitioner was an exceedingly credible witness.

Contrary to Dr. Robson's opinions and Respondent's position, everything changed for Petitioner on September 4, 2015. She has never really returned to her level of activity pre-September 4, 2015. While she has returned to full duty work periodically since that accident she has not been asymptomatic and she ended up being involved in additional accidents, such as the one herein. Petitioner's treatment after the September 4, 2015 accident was initially managed by Respondent. She was sent to Work Care and, in turn, to Dr. Hayward. Medical personnel at Work Care opined that Petitioner's condition was related to her work activities/accident, that objective findings were consistent with a work-related etiology and that work activities had aggravated an underlying pre-existing condition for which a neurology consultation was recommended.

Work Care referred Petitioner to Dr. Hayward who acknowledged that Petitioner had a bulging disc at L3-4 on the left side which was contacting the nerve. He released her from his care because he didn't feel she needed surgery, not because she was at maximum medical improvement. A referral to an occupational medicine doctor for further treatment was recommended. While he saw no reason she couldn't return to work, it is interesting that just five days prior to the final visit with Dr. Hayward, Petitioner attended physical therapy and was noted to have limited lumbar AROM secondary to pain and the inability to perform normal activities secondary to lumbar and lower extremity radicular pain. She demonstrated an antalgic gait and difficulty walking. It was recommended that she continue with physical therapy; however, that wasn't done because Dr. Hayward released her to return to work. Dr. Hayward's records (PX 5) don't include copies of the therapy records. His office note of November 9, 2015 doesn't discuss them. As such, it is unclear to the Arbitrator if he knew what was going on in therapy, including Petitioner's limitations. In light of the foregoing, as well as Dr. Hayward's belief that Petitioner should follow up with occupational medicine and the therapist's recommendation for additional therapy, the Arbitrator finds Petitioner remained symptomatic when discharged by the doctor and not yet at maximum medical improvement.

Against this backdrop Respondent sent Petitioner back to work and, unfortunately, she sustained another accident on November 29, 2015, which is the subject of the instant claim. The Arbitrator found Petitioner to be a very credible witness and her reluctance to return to work after being discharged by Dr. Hayward, along with her disappointment about being switched to a different shift, did not negate her credibility.

In his deposition, Dr. Robson admitted that Petitioner's accidents resulted in a change of her work status and her symptoms. (RX18, p.20; RX19, p.25-26) He admitted that Petitioner consistently complained of pain following her work accidents. *Id.* at 26. He testified that he had no basis to dispute Dr. Gornet's records indicating the fact that Petitioner's symptoms increased after being involved in those incidents, and he admitted that Petitioner showed no signs of symptom magnification or malingering. *Id.* at 28-29, 32. He acknowledged that Petitioner's discogram demonstrated a severely provocative disc at L5 to S1. *Id.* at 21. He further admitted that annular tears could produce Petitioner's lumbar spine symptoms. *Id.* at 22. He acknowledged that, although he failed to appreciate Petitioner's annular tear, the radiologist who performed Petitioner's MRI of March 23, 2017, Dr. Ruyle, documented an annular tear visible at the apex of the protrusion at L5-S1. *Id.* at 22-23. When asked whether he agreed with Dr. Ruyle's interpretation, Dr. Robson stated, "I agree." *Id.* at 23. He further admitted that Petitioner's work accidents were a mechanism of injury consistent with her current pathology and symptoms, and significantly, that these incidents could aggravate Petitioner's pre-existing condition. *Id.* at 24. He also acknowledged that he did not possess any imaging studies for comparison prior to Petitioner's work injuries to say that Petitioner's lumbar spine herniations were definitively pre-existing. *Id.* at 20. Significantly, he acknowledged that Petitioner required no treatment for eleven (11) months prior to her work injury in September of 2015. (RX18, p.20) Even though he diagnosed Petitioner with simply a "strain," he admitted that Petitioner's symptoms had been unresolved and persistent since her work injuries. (RX19, p.26) Dr. Robson never addressed the cumulative effect of Petitioner's last four accidents, he did not comment on the October 24, 2016 accident whatsoever, he did not address the issue of "aggravation," and he failed to review all pertinent medical records (Hayward and Work Care) as part of his examination review and report. Dr. Robson also testified

that Petitioner has had the same low back and left-sided symptoms since 2014 (RX 19, p. 25). However, that's incorrect. Records from 2014 don't indicate any left lower extremity issues emanating from Petitioner's low back. The same cannot be said after September 4, 2015 or November 29, 2015. Indeed, the MRIs performed after the November 29, 2015 accident showed new findings at L5-S1, including a herniated disc, and increasing problems at L3-4. For these reasons, the Arbitrator is not persuaded by Dr. Robson's opinions.

In contrast, Dr. Gornet opined that Petitioner has a disc injury at L3-L4 and a disc injury, annular tear and herniation at L5-S1. He causally related these conditions to her November 29, 2015 accident. His opinion as to causation is supported by the objective diagnostic studies and the circumstantial evidence. Dr. Gornet noted that Petitioner suffers from minimal to degeneration, which is supported by the evidence and the findings of Work Care and Dr. Hayward. (PX3, 9/10/15; PX5, 11/9/15; PX8, 12/10/15) Dr. Gornet's diagnosis of an L5-S1 annular tear with herniations was confirmed by the objective imaging studies and the discogram procedure. (PX11; PX12; PX14) Dr. Gornet also noted that Petitioner's complaints markedly increased and have been unabated since her injuries, leading him to credibly conclude that Petitioner's work assaults aggravated and caused her current condition of ill-being. (PX15, p.15-16) The Arbitrator, therefore, finds his opinion persuasive and finds that Petitioner met her burden of proof in establishing that her current condition of ill-being in her low back is related to her work accident herein. The Arbitrator does not find Dr. Gornet's opinions less persuasive given the fact he did not personally review outside medical records on Petitioner and may not have known about Petitioner's problems in 2013 and 2014. He was questioned at length by both parties during his deposition and adequately addressed issues regarding pre-existing issues.

Although Petitioner's consolidated claims involve multiple injuries that all seemingly impacted her condition, the Arbitrator finds that Petitioner's apex injury that negatively impacted her condition of ill-being the most is the instant on occurring on November 29, 2015. Petitioner was able to return to work following her first two accidents on June 29, 2013, and September 4, 2015, and neither of these led to a surgical recommendation or significant treatment. (PX3; PX5) Following her accident on November 29, 2015, however, Petitioner's condition dramatically declined, and the herniated disc at L5-S1 was diagnosed. Petitioner's symptoms did not respond positively to conservative care, and she was ultimately recommended for surgery. While she sustained injuries after this date, both Dr. Gornet and Dr. Robson agree that the October 30th accident did not result in a significant change on pathology, and her treatment recommendations per Dr. Gornet have likewise remained the same. Dr. Gornet also stated the same regarding the October 24th accident. Dr. Robson did not address the October 24th accident. Dr. Gornet likewise testified that Petitioner's condition of ill-being was aggravated by the accident on November 29, 2015. (PX15, pp.15-16) Accordingly, the Arbitrator finds that Petitioner's current condition of ill-being in her low back is causally related to her third work accident occurring on November 29, 2015.

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

Petitioner is entitled to recover reasonable medical expenses as found in Petitioner's Exhibit 1 that are causally related to the November 29, 2015 accident. Respondent's dispute as to medical bills was based upon liability. Consistent with her causation determination set forth above (and incorporated herein by reference), Petitioner is awarded those medical bills incurred by her since November 29, 2015subject to the Medical Fee Schedule. Respondent shall receive credit for any bills previously paid by it, including any paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

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

Petitioner is awarded prospective medical care in the form of low back surgery as recommended by Dr. Gornet. In so concluding the Arbitrator incorporates herein by reference her causation findings discussed above.

Succinctly stated, Petitioner was able to work full duty prior to November 29, 2015. She has been symptomatic since November 29, 2015 and, while periodically returning to full or light duty work thereafter (and contra to her treating doctor's orders) she has remained symptomatic and been involved in additional accidents. Physical therapy and injections have not helped. She has yet to return to baseline. Additional treatment is in order and Dr. Gornet has testified, and his records reflect, that surgery was first recommended after the November 29, 2015 accident and he continues to recommend it.

Issue (L): What temporary benefits are in dispute? (TTD)

Petitioner's claim for temporary total disability benefits is denied. The lost time Petitioner seeks was ordered after her October 30, 2016 accident and, as such, the Arbitrator feels it would be more appropriate to award it in conjunction with that accident (case #16 WC 36411).

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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

Stephanie Matlock,

Petitioner,

19IWCC0604

vs.

NO: 16 WC 036410

State of IL / Choate Mental Health,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 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.

19IWCC0604

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)(l) of the Act, claims against the State of Illinois are not subject to judicial review.

DATED: NOV 6 - 2019

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Maria E. Portela

Thomas J. Tyrrell

Kathryn Doerries

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

MATLOCK, STEPHANIE
Employee/Petitioner

Case# **16WC036410**

16WC004246
15WC030798
16WC002296
16WC036411

ST OF IL/CHOATE MENTAL HEALTH
Employer/Respondent

19IWCC0604

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:

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

APR 2 - 2018

RANDALL A. HARDIA, Acting Secretary
Illinois Workers' Compensation Commission

19IWCC0604

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Stephanie Matlock
Employee/Petitioner

v.

State of Illinois/Choate Mental Health
Employer/Respondent

Case # **16** WC **36410**

Consolidated cases: **16 WC 04246**
15 WC 30798
16 WC 02296
16 WC 36411

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury? (Lumbar spine only)
G. [ ] What were Petitioner's earnings?
H. [ ] What 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 [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, **10/24/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**51,477.74**; the average weekly wage was $**989.96**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

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

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

Respondent ***is*** entitled to a 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's current condition of ill-being is causally related to her work-related accident occurring on October 24, 2016; however, no benefits are awarded with regard to this claim, as TTD is awarded in case #16 WC 36411 and medical expenses and prospective medical care are awarded in case #16 WC 2296.

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

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

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

Nancy Lindsay
Signature of Arbitrator

9.23.18
Date

ICArbDec19(b)

APR 2 - 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner is employed as a security therapy aide for Respondent, Choate Mental Health and Development Center. Petitioner has five applications for adjustment of claim pending against Respondent. All five claims involve alleged injuries to Petitioner's knees, low back and neck and they were consolidated at the time of arbitration with the parties understanding that separate decisions would issue. The parties further stipulated that this 19(b) hearing was solely limited to Petitioner's alleged low back condition and that all issues regarding injuries to other body parts were being reserved. Therefore, the Arbitrator's findings and conclusions only address the alleged low back claim. None of Petitioner's five accidents against Respondent are disputed. The focus of the dispute is causal connection and Petitioner's need for prospective medical care.

The Arbitrator finds:

On June 30, 2013, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. (RX1). Petitioner indicated that on June 29, 2013, she was knocked down while assisting with a hostile patient and landed on the edge of a dresser. (RX1). Petitioner indicated she injured the bridge of her nose, left buttock, right upper arm, lower arm/hand, and left and right knees. (RX1). Respondent does not dispute that this accident occurred. (AX 5)

On March 10, 2014, Petitioner presented to Dr. Lori Moyers at Cape Family Practice to establish herself as a patient. (RX20). It was noted Petitioner was a heavy every day smoker and had previously undergone removal of her thyroid. (RX20).

On April 8, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner was seen for low thyroid levels and complained of right hip pain. (RX20). Petitioner was given an injection into her hip. (RX20).

On May 13, 2014, Petitioner returned to Dr. Moyers. (RX20). Petitioner complained of swelling all over and pain in her feet. (RX20). Petitioner was given a fatigue panel. (RX20).

On June 10, 2014, Petitioner saw Dr. Moyers. (RX20). Petitioner complained of shortness of breath, increased stress, and bilateral knee pain. (RX20). Petitioner requested a steroid shot, but declined it as it was out of network. (RX20). Petitioner was scheduled for an EKG and stress test. (RX20).

On July 9, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner complained of chronic back pain on lower left side. Petitioner indicated it had started about a year earlier and had gotten worse. Petitioner also indicated her back actually "went out" approximately five months earlier. Petitioner did not mention any accident or injury with regard to her back. It was noted Petitioner had a history of syringomyelia. A lumbar spine x-ray was ordered and Petitioner was prescribed physical therapy.

On August 11, 2014, Petitioner returned to Dr. Moyers. Petitioner indicated she had undergone the L-spine x-ray, but had not started the physical therapy yet due to her schedule. Petitioner also complained of left foot pain. Petitioner was referred to another doctor for her foot. (RX20).

On September 8, 2014, Petitioner followed up with Dr. Moyers. Petitioner complained of fatigue, abdominal pain, joint/muscle pain, and anxiety. (RX20).

On October 10, 2014, Petitioner returned to Dr. Moyers. Petitioner complained of fatigue, thyroid issues, joint/muscle aches, and anxiety. It was noted Petitioner had multiple trigger points. (RX20).

On November 11, 2014, Petitioner saw Dr. Moyers. Petitioner complained the prescription Savella caused nausea and had not helped her pain at all. (RX20).

On January 16, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of low thyroid levels and a rash all over her body. (RX20).

On June 4, 2015, Petitioner returned to Dr. Moyers for her thyroid. Petitioner returned on June 15, 2015 complaining of congestion and sinus pressure. (RX20).

On July 15, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of continued allergy symptoms and weight gain. (RX20).

Petitioner was involved in an undisputed work accident on September 4, 2015. (AX 1)

On September 8, 2015, Petitioner returned to Dr. Moyers. Petitioner complained of a spot on her left foot and low energy/fatigue. (RX20).

On September 9, 2015, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. Petitioner indicated that on September 4, 2015, she was knocked down twice by an aggressive patient. Petitioner indicated she injured her lower back, upper back, and both knees. (RX4).

On September 10, 2015, Petitioner presented to Work Care regarding her 9/4/15 accident. At that time she was complaining of pain in her low back, neck, bilateral knees, and left foot. Petitioner indicated she was in a patient altercation and was thrown to the floor two times. During the altercations she began dry heaving and vomiting. Petitioner indicated her primary problem was her neck; her secondary problem was her low back. It was noted Petitioner was previously diagnosed with syringomyleia and fibromyalgia. Petitioner indicated her primary care physician did not take work comp. Petitioner complained of constant aching pain in her back aggravated by use and relieved by rest. X-rays were described as unremarkable with no degenerative findings. Petitioner was diagnosed with a cervical spine radiculopathy and strain, thoracic spine strain, lumbar spine strain, and bilateral knee contusions. Petitioner was prescribed medication and physical therapy and taken off work through September 11, 2015 to be followed by sedentary work restrictions as of September 12, 2015 Petitioner was also referred for a neurology consult for a

"pre-existing spinal condition." FNP-BC Dena Kommer addressed causation stating, "The cause of this problem is related to work activities. The objective findings are consistent with the history of a work-related etiology. Work activities have aggravated an underlying pre-existing condition." (PX3)

Petitioner testified, without rebuttal, that Respondent could not accommodate her work restrictions/light duty and she remained off work.

On September 17, 2015, Petitioner returned to Work Care and reported she was no better. Petitioner indicated her primary problem was her neck and that she had burning down into her shoulders. She also had bilateral knee pain and muscle spasms in her lumbar area. Diagnoses and recommendations remained the same. She was referred to Dr. Hayward. (PX3).

On September 16, 2015 Petitioner signed her Application for Adjustment of Claim in case #15 WC 30798 alleging injuries to her body as a whole and bilateral knees due to an accident on September 4, 2015 when she was attacked by a resident. (AX 2)

On September 17, 2015, Petitioner underwent x-rays of her left knee. The findings were normal with mild osteoarthritic changes noted. Petitioner also underwent x-rays of her right knee. The findings were normal with minimal osteoarthritic changes noted. Additionally, Petitioner underwent x-rays of her lumbar spine. The findings showed normal curvature and alignment maintained except for mild right convex curvature centered near L1/2, mild loss of disc height from L3/4 through L5/S1, and mild lumbar facet arthropathy present. There was no fracture or subluxation identified, sacral arcuate lines intact, and soft tissues were unremarkable. Petitioner also underwent x-rays of her thoracic spine. The findings showed no compression fracture or subluxation. Finally, Petitioner underwent x-rays of her cervical spine. The findings were normal. (PX3).

Petitioner completed a questionnaire for Dr. Thalman's office on September 24, 2015 regarding her September 4, 2015 accident. Dr. Thalman is a chiropractor. (PX 6; AX 12)

As ordered by Work Care, Petitioner presented to physical therapy at Mid America Rehab on September 29, 2015. Petitioner reported trying to break up a fight between patients earlier in September and being injured in the process. She had undergone x-rays but no other tests. Her complaints included pain in the neck, upper back, mid back, low back and down her left leg. She reported some occasional arm and leg pain and burning into the shoulder blade region and both legs. She also reported numbness and tingling down her legs at times. The therapist described Petitioner's level of pain as moderate to severe and documented an antalgic gait along with decreased range of motion. Petitioner was to be seen three times a week for four weeks. (PX 2)

Petitioner attended therapy as instructed. At the October 7, 2015 session Petitioner requested that she not have to lay on the treatment table as it bothered her. She reported increased pain down her left leg when side bending to the right. She was unable to tolerate "ther-ex:" secondary to increasing pain. She also reported that she was always having to change positions to relieve her pain which was admittedly "getting to her." (PX 2)

On October 8, 2015, Petitioner followed up at Work Care. Petitioner indicated her primary concern was her lumbar spine, followed by her cervical spine and knees. Petitioner described both as aching and unrelenting. Petitioner also reported that walking increased her symptoms in all areas and she was experiencing a radiculopathy that would come and go. Petitioner indicated she had an appointment pending with Dr. Hayward for her spine, although she had concerns about seeing him. According to the notes, the MRI was on hold per the case manager until after Petitioner's exam with Dr. Hayward. It was noted Petitioner refused to see the doctor who diagnosed her with syringomelia. Petitioner indicated that physical therapy was not helping much. It was noted symptom magnification was present but her attitude and effort were felt to be "fair." Restricted duty was continued. (PX 3)

On October 12, 2015, Petitioner presented to Dr. Franklin Hayward at Heartland Spine Institute. Petitioner provided the doctor with a detailed account of her work accident in September and her medical care since the accident and told the doctor that she was undergoing therapy with no relief. Petitioner also described her current symptoms as new, and told the doctor about a work injury two and one-half years earlier when she fell on her left buttock while confronting an aggressive resident. She also recalled a neck injury when a resident pushed her head into a wall but couldn't recall the date. There was also an incident when her right thumb was bent backwards and an incident when she fell to her knees during an altercation but she couldn't recall those dates of injury. Petitioner denied any history of back surgery and explained she had seen Dr. Stahley for tremors. Petitioner complained of low back pain, weakness all over, dizziness, balance difficulty, nausea, headache, numbness in her feet, and numbness and tingling in the 4th and 5th fingers of the right hand, all of which began after the accident. Petitioner felt the accident had worsened her tremors. Dr. Hayward ordered MRIs of Petitioner's cervical and lumbar spine and continued Petitioner's restrictions. He referred Petitioner back to Dr. Stahley and/or her family doctor for her tremors. (PX5).

Petitioner returned for physical therapy on October 14, 2015 having last attended on October 7, 2015. Petitioner was reporting continued pain down her left leg all the way to the ankle. She was still waiting for the MRI to be scheduled. (PX 3)

Petitioner attended physical therapy on October 16, 2015 reporting some slight subjective improvement that day but also having tremors in her upper back and a "grabbing" sensation in her left low back along with sharp pain when trying to sit straight. (PX 3)

Petitioner again attended physical therapy on October 19, 2015 reporting increased pain that day and over the weekend (associated with increased standing). Petitioner attempted more therapy at this visit. (PX 3)

As of October 22, and October 26, 2015 Petitioner was still having trouble with some aspects of therapy and her MRI was still pending. As of October 28, 2015 her MRI was finally being scheduled. (PX 3)

On November 2, 2015, Petitioner underwent an MRI of her lumbar spine. The impressions were: 1) minor degenerative disc disease, disc bulges cause minor foraminal stenoses at L3/4 and L4/5, left L3 nerve root contacts the disc bulge near the foramen, and could be a source of pain; 2)

no lumbar spine central canal stenosis; 3) benign hemangioma in the T10 vertebra; and 4) LLQ borderline nodes vs mild mesenteric lymphadenitis. Petitioner also underwent a cervical spine MRI. The impressions were: 1) c-spine straightening may be due to positioning or muscle spasm; 2) minor cervical disc bulges, no cord compression or central canal stenosis; 3) tiny hydromelia, syrinx at C7/T1; 4) moderate left foraminal stenosis at C6/7; 5) benign hemangioma in the T4 vertebra; and 6) S/P thyroidectomy. (PX5).

Petitioner attended physical therapy on November 4, 2015 reporting she had undergone the MRI but was unaware of the results. Sitting and bending were still bothering her and she had an ongoing antalgic gait and difficulty walking. It was recommended that she continue physical therapy three times a week. (PX 3)

On November 6, 2015, Petitioner returned to Work Care. Petitioner indicated her neck pain was 7 out of 10, her back pain was 7 out of 10, and her bilateral knee pain was 7 out of 10. She was also noted to be depressed. Her condition was again noted to be related to her work activities. Petitioner's prescriptions were refilled and she was to start an exercise program. (PX3).

On November 9, 2015, Petitioner followed up with Dr. Hayward. Petitioner continued to complain of back and leg pain that the doctor described as being in a non-dermatomal distribution. Petitioner also reported she was not improving and asked the doctor to refer her to a neurologist to facilitate a neurology consultation as part of her claim. Dr. Hayward explained that he felt she needed to follow up with Dr. Stahley regarding her chronic condition and that she might need to do that under her own health insurance. On examination, Dr. Hayward stated that Petitioner's motor strength was intact. He further noted Petitioner had Waddell's testing, three out of five. Dr. Hayward reviewed Petitioner's MRIs which showed age appropriate mild degenerative changes and a bulge at L3/4 which was making contact with her L3 nerve root; however, he felt Petitioner had no L3 radiculopathy as her leg pain was all posterior and radiating down to the leg and foot which he could not explain. Petitioner also had clearly reproducible pain to palpation of her lumbar and cervical spines with the lumbar region being more tender. Petitioner was diagnosed with myofascial muscle pain. Dr. Hayward also noted Petitioner's history of fibromyalgia and syringomyelia and felt that might be the cause of her myofascial pain. Dr. Hayward saw no evidence to suggest radiculopathy. Dr. Hayward noted that whether the tremors were related to her work accident was an issue for Dr. Stahley to address. Dr. Hayward also noted that there were no surgical indications and, while he released Petitioner from his care without any restrictions due to the absence of any physical limitations, he did recommend a referral to an occupational medicine doctor for further treatment of her condition given that there was no acute surgical indication. (PX5).

According to the November 19, 2015 physical therapy discharge note, Petitioner had been discharged from further care in light of Dr. Hayward's release to return to work. Petitioner had last undergone therapy on November 4, 2015. (PX 3)

On November 29, 2015, Petitioner sustained another accident while working for Respondent. Petitioner filled out a Worker's Compensation Employee's Notice of Injury form (d/a: 11/29/15). Petitioner indicated she was attempting to restrain an aggressive patient. Petitioner

indicated she injured her left wrist/hand, right hand, bilateral forearms, neck, and back. (RX7). Respondent does not dispute that this accident occurred. (AX 3)

On November 30, 2015, Petitioner returned to Dr. Moyers, her primary care doctor. Petitioner complained of chronic low back pain and indicated she was attacked by a patient on November 29, 2015. She made no mention of the September 4, 2015 accident. Petitioner indicated she had seen a neurosurgeon who did not feel she needed surgery and released her back to work. Petitioner indicated she was then attacked again on the 29th while on light duty and had pain radiating down her left leg into her foot. It was noted Petitioner had had C-spine and L-spine MRIs. Petitioner was diagnosed with C-spine and T-spine sprains and disc degeneration in her lumbar region. Petitioner was prescribed physical therapy. (RX20).

On December 7, 2015, Petitioner returned to Work Care regarding her September 4, 2015 accident. Petitioner indicated her back pain, neck pain, and bilateral knee pain was a 7 out of 10 and that she had sustained a new accident at work that was being handled by another provider so she requested a release from the previous injury. Petitioner was discharged at her request. (PX3).

On December 10, 2015, Petitioner presented to Dr. Matthew Gornet at The Orthopedic Center of St. Louis. Petitioner complained of low back pain and neck pain. Petitioner indicated her problem began on September 4, 2015 after she was involved in an altercation with an aggressive patient. Petitioner indicated she did have some spinal pain and chiropractic care in 2004, but no intervening treatment since that time. Petitioner was diagnosed with: a disc injury at L3/4; disc injury, annular tear, and herniation at L5/S1; and disc injury at C6/7. Dr. Gornet noted that he felt Petitioner had, at a minimum, suffered an aggravation/re-aggravation of her "work injury." Dr. Gornet put treatment for the neck on hold while Petitioner treated for the low back. Dr. Gornet recommended a steroid injection at L5/S1 and physical therapy. A new cervical MRI was ordered. Petitioner was taken off of work. (PX 8)

On December 15, 2015, Petitioner followed up with Dr. Moyers regarding her lower back. Petitioner indicated she was treating with Dr. Gornet and was scheduled to undergo injections in her lower back. Petitioner reported that her left hip pain was continuing and was radiating down to her left knee and foot. Petitioner requested a referral to a mental health specialist for anxiety and insomnia. Petitioner was to remain off work per Dr. Gornet and was referred to Brad Robison. (RX20)

On January 13, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 2296 alleging injuries to her neck, back, bilateral hands and arms, and body as a whole as a result of an accident on November 29, 2015 described as an "altercation with patient/aggravation." (AX 4)

On January 14, 2016, Petitioner underwent a left L5/S1 epidural steroid injection by Dr. Kaylea Boutwell. (PX9)

On February 1, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 004246 alleging injuries to her bilateral knees, left buttock, right arm, back, and body as a whole as a result of an accident on June 29, 2013. (AX 6)

On February 29, 2016, Petitioner underwent an MRI of her cervical spine without contrast. The impressions were: 1) central-left foraminal broad-based protrusion at C6/7 measuring up to 3.5 mm in the left foramen, resulting in moderate left foraminal stenosis; 2) central broad-based protrusions at the C3/4, C4/5 and C5/6 levels; and 3) 1-1.5 mm maximal diameter cervical cord syrinx focally at the C7/T1 disc level. (PX11).

That same day, Petitioner followed up with Dr. Gornet. Dr. Gornet reviewed Petitioner's cervical MRI noting that it showed Petitioner had a fragment of disc on the left side at C6/7, subtle changes on the right side at C5/6 and C6/7, and central disc protrusions at C3/4, C4/5, and C5/6. Dr. Gornet also stated in his notes that Petitioner had a foraminal herniation at L3/4 on the left and recommended a transforaminal steroid injection. He again noted that Petitioner's symptoms related to an accident on September 4, 2015. If that did not help, a CT discogram and MRI spectroscopy would be next. Petitioner was given work restrictions fo "office work only" on a trial basis. (PX8).

On March 16, 2016, Petitioner underwent a transforaminal steroid injection under fluoroscopic guidance at L3/4 left with facet block at L3/4 left. Petitioner tolerated the procedure well. (PX12; PX 8).

On May 9, 2016, Petitioner followed up with Dr. Gornet. Petitioner indicated the injection gave her a month of relief, but she had continued symptoms and pain. Dr. Gornet recommended an MRI spectroscopy and CT discogram. Petitioner's work restrictions were continued and her prescriptions refilled. (PX8)

On May 10, 2016, and at Respondent's request, Petitioner underwent a Section 12 examination by Dr. David Robson at Comprehensive Spine Care. Petitioner gave a history of being attacked by a patient at work on September 4, 2015, injuring her neck and back. Dr. Robson also reviewed an accident report from November 29, 2015 indicating Petitioner was injured by an aggressive patient. Petitioner gave no history of prior treatment for her neck or back, but when interviewed, did recall a remote history of low back treatment with a chiropractor in 2011. Dr. Robson reviewed medical records including those from physical therapy, Dr. Moyers, Dr. Gornet, injection reports, and imaging studies. Dr. Robson diagnosed Petitioner with mild degenerative changes of the lumbar spine, mild disc bulging at L5/S1, mild degenerative changes at the cervical spine, and syringomyelia at C7/T1. Dr. Robson opined physical therapy was warranted for a flare-up of low back pain, but further treatment was not reasonable or necessary as Petitioner had a known history of chronic lower back and neck problems. Dr. Robson further opined the September 4, 2015 and November 29, 2015 injuries caused a temporary aggravation of her pre-existing neck and lower back complaints, but Petitioner was at MMI and could return to work without restrictions. (RX16)

On June 16, 2016, Petitioner presented to Dr. Eugene Kostiuk at Clay Medical Center. Petitioner complained of anxiety, depression, and difficulty sleeping. Petitioner was diagnosed with post-traumatic stress disorder and counseling was recommended. (PX13)

On June 28, 2016, Petitioner underwent a discogram with x-ray interpretation at L3/4, L4/5, and L5/S1 with facet block left at L3/4, L4/5, and L5/S1. The summary indicated: non-provocative

disc at L4/5; minimally provocative disc at L3/4 for back pain, some butt pain; and L5/S1 severely provocative of concordant back pain. (PX14)

On July 26, 2016, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) broad based or bilobed disc herniation on L3/4, larger on the left, extending towards the foramina, also worse on the left, without central stenosis; and 2) smaller central protrusion at L5/S1 without significant impression upon the dura. (PX11)

On July 26, 2016, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed the MRI spectroscopy and CT discogram, noting Petitioner had a non-provocative disc at L4-5, minimally provocative disc at L3-4 and a severely provocative disc at L5-S1 on the discogram; however, the MRI spectroscopy did not detect any reading at L5-S1. There was a large central annular tear at L5-S1. Dr. Gornet also reviewed Dr. Robson's IME report and noted his explanations of it to Petitioner. He pointed out that Dr. Robson apparently felt Petitioner had sustained temporary aggravations of her pre-existing neck and low back complaints in relation to her 9/4/15 and 11/29/15 accidents. Dr. Gornet explained to Petitioner that while she did candidly acknowledge a history of pre-existing complaints in her spine there was no indication that her level of complaints or severity was anywhere near the level of her current ones. He further noted that Dr. Robson did not have the opportunity to review the CT discogram report and visualize the central annular tear as well as the reproduction of symptoms at L5-S1. As her adjacent levels for the most part were "fairly clean" and she had failed conservative care, to date, Dr. Gornet recommended Petitioner undergo an anterior lumbar fusion. Her work restrictions remained unchanged. (PX8).

Petitioner resumed full duty work for Respondent in July of 2016.

Deposition of Dr. Gornet

Dr. Matthew Gornet testified via evidence deposition on September 15, 2016. (PX15). Dr. Gornet testified he is an orthopedic surgeon whose practice is devoted to spine surgery. (PX15, p. 4). He performs research, clinical trials, and treats patients. (PX15, p. 4-5). Dr. Gornet testified Petitioner first saw him on December 10, 2015. (PX15, p. 6). She acknowledged a history of some prior low back/neck pain. (PX15, p. 7). Dr. Gornet testified he reviewed imaging studies of Petitioner's lumbar and cervical spine. (PX15, p. 7-8). Dr. Gornet diagnosed Petitioner with a disc injury at L3/4; a disc injury, annular tear and herniation at L5/S1; and a disc injury at C6/7. (PX15, p. 9). Conservative care of injections and physical therapy was recommended, as well as new imaging studies. (PX15, p. 9). Dr. Gornet testified it was his understanding Petitioner had had a couple work injuries and it was impossible to tell which findings were objectively caused by which accident when looking at x-rays, MRIs, or other films. (PX15, p. 10).

Dr. Gornet testified that Petitioner only received temporary relief from the injection. (PX15, p. 11). Petitioner then underwent an MRI spectroscopy and CT discogram and he then recommended to undergo an anterior lumbar fusion at L5/S1. (PX15, p. 12-14). Dr. Gornet opined Petitioner's work injury of September 24, 2015 aggravated her underlying condition and the November 29, 2015 injury aggravated it further. (PX15, p. 15-16) As he explained it:

> . . . [T]his is a woman who may have had some mild disc degeneration prior to this. She does have a history of low back pain dating back several years. That being said, there is no indication that she had a significant major problem that she does today. Therefore, almost de facto we can state that her condition is one that is ongoing, and in her overall health status this condition is relatively new and dates to approximately September of 2015.
>
> Now, that being said, what I believe happened is, is that this woman has some preexisting disc degeneration. Disc degeneration is a normal part of life and can be relatively asymptomatic, but it does weaken the disc. She's in an altercation, she has applied mechanical load which injures the disc and it causes a tear.
>
> I believe November 29th aggravated that further, making her more symptomatic, and at this point in time, she continues to be symptomatic. We can say as a matter of course that this is not a temporary condition, because the patient's symptoms have never returned back to baseline prior to the injury. (PX 15, pp. 15-16)

On cross-examination, Dr. Gornet admitted that he did not review any medical records outside of his own and the IME report. (PX15, p. 18). He further explained that Petitioner's syringomyelia refers to some mild fluid contained within her spinal cord. It usually does not progress except in very rare circumstances. He did not feel it had anything to do with her current complaints. (PX 15, pp. 18-19) Dr. Gornet testified he compared the MRIs of Petitioner's cervical and lumbar spine taken November 2, 2015 to the ones he had done. (PX15, p. 19-20). He testified the more recent MRIs did not show newer pathology, just a more accurate definition of the pathology present. (PX15, p. 20). There was no major progression. (PX15, p. 20). Dr. Gornet testified myofascial muscle pain is a subjective complaint. (PX15, p. 21). Dr. Gornet agreed Petitioner gave him a history of spine pain and chiropractic care in 2004, but did not recall any intervening treatment since that time. (PX15, p. 22). Dr. Gornet testified if that was inaccurate, and there was a "significant event" that was near that time frame it could possibly change his opinion and he would evaluate any new information. However, Petitioner clearly detailed to him that she felt she had spinal problems in the past. (PX15, p. 23)

Dr. Gornet testified he did not have Dr. Hayward's medical records and was unaware Dr. Hayward found three out of five Waddell's testing. (PX15, p. 24). Dr. Gornet testified Waddell's testing is a way to evaluate inorganic or other findings in patients that is associated with non-necessarily physiologic presentations of low back pain and can be used to determine if there is the possibility of symptom magnification. (PX15, p. 25). Dr. Gornet testified a three out of five would be a moderately positive Waddell's sign. However, he did not detect any functional overlays during his exams with Petitioner. (PX15, pp. 25-26)

Dr. Gornet testified he has put any treatment for Petitioner's neck on hold at this point in hopes that treating the low back would alleviate Petitioner's complaints. (PX15, p. 26-27). Petitioner has not undergone any injections for her neck and there is no surgical recommendation at this time. (PX15, p. 27)

Dr. Gornet testified his causation opinion is based upon the history Petitioner gave him regarding the injuries, her medical history she told him, and the records he had for review. (PX15, p. 28). Dr. Gornet admitted that if the history Petitioner gave him regarding her prior back complaints and treatment was inaccurate, it could change his opinion. (PX15, p. 28)

Dr. Gornet testified that he is relating Petitioner's need for surgery to both the September 4, 2015 and November 29, 2015 accidents. (PX15, p. 28). Dr. Gornet testified that there were no structural changes in Petitioner's spine in comparing the two MRIs. (PX15, p. 28). Dr. Gornet agreed that a herniation on an MRI cannot be dated. (PX15, p. 29)

Additional Medical Treatment

On October 6, 2016, Petitioner followed up with Dr. Gornet. Petitioner complained of continued low back pain. Dr. Gornet continued to recommend an anterior lumbar fusion at L5/S1 and refilled Petitioner's prescriptions. (PX8).

Deposition of Dr. Robson

Dr. Robson testified via evidence deposition on October 24, 2016. (RX18). Dr. Robson testified he is a board certified orthopedic spine surgeon who treats conditions of the cervical, thoracic, and lumbar spine. (RX18, p. 4-5). Dr. Robson testified he performed an IME on Petitioner on May 10, 2016. (RX18, p. 7). He reviewed Petitioner's medical records which showed Petitioner had lower back complaints prior to September 4, 2015. (RX18, p. 8). Specifically, Petitioner had treated with Dr. Moyers on July 9, 2014 complaining of chronic back pain and indicated her back had previously gone out five months prior. (RX18, p. 8). Dr. Robson testified this was inconsistent with the history Petitioner gave on his Patient Questionnaire where she denied any pre-existing problems prior to September 2015. (RX18, p. 9). Also, Dr. Robson testified that when he asked her directly about any prior treatment, she indicated she had some chiropractic care in 2011, but did not mention any problems or treatment in 2014. (RX18, p. 8)

Dr. Robson testified he reviewed the films of Petitioner's cervical and lumbar spine MRIs done on November 2, 2015. (RX18, p. 9). He did not see any significant herniation or protrusion lateralizing in Petitioner's neck. (RX18, p. 9). With regard to the lumbar spine, he thought she had some loss of disc height at L3/4 and L5/S1, but did not see any significant foraminal stenosis at either level. (RX18, p. 10). There was some minimal bulging at L5/S1. (RX18, p. 10). Dr. Robson testified he did not diagnose an annular tear at L5/S1. (RX18, p. 10). Dr. Robson testified he pulled up the films of Petitioner's lumbar spine MRI just prior to being deposed and re-examined them. (RX18, p. 10). While Dr. Gornet noted an annular tear at L5/S1 on axial image 12, Dr. Robson disagreed as there was no high intensity zone or a white spot or a bright lesion that would denote an annular tear. (RX18, p. 10)

Dr. Robson testified he took a history from Petitioner regarding the September 4, 2015 and November 29, 2015 injuries and performed a physical examination. (RX18, p. 11). On physical examination, Dr. Robson testified Petitioner's examination was normal, except some decreased range of motion of the cervical spine. (RX18, p. 11-12). Petitioner's lumbar spine showed normal gait and normal neurological testing. (RX18, p. 12)

Dr. Robson testified Petitioner had previously been diagnosed with fibromyalgia which is purported to cause cervical and lumbar spine problems and often time physical therapy and trigger point injections are required. (RX18, p. 12). Petitioner's medical records indicate she had previously undergone physical therapy and trigger point injections prior to September 4, 2015. (RX18, p. 12).

Dr. Robson diagnosed Petitioner with a cervical strain and lumbar strain, based on his review of the medical records, the history taken from Petitioner, and the physical examination he performed on her. (RX18, p. 12-13). He did not believe Petitioner required any additional treatment, opined she was at MMI, and could return to work without restriction. (RX18, p. 13-14).

On cross-examination, Dr. Robson testified he had not seen the results of Petitioner's CT discogram. (RX18, p. 15). Dr. Robson testified he does not perform discograms even though he is trained to do it because he is not a big believer in that test. (RX18, p. 16). Dr. Robson testified patients are supposed to be blinded as to what levels are being tested, but it depends on who is performing it. (RX18, p. 17).

Dr. Robson testified he did not see any signs of malingering or Waddell's signs in his examination, but Petitioner was inconsistent as far as forthcoming with her past medical history. (RX18, p. 18). Dr. Robson testified Petitioner indicated on the Patient Questionnaire she filled out that she had not had any prior problems with her back before her 2015 injury. (RX18, p. 18-19). He said this was inconsistent with what was in Dr. Gornet's notes and Dr. Moyer's notes. 9RX18, p. 18-19). He testified this was also inconsistent with what Petitioner told him about receiving chiropractic care in 2011. (RX18, p. 19). Dr. Robson testified Petitioner did not tell him that she had a previous injury on June 29, 2013. (RX18, p. 21). Dr. Robson testified he had no criticism of her care and treatment up to date. (RX18, p. 22).

Additional Medical Treatment

On October 29, 2016, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form for an accident occurring that day. Petitioner indicated that on October 24, 2016, she was jerked around while trying to break up a fight between three aggressive patients. (RX 10) Respondent does not dispute that this accident occurred. (AX 7)

On October 30, 2016, Petitioner filled out a Workers' Compensation Employee's Notice of Injury form regarding an accident that occurred that day. Petitioner indicated she was thrown over the back of a couch with a patient while trying to stop his violent behavior. Petitioner indicated she injured her hips, left leg, and had whole spine pain. (RX13). Respondent does not dispute that this accident occurred. (AX 9)

On November 21, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 0036410 alleging injuries to her back, neck, and body as a whole as result of an accident on October 24, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 8)

On November 21, 2016 Petitioner also signed her Application for Adjustment of Claim in case #16 WC 0036411 alleging injuries to her back, neck, and body as a whole as result of an accident on October 30, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 10)

On November 23, 2016, Petitioner returned to Dr. Gornet. Petitioner indicated she was in two new altercations on October 24, 2016 and October 30, 2016. Petitioner indicated she felt she had aggravated her underlying back condition and injured her neck and shoulders. Dr. Gornet recommended observation and indicated if Petitioner's symptoms continued to be elevated, he would recommend new imaging studies to see if there is a new disc injury. Petitioner was taken off work. Dr. Gornet noted, "At a minimum, these new injuries have aggravated her underlying conditions in her cervical and lumbar spines." (PX8).

On January 9, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet described Petitioner as being "clinically worse." He recommended a new MRI, but indicated unless it was dramatically changed, he would move forward with the anterior lumbar fusion at L5/S1. (PX8)

On March 23, 2017, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) L3/4 and L4/5 annular disc bulges with superimposed left foraminal protrusions at both levels resulting in moderate left greater than right foraminal stenosis but no central canal stenosis; and 2) left paracentral focal protrusion at L5/S1 resulting in dural displacement and contact with the traversing left S1 root sleeve but no definite central canal or foraminal stenosis. (PX11)

On March 23, 2017, Petitioner returned to Dr. Gornet, regarding her with-related injuries, including new altercations of 10/24/16 and 10/30/16 as well as her original injury of 9/4/15. He noted that the MRI did not show any dramatic changes. The options of a lumbar fusion and a disc replacement at L5/S1 were discussed. (PX8)

On April 27, 2017, Petitioner underwent another Section 12 examination with Dr. Robson. Petitioner gave a history of a new injury on October 30, 2016 when she was in another patient altercation. Petitioner complained of low back pain radiating down into her left leg and foot. Dr. Robson reviewed accident reports, medical records, and imaging studies, including MRIs of Petitioner's lumbar spine from November 2, 2015, September 26, 2016, and March 23, 2017. Dr. Robson's assessment was mild disc desiccation at L3/4 and L4/5 and diffuse disc bulging asymmetric to the left at L5/S1. Dr. Robson noted Petitioner had previous low back complaints in 2014 for which she treated and took pain medication. Dr. Robson opined there was no causal relationship between Petitioner's current condition and the reported accident, and that her current condition was related to her pre-existing condition. Dr. Robson opined that he did not believe surgical intervention was medically necessary. He further opined Petitioner was at MMI and could return to work without restrictions. (RX17)

On May 11, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet continued to recommend a disc replacement at L5/S1. (PX8)

Second Deposition of Dr. Robson

Dr. Robson testified again via evidence deposition on July 27, 2017. (RX19). Dr. Robson testified he performed a second IME on Petitioner on April 27, 2017. (RX19, p. 7). Dr. Robson testified that he reviewed medical records and performed a physical examination. (RX19, p. 7). Dr. Robson reviewed MRI films of Petitioner's lumbar spine from November 2, 2015, July 26, 2016, and March 23, 2017. (RX19, p. 9). Dr. Robson testified he compared all three lumbar spine MRI films. (RX19, p. 10). The March 23, 2017 MRI showed some mild loss of disc height between her third and fourth lumbar, her fourth and fifth lumbar, and L5/S1. (RX19, p. 10). There was a small asymmetric disc bulge to the left at L5/S, and, in comparison to the two previous MRIs, Dr. Robson felt it was unchanged or maybe even slightly better. (RX19, p. 10). The size of the disc bulge did not appear as large. (RX19, p. 10).

Dr. Robson testified that Petitioner indicated to him that she was injured at work when she was breaking up a fight between two patients on October 30, 2016. (RX19, p. 11). Petitioner said this increased her back pain. (RX19, p. 11). Dr. Robson performed a physical examination of Petitioner which was normal, except some limited range of motion in forward flexion. (RX19, p.11). Dr. Robson testified there were no structural changes between Petitioner's lumbar MRIs taken in 2016 and March 23, 2017. (RX19, p. 11).

Dr. Robson diagnosed Petitioner with mild dehydration of the disc between her third and fourth lumbar and her fourth and fifth lumbar vertebra and a diffuse disc bulge asymmetric to the left at L5/S1. (RX19, p. 12). Dr. Robson testified this diagnosis was not related to the October 30, 2016 work injury. (RX19, p. 12). Dr. Robson testified Petitioner did not need any further treatment related to the October 30, 2016 injury and that she was at MMI. (RX19, p. 13). Dr. Robson testified he personally would not perform the recommended surgery. (RX19, p. 13). He further testified that he could not attribute the need for same to an October 30, 2016 injury. (RX19, p. 13). Dr. Robson explained that he would personally not do the surgery because the only positive test that came back was the discogram which has subjective components to it. (RX19, p. 14). The imaging studies did not demonstrate instability, and while there was some pathology, he did not see it in what he would offer surgical intervention to. (RX19, p. 14). Dr. Robson testified the medical literature is replete with evidence that discograms are not completely objective studies. (RX19, p. 14).

On cross-examination, Dr. Robson testified Petitioner had pre-existing lumbar complaints, referring to medical records he reviewed from 2014. (RX19, p. 17-18). Dr. Robson agreed that Petitioner had not been recommended to see a spine specialist prior to September 2015 in the medical records he reviewed. (RX19, p. 19). Dr. Robson testified he did not review Dr. Hayward's records or records from Work Care and that if Dr. Hayward's records contained more information about the September 4, 2015 accident he would have liked to have reviewed it. (RX19, p. 20-21).

Dr. Robson testified only a minority of spine surgeons and specialists in the medical community use CT discograms. (RX19, p.21-22). Dr. Robson testified he did not find an annular tear on Petitioner's lumbar spine MRIs. (RX19, p. 22). Dr. Robson testified he thought the disc protrusion at L5/S1 was actually smaller on Petitioner's March 23, 2017 MRI. (RX19, p. 23).

Dr. Robson testified that a patient altercation where a person was jostled around and thrown to the ground, such as the ones Petitioner had been involved in, can be the type of mechanism of injury that can cause a disc injury in the lumbar spine. (RX19, p. 24). He also testified that kind of altercation could hypothetically aggravate a pre-existing lumbar condition. (RX19, p. 24).

Dr. Robson testified that the symptoms Petitioner complained of are the type that tend to wax and wane. (RX19, p. 25). Dr. Robson testified that there were no structural changes in Petitioner's lumbar spine after the October 30, 2016 injury, which both the radiologist and Dr. Gornet agreed with. (RX19, p. 25). Dr. Robson was asked if Petitioner's symptoms have ever returned to a baseline or pre-injury status and he replied:

> Well, it's really hard to tell. She's had the same low back and left-sided symptoms since 2014, so I can't tell which – symptoms like that tend to wax and wane. I don't know what impact this injury on October 30th of 2016 had. It certainly didn't change the structures of her lumbar spine as [we] all agree to. (RX 19, p. 25)

Dr. Robson testified it would be rare to see a person have symptoms aggravated without seeing a change on MRI. (RX19, p. 25-26). These types of symptoms tend to wax and wane in patients and they will experience flare-ups from time to time. (RX19, p. 26). Dr. Robson further testified that he had no record of the 10/24/16 accident and he wasn't sure if he had Dr. Gornet's 11.23.16 note. However, he took no issue with Dr. Gornet's records indicating Petitioner's symptoms increased after the two October of 2016 accidents. (RX 19, pp. 27-28) Dr. Robson testified that surgery is not always the solution for someone who has failed conservative care. (RX19, p. 30). In his practice, he would try to talk to Petitioner about living with her condition rather than face the risk of a complication. (RX19, p. 30). He does not believe the risk outweighs the potential rewards should she undergo surgery. (RX19, p. 31).

Dr. Robson testified that when treating a patient, one considers MRI findings, physical exam findings, and patient symptoms. (RX19, p. 32). Dr. Robson also testified that symptoms have a good subjective component to them, especially in a litigated case, whereas objective findings tend to be standard. (RX19, p. 32).

Additional Medical Treatment

On August 17, 2017, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed Dr. Robson's IME report with Petitioner. Dr. Gornet reiterated his recommendation of a disc replacement at L5/S1. Her work restrictions remained unchanged. (PX8)

On December 14, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet indicated Petitioner's exam was unchanged and there were no new issues, Dr. Gornet again recommended a disc replacement at L5/S1 and possible fusion, if needed. She remained temporarily totally disabled. (PX8)

The Arbitration Hearing

Petitioner's case against Respondent proceeded to arbitration on January 25, 2018 pursuant to a 19(b) Petition she had filed. The disputed issues were causal connection, medical bills, temporary total disability benefits and prospective medical care. Petitioner was the sole witness testifying at the hearing. Respondent's representative at the hearing was Cathy Kennedy. At the commencement of the proceeding, Petitioner's attorney moved, without objection, to amend the Application for Adjustment of Claim in case #15 WC 30798 (D/A: 9.4.15) to include alleged injuries to the neck and back.

Petitioner testified she is currently employed with Respondent as a Security Therapy Aide I. She works with the criminally insane and it is her job to keep everyone safe and help monitor patients. She also has to intervene if patients become aggressive.

Petitioner testified that she was injured on September 4, 2015 when she tried to stop a patient from charging another patient. Petitioner testified she "got hit like a linebacker" and flew backwards on the floor and injured her back, knees, and neck. (See also RX 4.) Petitioner testified her primary care doctor did not take work comp, so she went to Work Care. Petitioner testified she was given work restrictions that could not be accommodated, so she was taken off of work and paid extended benefits. Petitioner then saw Dr. Hayward. She underwent an MRI and he released her back to work sometime in November of 2015.

Petitioner further testified that on November 29, 2015, she was trying to hold the leg of a patient who had attacked another patient and she was jostled around, inflaming her lower back. (See RX 7.) Petitioner testified she began treating with Dr. Gornet and was taken off of work. Petitioner testified that Dr. Gornet has also given her restrictions, at times, but has never released her to full duty since she began treating with him. She has undergone multiple imaging studies and has had injections. Petitioner testified she underwent an IME with Dr. Robson and after receiving his report she was advised she needed to go back to work on a full duty basis.

Petitioner testified that she did return to full duty work and on October 24, 2016, she was trying to hold back a patient from attacking another patient who was jumping over her back, and she was "getting landed on" while the patient was trying to pummel another patient. She injured her back and it made her foot numb that day. (See also RX 10.) Then on October 30, 2016, she grabbed a patient's arm to prevent him from throwing a punch, which pulled her over a couch. She landed in the crack of the couch holding him while he was fighting, injuring her back and neck. (See RX 13) Petitioner testified that after that accident Dr. Gornet said "that was enough" and he took her completely off of work.

Petitioner testified that she had a prior work accident in June of 2013 when she was trying to restrain a patient and was standing on a bed. She dropped down, hitting her buttocks on the edge of the nightstand, and kind of "cranked this way" with the weight of her body and hurt her back. (RX 1) Petitioner testified that she sought very little medical treatment for this although she thought she may have seen her doctor in 2014 for some residual pain but she didn't "deal with it." Petitioner also testified that her primary care doctor's records indicate she had some back pain in 2014 and she explained that those complaints were referable to her 2013 accident. She did not seek any other treatment then this and did not miss any work due to this injury. Petitioner testified she

did not believe that the 2013 accident was in any way responsible for the symptoms that she has now.

Petitioner testified that prior to September 4, 2015 she was doing well with regard to her low back. She was going to the gym twice a day, biking, and running two miles a day after work. She testified she cannot do those things now. She testified Dr. Gornet is recommending lower back surgery which she would like to undergo as she is tired of the pain.

Petitioner testified after her second IME with Dr. Robson, she received notification that she would no longer be receiving workers' compensation benefits. Petitioner testified that she did not tell Dr. Robson about having low back issues prior to September of 2015 because she thought it was different than her 2004 diagnosis of fibromyalgia. To her fibromyalgia referred to muscular aches whereas "back pain" referred to her spine. Petitioner also testified she did not mention the 2013 injury and 2014 treatment to Dr. Robson because she had "let it go" and it did not cause her any more grief.

On cross-examination, Petitioner testified that when her workers' compensation benefits were terminated, she went on a non-occupational leave and has been receiving benefits through non-occ since that time. Petitioner further testified she still has her group insurance through her employment. Petitioner testified that she has not undergone the recommended surgery through her group insurance because she wants Dr. Gornet to perform the surgery. Petitioner admitted that she has not asked if Dr. Gornet accepts her insurance and that she is just waiting to see how this plays out. If she were to lose her workers' compensation case, she would still pursue having the surgery done through her group insurance.

Petitioner testified she did not miss any time from work for her 2013 injury nor did she admit any medical records indicating she treated for her back in 2013 into evidence. Petitioner testified after the September 2015 injury, Dr. Hayward released her to return to work full duty on November 12, 2015, but she did not return until November 24, 2015 because she was shocked he had released her.

Petitioner testified the November 29, 2015 injury occurred five days after she had returned to work full duty. At that time, Petitioner was bumped from day shift to evening shift by a more senior employee. Petitioner admitted that she was upset that she was bumped to evening shift.

Petitioner testified she was off of work until July of 2016 when she returned to work full duty. She was working full duty at the time of the October 24, 2016 injury and continued to work full duty until the October 30, 2016 injury.

Petitioner testified that she is not currently working and does not have any kind of employment. When asked if she makes and sells jewelry online, she admitted that she did have a "hobby" of that. Petitioner testified she makes coin rings using a little mandrill, which she uses to pound on the coin.

Petitioner testified she smokes one pack of cigarettes a day and has been counseled regarding same. She has been diagnosed with fibromyalgia. Petitioner testified she underwent chiropractic care for her back in 2004, but could not remember if she did so in 2011.

Petitioner testified she is not using any kind of brace or protective device. She takes over-the-counter medication pretty much daily. Workers' compensation refused to pay for one medication she was prescribed and another medication bothered her stomach. She is not currently undergoing physical therapy.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in her low back is causally related to her October 24, 2016 work accident. In so concluding, the Arbitrator relies upon the more persuasive opinions of Dr. Gornet over those of Dr. Robson.

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 902 N.E.2d 1269, 1273 (5d Dist. 2009). When a pre-existing condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] 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." *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 864 N.E.2d 266, 272-273 (5th Dist. 2007).

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, 672 (Ill. 2003). [Emphasis original]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1st Dist. 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (Ill. 1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977). The Supreme Court's decision in *Sisbro, Inc.* highlighted that even though a workers' compensation claimant has a pre-existing condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003).

Petitioner has filed five claims against Respondent for injuries to her low back, neck and knees. Respondent has not disputed any of the accidents.

At the center of the causation dispute in this case is Respondent's position, and Dr. Robson's belief, that Petitioner's need for treatment as proposed by Dr. Gornet stems from a chronic pre-existing low back condition made apparent on July 19, 2014, as opposed to any/all of the four very hostile and physical assaults on Petitioner while working. The Arbitrator doesn't agree with Respondent's position or the opinion of its examining doctor. July 9, 2014 is the first mention in the records of any low back issues. Petitioner did not even mention an injury to her back on the June 30, 2013 Notice of Injury form. While there is a reference in some of the medical histories to chiropractic care in 2004 no records were introduced to further set forth the nature of this treatment and, more significantly, Petitioner underwent no further treatment for her back for over ten years. Nothing in the record herein suggests that Petitioner had a diagnosed and treated chronic low back condition before July 9, 2014. The Arbitrator views the reference to "chronic" back pain in the July 9, 2014 medical office note as distinguishing Petitioner's complaints from an acute problem. While the doctor ordered some physical therapy and an x-ray, the therapy was not undertaken, no formal diagnosis for her back followed, and, most significantly, Petitioner continued to treat with Dr. Moyers for another fourteen months or so with no further mention of back pain or complaints or treatment to her back. The Arbitrator sees a distinct difference between vague references to fatigue and joint/muscle aches and pain and the very specific complaints Petitioner voiced on September 10, 2015 at Work Care and thereafter. Respondent produced no evidence of extensive back treatment pre-dating September 4, 2015. In light of the above, the Arbitrator does not find Petitioner's denial of prior back problems in Dr. Robson's questionnaire to be intentionally deceitful or misleading. Petitioner had been working full duty before September 4, 2015 and engaged in all activities of life, including hobbies and sports. Under these circumstances the Arbitrator finds it reasonable to infer from Petitioner's denial of prior problems that, in her mind, she wasn't having "problems." Petitioner was an exceedingly credible witness.

Contrary to Dr. Robson's opinions and Respondent's position, everything changed for Petitioner on September 4, 2015 (the d/a in Case #15 WC 30798). She has never really returned to her level of activity pre-September 4, 2015. While she has returned to full duty work or light duty work periodically since that accident she has not been asymptomatic and she ended up being involved in additional accidents, including the one herein. Petitioner's treatment after September 4, 2015 was initially managed by Respondent. She was sent to Work Care and, in turn, to Dr. Hayward. Medical personnel at Work Care opined that Petitioner's condition was related to her work activities/accident, that objective findings were consistent with a work-related etiology and that work activities had aggravated an underlying pre-existing condition for which a neurology consultation was recommended.

Work Care referred Petitioner to Dr. Hayward who acknowledged that Petitioner had a bulging disc at L3-4 on the left side which was contacting the nerve. He released her from his care because he didn't feel she needed surgery, not because she was at maximum medical improvement. A referral to an occupational medicine doctor for further treatment was recommended. While he saw no reason she couldn't return to work, it is interesting that just five days prior to the final visit with Dr. Hayward, Petitioner attended physical therapy and was noted to have limited lumbar AROM secondary to pain and the inability to perform normal activities secondary to lumbar and lower extremity radicular pain. She demonstrated an antalgic gait and difficulty walking. It was recommended that she continue with physical therapy; however, that wasn't done because Dr. Hayward released her to return to work. Dr. Hayward's records (PX 5) don't include copies of the

therapy records. His office note of November 9, 2015 doesn't discuss them. As such, it is unclear to the Arbitrator if he knew what was going on in therapy, including Petitioner's limitations. In light of the foregoing, as well as Dr. Hayward's belief that Petitioner should follow up with occupational medicine and the therapist's recommendation for additional therapy, the Arbitrator finds Petitioner remained symptomatic when discharged by the doctor and not yet at maximum medical improvement.

Against this backdrop Respondent sent Petitioner back to work and, unfortunately, she sustained another accident on November 29, 2015. The Arbitrator found Petitioner to be a very credible witness and her reluctance to return to work after being discharged by Dr. Hayward, along with her disappointment about being switched to a different shift, does not negate her credibility.

After the November 29, 2015 accident Petitioner began treating with Dr. Gornet who has repeatedly and consistently opined that, at a minimum, Petitioner suffered an aggravation or re-aggravation as a result of her accidents on November 29, 2015, October 24, 2016 and October 30, 2016.

In his deposition, Dr. Robson admitted that Petitioner's accidents resulted in a change of her work status and her symptoms. (RX18, p.20; RX19, p.25-26) He admitted that Petitioner consistently complained of pain following her work accidents. *Id.* at 26. He testified that he had no basis to dispute Dr. Gornet's records indicating the fact that Petitioner's symptoms increased after being involved in those incidents, and he admitted that Petitioner showed no signs of symptom magnification or malingering. *Id.* at 28-29, 32. He acknowledged that Petitioner's discogram demonstrated a severely provocative disc at L5 to S1. *Id.* at 21. He further admitted that annular tears could produce Petitioner's lumbar spine symptoms. *Id.* at 22. He acknowledged that, although he failed to appreciate Petitioner's annular tear, the radiologist who performed Petitioner's MRI of March 23, 2017, Dr. Ruyle, documented an annular tear visible at the apex of the protrusion at L5-S1. *Id.* at 22-23. When asked whether he agreed with Dr. Ruyle's interpretation, Dr. Robson stated, "I agree." *Id.* at 23. He further admitted that Petitioner's work accidents were a mechanism of injury consistent with her current pathology and symptoms, and significantly, that these incidents could aggravate Petitioner's pre-existing condition. *Id.* at 24. He also acknowledged that he did not possess any imaging studies for comparison prior to Petitioner's work injuries to say that Petitioner's lumbar spine herniations were definitively pre-existing. *Id.* at 20. Significantly, he acknowledged that Petitioner required no treatment for eleven (11) months prior to her work injury in September of 2015. (RX18, p.20) Even though he diagnosed Petitioner with simply a "strain," he admitted that Petitioner's symptoms had been unresolved and persistent since her work injuries. (RX19, p.26) Dr. Robson never addressed the cumulative effect of Petitioner's last four accidents, he did not comment on the October 24, 2016 accident whatsoever, he did not address the issue of "aggravation," and he failed to review all pertinent medical records (Hayward and Work Care) as part of his examination review and report. He further incorrectly stated that Petitioner's low back and left-sided complaints have been the same since 2014 (RX 19, p. 25) as Petitioner had no left lower extremity complaints before the September 4, 2015 accident. For these reasons, the Arbitrator is not persuaded by his opinion.

In contrast, Dr. Gornet opined that Petitioner has a disc injury at L3-L4 and a disc injury, annular tear and herniation at L5-S1. He causally related these conditions to her September 4, 2015

accident and her November 29, 2015 accident. His opinion as to causation is supported by the objective diagnostic studies and the circumstantial evidence. Dr. Gornet noted that Petitioner suffers from minimal to degeneration, which is supported by the evidence and the findings of Work Care and Dr. Hayward. (PX3, 9/10/15; PX5, 11/9/15; PX8, 12/10/15) Dr. Gornet's diagnosis of an L5-S1 annular tear with herniations was confirmed by the objective imaging studies and the discogram procedure. (PX11; PX12; PX14) Dr. Gornet also noted that Petitioner's complaints markedly increased and have been unabated since her injuries, leading him to credibly conclude that Petitioner's work assaults, including those on October 24, 2016 and October 30, 2016 aggravated and caused her current condition of ill-being. (PX15, pp.15-16) The Arbitrator, therefore, finds his opinion persuasive and finds that Petitioner met her burden of proof in establishing that her current condition of ill-being in her low back is related to her work accident of October 24, 2016.

Prior to November 29, 2015, the evidence suggests that although Petitioner was still symptomatic and her condition had not entirely resolved, she was released to return to work full duty, and was performing full duty work until she was injured on November 29, 2015. Dr. Gornet's treatment recommendations did not change after Petitioner was involved in subsequent altercation/accidents in October of 2016, one of which is the subject of this claim. Dr. Gornet's office notes subsequent to the October 24, 2016 accident indicate that Petitioner's condition of ill-being in her low back was aggravated by the accidents on October 24 and 30, 2016. The weight of the evidence supports that Petitioner's pre-existing condition in her low back was aggravated as a result of the injury herein and made more symptomatic. Accordingly, the Arbitrator finds that Petitioner's current condition of ill-being in her low back is related to her accident of October 24, 2016.

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 entitled to recover reasonable medical expenses that are causally related to the October 24, 2016 accident. However, the Arbitrator declines to award any medical bills with regard to this case as same were awarded in case #16 WC 2296 (D/A – 11/29/15). Petitioner has continued to treat with Dr. Gornet since her November 29, 2015 accident. Prior to her visit with Dr. Gornet on November 23, 2016 (her first visit post-accident) Dr. Gornet had not released Petitioner from his care. As such the visits since October 24 and October 30, 2016 have continued to relate to the earlier accident of November 29, 2015.

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

Prospective medical care is denied as it has been awarded in case #16 WC 2296.

Although Petitioner's consolidated claims involve multiple injuries that have all seemingly impacted her condition, the Arbitrator finds that Petitioner's apex injury that negatively impacted her condition of ill-being the most to be the injury on November 29, 2015. Petitioner was able to

return to work following her first two injuries on June 29, 2013, and September 4, 2015, and neither of these led to a surgical recommendation or significant treatment. (PX3; PX5) Following her injury on November 29, 2015, however, Petitioner's condition dramatically declined. Petitioner's symptoms did not respond positively to conservative care, and she was ultimately recommended for surgery. While she sustained other accidents on October 24 and October 30, 2016, both Dr. Gornet and Dr. Robson agreed that the October 30, 2016 accident did not result in a significant change in pathology, and her treatment recommendations per Dr. Gornet have likewise remained the same. Again, Dr. Robson never addressed the October 24, 2016 accident. Dr. Gornet's office notes subsequent to the October 24, 2016 accident indicate that Petitioner's condition of ill-being in her low back was aggravated by the accidents on October 24 and 30, 2016. While Petitioner's current condition in her low back is causally connected to the accident herein, the Arbitrator finds it significant that Dr. Gornet first recommended surgery after Petitioner's November 29, 2015 accident (which is the subject of case #16 WC 02296). As such, the Arbitrator finds it to be the appropriate case in which to award prospective care.

Issue (L): What temporary benefits are in dispute? (TTD)

Petitioner's claim for temporary total disability benefits is denied with regard to this case and is addressed in claim #16 WC 36411 as it was after that accident (October 30, 2016) that Petitioner was taken completely off work.

****

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

Stephanie Matlock,

Petitioner,

19IWCC0605

vs.

NO: 16 WC 036411

State of IL / Choate Mental Health,

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 expenses and 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 April 2, 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.

19IWCC0605

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)(l) of the Act, claims against the State of Illinois are not subject to judicial review.

DATED: NOV 6 - 2019

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MEP/ypv
049

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn Doerries

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

MATLOCK, STEPHANIE
Employee/Petitioner

Case# **16WC036411**

16WC004246
15WC030798
16WC002296
16WC036410

ST OF IL/CHOATE MENTAL HEALTH
Employer/Respondent

19IWCC0605

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:

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

0558 ASSISTANT ATTORNEY GENERAL
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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

APR 2 - 2018

DONALD A. HARRIA, Acting Secretary
Illinois Workers' Compensation Commission

19IWCC0605

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Stephanie Matlock
Employee/Petitioner

v.

State of Illinois/Choate Mental Health
Employer/Respondent

Case # **16** WC **36411**

Consolidated cases: **16 WC 04246**
15 WC 30798
16 WC 02296
16 WC 36410

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury? (Lumbar spine only)
G. [ ] What were Petitioner's earnings?
H. [ ] What 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 [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

19IWCC0605

FINDINGS

On the date of accident, **10/30/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**51,477.74**; the average weekly wage was $**989.96**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

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

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

Respondent ***is*** entitled to a 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's current condition of ill-being is causally related to her work-related accident of October 30, 201.

Petitioner's claim for medical expenses and prospective care is denied as same has been awarded in case #16 WC 02296.

Respondent shall pay Petitioner temporary total disability benefits of **$659.97/week** for **36 2/7** weeks commencing May 17, 2017 through January 25, 2018, as provided in Section 8(b) of the Act.

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

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

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

Signature of Arbitrator

8.23.18
Date

ICArbDec19(b)

APR 2 - 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner is employed as a security therapy aide for Respondent, Choate Mental Health and Development Center. Petitioner has five applications for adjustment of claim pending against Respondent. All five claims involve alleged injuries to Petitioner's knees, low back and neck and they were consolidated at the time of arbitration with the parties understanding that separate decisions would issue. The parties further stipulated that this 19(b) hearing was solely limited to Petitioner's alleged low back condition and that all issues regarding injuries to other body parts were being reserved. Therefore, the Arbitrator's findings and conclusions only address the alleged low back claim. None of Petitioner's five accidents against Respondent are disputed. The focus of the dispute is causal connection and Petitioner's need for prospective medical care.

The Arbitrator finds:

On June 30, 2013, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. (RX1). Petitioner indicated that on June 29, 2013, she was knocked down while assisting with a hostile patient and landed on the edge of a dresser. (RX1). Petitioner indicated she injured the bridge of her nose, left buttock, right upper arm, lower arm/hand, and left and right knees. (RX1). Respondent does not dispute that this accident occurred. (AX 5)

On March 10, 2014, Petitioner presented to Dr. Lori Moyers at Cape Family Practice to establish herself as a patient. (RX20). It was noted Petitioner was a heavy every day smoker and had previously undergone removal of her thyroid. (RX20).

On April 8, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner was seen for low thyroid levels and complained of right hip pain. (RX20). Petitioner was given an injection into her hip. (RX20).

On May 13, 2014, Petitioner returned to Dr. Moyers. (RX20). Petitioner complained of swelling all over and pain in her feet. (RX20). Petitioner was given a fatigue panel. (RX20).

On June 10, 2014, Petitioner saw Dr. Moyers. (RX20). Petitioner complained of shortness of breath, increased stress, and bilateral knee pain. (RX20). Petitioner requested a steroid shot, but declined it as it was out of network. (RX20). Petitioner was scheduled for an EKG and stress test. (RX20).

On July 9, 2014, Petitioner followed up with Dr. Moyers. (RX20). Petitioner complained of chronic back pain on lower left side. Petitioner indicated it had started about a year earlier and had gotten worse. Petitioner also indicated her back actually "went out" approximately five months earlier. Petitioner did not mention any accident or injury with regard to her back. It was noted Petitioner had a history of syringomyelia. A lumbar spine x-ray was ordered and Petitioner was prescribed physical therapy.

On August 11, 2014, Petitioner returned to Dr. Moyers. Petitioner indicated she had undergone the L-spine x-ray, but had not started the physical therapy yet due to her schedule. Petitioner also complained of left foot pain. Petitioner was referred to another doctor for her foot. (RX20).

On September 8, 2014, Petitioner followed up with Dr. Moyers. Petitioner complained of fatigue, abdominal pain, joint/muscle pain, and anxiety. (RX20).

On October 10, 2014, Petitioner returned to Dr. Moyers. Petitioner complained of fatigue, thyroid issues, joint/muscle aches, and anxiety. It was noted Petitioner had multiple trigger points. (RX20).

On November 11, 2014, Petitioner saw Dr. Moyers. Petitioner complained the prescription Savella caused nausea and had not helped her pain at all. (RX20).

On January 16, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of low thyroid levels and a rash all over her body. (RX20).

On June 4, 2015, Petitioner returned to Dr. Moyers for her thyroid. Petitioner returned on June 15, 2015 complaining of congestion and sinus pressure. (RX20).

On July 15, 2015, Petitioner followed up with Dr. Moyers. Petitioner complained of continued allergy symptoms and weight gain. (RX20).

Petitioner was involved in an undisputed work accident on September 4, 2015. (AX 1)

On September 8, 2015, Petitioner returned to Dr. Moyers. Petitioner complained of a spot on her left foot and low energy/fatigue. (RX20).

On September 9, 2015, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form. Petitioner indicated that on September 4, 2015, she was knocked down twice by an aggressive patient. Petitioner indicated she injured her lower back, upper back, and both knees. (RX4).

On September 10, 2015, Petitioner presented to Work Care regarding her 9/4/15 accident. At that time she was complaining of pain in her low back, neck, bilateral knees, and left foot. Petitioner indicated she was in a patient altercation and was thrown to the floor two times. During the altercations she began dry heaving and vomiting. Petitioner indicated her primary problem was her neck; her secondary problem was her low back. It was noted Petitioner was previously diagnosed with syringomyleia and fibromyalgia. Petitioner indicated her primary care physician did not take work comp. Petitioner complained of constant aching pain in her back aggravated by use and relieved by rest. X-rays were described as unremarkable with no degenerative findings. Petitioner was diagnosed with a cervical spine radiculopathy and strain, thoracic spine strain, lumbar spine strain, and bilateral knee contusions. Petitioner was prescribed medication and physical therapy and taken off work through September 11, 2015 to be followed by sedentary work restrictions as of September 12, 2015 Petitioner was also referred for a neurology consult for a

"pre-existing spinal condition." FNP-BC Dena Kommer addressed causation stating, "The cause of this problem is related to work activities. The objective findings are consistent with the history of a work-related etiology. Work activities have aggravated an underlying pre-existing condition." (PX3)

Petitioner testified, without rebuttal, that Respondent could not accommodate her work restrictions/light duty and she remained off work.

On September 17, 2015, Petitioner returned to Work Care and reported she was no better. Petitioner indicated her primary problem was her neck and that she had burning down into her shoulders. She also had bilateral knee pain and muscle spasms in her lumbar area. Diagnoses and recommendations remained the same. She was referred to Dr. Hayward. (PX3).

On September 16, 2015 Petitioner signed her Application for Adjustment of Claim in case #15 WC 30798 alleging injuries to her body as a whole and bilateral knees due to an accident on September 4, 2015 when she was attacked by a resident. (AX 2)

On September 17, 2015, Petitioner underwent x-rays of her left knee. The findings were normal with mild osteoarthritic changes noted. Petitioner also underwent x-rays of her right knee. The findings were normal with minimal osteoarthritic changes noted. Additionally, Petitioner underwent x-rays of her lumbar spine. The findings showed normal curvature and alignment maintained except for mild right convex curvature centered near L1/2, mild loss of disc height from L3/4 through L5/S1, and mild lumbar facet arthropathy present. There was no fracture or subluxation identified, sacral arcuate lines intact, and soft tissues were unremarkable. Petitioner also underwent x-rays of her thoracic spine. The findings showed no compression fracture or subluxation. Finally, Petitioner underwent x-rays of her cervical spine. The findings were normal. (PX3).

Petitioner completed a questionnaire for Dr. Thalman's office on September 24, 2015 regarding her September 4, 2015 accident. Dr. Thalman is a chiropractor. (PX 6; AX 12)

As ordered by Work Care, Petitioner presented to physical therapy at Mid America Rehab on September 29, 2015. Petitioner reported trying to break up a fight between patients earlier in September and being injured in the process. She had undergone x-rays but no other tests. Her complaints included pain in the neck, upper back, mid back, low back and down her left leg. She reported some occasional arm and leg pain and burning into the shoulder blade region and both legs. She also reported numbness and tingling down her legs at times. The therapist described Petitioner's level of pain as moderate to severe and documented an antalgic gait along with decreased range of motion. Petitioner was to be seen three times a week for four weeks. (PX 2)

Petitioner attended therapy as instructed. At the October 7, 2015 session Petitioner requested that she not have to lay on the treatment table as it bothered her. She reported increased pain down her left leg when side bending to the right. She was unable to tolerate "ther-ex:" secondary to increasing pain. She also reported that she was always having to change positions to relieve her pain which was admittedly "getting to her." (PX 2)

On October 8, 2015, Petitioner followed up at Work Care. Petitioner indicated her primary concern was her lumbar spine, followed by her cervical spine and knees. Petitioner described both as aching and unrelenting. Petitioner also reported that walking increased her symptoms in all areas and she was experiencing a radiculopathy that would come and go. Petitioner indicated she had an appointment pending with Dr. Hayward for her spine, although she had concerns about seeing him. According to the notes, the MRI was on hold per the case manager until after Petitioner's exam with Dr. Hayward. It was noted Petitioner refused to see the doctor who diagnosed her with syringomelia. Petitioner indicated that physical therapy was not helping much. It was noted symptom magnification was present but her attitude and effort were felt to be "fair." Restricted duty was continued. (PX 3)

On October 12, 2015, Petitioner presented to Dr. Franklin Hayward at Heartland Spine Institute. Petitioner provided the doctor with a detailed account of her work accident in September and her medical care since the accident and told the doctor that she was undergoing therapy with no relief. Petitioner also described her current symptoms as new, and told the doctor about a work injury two and one-half years earlier when she fell on her left buttock while confronting an aggressive resident. She also recalled a neck injury when a resident pushed her head into a wall but couldn't recall the date. There was also an incident when her right thumb was bent backwards and an incident when she fell to her knees during an altercation but she couldn't recall those dates of injury. Petitioner denied any history of back surgery and explained she had seen Dr. Stahley for tremors. Petitioner complained of low back pain, weakness all over, dizziness, balance difficulty, nausea, headache, numbness in her feet, and numbness and tingling in the 4th and 5th fingers of the right hand, all of which began after the accident. Petitioner felt the accident had worsened her tremors. Dr. Hayward ordered MRIs of Petitioner's cervical and lumbar spine and continued Petitioner's restrictions. He referred Petitioner back to Dr. Stahley and/or her family doctor for her tremors. (PX5).

Petitioner returned for physical therapy on October 14, 2015 having last attended on October 7, 2015. Petitioner was reporting continued pain down her left leg all the way to the ankle. She was still waiting for the MRI to be scheduled. (PX 3)

Petitioner attended physical therapy on October 16, 2015 reporting some slight subjective improvement that day but also having tremors in her upper back and a "grabbing" sensation in her left low back along with sharp pain when trying to sit straight. (PX 3)

Petitioner again attended physical therapy on October 19, 2015 reporting increased pain that day and over the weekend (associated with increased standing). Petitioner attempted more therapy at this visit. (PX 3)

As of October 22, and October 26, 2015 Petitioner was still having trouble with some aspects of therapy and her MRI was still pending. As of October 28, 2015 her MRI was finally being scheduled. (PX 3)

On November 2, 2015, Petitioner underwent an MRI of her lumbar spine. The impressions were: 1) minor degenerative disc disease, disc bulges cause minor foraminal stenoses at L3/4 and L4/5, left L3 nerve root contacts the disc bulge near the foramen, and could be a source of pain; 2)

no lumbar spine central canal stenosis; 3) benign hemangioma in the T10 vertebra; and 4) LLQ borderline nodes vs mild mesenteric lymphadenitis. Petitioner also underwent a cervical spine MRI. The impressions were: 1) c-spine straightening may be due to positioning or muscle spasm; 2) minor cervical disc bulges, no cord compression or central canal stenosis; 3) tiny hydromelia, syrinx at C7/T1; 4) moderate left foraminal stenosis at C6/7; 5) benign hemangioma in the T4 vertebra; and 6) S/P thyroidectomy. (PX5).

Petitioner attended physical therapy on November 4, 2015 reporting she had undergone the MRI but was unaware of the results. Sitting and bending were still bothering her and she had an ongoing antalgic gait and difficulty walking. It was recommended that she continue physical therapy three times a week. (PX 3)

On November 6, 2015, Petitioner returned to Work Care. Petitioner indicated her neck pain was 7 out of 10, her back pain was 7 out of 10, and her bilateral knee pain was 7 out of 10. She was also noted to be depressed. Her condition was again noted to be related to her work activities. Petitioner's prescriptions were refilled and she was to start an exercise program. (PX3).

On November 9, 2015, Petitioner followed up with Dr. Hayward. Petitioner continued to complain of back and leg pain that the doctor described as being in a non-dermatomal distribution. Petitioner also reported she was not improving and asked the doctor to refer her to a neurologist to facilitate a neurology consultation as part of her claim. Dr. Hayward explained that he felt she needed to follow up with Dr. Stahley regarding her chronic condition and that she might need to do that under her own health insurance. On examination, Dr. Hayward stated that Petitioner's motor strength was intact. He further noted Petitioner had Waddell's testing, three out of five. Dr. Hayward reviewed Petitioner's MRIs which showed age appropriate mild degenerative changes and a bulge at L3/4 which was making contact with her L3 nerve root; however, he felt Petitioner had no L3 radiculopathy as her leg pain was all posterior and radiating down to the leg and foot which he could not explain. Petitioner also had clearly reproducible pain to palpation of her lumbar and cervical spines with the lumbar region being more tender. Petitioner was diagnosed with myofascial muscle pain. Dr. Hayward also noted Petitioner's history of fibromyalgia and syringomyelia and felt that might be the cause of her myofascial pain. Dr. Hayward saw no evidence to suggest radiculopathy. Dr. Hayward noted that whether the tremors were related to her work accident was an issue for Dr. Stahley to address. Dr. Hayward also noted that there were no surgical indications and, while he released Petitioner from his care without any restrictions due to the absence of any physical limitations, he did recommend a referral to an occupational medicine doctor for further treatment of her condition given that there was no acute surgical indication. (PX5).

According to the November 19, 2015 physical therapy discharge note, Petitioner had been discharged from further care in light of Dr. Hayward's release to return to work. Petitioner had last undergone therapy on November 4, 2015. (PX 3)

On November 29, 2015, Petitioner sustained another accident while working for Respondent. Petitioner filled out a Worker's Compensation Employee's Notice of Injury form (d/a: 11/29/15). Petitioner indicated she was attempting to restrain an aggressive patient. Petitioner

indicated she injured her left wrist/hand, right hand, bilateral forearms, neck, and back. (RX7). Respondent does not dispute that this accident occurred. (AX 3)

On November 30, 2015, Petitioner returned to Dr. Moyers, her primary care doctor. Petitioner complained of chronic low back pain and indicated she was attacked by a patient on November 29, 2015. She made no mention of the September 4, 2015 accident. Petitioner indicated she had seen a neurosurgeon who did not feel she needed surgery and released her back to work. Petitioner indicated she was then attacked again on the 29th while on light duty and had pain radiating down her left leg into her foot. It was noted Petitioner had had C-spine and L-spine MRIs. Petitioner was diagnosed with C-spine and T-spine sprains and disc degeneration in her lumbar region. Petitioner was prescribed physical therapy. (RX20).

On December 7, 2015, Petitioner returned to Work Care regarding her September 4, 2015 accident. Petitioner indicated her back pain, neck pain, and bilateral knee pain was a 7 out of 10 and that she had sustained a new accident at work that was being handled by another provider so she requested a release from the previous injury. Petitioner was discharged at her request. (PX3).

On December 10, 2015, Petitioner presented to Dr. Matthew Gornet at The Orthopedic Center of St. Louis. Petitioner complained of low back pain and neck pain. Petitioner indicated her problem began on September 4, 2015 after she was involved in an altercation with an aggressive patient. Petitioner indicated she did have some spinal pain and chiropractic care in 2004, but no intervening treatment since that time. Petitioner was diagnosed with: a disc injury at L3/4; disc injury, annular tear, and herniation at L5/S1; and disc injury at C6/7. Dr. Gornet noted that he felt Petitioner had, at a minimum, suffered an aggravation/re-aggravation of her "work injury." Dr. Gornet put treatment for the neck on hold while Petitioner treated for the low back. Dr. Gornet recommended a steroid injection at L5/S1 and physical therapy. A new cervical MRI was ordered. Petitioner was taken off of work. (PX 8)

On December 15, 2015, Petitioner followed up with Dr. Moyers regarding her lower back. Petitioner indicated she was treating with Dr. Gornet and was scheduled to undergo injections in her lower back. Petitioner reported that her left hip pain was continuing and was radiating down to her left knee and foot. Petitioner requested a referral to a mental health specialist for anxiety and insomnia. Petitioner was to remain off work per Dr. Gornet and was referred to Brad Robison. (RX20)

On January 13, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 2296 alleging injuries to her neck, back, bilateral hands and arms, and body as a whole as a result of an accident on November 29, 2015 described as an "altercation with patient/aggravation." (AX 4)

On January 14, 2016, Petitioner underwent a left L5/S1 epidural steroid injection by Dr. Kaylea Boutwell. (PX9)

On February 1, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 004246 alleging injuries to her bilateral knees, left buttock, right arm, back, and body as a whole as a result of an accident on June 29, 2013. (AX 6)

On February 29, 2016, Petitioner underwent an MRI of her cervical spine without contrast. The impressions were: 1) central-left foraminal broad-based protrusion at C6/7 measuring up to 3.5 mm in the left foramen, resulting in moderate left foraminal stenosis; 2) central broad-based protrusions at the C3/4, C4/5 and C5/6 levels; and 3) 1-1.5 mm maximal diameter cervical cord syrinx focally at the C7/T1 disc level. (PX11).

That same day, Petitioner followed up with Dr. Gornet. Dr. Gornet reviewed Petitioner's cervical MRI noting that it showed Petitioner had a fragment of disc on the left side at C6/7, subtle changes on the right side at C5/6 and C6/7, and central disc protrusions at C3/4, C4/5, and C5/6. Dr. Gornet also stated in his notes that Petitioner had a foraminal herniation at L3/4 on the left and recommended a transforaminal steroid injection. He again noted that Petitioner's symptoms related to an accident on September 4, 2015. If that did not help, a CT discogram and MRI spectroscopy would be next. Petitioner was given work restrictions fo "office work only" on a trial basis. (PX8).

On March 16, 2016, Petitioner underwent a transforaminal steroid injection under fluoroscopic guidance at L3/4 left with facet block at L3/4 left. Petitioner tolerated the procedure well. (PX12; PX 8).

On May 9, 2016, Petitioner followed up with Dr. Gornet. Petitioner indicated the injection gave her a month of relief, but she had continued symptoms and pain. Dr. Gornet recommended an MRI spectroscopy and CT discogram. Petitioner's work restrictions were continued and her prescriptions refilled. (PX8)

On May 10, 2016, and at Respondent's request, Petitioner underwent a Section 12 examination by Dr. David Robson at Comprehensive Spine Care. Petitioner gave a history of being attacked by a patient at work on September 4, 2015, injuring her neck and back. Dr. Robson also reviewed an accident report from November 29, 2015 indicating Petitioner was injured by an aggressive patient. Petitioner gave no history of prior treatment for her neck or back, but when interviewed, did recall a remote history of low back treatment with a chiropractor in 2011. Dr. Robson reviewed medical records including those from physical therapy, Dr. Moyers, Dr. Gornet, injection reports, and imaging studies. Dr. Robson diagnosed Petitioner with mild degenerative changes of the lumbar spine, mild disc bulging at L5/S1, mild degenerative changes at the cervical spine, and syringomyelia at C7/T1. Dr. Robson opined physical therapy was warranted for a flare-up of low back pain, but further treatment was not reasonable or necessary as Petitioner had a known history of chronic lower back and neck problems. Dr. Robson further opined the September 4, 2015 and November 29, 2015 injuries caused a temporary aggravation of her pre-existing neck and lower back complaints, but Petitioner was at MMI and could return to work without restrictions. (RX16)

On June 16, 2016, Petitioner presented to Dr. Eugene Kostiuk at Clay Medical Center. Petitioner complained of anxiety, depression, and difficulty sleeping. Petitioner was diagnosed with post-traumatic stress disorder and counseling was recommended. (PX13)

On June 28, 2016, Petitioner underwent a discogram with x-ray interpretation at L3/4, L4/5, and L5/S1 with facet block left at L3/4, L4/5, and L5/S1. The summary indicated: non-provocative

disc at L4/5; minimally provocative disc at L3/4 for back pain, some butt pain; and L5/S1 severely provocative of concordant back pain. (PX14)

On July 26, 2016, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) broad based or bilobed disc herniation on L3/4, larger on the left, extending towards the foramina, also worse on the left, without central stenosis; and 2) smaller central protrusion at L5/S1 without significant impression upon the dura. (PX11)

On July 26, 2016, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed the MRI spectroscopy and CT discogram, noting Petitioner had a non-provocative disc at L4-5, minimally provocative disc at L3-4 and a severely provocative disc at L5-S1 on the discogram; however, the MRI spectroscopy did not detect any reading at L5-S1. There was a large central annular tear at L5-S1. Dr. Gornet also reviewed Dr. Robson's IME report and noted his explanations of it to Petitioner. He pointed out that Dr. Robson apparently felt Petitioner had sustained temporary aggravations of her pre-existing neck and low back complaints in relation to her 9/4/15 and 11/29/15 accidents. Dr. Gornet explained to Petitioner that while she did candidly acknowledge a history of pre-existing complaints in her spine there was no indication that her level of complaints or severity was anywhere near the level of her current ones. He further noted that Dr. Robson did not have the opportunity to review the CT discogram report and visualize the central annular tear as well as the reproduction of symptoms at L5-S1. As her adjacent levels for the most part were "fairly clean" and she had failed conservative care, to date, Dr. Gornet recommended Petitioner undergo an anterior lumbar fusion. Her work restrictions remained unchanged. (PX8).

Petitioner resumed full duty work for Respondent in July of 2016.

Deposition of Dr. Gornet

Dr. Matthew Gornet testified via evidence deposition on September 15, 2016. (PX15). Dr. Gornet testified he is an orthopedic surgeon whose practice is devoted to spine surgery. (PX15, p. 4). He performs research, clinical trials, and treats patients. (PX15, p. 4-5). Dr. Gornet testified Petitioner first saw him on December 10, 2015. (PX15, p. 6). She acknowledged a history of some prior low back/neck pain. (PX15, p. 7). Dr. Gornet testified he reviewed imaging studies of Petitioner's lumbar and cervical spine. (PX15, p. 7-8). Dr. Gornet diagnosed Petitioner with a disc injury at L3/4; a disc injury, annular tear and herniation at L5/S1; and a disc injury at C6/7. (PX15, p. 9). Conservative care of injections and physical therapy was recommended, as well as new imaging studies. (PX15, p. 9). Dr. Gornet testified it was his understanding Petitioner had had a couple work injuries and it was impossible to tell which findings were objectively caused by which accident when looking at x-rays, MRIs, or other films. (PX15, p. 10).

Dr. Gornet testified that Petitioner only received temporary relief from the injection. (PX15, p. 11). Petitioner then underwent an MRI spectroscopy and CT discogram and he then recommended to undergo an anterior lumbar fusion at L5/S1. (PX15, p. 12-14). Dr. Gornet opined Petitioner's work injury of September 24, 2015 aggravated her underlying condition and the November 29, 2015 injury aggravated it further. (PX15, p. 15-16) As he explained it:

> . . . [T]his is a woman who may have had some mild disc degeneration prior to this. She does have a history of low back pain dating back several years. That being said, there is no indication that she had a significant major problem that she does today. Therefore, almost de facto we can state that her condition is one that is ongoing, and in her overall health status this condition is relatively new and dates to approximately September of 2015.
>
> Now, that being said, what I believe happened is, is that this woman has some preexisting disc degeneration. Disc degeneration is a normal part of life and can be relatively asymptomatic, but it does weaken the disc. She's in an altercation, she has applied mechanical load which injures the disc and it causes a tear.
>
> I believe November 29th aggravated that further, making her more symptomatic, and at this point in time, she continues to be symptomatic. We can say as a matter of course that this is not a temporary condition, because the patient's symptoms have never returned back to baseline prior to the injury. (PX 15, pp. 15-16)

On cross-examination, Dr. Gornet admitted that he did not review any medical records outside of his own and the IME report. (PX15, p. 18). He further explained that Petitioner's syringomyelia refers to some mild fluid contained within her spinal cord. It usually does not progress except in very rare circumstances. He did not feel it had anything to do with her current complaints. (PX 15, pp. 18-19) Dr. Gornet testified he compared the MRIs of Petitioner's cervical and lumbar spine taken November 2, 2015 to the ones he had done. (PX15, p. 19-20). He testified the more recent MRIs did not show newer pathology, just a more accurate definition of the pathology present. (PX15, p. 20). There was no major progression. (PX15, p. 20). Dr. Gornet testified myofascial muscle pain is a subjective complaint. (PX15, p. 21). Dr. Gornet agreed Petitioner gave him a history of spine pain and chiropractic care in 2004, but did not recall any intervening treatment since that time. (PX15, p. 22). Dr. Gornet testified if that was inaccurate, and there was a "significant event" that was near that time frame it could possibly change his opinion and he would evaluate any new information. However, Petitioner clearly detailed to him that she felt she had spinal problems in the past. (PX15, p. 23)

Dr. Gornet testified he did not have Dr. Hayward's medical records and was unaware Dr. Hayward found three out of five Waddell's testing. (PX15, p. 24). Dr. Gornet testified Waddell's testing is a way to evaluate inorganic or other findings in patients that is associated with non-necessarily physiologic presentations of low back pain and can be used to determine if there is the possibility of symptom magnification. (PX15, p. 25). Dr. Gornet testified a three out of five would be a moderately positive Waddell's sign. However, he did not detect any functional overlays during his exams with Petitioner. (PX15, pp. 25-26)

Dr. Gornet testified he has put any treatment for Petitioner's neck on hold at this point in hopes that treating the low back would alleviate Petitioner's complaints. (PX15, p. 26-27). Petitioner has not undergone any injections for her neck and there is no surgical recommendation at this time. (PX15, p. 27)

Dr. Gornet testified his causation opinion is based upon the history Petitioner gave him regarding the injuries, her medical history she told him, and the records he had for review. (PX15, p. 28). Dr. Gornet admitted that if the history Petitioner gave him regarding her prior back complaints and treatment was inaccurate, it could change his opinion. (PX15, p. 28)

Dr. Gornet testified that he is relating Petitioner's need for surgery to both the September 4, 2015 and November 29, 2015 accidents. (PX15, p. 28). Dr. Gornet testified that there were no structural changes in Petitioner's spine in comparing the two MRIs. (PX15, p. 28). Dr. Gornet agreed that a herniation on an MRI cannot be dated. (PX15, p. 29)

Additional Medical Treatment

On October 6, 2016, Petitioner followed up with Dr. Gornet. Petitioner complained of continued low back pain. Dr. Gornet continued to recommend an anterior lumbar fusion at L5/S1 and refilled Petitioner's prescriptions. (PX8).

Deposition of Dr. Robson

Dr. Robson testified via evidence deposition on October 24, 2016. (RX18). Dr. Robson testified he is a board certified orthopedic spine surgeon who treats conditions of the cervical, thoracic, and lumbar spine. (RX18, p. 4-5). Dr. Robson testified he performed an IME on Petitioner on May 10, 2016. (RX18, p. 7). He reviewed Petitioner's medical records which showed Petitioner had lower back complaints prior to September 4, 2015. (RX18, p. 8). Specifically, Petitioner had treated with Dr. Moyers on July 9, 2014 complaining of chronic back pain and indicated her back had previously gone out five months prior. (RX18, p. 8). Dr. Robson testified this was inconsistent with the history Petitioner gave on his Patient Questionnaire where she denied any pre-existing problems prior to September 2015. (RX18, p. 9). Also, Dr. Robson testified that when he asked her directly about any prior treatment, she indicated she had some chiropractic care in 2011, but did not mention any problems or treatment in 2014. (RX18, p. 8)

Dr. Robson testified he reviewed the films of Petitioner's cervical and lumbar spine MRIs done on November 2, 2015. (RX18, p. 9). He did not see any significant herniation or protrusion lateralizing in Petitioner's neck. (RX18, p. 9). With regard to the lumbar spine, he thought she had some loss of disc height at L3/4 and L5/S1, but did not see any significant foraminal stenosis at either level. (RX18, p. 10). There was some minimal bulging at L5/S1. (RX18, p. 10). Dr. Robson testified he did not diagnose an annular tear at L5/S1. (RX18, p. 10). Dr. Robson testified he pulled up the films of Petitioner's lumbar spine MRI just prior to being deposed and re-examined them. (RX18, p. 10). While Dr. Gornet noted an annular tear at L5/S1 on axial image 12, Dr. Robson disagreed as there was no high intensity zone or a white spot or a bright lesion that would denote an annular tear. (RX18, p. 10)

Dr. Robson testified he took a history from Petitioner regarding the September 4, 2015 and November 29, 2015 injuries and performed a physical examination. (RX18, p. 11). On physical examination, Dr. Robson testified Petitioner's examination was normal, except some decreased range of motion of the cervical spine. (RX18, p. 11-12). Petitioner's lumbar spine showed normal gait and normal neurological testing. (RX18, p. 12)

Dr. Robson testified Petitioner had previously been diagnosed with fibromyalgia which is purported to cause cervical and lumbar spine problems and often time physical therapy and trigger point injections are required. (RX18, p. 12). Petitioner's medical records indicate she had previously undergone physical therapy and trigger point injections prior to September 4, 2015. (RX18, p. 12).

Dr. Robson diagnosed Petitioner with a cervical strain and lumbar strain, based on his review of the medical records, the history taken from Petitioner, and the physical examination he performed on her. (RX18, p. 12-13). He did not believe Petitioner required any additional treatment, opined she was at MMI, and could return to work without restriction. (RX18, p. 13-14).

On cross-examination, Dr. Robson testified he had not seen the results of Petitioner's CT discogram. (RX18, p. 15). Dr. Robson testified he does not perform discograms even though he is trained to do it because he is not a big believer in that test. (RX18, p. 16). Dr. Robson testified patients are supposed to be blinded as to what levels are being tested, but it depends on who is performing it. (RX18, p. 17).

Dr. Robson testified he did not see any signs of malingering or Waddell's signs in his examination, but Petitioner was inconsistent as far as forthcoming with her past medical history. (RX18, p. 18). Dr. Robson testified Petitioner indicated on the Patient Questionnaire she filled out that she had not had any prior problems with her back before her 2015 injury. (RX18, p. 18-19). He said this was inconsistent with what was in Dr. Gornet's notes and Dr. Moyer's notes. 9RX18, p. 18-19). He testified this was also inconsistent with what Petitioner told him about receiving chiropractic care in 2011. (RX18, p. 19). Dr. Robson testified Petitioner did not tell him that she had a previous injury on June 29, 2013. (RX18, p. 21). Dr. Robson testified he had no criticism of her care and treatment up to date. (RX18, p. 22).

Additional Medical Treatment

On October 29, 2016, Petitioner filled out a Worker's Compensation Employee's Notice of Injury form for an accident occurring that day. Petitioner indicated that on October 24, 2016, she was jerked around while trying to break up a fight between three aggressive patients. (RX 10) Respondent does not dispute that this accident occurred. (AX 7)

On October 30, 2016, Petitioner filled out a Workers' Compensation Employee's Notice of Injury form regarding an accident that occurred that day. Petitioner indicated she was thrown over the back of a couch with a patient while trying to stop his violent behavior. Petitioner indicated she injured her hips, left leg, and had whole spine pain. (RX13). Respondent does not dispute that this accident occurred. (AX 9)

On November 21, 2016 Petitioner signed her Application for Adjustment of Claim in case #16 WC 0036410 alleging injuries to her back, neck, and body as a whole as result of an accident on October 24, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 8)

On November 21, 2016 Petitioner also signed her Application for Adjustment of Claim in case #16 WC 0036411 alleging injuries to her back, neck, and body as a whole as result of an accident on October 30, 2016 when she was in an altercation with a patient resulting in an aggravation of an injury. (AX 10)

On November 23, 2016, Petitioner returned to Dr. Gornet. Petitioner indicated she was in two new altercations on October 24, 2016 and October 30, 2016. Petitioner indicated she felt she had aggravated her underlying back condition and injured her neck and shoulders. Dr. Gornet recommended observation and indicated if Petitioner's symptoms continued to be elevated, he would recommend new imaging studies to see if there is a new disc injury. Petitioner was taken off work. Dr. Gornet noted, "At a minimum, these new injuries have aggravated her underlying conditions in her cervical and lumbar spines." (PX8).

On January 9, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet described Petitioner as being "clinically worse." He recommended a new MRI, but indicated unless it was dramatically changed, he would move forward with the anterior lumbar fusion at L5/S1. (PX8)

On March 23, 2017, Petitioner underwent an MRI of her lumbar spine without contrast. The impressions were: 1) L3/4 and L4/5 annular disc bulges with superimposed left foraminal protrusions at both levels resulting in moderate left greater than right foraminal stenosis but no central canal stenosis; and 2) left paracentral focal protrusion at L5/S1 resulting in dural displacement and contact with the traversing left S1 root sleeve but no definite central canal or foraminal stenosis. (PX11)

On March 23, 2017, Petitioner returned to Dr. Gornet, regarding her with-related injuries, including new altercations of 10/24/16 and 10/30/16 as well as her original injury of 9/4/15. He noted that the MRI did not show any dramatic changes. The options of a lumbar fusion and a disc replacement at L5/S1 were discussed. (PX8)

On April 27, 2017, Petitioner underwent another Section 12 examination with Dr. Robson. Petitioner gave a history of a new injury on October 30, 2016 when she was in another patient altercation. Petitioner complained of low back pain radiating down into her left leg and foot. Dr. Robson reviewed accident reports, medical records, and imaging studies, including MRIs of Petitioner's lumbar spine from November 2, 2015, September 26, 2016, and March 23, 2017. Dr. Robson's assessment was mild disc desiccation at L3/4 and L4/5 and diffuse disc bulging asymmetric to the left at L5/S1. Dr. Robson noted Petitioner had previous low back complaints in 2014 for which she treated and took pain medication. Dr. Robson opined there was no causal relationship between Petitioner's current condition and the reported accident, and that her current condition was related to her pre-existing condition. Dr. Robson opined that he did not believe surgical intervention was medically necessary. He further opined Petitioner was at MMI and could return to work without restrictions. (RX17)

On May 11, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet continued to recommend a disc replacement at L5/S1. (PX8)

Second Deposition of Dr. Robson

Dr. Robson testified again via evidence deposition on July 27, 2017. (RX19). Dr. Robson testified he performed a second IME on Petitioner on April 27, 2017. (RX19, p. 7). Dr. Robson testified that he reviewed medical records and performed a physical examination. (RX19, p. 7). Dr. Robson reviewed MRI films of Petitioner's lumbar spine from November 2, 2015, July 26, 2016, and March 23, 2017. (RX19, p. 9). Dr. Robson testified he compared all three lumbar spine MRI films. (RX19, p. 10). The March 23, 2017 MRI showed some mild loss of disc height between her third and fourth lumbar, her fourth and fifth lumbar, and L5/S1. (RX19, p. 10). There was a small asymmetric disc bulge to the left at L5/S, and, in comparison to the two previous MRIs, Dr. Robson felt it was unchanged or maybe even slightly better. (RX19, p. 10). The size of the disc bulge did not appear as large. (RX19, p. 10).

Dr. Robson testified that Petitioner indicated to him that she was injured at work when she was breaking up a fight between two patients on October 30, 2016. (RX19, p. 11). Petitioner said this increased her back pain. (RX19, p. 11). Dr. Robson performed a physical examination of Petitioner which was normal, except some limited range of motion in forward flexion. (RX19, p.11). Dr. Robson testified there were no structural changes between Petitioner's lumbar MRIs taken in 2016 and March 23, 2017. (RX19, p. 11).

Dr. Robson diagnosed Petitioner with mild dehydration of the disc between her third and fourth lumbar and her fourth and fifth lumbar vertebra and a diffuse disc bulge asymmetric to the left at L5/S1. (RX19, p. 12). Dr. Robson testified this diagnosis was not related to the October 30, 2016 work injury. (RX19, p. 12). Dr. Robson testified Petitioner did not need any further treatment related to the October 30, 2016 injury and that she was at MMI. (RX19, p. 13). Dr. Robson testified he personally would not perform the recommended surgery. (RX19, p. 13). He further testified that he could not attribute the need for same to an October 30, 2016 injury. (RX19, p. 13). Dr. Robson explained that he would personally not do the surgery because the only positive test that came back was the discogram which has subjective components to it. (RX19, p. 14). The imaging studies did not demonstrate instability, and while there was some pathology, he did not see it in what he would offer surgical intervention to. (RX19, p. 14). Dr. Robson testified the medical literature is replete with evidence that discograms are not completely objective studies. (RX19, p. 14).

On cross-examination, Dr. Robson testified Petitioner had pre-existing lumbar complaints, referring to medical records he reviewed from 2014. (RX19, p. 17-18). Dr. Robson agreed that Petitioner had not been recommended to see a spine specialist prior to September 2015 in the medical records he reviewed. (RX19, p. 19). Dr. Robson testified he did not review Dr. Hayward's records or records from Work Care and that if Dr. Hayward's records contained more information about the September 4, 2015 accident he would have liked to have reviewed it. (RX19, p. 20-21).

Dr. Robson testified only a minority of spine surgeons and specialists in the medical community use CT discograms. (RX19, p.21-22). Dr. Robson testified he did not find an annular tear on Petitioner's lumbar spine MRIs. (RX19, p. 22). Dr. Robson testified he thought the disc protrusion at L5/S1 was actually smaller on Petitioner's March 23, 2017 MRI. (RX19, p. 23).

Dr. Robson testified that a patient altercation where a person was jostled around and thrown to the ground, such as the ones Petitioner had been involved in, can be the type of mechanism of injury that can cause a disc injury in the lumbar spine. (RX19, p. 24). He also testified that kind of altercation could hypothetically aggravate a pre-existing lumbar condition. (RX19, p. 24).

Dr. Robson testified that the symptoms Petitioner complained of are the type that tend to wax and wane. (RX19, p. 25). Dr. Robson testified that there were no structural changes in Petitioner's lumbar spine after the October 30, 2016 injury, which both the radiologist and Dr. Gornet agreed with. (RX19, p. 25). Dr. Robson was asked if Petitioner's symptoms have ever returned to a baseline or pre-injury status and he replied:

> Well, it's really hard to tell. She's had the same low back and left-sided symptoms since 2014, so I can't tell which – symptoms like that tend to wax and wane. I don't know what impact this injury on October 30th of 2016 had. It certainly didn't change the structures of her lumbar spine as [we] all agree to. (RX 19, p. 25)

Dr. Robson testified it would be rare to see a person have symptoms aggravated without seeing a change on MRI. (RX19, p. 25-26). These types of symptoms tend to wax and wane in patients and they will experience flare-ups from time to time. (RX19, p. 26). Dr. Robson further testified that he had no record of the 10/24/16 accident and he wasn't sure if he had Dr. Gornet's 11.23.16 note. However, he took no issue with Dr. Gornet's records indicating Petitioner's symptoms increased after the two October of 2016 accidents. (RX 19, pp. 27-28) Dr. Robson testified that surgery is not always the solution for someone who has failed conservative care. (RX19, p. 30). In his practice, he would try to talk to Petitioner about living with her condition rather than face the risk of a complication. (RX19, p. 30). He does not believe the risk outweighs the potential rewards should she undergo surgery. (RX19, p. 31).

Dr. Robson testified that when treating a patient, one considers MRI findings, physical exam findings, and patient symptoms. (RX19, p. 32). Dr. Robson also testified that symptoms have a good subjective component to them, especially in a litigated case, whereas objective findings tend to be standard. (RX19, p. 32).

Additional Medical Treatment

On August 17, 2017, Petitioner returned to Dr. Gornet. Dr. Gornet reviewed Dr. Robson's IME report with Petitioner. Dr. Gornet reiterated his recommendation of a disc replacement at L5/S1. Her work restrictions remained unchanged. (PX8)

On December 14, 2017, Petitioner followed up with Dr. Gornet. Dr. Gornet indicated Petitioner's exam was unchanged and there were no new issues, Dr. Gornet again recommended a disc replacement at L5/S1 and possible fusion, if needed. She remained temporarily totally disabled. (PX8)

The Arbitration Hearing

Petitioner's case against Respondent proceeded to arbitration on January 25, 2018 pursuant to a 19(b) Petition she had filed. The disputed issues were causal connection, medical bills, temporary total disability benefits and prospective medical care. Petitioner was the sole witness testifying at the hearing. Respondent's representative at the hearing was Cathy Kennedy. At the commencement of the proceeding, Petitioner's attorney moved, without objection, to amend the Application for Adjustment of Claim in case #15 WC 30798 (D/A: 9.4.15) to include alleged injuries to the neck and back.

Petitioner testified she is currently employed with Respondent as a Security Therapy Aide I. She works with the criminally insane and it is her job to keep everyone safe and help monitor patients. She also has to intervene if patients become aggressive.

Petitioner testified that she was injured on September 4, 2015 when she tried to stop a patient from charging another patient. Petitioner testified she "got hit like a linebacker" and flew backwards on the floor and injured her back, knees, and neck. (See also RX 4.) Petitioner testified her primary care doctor did not take work comp, so she went to Work Care. Petitioner testified she was given work restrictions that could not be accommodated, so she was taken off of work and paid extended benefits. Petitioner then saw Dr. Hayward. She underwent an MRI and he released her back to work sometime in November of 2015.

Petitioner further testified that on November 29, 2015, she was trying to hold the leg of a patient who had attacked another patient and she was jostled around, inflaming her lower back. (See RX 7.) Petitioner testified she began treating with Dr. Gornet and was taken off of work. Petitioner testified that Dr. Gornet has also given her restrictions, at times, but has never released her to full duty since she began treating with him. She has undergone multiple imaging studies and has had injections. Petitioner testified she underwent an IME with Dr. Robson and after receiving his report she was advised she needed to go back to work on a full duty basis.

Petitioner testified that she did return to full duty work and on October 24, 2016, she was trying to hold back a patient from attacking another patient who was jumping over her back, and she was "getting landed on" while the patient was trying to pummel another patient. She injured her back and it made her foot numb that day. (See also RX 10.) Then on October 30, 2016, she grabbed a patient's arm to prevent him from throwing a punch, which pulled her over a couch. She landed in the crack of the couch holding him while he was fighting, injuring her back and neck. (See RX 13) Petitioner testified that after that accident Dr. Gornet said "that was enough" and he took her completely off of work.

Petitioner testified that she had a prior work accident in June of 2013 when she was trying to restrain a patient and was standing on a bed. She dropped down, hitting her buttocks on the edge of the nightstand, and kind of "cranked this way" with the weight of her body and hurt her back. (RX 1) Petitioner testified that she sought very little medical treatment for this although she thought she may have seen her doctor in 2014 for some residual pain but she didn't "deal with it." Petitioner also testified that her primary care doctor's records indicate she had some back pain in 2014 and she explained that those complaints were referable to her 2013 accident. She did not seek any other treatment then this and did not miss any work due to this injury. Petitioner testified she

did not believe that the 2013 accident was in any way responsible for the symptoms that she has now.

Petitioner testified that prior to September 4, 2015 she was doing well with regard to her low back. She was going to the gym twice a day, biking, and running two miles a day after work. She testified she cannot do those things now. She testified Dr. Gornet is recommending lower back surgery which she would like to undergo as she is tired of the pain.

Petitioner testified after her second IME with Dr. Robson, she received notification that she would no longer be receiving workers' compensation benefits. Petitioner testified that she did not tell Dr. Robson about having low back issues prior to September of 2015 because she thought it was different than her 2004 diagnosis of fibromyalgia. To her fibromyalgia referred to muscular aches whereas "back pain" referred to her spine. Petitioner also testified she did not mention the 2013 injury and 2014 treatment to Dr. Robson because she had "let it go" and it did not cause her any more grief.

On cross-examination, Petitioner testified that when her workers' compensation benefits were terminated, she went on a non-occupational leave and has been receiving benefits through non-occ since that time. Petitioner further testified she still has her group insurance through her employment. Petitioner testified that she has not undergone the recommended surgery through her group insurance because she wants Dr. Gornet to perform the surgery. Petitioner admitted that she has not asked if Dr. Gornet accepts her insurance and that she is just waiting to see how this plays out. If she were to lose her workers' compensation case, she would still pursue having the surgery done through her group insurance.

Petitioner testified she did not miss any time from work for her 2013 injury nor did she admit any medical records indicating she treated for her back in 2013 into evidence. Petitioner testified after the September 2015 injury, Dr. Hayward released her to return to work full duty on November 12, 2015, but she did not return until November 24, 2015 because she was shocked he had released her.

Petitioner testified the November 29, 2015 injury occurred five days after she had returned to work full duty. At that time, Petitioner was bumped from day shift to evening shift by a more senior employee. Petitioner admitted that she was upset that she was bumped to evening shift.

Petitioner testified she was off of work until July of 2016 when she returned to work full duty. She was working full duty at the time of the October 24, 2016 injury and continued to work full duty until the October 30, 2016 injury.

Petitioner testified that she is not currently working and does not have any kind of employment. When asked if she makes and sells jewelry online, she admitted that she did have a "hobby" of that. Petitioner testified she makes coin rings using a little mandrill, which she uses to pound on the coin.

Petitioner testified she smokes one pack of cigarettes a day and has been counseled regarding same. She has been diagnosed with fibromyalgia. Petitioner testified she underwent chiropractic care for her back in 2004, but could not remember if she did so in 2011.

Petitioner testified she is not using any kind of brace or protective device. She takes over-the-counter medication pretty much daily. Workers' compensation refused to pay for one medication she was prescribed and another medication bothered her stomach. She is not currently undergoing physical therapy.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in her low back is causally related to her October 30, 2016 work accident. In so concluding, the Arbitrator relies upon the more persuasive opinions of Dr. Gornet over those of Dr. Robson.

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 902 N.E.2d 1269, 1273 (5d Dist. 2009). When a pre-existing condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] 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." *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 864 N.E.2d 266, 272-273 (5th Dist. 2007).

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, 672 (Ill. 2003). [Emphasis original]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1st Dist. 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (Ill. 1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977). The Supreme Court's decision in *Sisbro, Inc.* highlighted that even though a workers' compensation claimant has a pre-existing condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003).

Petitioner has filed five claims against Respondent for injuries to her low back, neck and knees. Respondent has not disputed any of the accidents.

At the center of the causation dispute in this case is Respondent's position, and Dr. Robson's belief, that Petitioner's need for treatment as proposed by Dr. Gornet stems from a chronic pre-existing low back condition made apparent on July 19, 2014, as opposed to any/all of the four very hostile and physical assaults on Petitioner while working. The Arbitrator doesn't agree with Respondent's position or the opinion of its examining doctor. July 9, 2014 is the first mention in the records of any low back issues. Petitioner did not even mention an injury to her back on the June 30, 2013 Notice of Injury form. While there is a reference in some of the medical histories to chiropractic care in 2004 no records were introduced to further set forth the nature of this treatment and, more significantly, Petitioner underwent no further treatment for her back for over ten years. Nothing in the record herein suggests that Petitioner had a diagnosed and treated chronic low back condition before July 9, 2014. The Arbitrator views the reference to "chronic" back pain in the July 9, 2014 medical office note as distinguishing Petitioner's complaints from an acute problem. While the doctor ordered some physical therapy and an x-ray, the therapy was not undertaken, no formal diagnosis for her back followed, and, most significantly, Petitioner continued to treat with Dr. Moyers for another fourteen months or so with no further mention of back pain or complaints or treatment to her back. The Arbitrator sees a distinct difference between vague references to fatigue and joint/muscle aches and pain and the very specific complaints Petitioner voiced on September 10, 2015 at Work Care and thereafter. Respondent produced no evidence of extensive back treatment pre-dating September 4, 2015. In light of the above, the Arbitrator does not find Petitioner's denial of prior back problems in Dr. Robson's questionnaire to be intentionally deceitful or misleading. Petitioner had been working full duty before September 4, 2015 and engaged in all activities of life, including hobbies and sports. Under these circumstances the Arbitrator finds it reasonable to infer from Petitioner's denial of prior problems that, in her mind, she wasn't having "problems." Petitioner was an exceedingly credible witness.

Contrary to Dr. Robson's opinions and Respondent's position, everything changed for Petitioner on September 4, 2015 (the d/a in Case #15 WC 30798). She has never really returned to her level of activity pre-September 4, 2015. While she has returned to full duty work or light duty work periodically since that accident she has not been asymptomatic and she ended up being involved in additional accidents, including the one herein. Petitioner's treatment after September 4, 2015 was initially managed by Respondent. She was sent to Work Care and, in turn, to Dr. Hayward. Medical personnel at Work Care opined that Petitioner's condition was related to her work activities/accident, that objective findings were consistent with a work-related etiology and that work activities had aggravated an underlying pre-existing condition for which a neurology consultation was recommended.

Work Care referred Petitioner to Dr. Hayward who acknowledged that Petitioner had a bulging disc at L3-4 on the left side which was contacting the nerve. He released her from his care because he didn't feel she needed surgery, not because she was at maximum medical improvement. A referral to an occupational medicine doctor for further treatment was recommended. While he saw no reason she couldn't return to work, it is interesting that just five days prior to the final visit with Dr. Hayward, Petitioner attended physical therapy and was noted to have limited lumbar AROM secondary to pain and the inability to perform normal activities secondary to lumbar and lower extremity radicular pain. She demonstrated an antalgic gait and difficulty walking. It was recommended that she continue with physical therapy; however, that wasn't done because Dr. Hayward released her to return to work. Dr. Hayward's records (PX 5) don't include copies of the

therapy records. His office note of November 9, 2015 doesn't discuss them. As such, it is unclear to the Arbitrator if he knew what was going on in therapy, including Petitioner's limitations. In light of the foregoing, as well as Dr. Hayward's belief that Petitioner should follow up with occupational medicine and the therapist's recommendation for additional therapy, the Arbitrator finds Petitioner remained symptomatic when discharged by the doctor and not yet at maximum medical improvement.

Against this backdrop Respondent sent Petitioner back to work and, unfortunately, she sustained another accident on November 29, 2015. The Arbitrator found Petitioner to be a very credible witness and her reluctance to return to work after being discharged by Dr. Hayward, along with her disappointment about being switched to a different shift, does not negate her credibility.

After the November 29, 2015 accident Petitioner began treating with Dr. Gornet who has repeatedly and consistently opined that, at a minimum, Petitioner suffered an aggravation or re-aggravation as a result of her accidents on November 29, 2015, October 24, 2016 and October 30, 2016.

In his deposition, Dr. Robson admitted that Petitioner's accidents resulted in a change of her work status and her symptoms. (RX18, p.20; RX19, p.25-26) He admitted that Petitioner consistently complained of pain following her work accidents. *Id.* at 26. He testified that he had no basis to dispute Dr. Gornet's records indicating the fact that Petitioner's symptoms increased after being involved in those incidents, and he admitted that Petitioner showed no signs of symptom magnification or malingering. *Id.* at 28-29, 32. He acknowledged that Petitioner's discogram demonstrated a severely provocative disc at L5 to S1. *Id.* at 21. He further admitted that annular tears could produce Petitioner's lumbar spine symptoms. *Id.* at 22. He acknowledged that, although he failed to appreciate Petitioner's annular tear, the radiologist who performed Petitioner's MRI of March 23, 2017, Dr. Ruyle, documented an annular tear visible at the apex of the protrusion at L5-S1. *Id.* at 22-23. When asked whether he agreed with Dr. Ruyle's interpretation, Dr. Robson stated, "I agree." *Id.* at 23. He further admitted that Petitioner's work accidents were a mechanism of injury consistent with her current pathology and symptoms, and significantly, that these incidents could aggravate Petitioner's pre-existing condition. *Id.* at 24. He also acknowledged that he did not possess any imaging studies for comparison prior to Petitioner's work injuries to say that Petitioner's lumbar spine herniations were definitively pre-existing. *Id.* at 20. Significantly, he acknowledged that Petitioner required no treatment for eleven (11) months prior to her work injury in September of 2015. (RX18, p.20) Even though he diagnosed Petitioner with simply a "strain," he admitted that Petitioner's symptoms had been unresolved and persistent since her work injuries. (RX19, p.26) Dr. Robson never addressed the cumulative effect of Petitioner's last four accidents, he did not comment on the October 24, 2016 accident whatsoever, he did not address the issue of "aggravation," and he failed to review all pertinent medical records (Hayward and Work Care) as part of his examination review and report. He further incorrectly stated that Petitioner's low back and left-sided complaints have been the same since 2014 (RX 19, p. 25) as Petitioner had no left lower extremity complaints before the September 4, 2015 accident. For these reasons, the Arbitrator is not persuaded by his opinion.

In contrast, Dr. Gornet opined that Petitioner has a disc injury at L3-L4 and a disc injury, annular tear and herniation at L5-S1. He causally related these conditions to her September 4, 2015

accident and her November 29, 2015 accident. His opinion as to causation is supported by the objective diagnostic studies and the circumstantial evidence. Dr. Gornet noted that Petitioner suffers from minimal to degeneration, which is supported by the evidence and the findings of Work Care and Dr. Hayward. (PX3, 9/10/15; PX5, 11/9/15; PX8, 12/10/15) Dr. Gornet's diagnosis of an L5-S1 annular tear with herniations was confirmed by the objective imaging studies and the discogram procedure. (PX11; PX12; PX14) Dr. Gornet also noted that Petitioner's complaints markedly increased and have been unabated since her injuries, leading him to credibly conclude that Petitioner's work assaults, including those on October 24, 2016 and October 30, 2016 aggravated and caused her current condition of ill-being. (PX15, pp.15-16) The Arbitrator, therefore, finds his opinion persuasive and finds that Petitioner met her burden of proof in establishing that her current condition of ill-being in her low back is related to her work accident of October 30, 2016.

Prior to November 29, 2015, the evidence suggests that although Petitioner was still symptomatic and her condition had not entirely resolved, she was released to return to work full duty, and was performing full duty work until she was injured on November 29, 2015. Dr. Gornet's treatment recommendations did not change after Petitioner was involved in subsequent altercation/accidents in October of 2016, one of which is the subject of this claim. Dr. Gornet's office notes subsequent to the October 30, 2016 accident indicate that Petitioner's condition of ill-being in her low back was aggravated by the accidents on October 24 and 30, 2016. The weight of the evidence supports that Petitioner's pre-existing condition in her low back was aggravated as a result of the injury herein and made more symptomatic. Accordingly, the Arbitrator finds that Petitioner's current condition of ill-being in her low back is related to her accident of October 30, 2016.

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 entitled to recover reasonable medical expenses that are causally related to the October 30, 2016 accident. However, the Arbitrator declines to award any medical bills with regard to this case as same were awarded in case #16 WC 2296 (D/A – 11/29/15). Petitioner has continued to treat with Dr. Gornet since her November 29, 2015 accident. Prior to her visit with Dr. Gornet on November 23, 2016 (her first visit after the 10/30/16 accident) Dr. Gornet had not released Petitioner from his care. As such the Arbitrator views the visits since October 24 and October 30, 2016 as continuing to relate to the earlier accident of November 29, 2015.

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

Prospective medical care is denied as it has been awarded in case #16 WC 2296.

Although Petitioner's consolidated claim involves multiple injuries that have all seemingly impacted her condition, the Arbitrator finds that Petitioner's apex injury that negatively impacted her condition of ill-being the most to be the accident on November 29, 2015. Petitioner was able

to return to work following her first two accidents on June 29, 2013, and September 4, 2015, and neither of these led to a surgical recommendation or significant treatment. (PX3; PX5) Following her accident on November 29, 2015, however, Petitioner's condition dramatically declined. Petitioner's symptoms did not respond positively to conservative care, and she was ultimately recommended for surgery. While she sustained other accidents on October 24 and October 30, 2016, both Dr. Gornet and Dr. Robson agreed that the October 30, 2016 accident did not result in a significant change in pathology, and her treatment recommendations per Dr. Gornet have likewise remained the same. Again, Dr. Robson never addressed the October 24, 2016 accident. Dr. Gornet's office notes subsequent to the October 24, 2016 accident indicate that Petitioner's condition of ill-being in her low back was aggravated by the accidents on October 24 and 30, 2016. While Petitioner's current condition in her low back is causally connected to the accident herein, the Arbitrator finds it significant that Dr. Gornet first recommended surgery after Petitioner's November 29, 2015 accident (which is the subject of case #16 WC 02296). As such, the Arbitrator finds it to be the appropriate case in which to award prospective care.

Issue (L): What temporary benefits are in dispute? (TTD)

Consistent with her causation determination Petitioner is awarded temporary total disability benefits commencing May 17, 2017 through January 25, 2018 a period of 36 2/7 weeks. Respondent did not dispute the dates of TTD, only liability for the benefits. After the October 30, 2016 accident Petitioner returned to see Dr. Gornet on November 23, 2016 and he took her off work completely in light of her most recent accidents. As such, the Arbitrator deems it most appropriate to award TTD in conjunction with this claim.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARYNA ALVAREZ,

Petitioner,

vs.

NO: 15 WC 007456

2542 INC. d/b/a SELECT ULTRA LOUNGE and ILLINOIS STATE TREASURER AS CUSTODIAN OF THE ILLINOIS WORKERS' BENEFIT FUND,

19IWCC0606

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Illinois State Treasurer as Custodian of the Illinois Workers' Benefit Fund ("Respondent") herein and notice given to all parties, the Commission, after considering the issues of disfigurement and the permanent partial disability rate 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, while working as a server for Respondent 2542 Inc. on January 25, 2015, fell to the floor after being pushed by her supervisor. In the process of falling, Petitioner's right arm struck the corner of a box, and she sustained a laceration to her right arm approximately three to four inches in length.

Petitioner filed a workers' compensation claim against Respondent 2542 Inc. and testified on her own behalf at the ensuing arbitration hearing on July 20, 2018. The presiding arbitrator viewed Petitioner's right arm and noted a healed laceration leaving a scar three to four inches in length. The arbitrator awarded Petitioner 25 weeks of permanent partial disability benefits as compensation for her disfigurement. No documentary evidence regarding the scar was made part of the record. An appeal of the arbitration decision was taken on an unrelated issue.

On September 10, 2019, the hearing pursuant to the appeal of the arbitration decision was held. Petitioner was present at this hearing and allowed the Commission to view her right arm.

The Commission viewed the scar, which is now one and a half to two inches in length as opposed to the prior three to four inches at the time of her July 20, 2018 arbitration hearing. Petitioner, herself,

19IWCC0606

indicated to the Commission the scar was smaller in size than previously. The Commission finds the decreased length of the scar corresponds proportionally to a decrease to the degree Petitioner is disfigured by the scar.

The acknowledged improvement of Petitioner's disfigurement compels the Commission to modify the compensation awarded to Petitioner under Section 8(c) of the Act from 25 weeks to 15 weeks.

The Commission, otherwise, affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Illinois State Treasurer as Custodian of the Illinois Workers' Benefit Fund shall pay reasonable and necessary medical services of $124.87, as provided in §8(a) of the Act and adjusted in accord with the medical fee schedule as provided in §8.2 of the Act

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Illinois State Treasurer as Custodian of the Illinois Workers' Benefit Fund shall pay Petitioner permanent partial disability benefits of $253.00 per week for 15 weeks because of injuries sustained caused the disfigurement of Petitioner's right arm as provided in §8(c) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Illinois State Treasurer as Custodian of the Illinois Workers' Benefit Fund has the right to recover benefits paid due and owing to Petitioner from Respondent 2542 Inc. d/b/a Select Ultra Lounge pursuant to §5(b) and §4(d) of the Act

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 2542 Inc. d/b/a Select Ultra Lounge/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent 2542 Inc. d/b/a Select Ultra Lounge/Employer/Owner/Officer that are paid to Petitioner from the Injured Workers' Benefit Fund.

Pursuant to §19(f)(1) of the Act, the decision of the Commission shall not be subject to review as the claim is against the State of Illinois.

DATED: NOV 6 - 2019
LEC/mav
O: 09/10/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALVAREZ, MARYNA
Employee/Petitioner

Case# **15WC007456**

2542 INC D/B/A SELECT ULTRA LOUNGE AND THE ILLINOIS STATE TREASURER AS CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

19IWCC0606

On 10/15/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

2643 ALAN H SHIFRIN & ASSOC, LTD
VICTOR PRICE
3315 ALGONQUIN RD SUITE 202
ROLLING MEADOWS, IL 60008

0000 2542 INC/SELECT ULTRA LOUNGE
2542 PETERSON AVE
CHICAGO, IL 60659

0000 2542 INC/SELECT ULTRA LOUNGE
BOGDAN M BACESCU REG AGENT
4530 N CENTRAL AVE APT 3
CHICAGO, IL 60625

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE COPELAND
100 W RANDOLPH ST 13TH 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
ARBITRATION DECISION

Maryna Alvarez
Employee/Petitioner

v.

2542 Inc., d/b/a Select Ultra Lounge and the Illinois State Treasurer as Custodian of the Injured Workers' Benefit Fund,
Employer/Respondent

Case # **15** WC **7456**

Consolidated cases: _____

19IWCC0606

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **July 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☒ What was Petitioner's age at the time of the accident?
I. ☒ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 25, 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 $**520.00**; the average weekly wage was $**220.00**.

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

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

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

Respondent **Select Ultra Lounge** 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 §8(j) of the Act.

ORDER

Medical Benefits

Respondent shall pay reasonable and necessary medical services of $**124.87**, as provided in §8(a) of the Act and adjusted in accord with the Medical Fee Schedule provided in §8.2 of the Act.

Permanent Partial Disability: Disfigurement

Respondent shall pay Petitioner permanent partial disability benefits of $**253.00**/week for **25** weeks, because the injuries sustained caused the disfigurement of the **right arm**, as provided in §8(c) of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §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 §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

October 15, 2018
Date

ICArbDec p. 2

OCT 15 2018

Maryna Alvarez v. 2542 INC, d/b/a Select Ultra Lounge and the Illinois State Treasurer as Custodian of the Injured Workers' Benefit Fund
15 WC 7456

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***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 accident?; ***G:*** What were Petitioner's earnings?; ***H:*** What 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? TTD; ***L:*** What is the nature and extent of the injury?

STATEMENT OF FACTS

Petitioner Maryna Alvarez is a 27 year-old married woman who was 27 years old at the time of her accident. She testified that she was hired as a cocktail server for Select Ultra Lounge. She was hired by Yamni Brain, the owner. He agreed to pay her $10.00 per hour plus tips.

She began working on Friday, January 24, 2015 from 7 p.m. to 1 a.m. On Saturday, January 25, she worked from 8 p.m. to 1 a.m. She testified that she did not wear a uniform and that there were no particular work rules.

At the end of her shift on the January 25, she testified that she became involved in an argument with Yamni the owner. She told him that she did not like the "atmosphere" of rude customers. Yamni became angry and pushed her, causing her to fall and strike her right elbow on a sharp object. The bartender helped her up and assisted in stopping the bleeding. She then called 911.

Petitioner was transported to the Emergency Room at Swedish Covenant Hospital where she received 9 stitches in her right arm. She had a follow up appointment with her own doctor and currently has a 3 - 4 inch scar close to the elbow on her lower right arm.

Petitioner received follow-up care from Garcia Rosenberg and Associates on February 2 and February 5, 2015. She testified that sutures were removed on February 5. Petitioner's Exhibit #7 shows billing for an office visit February 3, 2015, $120.78, and removal of sutures on February 9, 2015, $73.14. There is a $146.24 charge for February 12, 2015 relating to a "previous visit." Petitioner's Exhibit #7 also includes charges of $160.00 for a March 16, 2015 office visit and $160.00 for April 16, 2015 office visit.

There were no clinical records for any of the medical care provided to Petitioner admitted in evidence.

CONCLUSIONS OF LAW

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

§3, paragraph 12 of the Act states that *"establishments open to the public wherein alcoholic beverages are sold to the general public for consumption on the premises"* are subject to the provisions of the Act. Because Select Ultra Lounge was in the business of serving alcoholic beverages, the Arbitrator finds that Petitioner proved that Respondent was subject to the automatic coverage of the Act at the time of Petitioner's accidental injury.

B: Was there an employee-employer relationship?

Petitioner testified that she met with the owner of the Lounge, Yamni Brain, who offered her a job as a server with a salary of $10.00 an hour plus tips. There was no evidence disputing her status as an employee. As a result, the Arbitrator finds that Petitioner proved that there was an employer-employee relationship.

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

Petitioner testified credibly that in the course of the discussion and argument with Respondent's owner about working conditions she was pushed down. As she fell, petitioner caught her on a sharp. The Arbitrator finds that Petitioner proved that she sustained an accidental injury that arose out of and in the course of her employment by Respondent.

D: What was the date of the accident?

There was no genuine dispute petitioner sustained an accidental injury on January 25, 2015.

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

Petitioner testified credibly that her employer, Respondent's owner, pushed her down in the course of an argument about Petitioner's working conditions. There is credible evidence that Respondent had actual knowledge of Petitioner's injury at the time the injury was sustained.

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

Petitioner testified that she sustained a cut on her right arm when Respondent's owner pushed her down and she fell against something sharp. Petitioner's Exhibit #5, billing from City of Chicago EMS, and Exhibit #6, billing from Swedish Covenant Hospital, confirm that petitioner received Petitioner received emergency care on January 25, 2015. Petitioner's Exhibit #6 contains charges for 7 – 12 sutures. Petitioner testified credibly that the scar on her forearm was from the cut she sustained at work on January 25, 2015. The Arbitrator finds that Petitioner proved that the scar she displayed at trial is a result of the injury which occurred on January 25, 2016.

G: What were Petitioner's earnings?

Petitioner testified credibly that she was to be paid $10.00 per hour. She only worked there two days and was never paid. Therefore, the Arbitrator finds that her average weekly wage to be the statutory minimum of $253.00.

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

It was not genuinely disputed that petitioner was 27 years old at the time of her accidental injury.

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

It was not genuinely disputed that Petitioner was married at the time of her accidental 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?

Petitioner testified that she received emergency care from City of Chicago paramedics and in the emergency department of Swedish Covenant Hospital.

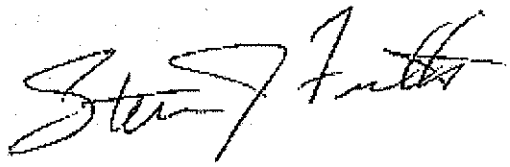
Petitioner's Exhibits #5 and #6, billing statements, confirm petitioner received those emerged services. Petitioner's Exhibit #7, a patient billing ledger from Garcia Rosenberg & Associates, document Petitioner's follow-up outpatient care by Tricare North & South on February 9, 2015, for removal of sutures, as well as follow-up visits on February 12, March 16, and April 16, 2015. The Arbitrator finds that Petitioner proved that the medical services she received were reasonable and necessary and that the charges for those services were also reasonable and necessary

K: What temporary benefits are in dispute? TTD

There was no evidence that Petitioner was disabled from her ability to perform duties as a cocktail waitress. Accordingly, the Arbitrator finds that Petitioner failed to prove that she was entitled to total temporary disability.

L: What is the nature and extent of the injury?

Petitioner sustained a laceration on the right arm just below the elbow which required 9 sutures to close. As a result, she now has a 3 to 4 inch scar. Therefore, the Arbitrator awards 25 weeks' disfigurement.



October 15, 2018

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary E. Nickens,
Petitioner,

vs.

No. 16 WC 011059

19IWCC0607

Continental Tire of North America,
Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(b) AND §8(a)

Timely Petition for Review under §19(b) and §8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, and prospective medical care, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

I. FINDINGS OF FACT

Petitioner testified that he had worked for Respondent for 37 years, performing tasks that required him to repeatedly use his hands and arms to forcefully grip tools, lift weights, strip wires, and twist caps to make connections. For the first 10 years of his employment, he worked as an ETN (maintenance industrial/mechanical electrician), maintaining, repairing and troubleshooting equipment. He also regularly utilized various hand and vibratory power tools, including hammer drills.

In 1991 Petitioner began transitioning into "tool and gauge." He continued to perform electronic technician duties requiring the use of hand and vibratory power tools. The "tool and gauge" position also required him to calibrate plant equipment. Petitioner testified that there were hundreds of scales, gauges, and transducers in the plant. He explained that he was repeatedly required to lift weights weighing up to 50 pounds to perform the calibrations. Petitioner testified that he handled the weights an average of 2-3 hours per day. Petitioner also testified that he used various hand tools, including crimpers, wire cutting pliers, screwdrivers, and pipe wrenches, as well as calipers and thermocouple connectors requiring very forceful crimping and wire stripping. Petitioner further testified that he used pipe wrenches and power tools.

In 2002 a new program was introduced at the plant requiring Petitioner to manually enter data into a computer in addition to his other tool and gauge duties. Petitioner testified that, on average, he would spend 50% of his work time entering data on his computer. He testified that his data entry work varied from day to day; he might spend an entire week performing calibrations, then enter data the following week full-time. His supervisor, Chris Holloway, agreed that he might average up to 20 hours per week of data entry.

In 2007 or 2008 Petitioner was taken off the overtime schedule at his request. As a result, his maintenance/repair duties and use of vibratory tools were reduced to a small percentage of his overall duties. Notably, Respondent's counsel asked if his job since 2007 was highly repetitious and required repetitive heavy lifting, repetitive forceful gripping, and exposure to vibration. Petitioner responded affirmatively in response to each inquiry. Petitioner's supervisor, Mr. Holloway, was asked whether Petitioner's testimony concerning his job duties was accurate. Specifically, "[Petitioner testified] as to his job duties as of 2007 through about the present. Was that testimony accurate?...His description of what he was doing from 2007 to 2018?" Mr. Holloway agreed that Petitioner's testimony was accurate.

In 2015, his official job title changed to "calibration technician," but his job duties did not, and he continued to calibrate the scales and gauges throughout the plant. A motion study performed by Respondent noted that the plant contained 6,570 pressure gauges, temperature monitors, and weigh scales that required calibration, almost 5,000 of which required annual calibration, 526 required semiannual calibrations, 526 required quarterly calibrations; the remaining scales required multi-year calibrations.

Petitioner testified there were 2,601 calibrations performed in 2013, 2,078 in 2014 and 1,941 in 2015. He testified that he used 50-pound calibration weights to calibrate about a third of the scales. In so doing, he carried the weights, grasping them forcefully, and placed them gently and deliberately on the scale in increments until the calibration capacity of the scale was reached. Then he removed the weights in increments until the scale was empty. Petitioner acknowledged that not all the calibrations required Petitioner to lift heavy weights, but many required forceful, repetitious use of his upper extremities. On some of the equipment, he used a self-contained nitrogen charged pressure calibrator, which had to be connected with two threadlike connectors. On others, he had to forcefully strip and crimp thermocouple wiring and pull wires through conduit.

Petitioner underwent right shoulder surgery in November 2014 and was completely off work until March 23, 2015. He returned to work on light duty, restricted from lifting over 10 pounds with his right arm until October 2016. Petitioner testified that while on light duty, he continued to perform his usual tasks, using both upper extremities but lifting weights mainly with his left arm. He entered data as usual. The Commission notes that Petitioner is right-handed, but his NCS results were worse on his left side for both carpal and cubital tunnel.

Petitioner explained the activities during which he felt symptoms. He testified that his hands went numb when he was lifting the weights, when he was forcefully crimping and stripping wires or using hand tools, and when he was entering data. He also experienced numbness and tingling when he used his hands doing tasks at home. Petitioner testified that he might not use some of the hand tools frequently, but he was likely to use them for extended periods. At hearing, Petitioner testified that he believed he began observing carpal tunnel symptoms around 2013 or 2014 but did not know the cause of said symptoms. He did not report them to anyone or seek medical treatment for them until his left elbow became painful.

On October 28, 2015, Petitioner reported his left elbow symptoms to Respondent's on-site medical provider and his supervisor, David Harrison. Two days earlier, while entering data, he felt a sharp pain in his elbow and numbness from his elbow, to his hand; "like hitting your funny bone." Respondent's on-site medical provider gave Petitioner hand and elbow splints and ordered a course of physical therapy. Petitioner testified that this conservative care provided no relief from his symptoms.

Petitioner then sought medical treatment from Dr. Joon Ahn, an orthopedic surgeon, on November 16, 2015. Petitioner reported having numbness in all five digits, more so in the ulnar two digits, dropping things, and waking two to three times a night with upper extremity numbness and tingling, even with splinting and conservative treatment. Dr. Ahn diagnosed Petitioner with bilateral carpal tunnel and bilateral cubital tunnel syndromes. He ordered EMG/nerve conduction studies, which were performed on November 30, 2015. The results were positive for bilateral carpal tunnel and left cubital tunnel syndromes. In January of 2016, Dr. Ahn recommended surgery for Petitioner's bilateral carpal tunnel and left cubital tunnel syndromes.

At the direction of Respondent, Petitioner underwent a Section 12 examination on February 23, 2016 with Dr. David Brown, a plastic/hand surgeon. Dr. Brown reviewed Petitioner's medical records, a motion study of a calibration technician and a job description provided by Respondent. He also had a discussion with Petitioner about his job duties. Dr. Brown diagnosed Petitioner with bilateral carpal tunnel syndrome and left ulnar neuropathy. He recommended surgery for Petitioner's carpal tunnel syndrome and further conservative care for the left ulnar neuropathy. Dr. Brown opined that Petitioner's upper extremity conditions were not caused by his work activities because they were not highly repetitive and did not require forceful gripping, pinching, repetitive heavy lifting or sustained vibration exposure. He also noted Petitioner's age and elevated body mass were other risk factors.

On July 28, 2016, Petitioner's counsel sent a letter to Dr. Ahn requesting his opinion as to whether Petitioner's upper extremity conditions were work related. Attached to the letter was a detailed, four-page, job description (PX4) prepared by the Petitioner setting forth the duties he performed during his entire career with Respondent. Petitioner indicated therein that he began noticing his carpal tunnel symptoms around July of 2015 while at home and at work. Dr. Ahn replied to the letter, opining in a subsequent report that, if the Petitioner's job description were accurate, then his job duties were a contributing factor in the development of Petitioner's bilateral carpal and bilateral cubital tunnel syndromes.

Thereafter, Respondent forwarded the job description Petitioner created to Dr. Brown for his review. Dr. Brown noted in a supplemental report that the job description Petitioner created was a "different job" than the one Petitioner described during the February 23, 2016 examination. Dr. Brown opined that if the job description he received were accurate, the work activities would be a contributing factor to the development of Petitioner's bilateral carpal tunnel syndrome and his left ulnar neuropathy. However, if Petitioner's job duties were as reported to him on February 23, 2016, the injuries would not be work related.

Petitioner's treating physician, Dr. Joon Ahn, and Respondent's Section 12 examiner, Dr. David Brown, testified by way of deposition.

Dr. Ahn testified that carpal and cubital tunnel syndromes are multi-factorial conditions that are progressive and may take a long time to develop. He noted that Petitioner was a long-term employee at Respondent's plant and opined that he might have been experiencing "sub-clinical" symptoms for a long period before becoming symptomatic. Petitioner's NCS indicated mild to moderate disease, which Dr. Ahn believed may have taken months or years to develop. Dr. Ahn described the process of "micro-traumas" occurring over years as a result of various repetitive, forceful or vibratory work tasks, and he noted that there may be a disparity between the damage being done to a worker's carpal and cubital nerves and the symptoms he experiences. Dr. Ahn opined that the damage done by vibratory tools and forceful gripping connected with Petitioner's maintenance duties caused cumulative damage to his nerves, even though they occurred much less frequently after Petitioner's 2008 job change. Dr. Ahn further testified that Petitioner's continued calibration work and computer work were the "straw that broke [the] camel's back." Dr. Ahn agreed that Petitioner's BMI was high, and that obesity and aging can be non-occupational factors contributing to the development of carpal and cubital tunnel, but he opined that the repetitive micro-traumas Petitioner experienced and continued to experience, contributed to his injuries. To alleviate the conditions, Dr. Ahn recommended bilateral carpal tunnel releases, a left ulnar nerve release at the elbow and a repeat nerve conduction study for the right elbow.

Respondent's Section 12 examiner, Dr. Brown, disagreed with Dr. Ahn's causation finding, concluding that Petitioner's job duties did not put Petitioner at risk for developing repetitive stress injuries. He testified that the duties performed by Petitioner were not highly repetitive, involved no forceful gripping or pinching or heavy lifting, and did not expose him to vibrations. Dr. Brown based his opinion on the job description and motion study provided by Respondent and Petitioner's initial description of his duties during his Section 12 examination. He opined that if Petitioner's work activities were a contributing factor, his symptoms would have developed while he was performing the more physically demanding maintenance tasks. Dr. Brown would not have expected the symptoms to develop seven years later, after Petitioner had moved to doing primarily calibration work and data entry. Based upon the timing of the onset of symptoms and his conclusion that Petitioner's tasks were not sufficiently repetitive or forceful, Dr. Brown opined that the work tasks did not contribute to or aggravate Petitioner's carpal and cubital tunnel conditions.

II. CONCLUSIONS OF LAW

The Arbitrator denied all benefits, based upon his findings that Petitioner did not sustain repetitive trauma injuries arising out of and in the course of his employment with Respondent and that Petitioner's current state of ill-being is not related to his work activities. The Commission has considered the entire record and views the evidence differently. The Commission finds that Petitioner proved he sustained accidental injuries arising out of and in the course of his employment with Respondent on October 28, 2015, two days after he noticed pain in his left elbow while entering data.

In so concluding, the Commission finds several hearing exhibits detail the individual tasks performed by Petitioner and the tools he used in his work for Respondent over his 37 years of employment. Together with Petitioner's testimony about his job duties, which was corroborated by Mr. Holloway, and Dr. Ahn's description of Petitioner's upper extremity conditions as cumulative over a period of years, these exhibits document what the Commission finds to be repetitious and forceful, hand-intensive work over many years, rendering Dr. Ahn's opinions both plausible and persuasive.

Both Dr. Ahn and Dr. Brown agreed that Petitioner suffered from bilateral carpal tunnel syndrome and left cubital tunnel syndrome. Both doctors recommended carpal tunnel releases and further treatment for his left cubital tunnel syndrome. And both doctors agreed that if Petitioner's job duties involved extensive and repetitious use of hand drills, power tools and forceful gripping and twisting, such as those activities described in his four-page job description, his work activities could be a contributing factor to his diagnoses. The Commission finds Dr. Ahn's explanation of the effect of cumulative micro-traumas on Petitioner's condition reflects the precise type of gradual injury resulting in eventual breakdown found to be compensable in similar fact patterns. Dr. Ahn's opinions are more persuasive than those of Dr. Brown in this case, and the Commission finds that Petitioner proved that his work activities were sufficiently forceful and repetitive to have caused or contributed to cause his carpal and cubital tunnel conditions.

With regard to the issue of notice, the Commission finds that Petitioner provided timely notice to Respondent. He testified that he may have begun to feel numbness and tingling in both hands as early as 2013 or 2014, but he was unaware that these feelings were related to his repetitive work activities. His testimony that he reported his left elbow symptoms to his supervisor, David Harrison, on October 28, 2015, only two days after he suffered pain and tingling in his left arm while entering data on the plant computer was unrebutted. Petitioner's testimony that Respondent's on-site medical provider provided him with elbow and wrist splints is also uncontroverted. It is clear that Petitioner's physical condition worsened to the point that he needed medical attention, which he sought with Respondent's on-site medical provider, on October 28, 2015. His repetitive trauma injury manifested at this point and, thus, Commission finds that Petitioner has established that he provided timely notice to Respondent.

With regard to medical expenses, Respondent's denial of liability for medical care is based on its belief that Petitioner failed to sustain his burden of proof regarding accident and causal connection. Having herein reversed the Arbitrator's ruling and found accident and causal connection, the Commission now analyzes the reasonableness and necessity of Petitioner's medical care. Petitioner's initial treatment was administered by Respondent's on-site health services. The on-site clinic recommended physical therapy and the use of wrist and elbow splints, which Petitioner wore as instructed; however, Petitioner testified that these conservative measures provided no relief. Therefore, on November 16, 2015, Petitioner sought evaluation and treatment from Dr. Joon Ahn. The medical bills submitted into evidence are for evaluation and treatment rendered by Dr. Ahn and Dr. Nemani, who performed the nerve conduction study ordered by Dr. Ahn. Thus, the Commission finds that the submitted bills were reasonable and necessary for the treatment of Petitioner's work-related carpal and cubital tunnel conditions.

With regard to issue of prospective medical care, the Commission orders Respondent to authorize the treatment recommended by Dr. Ahn, specifically, the bilateral carpel tunnel releases, the left ulnar transposition surgery and the repeat nerve conduction study of Petitioner's right elbow. The Commission finds that the recommended treatment is reasonable and necessary to alleviate Petitioner from the effects of his work-related carpal and cubital tunnel conditions.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 24, 2018, in this matter, 16 WC 11059, is hereby reversed. The Commission finds that Petitioner sustained repetitive trauma injuries with a manifestation date of October 28, 2015 that arose out of and in the course of his employment, and Petitioner proved by a preponderance of the evidence that his current condition of ill-being is causally related to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical bills related to the diagnosis and care provided by Dr. Ahn and Dr. Nemani for Petitioner's bilateral carpal and cubital tunnel conditions, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay, according to the fee schedule, for Petitioner's bilateral carpal tunnel releases, his left ulnar nerve transposition surgery and the repeat nerve conduction studies of Petitioner's right elbow, as recommended by his treating physician, Dr. Ahn, pursuant to §8(a) and §8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980), but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

19IWCC0607

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 6 - 2019
o-09/12/19
mp/dak
68

Marc Parker

Barbara N. Flores

DISSENT

I respectfully dissent from the Decision of the majority. Whether Petitioner met his burden of proving a compensable work-related accident hinged on the validity of the four-page job description he authored after his Section 12 examination findings were communicated to him. Both Dr. Brown and Dr. Ahn agreed that Petitioner's condition was causally related to his repetitive work activities if the job description prepared by Petitioner was accurate. After carefully reviewing the entire record, I would have found that Petitioner failed to establish the accuracy of his self-prepared job description, and therefore, I would have affirmed and adopted the Decision of the Arbitrator.

At Petitioner's Section 12 examination on February 23, 2016, Dr. Brown reviewed a job description provided by Respondent and obtained information directly from Petitioner regarding his job duties. Dr. Brown opined that Petitioner's work activities as described did not put Petitioner at an increased risk for carpal tunnel syndrome or cubital tunnel syndrome. He indicated that the described activities were not highly repetitive in nature and did not require repetitive or sustained forceful gripping or pinching, repetitive heavy lifting, or sustained vibration exposure.

It was only after Dr. Brown's findings were communicated to Petitioner that he prepared the four-page job description, which stated that he had in fact participated in, among other things, very repetitive hand motions and the use of tools that involved squeezing, tightly gripping, pinching, twisting, lifting, pulling, pushing, prying, moving in awkward positions, etc. Dr. Brown subsequently indicated that this four-page job description conveyed an entirely different job than the one Petitioner initially described to him at his Section 12 examination on February 23, 2016.

Given that Petitioner's job descriptions changed dramatically from before and after the Section 12 examination, it is reasonable to conclude that Dr. Brown's opinions influenced the content of the four-page job description. The change in Petitioner's described job duties calls into question the credibility of the self-prepared job description, especially given that it differs from what Petitioner himself originally told Dr. Brown. The job description appeared to have been created by Petitioner in an attempt to fill in the gaps that Dr. Brown suggested needed to be shown in order to establish compensable repetitive activities.

At his February 13, 2017 deposition, Dr. Ahn acknowledged that his causal opinion could change if the job description prepared by Petitioner was not accurate and he could not recall if he ever had a conversation with Petitioner regarding his specific job activities. As such, Dr. Ahn's causal opinion loses persuasiveness if Petitioner's job description cannot be relied upon.

The entirety of Petitioner's case rested on his own self-prepared job description, which I would have found lacked credibility. For the reasons stated above, I respectfully dissent from the Decision of the majority and would have instead affirmed and adopted the Decision of the Arbitrator.

dls/met
46

Deborah L. Simpson
Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ILLINOIS WORKERS' COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DEPARTMENT,

Petitioner,

19IWCC0608

vs.

No: 19 WC 20269
10 INC 45

KATHY HAITAS, INDIVIDUALLY & PRESIDENT,
AGISSILAOS HAITAS, INDIVIDUALLY & SECRETARY,
HERMES & ASSOCIATES,

Respondents

DECISION AND OPINION ON PETITION FOR
FINES DUE TO INSURANCE NON-COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Department, brings this action, by and through the Office of the Attorney General, against the above captioned Respondents, alleging a violation of Section 4(a) of the Illinois Workers' Compensation Act. Proper and timely notice was provided to Respondents and a hearing was held before Commissioner Maria Portela in New Lenox, Illinois on 4/17/19. No one appeared on behalf of Respondents. Hermes & Associates was served with timely and proper notice.

Petitioner alleges that Respondent knowingly and willfully lacked workers compensation insurance coverage from 5/03/2003 to present in violation of Section 4(a) of the Illinois Workers' Compensation Act. Petitioner seeks the maximum fine allowed under the act, $500.00 per day for each of the 2,189 days Hermes & Associates did business and failed to provide coverage for its employees.

This Commission notes at the outset that on 12/3/18, Respondents, after proper and timely notice, were found to be in default and found to have knowingly and willfully failed to insure their liability to pay compensation in accordance with Section 4(a) of the Act.

The Workers' Compensation Commission Insurance Compliance Department Notice of Non-Compliance and Notice of Insurance Compliance Hearing states Kathy Haitas was not in compliance with the requirements of Section 4(a) of the act from 5/28/03 through present. After considering the entire record, the Commission finds that Respondent knowingly and willfully violated Section 4(a) of the Act and Section 7100.00 of the Rules Governing Practice before the Illinois Workers' Compensation Commission, from 5/28/03 to present. The Commission finds, after reasonable notice and hearing, Respondents knowingly and willfully failed or refused to comply with the provisions of Section 4(a) of the Act and 7100.00(b) of the Rules Governing Practice before the Illinois Workers' Compensation Commission. The Commission assesses a civil penalty under Section 4 of the Act in the sum of $1,093,141.00 against Respondents for the reasons set forth below:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Hermes & Associates Corporation filed for incorporation in IL on 5/17/2003, and were incorporated as a Domestic BCA. (PX 2). Respondents filed Domestic/Foreign Corporation Reports in 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, and 2014. (PX 7). Therefore, the Commission finds Respondents were operating as a business.

2. Employer Wage and Contribution Reports for Hermes & Associates indicate three workers, Kathy Haitas, Agissilaos Haitas and Anna Haitas received wages and were on payroll. (PX 8).

3. The Commission notes that PX 8 also contains a Quarterly Wage Correction Report for the quarter ending 12/31/2011, which includes the name of Dana Lynn Polk as an employee. However, this report is for a completely different company ("Heartland Health Systems Inc.") and has no bearing on our decision in this matter.

4. The Insurance Compliance Division sought the certification of the National Center for Compensation Insurance ("NCCI") to determine whether the Respondent had any workers' compensation policy. The returned certification from NCCI states that their records did not show proof of workers' compensation insurance for the period from 7/20/05 to 1/18/2010, and from 2/20/2013 to 4/21/2015. (PX 3). Respondents had filed for workers compensation insurance for period of 1/19/2013 to 1/19/2014 but filed cancellation effective on 2/19/13. (PX 3).

5. On 2/4/2010, Respondents Kathy Haitas and Agissilaos Haitas were duly served with a Workers' Compensation Insurance Coverage Notice of Non-Compliance. (PX 5).

6. As of 6/30/15, no IL Employers' Quarterly Withholding Income Tax Returns for June 2005 to June 2015 were processed. As of 6/30/15, no IL Corporation Income and Replacement Tax Returns for 2005 to 2014 were processed. (PX 7).

7. On 12/16/15, Respondents reached an Insurance Compliance Settlement Agreement with the IWCC to pay a fine of $10,000 for non-compliance with the requirements of 820 ILCS 305/4, with the first payment due 3/15/16 of $305.00, then 35 payments of $277.00 to follow. The settlement also required the Respondents to continue workers' compensation insurance coverage and pay all the benefits due and owing to any Petitioner(s) who has/have sustained compensable injuries during the period(s) of non-compliance. (PX 9). Respondents paid a total of $1,359 as of 6/21/2019.

8. On 8/8/2018, the Insurance Compliance division requested a search with the Illinois Workers' Compensation Commission, Office of Self-Insurance Administration. A certificate from Maria Sarli-Dehlin states that no certificate of approval to self-insure was issued by the Illinois Workers' Compensation Commission. (PX 4).

9. On 10/3/2018, Kathy Haitas and Agissiliaos Haitas were duly served with a Notice of Hearing scheduling an Insurance Compliance Hearing before the Commission on 12/3/18. (PX 1).

10. On 12/3/2018, Respondents failed to appear for the Insurance Compliance Hearing either on their own behalf or through legal counsel. Commissioner Charles DeVriendt issued an order of default against Respondents and continued the matter to 4/17/2019 for a hearing on the fines and penalties. (PX 1).

11. On 12/26/2018, Petitioner sent a Notice of Insurance Compliance Hearing for 4/17/2019 by certified mail to Respondent. The notice included the order of default entered on 12/3/18. (PX 1). The notice also indicated that the hearing was to address non-compliance with the mandatory insurance coverage provisions of the Illinois Workers' Compensation Act during the period from 5/28/2003 to present during periods of business as applicable. (PX 1).

12. Respondents failed to appear on 4/17/2019 either on their own behalf or through legal counsel. A hearing took place before Commissioner Portela and a record was made.

19IWCC0608

13. The Commission finds Respondents are in violation of the Illinois Workers' Compensation Act because they are operating as a business, with employees, and without proper Workers' Compensation Insurance.

Through this case, the Commission can deter other businesses from disregarding the insurance laws of this State by exacting a severe penalty commensurate with the conduct of Kathy Haitas, Agissilaos Haitas and Hermes & Associates. For the foregoing reasons, and after considering the entire record, the Commission finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act under Section 3 and was an employer during the periods of non-compliance. The Commission finds that Respondents have knowingly and willfully failed to comply with the requirements of Section 4(a) of the Act and shall be assessed penalties under Section 4(d) of the Act. The Commission finds Respondents knowingly and willfully were in non-compliance with Section 4 of the Act for a period of 2,189 days and shall pay a penalty of $1,094,500.00 under Section 4 of the Act, with a credit for $1,359.00 already paid by Respondent from the $10,000.00 Insurance Compliance Settlement Agreement.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents, Kathy Haitas, Individually & President, Agissilaos Haitas, Individually & Secretary, Hermes & Associates, shall pay to the Illinois Workers' Compensation Commission the sum of $1,093,141.00 pursuant to Section 4(d) of the Act.

Bond for the removal of this case to the Circuit Court by respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 7 - 2019

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn A. Doerries

R: 4/17/19
49

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☐ 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

SCOTT RUSSELL NEWELL,

Petitioner,

19IWCC0609

vs.

NO: 18 WC 14643

TITAN WHEEL, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's award up from 12.5% loss of person as a whole to 15% loss of use of person as a whole. In determining Petitioner's permanent partial disability, the Commission weighs the five factors listed in §8.1b of the Act differently than the Arbitrator, as explained below:

1) No impairment rating was submitted, so this factor is given no weight.

2) Petitioner worked as a metrologist and was able to return to his prior position, though he credibly testified he now needs assistance to perform some of his tasks in the form of a hoist, helper, tow motor, or aide. (T. 24) This factor is given greater weight.

3) Petitioner was 54 years old at the time of the accident and arguably, has several working years in his future. This factor is given some weight.

19IWCC0609

4) There is no evidence that Petitioner's future earning capacity has been impacted as he has returned to the same job he held pre-injury. This factor is given no weight.

5) The Petitioner's disability is corroborated by the medical records. Although Petitioner was discharged as to his work injury by June 7, 2017, he did tell his physician on discharge he was having residual soreness in the shoulder on occasion. Petitioner's injury involved a biceps tendon tenodesis, along with other significant pathologies. Additionally, Petitioner returned to his primary physician in October of 2017 with problems to his left elbow which he had been having since the surgery. This factor is given greater weight.

Based on the above analysis, the Commission finds that Petitioner is entitled to permanent partial disability benefits of 15% of the person as a whole, as provided in §8(d)2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $505.05 per week for a period of 2 2/7 weeks, from February 9, 2017 through February 24, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $454.54 per week for a period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,305.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 7 - 2019

Maria Elena Portela

Maria E. Portela

Thomas J. Tyrrell

MEP/dmm
O:100819
49

19IWCC0609

DISSENT

I would affirm and adopt the Arbitrator's award of permanent partial disability benefits of 12.5% loss of use of a person as a whole. The medical records show Petitioner sustained a left shoulder injury that resulted in an arthroscopy of the left shoulder with extensive debridement with chondroplasty of glenoid and removal of loose bodies and debridement of partial supraspinatus rotator cuff tear, arthroscopic acromioplasty, arthroscopic clavicle excision and subpectoral bicep tenodesis, which was performed on February 9, 2017. PX5. On February 24, 2017, Petitioner reported to his treating doctor, Dr. Smith, he was doing well and that his pain was controlled without medication. On that date, Petitioner was released to return to light duty work with limited use of his left upper extremity. PX5. He began a three-month course of physical therapy and on April 7, 2017, he reported to his treating doctor that he was back to regular duty. PX5.

Petitioner retuned to Dr. Smith on June 7, 2017, and reported he was doing well, and he experiences just a little soreness on the shoulder occasionally. PX5. On examination, his range of motion and strength were good and testing was negative. Dr. Smith noted Petitioner is able to perform his daily activities with no problems. PX5. Further, he was pleased with how well Petitioner had done and that he had a good outcome with his surgery. Petitioner was released from care. PX5.

Petitioner testified at Arbitration he can lift up to 100 pounds, but not for very long. He continues to experience pain 1/10 on a regular basis but does have periods where he has no pain. Petitioner continues to perform his regular job as a metrologist for Respondent. T.23.

The majority cites to Petitioner's complaints to his left elbow which he reported to his treater in October of 2017. PX2. There is no evidence Petitioner sought ongoing medical care relative to the left elbow nor is there evidence he sustained loss of motion or permanent disability associated with the left elbow to justify an increase in permanency.

Based on the foregoing, I would affirm and adopt the Arbitrator's award of 12.5% loss of use of a person as a whole for the injury sustained to Petitioner's left shoulder as a result of the work-related accident.

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEWELL, SCOTT RUSSELL
Employee/Petitioner

Case# **18WC014643**

TITAN WHEEL INC
Employer/Respondent

19IWCC0609

On 4/30/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICES PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0265 HEYL ROYSTER VOELKER & ALLEN
DANIEL SIMMONS
3731 WABASH AVE
SPRINGFIELD, IL 62711

19IWCC0609

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

☐ 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

SCOTT RUSSELL NEWELL
Employee/Petitioner

v.

TITAN WHEEL, INC.
Employer/Respondent

Case # **18** WC **14643**

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 **Quincy**, on **February 6, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 24, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,393.64**; the average weekly wage was $**757.57**.

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

Respondent shall be given a credit of $**1,040.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,040.00**.

ORDER

As explained in the Arbitration Decision, Respondent shall pay Petitioner temporary total disability benefits of **$505.05 per week** for **2 2/7 weeks**, from February 9, 2017, through February 24, 2017, for a total of **$1,154.40**. Respondent shall receive credit for prior payments made of **$1,040.00**, leaving an underpayment and balance due of **$114.40**.

Respondent shall pay Petitioner the sum of **$454.54 per week** for a further period of **62.5 weeks**, as provided in **Section 8(d)2**, because the injuries sustained caused a **12.5% loss of use of the body as a whole**.

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

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

Signature of Arbitrator

April 25, 2019
Date

APR 30 2019

STATE OF ILLINOIS)
) SS
COUNTY OF ADAMS)

19IWCC0609

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SCOTT RUSSELL NEWELL
Employee/Petitioner

v. Case #: 18 WC 14643

TITAN WHEEL, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on August 24, 2016, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in injury to his left shoulder which required surgery. The parties further stipulated that all medical bills had been paid by Respondent and that Petitioner's average weekly wage was $757.57. The parties agreed that following surgery Petitioner was temporarily and totally disabled from February 9, 2017, through February 27, 2017, and that Respondent paid benefits in the amount of $1,040.00. At issue at the time of trial was an alleged underpayment of TTD benefits and the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 54 years old, married, and had no dependent children. He was employed by Respondent as a metrologist and had been so employed for more than 30 years. He testified that on August 24, 2016, he and a co-worker were lifting an "inspection mandrel" from a box when he felt a pop and burning sensation in his left shoulder. He explained that the mandrel is a metal template that is used to ensure that wheel hubs are being manufactured correctly. It is about 30 inches in diameter and weighs about 200 pounds.

Petitioner testified that he received initial treatment through Respondent's Family Wellness Center (PX2), who referred him for physical therapy. He underwent therapy from September 9, 2016, through September 21, 2016, (PX3, PX4), which resulted in minimal to no change in his condition.

On October 14, 2016, Petitioner underwent an MR Arthrogram of the left shoulder. It revealed a posterior glenoid labrum tear, moderate tendinosis of the anterior infraspinatus and supraspinatus without evidence of tear, and mild osteoarthritis of the glenohumeral joint. PX4.

On December 5, 2016, Petitioner presented to Dr. Adam Derhake at Quincy Medical Group, who reviewed the MR Arthrogram. Dr. Derhake recommended a left shoulder subacromial injection and, if no improvement, he would then recommend surgery. PX4.

Petitioner testified that he decided against the injection, and sought a second opinion from Dr. Patrick Smith, an orthopedic surgeon in Columbia, Missouri, who had operated on his right shoulder in 2013.

Petitioner presented to Dr. Smith on February 1, 2017, who noted that he had previously performed surgery on Petitioner's opposite shoulder. Petitioner reported a consistent history of the accident and his treatment to date. On examination, there was tenderness to palpation over the upper biceps area, painful range of motion, positive Neer and Hawkins impingement tests, and positive O'Brien's test. Dr. Smith reviewed x-rays and the MR Arthrogram previously done. He opined that Petitioner had a significant labral tear superiorly, extending posteriorly, as well as impingement syndrome and supraspinatus tendinopathy. He did not believe that a steroid injection was going to help and instead recommended surgery. PX5.

On February 9, 2017, Petitioner underwent surgery by Dr. Smith. Procedures included (1) arthroscopy of the left shoulder with extensive debridement with chondroplasty of the glenoid and removal of loose bodies and debridement of a partial supraspinatus rotator cuff tear; (2) arthroscopic acromioplasty; (3) arthroscopic distal clavicle resection; and (4) sub-pectoral biceps tenodesis. PX5.

Intraoperatively, Dr. Smith noted that Petitioner had an unstable SLAP type II lesion, which he did not feel was repairable. As such, he performed a biceps tenodesis which consisted of removal of the intraarticular portion of the biceps off of the superior labrum for a sub-pectoral biceps tenodesis. He also shaved off the fraying of the labrum. Dr. Smith also noted a significant area of unstable grade 4 chondromalacia of the inferior glenoid, down to the bone, with loose chondral fragments. There was also partial tearing of the supraspinatus towards its attachment at the greater tuberosity involving approximately 50% of the rotator cuff. For these findings, Dr. Smith performed a chondroplasty of the glenoid labrum, smoothing off the anterior inferior glenoid, removed the loose chondral bodies present, and also shaved and debrided the partial supraspinatus rotator cuff tear. Dr. Smith also noted signs of impingement with spurring through the anterior inferior acromion and inferiorly in the distal clavicle. He released the coracoacromial ligament to remove 3mm to 4mm of acromion bone; he also removed 7mm to 8mm of the distal clavicle bone. Finally, in performing the sub-pectoral biceps tenodesis, a 3-centimeter incision was made. As the biceps tendon had already been freed, Dr. Smith cut off all but 15mm from the musculotendinous junction of the biceps tendon, through which he placed an Anthrex FiberLoop to obtain good "purchase" of the biceps tendon. The bicipital groove was exposed with electrocautery and bone was debrided. He then drilled a hole at the lower portion of the bicipital groove for the Anthrex biceps button through which the Anthrex sutures were passed and secured. PX5.

Petitioner followed up with Dr. Smith on February 24, 2017, and reported that he was doing well and that his pain was controlled without medication. Dr. Smith went over his operative findings in detail at that time, and they reviewed the operative video as part of the

explanation. Dr. Smith allowed Petitioner to start going without the shoulder immobilizer, to work on range of motion of the shoulder and the elbow. Petitioner was referred to physical therapy for three days a week and was released to return to light duty work, with limited use of his left upper extremity. PX5.

On February 27, 2017, Petitioner presented to First Choice Physical Therapy for an initial evaluation. He reported that his pain at that time was 2/10, and that his pain otherwise was at 1/10 at its best and 9/10 at its worst. He reported difficulty sleeping, reaching, dressing, and lifting or reaching at the shoulder level. He demonstrated significant deficits in left shoulder strength and range of motion. Petitioner underwent physical therapy throughout March. PX6.

On April 7, 2017, Petitioner returned to Dr. Smith and reported he was attending therapy three times a week and was making progress, but still had soreness which affected his sleep at night. He also reported that he was back to regular duty work. On examination, there was noted to be postoperative residual weakness. Dr. Smith recommended continued physical therapy, specifically for strengthening, and allowed Petitioner to continue regular duty work. PX5.

Petitioner underwent physical therapy throughout the months of April and May, with his final treatment on June 2, 2017. The Discharge report of June 7, 2017, notes that Petitioner's pain level improved from 1/10 to 0/10 at its best, and from 9/10 to 3/10 at its worst. It was noted that he continued to have aching and stinging associated with sleeping, dressing, lifting, and activities of daily living. He also had mild limitations with sleeping (could not sleep on his left side) and with reaching overhead. PX6. The Arbitrator notes that Petitioner testified his current subjective complaints of pain are the same as when he was discharged from physical therapy.

On June 7, 2017, Petitioner returned to Dr. Smith and reported he was doing well. He still experienced a little soreness in the shoulder occasionally, was not taking pain medication, and was doing home exercises. He noted that his pain level and strength were good, and that he was able to do his daily activities with no problems. On examination, range of motion and strength were good, and testing was negative. Dr. Smith stated that he was pleased with how well Petitioner had done and that he had had a good outcome with his surgery. It was noted that he was continuing to work full duty. Dr. Smith released Petitioner from care and advised him to return if he had further difficulty. PX5. The Arbitrator notes this is the final treatment record.

With regard to his current condition, Petitioner testified that he continues to experience a burning pain when he moves his left arm through the extremes of range of motion and over his head. He stated that the pain is in his shoulder and biceps. He continues to experience pain of 1/10 on a regular basis, but does have periods where he has no pain. He stated that his worst pain is 3/10. He testified that he has a burning pain when working with his left arm over his head for a length of time, and that he can only reach up three inches above his waist line when reaching around his back. He can lift up to 100 pounds, but not for very long, and he gets a burning sensation if he lifts heavy weights. He testified that he has pain while sleeping, which is an ongoing problem, but does not have pain all of the time. Petitioner testified that he no longer lifts heavy items such as the inspection mandrel without assistance or the use of a hoist or a forklift.

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 (K), Petitioner's entitlement to alleged underpayment of temporary total disability, the Arbitrator finds the following:

The parties agreed and stipulated that Petitioner was temporarily and totally disabled from February 9, 2017, through February 27, 2017, a period of 2 2/7 weeks. The parties further stipulated that Petitioner's average weekly wage was $757.57, and that Respondent had paid TTD benefits in the amount of $1,040.00.

The Arbitrator finds that Petitioner's temporary total disability rate is $505.05 and that he is entitled to TTD benefits in the amount of $1,154.40. The Arbitrator further finds that Respondent underpaid TTD benefits in the amount of $114.40 ($1,154.40-$1,040.00) and is liable for payment of same.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although Petitioner's date of accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to Subsection (a). As such, the Arbitrator places no weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that Petitioner was employed as a metrologist at the time of the accident, had been so employed for 30 years, and that he was able to return to work in that capacity without any restrictions from Dr. Smith as a result of said injuries. He testified that he now lifts with help or uses a hoist when having to lift very heavy items. The Arbitrator places greater weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 54 years old at the time of the accident. The Arbitrator notes that he has approximately 10 to 13 more work years ahead of him, during which time he must deal with his disability. Over time, his condition could improve, stay the same, or get worse. The Arbitrator places greater weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to his same position with Respondent. There was no evidence that his future earning capacity has

been or will be impacted as a result of this injury. As such, the Arbitrator places no weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner sustained a left shoulder injury that resulted in surgery. The procedures performed included (1) arthroscopy of the left shoulder with extensive debridement with chondroplasty of the glenoid and removal of loose bodies and debridement of a partial supraspinatus rotator cuff tear; (2) arthroscopic acromioplasty; (3) arthroscopic distal clavicle resection; and (4) sub-pectoral biceps tenodesis. He underwent postoperative physical therapy for more than three months. By all accounts, he was diligent in his own recovery and, in fact, returned to full duty work before he was released by Dr. Smith to do so.

Dr. Smith's note following Petitioner's final visit of June 7, 2017, documents that he was doing well, with occasional soreness in the shoulder. His pain level and strength were good, and he was able to do his daily activities with no problems. On examination, range of motion and strength were good, and testing was negative. Dr. Smith stated that he was pleased with how well Petitioner had done and that he had had a good outcome with his surgery.

Petitioner testified that he continues to experience a burning pain in his left shoulder and bicep when he moves his arm through the extremes of range of motion and over his head. He noted pain of 1/10 on regular basis and 3/10 at its worst, but noted that he sometimes has periods of no pain. He testified that he has a burning pain when working with his left arm over his head for a length of time, and that he can only reach up three inches above his waist line when reaching around his back. He can lift up to 100 pounds, but not for very long, and he gets a burning sensation if he lifts heavy weights. He testified that he has pain while sleeping, which is an ongoing problem, but does not have pain all of the time. He testified that he no longer lifts heavy items such as the inspection mandrel without assistance or the use of a hoist or a forklift.

The Arbitrator notes that Petitioner's testimony is generally consistent with his treating records, including the physical therapy discharge report, though all of his current complaints are not specifically detailed in Dr. Smith's final treatment record. However, the Arbitrator found Petitioner to be very credible and forthright in his testimony with regard to his current complaints, which are found to be consistent with the surgical procedures that he underwent. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 12.5% loss of use of the body as a whole (62.5 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $757.57. The Arbitrator finds his permanent partial disability rate is $454.54.

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

☒ 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

RICK KENT,
Petitioner,
vs.

NO: 16 WC 3870

HCC, INC.,
Respondent.

19IWCC0610

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, temporary total disability, and permanent partial disability, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 2018 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 8 - 2019

D. Douglas McCarthy

DDM/tdm
D: 11/6/19
052

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KENT, RICK
Employee/Petitioner

Case# **16WC003870**

HCC INC
Employer/Respondent

19IWCC0610

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

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

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

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT ULRICH
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rick Kent
Employee/Petitioner

v.

HCC Inc.
Employer/Respondent

Case # **16** WC **3870**
(Consolidated cases:

19IWCC0610

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Ottawa on December 29, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 15, 2015,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,016.00**; the average weekly wage was **$808.00**.

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

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

Respondent ***owes*** for all appropriate charges for all reasonable and necessary medical services for which they are liable.

To date, Respondent has paid **$2,164.00** 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 **$2,154.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,154.68.**

Respondent is entitled to a credit of **$2,176.82** under Section 8(j) of the Act.

ORDER

Medical Benefits

Respondent shall pay the bills totaling **$90,845.46**, subject to the fee schedule and pursuant to §8 and §8.2 of the Act and subject to credit for any payments made by respondent directly or pursuant to §8 j of the Act.

Temporary total disability

Petitioner is entitled to temporary total disability from December 24, 2015 to January 21, 2016; March 31, 2016 to June 13, 2016; and April 25, 2017 to June 22, 2017, which is 23-2/7 weeks @ $538.67 per week.

Permanent Partial disability

Petitioner is entitled to 52.25 weeks @ $484.00 per week as petitioner's permanent disability has resulted in 15% loss of use of the right hand + 12-1/2% loss of use of the left hand under §8 (e) 9 of the Act.

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

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

Christine May

Signature of Arbitrator

November 1, 2018

Date

NOV 5 - 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rick Kent **Petitioner,**	)	
vs.	)	**No. 16 WC 3870**
HCC, Inc. **Respondent.**	)	**19IWCC0610**

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

This matter was heard in Ottawa on December 28, 2017. The parties agree that on December 15, 2015, petitioner and respondent were operating under the provisions of the Illinois Workers' Compensation Act; that petitioner earned $42,016.00 in the year pre-dating the claimed accident; and that his average weekly wage, as calculated pursuant to § 10 of the Act, was $808.00.

At issue in this case is:

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

STATEMENT OF FACTS

Petitioner, Rick Kent Testimony

Petitioner testified he had been employed by respondent for 21 years. His first job was a robotic welder, which required loading fixtures, clamping and welding them. The next position was in the Gateway department. There he put together connectors.

The last job he worked, which is the job he was working on December 15, 2015, was as an engineering lab tech. In that job, he made parts for prototypes; clamping them together. He would weld and grind, using air tools. He worked with his hands. He estimated he spent 50% of his time manually clamping on parts, 20% grinding with a drill and 15% putting bolts on with hand tools. The job required drilling into aluminum at least 500 holes per day. He was the only engineering lab tech.

Petitioner testified that he had been living with pain in his hands for about three years. On December 15, 2015, while working as an engineering lab technician he was doing a lot of drilling

and noticed a lot of pain in his wrist. He reported the problem to his supervisor, Jim Legner. He was sent by respondent's safety person to IVCH.

On December 24, 2015, petitioner was seen by Dr. Rhode for right and left pain; right worse than left. He also had numbness in both elbows. He was put on five-pound weight-lifting restriction. He was seen again by Dr. Rhode on January 21, 2016.

On January 27, 2016, he was examined by Dr. Vender under §12. The exam took ten minutes. Dr. Vender never asked petitioner about his job. He looked at petitioner's hand for only one or two minutes. Dr. Vender never asked petitioner to look at the video. Dr. Vender discussed the need for carpal tunnel surgery.

Petitioner underwent a carpal tunnel release on April 25, 2017. On June 22, 2017 he was released to return to work. His last visit was on July 20, 2017.

Petitioner testified that he begins working at 6 and by 10 he has soreness and numbness in his hand. Despite surgery, he has lost strength in his grip.

Steven Romagnoli Testimony

Steven Romagnoli testified in behalf of petitioner. Romagnoli had been employed by respondent for fourteen years. He started as a welder. He was then moved to robotics and now works as an engineering lab tech. The job includes assembly, welding and drilling holes. The job requires him to use his hands all day. The drill press requires use of both hands; there is vibration from the drills.

Romagnoli viewed respondent's video tape and disagreed that it truly depicted the job of engineering lab tech.

Medical Bills (PX.1)

Petitioner claims the following bills are related to his claim:

$601.00 Illinois Valley Community Hospital-12/15/2015
$46.00 Dr. Merle A. Piacenti MD-12/15/2015
$1,676.00 St. Mary Clinic – 01/18/16
$43,077.73 Orland Orthopedics – 12/24/2015 to 07/20/2017
$14, 505.40 South Chicago Surgical Solutions – 4/25/2017
$14,505.40 South Chicago Surgical Solutions – 3/15/2016
$3,907.10 Bob Rady Inc. – 3/15/16 & 4/25/17
$14,229.76 Mendota Community Hospital -03/08/2016 to 9/26/2016
$270.00 Rockford Health Systems – 3/1/2016
$642.49 RX Development Associates – 6/23/2017
$50.58 Infinite Strategic Innovations – 6/23/2017

Illinois Valley Community Hospital Records (PX.2)

Petitioner was seen on December 15, 2015 and provided a history of being very busy the last six months at work and complaining of pain in right wrist and hand with movements, along with numbness and tingling down fingers. He reportedly had lost strength and was now dropping things. He described the pain as sharp which kept him up at night. He also complained of pain in the left wrist and hand; but it was not as bad as the right. He is ambidextrous. X-rays of the wrist showed degenerative changes about the first metacarpal-multiangular joint. Diagnosis was right wrist overuse syndrome

OSF St. Paul Medical Center Records (PX.3)

Petitioner received physical therapy and pre-op tests at Mendota Hospital.

Orland Park Orthopedics/Dr. Blair Rhode Records (PX.4)

Petitioner was first seen by Dr. Rhode on December 24, 2015. He reported bilateral wrist repetitive exposure injury. Petitioner reported it began in October, 2015 but that the symptoms had worsened over the past two weeks. He reported his job required a significant amount of drilling and putting on bolts. Dr. Rhode noted petitioner was exposed to highly repetitive work as a lab tech operating drills and manipulating object such as bolts and concluded petitioner had evidence of work-related bilateral carpal and cubital tunnel syndrome. He was put on light duty and an EMG was ordered.

December 30, 2015 he was seen again by Dr. Rhode for bilateral elbow and wrist pain. Dr. Rhode opined that petitioner's tests were positive for work related bilateral cubital and carpal tunnel syndrome. Petitioner was ordered off work and to follow up after the EMG.

The January 18, 2016 EMG was negative except for evidence of mild right carpal tunnel syndrome.

Petitioner returned to Dr. Rhode on January 21, 2016. Dr. Rhode confirmed petitioner's condition as bilateral work-related carpal tunnel and cubital tunnel syndrome; with EMG showing evidence of right carpal tunnel condition. Treatment options were discussed. Petitioner was awaiting an IME before proceeding with treatment.

Petitioner was seen again on by Dr. Rhode on February 4, 2016, after seeing Dr. Vender for an IME which determined petitioner was a candidate for carpal tunnel surgery, but that the condition was not work-related.

Petitioner was seen on March 31, 2016 for follow up of carpal tunnel release done approximately 10 days earlier. He was seen by PA Bordick on April 29, 2016; OT program was prescribed. He followed up on May 12, 2016; OT continued.

On Jun 9, 2016, petitioner's condition was stable. He was released to return to full duty work as of June 13, 2016 and was to follow up in four weeks to consider MMI. On July 21, 2016 petitioner reported he had symptoms after returning to full duty work and being put through the wringer. He was released at MMI and to return as needed.

Petitioner returned to Dr. Rhode on April 3, 2017 due to intolerable left wrist pain. He was to continue full duty until surgery scheduled. He was seen on June 8, 2017, for follow up post left wrist surgery. On June 22, 2017 petitioner was released to return to full-duty work and to return in four weeks to be released from care. On July 20, 2017, petitioner was released from care having reached MMI.

[The March 11, 2016 and April 25, 2017 operative reports by Dr. Blair Rhode are part of Petitioner's Exhibit 1]

St. Margaret's Health System: Neurology Clinic Records (PX.5)

The January 18, 2016 EMG done by Dr. Angela Benavides

Dr. Robert Eilers November 14, 2016 Evaluation Report (PX.6)

Dr. Eilers evaluated petitioner and authored a report on November 14, 2016. Dr. Eilers noted petitioner had worked for respondent for 20 years in robotic welding and opined that petitioner's bilateral carpal tunnel syndrome was the result of petitioner's repetitive work activities.

Photos (PX.7)

Photos of the parts petitioner worked on at respondent.

Employee Statement of Information (RX.1)

Petitioner completed a report on December 11, 2015 indicating he was working on assembly of tines on hook that occurred on December 11, 2015. He had complaints of right wrist, numbness of fingers, pain in wrist. Left not as bad.

Illinois Valley Community Hospital December 15, 2015 Record (RX.2)

This is part of Petitioner's exhibit 2.

St. Margaret Hospital/Dr. Angela Benavides January 18, 2016 EMG Report (RX.3)

This is the same as Petitioner's Exhibit 5 and included in Petitioner's Exhibit 4.

Hand to Shoulder Associates/Dr. Michael Vender January 27, 2016 Report (RX.4)

Dr. Michael Vender examined petitioner and reviewed medical records along with a video tape of an individual performing petitioner's job and job description. Dr. Vender indicated the EMG showed significant carpal tunnel syndrome on the right and ulnar nerve change at the left elbow, but did not believe there was any clinically-significant ulnar neuropathy at the left elbow. Dr. Vender believed carpal tunnel surgery was appropriate.

Dr. Vender did not find the five work activities as depicted on the video were not forceful and appeared to be routine. Dr. Vender, therefore, concluded petitioner's carpal tunnel condition was not caused by the work activity.

Dr. Blair Rhode June 13, 2016 Report (RX. 5)

This was included as part of Petitioner's Exhibit 4.

Dr. Blair Rhode August 10, 2016 Report (RX.6)

This was included as part of Petitioner's Exhibit 4.

Video (RX.7)

The video shows four women assembly a device. They used some drills and hammers.

Video (RX.8)

The video shows the same type of assembly as depicted in Respondent's Exhibit 7.

CONCLUSIONS OF LAW

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

C. With respect to the issue of whether an accident occurred that rose out of and in the course of petitioner's employment with respondent, the Arbitrator makes the following conclusions of law:

Petitioner proved, by clear and convincing evidence, that his bilateral carpal tunnel condition was caused by a repetitive accident that arose out of and in the course of his employment

with respondent on December 15, 2015. The Arbitrator considered the testimony of the petitioner and co-worker, Steve Romagnoli, as to the nature of the job of engineering lab tech that petitioner was performing when he was injured on December 15, 2015. The Arbitrator also considered the history contained in IVCH medical records, petitioner's history to and opinion of Dr. Blair Rhode and the opinion of Dr. Robert Eilers in reaching this conclusion.

The Arbitrator discounted Dr. Michael Vender's opinion as his opinion was based upon a video that by all accounts did not accurately portray petitioner's job duties. The videos introduced by respondent showed four women working on a line. The women performed some drilling. However, petitioner testified that only one person performed the job of engineering lab tech, which does not correlate with respondent's videos. Furthermore, petitioner introduced photos of the parts he was working on appears to be different than the parts depicted in respondent's videos.

F. With respect to the issue of whether petitioner's condition of ill-being is causally related to the claimed accidental injuries, the Arbitrator makes the following conclusions of law:

Petitioner testified he had been living with pain in his hands for about three years. In the six months before December 15, 2015, petitioner noticed he was having more and more problems. In the two weeks leading up to December 15, 2015 he was doing a lot of drilling.

The records from IVCH confirm petitioner's testimony and diagnosed right wrist overuse syndrome. Dr. Rhode determined petitioner's highly repetitive work of drilling and putting on bolts caused the bilateral carpal tunnel and cubital tunnel condition. Dr. Eilers, who examined petitioner at his own request, confirmed the bilateral carpal tunnel condition was caused by petitioner's repetitive work for respondent.

Based upon the foregoing, the Arbitrator finds, by clear and convincing evidence, that petitioner's bilateral carpal tunnel condition was caused by the repetitive work accident of December 15, 2015.

The Arbitrator makes this determination despite the opinion of Dr. Michael Vender. The Arbitrator determined Dr. Vender's opinion was not credible as it relied upon a video that did not accurately depict petitioner's work.

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

Based upon the evidence, the Arbitrator finds the following medical bills, totaling $90,845.46, were reasonable and necessary to treat petitioner of his work injury, and awards same to be paid in accordance with §8 and §8.2 of the Act, and with credit to be given to respondent for all payments made directly or pursuant to §8j of the Act:

$601.00 Illinois Valley Community Hospital-12/15/2015
$46.00 Dr. Merle A. Piacenti MD-12/15/2015
$1,676.00 St. Mary Clinic – 01/18/16
$43,077.73 Orland Orthopedics – 12/24/2015 to 07/20/2017
$14, 505.40 South Chicago Surgical Solutions – 4/25/2017
$14,505.40 South Chicago Surgical Solutions – 3/15/2016
$3,907.10 Bob Rady Inc. – 3/15/16 & 4/25/17
$11,563.76 Mendota Community Hospital -03/08/2016 to 06/09/2016 (only)
$270.00 Rockford Health Systems – 3/1/2016
$642.49 RX Development Associates – 6/23/2017
$50.58 Infinite Strategic Innovations – 6/23/2017

K. In support of the Arbitrator's decision with regard to temporary benefits, the Arbitrator makes the following conclusions of law:

The evidence supports a finding that petitioner was off work as stipulated from December 24, 2015 to January 21, 2016; March 31, 2016 to June 13, 2016; and April 25, 2017 to June 22, 2017, which is 23-2/7 weeks. The Arbitrator therefore awards 23-2/7 weeks at $538.67 per week.

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

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

With regard to subsection (i) of §8.1b (b) the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, the Arbitrator can give no weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner is employed as an engineering lab tech that requires extensive use of his hands. Therefore, the Arbitrator gives more weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 56 years of age. Therefore, the Arbitrator gives less weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes petitioner was able to return to work at his regular salary; thus there is no evidence of loss of future earning capacity. The Arbitrator therefore gives no weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes at the time he was released from Dr. Rhode's care on July 20, 2017, petitioner had no pain in the right wrist and only minimal pain in the left wrist; also petitioner was working at his regular position. The Arbitrator, therefore, gives less weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right hand and 12-1/2% loss of use of the left hand pursuant to § 8 (e) 9 of the Act.

M. In support of the Arbitrator's decision with regard to penalties and attorney's fees, the Arbitrator finds the following:

Respondent relied upon the opinion of Dr. Vender in disputing petitioner's claim. Although Dr. Vender's opinion is not sufficient to defeat the claim for benefits, the reliance by respondent on Dr. Vender's opinion is sufficient to defeat the claim for penalties and attorney's fees. For this reason, the Arbitrator denies the claim for penalties and attorney's fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ 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

Joaquin Ortiz-Martinez,

Petitioner,

vs. NO: 17 WC 21046

BCH Emerald, LLC,

Respondent.

19IWCC0611

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator's finding Petitioner did not sustain an accident arising out of and in the course of employment on April 25, 2017 and affirms the denial of his claim for compensation, medical expenses, prospective medical care, penalties and attorneys' fees. The Commission finds the contemporaneous medical records do not support Petitioner's testimony. On May 2, 2017, Dr. Castellanos saw Petitioner who complained of knee effusion and left leg pain. Dr. Castellanos noted, "Ecchymosis unexplainable at this point as no evidence of trauma." There was no mention of an accident. PXA. On May 6, 2017, Dr. Castellanos noted Petitioner reported no pain and the bruising from the calf extending to the left heel had resolved for the most part. Dr. Castellanos noted, "Once again, when asked, patient denies any specific trauma indicated that this occurred incidentally as he was kneeling 2 weeks ago." Again, there was no mention of an accident. On examination, the left knee had full range of motion and there was no tenderness of the patella. PXA.

The Commission modifies the Arbitrator's decision and vacates the credit to Respondent for $6410.24 paid in temporary total disability benefits and $17,505.00 for medical expenses. Section 8(j) of the Act allows for credit for benefits paid where compensation is awarded. Since no compensation has been awarded, the credit is inapplicable. The Commission finds such amounts were paid by Respondent.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's October 19, 2018 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained an injury arising out of and in the course of his employment, his claim is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the credit of $6,410.24 for temporary total disability benefits and $17,505.00 for medical expenses is vacated.

Pursuant to Section 19(f)(2) of the Act, no bond is required as no award for the payment of money has been rendered. The 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 8 - 2019
LEC/maw
o09/11/19
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen J. Mathis

D. Douglas McCarthy

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ORTIZ-MARTINEZ, JOAQUIN
Employee/Petitioner

Case# **17WC021046**

BCH EMERALD LLC
Employer/Respondent

19IWCC0611

On 10/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0560 WIEDNER & McAULIFFE LTD
KYLE P CARLSON
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOAQUIN ORTIZ-MARTINEZ
Employee/Petitioner

v.

BCH EMERALD, LLC
Employer/Respondent

Case # **17** WC **21046**

Consolidated cases: **n/a**

19IWCC0611

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay** , Arbitrator of the Commission, in the city of **Chicago**, on **July 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 _____

FINDINGS

On **April 25, 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.

In the year preceding the injury, Petitioner earned $**26,890.00**; the average weekly wage was $**525.84**.

On the date of accident, Petitioner was **44** 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 $**6,410.24** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**17,505.00** for other benefits, for a total credit of $**23,915.24** under section 8(j) of the Act.

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

ORDER

The Petitioner failed to prove by a preponderance of the evidence that an accident occurred arising out of and in the course of his employment with Respondent.

Respondent is awarded a credit against Petitioner of $6,410.24 for TTD benefits paid. Respondent is awarded a credit of $17,505.00 for medical treatment expense benefits paid.

Respondent shall have no liability for Petitioner's prospective medical treatment.

As such, Petitioner is not entitled to the payment of requested medical bills, prospective medical care, temporary total disability benefits or penalties and fees.

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

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

Tiffany Kay

Signature of Arbitrator

10/18/18

Date

OCT 19 2018

PROCEDURAL HISTORY

This matter was pursued under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") by Joaquin Ortiz-Martinez (hereinafter "Petitioner) and sought relief from BCH Emerald, LLC (hereinafter "Respondent"). Additionally, Petitioner is seeking penalties and a fees motion. This matter was heard on July 17, 2018 in Chicago, Illinois before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay"). This matter was tried and a decision rendered by Arbitrator Kay. Arbitrator Kay has examined the submitted records.

The parties proceeded to hearing on July 17, 2018, with disputed issues as to whether the Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent, whether the Respondent was given notice of the accident within the time limits stated in the act, whether the current condition of ill-being is causally connected to his injury, whether the Respondent is liable for unpaid medical bills, whether the Petitioner is entitled to Temporary Total Disability benefits, and whether the Petitioner is entitled to penalties/attorney's fees under §19(k), §19(l) and §16 of the Act. (Arb.X1) The Arbitrator notes that a petition for attorney's fees by a former attorney is pending. The Petitioner's counsel stipulated that the former counselor was notified of the proceedings on July 17, 2018.

The parties stipulated that Respondent was operating under the Act on April 25, 2017. (Arb.X1) In addition, the parties stipulate that Petitioner earned $26,890.00 in earnings during the year preceding the injury and average weekly wage of $525.84. (Arb.X1) Petitioner was 44 years of age at the time of the incident, married with 0 dependents. (Arb. X1)

The Arbitrator notes that the Request for Hearing form originally stipulated that the date of accident was April 23, 2017. (ArbX1) However, during the trial the parties amended the form to reflect the date of accident as April 25, 2017. (ArbX1).

ARBITRATORS SUMMARY OF TESTIMONY & MEDICAL EVIDENCE

Petitioner alleges a left knee injury of April 2017. Petitioner has undergone conservative treatment, an August 2, 2017 arthroscopic knee surgery with Dr. O'Keefe, post-operative therapy, and has been recommended for a second knee surgery (autologous cultured chondrocytes on porcine collagen membrane, a/k/a "MACI"). Respondent denied authorization for the second surgery based on a Section 12 IME opinion from Dr. Michael Grear. (R.X5) Petitioner primarily seeks surgical authorization and TTD benefits.

Mr. Antonio Infante (hereinafter "Mr. Infante") was the first witness to testify. (T.14) The Arbitrator notes that he testified through a Spanish and English interpreter, Mr. Omar Montiel, provided by Petitioner. Respondent had no objection to the interpreter.

Mr. Infante testified he was 68 years old and had lived in the United States for 35 years. (T.14). He had been working as a Construction Supervisor for Respondent for 35 years. Respondent BCH Emerald LLC is either d/b/a or is closely affiliated with Wilmette Real Estate. (T. 14-15).

Mr. Infante testified he was working for Respondent on April 23, 2017. He signed an Affidavit, which was not submitted into evidence, at Petitioner's attorney's request prior to trial. Mr. Infante testified this affidavit

concerned the events of April 23, 2017. That day, he was supervising his construction crew at 1560 Oak Street in Evanston, IL. They were hanging frames in a property. (T. 16). They were "small frame[s]", and the work was all in the interior of the building. It involved carpentry. He was supervising a five-person crew who each worked in different parts of the building while Mr. Infante himself traveled throughout the building during the course of the day. (T. 17).

Petitioner was a member of Mr. Infante's work crew. Petitioner was working in the lobby of the building near a stairwell. Mr. Infante testified that at approximately 2pm on April 23, 2017, Petitioner reported an incident to him (T. 18). Mr. Infante was in the basement of the building. Petitioner came downstairs and showed Mr. Infante his knee, which Mr. Infante testified was "swollen, and it had a picket in there by an injury there inside the knee." (T. 19). Mr. Infante testified that Petitioner pulled his pants up to show Mr. Infante the swelling. Mr. Infante testified Petitioner could have been walking "differently" (i.e. with a limp) but that if Petitioner was, then Mr. Infante did not notice it at the time. (T. 19).

Mr. Infante indicated Petitioner was working alone in the lobby and that there were no witnesses to the alleged accident to his knowledge but that he could not know for sure because he was not there. Mr. Infante did not ask anyone else if they witnessed the accident. (T. 20). Petitioner had worked under Mr. Infante's supervision for the last eight to 10 years. (T. 20). Mr. Infante testified that Petitioner was "one of the more well-educated employees, and he did not complain about his work assignments." (T. 20).

Mr. Infante testified that Petitioner described falling "down from the ladder and he fell down on his knee and he fell on top of a screw." He confirmed this was one screw, not multiple screws. Mr. Infante knew the ladder Petitioner had been assigned to use was four feet tall. (T. 21-22).

Returning to the Affidavit he signed, Mr. Infante confirmed Petitioner personally gave the Affidavit to him and that he signed it at Petitioner's request. (T. 22). Mr. Infante partially read the affidavit into the record:

> "At approximately 2 p.m., Joaquin Ortiz-Martinez came to me limping and advising me that he fell off the ladder and hit his left knee on the ground." (T. 22-23).

Mr. Infante did not inform anyone else at BCH Emerald or Wilmette Partners about the reported fall off of the ladder Petitioner had described. Mr. Infante testified no one ever asked him about the incident from the either BCH Emerald or Wilmette Partners. (T. 23). Mr. Infante did not fill out any injury forms with Petitioner, but he believed one must have been filled out because otherwise the workers' compensation insurance process would not have been initiated. (T. 24).

Mr. Infante described Petitioner having a prior work injury with Respondent five or six years prior where he "fell down working on window," but he could not recall the body parts involved. Petitioner had only missed a few days of work for that prior accident. (T. 25). Paperwork was completed at the respondent company to document that accident. (T. 26).

On cross-examination, Mr. Infante testified that Petitioner gave him a "letter" instructing him to appear for trial. He produced a subpoena from his pocket on the stand. Mr. Infante indicated he did not prepare for his testimony in any way. He denied receiving any other documents about this case (other than work status forms while Petitioner was working). (T. 27-28).

Mr. Infante confirmed his prior testimony that Petitioner had reported the alleged accident on April 23, 2017. Their work schedule was Monday through Friday 7am to 5pm, and on Saturday for 5 hours. They did not work on Sundays. Upon further questioning, Mr. Infante indicated he was not positive on the exact date Petitioner told him of the alleged accident other than sometime in April of 2017. (T. 29).

Mr. Infante was presented with a set of time sheets bearing his signature for several weeks in April 2017. He confirmed that he signed off on each of the time sheets for each of the crew members he supervised. He agreed that the time sheets showed that April 23, 2017 was in fact a Sunday. (T. 30). Mr. Infante agreed that he and Petitioner never worked on Sundays and thus April 23, 2017 could not have been the date of the conversation between them. (T. 31).

Mr. Infante testified that immediately after the reported April 2017 accident, Petitioner continued to work full time through May at least part of June 2017. (T. 31-32).

Respondent questioned Mr. Infante regarding the discrepancy between his prior testimony that he did not witness whether or not Petitioner was limping on April 23, 2017 and the portion of the Affidavit he read into evidence that stated that Petitioner "came to me limping." (T. 32-34; compare T. 19 to T. 22-23). Mr. Infante explained that he did not notice whether Petitioner was limping because he "didn't pay any specific attention to it."

Upon re-direct, Mr. Infante again confirmed no work injury could have occurred on April 23, 2017 as that was a Sunday when he and Petitioner were not working. (T. 38-39). He did testify that the incident occurred at some point in April 2017 "possibly in the middle of the week." (T. 39). Petitioner finished out his shift the day of the alleged accident.

Mr. Infante agreed that Petitioner continued to work full duty until he began missing work on July 6, 2017. (T. 40).

Petitioner was the second witness to testify. Petitioner is 45 years old and married. He had completed "up to number six" (unclear grades or years) of formal education in Mexico. He had lived in the U.S. for the past 24 years. (T. 43). His employer for the past eight to ten years was Wilmette Real Estate, and he testified BCH Emerald is "part of" that company. He described his job duties as "Everything. Maintenance, carpentry. Everything. Maintenance." He recalled working at the 1560 Oak Street location in Evanston, IL. (T. 44). Petitioner had been working there for six months to a year doing carpentry, including installing cabinets and picture frames. This worksite was a museum. (T. 45).

Petitioner testified that his alleged work injury occurred on a Tuesday at 2pm in the afternoon, which corresponded to April 25, 2017. Petitioner amended the Request for Hearing (A.X1) and the Application for Adjustment (A.X2) to reflect the new alleged date of accident. (T. 46-47). Petitioner testified that he was working in the lobby hanging a picture. Petitioner described his mechanism of accident:

> "I was screwing it [the picture frame]. There were some people in there who did not want the floor to be scratched because they had just varnished it. They asked me to cover it [the floor] up. Then I placed the ladder four feet. Then the piece of cloth was very slippery and then the ladder moved and then I went down. There were screws on there, all kinds of them on the ground, yes." (T. 48).

Petitioner described the "cloth" as a tarp. Petitioner was on the ladder at the time it slipped. The screws he described "came out of my pocket." (T. 49). The testimony was not initially clear regarding whether the screws fell out of his pocket or were set on the ladder before it slipped, but Petitioner stated there were screws and screwdrivers on the ground and also some on the ladder. (T. 49-51).

Petitioner was asked which part of the body hit the ground first. He indicated his left knee. (T. 52). He stated that both knees almost struck the ground at the same time but that the right knee ended up hitting one of the steps. Petitioner testified he came into contact with a screw and with the ground. Petitioner testified he was not able to stand up and remained sitting for five minutes due to pain. He testified he then went to report the incident to Mr. Infante. (T. 53). Petitioner testified "I told him that I had fallen down from the ladder." He stated he was not asked to fill out any paperwork regarding the accident at any time. (T. 54).

On May 2, 2017, Petitioner presented to Peterson Urgent Care and sought treatment with his physician Dr. Jose Castellanos (hereinafter "Dr. Castellanos"). Petitioner had a prepatellar effusion with ecchymosis (bruising) along the lateral aspect (side) of his left calf to the lateral malleolus (inner ankle, i.e. right side of the left ankle) with no evidence of calf tenderness. Petitioner was not restricted from working and did in fact continue to work.

On May 6, 2017, Petitioner returned to Peterson Urgent Care with complaints of left knee swelling. (P.XA p18-19) "Pt has evident bruising of the calf extending to the left heel. At this time. He has no pain. The bruising has resolved. [for] The most part. . . . Assessment left knee pain/ecchymosis resolving." Petitioner was questioned as to any specific trauma that could have caused his complaints. The note reflects "When asked, patient denies any specific trauma indicated that his occurred incidentally as he was kneeling 2 weeks ago." Dr. Castellanos could find no explanation for why the ecchymosis had occurred in the first place. Petitioner demonstrated full range of motion, no tenderness to the patella, and ambulated without a limp. Petitioner was not restricted from working and did in fact continue to work.

On June 6th, 2017, Respondent completed a "Workers Compensation – First Report of Injury or Illness," describing Petitioner's injury as having fallen from a two-foot ladder while hanging exhibit signs causing Petitioner to land on screws and injure his left knee. (R.X2).

On June 11, 2017, Peterson Urgent Care recommended that Respondent set up a workers' compensation case. The new mechanism of injury described was that while hanging an exhibit signage, Petitioner fell two feet from a ladder. This is inconsistent with Dr. Castellanos' earlier notes of May 2 and 6, 2017. Petitioner was referred for an orthopedic evaluation.

On June 20th, 2017, Dr. Castellanos ordered a second MRI where "sagittal images demonstrated an intrameniscal tear of the posterior horn of the medial meniscus." (P.X A). On June 27th, 2017, Dr. Castellanos diagnosed Petitioner with an intrameniscal tear of the posterior horn of the medial meniscus. Petitioner was referred to physical therapy and to Dr. John O'Keefe, (hereinafter "Dr. O'Keefe") an orthopedic physician for further evaluation and recommendations. (P.XA).

On July 5th, 2017, Dr. O'Keefe described the history of the "instability and pain" of the "left knee" as a work-related injury that occurred in April while reaching with his left knee to land after falling off a 2-foot ladder. Dr. O'Keefe restricted Petitioner's duty and ordered physical therapy. (P.XA). Petitioner testified that when he first presented to Dr. O'Keefe the intensity of his pain was at a seven or eight. He described the pain as constant and dull. (T. 58). Petitioner denied any left knee injuries had occurred before or after April 25, 2017.

On July 19th, 2017, Dr. O'Keefe examined Petitioner and noted an injury to the "left knee after spraining fall at work April 2017." (P.XA). Dr. O'Keefe had Petitioner continued physical therapy and he advised Petitioner to follow-up in 2 or 3 weeks to see if his symptoms worsened.

On June 20, 2017, Petitioner returned for a re-MRI. Clinical history was "Persistent left knee pain, possible internal derangements." The MRI interpretation from Dr. Kuritza was "intrameniscal tear of the posterior horn of the medial meniscus. It does not appear to extend to any of the articulating surfaces at this time." Dr. Kuritza specifically found the ACL (and all ligaments) and lateral meniscus were unremarkable. (Dr. O'Keefe would later diagnose an ACL strain "per the MRI"). Fluid collection was still present. There was no mention of any chondromalacia or cartilage injury (Dr. O'Keefe would go on to diagnose a very severe cartilage injury as the basis for his MACI surgery suggestion).

On June 27, 2017, Petitioner presented to Dr. Castellanos for the MRI review. He was continuing to work at this time. The chief complaint was noted to be "Patient doesn't today [sic] secondary to a recent work related injury. They [sic] resulted in left knee swelling associated with pain [and effusion]." The physical examination revealed an effusion but minimal tenderness, nearly full range of motion, and ambulation without a limp. Per Dr. Castellanos, the June 20, 2017 MRI showed intact ligaments; a buildup of infrapatellar fluid consistent with peripatellar bursitis; a post-traumatic hematoma (clotted blood swelling in tissue); and "also noted additionally, the posterior horn of the middle [sic – medial] meniscus had a[n] intrameniscal tear." Dr. Castellanos recommended physical therapy and referred Petitioner for an orthopedic evaluation.

On July 3, 2017, Petitioner returned to Peterson but was seen by a PA-C, Ms. Sarah Purdy, with the assistance of a Spanish translator. Petitioner complained of ongoing left knee pain and swelling with 4/10 subjective pain "however, somewhat improved." Petitioner reported difficulty taking so much time off of work for office visits and that he could not attend physical therapy due to his work attendance requirements. He was still doing full duty work and reported taking no medications. The physical exam showed "he is comfortable in the room," "some mild effusion to the left patella," minimal tenderness, and full range of motion. Petitioner ambulated "without any issues." Mr. Purdy reviewed the June 20, 2017 MRI and agreed there was an "inner" meniscal tear of the posterior horn of the medial meniscus. Her diagnosis was 1) left medial meniscus tear and 2) infrapatellar effusion secondary to trauma. Ms. Purdy discharged Petitioner from care PRN to follow up for ongoing care with an orthopedic physician. She prescribed only physical therapy "if he is able to fit it in his schedule" and over the counter medications PRN. On July 8, 2018, PA-C Sara Pundy went on to provide a return to work full duty release via a separate work status report.

On July 5, 2017, Petitioner presented to orthopedic surgeon Dr. O'Keefe for an initial orthopedic evaluation. There he reported a self-described mechanism of injury of falling from a ladder and landing directly on his left knee. Dr. O'Keefe detailed that Petitioner was a "10-year veteran with this carpentry crew. At present, they are building an antique museum on Oakton and Central in Evanston. He was six hours into his shift. Tried to work two additional hours when on April 23, 2017, he was reaching forward with his left knee to land on a 2-foot high ladder. The ladder slid. He fell heavily smashing the left knee on the wooden floor. He had immediate pain and tenderness. It swelled. He did report it that day to Pedro, his supervisor. He told him 2-3x/wk since . . . " Dr. O'Keefe describes Petitioner's job duties as heavy with 60-80 lb loads 6-10x/hour. Petitioner denied prior left knee problems. For the first time, symptoms of left knee locking and popping were recorded. Dr. O'Keefe also noted a "grade 3-4" knee joint effusion, "intense" tenderness, grade 2-3 ACL laxity, positive Lachman's, positive McMurray's, diminished pulses, diminished range of motion, "power his horrible, much less than 4/5 with quad and hamstring." Dr. O'Keefe prescribed physical therapy, pain medication

(Hydrocodone/Acetaminophen), and consideration of arthroscopic knee surgery if symptoms failed to improve. Petitioner was first taken off work by Dr. O'Keefe at this appointment. Petitioner was prescribed a cane at this appointment. A separate note also for July 5, 2017 shows Dr. O'Keefe's interpretation of the May 2, 2107 X-Rays.

On July 7, 2017, Petitioner presented to Rehabilitation and Pain Management for a physical therapy initial evaluation. Chief complaints of subjective knee plain 0-3/10 relieved by medication and aggravated by prolonged sitting, prolonged standing, and ascending/descending stairs. Petitioner stated he was experiencing knee locking and cramping but that the pain would go away when he bends his left knee. Petitioner related a date of injury of April 23, 2017 "when he fell off the ladder and landed on his left knee" with immediate pain and swelling. The diagnostic X-Ray and MRI history was reviewed. Petitioner described working as a carpenter with heavy job duties including a lot of lifting and carrying approximately 80 lbs. and climbing ladders multiple times per day. During the functional examination, out of 20 categories Petitioner only reported "A little bit of difficulty" with activities of "hobbies, recreational, or sporting activities", squatting, going up 10 stairs/1 flight, and standing for 1 hour. The rest of the activities he reported no difficulty. Total functionality score was 76/80, where a higher score represents more functionality. The physical examination showed tenderness to palpation, some loss of range of motion, and some loss of strength (4-/5) with the knee extensors and flexors.

On July 17, 2017, Petitioner continued with physical therapy. He "still reports minimal pain (PS 1/10) in the left knee. On July 19, 2017, Petitioner continued with physical therapy. He reported "intermittent left knee pain with PS 2/10." On July 21, 2017, Petitioner attended another physical therapy session and "denies any new complaint except for the intermittent left knee pain with PS 2/10."

On July 19, 2017, Petitioner saw Dr. O'Keefe prior to his physical therapy session of the same day. Dr. O'Keefe described left knee locking twice per day and persistent pain with failure to advance past 5 lbs. in therapy. He noted mechanical popping and limited arc motion not present prior to the alleged accident. Dr. O'Keefe diagnosed a left knee meniscal tear of posterior horn, articular injury to the medial femoral condyle "as seen on MRI", and an ACL sprain with laxity "also seen on abnormal MRI from June 2017." Dr. O'Keefe prescribed PT, medication (Relafen, Prevacid, Ultram ER/Tramadol, and LidoPro patches), and surgery. Regarding the pain medication, Dr. O'Keefe stated, "He has some of the Norco at home, but he is narcotic adverse. He is resting acceptably with the Ultram."

On July 25, 2017, Petitioner Since the surgery, underwent a pre-operative chest X-Ray, which was unremarkable. Petitioner underwent other pre-operative clearance testing with Dr. Castellanos at Peterson Surgical Center. An EKG was performed. Petitioner admitted to smoking 2-3 cigarettes/day. As of the date of trial, Petitioner testified he was still experiencing difficulty walking, his knee "clicks a lot," with pain associated with the clicking. He had been wearing a brace and continuing with therapy post-operatively and walks with a limp. (R.X5, at 11).

On July 26, 2017, Petitioner underwent physical therapy. On July 31, 2017, Petitioner underwent physical therapy. "Patient reports he is feeling better. Pain in the left knee comes and goes and is minimal." He was noted to have surgery scheduled for August 2, 2017. That day, he "tolerated all exercises well without increase in left knee symptoms."

Petitioner testified he worked after the alleged April 25, 2017 injury through July 5, 2017 when Dr. O'Keefe took him completely off of work. (T. 60).

On August 2, 2017, Dr. O'Keefe performed surgery on Petitioner for the posterior horn tear and cartilage injury on the medial femoral condyle. During surgery, Dr. O'Keefe opined that: "...instability and tear of medial meniscus is what damaged the medial femoral condyle. It is my board-certified opinion, the trauma and meniscal tear from the work injury of April, 2017 produced the outer bridge Grade IV lesion on the medial femoral condyle." Dr. O'Keefe further noted that Petitioner is a "good candidate for a MACI-type autologous implantation procedure" and that "we will get work comp[ensation] to authorize that as being medically appropriate and necessary because of his heavy unprotected fall while working April 2017. The patient worked for years and never had debility or restrictions or complaints of pain or limitations in left knee prior." (P.XA p. 83-85).

On August 4, 2017, Petitioner returned to physical therapy. He confirmed the surgery had proceeded two days prior. Petitioner reported an increased "pain in the left knee with PS 5/10, increased with movement. He took pain medication prior to therapy." He was wearing his DME CPM and utilizing crutches to ambulate. He tolerated the exercises well. On August 7, 2017, Petitioner continued with therapy and reported "minimal pain." He was wearing his CPM, wearing a knee brace, and using an ice machine at home. On August 9, 2017, Petitioner returned to therapy. His sutures were scheduled for removal the next day. On August 11, 2017, Petitioner returned to therapy. The stitches had been removed. He reported only minimal discomfort and performed the exercises without any increase in symptoms.

On August 14, 2017, Dr. O'Keefe saw Petitioner and performed an aspiration of the hemarthrosis to release the pooling blood in the joint space. Dr. O'Keefe again recommended MACI surgery and described Petitioner as an "ideal candidate" for the procedure. "He is 44. He is active. He has many more years of hard work ahead of him. We are asking work comp to promptly authorize that surgery before he develops traumatic arthritis that is global." He even referred to the surgical photographs as allegedly supporting his diagnosis of outer bridge grade 4 cartilage injury to the medial femoral condyle. Crutches were prescribed. There is a separate note for the actual aspiration. It describes removal of 80 mL of blood.

On August 14, 2017, Petitioner also attended therapy. He was continuing to report "minimal" pain. He denied any numbness or tingling in his left leg. He reported that "he continues to go to the pool for exercise which helps with the pain and left knee movement." On August 16, 2017, Petitioner attended therapy reporting minimal pain on top of his left knee PS 1-2/10. On August 23, 2017, Petitioner attended therapy. He denied any knee pain at rest but advised of intermittent leg cramps with pain 5/10. He was continuing to exercise in the pool and use his CPM (had raised from 50, to 70, to 100 degrees at this point). Petitioner had no reproduction of knee symptoms with exercises and had only mild discomfort with range of motion testing. The range of motion was improved, and swelling had decreased. On August 25, 2017, Petitioner attended therapy. He reported minimal discomfort "in the back" of his left knee. He reported lasting relief (presumably of the cramping complaints) since the last session. Range of motion and strength were improved. On August 30, 2017, Petitioner attended physical therapy. He reported minimal pain PS 2/10 with activity, and the CPM at home was up to 110 degrees. Range of motion was improving. On September 1, 2017, Petitioner attended therapy. He reported increased pain PS 2-3/10 intermittently on the lateral side of his left knee (note: was previously top, then bottom, now lateral). Range of motion was improving. On September 6, 2017, Petitioner attended therapy. He denied any new complaints but reported continuing intermittent pain with activity. On September 8, 2017, Petitioner attended physical therapy. He reported minimal pain 2-3/10 associated with activity such as prolonged walking or sitting. He completed the exercises with no increase in symptoms.

On September 13, 2017, Petitioner attended therapy and was evaluated for a discharge. He described "an aching pain on the medial aspect of his left leg going up to the thigh with PS 2/10." He reported pain fluctuated 0-4/10 in the last 24 hours. Petitioner described continuing swelling after prolonged walking, stiffness with

prolonged sitting, and increased pain over the course of the day. Another 20-activity functionality score was obtained. Compared to the July 7, 2017 initial therapy evaluation prior to Dr. O'Keefe's surgery of August 2, 2017, Petitioner's self-reported, subjective functionality score had significantly decreased from 76/80 down to 48/80 (where a higher score represents more functionality). The physical therapist stated that Petitioner would continue to benefit from additional therapy to improve left knee strength and mobility. Petitioner was noted to be compliant with HEP and continually swimming for exercise.

On September 14, 2017, Dr. O'Keefe saw Petitioner for follow up and status of the MACI authorization. Dr. O'Keefe was upset the MACI had not been authorized and indicated Petitioner was developing "traumatic arthritis that will be global." Dr. O'Keefe reiterated his strong opinion that Petitioner suffered a Grade IV outerbridge injury to the medial femoral condyle and trochlea. Physical therapy was to continue with specific recommendations. There is a work status form corresponding to this note taking Petitioner completely off work and seeking a MACI surgery authorization.

On September 15, 2017, Petitioner attended therapy as Dr. O'Keefe had prescribed more sessions. Petitioner denied any left knee pain but reported mild discomfort with prolonged walking and standing. On September 19, 2017, Petitioner attended therapy. He reported his left knee "is doing better" and that he continues to swim. On September 20, 2017, Petitioner attended therapy. He reported "pressure-type" pain in the inferior, superior, and medial aspect of the left knee. (Pain location continues to evolve.) He stated his pain had improved however and was mostly 1-2/10. On September 22, Petitioner attended therapy. The pain complaints were copy-pasted over from the September 20 note. On September 29, 2017, Petitioner attended therapy. He reported no new complaints and intermittent pain that could be relieved with rest. On October 2, 2017, Petitioner attended therapy. He reported minimal 2-3/10 left knee pain aggravated by prolonged walking and bending. He had a tight hamstring the last two sessions. On October 4, 2017, Petitioner attended therapy. He reported less pain since the last visit and that activity aggravated the pain. Treadmill walking endurance was added to the therapy exercises; he walked 1 mph for 5 minutes. He needed to improve his walking gait mechanics. On October 9, 2017, Petitioner attended therapy. He described continued pain over the superior aspect of the left knee 1-2/10 and continued swimming. He underwent hamstring stretches and held off on the treadmill.

On October 17, 2017, Petitioner returned to Dr. O'Keefe. Petitioner complained of painful grinding and popping with walking longer distances. An IME was noted to have been scheduled in Schaumburg, IL. Dr. O'Keefe emphasized that any delay in MACI authorization could result in global arthritis of the patella and tibial surfaces. Medications were prescribed, including Norco 10s.

On October 20, 2017, Petitioner attended an IME with Dr. Grear. He testified "It seems to me like he was making fun of me because there was no – not an interpreter in there present that day." He testified he was not able to understand all of the questions Dr. Grear was asking. He admitted his niece had accompanied him and was present to interpret with Dr. Grear. She was about 22 years old and had come to assist Petitioner because he had difficulty walking. Petitioner testified that his niece "doesn't speak [English] too well, but yet she speaks it." (T. 61). No one from the doctor's office or insurance company was there to translate. (T. 62). There is a gap in therapy hereafter until November 15, 2017. On November 15, 2017, Petitioner attended therapy. He was noted to be 10 weeks s/p the meniscal repair surgery of August 2, 2017. Petitioner reported knee stiffness in the morning with "minimal pain."

Dr. Grear testified that Petitioner was accompanied to the IME by his 23-year-old niece "who spoke English and understood English and acted as his interpreter." (RX5, at 12). Dr. Grear testified "I didn't feel there was a problem with communication." (RX5, at 13).

Dr. Grear opined that the swelling of Petitioner's knee is a direct result of "the chronic edema" instead of a work-related injury. Dr. Grear performed a physical examination of Petitioner's left knee that revealed diminished range of motion, chronic inflammation, no evidence of any significant fluid accumulation, pain with maximum range of motion, difficulty weight-bearing, antalgic gait, and use of a brace and crutches to ambulate. There was evidence of muscle atrophy in the left lower extremity compared to the right, but he had normal circulation and good motor function of the left extensor hallucis longus. (RX5, at 14).

Dr. Grear reviewed the two left knee MRIs Petitioner underwent on June 17 and 20, 2017. The first was a compromised study due to patient motion. Dr. Grear personally reviewed both sets of the MRI films. (RX5, at 15). Dr. Grear testified he agreed with the radiologist's report and interpretations of the films. (RX5, at 16). The MRI revealed no problems with the ACL, no lateral meniscus problem, no chondral defect, no cartilage injury, and no chondromalacia. There was a large fluid collection consistent with prepatellar bursitis and a post-traumatic hematoma in the area of the prepatellar bursa. (RX5, at 16). On the MRIs, the medial meniscus had evidence of an intrameniscal tear without communication with the surface of the meniscal tissue. Dr. Grear specifically testified that this finding is not diagnostic for a "medial meniscal tear." (RX5, at 17). Dr. Grear explained that if a treating physician disagrees with a radiologist's MRI interpretation, they always have the option of asking the radiologist to take another look at the films and issue an amended MRI report. (RX5, at 18).

Dr. Grear's October 2017 IME appointment occurred after the August 2, 2017 surgery. His diagnoses for Petitioner's left knee were post-traumatic prepatellar bursitis that had resolved and status post arthroscopic surgery of the left knee with intraarticular fibrosis (scar tissue) and chronic swelling. Dr. Grear attributed the swelling to the August 2, 2017 knee surgery. (RX5, at 19-20).

Dr. Grear testified that there were inconsistencies between Petitioner's description of the mechanism of the injury and the mechanism reflected in the medical records. Most significantly, he noted that at the May 2 and 6, 2017 appointments with Dr. Castellanos, with whom Petitioner had no problem communicating in Spanish, Dr. Castellanos had been confused as to the origin of the problem because Petitioner denied any history of trauma. Further, there was significant swelling and ecchymosis into the left calf present at both appointments. (RX5, at 21).

Dr. Grear was of the opinion that Petitioner demonstrated clear improvement in physical therapy prior to the August 2, 2017 surgery. He noted the final therapy session was only a few days before the surgery, and in the last physical therapy note Petitioner was demonstrating reduced pain, improved motion, and the ability to perform 15 repetitions of squats. Further, Petitioner could stand on a single leg (each left and right separately) and toss a ball for two minutes without an increase in symptoms, and Petitioner was able to step up and down with five-pound ankle weights 30 times without any significant increase in symptoms. (RX5, at 22).

Regarding the medical necessity of the August 2, 2017 surgery, Dr. Grear testified that continued conservative care would have resulted in an acceptable end result. Petitioner specifically told Dr. Grear that he felt worse after the surgery. (RX5, at 23). Post-operatively, Petitioner's physical therapy had hit a plateau with minimal additional improvement. (RX5, at 23).

Regarding the intrameniscal tear on the MRI, Dr. Grear indicated those findings were usually degenerative rather than acute and that he would guess 20-25% of the general population with Petitioner's age and build might demonstrate similar findings. (RX5, at 24). An intrasubstance meniscal tear is something Dr. Grear would not recommend surgical intervention to address. (RX5, at 24).

Dr. Grear also reviewed Dr. O'Keefe's August 2, 2017 operative report and intraoperative color photographs. He strongly disagreed with Dr. O'Keefe that there was any grade four cartilage lesion present in the MRI imaging and that such a significant cartilage lesion should have been visible on the MRI if it were truly present. (RX5, at 27). On the grading scale, a grade four cartilage injury is among the most severe cartilage injuries. (RX5, at 27). When a grade four cartilage injury is caused by an acute incident, it would be immediately evident to the patient and visible upon any MRI imaging. (RX5, at 28). Dr. Grear also saw no lateral meniscal problems on the MRIs, but Dr. O'Keefe's operative report indicated the use of two tree stand anchors were used to address a lateral meniscus injury. (RX5, at 28). The use of two such anchors would indicate an injury severe enough that it would have been clearly evidence upon any MRI. (RX5, at 28). Dr. Grear confirmed the intraoperative color photographs did not show any evidence of a displaced lateral meniscus that would have required mitek sutures (a/k/a anchors) and that while there was minor chondromalacia present that was much less severe than a grade four cartilage injury.

Dr. Grear confirmed that the August 2, 2017 surgery was neither medically necessary nor causally related to the alleged April 2017 work accident. (RX5, at 30). He opined Petitioner had achieved MMI as of August 1, 2017 (the day prior to surgery) for his left knee. Dr. Grear opined Petitioner could have returned to work full duty before the August 2, 2017 surgery based on his review the final pre-operative physical therapy note and his understanding of Petitioner's job duties. (RX5, at 30). Dr. Grear opined that any work restrictions Petitioner needed as of the October 2017 IME appointment were not related to the alleged April 2017 work injury. (RX5, at 31).

Dr. Grear agreed that, regardless of causation, Petitioner did need further treatment for his left knee if he wanted to return to a normal activity level. (RX5, at 31-32). Dr. Grear was not certain that a MACI surgery was Petitioner's best or only option however. He recommended that Petitioner try aggressive physical therapy and if that failed to resolve the knee complaints, then Dr. Grear agreed that a second opinion from another treating physician could be useful to develop Petitioner's plan of treatment. The MACI procedure was fairly new and usually performed in a university setting. (RX5, at 32-33).

Dr. Grear did not disagree with Dr. O'Keefe's AMA impairment rating of 40% of the left leg (stated in his narrative opinion, see RX6). However, Dr. Grear indicated that, when looking at the knee regardless of causation, Petitioner was not at MMI. (RX5, at 34, 39).

Dr. Grear reviewed Dr. O'Keefe's December 7, 2017 narrative rebuttal to the opinions Dr. Grear expressed in his November 13, 2017 IME report. Dr. O'Keefe's criticisms and comments did not change Dr. Grear's opinion that the August 2, 2017 surgery was not medically necessary. (RX5, at 34-35). Dr. Grear did not believe whether you considered Petitioner to be a Laborer vs. a Carpenter would change any of his opinions. (RX5, at 35-36). Dr. Grear admitted that he may have mistaken whether Petitioner had one or two post-operative hemarthrosis aspirations with Dr. O'Keefe, but that would not change his opinions. (RX5, at 36-38). Dr. Grear noted that some of his disagreements with Dr. O'Keefe could stem from the fact that Dr. O'Keefe may not have had the PCP records from Dr. Castellanos and the physical therapy records available for review. (RX5, at 38-39).

Dr. Grear is familiar with Carpentry job requirements, he acknowledge Petitioner is in his early 40s, and that Petitioner had been doing the same job for some time. (RX5, at 48-50). However, that did not change Dr. Grear's opinion that the intrameniscal tear was pre-existing any alleged April 2017 work accident. Dr. Grear further testified that the intrameniscal tear was not "more likely than not" related to Petitioner's work and could well be a degenerative finding caused by genetics rather than work activity. (RX5, at 50-51). Dr. Grear indicated

Carpenters do not necessarily have a higher incident rate of meniscal tears than the general population. (RX5, at 51).

On November 16, 2017, Petitioner returned to Dr. O'Keefe. "Patient remains sore and debilitated." Dr. O'Keefe requested authorization for the MACI or that Respondent set up an IME "with a doctor who performs cartilage implantation procedures." Dr. O'Keefe opined the MACI surgery would be work-related treatment. Dr. O'Keefe noted Petitioner was on "maximum doses" of his medications and that "He is trying Ultram, but it is not helpful yet. He uses the Norco 10."

On December 6, 2017, Petitioner underwent a left knee X-Ray with Dr. Milroy Emmanuel showing soft tissue swelling with no definite evidence of recent fracture. Clinical correlation was requested.

On December 7, 2017 Dr. O'Keefe authored a narrative rebuttal to Dr. Grear's IME opinions. (See also RX6, last three pages). Dr. O'Keefe stated there were "several horribly inappropriate occurrences" at the IME. The main criticism was that there was no professional interpreter present; however, he failed to note Petitioner's 23-year-old niece was there to translate. Dr. O'Keefe directly contradicted Dr. Grear's interpretations of the MRI films and August 2, 2017 operative photos. Dr. O'Keefe believes the meniscal tear is evident and there is a "discreetly focal, severe Outerbridge grade IV cartilage injury on the medial femoral condyle." Notably, that is not what the radiologist's report indicated. Dr. O'Keefe also described new details about the injury. He specifically stated that the April 2017 2-foot fall off a footstool/ladder involved "torqueing" (twisting) and that Petitioner experienced a "huge pop and immediate swelling" and that Petitioner could not walk thereafter. The Arbitrator notes that this is the first mention of knee twisting in the records. Dr. O'Keefe ascribes the surgical complication of hemarthrosis as the fault Respondent in delaying the MACI authorization. Dr. O'Keefe declared that Dr. Grear was not a surgeon who practices ACI procedures. Dr. O'Keefe agreed with Dr. Grear's recommendation for an MRI on a high-field magnet for better resolution. He planned to schedule that with radiologist Dr. Kuritza. (It does not appear this ever occurred however). Dr. O'Keefe opined that if the MACI surgery did not proceed, Petitioner was at MMI with an AMA impairment rating of 40% of the left knee (although he did not show any calculations). Dr. O'Keefe also stated that Petitioner would require a TKR surgery within 2 years if the MACI surgery was not approved. Dr. O'Keefe argued that Petitioner's current condition and these future treatment recommendations were causally related to the alleged April 2017 work injury.

On January 9, 2018, Petitioner followed up with Dr. O'Keefe. He described pain, weakness, and loss of range of motion. The plan was to continue therapy (1x/week for 1 month) and prescription medication. Dr. O'Keefe made comments in his treatment note directly addressed to the Respondent's claims adjuster and accusing Respondent of being "negligent." Dr. O'Keefe issued a number of prescriptions: Tramadol extended release, Dendracin lotion, Prevacid, Relafen, and Lidopro Patch.

It appears Dr. O'Keefe never recorded any awareness of Petitioner's January 2018 motor vehicle accident.

On February 8, 2018, Petitioner returned to Dr. O'Keefe. Dr. O'Keefe also reviewed and commented on Dr. Grear's IME report. A slightly different mechanism of injury was described: "patient is a ten-year veteran as a carpenter when he was hurt 04/23/2017, falling off a two-foot height onto a pile of nails on a hard floor." Dr. O'Keefe outlined the supposed Outerbridge grade IV articular injury discovered during the August 2, 2017 surgery for meniscal repair and his recommendation for an additional MACI surgery. Dr. O'Keefe stated there was no interpreter present for the IME and that this was "unconscionable," but he failed to note that Petitioner's niece was there to translate. Dr. O'Keefe stated "it is not surprising Dr. Grear's IME report is fraught with errors." Dr. O'Keefe stated Petitioner had no pre-DOI knee complaints. Dr. O'Keefe states Petitioner was not able to

return to work within his restrictions during an attempt approximately two months prior. Dr. O'Keefe again stated that Petitioner is heading towards left knee global traumatic arthritis and could require a total knee replacement ("TKR") if the MACI is not approved. Dr. O'Keefe further demanded Respondent either authorize the MACI surgery or set up an IME with Dr. Cole at Midwest Orthopedics at RUSH. The treatment plan was for Petitioner to be released to return to work with light duty restrictions of < 10-pound lift with two hands, no ladders, no kneeling. (This could not be accommodated). Petitioner was to continue physical therapy 1x/week for one month. Medications were Relafen and Prevacid, and Petitioner had some tramadol/Ultram left at home and "is not requiring Norco."

On March 14, 2018, Petitioner returned to Dr. O'Keefe. The MACI surgery was recommended again. Petitioner was kept off work.

On April 17th, 2018, Dr. O'Keefe was deposed. He testified that he has been a Board Certified Orthopedic Surgeon since 1986. He has been practicing orthopedics for 39 years. He first treated Petitioner on July 5th, 2017, and that Petitioner told him that he had hurt his left knee during work after falling from a ladder. Dr. O'Keefe stated that on that day:

> "He has traumatic effusion. It is documented ¾. He is intensely tender at certain parts of his knee. He has major ligaments that are incompetent meaning sprained severely. His range of motion is limited and it's painful at the end points. The testing looking for meniscal tears is positive. He has normal strength in his leg in a laboring guy that is supposed to commonly handle 80-pound loads, and his pulse are good at this point. So explicit swelling there is an effusion. Yeah, there is blood fluid probably is what is in the joint and he is tender and acting like he has got tearing of the ligaments that I can palpate about the knee joint." (P.XC p12-13).

According to Dr. O'Keefe, in the last one to two years the MACI procedure has been approved in the United States of America and has performed "seven or "ten" of MACI procedure surgeries. (P.XC p. 29:1-22). Dr. O'Keefe described the MACI procedure surgery as "amazing." (P.Xp.30:2) The procedure increases power, allows longer periods of standing, increases weight load ability, and potentially elevates all symptoms of pain. In addition, Dr. O'Keefe estimated that if Petitioner did have this cartilage injury, he would be "probably 80 or 85 percent of what [he] was before he was hurt." (P.XC p. 31 1-10). If the MACI procedure surgery is not performed, Petitioner will go on to "develop a relentless, progressive, traumatic arthritis needing a knee replacement," but if Petitioner, who is a "perfect candidate" for the procedure, does get the MACI, Petitioner can go back to carpentry for "another 15 years." (P.XC p. 31: 1-10).

Dr. O'Keefe does not believe that Petitioner can return to work until he receives the MACI procedure surgery. (See Dep. Dr. O'Keefe P.P. 38:4-12). Without the surgery, Petitioner cannot even be a "medium duty laboring carpenter" and cannot climb or carry even 40 pounds. (P.XC p.38: 4-12). Dr. O'Keefe disagrees with Dr. Grear's opinion that on July 31, 2017, Petitioner was able to return to work because Petitioner's "complaints of pain had improved, and his complaints of pain were transient." (P.XC p.21:14-20). During this time, Dr. O'Keefe had written "[Petitioner] remains unstable with his gait. It's locking now twice a day. He has persistent pain. He is unable to advance past five pounds with therapy. He is having mechanical popping and a limited arc of motion that was not present before the injury of 4 of '17." (P.XC p. 23: 4-9). Dr. O'Keefe further asserted that in July of 2017, Petitioner was being prepared for surgery so any improvement was due to use of a cane, the use of "narcotic medicine" and that Petitioner was off work instead of "pounding on his sore knee with a hammer." However, Petitioner at this time still was having "locking several times a day. He doesn't have good power and

he is needing high doses of prescription medicine." (P.XC p.63-64). Consequently, Dr. O'Keefe asserted that surgery was needed because "that is not a state you want to be in a long time." (P.XC p.63: 22).

Petitioner was asked what activities he was able to perform prior to the injury that he could not perform now. He testified "I'm not able to do anything." When asked to be more specific, he testified "Well, yes, I'm not able to do anything." When asked again to be more specific, he testified he was unable to kneel, run, or be on top of a ladder. This corresponded to the restrictions he had received from Dr. O'Keefe. (T. 63).

Petitioner testified he wanted to proceed with the second surgery recommended by Dr. O'Keefe and that he wanted to go back to work. (T.63). Petitioner is currently off work.

CONCLUSIONS OF LAW

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 the Petitioner failed to prove by a preponderance of the evidence that his accident arose out of and in 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).

The phrase "in the course of" refers to the location, time, and circumstances surrounding the accident. Here, the issue of whether the injury occurred in the course of Petitioner's employment largely comes down to a credibility determination between Petitioner, Mr. Infante and the medical records/exhibits entered into evidence. Mr. Infante, Petitioner's witness, testified that Petitioner was working alone in the lobby and that there were no witnesses to the alleged accident to his knowledge but that he could not know for sure because he was not there. Mr. Infante did not ask anyone else if they witnessed the accident. (T. 20). Petitioner later testified that there was no one present when the incident occurred. The Application for Adjustment of Claim and the Request for Hearing forms both stated that the accident occurred on April 23, 2017. (ArbX1&2) However, during cross examination of Mr. Infante, evidence was produced that that the alleged date of accident, April 23, 2017, was a Sunday. Mr. Infante conceded that Petitioner could not have been working on that date. Petitioner chose to amend his allegations to reflect a Tuesday, April 25, 2017 date of accident. However, it appeared that the date was chosen arbitrarily.

The first two treatment notes with Petitioner's Spanish-speaking primary care physician, Dr. Castellanos, indicate Petitioner repeatedly denied suffering any acute injury. There was a mention of a potential injury "while kneeling" but even this was not specified to have allegedly occurred while Petitioner was working. Further, the presence of a left calf injury at these initial two appointments is completely unexplained by Petitioner's theory of this case and appears to indicate a mechanism of injury other than a direct impact to the left knee.

The medical histories and trial testimony are conflicting. The Commission recognizes that "when faced with conflicting medical histories that the histories which were taken most contemporaneously with the accident date are more likely to be accurate than those taken at a later time." Saleem v. Simmons Airlines, 1999 Ill. Wrk.

Comp. LEXIS 955 (99 I.I.C. 42). The Commission bases such decisions on the Illinois Supreme Court's holding in Shell Oil v. Industrial Comm'n, 2 Ill. 2d 590 (1954), wherein the Court stated contemporaneous medical records are more reliable than later testimony because "it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." See Rule v. Community Care Systems, Inc., 2015 Ill. Wrk. Comp. LEXIS 1609 (15 IWCC 955); Rodriguez v. Daimler Trucks, 2014 Ill. Wrk. Comp. LEXIS 932 (14 IWCC 985); Holden v. St. Patrick's Residence, 2014 Ill. Wrk. Comp. LEXIS 572 (14 IWCC 579); Strickland v. Lowe's, 2014 Ill. Wrk. Comp. LEXIS 503 (14 IWCC 424); Stanley v. Wal-Mart, 2014 Ill. Wrk. Comp. LEXIS 109 (14 IWCC 80); Norbury v. Conway Freight Inc., 2013 Ill. Wrk. Comp. LEXIS 1101 (13 IWCC 1043); Oswald v. Prairie State Group, 2013 Ill. Wrk. Comp. LEXIS 528 (13 IWCC 551); Vargas v. Millard Maintenance Service, 2003 Ill. Wrk. Comp. LEXIS 19 (3 IIC 18). Applying those principals to this case, the Arbitrator notes that during Petitioner's first office visits in May of 2017, he denied any acute traumatic event/injury initially despite repeated questioning by Spanish-speaker Dr. Castellanos, his primary physician.

At trial, Petitioner's testimony did very little to clarify the precise mechanism of injury he was alleging. The height of the ladder was not consistent (see Dr. O'Keefe's notes regarding a 2-foot fall vs. Petitioner's 4-foot ladder testimony). Whether he fell on a "wood floor" (per Dr. O'Keefe's July 5, 2017 initial evaluation), a single screw, multiple screws, or a "pile of nails" (per Dr. O'Keefe February 8, 2018) was not consistent. How the screws came to be on the floor was inconsistent (petitioner testified they were in his pocket and that they were on the ground and that they were on the ladder at trial). At trial, Petitioner denied any April/May 2017 left calf injury despite the findings in the May 2017 PCP notes.

Petitioner's credibility was further reduced because of his denial of any other left knee accidents before or after April 2017 at trial. When confronted on cross examination, Petitioner admitted that he suffered a January 2018 car accident with left knee X-Rays performed at the hospital immediately afterward. The Arbitrator also notes the independent interpretation of the January 5, 2018 left knee X-Rays to reveal only "early degenerative changes" is not consistent with Dr. O'Keefe's alleged diagnosis of a grade IV cartilage injury (RX8). Petitioner also testified that the pre-operative physical therapy in July 2017 did not help him at all, but the therapy notes clearly reveal he was improving during that time.

The Arbitrator notes that both Petitioner and Mr. Infante testified that no report of injury form was contemporaneously completed following the alleged accident in April 2017. They both also testified they were familiar with injury notification procedures and had previously filled out injury reports following a prior November 14, 2014 accident. Even though that accident was minor, they filled out an injury report at that time. Mr. Infante testified in this case that he never told anyone else at the company about Petitioner's alleged left knee injury. The Arbitrator finds this testimony to be self-serving and not credible.

Due to the aforementioned contradictions found between the Petitioner's testimony, witnesses testimony, subjective complaints, and the non-rebutted exhibits entered into evidence, the Petitioner's testimony was not found to be credible. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his injury occurred in the course of his employment with Respondent. Therefore, the issue of whether the injury arose out of his employment with Respondent is moot.

With respect to issue (E), (F), (J) and (K) 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.

With respect to issue (N) whether Respondent is due any credit?

Based on the findings above that Respondent has no liability to Petitioner for any benefits claimed for the alleged April 25, 2017 accident, Respondent is entitled to a credit for all disputed benefits that were paid including $6,410.24 for TTD and $17,505.00 for medical expenses. These are reflected in RX3 (TTD ledger) and RX4 (medical expense ledger).

With respect to the objections by Petitioner regarding Respondent's Exhibits #2, #6, and #8, the Arbitrator finds as follows:

Respondent Exhibit #2: Workers Compensation First Report of Injury or Illness

At the end of the trial, during the admission of evidence, the Respondent attempted to enter into evidence Respondent's Exhibit #2 the Workers Compensation First Report of Injury or Illness. Petitioner objected to this document because it indicated that the date Respondent was notified was June 6, 2017. Furthermore, Petitioner argued that based upon the testimony that was proffered on the date of hearing the date is not accurate. Arbitrator sustains the Petitioner's objection based upon a lack of foundation being provided for the exhibit and it is not received into evidence. The Arbitrator gives no consideration to Respondent's exhibit 2.

Respondent Exhibit #6: Exhibits to Dr. Grear Evidence Deposition Transcript

At the end of the trial, during the admission of evidence, the Respondent attempted to enter into evidence Respondent's Exhibit #6. The Arbitrator overrules this objection.

Respondent Exhibit #8: MVA/Allstate Insurance Records

At the end of the trial, during the admission of evidence, the Respondent attempted to enter into evidence Respondent's Exhibit #8 which is a subpoena to Allstate for the subsequent motor vehicle accident that Petitioner was involved in during January 2018. The Arbitrator sustains the Petitioner's objection based upon a lack of foundation being provided for the exhibit and it is not received into evidence. The Arbitrator gives no consideration to Respondent's exhibit 3.

Tiffany Kay

Signature of Arbitrator

10/18/18

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LORNA MOSLEY,

Petitioner,

vs.

NO: 09 WC 15059

STATE OF ILLINOIS/ SHAPIRO DEVELOPMENTAL CENTER,

19IWCC0612

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, teporary total disability, maintenance, nature and extent of disability, and penalties and fees pursuant to Section 16, Section 19(k) and Section 19(l) of the Act. and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner sustained a work injury on October 1, 2008 in her employment as an aide at Shapiro Developmental Center while assisting a blind, disabled individual in transferring to a wheelchair following a fire alarm. Petitioner had extensive medical attention to her spine. Respondent was unable to accommodate Petitioner's permanent work restrictions as determined by a functional capacity evaluation performed on July 7, 2010.

On July 29, 2011 Petitioner met with Steve Blumenthal for an initial vocational rehabilitation analysis. During this period Petitioner was continuing to receive maintenance benefits. Mr. Blumenthal recommended Petitioner obtain her GED certificate and complete a basic computer training program. Respondent accepted Mr. Blumenthal's report. Petitioner did successfully obtain her GED on September 14, 2013 for which Respondent paid.

Thereafter, Petitioner enrolled in basic computer skills course pursuant to the recommendation of Mr. Blumenthal which was also paid for by Respondent. While enrolled in this program Petitioner continued to receive maintenance benefits. Petitioner failed this course for failure to sit for the final examination.

The Commission vacates the award of maintenance from January 27, 2015 through February 15, 2016 on the basis that Petitioner failed to establish that she undertook a valid job search. On January 27, 2015 Respondent cut maintenance payments and terminated formal vocational rehabilitation due to Petitioner failing a basic computer skills course coupled with documented continuing non-compliance with formal vocational rehabilitation with Respondent's designee Ms. Peterlin. Ms. Peterlin's file is replete with notes reflecting Petitioner's non-compliance for a variety of reasons. The Commission views the evidence differently from the Arbitrator and finds that Petitioner failed to participate in a valid job search from January 27, 2015 through February 15, 2016 when Petitioner secured new employment with ResCare. Petitioner earns $9.25 per hour/ forty hours per week in her employment at ResCare.

Petitioner brought a petition for penalties and fees pursuant to Sections 19(l), 19(k) or 16. The Commission finds that Respondent did not act unreasonably or vexatiously herein and affirms the Arbitrator's denial of penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $474.31 per week for a period of 67 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given a credit of $31,778.77 in temporary total disability payments made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $474.31 per week for 234.4 weeks, commencing July 29, 2010 through January 26, 2015, as provided in Section 8(b) of the Act. Maintenance payments awarded by the Arbitrator commencing January 27, 2015 through February 15, 2016 are hereby vacated for failure of Petitioner to establish a valid job search. Respondent shall be given a credit of $123,053.19 for maintenance payments made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $277.64 per week, commencing January 28, 2015, and continuing for the duration of Petitioner's disability, because the injuries sustained caused a loss of earnings as provided in Section 8(d)(1) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that petition for penalties and attorney's fees pursuant to Sections 19(k), 19(l) or 16 of the Act is denied.

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

19IWCC0612

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 14 2019
SM/msb
o-10/09/19
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOSLEY, LORNA Case# **09WC015059**

Employee/Petitioner

ST OF IL SHAPIRO DEVELOPMENTAL CENTER **19IWCC0612**

Employer/Respondent

On 11/14/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.53% 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:

0307 ELFENBAUM EVERS & AMARILIO
RACHAEL SINNEN
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
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

NOV 14 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

19IWCC0612

☐ 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

Lorna Mosley,
Employee/Petitioner
v.

Case # **09** WC **15059**

State of Illinois, Shapiro Developmental Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **10/11/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/1/2008**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$36,996.00**; the average weekly wage was $**711.46**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **3** 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 $**31,778.77** for TTD, $**0** for TPD, $**123,053.19** for maintenance, and $**0** for other benefits, for a total credit of $**154,831.96**.

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 $474.31 per week for 67 weeks, commencing April 16, 2009 through July 28, 2010, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $31,778.77 in TTD payments paid.

Respondent shall pay Petitioner maintenance benefits of $474.31 per week for 289 4/7 weeks, commencing July 29, 2010 through February 15, 2016, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $123,053.19 in maintenance payments paid.

Respondent shall pay the Petitioner permanent partial disability benefits of $277.64 per week, commencing on February 16, 2016, and continuing for the duration of Petitioner's disability, because the injuries sustained caused a loss of earnings as provided in Section 8(d)(1) of the Act.

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

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

Robert E. Johnson

Signature of Arbitrator

NOVEMBER 7, 2016

Date

NOV 14 2016

State of Illinois)
) ss.
County of Kankakee)

19IWCC0612

BEFORE THE WORKERS' COMPENSATION COMMISSIOM
OF THE STATE OF ILLINOIS

LORNA MOSLEY,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 09 WC 15059
	)	
STATE OF ILLINOIS /	)	
SHAPIRO DEVELOPMENTAL CENTER,	)	
	)	
Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

Petitioner's job duties

Petitioner, Lorna Mosley, testified that she was a state employee working at Shapiro Developmental Center since 1999. Tr p. 8. Shapiro Developmental Center is a center for physically and mentally disabled adults. Tr p. 7. Petitioner was working as a Mental Health Technician 3 which involved caring for patients and assisting with activities of daily living such as feeding, bathing, and transfers to and from wheelchairs and beds. Tr p. 7. Petitioner was certified through the State and also supervised shifts of 5 to 7 staff members. Tr pp. 7-8. The parties stipulate that, at the time of her work injury, Petitioner earned an average weekly wage of $711.46 and the parties further stipulated that the current rate for a Mental Health Technician 3 remains the same. Ax 1.

Petitioner testified that she was injured on October 1, 2008 when she was assisting a patient during a fire alarm and hit her low back against a window sill and heater causing a sharp pain. Tr pp. 9-10. Petitioner reported her injury to the shift coordinator that same day and immediately presented to Respondent's company clinic at Provena. *Id.* Prior to her work accident on October 1, 2008, Petitioner was not under any medical care for her low back nor did she have any prior work restrictions. Tr p. 17.

The medical records from Provena show that Petitioner presented to Respondent's company clinic, Provena Occupational Health, on October 1, 2008 reporting an injury at work when she

was assisting a patient from the bed into a wheelchair during a fire alarm. Petitioner complained of right thoracic back pain radiating around to her right upper chest. Petitioner was diagnosed with a thoracic strain with radiculopathy. Petitioner was placed off work. Px 1, p. 2. Petitioner started receiving TTD benefits. Tr p. 11.

Petitioner followed up the next day on October 2, 2008 complaining of thoracic back and cervical pain, and was placed on work restrictions. Px 1, p. 4. On October 6, 2008, Petitioner was seen again and was diagnosed with cervical, thoracic and lumbar strain, continued on modified work, and prescribed physical therapy. Px 1, p. 5.

On October 24, 2008, Petitioner's symptoms did not improve and she complained of low back pain radiating into the left buttock. An MRI was ordered showing a disc bulge at L5-S1. Px 1 p. 7; Px 2 p. 8. Following her MRI, Petitioner was referred to a pain specialist, Dr. Piska, who recommended epidural steroid injections that provided some relief. Px 1, pp. 8-14. The clinic records show that Petitioner underwent an FCE placing her at a light to medium physical demand level and a 2-4 week course of work conditioning was also recommended. Px 1, p. 14. On April 27, 2009, a second MRI was recommended (Px 1, p. 16) which was unchanged from her previous MRI (Px 1, p. 17; Px 2, p. 7). On May 11, 2009 Petitioner was referred by the company clinic to Dr. Jackson, an orthopedic surgeon, who suggested surgery and provided Petitioner with a TENS unit and trigger point injections. Px 1, pp. 31-35. On June 29, 2009 Petitioner was referred by the company clinic for a second opinion with Dr. Stadlin, a neurosurgeon, who recommended a physiatry consult. Px 1, p. 34. Petitioner continued to receive TTD benefits.

Petitioner was then referred by Respondent's company clinic to Dr. Juan C. Jiminez, a neurosurgeon. Petitioner presented to Dr. Jiminez on June 4, 2009. Petitioner reported a work injury on October 1, 2008 when assisting a resident out of bed during a fire alarm twisting her back. Dr. Jiminez reviewed Petitioner's May 7, 2009 MRI showing evidence of disk degeneration with bulging at L5-S1 with facet degeneration and bilateral foraminal stenosis. Dr. Jiminez opined that the pain generator was L5-S1 disk and recommended minimally invasive L5-S1 transforaminal decompression and fusion as Petitioner had failed conservative treatment including therapy and injections. Px 2, p. 17-19. Petitioner was not inclined to have surgery but was advised by Dr. Panuska at the company clinic "to consider the surgical approach. As conservative treatment has failed, this would be the next step in treatment." Px 1, p. 33. Petitioner ultimately agreed to surgery because her pain continued.

Respondent then authorized and Petitioner underwent surgery on November 18, 2009 with Dr. Jiminez. Px 2, pp. 38-41. Petitioner returned to Dr. Jiminez on December 10, 2009 and continued to complain of left leg numbness. Px 2, p. 62. Physical therapy was ordered (Px 2, pp. 71-72) which Petitioner underwent from January 25, 2010 through March 10, 2010 (Px 3, pp. 395-413) at Riverside Medical Center. She remained on TTD.

On May 28, 2010, Petitioner presented to Dr. Jasmine Maly on the referral of Dr. Jiminez and she complained of low back pain with radiating pain down the buttock area and left upper thigh. Px 3 p. 58. Respondent authorized and Petitioner underwent a series of three injections at L5-S1 with Dr. Maly on May 28 (Px 3, p. 66), July 6 (Px 3, p. 43), and July 20, 2010 (Px 3, p. 15). Petitioner continued to receive TTD benefits.

On July 7, 2010, Respondent authorized and Petitioner underwent an FCE as ordered by Dr. Jiminez. Px 3, p. 323. The report showed that Petitioner's work was classified at a heavy work level (lifting 90 lbs, occasionally). Petitioner only proved to be capable of a light/medium work level (lifting 23 lbs, occasionally). Px 3, p. 324. Petitioner demonstrated the ability to perform a waist to chest lift with a maximum of 30 lbs, carrying a maximum of 20 lbs over 100 feet, and pushing a maximum of 218 lbs over 100 feet in a wheelchair. Px 3, pp. 339-340. The report noted decreased overall strength, decreased active range of motion in the lumbar spine, decreased overall endurance, decreased sitting, standing and walking, and an inability to bed, squat, stoop or knell. Px 3, pp. 349-350.

On July 28, 2010, Petitioner returned to Dr. Jiminez following the FCE and he provided Petitioner with the following permanent restrictions; sedentary position; frequent changes of body positions; avoid repetitive bending and twisting; lifting, pushing and pulling of max 20 lbs; and alternative between sit/stand/walk every 30 minutes. Px 2, p. 10.

Petitioner testified that she spoke with State employees, Bonnie Norton (from workers' compensation) and Rhonda Petty (from personnel), to return to work for Respondent after receiving permanent restrictions. Petitioner was not offered any work. Petitioner tried to apply for an alternative work program through the State for other positions but was unable to apply because she needed updated medical documentation regarding her restrictions. Petitioner testified that Respondent denied payment for any follow up medical visits to obtain such documentation. Petitioner remained an employee for Respondent until she was discharged in March 2016. Nonetheless, Petitioner testified that she still wants to return to work for Respondent and would accept a job within her permanent restrictions if she is offered one. Tr pp. 17-19.

Petitioner continued to receive maintenance benefits until Respondent terminated them on December 8, 2010 stating in a letter that "our office only pays for employees who are temporarily disabled." Px 15. Benefits were later reinstated (Rx 3), terminated again without notice in March 2011, and then again reinstated that same month by agreement of the parties. Respondent arranged for an IME to confirm her restrictions before initiating a vocational assessment. Px 15. The IME was not arranged until October 2, 2012, approximately 18 months later.

While pending the scheduling of the IME, Petitioner returned to her primary doctor, Dr. Kolla, on May 20, 2011 and October 5, 2011 complaining of back pain. Dr. Kolla recommended that she return to Dr. Jiminez but authorization for any additional treatment was denied. Px 5. Despite this, on June 21, 2012, Respondent terminated Petitioner's maintenance benefits again for "lack of treatment continuity (16 consecutive months)." Px 15. Benefits were later reinstated following a re-filing of a Section 19(b) motion with penalties. Rx 3; Px 14.

On July 29, 2011, Petitioner met with Steve Blumenthal for an initial vocational evaluation. At this point, Petitioner continued to receive maintenance benefits. Tr p. 20. Mr. Blumenthal reviewed records from Dr. Jiminez, Open MRI and Riverside Medical Center. Px 8, p. 1.

Petitioner reported difficulty sitting, standing, climbing, driving and walking for long periods of time. Px 8, p. 4. Petitioner reported that she had not started looking for work as she did not know what to do. Petitioner's prior work history involved various unskilled labor positions at Burger King and Target. Petitioner also served as a Foster Parent. Petitioner had not yet obtained her GED and Mr. Blumenthal advised her to do so. Mr. Blumenthal also recommended that Petitioner complete a computer program to receive training in Microsoft Office programs. Px 8, p. 11.

Respondent accepted the vocational report and Petitioner enrolled at Kankakee Community College for her GED, which Respondent paid for. Petitioner attended in-person classes Monday through Friday and completed various tests. Tr pp. 21-22. Petitioner graduated and received her GED on September 4, 2013. Px 11. She continued to receive maintenance benefits.

Respondent sent Petitioner for a Section 12 examination with Dr. Frank Phillips, an owner and shareholder of Midwest Orthopaedics at Rush, on October 2, 2012 and again on August 6, 2015. Rx 1. He testified at an evidence deposition on October 11, 2016. Rx 1.

In October 2012, Petitioner continued to complain of low back pain radiating down both legs causing her legs to give out on occasion. Rx 1, pp 27-28. Dr. Phillip confirmed that there was no relevant prior medical history to explain her current condition and that Petitioner reported a consistent mechanism of injury and symptoms among her treating physicians including the IME. Rx 1, pp. 41, 51-52. Petitioner did not display any signs of malingering or symptom magnification. Rx 1, p. 52.

Dr. Phillips opined that Petitioner sustained a lumbar spine injury related to the October 1, 2008 work accident. He estimated that she should have reached MMI three to six months post injury. Dr. Phillips opined that surgery was not warranted and only an initial MRI, x-rays and physical therapy was reasonable and related. Rx 1, pp. 31-32. Regarding her ability to return to work, Dr. Phillips opined that she should return to her permanent restrictions of light to medium physical demand level per the March 23, 2009 FCE (Rx 1, p. 18) but that a current FCE would be appropriate to assess Petitioner's current activity level (Rx 1, pp. 25-26). However, Dr. Phillips never reviewed the July 28, 2010 FCE report. Rx 1, pp. 25-26.

Petitioner testified that a physician's assistant, not Dr. Phillips, performed the physical examination and history intake at both visits. Tr pp. 14-16. Petitioner estimated that on both occasions, Dr. Phillips was with Petitioner for approximately 5 minutes. *Id.*

Dr. Phillips reviewed the October 28, 2008 MRI study and opined that the L5-S1 disk bulge was a normal finding and that the MRI did not show any pathology or injury. Rx 1 p. 14. *He did not review the study of the May 7, 2009 MRI (Rx 1, p. 14) nor the November 14, 2009 CT scan* (Rx 1 pp. 39-40). Although Dr. Phillips did not believe Petitioner needed surgery, he stated that Dr. Jimenez's decision to perform surgery was not malpractice, grossly negligent or a violation of the standard of care. Rx 1 pp 40-41. Dr. Phillips admitted that Petitioner's treatment post-surgery was reasonable to treat her post-operative back condition (Rx 1, p. 25) and that her ongoing complaints is related to her postsurgical back condition (Rx 1, p. 30).

Petitioner began a guided job search on February 13, 2014 with Ms. Peterlin and prepared a resume with her assistance. Tr p. 22; Px 12. Petitioner continued to receive maintenance benefits.

Petitioner, over time, reported several obstacles that interfered with her job search. Petitioner's drivers' license was suspended for six months starting in April / May 2014. Further, Petitioner cared for her father who lived with her. She emptied his urinals, took him to doctor appointments and handled his financial affairs prior to his death in November 2015. Tr pp. 41-43. Her father and husband were both hospitalized periodically from January through September 2014. Tr pp. 23-26. Petitioner also had periodic issues with her computer and internet connection. Tr p. 29.

Despite her challenges, Petitioner continued to look for work and document her efforts to the best of her ability. Petitioner attempted to document all of her efforts and Petitioner testified that she did follow up on the job leads that she applied for but not every single initial contact or follow up was documented. Petitioner not only contacted the job leads that Ms. Peterlin provided with her but attempted to find her own job leads as well. Tr pp. 26- 28.

Petitioner provided Ms. Peterlin with her all her job logs including Petitioner's Exhibit 9 which consisted of job logs from June to October 2014. Respondent terminated Petitioner's maintenance benefits again on August 26, 2014 "due to non-compliance with vocational rehabilitation." Px 15. However, not every job lead that Ms. Peterlin provided was a viable position for Petitioner. Petitioner testified and documented that she applied for a position at Nancy's Pizza in June 2014 and Domino's Pizza in September 2014 at Ms. Peterlin's direction. However, both positions required a valid drivers' license (which Ms. Peterlin knew Petitioner did not have at the time). Tr pp. 29-30; 31-32; Px 9, pp. 1, 5. Petitioner also testified and documented that Ms. Peterlin had her apply for positions at Riverside Medical and WIS International, both of which were beyond her restrictions. Tr pp. 29-31; Px 5 p. 5. Petitioner also testified to some of the confirmation emails that Petitioner submitted to Ms. Peterlin showing that she had submitted online applications for various jobs. Benefits were reinstated September 1, 2014 and Petitioner was made current on maintenance benefits. Px 15.

In October 2014, Respondent paid for and Petitioner began a computer training program at Kankakee Community College. Petitioner took an intro to processing course but was unable to complete the class as her father fell on December 15, 2014 preventing her from taking the final. Rx 2. Respondent did not authorize payment for a repeat exam. As a result, Petitioner was unable to finish the computer program. Tr pp. 31-34. Respondent terminated maintenance benefits again on January 27, 2015 "based upon the non-compliance with Vocational Rehab." Px 15. Benefits were later reinstated again (Rx 3) and Respondent eventually permanently terminated maintenance benefits September 1, 2015. Tr p. 40-41.

Petitioner was never offered a job from any of the job leads Ms. Peterlin provided her with. Tr pp. 32-33. Petitioner eventually found work on her own at ResCare and started working there on February 16, 2016. Tr p. 35. Petitioner remains employed for ResCare which is a group home for the mentally disabled. Tr p. 45. ResCare differs from Petitioner's previous employer,

Shapiro, in that patients live in homes within a community and the patients at ResCare are more independent than those of Shapiro and simply require monitoring. Tr p. 48.

Petitioner testified that she informed her current employer of her permanent restrictions at her interview. Petitioner is not required to perform any work outside of her permanent restrictions and can call a manager for assistance if necessary. Petitioner does not have to assist patients with lifting, feeding, bathing, or transfers. Petitioner monitors patients during various tasks such as household chores, grocery shopping, and during food preparation to ensure that food temperatures are safe. Tr pp. 35-37; 48.

At ResCare, Petitioner makes $9.25 an hour. Petitioner's exhibit 13 shows Petitioner's check stubs from March 16, 2016 through August 31, 2016. Petitioner's check stubs confirm an hourly rate of $9.25, an average of 40 hours a week, and total gross regular earnings of $8,692.20 as of August 31, 2016. Px 13. Respondent never paid Petitioner wage differential benefits. Petitioner testified that since Respondent terminated her workers' compensation benefit, she has lost her health insurance since she could not afford to keep up with the payments. Tr p. 38.

Petitioner currently relies on her husband and children to assist with household chores and grocery shopping. Tr pp. 42-44. She continues to have trouble sleeping due to back and leg pain. She has stiffness after standing or sitting for long periods of time. She uses over-the counter remedies such as ice packs, heating pads, and Aleve or Tylenol every other day. Petitioner's pain prevents her from prior hobbies like riding a bike, working out at the gym and playing in the snow with her kids. Tr pp. 38-40. Her medical restrictions are permanent.

II. CONCLUSIONS OF LAW

As to issue "F", whether the Petitioner's present condition of ill-being is causally related to her injury, the Arbitrator finds as follows:

After hearing the testimony of Petitioner and reviewing the exhibits submitted, including the opinions of Respondent's examiner and Petitioner's treating physician, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injuries sustained on October 1, 2008.

Employers take their employees as they find them. St. Elizabeth's Hosp. v. Workers' Comp. Comm'n (Nichols), 371 Ill. App. 3d 882, 888 (2007). Causation in a workers' compensation case may be established by a chain of events showing prior good health, an accident and a subsequent injury. Gano Electric Contracting v. Industrial Comm'n, 631 N.E.2d 724 (1994). In resolving differences of medical opinion, the Commission may assign greater weight to the opinion of a treating physician than to a Section 12 examiner. International Vermiculite Co. v. Industrial Com., 77 Ill. 2d 1, 4 (Ill. 1979).

In this case, Petitioner was asymptomatic prior to her work place injury. At the time of her accident, Petitioner was working full duty and was not under medical care. This is undisputed. Following her accident Petitioner presented immediately to Respondent's company clinic with

initial complaints of back and neck pain. The Arbitrator finds Petitioner to be credible as her reports of a work place injury were consistent among all of her treating physicians including Respondent's Section 12 examiner. In addition, her complaints of low back pain radiating into her left lower extremity were consistently reported to her treating physicians. Under the care of Respondent's company clinic, Petitioner was placed on work restrictions, underwent physical therapy, obtained an MRI showing a disc bulge at L5-S1, and she received epidural steroid injections that provided Petitioner with little to no relief. Eventually, after initially refusing the offer of surgery, Petitioner ultimately underwent a L5-S1 transforaminal decompression and fusion with Dr. Jiminez followed by physical therapy, additional epidural steroid injections with Dr. Maly, and an FCE confirming the need for permanent restrictions. Based on the above, the Arbitrator finds that Petitioner has shown a history of prior good health, an accident and a subsequent injury under Gano and no credible contrary theory on causation has been presented.

Respondent's Section 12 examiner, Dr. Phillips, testified that although there was an injury and a need for permanent restrictions as a result of the work injury, it was the surgery itself (approved by Respondent) that was the source of Petitioner's current pain. See Rx 1, pp. 31-33. The Arbitrator notes that Dr. Phillips opined that Petitioner only sustained a lumbar strain yet also opined that Petitioner required permanent restrictions per her initial 2009 FCE (which are more restrictive than her 2010 FCE post-surgery). Dr. Phillips conceded that Petitioner's MRI showed a disc bulge at L5-S1 yet opined that this was a normal finding and surgery was therefore not warranted. Most notably, Dr. Phillips did not personally review the last MRI or CT films, which Dr. Jimenez did review and relied upon in forming his diagnosis and treatment recommendations. While Dr. Phillips stated that he would not perform surgery on Petitioner if she was his patient, he opined that Dr. Jiminez did not violate the standard of care by preforming the surgery. See Rx 1 pp. 34-35. Petitioner did not display any signs on malingering or symptom magnification and Dr. Phillips agreed that that her current complaints of pain were related to her back condition post-surgery; a surgery that was performed at least partially in reliance on referral from the company clinic. Dr. Phillips also agreed that Petitioner's treatment following surgery was reasonable to treat her post-operative back condition.

The Arbitrator does not find the opinions and findings of Respondent's Section 12 examiner, Dr. Phillips to be persuasive. Unlike Petitioner's treating surgeon Dr. Jiminez, Dr. Phillips did not personally review the May 7, 2009 MRI, the November 14, 2009 CT scan, nor the 2010 FCE report. Further, although Dr. Phillips relies on physical examination findings in forming his opinions, the Arbitrator notes that he did not personally perform a physical examination (or personally obtain a history) at either IME appointments, letting an assistant do so in his place. The Arbitrator relies on the opinions and findings of Dr. Jiminez that Petitioner's MRI findings required the treatment she obtained including surgery. In view of the above, the Arbitrator finds that Petitioner's current condition of ill-being is causally connected to her workplace accident of October 1, 2008.

As to issue "K", regarding Petitioner's entitlement to Temporary Total Disability and Maintenance benefits, the Arbitrator finds as follows:

Based on the Arbitrator's findings as set forth above , and the record as a whole, the Arbitrator finds that Petitioner is entitled to TTD benefits from April 16, 2009 through July 28, 2010, when

Petitioner was placed on permanent restrictions, reflecting a total of 67 weeks. The parties stipulated that Respondent is due a credit of $31,778.77 in TTD payments. There is no unpaid TTD.

Regarding maintenance benefits, the Arbitrator finds that Petitioner is entitled to maintenance benefits as she participated fully in attempting to find work throughout approximately five years of vocational rehabilitation programs starting when she obtained her GED after meeting with Mr. Blumenthal. After she obtained her GED, she later began a guided job search with Respondent's vocational counselor, Ms. Peterlin. Petitioner admittedly endured some obstacles that hindered her ability to look for work and document her efforts. Petitioner was the primary caretaker for her father who lived with her prior to his death. Her father (as well as her husband) was hospitalized periodically throughout her job search. Petitioner was successfully taking a computer course as recommended by Ms. Peterlin but she did not pass because she had to leave during her final exam when she received an emergency call that her father had fallen. See Rx 2. Respondent did not authorize payment for the class to be repeated or any additional classes. Petitioner did not have reliable transportation as her license was suspended and her vehicle was not working. Petitioner also had difficulties applying for jobs online due to computer and internet issues. Throughout these difficulties, it is reflected in both Petitioner's testimony and the vocational reports of Ms. Peterlin that Petitioner continued searching for work and attempting to comply with the retraining suggestions of Ms. Peterlin.

The Arbitrator notes that of the vocational reports that were submitted into evidence (the parties stipulate that Respondent's vocational services extended beyond what was documented in the reports admitted into evidence), Petitioner documented 352 contacts in her job logs from August 2014 through January 2015. See Rx 2. This did not include Petitioner's handwritten job search notes documenting various follow-ups and in person meetings. See Px 9. In addition, the vocational report documented interviews and applications that Petitioner submitted. Petitioner also submitted into evidence confirmations of job applications she submitted. See Px 10. Petitioner did not solely rely on Ms. Peterlin for job leads; she also attempted to find her own opportunities. The Arbitrator notes that Respondent's vocational rehabilitation was ineffective at times, providing Petitioner with job leads that she was ineligible for or incapable of performing due to her work restrictions. After vocational services were terminated yet again in January 2015 by Respondent, Petitioner continued to look for work for over a year and eventually found work on her own and started on February 16, 2016.

Based on the above, the Arbitrator finds that Petitioner is entitled to maintenance benefits from July 29, 2010 through February 15, 2016 reflecting 289 4/7 weeks. The parties stipulated that Respondent is owed a credit of $123,053.19 in maintenance benefits.

With regard to issue "M", the nature and extent of Petitioner's injury, the Arbitrator finds as follows:

The Arbitrator notes that Petitioner is requesting relief in the form of an award for a wage differential pursuant to Section 8(d)(1) of he Act. In order to qualify for a wage differential award, the Petitioner must prove a partial incapacity that prevents her from pursuing her usual

and customary line of employment and an impairment of earnings. Albrecht v. Industrial Commission, 271 Ill.App. 3d 756 (1995). In addition, there must be a "difference between the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which [she] was engaged at the time of the accident and the average amount which [she] is earning or is able to earn in some suitable employment or business after the accident." Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n, 47 N.E.3d 1167 (2016).

The evidence in this case supports that as a result of the work accident and lumbar surgery Petitioner proved a partial incapacity that has prevented her from pursuing her usual and customary line of employment as a mental health technician. She performed that job since 1999. As a mental health technician, she would be required to perform in the heavy physical demand level according to the FCE. Petitioner's valid 2010 FCE results places her at the light/medium physical demand level.

Dr. Jiminez, Petitioner's treating surgeon on referral from the company clinic, considered the FCE and put her on the following permanent restrictions: sedentary position; frequent changes of body positions; avoid repetitive bending and twisting; lifting, pushing and pulling of max 20 lbs; and alternative between sit/stand/walk every 30 minutes. While Dr. Phillips, Respondent's examining doctor, failed to review the 2010 FCE, he opined that Petitioner could return to work within the parameters of the 2009 FCE, which restricted Petitioner to a light to medium physical demand level. The FCE, Dr. Jiminez, and even Dr. Phillips support Petitioner's position that she is unable to return to her usual and customary line of employment.

The parties stipulate that Petitioner's average weekly wage was $711.46 and that the current rate for a Mental Health Technician 3 remains the same. Petitioner worked with two vocational counselors for over five years and after hundreds of job leads and contacts provided both by the counselors and herself, ultimately found employment on her own. She began working for ResCare on February 16, 2016 on a full-time basis working an average of 40 hours a week and earning $9.25 an hour. Petitioner earns less than when she was working as a mental health technician for Respondent. The Arbitrator finds that Petitioner's current average weekly wage with ResCare is $370.00 (40 hours at $9.25 an hour). See Px 13.

Respondent disputes that Petitioner's post-injury wages reflect her true earning capacity in a competitive job market. Namely, that Petitioner would have been able to find a higher paying job as an administrative assistant, receptionist, office clerk and service representative had she completed the computer program that she enrolled in at the community college. See Rx 2. Respondent's position is disingenuous as it was Respondent who did not authorize the payment of additional classes to complete the computer program and terminated benefits when Petitioner was unable to take the final exam for her intro course due to a family emergency. Even without completing the computer program, Petitioner still attempted to find work in these fields but was not offered a job. See Rx 2. Petitioner followed up with several job leads that Respondent provided only to discover that she was ineligible for the position. While Respondent disputes that Petitioner's current earnings reflect her true earning capacity, the job leads Respondent provided Petitioner included minimum wage positions such as retail sales associate, cashier, delivery driver, drive thru-operator, hostess, etc. See Rx 2. Petitioner's current work and earnings is similar to the positions she was encouraged to apply for by Ms. Peterlin. Thus, the Arbitrator

finds that Petitioner did sustain an impairment of her earning capacity. Furthermore, the Arbitrator notes that the vocational rehab report authored by vocational counselor Scott Blumenthal found Petitioner's earning capacity in her light duty restricted work status was between $9.05 and $12.53 per hour.

The evidence therefore establishes that the Petitioner is entitled to a wage differential award pursuant to Section 8(d)(1) of the Act. The difference between what Petitioner would be able to earn in the full performance of her occupation in which she was performing prior to his accident ($711.46) and the amount she is currently able to earn ($370.00) is $341.46. Under Section 8(d)(1) of the Act, Petitioner is entitled to two-thirds of that amount, or $227.64 per week for the duration of her disability, commencing on February 16, 2016.

With respect to issue "M", whether penalties and fees should be imposed on Respondent, the Arbitrator finds as follows:

The Arbitrator finds that based on the record as a whole, the Respondent did not act unreasonably or vexatiously herein, and based thereon declines to award penalties or attorney fees pursuant to either Sections 19(l), 19(k) or 16 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rick Karas,
Petitioner,

vs. NO: 14 WC 10140

The American Coal Company,
Respondent.

19IWCC0613

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 occupational disease, temporary total disability, permanent partial disability and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that, the Decision of the Arbitrator filed May 9, 2018, is hereby affirmed and adopted.

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

DATED: NOV 13 2019

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/wj
11/07/19
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KARAS, RICK
Employee/Petitioner

Case# 14WC010140

19IWCC0613

THE AMERICAN COAL COMPANY
Employer/Respondent

On 5/9/2018, 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 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:

5236 CULLEY FEIST KUPPART & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RICH KARAS
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 14 WC 10140

Consolidated cases: _____

19IWCC0613

An *Application for Adjustment 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 **September 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other: **Sections 1(d)-(f) of the Occupational Diseases Act**

Karas v. The American Coal Co., 14 WC 10140

FINDINGS

On **October 1, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$1,692.31**.

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

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

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

ORDER

The Arbitrator finds that the Petitioner has failed to prove the existence of coal workers' pneumoconiosis (CWP) or any other respiratory condition related to exposures to coal dust, rock dust and other substances while employed by Respondent and/or his prior coal mining employers.

All other issues are moot.

No benefits are awarded.

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

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

Signature of Arbitrator

May 7, 2018
Date

MAY 9 – 2018

STATEMENT OF FACTS

Petitioner lives in West Frankfort, Illinois and was 68 years old at the time of the hearing. He is a high school graduate, and testified that he had 39 years of coal mine employment, all of it underground. Petitioner testified that while he worked in the coal mines, he was regularly exposed to coal and rock dust, as well as roof glue ("rock lock") and diesel fumes which bothered his breathing. His last date of employment was 10/1/13 at Respondent's Galatia coal mine as a longwall maintenance foreman, and he testified he was exposed to and breathed rock dust and coal dust on that date. Petitioner testified that he turned 65, which was when he had set to retire, and testified that the coal mine environment had "a little" to do with his decision to leave, and "it was time to get out of the dust."

Petitioner was in the Navy from 1967 until 1971, after which he worked for Petrof Packing Company on the killing floor until 1972. In 1972 he started working as a coal miner at Old Ben No. 24 in Benton. He worked there until that mine closed in 1996. He went to work for Drummond Brothers in a coal mine in Alabama and worked there until 1999. On 2/1/00, he started working for the Respondent and continued to work for Respondent until his retirement in 2013. While working as a coal miner, he ran a buggy for two years. He ran a continuous miner for about a year. He was a repair trainee for a little less than a year. After that he was continuously a repairman on the unit at the face of the coal. Petitioner testified that the exertional requirements of all of his job duties involved heavy manual labor. He had to bend, stoop and squat on a regular basis to do his job duties as a coal miner, and he testified that these activities caused breathing problems. He testified that he has never had a job that didn't involve manual labor.

Petitioner testified that he was continuing to have breathing problems as of the date of hearing. He testified he first noticed problems breathing about five years prior to his retirement, around 2008. He would notice shortness of breath when carrying tools and parts, which he estimated weighed 5 to 60 pounds, down the coal face, and would sometimes notice it just walking down the face if it was real low. Petitioner testified that he is currently able to walk a block on level ground at a normal pace before he would notice a change in his breathing. He could climb one flight of stairs before noticing a change in his breathing. Petitioner testified that his breathing problems affect his activities of daily living. For example, he testified that if he works outside in the yard he has to take more breaks, and that he is "shot" after a couple of hours. Petitioner testified that he likes to fish, which he does from a boat, and that loading and unloading the boat causes him problems. Petitioner testified that while working in the coal mine he had to stop and take breaks because of his breathing problems.

Petitioner testified that he was a smoker from 1965 to 1990, when he quit, and that he does not currently smoke. He had been a pack a day smoker. Petitioner had a one-vessel bypass surgery in 2012. He has high blood pressure and diabetes, which are controlled with medication. He does not take any breathing medications. He testified that he treats with Dr. Lawler, and has seen cardiologist Dr. Lipoff, but agreed he had never gone to see either of them for breathing problems, though he wished he would have.

Petitioner testified that he completed his job everyday as a coal miner, but that at the time of his retirement it was harder to complete his tasks. As of the hearing date, he testified he did not believe he could go back and perform his mining job. Upon his retirement, Petitioner testified he signed up for Medicare and Social Security, as well as his mine workers' pension. Petitioner testified that he has not worked or looked for work since his retirement from mining.

Petitioner saw Dr. Houser one time at the request of his counsel. Dr. Houser questioned him about his respiratory problems and asked him about what triggers caused his respiratory problems, and Petitioner testified

he was honest with Dr. Houser about these triggers. He testified that he mows his two-acre yard with a riding lawnmower and does perform other activities that have to be done around the house, such as painting.

Petitioner was seen by Dr. William Houser on 6/11/14, and he testified via deposition on 3/30/16. Board certified in internal medicine and pulmonary disease, Dr. Houser testified that he evaluates and treats patients with all types of lung diseases. He has been affiliated with the Deaconess Hospital Black Lung Clinic since about 1979 as the medical director and routinely performs examinations for the Department of Labor. Since 1983 he has been a medical advisor for Social Security. (Px1).

At the time of his evaluation of Petitioner, Dr. Houser documented Petitioner's history with emphasis on respiratory complaints. Dr. Houser performed a complete physical examination, spirometry and reviewed a 1/27/14 chest x-ray. At the time of Dr. Houser's examination, Petitioner reported complaints of dyspnea with exertion, including activities such as walking, lifting or bending. He reported some sinus type drainage but no significant cough. He gave a history of being a pack-a-day smoker from 1965 to 1990. Physical examination of Petitioner's chest was within normal limits. Dr. Houser testified that most patients with simple pneumoconiosis (CWP), barring any other conditions they might have, would have a normal chest exam. Dr. Houser testified that none of the medications Petitioner was taking at the time of his examination were for the treatment of pulmonary problems. Pulmonary function studies performed by Dr. Houser were within normal limits. He testified that most patients with category 1 CWP would have normal pulmonary function. Dr. Houser testified that the inhalation of coal mine dust over a long period of time can result in shortness of breath. (Px1).

Dr. Houser testified that, per his review of the 1/27/14 chest x-ray, he noted S and T opacities in all lung zones and determined there was category 1/0 CWP. Dr. Houser testified that while he was still practicing medicine daily he relied on his own interpretations of chest x-rays in the diagnosis, care and treatment of his patients. As a pulmonologist, he testified that he did not need a radiologist or B-reader to diagnose CWP. He testified that the B-reader program has no clinical relevance, and to his knowledge is a medical-legal tool. He testified that Petitioner had radiographically apparent changes that represented pulmonary impairment.

Dr. Houser testified that the Petitioner's 40 years working as a coal miner was the cause of the CWP, as this would constitute sufficient exposure to cause the disease in a susceptible individual. Dr. Houser testified that CWP is caused by the inhalation of coal and rock dust and the body's reaction to that exposure. He testified that not every coal miner who is exposed to coal dust will get CWP, and that, at the present time, most coal miners do not develop CWP. Dr. Houser testified that CWP causes scarring and focal emphysema, and that the scarring is a permanent condition with no real applicable treatments. The areas of CWP scarring and the halo of focal emphysema around that scarring impairs the function of the lungs at the sites of such scarring and halos. Dr. Houser testified that there is no cure for CWP, which is a slowly progressive disease, which progression can occur even in the absence of further exposure. He testified that additional coal dust exposure would increase the likelihood of CWP progression, and that he couldn't have further exposure without endangering his health. He believed the presence of CWP makes a person more susceptible to pulmonary infections and pneumonia, and testified that chronic lung disease can also add stress to the heart. (Px1).

On cross examination, Dr. Houser agreed that he saw Petitioner at his attorney's request, and that he was not his patient. Dr. Houser also acknowledged that he has seen hundreds of individuals at the request of Petitioner's counsel. Dr. Houser testified that for eight to ten years prior to his retirement, he served as the medical director for the Southwestern Indiana Respiratory Disease Program, and one of this program's missions was to assist coal miners in obtaining black lung benefits. (Px1).

Dr. Houser agreed Petitioner related an insufficient history of cough and sputum to diagnose chronic bronchitis. Dr. Houser testified that a 25-pack year history of smoking same is significant, and that such a smoking history can be associated with dyspnea on exertion, which he agreed is a non-specific complaint that could be due to something other than respiratory disease. He also agreed his spirometry tech indicated Petitioner reported a 30-pack year history of smoking. Dr. Houser agreed that smoking can, in some cases, cause lung scarring, and that such scarring tends to be irregular, such as "s" and "t" types of opacities on x-ray. Dr. Houser testified that he is always careful when he takes a history from individuals to elicit from them all the triggers for their shortness of breath, and that Petitioner did not relate to him that smoke, dust or fumes were triggers for his shortness of breath. Petitioner indicated that exertion was the cause of it. Dr. Houser agreed that Petitioner's O2 saturation, 96%, was normal, and that spirometry did not reveal the presence of an obstructive defect. Based solely on spirometry, he agreed there was no limitation on Petitioner's exertion. (Px1).

Dr. Houser acknowledged his CWP diagnosis was based upon his interpretation of the chest x-ray, and that he would not have made such diagnosis solely based on Petitioner's history of exposure as a coal miner. Dr. Houser testified that his only occupational diagnosis for Petitioner was simple CWP, and that in general simple CWP is unlikely to progress once the exposure ceases. He testified that there is roughly a 5% chance of CWP progressing to a higher category in a 5-year period, and he couldn't say whether the Petitioner fell within that group. CWP was the only basis he had for testifying that Petitioner had clinically significant pulmonary impairment. (Px1).

Dr. Houser is an A-reader. He took the exam to be a B-reader in the early to mid-1980's but did not pass it and never took it again. Dr. Houser agreed with the position taken by the American Thoracic Society that an older worker with mild CWP may be at low risk for working in currently permissible exposure levels until he reaches retirement age, but that this would not be applicable to the 5% group at risk of worsening. (Px1). On redirect exam, Dr. Houser testified that Petitioner's smoking history was remote and that he didn't have a disease that would have been caused by smoking. He noted that lung scarring via smoking occurs in maybe 1% of cases, and that Petitioner had changes in the upper lung zones, which is generally not reported with smoking. (Px1).

Dr. Alexander, board certified in diagnostic radiology and nuclear medicine, and a certified B-reader, also reviewed Petitioner's 1/27/14 chest x-ray. He interpreted the chest x-ray as positive for CWP, category 1/1, with P/P opacities in all lung zones and some small, irregular "s" type opacities. (Px2 & 3).

Dr. Meyer reviewed the Petitioner's 1/27/14 chest x-rays on behalf of the Respondent. Dr. Meyer has been board certified in radiology since 1992 and a B reader since 1999. He testified that he is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the B reading course and the exam and submitting cases for the B-reading training module and exam. He testified that the 1/27/14 film was quality 3 because of poor contrast and some image noise, meaning the films were not as sharp, but that the film was of sufficient quality to interpret for CWP. Dr. Meyer testified that the image noise granulation could simulate small opacities in the lung, but that this could be differentiated by the fact that the image noise does not respect normal anatomic boundaries and will appear over the entire examination, not just the lungs. Dr. Meyer opined that there was no evidence of pneumoconiosis on the film. (Rx1).

Dr. Meyer explained that how a B-reader reviews x-ray films for opacities and to score them based on size and appearance. Specific occupational lung diseases are identified by the specific opacity types, and CWP is characterized by small round opacities, a predominantly upper lung zone opacity distribution and a general profusion (density) rate. Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties, and in his opinion have a better sense of what the variation of normal is. Dr. Meyer

testified that one of the most important parts of the B-reader training and examination is making a distinction between the 0/1 and 1/0 profusion on a film. (Rx1).

On cross exam, Dr. Mayer acknowledged that different x-ray readers can rate the same films at differing quality levels. He reiterated that while the lung opacities with CWP can occur throughout the lung, they usually are not in the lower lobes unless it is extensive, and it typically begins in the upper lobes. He agreed that mild CWP can be asymptomatic. Petitioner's films showed no evidence of acute cardiopulmonary disease. CWP can exist where it is not visible in films and is only determined via autopsy.

At the request of Respondent's counsel, Dr. Castle reviewed medical records and Petitioner's chest x-ray regarding Petitioner. He did not examine the Petitioner. Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. Dr. Castle's practice included treating patients with occupational lung disease, with some CWP patients in his practice who had coal workers' pneumoconiosis. He has been certified as a B-reader since 1985. (Rx2).

Dr. Castle testified that there were no abnormalities present consistent with CWP in Petitioner's 1/27/14 chest x-ray. He also testified that, based on his review of all the data, Petitioner did not suffer from any pulmonary disease or impairment as a result of his occupational exposure in the coal mining industry. Dr. Castle did testify that the Petitioner worked in or around the underground mining industry for a sufficient period of time to have possibly developed CWP if he were a susceptible host. Dr. Castle also noted that Petitioner had a significant enough history of cigarette smoking to develop chronic obstructive pulmonary disease (COPD) if he were a susceptible host. He testified another risk factor for the development of pulmonary symptoms is cardiac disease, and Petitioner had a documented history of rather severe coronary artery disease primarily involving a single vessel. Dr. Castle testified that this type of cardiac disease may result in significant shortness of breath and can include some physiologic changes. (Rx2).

Dr. Castle testified that Petitioner did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have the consistent rhonchi and rales, crackles or crepitations. His pulmonary examination was normal on virtually every occasion. Dr. Castle reviewed medical records from Methodist Hospital which contained a 1/15/15 pulmonary function study that was normal. Dr. Castle testified that all of the physiologic testing revealed entirely normal studies. Petitioner demonstrated no evidence of obstruction, restriction or diffusion abnormality. In Dr. Castle's opinion, Petitioner had no evidence of respiratory impairment from any cause including CWP and tobacco use. He testified that x-rays do not show pulmonary impairment, which is shown via valid ventilatory function studies. Dr. Castle testified that he agreed with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. (Rx2).

Dr. Castle that CWP is diagnosed based on an abnormal chest x-ray with small, round regular-type opacities primarily in the upper lung zones that, depending on the severity, can involve the middle and occasionally lower lung zones. He testified that the disease may not be symptomatic, and an individual can have an abnormal chest x-ray with no symptoms whatsoever and no findings beyond the abnormal chest x-ray. Dr. Castle testified that the scarring and fibrosis that occurs with CWP is permanent and irreversible, and involves an alteration of the lung structure that impacts the function of the involved lung tissue. Dr. Castle testified that most people that work in the mines do not get coal workers' pneumoconiosis. One has to be a susceptible host to get the disease, but which people may be more susceptible are unknown. Dr. Castle testified that simple CWP does not progress after coal exposure ends. He testified that if he applied the AMA Guides to Impairment 6th Edition to Petitioner's case, based upon the testing he had, Petitioner would be in Class 0. (Rx2).

any such respiratory problems. None of Dr. Lipoff's records indicate examination findings supporting a respiratory disease, but rather indicate reviews of systems respiratory were negative and there were no abnormal findings on chest examinations. The records reveal that Petitioner had a significant history of coronary artery disease.

As in most CWP cases that end up coming to hearing before the Commission, there are differing medical opinions with regard to whether chest x-rays show the appearance of CWP. The Arbitrator finds the x-ray interpretations by Drs. Meyer and Castle to be more credible than the interpretation by Dr. Alexander. First, the Arbitrator gives little weight to Dr. Houser's opinion that Petitioner had radiographic evidence of CWP given that he is not a B-reader, and has failed the B-reading exam the only time that he has taken it. This is particularly important in cases where, as noted by Dr. Meyer, any possible evidence of CWP would be in the 0/1 or 1/0 range, which is essentially borderline. While Dr. Houser has a lot of experience with CWP, the lack of B-reading credentials inhibits the weight of his opinion in a case where the entire theory of compensability requires the ability to properly read an x-ray for CWP. In particular, the Arbitrator believes that Dr. Meyer has the most significant experience and credentials in this case. He testified as to the special training and examination required to be a B-reader. Two B-readers interpreted the chest x-ray as negative for CWP (Meyer and Castle), while one B-reader (Alexander) interpreted the chest x-ray as positive for CWP. Dr. Meyer opined that the chest x-ray was quality 3 due to poor contrast and some image noise, which can cause a granular appearance to the image which can simulate small opacities in the lungs. Dr. Castle believed that the chest x-ray was quality 2. A finding of CWP, in a living person, is based solely on an abnormal chest x-ray (and in some cases CT scan) and history of coal dust exposure. Dr. Alexander's opinion was presented as a short report, and the fact that no evidence was presented which would allow him to explain and support his opinions limits the weight of his opinion versus that of Dr. Meyer and Dr. Castle.

Based on the above, the Petitioner has failed to prove by a preponderance of the evidence that he has CWP or any other causally related respiratory condition.

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

Based on the Arbitrator's findings with regard to the failure to prove the existence of CWP or other causally related respiratory condition, this issue is moot.

WITH RESPECT TO ISSUE (O), ARE SECTIONS 1 (d) and 1(f) OF THE OCCUPATIONAL DISEASES ACT APPLICABLE IN THIS CASE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to the failure to prove the existence of CWP or other causally related respiratory condition, this issue is moot.

The records of cardiologist Dr. Lipoff indicate the Petitioner was seen in consultation based on abnormal 10/27/09 preop ECG. Petitioner denied any clinical history of myocardial infarction, but he described exertional chest "burning" which occurred with a fast walk. Petitioner was a former smoker who quit in 1990. His review of systems respiratory was negative for dyspnea, cough and sputum production. His breath sounds were equal bilaterally without rales, rhonchi, wheezes or rubs. On 3/16/10, Petitioner reported the recurrence of exertional chest pain. A chest examination showed his breath sounds were equal bilaterally without rales, rhonchi, wheezes or rubs. Dr. Lipoff's assessment was unexplained exertional chest pain. Petitioner returned for a 10/19/10 checkup, and the doctor noted he had what sounded like occasional exertional angina pectoris. His chest was clear to percussion and auscultation. (Rx3).

On 4/7/11, Petitioner was complaining of angina pectoris with exertion. His review of systems was negative for dyspnea, cough and sputum production. His chest examination was again normal without rales, rhonchi, wheezes or rubs. The assessment was recurrent angina pectoris. On each examination through 4/19/12, Petitioner's breath sounds were equal bilaterally without rales, rhonchi, wheezes or rubs and his review of systems was negative for dyspnea, cough and sputum production. (Rx3).

Petitioner was seen by Dr. Lipoff on 9/25/12 for chest pain. He was experiencing exertional angina pectoris after walking approximately 100 feet. His review of systems respiratory was negative for dyspnea, cough and sputum production. His breath sounds were equal bilaterally without rales, rhonchi, wheezes or rubs. Cardiac catheterization and angiography were recommended. Petitioner returned with chest pain on 10/11/12. Review of systems again was negative for dyspnea, cough and sputum production, and chest examination showed his breath sounds were equal bilaterally without rales, rhonchi, wheezes or rubs. Dr. Lipoff referred Petitioner to Dr. Bender, and on 10/25/12 Petitioner underwent median sternotomy cardiopulmonary bypass, coronary artery bypass graft times one: saphenous vein graft to distal right coronary artery. When she followed up with Dr. Lipoff on 11/20/12, Petitioner was asymptomatic. Review of systems and chest examination again indicated no abnormalities. Petitioner's review of systems respiratory remained negative and his pulmonary physical examinations were normal through 12/17/13. When Petitioner was seen on 6/9/14, his cardiac and respiratory systems continued to be negative for dyspnea and cough. He remained asymptomatic at 6/17/14 follow-up. (Rx3).

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; WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT; and, WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he has contracted the disease of CWP (coal workers' pneumoconiosis), or any other respiratory disease, as the result of exposures to various substances while performing underground coal mining. Petitioner has also failed to prove that he sustained any objective respiratory impairment. Given these findings, Petitioner has also failed to prove that he sustained any occupational disease that was causally related to his employment with Respondent.

The Arbitrator initially notes that it appears that the only real respiratory disease that is being alleged by Petitioner is CWP. All of the physicians' chest and respiratory examinations of the Petitioner in this case appear to have been normal. There is no indication that the Petitioner had any treatment for or medications directed to

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jackie Rodgers,
Petitioner,

vs. No: 16 WC 10952

19IWCC0614

State of Illinois,
University of Illinois,
Respondent.

DECISION AND OPINION ON REVIEW

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

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 17, 2018, is hereby affirmed and adopted.

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

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 13 2019

Marc Parker

mp/wj
11-07-19
68

Deborah L. Simpson

Barbara N. Flores

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

RODGERS, JACKIE
Employee/Petitioner

Case# **16WC010952**

UNIVERSITY OF ILLINOIS
Employer/Respondent

19IWCC0614

On 12/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1937 TUGGLE SCHIRO LICHTENBERGER
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

DEC 17 2018

Kurt A. Carlson
KURT A. CARLSON, Acting Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JACKIE RODGERS,
Employee/Petitioner

v.

UNIVERSITY OF ILLINOIS,
Employer/Respondent

Case # **16** WC **10952**

Consolidated cases: _____

19IWCC0614

An *Application for Adjustment 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 **URBANA**, on **11/21/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/6/16**, 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 her low back ***is*** causally related to the accident.

Petitioner's current condition of ill-being as it relates to her left hip ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**38,480.00**; the average weekly wage was $**740.00**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**31,333.71** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**31,333,71**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The petitioner's current condition of ill-being as it relates to her left hip is not causally related to the injury on 3/6/16; the treatment for petitioner's left hip after 3/6/16 was not reasonable and necessary; the petitioner is not entitled to any temporary total disability benefits after 6/29/17; the petitioner is not entitled to any prospective medical treatment related to her left hip.

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.

Kaurean D. Kelly

Signature of Arbitrator

12/10/18
Date

ICArbDec19(b)

DEC 17 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 62 year old building service worker, alleges she sustained an accidental injury to her back and left hip that arose out of and in the course of her employment with respondent on 3/6/16. The respondent stipulates that petitioner sustained an accidental injury to her back, but disputes petitioner's claim that she sustained any accidental injury to her left hip that arose out of and in the course of her employment by respondent on 3/6/16. Petitioner worked for respondent in Ashton Woods. She would clean stairs, the house, the garage, and apartments. Petitioner denied any problems with her left hip prior to the accident on 3/6/16.

On 3/6/16 petitioner was sweeping the outside stairs that lead to the basement at Ashton Woods. She testified that as she was sweeping the stairs she missed the 3rd step and began falling, and as she fell she grabbed the left banister, and fell on her left hip on the concrete floors, and torqued her back. She testified that her back hurt worse than her left hip. Petitioner testified that she then got up on her hands and knees, and then her feet, and exited the stairwell. Petitioner testified that she then called her foreman Sandy Wilfong to report her injury. She testified that Sandy sent a worker to get her, and the worker then took her to Orchard Downs, respondent's home base where the foreman's office is located. Petitioner testified that she and Sandy completed the accident report. Neither party offered this report into evidence.

After completing the accident report Sandy took petitioner to the emergency room at Carle Foundation Hospital. Petitioner's chief complaint was documented back pain. She gave a history of falling backward off the stairs, twisting her back, landing on her right hand and wrist, and jamming her right thumb while at work. On examination petitioner was tender to palpation of the paraspinal muscle and soft tissue of the right lateral lower lumbar region. She also had tenderness to palpation of the right thumb. Petitioner was assessed with a low back strain. Petitioner made no mention of any left hip complaints. Petitioner was prescribed Norco, Robaxin and Clinoril, and instructed to follow up at Occupational Medicine. Petitioner was released to modified work on 3/6/16. She was restricted from lifting, pulling, and pushing over 10 pounds, and told to avoid bending and twisting of the back.

On 3/9/16 petitioner presented at Occupational Medicine for evaluation of her low back pain. Petitioner gave a history of sweeping the steps and misstepping on the last step, causing her to torque her back. Pain was worse to the lateral aspect. She stated that she did not actually hit her back when she twisted. She denied any radiating pain. She rated her pain at a 5/6 on a scale of 10. She reported that the pain was fairly consistent, and was localized more to the right side of the back. An examination revealed tenderness to the right low back. She was assessed with a low back strain. There are no documented

complaints of left hip pain. The Norco was discontinued. Petitioner was restricted from lifting, pushing, or pulling 10 pounds. She was also told to avoid bending and twisting at the waist, chronic bent over postures of the spine, climbing ladders or stairs, and kneeling and squatting. Respondent could not accommodate restrictions and began paying petitioner temporary total disability benefits as of 3/7/16.

On 3/15/16 she returned to Occupational Medicine and reported that she continued to have pain that radiated from the right low back down her leg, right lateral aspect. She rated her pain at 6-7 on a scale of 10. Petitioner was referred to physical therapy and for an x-ray. She was taken off the current medications and prescribed Flexeril. Her restrictions remained the same.

On 3/22/16 petitioner underwent a physical therapy evaluation. Petitioner complained of lumbar pain radiating to her right lower extremity. She gave a history of sweeping the steps at work and misstepped on the last step going down backwards, causing her to torque her back. She grabbed the pole and fell on her hands and knees on her side. Petitioner's internal rotation of her hips were 15 degrees on the left and 24 degrees on the right. Her external rotation of her hips were 21 degrees on the left and 22 degrees on the right. There were no documented left hip complaints.

On 3/29/16 petitioner returned to Occupational Medicine and reported that her condition remained unchanged. She also reported that the 2 physical therapy sessions had not helped at all. The x-ray of the back showed no gross abnormalities. She continued to remain tender to the right low lumbosacral musculature and to the SI joint area. Petitioner was diagnosed with continued low back pain with right leg sciatica. Physical therapy was continued and her restrictions remained in place. There were no documented left hip complaints.

On 4/22/16 at physical therapy petitioner noted that her pain was in her right low back, right buttocks and left groin area. She stated that she did not think the therapy was helping. She noted no improvement. Petitioner's therapy was placed on hold after 10 sessions. Petitioner's internal rotation of her hips were 20 degrees on the left and 25 degrees on the right. The external rotation of her hips were 25 degrees on the left and 30 degrees on the right.

On 5/2/16 petitioner followed up at Occupational Medicine for her low back pain, more on the right side. The radiation had improved, and the pain was mostly in her back. Petitioner's biggest concern at that time was that she began to have left groin pain. She stated that it began on 2/19/16 after some therapy when she was doing exercises. She stated that she was concerned because when she fell, she fell onto her left hip. She reported that she had completed therapy and it did not help. On examination

petitioner still had some tenderness to her low right back, and now had tenderness to the left low back as well. Straight leg raise caused pain to the right low back. Palpation on her left groin was very tender. She could not internally or externally rotate well at the hip. Petitioner was assessed with low back pain with right leg sciatica that was slightly improved, and a new complaint of left inguinal pain following therapy and some low back pain. X-rays of the hips and MRI of the low back were ordered. Her restrictions were continued for a week.

An x-ray of the left hip performed 5/2/16 showed moderate changes of degenerative arthritis in the left hip with joint space narrowing and small femoral head osteophytes.

On 5/9/16 petitioner returned to Occupational Medicine for reevaluation of her low back pain, left hip and groin pain. She rated her left hip pain with radiation into the left groin at a 3/10. The MRI was ordered again and her restrictions were continued. On 5/17/16 petitioner was discharged from physical therapy.

On 7/25/16 petitioner underwent an MRI of the lumbar spine. The impression was mild multilevel lumbar degenerative disc disease, including L2-L3 and L3-L4 mild central spinal canal stenosis, and no significant foraminal stenosis.

On 7/27/16 petitioner returned to Occupational Medicine. Petitioner continued to complain of marked left hip pain, pain with sitting and positional changes, and pain radiating to the left groin. Petitioner also stated that her right back continued to hurt with right sided low back pain with radiation to the right buttock, without radicular pain. She stated that 6 sessions of physical therapy resulted in mild improvement in her low back pain, but no change in her left hip pain. Petitioner's gait was markedly antalgic and she favored her left hip. Petitioner was assessed with a contusion and injury to the left hip; preexisting left hip degenerative arthritis; and, right lumbosacral strain with mild universal degenerative disc disease of the lumbar spine. Petitioner was referred to Dr. Gurtler and her physical therapy referral was renewed for her low back. Dr. Cohen noted that petitioner's left hip injury aggravated her preexisting moderately advanced degeneration of her left hip. Work restrictions were continued.

On 8/24/16 petitioner was reexamined by Dr. Cohen. She reported no improvement in her symptoms. Dr. Cohen noted that the referral to Dr. Gurtler, and the referral for additional therapy had not yet been approved. He further noted that she has bilateral degenerative arthritis in both knees and was undergoing steroid injections in the right knee by her primary doctor. Petitioner's restrictions were continued.

On 9/1/16 petitioner underwent another physical therapy evaluation for her lumbar spine degenerative joint disease. Petitioner complained of left greater than right groin and thigh pain. Petitioner identified the mechanism of injury on 3/6/16 as falling off 1-2 stairs backwards and landing on her left side on the concrete. Petitioner's left hip passive range of motion was 90 degrees. Her internal rotation was 10 degrees and external rotation was 25 degrees with left groin pain at end range.

On 9/16/16 petitioner presented to Dr. Bane's physician's assistant, Casey Shroyer, in the orthopedic department. She was referred by Dr. Cohen. Her chief complaint was left hip pain. She also complained of a sore back. On examination Shroyer noted that petitioner's rotation of her left hip caused pain, but her range of motion was still intact. Petitioner also had some tenderness over the lateral aspect of the hip. Following an examination petitioner was diagnosed with an underlying osteoarthritis, that was flared up by her fall. A hip contusion was also noted. Options given were physical therapy and an intra-articular injection. It was noted that petitioner's condition was not to the point where a hip replacement was recommended. Petitioner opted for additional physical therapy. The order was given.

On 9/26/16 petitioner returned to Dr. Cohen. Petitioner complained of persistent pain in the left hip, which gets worse as the day progresses. She also reported that her right low back pain continued and she was in therapy for that at the Spine Center. Physical therapy for the left hip was ordered. Petitioner was continued on restricted duty work. On 10/14/16 petitioner returned to Dr. Cohen and reported that she awoke on Tuesday morning with significant increase in her low back pain with radiation to the groin area, left greater than right, and radiation down the lateral aspect of her left thigh. She reported no improvement with physical therapy. Dr. Cohen recommended a left hip steroid injection to see if the pain was coming from the hip or back. Physical therapy was discontinued. On 10/26/16 petitioner underwent a left hip injection. She reported marked improvement with her left hip pain, with a mild flare up two days later, with significant improvement in her left hip since then. On 11/7/16 she reported that her right low back pain continued. Dr. Cohen noted that since her left hip pain was better, it appeared that most of her pain was emanating from her degenerative disc disease of the lumbar spine. She denied any radicular pain. She continued with complaints of pain with flexion, stooping, bending and twisting. Petitioner was referred back for additional therapy for her back. Her work restrictions were continued.

On 11/11/16 petitioner reported that in physical therapy she had 2 days of relief after her left hip injection. She stated that after that it began to give out on her when she would get up from the sofa. She stated that this happens about 30% of the time when she gets up from sitting, and was more likely to

happen later in the day. On 11/14/16 she reported minimal giving way of her left hip in the last three days.

On 12/5/16 petitioner returned to Dr. Cohen with persistent pain in her left hip. She stated that the hip goes out on her, but she does not lose her balance or fall. She also complained about pain in both knees, and stated that she had bilateral injections in both knees in January 2015. She also complained about persistent pain in the right side of her low back without radicular symptoms. Petitioner had an antalgic gait due to her left hip pain. Dr. Cohen diagnosed left hip moderate degenerative arthritis, left hip strain, and degenerative arthritis of the lumbar spine. He noted that Shroyer in Ortho had indicated that petitioner was not a candidate for surgical intervention on the left hip. Dr. Cohen placed petitioner at maximum medical improvement. He was of the opinion that her bilateral knee pain was probably aggravating her existing left hip and low back pain. Dr. Cohen referred petitioner back to Shroyer in Ortho for her left hip. Petitioner's work restrictions were continued. They included a 10 pound weight restriction on lifting, pulling and pushing. She was to avoid bending the back at the waist, static chronic bent postures to the spine, climbing ladders and stairs, and overhead work and overhead lifting. Petitioner was instructed to alternate sitting, standing, and walking every 20 minutes per hour per shift.

On 12/14/16 petitioner reported to her therapist that she was no better and no worse than when she was last seen. The therapist was of the opinion that there was nothing more to add at that point. Petitioner was discharged from therapy. Her left hip functional assessment remained unchanged. Her average left hip pain was rated at a 3.5/10. Her average low back pain was 3/10. Frequency of left hip and low back pain was 30-40% of the day.

On 3/8/17 petitioner returned to Dr. Cohen noting marked pain in the left hip and left groin. She also complained of left lower extremity radicular pain beginning in January. Dr. Cohen noted that these complaints were not present prior to then. He noted that the MRI study of the low back in May of 2016 did not show any foraminal stenosis or cord compression. Dr. Cohen assessed a new onset of left sciatica. Petitioner stated that she was on long term disability. He again referred her to Orthopedics for her left hip. Dr. Cohen continued her restrictions.

On 5/3/17 petitioner told Dr. Cohen that her left leg was getting worse. She noted radiating pain from her left lumbosacral area, sciatic region, radiating down to the lateral aspect of her ankle without involvement of the foot. She also complained of ongoing pain in her left hip radiating to her groin. Dr. Cohen noted that the referral to Orthopedics had not yet been approved. He made a referral to a nonsurgical spine provider for evaluation and consultation. Restrictions were continued.

On 5/25/17 petitioner presented to Dr. Rafferty for a physical. She reported that her fall in March caused right posterior shoulder pain, and she needed help with pain management.

On 6/5/17 petitioner underwent a Section 12 examination performed by Dr. John Scott Player, at the request of the respondent. Prior to her examination, Dr. Player was sent a stack of medical records pertaining to petitioner. He reviewed these records and performed an examination. Petitioner gave a history of no problems with her left hip before the fall on 3/6/16. She gave a history of sweeping the stairs and being on the last step in the basement when she lost her balance. She stated that she attempted to stop her fall by catching either the banister or newel post. She grabbed the pole and stated that "I fell onto the basement floor on my left side." She reported pain in her right lower back, but not much pain in the left hip at that time. She stated that the left hip pain became severe about a week later. Petitioner complained of more left hip and groin pain, and stated that her lower back pain had not improved. She described her symptoms as being in the left hip in the groin, not over the greater trochanter. She also reported pain radiating from her left lower buttock area down to the lateral left ankle. Dr. Player performed a physical examination that revealed no tenderness over the left trochanteric bursa, antalgic gait on the left, an inch of left quadriceps atrophy, ½ inch of left calf atrophy, no muscle strength deficit, small reductions in left hip range of motion, and normal flexion. He also noted range of motion deficits that were consistent with moderately severe left hip psoriatic arthritis.

Dr. Player reviewed the mechanism of injury histories petitioner provided on 3/6/16 and 3/9/16 and noted that there was no evidence for direct trauma to the back or the left hip, nor was there any documentation of a direct trauma to the left hip, or even any left hip complaints. He noted that in the next history petitioner provided on 3/21/16 she stated that she fell on her hands and knees, and her side, but it is not clear what that means. He noted that the records documented no complaint of left hip or groin pain until 4/22/16, which is directly contrary to her history that she had excruciating left hip pain within a week of the accident. Dr. Player noted that petitioner gave a third mechanism of injury on 5/2/16 when she stated that she fell and hit her left hip. Dr. Player noted that Dr. Cohen placed petitioner at maximum medical improvement on 12/5/16 for the low back, and then in January of 2017 reported radicular complaints down the left lower extremity. He noted that Dr. Cohen also documented continued left leg radicular pain from the low back and left hip on 5/3/17.

Dr. Player diagnosed petitioner with left hip psoriatic arthritis. He stated that the psoriatic part was because she had multiple plaques on her knees and on her elbows. He was of the opinion that psoriatic arthritis affects the hips and knees. He was of the opinion that the psoriasis is an autoimmune condition,

and autoimmune conditions can also cause arthritis of the hip. Petitioner was diagnosed with psoriasis in 1976.

On 6/15/17 petitioner began a course of physical therapy for her right shoulder. She stated that she started experiencing pain one night while sitting on the couch in April of 2017. She stated that she mostly noticed pain in her shoulder at night. She gave a history of falling down a set of stairs approximately 1 ¼ years ago and landed on her left side, but was not sure if it contributed to her current condition. Petitioner underwent 5 therapy sessions.

On 6/28/17 petitioner returned to Dr. Cohen after seeing Dr. Player. She continued to complain of pain radiating down her left leg and pain in her left hip and groin area. She also reported pain in her left low back and left sciatic notch tenderness. Dr. Cohen noted that petitioner's case was closed by respondent and no further treatment would be authorized. Restrictions were continued.

Petitioner was paid workers' compensation benefits from 3/7/16 through 6/29/17, in the amount of $31,333,71. Thereafter petitioner applied for SURS benefits.

On 7/19/17 petitioner was seen by Dr. Fletcher at Safe Works Illinois for her left hip and low back. Petitioner gave a history of sweeping a stairway of 26 steps and was on the 3rd step from the bottom, lost her balance and fell on her left side. She described her primary problem as pain located in the lumbosacral area, lower back, groin, left gluteus maximus, left hip and left leg. Petitioner underwent a Pain Disability Questionnaire that placed her total PDQ at 119, which was in the extreme pain category. She was diagnosed with left hip pain. The hip strength and external rotation for petitioner's left and right hip were 5/5. Dr. Fletcher examined petitioner and performed a record review. He continued Dr. Cohen's work restrictions. He recommended a home exercise program and updated MRI of the left hip with contrast, and the lumbar spine. He was of the opinion that petitioner's problems are related to her work activities.

On 9/1/17 petitioner underwent an MRI of the left and right hip with contrast. The impression with respect to the left hip was severe osteoarthritis with joint space narrowing, subchondral fluid, subchondral cyst formation and marginal spurring of the left hip joint with bone on bone appearance. Diffuse fraying, blunting and tearing of the left acetabulum, left paralabral cyst lateral to the acetabular labrum and acetabulum measuring 2.3 cm superior to inferior, 2.9 cm AP, and 1.2 cm transverse diameter. Left cam type femoral acetabular impingement. Mild left superficial greater trochanteric bursitis. The impression

with respect to the right hip was normal right hip joint. Mild right superficial greater trochanteric bursitis. Mild right greater trochanteric bursitis.

Petitioner returned to Dr. Fletcher on 9/6/17. Petitioner's PDQ rating was still severe at 113. Following an examination his diagnosis was pain in the left hip, and other sprain of the left hip, subsequent encounter. Dr. Fletcher reviewed the results of the left hip MRI and assessed left hip osteoarthritis; left hip labral tear with CAM impingement; and chronic low back pain which may be mechanical. He was of the opinion that these problems are related to work activities. Dr. Fletcher continued petitioner's work restrictions. Dr. Fletcher recommended a left hip arthroscopy.

On 11/20/17 petitioner presented to Dr. Robert Bane's office for the 2nd time and was seen by Dr. Bane. Petitioner reported left hip pain for almost 2 years. She gave a history of cleaning stairs when she fell down the stairs and landed on her left hip. She reported constant pain that was worse at night, and increased pain while walking. She rated her pain at 6/10. Petitioner had maximal tenderness over the inguinal area. She had 0 degrees of hip extension and 90 degrees of hip flexion, 0 degrees of hip internal rotation and 15 degrees of hip external rotation. Dr. Bane reviewed an MRI of the left hip performed 9/1/17 that revealed severe osteoarthritis with complete bone on bone changes. Chondral debris and osteophytes, as well as subchondral sclerosis and some cystic changes were noted.

Dr. Bane reviewed petitioner's records and noted that there was no mention of any left hip pain after the injury. He noted that petitioner reported left groin pain that seemed to be getting worse with physical therapy on 5/2/17. She denied any problems with her left hip before the fall. Dr. Bane was of the opinion that petitioner's left hip osteoarthritis predated the fall. He noted that there is a note of groin pain in the therapy records dated 4/22/16. Dr. Bane was of the opinion that the therapy that petitioner was doing after the fall probably aggravated the pre-existing osteoarthritis in her left hip. He was of the opinion that petitioner's previously asymptomatic left hip osteoarthritis was unmasked because of rehab that she was doing because of her fall at work. He was also of the opinion that in a round about way the work related accident exacerbated the previously asymptomatic osteoarthritis in her left hip. Dr. Bane was of the opinion that her left hip condition had deteriorated over the last year and a half. Dr. Bane recommended a left total hip arthroplasty. Dr. Bane told petitioner to stop smoking at least one month prior to surgery to minimize risk of complication.

On 11/27/17 the evidence deposition of Dr. Fletcher was taken on behalf of petitioner. Dr. Fletcher is board certified in occupational medicine. Dr. Fletcher is the principal at SafeWorks since 2001. He sees workers that get injured on the job every day. As part of his examination of petitioner, Dr. Fletcher

reviewed 2 years of records of petitioner dating back to when she presented to the emergency room following her fall. He also reviewed the evaluation of Dr. Player. Dr. Fletcher testified that when he last saw petitioner he did not anticipate any further treatment for her lumbar spine. He thought that eventually petitioner would need a left hip replacement, but could start with an arthroscopy. He noted that he referred petitioner to Dr. Sidell. Dr. Fletcher testified that he reviewed no records prior to 3/6/16.

Dr. Fletcher opined that petitioner had preexisting degenerative conditions in both her left hip and lumbar spine, and that the accident aggravated and accelerated her left hip condition probably causing an acute labral tear, superimposed on a preexisting Cam impingement and osteoarthritis of the left hip. He opined that the accident as petitioner described could aggravate a preexisting condition. Dr. Fletcher based these opinions on the fact that petitioner stated that she was asymptomatic prior to the fall on 3/6/16, and had continuously given subjective complaints since 3/6/16. He believed that the description of the fall and the twist, is a mechanism of injury that could cause an acute labral tear of the hip. He noted that he saw hip complaints in the records in late April of 2016, and that she had fallen on her left side of her body, specifically the hip on 3/6/16. Dr. Fletcher testified that he saw no differing accident histories in the records. Dr. Fletcher was of the opinion that the reference in the note dated 5/2/16 with respect to some type of groin injury or something on the left that happened during a physical therapy appointment in February of 2016 had to be an error based on his review of the records. He saw no records that show she was injured prior to the fall.

On cross examination Dr. Fletcher noted that a PDQ is a self reported disability. Dr. Fletcher stated that petitioner could have been sent to him by her attorney Litchtenberger, since he had sent him some records to review.

Petitioner was awarded SURS benefits at the end of November 2017. She was paid from the date they were awarded, and not retroactively to the time workers' compensation benefits were stopped on 6/29/17.

On 1/25/18 petitioner underwent a left total hip arthroplasty performed by Dr. Bane. Her postoperative diagnosis was left hip primary osteoarthritis. Petitioner was discharged home on 1/28/18 in good condition. Petitioner was provided with home health care services that included physical therapy. Petitioner followed-up post-operatively with Dr. Bane. This treatment included a course of physical therapy that began on 2/20/18.

On 2/23/18 petitioner followed-up with Dr. Bane. She noted that she had no pain in her left hip. She did not feel she needed to use her cane. She reported slight soreness after therapy session, but otherwise was progressing well. Petitioner stated that she was very happy with her progress. Dr. Bane continued petitioner in physical therapy. Given the physical demanding nature of her job, and the fact that petitioner had not worked for about 2 years, Dr. Bane did not think that she would be getting back to that level of work. Dr. Bane was of the opinion that she was doing very well with her hip and he believed she would continue to make very good progress and overall have a good quality of life.

On 3/1/18 the evidence deposition of Dr. John Scott Player, an orthopedic physician and prior orthopedic surgeon until he developed an eye problem, was taken on behalf of the respondent. Dr. Player opined that there is a greater than 51% probability that the autoimmune condition that was causing petitioner's skin lesions would also be responsible for her left hip condition. Dr. Player noted that Shroyer documented tenderness over the bursa of the left hip, known as trochanteric bursitis, and even if this occurred as part of the accident, it would have no effect on the degenerative condition occurring within the hip joint itself. He opined that since there is no documentation of any type of left hip or groin pain until 6 weeks after the 3/6/16 accident, there is no causal connection between her arthritic condition in her left hip and the injury on 3/6/16. Regardless of causation, Dr. Player was of the opinion that petitioner would require a 30 pound lifting and carrying restriction relative to the left hip.

On cross examination, Dr. Player opined that the progression of petitioner's psoriatic arthritis is what caused the need for a hip replacement surgery. He opined that her psoriatic arthritis was mild when he saw her in June of 2017.

Petitioner's last documented physical therapy was on 3/13/18.

On 4/6/18 petitioner returned to Dr. Bane. She stated that the pain she had before surgery was basically gone. She was walking fairly well with minimal limp. X-rays showed satisfactory placement of the total hip arthroplasty. He recommended that she not return to the physical job she had prior to the difficulty with her left hip, because that would only cause wear and tear and earlier failure of her total hip arthroplasty. He restricted her lifting to up to 40 or 50 pounds. He did not want her to work a job that required her to be on her feet for most of the day or to do bending, squatting, or twisting activity. He thought she would have difficulty carrying a heavy vacuum cleaner upstairs. Dr. Bane said these restrictions are permanent. Petitioner was instructed to follow up in 9 months.

On 7/24/18 the evidence deposition of Dr. Bane, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Bane testified that he had noted the possibility of psoriatic arthritis of the left hip in his operative report. He noted that psoriatic arthritis is an inflammatory arthritis. He noted that petitioner had a history of psoriasis. He opined that what he found in petitioner's left hip during surgery was either osteoarthritis or psoriatic arthritis. Dr. Bane testified that there was some preexisting condition in her left hip that predated the injury. He further stated that he saw a worsening of the arthritic condition between the time she saw Shroyer and saw him. Dr. Bane opined that while petitioner was in physical therapy for her back the exercises that she was probably doing for her back exacerbated her hip. He was of the opinion that if people have a bad back, their hip can often get worse because their back does not move as well and then you tend to move more through your hip every time you bend forward. Dr. Bane was of the opinion that the fall itself did not exacerbate her left hip, but strained her back. He opined that because of the altered mechanics with her back and then going through physical therapy, her previously asymptomatic hip became painful. Dr. Bane did not feel petitioner had reached maximum medical improvement for her left hip as of 4/6/18. He also did not feel she could do physical work at that point. However, she might be able to do an office job.

On cross examination Dr. Bane stated that his restrictions on petitioner in January of 2019 would be the same as they were in April of 2018 given the fact that she had had a hip replacement. Dr. Bane did not have a job description for petitioner's job, nor did he remember all the details they went over. He understood, based on what petitioner told him, that her job required her to lift up to 50 pounds, be on her feet most of the day, do a frequent amount of bending, twisting and squatting, and that she was primarily involved in cleaning type activities like a housekeeper. Dr. Bane felt that when petitioner reaches maximum medical improvement she could do any type of sitting work, handle work that would require lifting of smaller amounts up to 20 pounds, do work where she does not have to be on her feet all day and go up and down all day, and do work where she did not have to do a lot of awkward lifting and twisting, crawling around, or work on the floor. Dr. Bane opined that osteoarthritis, as well as psoriatic arthritis, are progressive conditions that will get worse over time as part of the natural degenerative process. He opined that petitioner's pretty significant physical change from 9/6/16 through November of 2017 in regards to her left hip while she was not working, was change attributable to just the natural degenerative process. Dr. Bane did not go through all the physical therapy records to see what she was doing so he does not know what may or may not have contributed to her left hip pain in therapy. He based his opinion on therapy notes where petitioner stated that her left hip pain began after some therapy when they were asking her to do some exercises.

On redirect examination Dr. Bane was of the opinion that petitioner's back problem and physical therapy unmasked her left hip condition, and then from September of 2016 to November 2017 the change in her condition was due to the natural history of the arthritic disease process itself. Dr. Bane testified that physical therapy exercises caused some symptoms and problems with her left hip for some time, but then that natural deterioration or progression beyond that time, including when she was examined by Shroyer and him, was probably related to the disease process rather than to any flare up in physical therapy.

Petitioner testified that her medical bills have been paid by either workers' compensation or her insurer Health Alliance. She is not sure if all bills have been paid. Petitioner testified that she is still under restrictions and doctor's care and has not returned to work anywhere.

Petitioner denied any pain in her left hip before the injury on 3/6/16. She testified that she was diagnosed with psoriasis in 1976 and has had it since then. Petitioner stated that she had bilateral knee pain prior to 3/6/16 and had injections to her knees, but no physical therapy.

Petitioner testified that she believes the reference to a "February 19, 2016" report was supposed to be a reference to an "April 19, 2016" report since she had no physical therapy on 2/19/16 and it was before the injury on 3/6/16. Petitioner testified that she first noticed pain, increased pain, in her left hip while in physical therapy. Then on recross examination she testified that she had pain in her left hip immediately after the fall when she hit the concrete, but also torqued her back at the same time, and that hurt her worse at that time.

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

Petitioner alleges her current condition of ill-being as it relates to her left hip and low back are causally related to the injury she sustained on 3/6/16. Respondent disputes petitioner's current condition of ill-being as it relates to her left hip is causally related to the injury on 3/6/16.

First, the arbitrator finds significant inconsistencies in the accident histories petitioner testified to at trial and those in the medical records. The arbitrator finds the petitioner provided 9 accident histories following the injury.

1. On 3/6/16 she reported at Carle of "falling backward off stairs, twisting her back landing on her right hand and wrist, and jamming her right thumb while at work."
2. On 3/9/16 she reported to Occupational Medicine "sweeping the step and misstepped on the last step, causing her to torque her back..did not actually hit her back when she twisted."

3. On 3/22/16 she reported to therapy "sweeping stairs at work and she misstepped on the last step going down backwards, causing her to torque her back, She grabbed the pole and fell on her hands and knees on her side."

4. On 9/1/16 she reported to therapy "falling off 1-2 stairs backwards and landing on her left side on the concrete."

5. On 6/5/17 she reported to Dr. Player "sweeping the stairs and being on the last step in the basement when she lost her balance. Attempted to stop fall by catching either the banister or newel post. Grabbed the pole and fell onto the basement floor on my left side."

6. On 6/15/17 she reported to therapy "falling down a set of stairs approximately 1 ¼ years ago and landed on her left side."

7. On 7/19/17 she reported to Dr. Fletcher "sweeping a stairway of 26 steps and was on the 3rd step from the bottom, lost her balance and fell on her left side."

8. On 11/20/17 she reported to Dr. Bane "cleaning stairs when she fell down the stairs and landed on her left hip."

9. At trial petitioner testified that "as she was sweeping the stairs she missed the 3rd step and began falling, and as she fell she grabbed the left banister, and fell on her left hip on the concrete floor, and torqued her back."

In addition to the differing accident histories, petitioner also provided differing histories as to when her left hip complaints actually began. Following the injury on 3/6/16 petitioner's only complaints on the date of accident were related to her right low back and right thumb. On 3/9/16 she reported low back pain more localized to the right side. On 3/15/16 she complained of pain radiating from the right low back down her right leg. On 3/22/16 she complained of lumbar pain radiating down her right leg. She had no left groin or left hip complaints. However, the arbitrator finds it significant that an examination of petitioner's hips on that date revealed a reduction in petitioner's left hip rotation as compared to the right without any complaints. On 3/29/16 her condition remained unchanged. On 4/22/16, petitioner continued to complain of right low back and right buttocks pain, and for the first time complained of pain in the left groin area. She made no mention of any left hip pain. On 5/2/16 she reported pain mostly in her back. She also reported that she had begun experiencing left groin pain. Again, no left hip pain was mentioned. An x-ray that day showed moderate changes of degenerative arthritis in the left hip with joint

space narrowing and small femoral head osteophytes. On 5/9/16 petitioner continued to complained of low back pain, left groin pain, and for the first time left hip pain.

The arbitrator also finds it significant that on 8/24/16 petitioner reported to Dr. Cohen that she had bilateral degenerative arthritis in both knees for which she was undergoing steroid injections in the right knee with these knee problems dating back to 2015.

Based only on the accident histories and reported complaints, the arbitrator finds it significant, and self serving that the mechanism of injury petitioner provided her healthcare providers does not include any mention of falling on her left side on the concrete until after her left hip complaints begin and an x-ray of her left hip showed moderate changes of degenerative arthritis in the left hip with joint space narrowing and small femoral head osteophytes. The arbitrator also finds it significant that prior to any left hip or left groin complaints petitioner already had documented decreased rotation of her left hip when compared to her right. Additionally, the arbitrator finds it significant that the worsening of petitioner's left hip condition coincides with her reports of bilateral degenerative arthritis in her knees and steroid injections into her right knee. The arbitrator finds it significant that the records most contemporaneous to the accident to be the most reliable, thus finding the most likely mechanism of injury is that petitioner fell backwards off the stair twisting her back and landed on her right hand and wrist, and jamming her right thumb. The arbitrator finds all accident histories where petitioner reports she fell on her left side on the concrete to be self serving and unreliable.

The arbitrator next looks at the casual connection opinions offered by Dr. Cohen, Dr. Player, Dr. Fletcher, and Dr. Bane.

Dr. Cohen offered conflicting opinions with respect to the causal connection of petitioner's left hip injury to the injury on 3/6/16. On 7/2/16 Dr. Cohen was of the opinion that petitioner's left hip injury aggravated her preexisting moderately advanced degeneration of her left hip. Then on 12/5/16 he was of the opinion that petitioner's bilateral knee pain was probably aggravating her existing left hip and low back pain. Based on these inconsistencies the arbitrator finds Dr. Cohen's casual connection opinions as they related to petitioner's left hip less than persuasive.

Dr. Player examined petitioner on 6/5/17 at the request of the respondent. Although petitioner provided Dr. Player with a history of falling on her left side on the basement floor, he reviewed the medical records most contemporaneous to the injury and noted that there was no evidence for direct trauma to the back or the left hip, nor was there any documentation of a direct trauma to the left hip, or

even any left hip complaints. Dr. Player noted psoriatic arthritis in petitioner left hip with multiple plaques on her knees and elbows. Petitioner reported that she has had psoriasis since 1976. Dr. Player opined that it is more likely than not that petitioner's autoimmune condition that was causing her skin condition would be responsible for her left hip condition. He further opined that since there is no documentation of any type of left hip or groin pain until 6 weeks after the injury, there is no causal connection between her arthritic condition in her left hip and the injury on 3/6/16. The arbitrator finds Dr. Players opinions most persuasive given that they are based on a thorough review of the medical records and the accident histories most contemporaneous to the injury on 3/6/16.

Petitioner saw Dr. Fletcher on the referral of her attorney on 7/19/17. Petitioner gave him a history of losing her balance while sweeping the 3rd step from the bottom and falling on her left side. Based on this history, Dr. Fletcher opined that petitioner's problems were related to her work activities. He opined that the injury aggravated and accelerated her left hip condition. Given that the accident history Dr. Fletcher relied on in formulating his causal connection opinion is inconsistent with those provided most contemporaneously to the injury, and one which was only provided after petitioner began complaining of left hip pain, the arbitrator finds Dr. Fletcher's causal connection opinions as they relate to petitioner's left hip less than persuasive.

Petitioner presented to Dr. Bane on 11/20/17. She reported left hip pain for almost two years, which would place the onset of her left hip pain prior to the injury on 3/6/16. She gave him a history of cleaning stairs and falling down the stairs and landing on her left hip. Dr. Bane reviewed petitioner's medical records and noted that she had no left hip pain after the injury. He also noted that petitioner reported left groin pain that seemed to be getting worse with physical therapy on 5/2/17. The arbitrator notes that what petitioner noted on 5/2/16 was that her left groin pain began in physical therapy on 2/19/16 after doing some exercises. This would have been prior to the date of injury. However, there is no physical therapy record for that day that supports this claim. Nonetheless, Dr. Bane was of the opinion that the therapy petitioner stated she was doing after the fall probably aggravated the pre-existing osteoarthritis in her left hip. He was of the opinion that her previously asymptomatic left hip osteoarthritis was unmasked because of rehab that she was doing because of her fall at work.

In his deposition Dr. Bane noted the possibility of psoriatic arthritis of the hip in his operative report. He noted that this an inflammatory arthritis. He believed that the exercises she was doing in physical therapy for her back aggravated her left hip. But then testified that he did not go through all the physical therapy records to see what exercises petitioner was doing, so he really does not know what may

or may not have contributed to her left hip pain in therapy. Dr. Bane was of the opinion that fall itself did not exacerbate petitioner's left hip. He related her left hip problems to therapy. Dr. Bane then opined that both osteoarthritis as well as psoriatic arthritis are progressive conditions that will get worse over time as part of the natural degenerative process. He even opined that petitioner's pretty significant physical change in her left hip from 9/6/16 through November of 2017 while she was not working, was change not attributable to the injury, but change solely attributable to just the natural degenerative process. Based on the fact that Dr. Bane admitted he did not know what exercises petitioner was doing in therapy, the fact that he believed the petitioner's pretty significant physical change in her left hip from 9/6/16 through November of 2017 while she was not working was change attributable to just the natural degenerative process, and the fact that on 9/6/16 he was of the opinion that petitioner's condition was not to the point where a hip replacement was recommended, the arbitrator finds Dr. Bane's opinion that petitioner's current condition of ill-being as it relates to her left hip is causally related to her injury on 3/6/16 to be less that persuasive.

Based on the above, as well as the credible record, the arbitrator finds the petitioner's current condition of ill-being as it relates to her left hip is not causally related to the injury she sustained on 3/6/16. The arbitrator further finds the petitioner did not sustain an injury to her left hip as a result of the injury she sustained on 3/6/16, nor did she prove by a preponderance of the credible evidence that she aggravated it during her therapy for her low back given the fact that there is no documentation stating what activities petitioner was doing in therapy, or specifically those that may have aggravated her left hip. The arbitrator also finds it significant that on the date of injury petitioner reported falling backward off stairs, twisting her back landing on her right hand and wrist, and jamming her right thumb while at work, and continued with this history until she started complaining of left hip complaints and changed her twisting injury to where she fell on her left hip instead of her right side if her body, which the arbitrator finds self serving and less than credible. Unfortunately, the casual connection opinions the petitioner would like the court to rely on are based on this history which the arbitrator does not find credible.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner's current condition of ill-being as it relates to her left hip not causally related to the injury on 3/6/16 the arbitrator finds no medical services petitioner underwent for her left hip were reasonable and necessary.

The parties stipulate that the medical services to petitioner's low back were reasonable and necessary.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner's current condition of ill-being as it relates to her left hip not causally related to the injury on 3/6/16 the arbitrator finds the petitioner is not entitled to any prospective medical expenses as they relate to her left hip.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Having found the petitioner's current condition of ill-being as it relates to her left hip not causally related to the injury on 3/6/16 the arbitrator finds the petitioner is not entitled to any temporary total disability benefits after 6/29/17.

The arbitrator notes that the parties stipulated that petitioner was temporarily totally disabled from 3/7/16 through 6/29/17 and all these benefits have been paid in the amount of $31,333.71.

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

Gracie M Nealy,
Petitioner,

vs.

Greater Peoria Mass Transit District
d/b/a Citylink,
Respondent.

19IWCC0615

NO: 17 WC 33194

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical, accident, 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 October 11, 2018, is hereby affirmed and adopted.

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

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

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

DATED:
o11/7/19 NOV 14 2019
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0615

NEALY, GRACIE M
Employee/Petitioner

Case# **17WC033194**

GREATER PEORIA MASS TRANSIT DISTRICT
D/B/A CITYLINK
Employer/Respondent

On 10/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0980 HASSELBERG GREBE SNODGRASS
KENNETH M SNODGRASS JR
401 MAIN ST SUITE 1400
PEORIA, IL 61602

0102 CASSIDY & MUELLER PC
TIMOTHY J CASSIDY
416 MAIN ST SUITE 323
PEORIA, IL 61602

19IWCC0615

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

GRACIE M. NEALY,
Employee/Petitioner

Case # 17 WC 33194

v.

GREATER PEORIA MASS TRANSIT DISTRICT d/b/a CITYLINK,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **July 24, 2018**. Proofs were left open related only to submission of evidence of bus video and on September 11, 2018, proofs were closed. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 5, 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.

ORDER

BECAUSE PETITIONER DID NOT SUSTAIN AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF 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.

D. Dylan McCarty

Signature of Arbitrator

10-5-2018
Date

OCT 11 2018

Nealy v. CityLink
Commission No.: 17 WC 33194

IN SUPPORT OF THE ARBITRATOR'S DECISOIN RELATING TO (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT? THE ARBITRATOR FINDS THE FOLLOWING FACTS:

On January 11, 2018, the Petitioner underwent surgery by Dr. Jeffrey Garst described as a right shoulder arthroscopy with acromioplasty, distal clavicle excision long head of biceps tenotomy and rotator cuff repair. The post-operative diagnosis was right shoulder small full-thickness rotator cuff tear with biceps tenosynovitis along with impingement and AC joint arthritis. The Petitioner claims this condition was caused by an October 5, 2017, accident arising out of and in the course of her employment by the Respondent. (PX 2).

The Petitioner testified that she works as a bus driver and part-time supervisor for the Respondent, Greater Peoria Mass Transit District d/b/a CityLink. On October 5, 2017, she was operating a bus for CityLink as a bus driver on the 23 Pekin route. The Pekin route leaves the bus transfer center in downtown Peoria and goes to the Pekin Courthouse in Pekin, and then returns to the transfer center, and the route continues in that fashion through her shift that began at a little before 6:00 a.m. and ended at 2:10 p.m.

The Petitioner testified that she had parked her bus at the stop at the Pekin Courthouse where there was a wheelchair passenger using a non-motorized wheelchair. The Petitioner testified that she "kneeled" or lowered the bus and deployed a ramp so that the wheelchair passenger could get on the bus. The passenger was having difficulty getting on the ramp of the bus, so the passenger's wife who had already gotten on the bus, got off and then asked the Petitioner if she could assist getting her husband on the ramp.

The Petitioner testified that she said yes, got out of her driver's seat and went to assist the wheelchair passenger get on the ramp. The Petitioner testified that the wheelchair passenger was facing backwards towards the ramp and the Petitioner was standing on the ramp and that she put her hands on the back handles of the wheelchair to help pull the passenger up the ramp.

The Petitioner testified that she "pulled with great force" and then she "felt something in my shoulder and neck area and back." The Petitioner testified that she did not attempt to assist the passenger again.

The Petitioner testified that the wheelchair passenger's wife then assisted her husband and eventually got the passenger on the bus. A bus seat was lifted and the wheelchair passenger was put where the seat was and the Petitioner then had to secure the wheelchair with secure straps. The Petitioner testified four different straps are put on the wheelchair to secure it; two in the front and two in the back.

The Petitioner testified that when she was strapping the wheelchair to secure it, she "felt pain and tingling in my arm, and I was struggling with the straps." The Petitioner testified that "as

I began to pull the straps my pain got intense as I was pulling them straps" and the pain was "intense."

The Petitioner testified that at some point the wheelchair passenger began to curse and swear and was rude saying he did not care if the other passengers made it to the transfer center or not. Because of the wheelchair passenger's behavior, the Petitioner called a supervisor, Chris Ripka, and told him to meet her at the transfer center.

Chris Ripka testified that he is and has been a supervisor at CityLink for six to seven years. He testified that on October 5, 2017, he was a line-up supervisor that monitored the buses, monitored traffic flow, car crashes, house fires, assists passengers, assists drivers and similar type duties. Mr. Ripka testified that the Petitioner called him from the Pekin Courthouse and she asked that he meet her at the transfer center because she had an issue concerning a wheelchair.

Both the Petitioner and Mr. Ripka testified that when the Petitioner's bus arrived at the transfer center, Mr. Ripka met the bus and the Petitioner reported to him that the wheelchair passenger was being rude and difficult. Mr. Ripka testified that he went onto the bus to talk with the wheelchair passenger about his behavior.

The Petitioner testified that after Mr. Ripka spoke with the wheelchair passenger that she did not unstrap the wheelchair from its secure position and that Mr. Ripka removed the straps.

Mr. Ripka testified that the policies and procedures of the Respondent require an employee to immediately report any accident or injury. He explained that the policy requires an immediate report of an accident or injury because a bus driver could be a liability if he or she is driving a bus hurt. Mr. Ripka testified that the policy with respect to reporting work-related injuries is that the employee is required to immediately report the accident or injury to a supervisor or to dispatch.

Mr. Ripka testified that when the Petitioner called him asking that he meet her at the transfer center, she did not report any accident or injury. Mr. Ripka testified that when he met the Petitioner at the transfer center to discuss the wheelchair passenger's behavior, she did not report any accident or injury.

The Petitioner testified that she did not report any accident or injury to Mr. Ripka when she called him from the bus and that she did not report an accident or injury when she met him at the transfer center. The Petitioner testified that after her shift ended at 2:10 p.m. at some point she went to dispatch and reported the accident to Jeff Lowe.

Jeff Lowe completed a Post-Accident Drug and Alcohol Testing form indicating that an alcohol test was not performed because the "driver didn't report it for about two hours." (RX 1).

The Petitioner testified that after she reported the accident, she was sent to the company physicians at OSF Center for Occupational Health where she saw Dr. Moody and "told him what happened." Dr. Moody's October 5, 2017, notes contain a history whereby it says that the Petitioner "states that earlier today she was manipulating a wheelchair, using a pulling motion when she had sudden onset of right trapezius pain." (RX 4).

Admitted into evidence as Respondent's Ex. No. 5 is the bus surveillance video showing the activities of the Petitioner and passengers both before, after and at the time of the Petitioner attempting to assist the wheelchair passenger onto the bus ramp. At 11:42:56 of the video, Petitioner gets out of her driver's seat and goes down the ramp to the passenger in the wheelchair. At 11:42:59, Petitioner places both of her hands on the handles of the passenger's wheelchair and one or two seconds later at 11:43:01, the Petitioner removes her hands from the handles of the wheelchair. During this one to two second period that the Petitioner has her hands on the wheelchair, it does not appear that she makes any effort to pull the wheelchair.

At the time that the Petitioner has her hands on the handles of the wheelchair and thereafter, the Petitioner shows no indications or behaviors of pain or discomfort.

At 11:46:44 of the video, the Petitioner bends down near the passenger in the wheelchair and reaches with her arms and stoops to secure the wheelchair by maneuvering the straps. The video shows that for approximately two minutes thereafter until 11:48:55, the Petitioner strapping the wheelchair securely with the four straps without any apparent discomfort or pain to her right shoulder and neck, or any other body part.

After the Petitioner is done strapping the wheelchair, the video continues for approximately one-half hour and at no time is the Petitioner seen in any apparent discomfort, distress or pain. At 11:49:04 of the video, the Petitioner is shown maneuvering her seatbelt causing her right arm to reach quickly above shoulder level and over her head without any appearance of discomfort.

While at the transfer center where the Petitioner met Mr. Ripka, the video shows at 12:09:52 the Petitioner re-enter the bus and go to the passenger in the wheelchair to unstrap him. The Petitioner is shown bending and reaching with her right arm to unstrap the wheelchair through 12:10:21 (approximately 30 seconds) and she is in no apparent discomfort, distress or pain.

At 12:15:32 of the video, the Petitioner is shown in the driver's seat and she maneuvers her seatbelt to attach it, raising her right hand and arm above shoulder level and over her head while in no apparent discomfort, distress or pain.

The Arbitrator finds that the Petitioner has failed to satisfy her burden of proof to show that she was involved in an accident that arose out of and in the course of her employment by Respondent on October 5, 2017. The video (Respondent's Ex. No. 5) shows the Petitioner at the time that she claims she was injured when attempting to assist the wheelchair passenger onto the bus ramp. The Petitioner testified that she put her hands on the handles of the wheelchair and "pulled with great force" when she felt something in her shoulder and neck area and back. The Petitioner told Dr. Moody that she was "manipulating a wheelchair using a pulling motion when she had sudden onset" of right shoulder pain. The video, however, shows the Petitioner merely placing her hands on the handles of the wheelchair for one or two seconds and she does not pull or exert any force to pull the wheelchair onto the ramp nor does it show any manifestation of a "sudden onset" of shoulder pain. The video shows that the Petitioner simply places her hands on the handles of the wheelchair for a brief moment and then removes them.

The video shows that after the Petitioner removed her hands from the handles of the wheelchair, she shows no apparent discomfort, distress or pain and the Petitioner's activities as depicted in the video thereafter continue to show the Petitioner in no discomfort, distress or pain.

The Petitioner testified that while she was strapping the wheelchair to secure it, she felt pain and tingling in her right arm and that as she began to pull the straps, her pain in her right arm and shoulder "got intense" and the pain was "intense." The video shows the Petitioner strapping the wheelchair to secure it and the Petitioner is able to maneuver freely, including her right arm, to strap and secure the wheelchair and there are no indications that the Petitioner is in distress, discomfort or "intense pain."

The Petitioner testified that after she attempted to assist the wheelchair passenger onto the bus and strapped his wheelchair to secure it, she secured her own seatbelt in her driver's seat. The Petitioner testified that she uses her left arm to fasten her own seatbelt and not her right. However, the video shows that the Petitioner, at least twice, fasten and unfasten her seatbelt with a maneuver that includes her right hand and arm reaching above shoulder level and moving her seatbelt over her head with her right arm in no apparent discomfort, distress or pain.

The Petitioner testified that while at the transfer center where she met her supervisor, Mr. Ripka, regarding the wheelchair passenger's behavior that she did not unstrap the wheelchair passenger and this had to be done by Mr. Ripka. However, the video shows the Petitioner (not Mr. Ripka) unstrapping the passenger's wheelchair using her right arm in no apparent discomfort, distress or pain.

Mr. Ripka testified that it is the Respondent's policy that bus drivers "immediately" report any accident or injury to a supervisor or to dispatch. He testified that the policy requires that any accident or injury be immediately reported due to liability concerns. The Petitioner testified that "normally" any accident or injury is to be reported to a supervisor when one is seen but also testified to an exception as being able to report the accident or injury to dispatch after the end of a driver's shift.

Shortly after the Petitioner assisted the wheelchair passenger onto the bus ramp and securely strapped his chair, she called her supervisor, Chris Ripka, regarding the wheelchair passenger's behavior and admits that she did not report the accident or injury at that time. Mr. Ripka met the Petitioner at the transfer center and had a discussion with the Petitioner regarding the wheelchair passenger's behavior and she admits that at this time she did not report any accident or injury. The Arbitrator finds that the failure of the Petitioner to follow Respondent's policy to immediately report an accident or injury was not followed by the Petitioner because no accident or injury occurred.

Based on what is depicted in the bus surveillance video (RX 5), which the Petitioner testified accurately shows her activities, the Petitioner did not sustain an accident that arose out of and in the course of her employment by Respondent. The failure of the Petitioner to report any accident or injury immediately or closely after she claims it occurred at the time she spoke to her supervisor at least two times, is consistent with there being no accident.

The Arbitrator finds that there are inconsistencies between the Petitioner's testimony and what is actually depicted in the video. The Petitioner testified she "exerted great force" in pulling the wheelchair which is inconsistent with the video. The Petitioner testified she told Dr. Moody "what happened" and Dr. Moody wrote that Petitioner told him that when she "manipulated" the wheelchair, she had a "sudden onset" of pain. This is inconsistent with the video

The Arbitrator also notes that the Petitioner at arbitration claimed for the first time that she may have injured her shoulder adjusting the straps on the wheelchair after the passenger was on the bus. In her written accident report, the employee's notice of injury, the initial history to Dr. Moody, the history to Nurse Practitioner Mullens at OSF on October 19, 2017 and the initial history to Dr. Garst, the Petitioner only mentions being injured while pulling, attempting to pull or manipulating the wheelchair. As noted above, the video (RX 5) only shows her hands on the wheelchair handles for 1 to 2 seconds. It does not show her pulling the wheelchair back with great or any force. The video does show her spending over two minutes bending and reaching to fasten the wheelchair into place. The view of that activity is less clear then the view of her earlier activity, so it is possible that she could have sustained a shoulder injury at that time. However, if that were the case, she surely would have described that activity to her employer or one of her doctors.

The above inconsistencies obviously affect the Petitioner's credibility. The Arbitrator finds that she has failed to maintain her burden of proof with respect to accident. The Cliam is denied. All other issues become moot.

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

Linda Lanham,

Petitioner,

19IWCC0616

vs.

NO: 18 WC 7609

Family Hospice,

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, temporary disability, medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 10, 2019, is hereby affirmed and adopted.

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

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

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

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:
o11/7/19
DLS/rm
046

NOV 14 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

19IWCC0616

LANHAM, LINDA
Employee/Petitioner

Case# **18WC007609**

FAMILY HOSPICE
Employer/Respondent

On 4/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

01438 RNB&K
ANDREW M FERNANDEZ
205 W RANDOLPH ST SUITE 2110
CHICAGO, IL 60606

19IWCC0616

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Linda Lanham
Employee/Petitioner

v.

Family Hospice
Employer/Respondent

Case # 18 WC 07609

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 Collinsville, on February 28, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, January 8, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $86,141.64; the average weekly wage was $1,656.57.

On the date of accident, Petitioner was 61 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $44,175.20 for TTD, $0.00 for TPD, $0.00 for maintenance, and $1,968.28 for other benefits, for a total credit of $46,143.48.

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

ORDER

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the total knee replacement surgery recommended by Dr. Gregory Simmons.

Respondent shall pay Petitioner temporary partial disability benefits for five and five-sevenths (5 5/7 weeks) commencing January 24, 2018, through March 4, 2018, in the amount of $4,998.24 (see explanation in Conclusions of Law), as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,104.38 per week for 53 5/7 weeks commencing January 9, 2018, through January 23, 2018, and March 5, 2018, through February 28, 2019, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

April 5, 2019
Date

APR 10 2019

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on January 8, 2018. According to the Application, Petitioner sustained a "Fall on ice" and injured her "Right knee, left knee and body as a whole" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and temporary partial disability benefits as well as prospective medical treatment. In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits of 53 5/7 weeks, commencing January 9, 2018, through January 23, 2018, and March 5, 2018, through February 28, 2019 (the date of trial). In regard to temporary partial disability benefits, Petitioner claimed she was entitled to temporary partial disability benefits of five and five-sevenths (5 5/7) weeks, commencing January 24, 2018, through March 4, 2018. The prospective medical treatment sought by Petitioner was right total knee replacement surgery, as recommended by Dr. Gregory Simmons, an orthopedic surgeon. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as the Director of Nursing. Petitioner's job duties included managing RNs and CNAs, and Petitioner would also work in the field providing nursing care to various patients. When Petitioner worked in the field, her job duties could be physically demanding.

At trial, Petitioner testified she arrived at Respondent's place of business and parked her car. The parking lot was adjacent to Respondent's place of business and Respondent owned and maintained the parking lot. Petitioner stated that there was an accumulation of ice on the surface of the parking lot. When Petitioner got out of her car, she walked around it, but then slipped and fell because of the accumulation of ice. Petitioner stated that when she fell, she twisted her right knee and landing on her right side. After Petitioner sustained the fall, other employees helped her get up. A fellow employee then drove Petitioner to the office of Dr. James Wade, Petitioner's family physician.

Dr. Wade evaluated Petitioner on January 8, 2018. At that time, Petitioner advised she fell on ice one hour prior and had severe pain and swelling in the right knee. Dr. Wade referred Petitioner to Dr. Gregory Simmons, an orthopedic surgeon (Petitioner's Exhibit 1).

Petitioner had been previously treated by Dr. Wade for right knee symptoms. Dr. Wade saw Petitioner on December 29, 2016. At that time, Petitioner complained of right knee pain and swelling that had been present for a while. Petitioner did not report having sustained an injury. Dr. Wade aspirated fluid from the right knee and administered an injection. He also ordered an MRI scan (Petitioner's Exhibit 1).

The MRI was performed on December 30, 2016. According to the radiologist, there were degenerative changes and partial resorption of the lateral meniscus, moderate lateral compartment osteoarthritis, mild medial compartment, patellofemoral compartment osteoarthritis and joint effusion with synovitis (Petitioner's Exhibit 3).

Dr. Wade subsequently saw Petitioner on April 19, 2017, and he diagnosed Petitioner with osteoarthritis of both knees. However, at that time, the primary reason for Petitioner being seen by Dr. Wade was because of neck symptoms. Dr. Wade's record of that date noted Petitioner had recently undergone a four level cervical fusion (Petitioner's Exhibit 1).

Dr. Wade again saw Petitioner on December 22, 2017, because of bilateral knee symptoms. However, Petitioner's left knee complaints were worse than those on the right. Dr. Wade reaffirmed his diagnosis of osteoarthritis in both knees and he administered injections in both knees (Petitioner's Exhibit 1).

Dr. Simmons evaluated Petitioner on January 8, 2018. At that time, Petitioner informed Dr. Simmons she fell on the ice that day and had worsening right knee pain. Dr. Simmons diagnosed osteoarthritis of the right knee and opined Petitioner had "...an aggravation of the arthritic condition." Dr. Simmons prescribed a knee brace and authorized Petitioner to remain off work (Petitioner's Exhibit 2).

When Dr. Simmons saw Petitioner on January 15, 2018, Petitioner had a full range of motion of the right knee, but still had pain/swelling. Dr. Simmons ordered an MRI scan of Petitioner's right knee (Petitioner's Exhibit 2).

The MRI was performed on January 19, 2018. According to the radiologist (who compared the MRI of that date to the prior MRI of December 30, 2016), the MRI revealed there was an unchanged complete tear of the lateral meniscus, an unchanged horizontal undersurface tear of the body and posterior horn of the medial meniscus, severe lateral and mild medial/patellofemoral compartment chondrosis and joint effusion with synovitis (Petitioner's Exhibit 3).

Dr. Simmons saw Petitioner on January 22, 2018, and reviewed the MRI. He opined it revealed an acute lateral meniscus tear. At that time, Dr. Simmons recommended Petitioner undergo a total knee arthroplasty. Dr. Simmons authorized Petitioner to return to work, but restricted her to seated type work for only four hours a day, five days a week (Petitioner's Exhibit 2).

At trial, Petitioner testified she returned to work part time on light duty. Petitioner limited her work to the office, but getting up from her seat caused increased right knee pain. Petitioner and Respondent stipulated Petitioner earned $1,968.28 during the five and five-sevenths (5 5/7) weeks she worked part-time.

Petitioner was again seen by Dr. Simmons on February 19, 2018. He noted that the MRI report mislabeled that Petitioner had a new onset medial meniscus tear. Dr. Simmons opined that, given Petitioner's arthritis, arthroscopic surgery would not work. Further, he noted "I think that injury has aggravated the arthritic condition...." He kept Petitioner on work restrictions (Petitioner's Exhibit 2).

Petitioner was seen by Dr. Wade on March 5, 2018. At that time, Petitioner's right knee symptoms had worsened. Dr. Wade authorized Petitioner to be completely off work (Petitioner's Exhibit 1).

Dr. Simmons subsequently saw Petitioner on March 23, April 23, and May 21, 2018. Petitioner continued to complain of pain, swelling and instability in the right knee. Dr. Simmons renewed his recommendation Petitioner undergo a total knee arthroplasty and continued to authorize Petitioner to remain off work (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Richard Hulsey, an orthopedic surgeon, on September 19, 2018. In connection with his examination of Petitioner, Dr. Hulsey reviewed medical records provided to him by Respondent. Dr. Hulsey opined Petitioner had advanced osteoarthritis of the right knee which predated the injury of January 8, 2018. In his medical report, Dr. Hulsey noted that "The mechanism of injury that she describes definitely can aggravate the underlying arthritis." However, Dr. Hulsey also noted that "...the work accident did not mechanically alter or accelerate the degenerative changes." He also noted Petitioner's pain complaints had not subsided since the fall and the pain had become more disabling. In the last sentence of his medical report, Dr. Hulsey noted "It is my opinion that she did aggravate a severe, underlying degenerative condition of the right knee." (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Hulsey agreed with Dr. Simmons that Petitioner should undergo a total knee replacement surgery. He opined Petitioner could return to work in a sit down job, but she could not walk long distances, go up/down stairs and could not squat, kneel or bend (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Hulsey was deposed on February 11, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Hulsey's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to Petitioner's need for a total knee replacement surgical procedure, Dr. Hulsey agreed it was appropriate; however, he testified Petitioner would have needed total knee replacement surgery irrespective of the accident. He was not able to opine as to a specific time in which the surgery would be needed, but stated it would not have been a long period of time. Dr. Hulsey acknowledged Petitioner's subjective pain complaints had not subsided since the fall, but he could not quantify the degree the pain had changed. He restated his opinion that the fall did not mechanically alter Petitioner's right knee (Respondent's Exhibit 1; pp 18-21).

On cross-examination, Dr. Hulsey agreed that Petitioner was not referred to an orthopedic surgeon and did not lose any time from work until the accident of January 8, 2018. He reaffirmed the last sentence in his medical report that Petitioner aggravated severe underlying degenerative arthritis. Dr. Hulsey did agree that it would be a contributing factor, but "...a minor factor based on the pathology at the time" (Respondent's Exhibit 1; pp 24-25, 29-30, 34).

At trial, Petitioner testified she had right knee symptoms which predated the accident, received injections and underwent an MRI scan. However, she stated Dr. Wade had not referred her to an orthopedic surgeon until she sustained the accident of January 8, 2018. Petitioner continues to have pain, swelling and instability in the right knee which has caused her to experience sleep disruption. Petitioner has not been able to return to work and wants to proceed with the knee replacement surgery as recommended by Dr. Simmons.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of her employment by Respondent on January 8, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the circumstances of the accident of January 8, 2018, was unrebutted.

It was clear that the parking lot where Petitioner sustained the accident was owned and maintained by Respondent and that Respondent provided the parking lot for use by its employees. The parking lot had an accumulation of ice making it a hazardous condition on the employer's premises. Under these circumstances, it is clear that the fall sustained by Petitioner was compensable. Mores-Harvey v. Industrial Commission, 804 N.E.2d 1086 (Ill. App. 3rd Dist. 2004).

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of January 8, 2018.

In support of this conclusion the Arbitrator notes the following:

Both Petitioner's treating physician, Dr. Simmons, and Respondent's Section 12 examiner, Dr. Hulsey, have opined that the accident of January 8, 2018, aggravated Petitioner's pre-existing right knee osteoarthritis.

The fact that Dr. Hulsey opined that the accident of January 8, 2018 was a "minor factor" does not extinguish Respondent's liability because even if Petitioner had a pre-existing condition, the case will be compensable if Petitioner can prove the accident was a causative factor in his or her current condition of ill-being. Sisbro, Inc. v. Industrial Commission, 797 N.E.2d 665 (Ill. 2003).

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 total knee replacement surgery recommended by Dr. Gregory Simmons.

In support of this conclusion the Arbitrator notes the following:

Both Petitioner's treating physician, Dr. Simmons, and Respondent's Section 12 examiner, Dr. Hulsey, have opined total knee replacement surgery is appropriate.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 53 5/7 weeks commencing January 9, 2018, through January 23, 2018, and March 5, 2018, through February 28, 2019.

In support of this conclusion the Arbitrator notes the following:

Petitioner was under active medical treatment and authorized to be off work during the aforestated periods of time.

The Arbitrator further concludes Petitioner is entitled to temporary partial disability benefits for five and five-sevenths (5 5/7) weeks commencing January 24, 2018, through March 4, 2018. The total amount awarded to Petitioner for temporary partial disability benefits is $4,998.24.

In support of this conclusion the Arbitrator notes the following:

Petitioner was authorized to work light duty on a part time basis during the aforestated period of time and earned $1,968.28.

The above award was calculated as follows: Petitioner's salary would have been $9,465.64 for the period of five and five-sevenths (5 5/7) weeks. While on light duty Petitioner was paid $1,968.28. The difference between what Petitioner would have earned and what Petitioner was paid was $7,497.36, two thirds of that amount equals $4,998.24.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ 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

Joseph Garza,

Petitioner,

vs.

NO: 17 WC 25372

City of Chicago – Dept of Water,

19IWCC0617

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes the Arbitrator awarded Respondent a credit of $54,195.32 for payment of temporary total disability benefits but did not award the corresponding benefits. The Commission finds Petitioner was temporarily totally disabled from June 28, 2017 through June 17, 2018, a period of 50-5/7 weeks. ArbEX1, Request for Hearing form. The Commission awards temporary total disability benefits for the above period and affirms the Arbitrator's granting of credit to Respondent in the amount of $54,195.32 for temporary total disability benefits paid.

Pursuant to Section 8.1b of the Act, the Commission weighs the following five factors accordingly (*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)(i) – level of impairment

The Arbitrator noted no AMA impairment rating report was admitted into evidence by either party. The Arbitrator gave no weight to this factor. The Commission concurs with this finding.

Section 8.1b(b)(ii) – occupation of the injured employee

The Arbitrator noted Petitioner's occupation as a construction laborer with the Department of Water. The Arbitrator further noted following his treatment and recovery, Petitioner was able to return to work to his usual and customary position. The Arbitrator gave this some weight. The Commission finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 50 years-old at the time of his May 23, 2017 injury. The Arbitrator gave some weight to this factor. The Commission observes Petitioner has a lesser work-life expectancy which will require him to manage the effects of his injury for a shortened period of time. The Commission finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner returned to work in the same position and earning the same or more than prior to the injury. The Arbitrator noted there is no evidence that his future earning capacity was adversely impacted as a result of his injury. As such, he Arbitrator gave no weight to this factor. The Commission views the evidence differently and finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

In a prior work accident on December 16, 2014, case 15 WC 9902, Petitioner sustained a full thickness torn rotator cuff with retraction, right shoulder impingement and right biceps tendinopathy. He had preexisting osteoarthritis in the right shoulder which aggravated his work injuries. Petitioner also sustained a right middle trigger finger. Dr. Rimington performed arthroscopic repair of the rotator cuff and an open repair of the biceps tendon. Petitioner underwent extensive physical therapy after surgery and eventually returned to work at full duty. At arbitration in that case, Petitioner testified he continued to experience pain and weakness in his right shoulder, which affected him in the performance of most of his work duties. RX1.

Petitioner testified he worked in his normal position until May 23, 2017. T. 20. As a result of his May 23, 2017 right shoulder injury, Petitioner sought treatment with Physicians Immediate Care on June 28, 2017. X-rays taken that day showed no fractures or avulsions and no dislocations; mild degenerative joint disease of the AC joint; three dense lesions were noted as possible screws from the previous surgery. Petitioner was diagnosed with a right shoulder sprain and given light duty work restrictions, which Respondent did not accommodate. PX1.

Petitioner continued treating with Physicians Immediate Care and was prescribed physical therapy and given a bursa injection. He completed a course of physical therapy with no relief. A right shoulder MRI was ordered and obtained on August 28, 2017. The MRI was

compared to a MRI done on February 19, 2015. It was the radiologist's impression the MRI evidenced: 1) Interval postsurgical changes compatible with rotator cuff repair; Recurrent full-thickness retracted tear of the anterior to mid fibers of the supraspinatus tendon with partial-thickness articular surface tear of the posterior fibers; 2) Low to intermediate grade partial-thickness articular surface tear of the infraspinatus tendon with interstitial tear extending to the myotendinous junction; Mild subscapularis tendinosis; Mild infraspinatus and subscapularis muscle atrophy; 3) Tear and distal retraction of the long head of biceps tendon versus postsurgical changes of tenotomy; 4) Diminutive blunted appearance of the superior labrum may represent postsurgical changes or tear; Abnormal signal within the posterior superior labrum may represent tear or postsurgical changes; 5) Mild degenerative changes of the glenohumeral articular cartilage and acromioclavicular joint. PX1.

On August 29, 2017, Dr. Damasaru of Physicians Immediate Care noted he had reviewed the MRI and it evidenced full thickness supraspinatus tear, partial infraspinatus tear, tear of long head of biceps and possible labral tear. Dr. Damasaru diagnosed a complete rotator cuff tear or rupture of right shoulder. Dr. Damasaru referred Petitioner to Dr. Rubinstein at the Illinois Bone & Joint Institute. PX1.

On September 18, 2017, Dr. Rubinstein evaluated Petitioner who complained of persistent pain in his right shoulder. Dr. Rubinstein noted he reviewed the right shoulder MRI scan and report. Dr. Rubinstein noted the MRI evidenced Petitioner to have changes of his previous surgery with recurrent full thickness retracted tear of the anterior portion of the supraspinatus, some partial thickness tearing of other portions of the tendons, and there was also tearing of the long head of the biceps, which could either be from a tenotomy or from a new injury. Dr. Rubinstein noted it seemed likely Petitioner was in need of a repeat rotator cuff repair, but he would try conservative measures first including injections. PX2.

On October 20, 2017, Petitioner reported the injection provided him only 20% relief. Dr. Rubinstein noted, "At this stage of the game, it would appear to have a recurrent rotator cuff tear that is directly a result of the digging activity he was performing when he was injured on the job. While his previous rotator cuff tear may have contributed a bit to the weakness of his tendon, the current tear is a result of a new injury and not particularly due to his previous repair." Dr. Rubinstein recommended surgery to re-repair his rotator cuff tear and provided Petitioner another subacromial injection. PX2.

In his November 30, 2017 Operative Report, Dr. Rubinstein noted he performed a right shoulder arthroscopy with debridement. His post-operative diagnosis was unrepairable right shoulder rotator cuff tear. PX2.

Following surgery, Petitioner underwent a significant course of physical therapy at ATI Physical Therapy from December 19, 2017 through March 9, 2018 for 29 visits; and thereafter, attended work conditioning from March 19, 2018 through June 3, 2018 for 31 visits. PX3 and PX3A.

On June 8, 2018, Dr. Rubinstein evaluated Petitioner for a final time and noted Petitioner was nearing the completion of the work conditioning program. Dr. Rubinstein noted, "He feels like he will be able to return back to work, and we are going to release him to work as of Friday, June 15, 2018, without restriction." On examination, Dr. Rubinstein found full range of motion and minimal pain; he had regained almost all the function needed to return to work, and the physical therapist anticipated full necessary functioning upon completion of the work conditioning program. Petitioner was to follow-up in six weeks at which time Dr. Rubinstein would consider maximum medical improvement. PX2.

At the arbitration hearing, Petitioner testified he suffers from significant pain but is able to perform some of his duties. He works with three individuals on a crew who help him with various activities such as unloading the truck. T. 26-27. Petitioner testified to some difficulties in lifting his right arm which does not allow for digging; instead he performs the clean-up. T. 28. On cross-examination, Petitioner testified he is performing his usual and customary position as a laborer. T. 30. Dr. Rubinstein provided him a full-duty release without restrictions for lifting or digging. T. 30-31.

The Commission notes the Arbitrator gave significant weight to this factor. The Commission finds this factor weighs in favor of an increased permanence.

Based on the above factors and the record in its entirety, the Commission finds Petitioner sustained permanent disability to the extent of 14% loss of the person as a whole pursuant to §8(d)2 of the Act. The Arbitrator awarded permanency at the rate of $755.18 per week. The Commission notes the maximum permanent partial disability rate is $775.18 per week for the date of accident and corrects this clerical error.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's May 13, 2019 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,068.64 per week for a period of 50-5/7 weeks, representing June 28, 2017 through June 17, 2018, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act. The Commission notes Respondent paid $54,195.32 for temporary total disability benefits and is entitled to credit for same.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 70 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 14%.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest pursuant to §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.

DATED: NOV 15 2019
LEC/maw
o10/09/19
43

L. Elizabeth Coppoletti

Stephen J. Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARZA, JOSEPH
Employee/Petitioner

Case# **17WC025372**

CITY OF CHICAGO - DEPT OF WATER
Employer/Respondent

19IWCC0617

On 5/13/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4564 ARGIONIS & ASSOCIATES LLC
AL KORITSARIS
180 N LASALLE ST SUITE 1925
CHICAGO, IL 60601

0113 CITY OF CHICAGO CORP COUNSEL
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

19IWCC0617

- [ ] 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

JOSEPH GARZA
Employee/Petitioner

v.

CITY OF CHICAGO – DEPT. OF WATER
Employer/Respondent

Case # **17** WC **25372**

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 **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MAY 2, 2019**. By stipulation, the parties agree[1]:

On the date of accident, **May 23, 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 $**83,353.86**, and the average weekly wage was $**1,602.96**.

At the time of injury, Petitioner was **50** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**54,195.32** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**54,195.32**.

[1] At trial, a Request for Hearing form was admitted into evidence. (*Arbitrator's Exhibit* 1). On that form and during the hearing itself, the parties agreed they ***DID NOT*** wish to request a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (*Arbitrator's Exhibit* 1) (emphasis added).

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury:

FINDINGS:

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

(a) A physician licensed to practice medicine in all 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 from (a) above;
- (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.

(See 820 ILCS 305/8.1b)

With regards to factor (i) of Section 8.1b of the Act:

i. The Arbitrator notes that no AMA rating report was admitted into evidence by either party. As such, the Arbitrator gives ***no weight*** to this factor.

With regards to factor (ii) of Section 8.1b of the Act:

ii. The Arbitrator finds the Petitioner was employed as a construction laborer for the Respondent and was able to return to work in his prior capacity as a result of said injury. As such, the Arbitrator gives ***some weight*** to this factor.

With regards to factor (iii) of Section 8.1b of the Act:

iii. The Arbitrator notes that the Petitioner was 50-years-old at the time of the accident. The Arbitrator therefore gives ***some weight*** to this factor.

With regards to factor (iv) of Section 8.1b of the Act:

iv. The Arbitrator notes that the Petitioner returned to employment in his pre-injury position as a construction laborer for the Respondent. Furthermore, the record is devoid of any evidence of an impairment of earnings because of this May 23, 2017 work accident. As such, the Arbitrator therefore gives ***no weight*** to this factor.

With regards to factor (v) of Section 8.1b of the Act:

v. Evidence of disability corroborated by the treating medical records finds that the Petitioner continues to have pain and weakness in his right shoulder which affects him during the performance of many of his work duties. Due to the Petitioner's medically documented injuries and other physical complaints, the Arbitrator therefore gives ***significant weight*** to this factor.

Based on the above factors, and the entire record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of a **15.89% loss of use of the person-as-a-whole** pursuant to **Section 8(d)2** and Section 8.1b of the Act.

ORDER:

Accordingly, Respondent shall pay Petitioner the sum of **$755.18**/week for a further period of **79.45** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **a 15.89% loss of use of the person-as-a-whole.**

Furthermore, Respondent shall pay Petitioner compensation that has accrued from **June 8, 2018** through **May 2, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

May 13, 2019
Date

MAY 13 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ramona Roofe,

Petitioner,

vs. NO: 10 WC 9352

City of Chicago,

Respondent.

19IWCC0618

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, prospective medical care 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.

I. FINDINGS OF FACT

A. Background

Petitioner was an "Operating Engineer C" for Respondent. Prior to the accident date, Petitioner was working in the chemical treatment department where she never had to lift over 20-40 pounds of garbage. When she did her annual HazMat training she wore an oxygen tank on her back weighing up to 60 pounds. She also underwent annual physicals. She had no low or mid-back problems, nor did she have any pain, symptoms or range of motion problems in her right hip or right shoulder.

B. Accident

On Friday December 18, 2009 Petitioner was assigned to work in the basins department, which is where sewage was cleaned. She was carrying a hose weighing between 75-100 pounds while walking across a concrete bridge. As she walked to the left there was a three-foot drop. There was no rope or indication. Petitioner fell with the hose wrapped around her shoulder, hitting her right knee on the concrete, then landing on her stomach.

C. Medical Treatment

Petitioner testified that she presented to the Advocate Health Care emergency room ("ER") due to chest pain later on the date of accident. On December 19, 2009 she was worked up for a heart attack, which was not confirmed. She complained of right-sided neck, shoulder and arm pain, among other symptoms. She was diagnosed with dyspnea on exertion, chest pain, muscle strain and uncontrolled diabetes.

On December 21, 2009, Petitioner was released from the ER, reported to work and sent to MercyWorks by her supervisor.

On December 23, 2009, Petitioner presented to MercyWorks complaining to Dr. Patel of back, shoulder and chest pain. After an examination she was diagnosed with a thoracic back strain, was placed on light duty and referred for physical therapy.

After undergoing physical therapy at MercyWorks Petitioner was referred to Dr. Julie Wehner for treatment on January 27, 2010 due to back pain that was not responding to conservative treatment. Petitioner testified that Dr. Wehner performed only a cursory back exam and diagnosed contusions or sprains. Dr. Wehner opined that Petitioner's subjective complaints were fairly diffuse with no neurological findings on her clinical exam. Dr. Wehner also opined that Petitioner had reached maximum medical improvement and could return to full duty.

Petitioner treated with Dr. Nam on February 4, 2010 complaining of low back and right shoulder pain. Right shoulder and lumbar MRI's were recommended. Petitioner was kept off work.

On February 24, 2010, a right shoulder MRI revealed minor hypertrophic changes of the acromioclavicular joint, perhaps a source of mild chronic impingement, with no evidence of a rotator cuff tear or fracture. The lumbar MRI revealed degenerative disc disease, mild bulging and degenerative changes in the facet joints at L5-S1 and L4-5, and a small central protrusion at L5-S1.

On March 1, 2010, Dr. Nam diagnosed right shoulder impingement syndrome with rotator cuff tendinitis and lumbar radiculopathy. Petitioner was kept off work and recommended for physical therapy.

On March 29, 2010, Petitioner complained to Dr. Nam of low back pain radiating down her right leg. She also still had right shoulder pain, although it was improving. Petitioner was

kept off work and therapy was continued.

On May 5, 2010, Petitioner treated with Dr. Candido on referral from Dr. Nam. Petitioner's chief complaint was low back pain. A lumbar injection was performed, which alleviated symptoms for one week.

On May 24, 2010, Petitioner informed Dr. Nam that she still had some upper and low back pain, but indicated her shoulder pain had improved.

On June 16, 2010, Petitioner indicated to Dr. Candido that her right lower back pain had mostly resolved, but she now had the same pain on her left and middle low back. A second lumbar injection was also provided.

A thoracic MRI was recommended and performed on July 6, 2010. Dr. Norfray, the interpreting radiologist, found that it revealed degenerative changes in the upper and mid thoracic spine without evidence of associated bulges or extrusions.

On July 16, 2010, Petitioner underwent right sacroiliac joint injections with Dr. Candido.

On August 12, 2010, Petitioner complained of ongoing pain after her injections. Thoracic and lumbar tenderness was noted along with moderate decreased range of motion. There was a mildly positive impingement sign with intact rotator cuff strength. There was a negative straight leg raise test. Dr. Nam reviewed the thoracic MRI and found old mild compression deformities at T6 and T7. He diagnosed a compression fracture at T6 and T7, lumbar radiculopathy and right shoulder impingement. A Functional Capacity Evaluation was discussed.

On August 23, 2010, Petitioner underwent a Section 12 examination with Dr. Graf at Respondent's request. Dr. Graf indicated that the injury described to him by Petitioner was much different than what he reviewed in witness statements provided to him. He noted that Petitioner demonstrated multiple non-organic pain signs on evaluation. Dr. Graf found that Petitioner's lumbar MRI revealed mild, age-appropriate degeneration at L5-S1 and a normal thoracic scan. He could not substantiate Petitioner's subjective complaints and found that the epidural steroid injections administered were not reasonable or necessary. He opined Petitioner had reached maximum medical improvement (retroactive to Dr. Wehner's designation on January 27, 2010) and could return to full duty work with no permanent restrictions.

On August 26, 2010 Petitioner again underwent right sacroiliac joint injections with Dr. Candido.

On October 18, 2010, Petitioner underwent a Functional Capacity Evaluation with Industrial Rehabilitation Specialist Jeffrey Goode. The results were valid. Petitioner complained of constant low back pain with intermittent pain down her right leg to her knee. Her right shoulder was much improved. The evaluation revealed Petitioner could work at a sedentary level and thus could not return to her pre-accident employment. She exhibited functional deficits in relation to sitting, walking, climbing, lift/carry and push/pull tolerances, which would be essential for her job.

On November 8, 2010, Petitioner complained to Dr. Nam of back pain and some right shoulder pain. Petitioner's right shoulder showed essentially full range of motion with 5/5 rotator cuff strength. Thoracic tenderness was noted from T5-T9 as well as in the lumbosacral spine. Petitioner was neurovascularly intact distally. Dr. Nam opined that Petitioner had reached maximum medical improvement and was placed on permanent sedentary work level restrictions.

On December 2, 2010, returned to Dr. Nam seeking a refill of pain medication. A physical exam revealed tenderness of the lumbosacral spine, moderate decreased range of motion, negative straight leg raise test and that Petitioner was neurovascularly intact. A refill of medication was granted and Petitioner was to follow-up as needed. Dr. Nam opined Petitioner had reached maximum medical improvement.

On January 19, 2011, Petitioner discussed a pain management plan with Dr. Thomas, her primary care physician. She was referred back to Dr. Candido.

On February 18, 2011, Petitioner complained to Dr. Candido of mid to low back pain which radiates to her pelvis while walking. She was diagnosed with degenerative joint disease, degenerative disc disease and hypertrophic facets.

A lumbar x-ray on February 24, 2011 revealed severe facet arthropathy at L4-5 and L5-S1, with narrowing of the L5-S1 disc space. No spondylolisthesis was found.

On March 24, 2011, Petitioner was diagnosed with degenerative joint disease, degenerative disc disease and hypertrophic facets, along with chronic low back pain with radiculopathy and moderate right hip arthritic changes and questionable bursitis. Another lumbar steroid injection was performed by Dr. Candido.

On April 21, 2011, Petitioner presented with a history of persistent right hip pain and painful ambulation. She underwent a right hip MRI, which revealed moderately severe right hip osteoarthritis, a chronic degenerative tear of the superior acetabular labrum and a fibroid in the uterine body which has a submucosal margin and displaces the endometrium.

On May 12, 2011, Petitioner presented to Dr. Hoffman on referral from Dr. Candido complaining of right hip pain. After reviewing x-ray and MRI results, as well as performing a physical exam, Dr. Hoffman diagnosed right hip arthritis. A right hip arthroplasty was contemplated.

Petitioner requested a second opinion and was referred by Dr. Candido to Dr. Mess.

On June 1, 2011, Petitioner presented to Dr. Mess who diagnosed degenerative joint disease of the right hip.

On August 30, 2011, Petitioner followed up with Dr. Candido, who noted Dr. Mess' findings of a superior labrum tear and osteoarthritis of the right hip.

On September 13, 2011, Petitioner presented at Accelerated Rehabilitation Centers on

referral from Dr. Candido. After examination, the therapist opined that the findings were consistent with the diagnosis. The therapist opined that Petitioner's rehabilitation potential was only fair given that she had already received multiple types of therapy with little overall relief. It was noted that she may be a candidate for aquatic therapy, however. Petitioner underwent such therapy and testified that it was helpful and improved her function.

On July 7, 2014, Petitioner underwent a second section 12 examination with Dr. Graf at Respondent's request. Dr. Graf noted that Petitioner continued to demonstrate multiple non-organic pain signs on evaluation. He also noted that Petitioner had a normal hip evaluation during his August 2010 examination, but she now complains of hip and groin pain which she attributes to the accident in question. Dr. Graf opined that Petitioner's hip condition was not causally related to the accident in question, noting that she claims right hip pain after falling on her left side. He maintained his opinion that Petitioner had reached maximum medical improvement as of January 27, 2010, and could return to her pre-accident employment with no restrictions.

On October 19, 2014, Petitioner's Counsel sent her for an independent medical exam with Dr. Hutchinson. Dr. Hutchinson opined that it was more likely than not that Petitioner was injured during the accident in question. With no pre-accident documentation of issues with her right shoulder, thoracic spine, lumbar spine and right hip, Dr. Hutchinson opined Petitioner's accident reasonably could have caused an exacerbation or aggravation of any pre-existing pathology. He opined the shoulder injury was temporary and should return to normal baseline. The thoracic injury was consistent with a chest wall strain or exacerbation of degenerative changes at T6-7. However, Dr. Hutchinson found subjective evidence of permanent disability here. The lumbar evidence was consistent with either an acute strain or exacerbation of degenerative changes. Lumbar complaints were not documented during the initial ER visit, but appeared in appropriate time once treatment at MercyWorks began. Dr. Hutchinson found subjective evidence of permanent disability. Regarding the hip, Dr. Hutchinson noted a significantly delayed time frame compared to the other injuries. He opined this injury was likely unrelated to the accident in question.

On September 21, 2015 Petitioner's Counsel sent her for an independent medical exam with Dr. Domb relating to the right hip condition. Dr. Domb opined that Petitioner's right hip osteoarthritis was either caused or exacerbated by the accident in question. He noted that Petitioner was hardly able to walk and was restricted to sedentary duty with the ability to sit and stand as needed. He added that if Petitioner was unable to travel to and from work, she would be unable to work. He recommended a diagnostic injection to determine the origin of her pain. If the pain is originating from her hip, Dr. Domb would then likely designate her a candidate for a minimally invasive hip replacement.

D. Current Condition

Petitioner continues to treat with Dr. Candido and receives prescription medications for pain from him. She takes 2-3 Hydrocodeine's daily depending on her pain level. Petitioner testified that her upper back pain is constant between her shoulder blades. The pain affects her sleep, as she must lay in a fetal position with a pillow between her legs. She is no longer active, as standing, sitting and walking increase her pain. Petitioner also reported hip pain when walking.

She estimated she could lift 5 pounds without pain. Petitioner goes grocery shopping with her husband and only carries one bag from the car to the house. She testified that lifting a gallon of milk places strain on her upper back. Petitioner testified that she has not worked since the accident.

II. CONCLUSIONS OF LAW

A. Causal Connection

The Arbitrator found that Petitioner established a causal connection between her work-related accident and upper and lower back strains. The Arbitrator also found that Petitioner's right shoulder strain had resolved and that her right hip condition was not causally related to said accident.

The Commission agrees with the Arbitrator's causal connection ruling as it pertains to Petitioner's upper back and lower back, as well as the lack of causal connection related to the claimed right hip condition. The Commission further finds that Petitioner's right shoulder condition was causally related to the accident.

Petitioner complained of right-sided neck, shoulder and arm pain at the emergency room. She continued to experience right shoulder and upper back complaints when she was evaluated at MercyWorks, which were confirmed on physical examination. Eventually a February 24, 2010 MRI revealed some pathology in the right shoulder at the acromioclavicular joint, perhaps a source of mild chronic impingement. The record reflects that Petitioner was asymptomatic in the right shoulder as well as the upper and lower back prior to her fall at work onto the right side. Petitioner reported shoulder complaints contemporaneous to the accident, which remained consistent until resolved as reflected in the medical records. Thus, the Commission finds that Petitioner has established a causal connection between her right shoulder condition and the accident at work through the chain of events.

B. Medical Expenses

The Arbitrator awarded medical expenses through August 23, 2010 based on the medical records and the examination report of Dr. Graf on the same date, with the exception of all charges related to epidural steroid injections, which Dr. Graf opined were not reasonable and necessary. The Arbitrator did not find Dr. Graf's retroactive maximum medical improvement date to be persuasive, however.

The Commission evaluates the persuasiveness of the physicians' opinions differently than the Arbitrator who found the opinions of Dr. Nam regarding maximum medical improvement to be unconvincing. Dr. Nam's medical records suggest that Petitioner's right shoulder pain had not fully resolved until December 2, 2010, at which time Dr. Nam opined that Petitioner reached maximum medical improvement and that her back condition would not exhibit any further improvement. The opinions of Dr. Nam are supported by objective medical evidence in the record and persuasively establish that Petitioner reached maximum medical improvement with respect to her conditions of ill-being effective December 2, 2010. The Commission therefore awards Petitioner all medical expenses submitted into evidence related to treatment through December 2,

2010 of her upper back, low back and right shoulder conditions.

C. Temporary Total Disability

The parties also dispute Respondent's liability for temporary total disability benefits. At arbitration, Petitioner claimed entitlement to temporary total disability benefits from December 21, 2009 through July 21, 2013. Respondent disputed liability for temporary total disability benefits beginning on January 28, 2010. The Commission again relies on the medical records of Dr. Nam and finds that Respondent is liable for temporary total disability benefits through the maximum medical improvement date of December 2, 2010. The Functional Capacity Evaluation along with the medical records of Drs. Nam and Candido are more persuasive to the Commission than the full duty releases given by Dr. Wehner on January 27, 2010 and Dr. Graf on August 23, 2010. Subsequent to the accident, Petitioner exhibited ongoing and consistent complaints of pain, and no evidence was provided that light or sedentary duty work was ever offered to Petitioner. To that end, the Commission finds that Respondent's liability for temporary total disability benefits extends to the maximum medical improvement date of December 2, 2010.

D. Permanent Partial Disability

The Commission evaluates the evidence of disability slightly differently than does the Arbitrator. Petitioner was 55 years old at the time of accident and had been placed on sedentary restrictions. Prior to her accident, Petitioner was employed in a labor-intensive job and she has not worked since the accident in question. She now takes 2-3 Hydrocodeine daily depending on her pain level, has difficulty sleeping and performing activities of daily living, as well as pain with sitting, standing and walking.

Based on the above, the Commission modifies the Arbitrator's award and finds that the accident in question has caused Petitioner a 10% loss of use of the person as a whole, in accordance with section 8(d)(2) of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner has met her burden of proof in relation to causal connection to her work accident suffered on December 18, 2009. Petitioner's upper back, low back and right shoulder conditions are related to said accident, but not her right hip condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,041.31 per week for 49 & 4/7th weeks from December 21, 2009 through December 2, 2010, 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 $664.72 (maximum rate) per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 10% loss of use of Petitioner's person as a whole.

19IWCC0618

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to her upper back, low back and right shoulder conditions for treatment through December 2, 2010 under §8(a) and §8.2 of the Act.

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 15 2019
d: 10/1/19
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROOFE, RAMONA
Employee/Petitioner

Case# **10WC009352**

CITY OF CHICAGO
Employer/Respondent

19IWCC0618

On 5/15/2017, 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 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
CHRISTOPHER MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ramona Roofe
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **10 WC 09352**

19IWCC0618

An *Application for Adjustment 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 **March 8, 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. 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 _____

19IWCC0618

FINDINGS

On **December 18, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$81,217.76**; the average weekly wage was **$1,561.88.**

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, in part,* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$5,945.54** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,945.54.**

Respondent is entitled to a credit of **$144,896.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner **reasonable and necessary medical services of $156.00**, as provided in §§ 8(a) **and 8.2 of the Act.**

Petitioner's claim for TTD benefits subsequent to January 27, 2010 is denied.

Respondent shall pay Petitioner **permanent partial disability benefits of $664.72/week for 25 weeks** because the injuries sustained caused the **5 % loss of use of the person as a whole, pursuant to §8(d)1 of the Act.**

Respondent shall pay Petitioner all compensation that has accrued from 12/18/2009 through 3/8/2017, and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

May 15, 2017
Date

ICArbDec p. 2

MAY 15 2017

FINDINGS OF FACT

Petitioner was employed by Respondent as an Operating Engineer C. The accident day was the first day that she worked in the Basins Department. Previously, she had worked in the Chemical Treatment Department, where she would have to lift 20 to 40 pounds and, occasionally, carry a 60 pound oxygen tank on her back.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on Friday, December 18, 2009. Petitioner was walking on a bridge, carrying a 75 to 100 pound hose on her right shoulder, and she slipped off the bridge, causing her to fall about 3 feet into sludge. She fell on on her left side. Her right knee and stomach hit the bridge. The hose was still on her shoulder and she needed assistance from co-workers to get up. She felt pain. Her knee hurt. She was in shock. She told her supervisor, Mike Kinzick, about the accident. She did finish her shift, just standing around. She went home and took Advil and Aleve.

Petitioner denied any prior problems or symptoms related to her low back or her mid-back. She denied prior problems or pain related to her right shoulder or right hip.

It was Petitioner's testimony that she went to the emergency room at Illinois Masonic Hospital for treatment on Friday night (the night of the accident). She was admitted for a heart attack and was released on December 21, 2009. The medical records from Illinois Masonic Hospital show that Petitioner presented there the night of December 19, 2009 for evaluation of chest pain. On cross-examination, Petitioner did not agree that she went to the ER on December 19, the day after the accident. The history at Masonic (taken on 12/19/2009 at 10:40 pm) was that it was the patient's first day on the job and she was carrying a 50 pound hose on her right shoulder all day, going up and down stairs, 25 at a time. Pain in her shoulder worsened as the day went on. She then felt dryness to her mouth and parathesias down her arm. "It feels like bricks on my chest." There was a burning pain to the right shoulder. The physical exam showed right and left trapezius muscle tenderness and limited range of motion of the right shoulder, secondary to muscle tenderness. Anterior chest wall tenderness was noted. The patient reported "injury" and "myalgias." The lower extremity exam was benign. There was no back pain, no lumbar pain, no thoracic pain. The back exam was normal. The impression was: Dyspnea on exertion; chest pain; muscle strain; and Type II DM-uncontrolled. The discharge summary documents that the patient had chest pain and dizziness with right and left shoulder pain after lifting at work. The discharge diagnosis was: 1) Chest pain; 2) Neck and shoulder muscle strain. Petitioner was advised to take Ibuprofen and take a muscle relaxant at night. She was discharged stable and was instructed to follow-up with her PCP. The Masonic records document that Petitioner did present there on Saturday night, the night after the accident. There was no history of a fall at work. There were no low back complaints or findings. There were no lower extremity complaints or findings. There were no complaints or findings regarding Petitioner's right hip. (PX 4)

Petitioner signed a report of injury on December 22, 2009, documenting that she injured her right and left chest and upper and lower back. (RX 1)

Petitioner was sent by Respondent to MercyWorks, Respondent's employee accident clinic, where she was first seen on December 23, 2009. Petitioner testified that she told the doctor how she was injured and said that she had pain in her back, shoulder and chest. The doctor charted that Petitioner complained of soreness and tightness in her chest. She complained or soreness and pain in the upper back. There was no radiating pain to the legs or up to the neck. The thoracic spine exam showed tenderness to palpation and limited rotation, flexion, and extension of the back, secondary to pain. The SLR test was negative. The diagnosis was: Thoracic back strain. Ibuprofen, PT and heat were recommended. Therapy started 12/29. On 12/30, the diagnosis was: "Thoracic L-S spine strain." The diagnosis was back to thoracic strain on 1/11/2010. On January 18, 2010,

mid back pain with thoracic spine and paraspinal tenderness was noted. There was no radiculopathy and the diagnosis was thoracic strain. On January 25, 2010, it was noted that there was no improvement after PT. The diagnosis was thoracic pain and the patient was to see Dr. Wehner. (PX 11, RX 8)

Petitioner had been placed on light duty by MercyWorks and Respondent paid TTD, beginning December 21, 2009. Respondent apparently had no restricted duty work available for Petitioner at that time.

Petitioner was seen by Dr. Wehner on January 27, 2010. Dr. Wehner documented that Petitioner had complaints of pain at the base of her neck, right shoulder posteriorly, thoracic spine pain, pain down the entire lumbar spine and at the L-S junction. The physical exam was benign. The hip exam was said to be without pain. Dr. Wehner thought that Petitioner had suffered contusions or sprains as a result of the accident. Her complaints were fairly diffuse and non-specific in nature. There were no neurologic findings. Based on a 12/18/09 strain injury, there was no reason to not return the patient to work at full duty. Petitioner was released to full duty work, at MMI. A HEP was recommended. (PX 11, RX 9)

Petitioner returned to Mercy Works on January 27, 2010 and was released form care. She was to return to work at full duty, take Ibuprofen and follow a HEP. The diagnosis was thoracic back pain. (RX 8, RX 10, PX 11) Petitioner received a copy of the full duty release from MercyWorks (RX 8) and did not contact Respondent regarding return to work.

TTD benefits were stopped. Petitioner then elected to receive Ordinary Disability Benefits from Respondent. She was paid $113.20 per day, beginning January 19, 2010 and ending on July 21, 2013. (RX 5)

Petitioner sought treatment with her PCP, Dr. Frances Thomas, on January 27, 2010. The presenting complaints were upper, mid and back pain. The history was of a fall at work on 12/18/2009. The patient described sharp, constant pain in the upper back and middle of the lower back. Active problems were noted to be: Hypertension; Low Back Pain; and Type II DM. The record subpoena of the PCP requested "all records 12/17/2009 to present" and the chart note of 1/27/2010 is the earliest document in the records, so we do not know for sure if Low Back Pain was an "Active Problem" prior to the accident date (Petitioner denied prior low back problems). In any event, the exam of the thoracolumbar spine showed no abnormalities and no tenderness to palpation. Motor strength was 5/5 and reflexes were normal and symmetrical. Dr. Thomas did not chart any mention of right hip or right shoulder pain. Petitioner was referred to an orthopedic surgeon, Dr. Ellis Nam. (PX 12)

Petitioner first saw Dr. Nam on February 4, 2010. The history was of persistent low back pain and right shoulder pain after she was injured at work on 12/18/09 when she was carrying a 100 pound hose on her shoulder and she tripped and fell, injuring her right shoulder and lower back. "She reported some tingling down her legs and severe pain in her right shoulder and no improvement with physical therapy." The physical exam revealed positive impingement signs in the right shoulder along with decreased range of motion, tenderness and an equivocal SLR test bilaterally regarding the low back. The diagnosis was: acute low back pain and r/o right shoulder rotator cuff tear. Dr. Nam ordered Petitioner off work, and ordered MRI's of the lumbar spine and right shoulder. (PX 5)

The MRI's were done on February 24, 2010. The lumbar MRI was said to show DDD and L4-L5 and L5-S1 bulging discs, without compression on the thecal sacs. The shoulder MRI did not show a rotator cuff tear. It was perhaps consistent with mild chronic impingement. (PX 12)

On March 1, 2010, Dr. Nam prescribed Vicodin, PT for the shoulder and again provided work restrictions. Petitioner began PT at ATI on March 11, 2010. (PX 15) On May 24, 2010, Dr. Nam referred Petitioner to a pain specialist. (PX 5)

Petitioner began pain management treatment with Dr. Kenneth Candido on May 5, 2010. The history was of low back pain since a fall at work on 12/18/2009. As part of the physical exam, Dr. Candido noted a positive FABER sign on the right for right hip and low back pain and the FABER on the left elicited low back pain. Dr. Candido's assessment was: Low Back Pain with L4-5 and L5-S1 disc protrusions. Dr. Candido recommended an increase in the Tramadol prescription and lumbar ESI injections. The injection gave relief for a short time. Further ESI's were given. Petitioner completed a pain diagram, showing pain between her shoulder blades, in the middle of her low back and the anterior portion of her right hip. (PX 8)

On June 30, 2010, Petitioner saw her PCP, Dr. Thomas, complaining of ongoing upper back pain, causing her to have trouble breathing. She related her complaints to the 12/18/2009 injury and advised that she had not had specific treatment for her upper back. Dr. Thomas ordered a thoracic spine MRI, which showed mild old compression deformities of T6 and T7, without evidence of edema in the marrow. There were no acute deformities. (PX 12)

Petitioner was seen by Dr. Nam on August 12, 2010. Dr. Nam thought that the thoracic MRI showed old mild compression deformities. Petitioner was still in pain and felt that she could not work. An FCE was ordered. (PX 5)

Petitioner was seen by Dr. Graf for a §12 exam at the request of Respondent on August 23, 2010. Dr. Graf reviewed the 2/24/2010 Lumbar MRI and thought that it showed mild degeneration at L5-S1, with no disc herniation or fracture. The Thoracic MRI of July 6, 2010 was unremarkable. Petitioner exhibited multiple non-organic signs. Her subjective complaints did not correlate with the objective findings. 3 ESI's were not reasonable or necessary, as there was no impingement shown on the MRI films (there was no evidence of a herniated disc or radiculopathy). Petitioner could return to work at full duty, without restrictions. She was at MMI. (RX 2)

Petitioner did not attempt to return to work after the Dr. Graf exam.

Dr. Graf examined Petitioner for a second §12 exam on July 7, 2014. Petitioner displayed 5 Waddell's signs. Dr. Graf noted that she had a normal hip exam at the first exam. Her current hip and groin pain is in no way causally related to the injury (she fell on her left side). Petitioner again exhibited pain out of proportion to the objective exam. Currently, the only objective findings are regarding the hip, which is not related to the injury. Petitioner was thought to be at MMI at the time of the last exam. (RX 2)

The FCE ordered by Dr. Nam, completed October 18, 2010, documented that Petitioner could work at a sedentary level. The study was valid. (PX 7)

Petitioner was seen by Dr. Nam on November 8, 2010. She was not interested in surgery. She was at MMI. On December 7, 2010, Dr. Nam signed a Sick Leave Certification, confirming MMI and advising that Petitioner could work at a sedentary job. (PX 5)

Petitioner did not attempt to return to work, anywhere, in any capacity.

Petitioner had further care from Dr. Candido. (PX 8) Dr. Thomas ordered a right hip MRI. (PX 12) The right hip MRI, done on April 21, 2011, showed moderately severe arthritis and a chronic degenerative tear of the superiror acetabular labrum. (PX 8) Dr. Thomas referred Petitioner to an orthopedist, Dr. David Hoffman, for a consultation regarding her hip. (PX 12)

Dr. Hoffman examined Petitioner on May 12, 2011. He thought that Petitioner had moderate OA and offered Petitioner a total hip arthroplasty. He did not address causation. (PX 5) Petitioner did not want a THA. Dr. Candido referred Petitioner to Dr. Mess for a second opinion regarding her hip.

Dr. Mess saw Petitioner on June 1, 2011. Petitioner reported right hip and groin pain since 2009, when she fell at work. She had no limp. The MRI showed DJD. Dr. Mess prescribed Voltaren and instructed the patient to return in 6 weeks. On July 13, 2011, it was noted that Petitioner was much better with the medication. She was to return when she was ready for a THA. (PX 10)

Medical records show that Petitioner continued treatment with Dr. Candido through May of 2014. (Px 8, PX 9) She had therapy at Accelerated Rehab in 2011 and at RIC in 2012. (PX 14, PX 13) Dr. Candido gave Petitioner restrictions of 5 ponds lifting. No walking more than 5 minutes and no sitting or standing for more than 10 minutes. Petitioner continues to see Dr. Candido for medication adjustment, monthly. (PX 8)

Petitioner never sought employment within the restrictions set by Dr. Candido. Petitioner has not worked since the accident. She retired from employment with Respondent on November 17, 2014, so that she could collect her pension. She believes that she has "light duty" work restrictions, but does not know her specific restrictions. She never requested any ADA accommodations from Respondent in order to attempt to return to work.

Petitioner was seen by Dr. Mark Hutchinson for an IME at her attorney's request on October 19, 2014. Dr. Hutchinson focused on Petitioner's hip, but he noted that the shoulder injury was consistent with a temporary RTC strain that did not result in a permanent aggravation. The injury could have caused an acute chest wall strain and a permanent aggravation of the T6-T7 compression changes. The lumbar spine complaints were not documented in the ER records, but a permanent aggravation of Petitioner's lumbar spine could have resulted from the injury. Dr. Hutchinson did not endorse causation regarding Petitioner's right hip complaints. Dr. Hutchinson's physical exam was not consistent with the non-organic factors noted by Dr. Wehner and Dr. Graf. Dr. Hutchinson noted negative FABER's bilaterally. The treatment to date had been reasonable and necessary and Petitioner would benefit from chronic pain management and medications. Petitioner was at MMI and her limitations and restrictions would be consistent with the FCE. Dr. Hutchinson did note some inconsistencies on exam, but not as many as Dr. Wehner and Dr. Graf were said to have observed. Ultimately, he could not rule in or rule out secondary gain. (PX 2)

Petitioner's attorney sent Petitioner for another IME on September 21, 2015, with Dr. Benjamin Domb. Dr. Domb sent a letter to Dr. Thomas. He opined that Petitioner had suffered an injury to her right hip, as a result of the accident, which either caused her condition of OA of the hip or aggravated a pre-existing condition. Dr. Domb documented a positive FABERs test. He bases his causal opinion on Petitioner's history that she had more hip pain than back pain at the time of the accident. Her pain is the same as at the time of the injury. A diagnostic injection of the hip should be done to confirm hip pathology. The patient might be a candidate for a minimally invasive hip replacement. (PX 3)

Currently, Petitioner has upper back pain of a burning nature between her shoulders, 24 hours a day. She can't sleep. She can't lie on her back, as it hurts. Sitting, stranding and walking make it hurt more. She can lift up to 5 pounds without pain. She can shop at the grocery store, but can carry only one bag. Her hip pain is not

constant. It is associated with walking. When asked when her hip pain first appeared, Petitioner responded: "Dr. Nam visit." She then testified that it began when she fell. She presently has no right shoulder pain. Respondent's group paid some of the medical bills, as did Petitioner's husband's group carrier.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between her employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

The Arbitrator finds Petitioner's testimony to be not credible due to the inconsistencies between Petitioner's testimony and the medical records and Petitioner's demeanor in answering questions on cross-examination. Petitioner put her head down, appeared evasive, did not make eye contact and spoke in a lower volume of voice on cross-examination, such that it was hard to understand her answers. Further, some of her testimony contradicted her other testimony. She did not appear to be truthful in some of her answers. The inconsistencies regarding Petitioner's testimony and the medical records will be discussed below.

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

The Arbitrator finds that Petitioner's current condition of ill-being is, in part, causally related to the injury. Causal connection is found with respect to the resolved upper and lower back strain/sprain conditions diagnosed by Dr. Graf. This finding is based upon the medical records and the persuasive opinions of Dr. Graff.

Petitioner's right shoulder strain has resolved, per Petitioner's testimony and the medical records.

Petitioner's right hip condition (OA and degenerative labral tear) is not causally related to the injury, based upon the medical records and the opinions of Dr. Graf. Dr. Hutchinson is correct in not endorsing causation regarding the hip. Dr. Domb's causation opinion is not persuasive, in that he relies upon Petitioner being symptomatic in the hip immediately after the accident, which is disproved by the medical records. Petitioner's first hip complaints are noted by Dr. Candido in May of 2010, some five months after the accident. It is reasonable to assume that the orthopedic surgeons who saw Petitioner before she was seen by Dr. Candido performed a FABER test to rule out hip pathology and did not comment on the test because it was negative and they were trying to treat Petitioner for a back condition. Interestingly, Dr. Hutchinson noted negative FABER's testing in October of 2014.

In making this finding on causation, the Arbitrator considered the medical records regarding treatment up to the time of the first visit with Dr. Nam.

The ER records show no history of a fall on 12/18. Petitioner was seen with complaints of anterior chest wall pain. It felt like there were bricks on her chest. She had right and left shoulder pain after lifting at work. She had a 24 hour admit to monitor her for a possible heart attack. There were no low back complaints or findings.

No thoracic pain was documented. There were no lower extremity complaints or findings (including the right hip).

The accident report that Petitioner filled out says that she injured her Right and Left chest and her back-upper/lower.

MercyWorks documented a thoracic back strain. Dr. Wehner documented a benign exam, including the hip, which was said to be without pain. Dr. Thomas diagnosed "upper, mid and back pain." The exam was benign. No hip or shoulder complaints or findings were noted.

Dr. Nam documented low back pain and right shoulder pain after a fall at work, when he examined Petitioner on February 4, 2010. There is no mention of hip pathology or complaints.

While Petitioner initially testified that she started experiencing right hip pain when she saw Dr. Nam, she later said that she had the hip pain right at the time of the injury. As shown above, she never mentioned hip pain to the initial providers and the providers did not document any findings regarding the hip.

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 bills exhibit was PX 16. Petitioner further claimed a reimbursement for bills paid by her husband's group carrier. (PX 18) Respondent submitted a claim for a §8(j) credit for group payments (RX 4) and an itemization of payments by Respondent (RX 6).

After considering the medical records and the Arbitrator's finding regarding causation, the Arbitrator awards the incurred medical bills up to the date of Dr. Graf's first §12 examination of Petitioner, August 23, 2010, with the exception of charges for the ESI procedures. The ESI procedures are found to be not reasonable and necessary, based upon Dr. Graf's opinion. Petitioner is at MMI as of August 23, 2010, based on Dr. Graf's report. His retroactive MMI finding to the time of the Dr. Wehner exam (January 27, 2010) is not persuasive regarding medical treatment.

Regarding PX 16, the Accelerated bills are **denied**, as they were incurred after 8/23/2010.

Th IL Masonic bills are **denied** as well. The bills incurred in 2010 are related to the denied ESI procedures, with the exception of a 7/12/2010 bill for a chest x-ray which is not supported by evidence of causation and medical necessity. The bills for 2011 and beyond are denied as they are incurred after 8/23/2010. Further, several bills for unrelated services were included (mammography, GI endoscopy, spirometry, etc.).

Regarding the Advocate Medical Group bills, the bills from 12/20/2009 and 12/21/2009 are denied. They are for the inpatient admit for chest pain/rule out MI. The bill from Dr. Thomas for the 1/27/2010 DOS is awarded: **$156.00**. The bill for 3/5/2010 includes follow up for diabetes and hypertension and a venipuncture was performed. **It is not awarded.** The bill for 6/30/2010 was paid. Other bills are after 8/23/10 and are **not awarded.**

The bill from ATI has a zero balance. **Therefore, nothing is awarded.**

The bill from Chicago Anesthesiology Pain Specialists has a balance from 2011 of $18.20. **Not awarded.**

The bill from Chicago Northside MRI is for a T Spine MRI in 2013. **Not awarded.**

The bill from Chicago Orthopaedic and Sports Medicine does not show unpaid amounts from before 8/23/2010. **Not awarded.**

The bills from Elite, RIC and Uptown Orthopedic surgeons, SC are incurred after 8/23/2010 and are **not awarded.**

No reimbursement to group is made regarding PX 18, as the lien was for treatment expenses after 8/23/2010.

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

Petitioner claims 187 weeks of TTD is owed, for the time period of 12/21/2009 through 7/21/2013. Respondent claims that TTD is owed from 12/21/2009 through 1/27/2010.

The Arbitrator finds that Petitioner is only entitled to TTD from 12/21/2009 through 1/27/2010 (the day that she was released to full duty work by Dr. Wehner and by MercyWorks).

Arguably, Petitioner is entitled to TTD until she reached MMI, August 23, 2010 (the date of the first Dr. Graf exam), pursuant to the holding in Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission , 236 Ill.2d 132 (2010). In this case, the Arbitrator relies upon the finding above regarding Petitioner's credibility and the fact that Petitioner chose to go off work on ordinary disability and later elected retirement without contacting Respondent to attempt to go back to work (either full duty work or, later, restricted work, or requesting an ADA accommodation from Respondent) in finding that Petitioner is not entitled to any of the claimed TTD. It goes without saying that in order to be successful on a claim for TTD benefits, a claimant must not only show that she did not work, but that she was unable to work. Lukasik v. Industrial Commission of Illinois , 124 Ill.App.3d 609 (1984) Here, Petitioner has failed to persuade the Arbitrator that she was unable to work due to her injuries.

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

After considering all of the evidence adduced, the Arbitrator finds that the injuries sustained caused the 5% loss of use of the person as a whole, in accordance with §8(d)1 of the Act.

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

Joe Shovan, Jr.,

Petitioner,

vs.

NO: 16 WC 4275

19IWCC0619

Coal Field Repair Services, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent partial disability, evidentiary errors, 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 10, 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.

19IWCC0619

The 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 2019
TJT:yl
o 11/5/19
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHOVAN JR, JOE
Employee/Petitioner

Case# **16WC004275**

COAL FIELD REPAIR SERVICES LLC
Employer/Respondent

19IWCC0619

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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

19IWCC0619

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

Joe Shovan, Jr.
Employee/Petitioner

v.

Coal Field Repair Services, LLC
Employer/Respondent

Case # 16 WC 04275

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on March 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 Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On May 29, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $46,540.00; the average weekly wage was $895.00.

On the date of accident, Petitioner was 66 years of age, married with 0 dependent child(ren).

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

Based upon the Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher

William R. Gallagher, Arbitrator

April 5, 2018

Date

ICArbDec p. 2

APR 10 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs, heart, pulmonary system and respiratory tracts. The Application alleged a date of last exposure of May 29, 2015, and that Petitioner sustained the occupational disease as a result of inhalation of coal mine dust, rock dust, fumes and vapors for a period in excess of 43 years (Arbitrator's Exhibit 2).

At the time of trial, Petitioner was 68 years old. Petitioner has a high school education. He has two and a half years of college and approximately a year at an automotive and diesel school in St. Louis. He received a certificate in automotive and diesel repair. Petitioner worked in the coal mines for 32 years with all of those years being underground. In addition to coal dust, Petitioner was regularly exposed to and breathed silica dust and rock dust as well as roof bolting glue fumes and diesel fumes. Petitioner left coal mining around 2004. At that time he was working for American Coal at the Galatia Mine. His job title when he left was mechanic. He left mining because he had an opportunity to get out of the coal mine. He had enough time in to get the medical retirement and to leave the mines and work on top of the ground.

Petitioner started coal mining in 1972 for Old Ben Coal as a bottom laborer. His job duties included shoveling on the belt, rock dusting and doing different jobs on the unit, including roof bolting, helping the miner operator and taking the place of people who were absent. His job duties also included rock dusting where he would take rock dust and spray it on to the mine surface. He testified that the rock dusting was a pretty dusty job. When shoveling the belts, he walked the belt lines and shoveled coal spills back on to the belt. He testified that shoveling coal back on the belt does not generate a lot of dust. Petitioner worked as a roof bolter before they instituted the use of the roof bolting glue pins. Petitioner next bid on the miner operator job. In this job he ran the miner that cuts the coal from the face of the mine. He was in that job for about a year. He then bid on a maintenance job in which he would service and repair machinery. All of that work was done inside the mine. While he was doing those repairs, he still had the same exposures as the other miners. He worked at Old Ben until 1980 when he was laid off. He then went to work at Inland Steel as a miner operator and later bid on a maintenance job. He worked at Inland Steel for seven years. He went to work for Kerr-McGee around 1987. Kerr-McGee subsequently became American Coal. He worked there until around 2004. His job at American Coal was as a mechanic which was the same as maintenance. He testified that he was exposed to diesel fumes while working as a mechanic. He was exposed to roof bolting glue fumes while working at Kerr-McGee/American Coal. Petitioner was not doing any roof bolting; however, when he did repairs on the machines there was a smell of fumes.

After Petitioner left the coal mine, he went to work for Coal Age which is a fabrication machine shop, repair shop. He testified that they do a lot of work on mining equipment including repairs and building new equipment. He testified that when the machines came in to be repaired there was a lot of coal dust on the machines. Sometimes when he was working on them it created quite a bit of dust. He testified that he was also around a lot of welding fumes in that job. He worked

for Coal Age for nine to ten years. He then went to work for Respondent. His job there was similar. He was repairing machines that came from the mine. He was also building new machines. He testified that there was dust on the machines. There was also welding being performed during his job with Respondent. Petitioner left his work with Respondent on May 29, 2015, the date of last exposure alleged in the Application. He has not worked anywhere since that time.

Petitioner testified that he was doing "pretty good" with his breathing right now. Petitioner testified that he worked on cars from time to time as a hobby. In addition to working on his cars, Petitioner bow hunts. He testified that he hunts from a tree stand. This past season he killed two deer. He testified that he does yard work and he enjoys being outside. Petitioner testified that Dr. Tara Robbins of Southern Illinois Medical Care Associates (SIMCA) in Marion is his family doctor. He has treated with SIMCA for several years. Petitioner was never a smoker. Petitioner takes medication for high blood pressure, cholesterol and prostate.

Petitioner testified that Coal Age was located in West Frankfort. It was not a mine site. He worked in a metal shop building. His work for Respondent was in a shop on the surface located between two mines, Viking and M Class. While Petitioner was working for Respondent he did not go underground. He worked until his 66th birthday. He testified that that his retirement was not exactly planned, but things changed at the shop where he worked and he "didn't like the way it was headed and decided that it was a good time to leave." When he left Respondent, he signed up for Medicare and Social Security. He was already collecting a pension for the other work he had done.

Petitioner recalled undergoing an x-ray screening by NIOSH one time while at Kerr-McGee. He also had an x-ray before he started his last job with Respondent. He testified there might have been other NIOSH screening x-rays that he did not remember.

Petitioner saw Dr. Glennon Paul on September 13, 2016, at the request of his counsel (Petitioner's Exhibit 1, Deposition Exhibit 2). Dr. Paul was the medical director of St. John's respiratory therapy and clinical assistant professor of medicine at SIU Medical School (Petitioner's Exhibit 1, p 6). Dr. Paul was the senior physician at the Central Illinois Allergy & Respiratory Clinic. Those physicians specialize in allergy and pulmonary disease. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems (Petitioner's Exhibit 1, p 7). Dr. Paul is semi-retired and occasionally does black lung evaluations. He is not taking any new patients. Dr. Paul supervises a DUI clinic's medical treatment program (Petitioner's Exhibit 1, p 38). Dr. Paul is board certified in asthma, allergy and immunology (Petitioner's Exhibit 1, p 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972 there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease (Petitioner's Exhibit 1, pp 9-10). Dr. Paul is not an A-reader or B-reader. He has never been board certified in pulmonary disease (Petitioner's Exhibit 1, p 44). Dr. Paul has seen hundreds of individuals at the request of Petitioner's counsel (Petitioner's Exhibit 1, p 38).

Dr. Paul testified that Petitioner had complaints of shortness of breath with four flights of stairs. He described the shortness of breath as mild (Petitioner's Exhibit 1, p 11). Dr. Paul testified that Petitioner had a cough that was sufficient for diagnosis of chronic bronchitis. He coughed off and on all the time. Dr. Paul testified that the diagnosis did not show up in his report because it is a clinical diagnosis (Petitioner's Exhibit 1, p 12). Dr. Paul testified that Petitioner did not have any evidence of obstructive airway disease on pulmonary function testing. Dr. Paul performed a methacholine test on Petitoiner. He testified that the results were close enough for him to diagnose Petitioner with hyperactive airways disease (Petitioner's Exhibit 1, p 12). Dr. Paul testified that the spirometry, lung volumes and diffusion capacity were all within normal limits. Petitioner was a lifetime non-smoker (Petitioner's Exhibit 1, pp 12-13).

Dr. Paul testified that based on all the data he had, he concluded that Petitioner had coal workers' pneumoconiosis caused by the coal dust environment (Petitioner's Exhibit 1, p 13). He testified that Petitioner also had mild hyperreactive airways disease caused by the coal mine environment. Dr. Paul opined that Petitioner had chronic bronchitis caused by the coal mine environment. Dr. Paul testified that based on these diagnoses, Petitioner could have no further exposure to the environment of a coal mine without endangering his health. Dr. Paul concluded that Petitioner had clinically significant pulmonary impairment caused by the coal mine environment (Petitioner's Exhibit 1, pp 14-15).

Dr. Paul testified that the x-ray evidence was consistent with radiographically apparent pulmonary impairment which was caused by the coal mine environment (Petitioner's Exhibit 1, p 15). Dr. Paul testified that in order to have pneumoconiosis, one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. Dr. Paul testified that the scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue (Petitioner's Exhibit 1, pp 16-17). Dr. Paul testified that by definition if one has coal workers' pneumoconiosis, he will have some impairment in the function of his lung at the site of the scarring whether it can be measured by spirometry or not (Petitioner's Exhibit 1, p 17).

Dr. Paul testified that there are causes for dyspnea on exertion other than pulmonary disease. In regard to Petitioner's shortness of breath, the only trigger he related to Dr. Paul was exertion with four flights of stairs. Dr. Paul did not review any treatment records regarding Petitioner. The past medical history he obtained from Petitioner did not include respiratory disease (Petitioner's Exhibit 1, pp 38-39). Petitioner did not relate to Dr. Paul ever having taken any breathing medications in the past and was not taking them at the time of his examination (Petitioner's Exhibit 1, p 38-39). Petitioner did not tell Dr. Paul that he left work at the time he did on the advice of a physician. Petitioner did not relate to Dr. Paul an inability to perform his last job duties. Physical examination of Petitioner's chest was normal. The spirometry was normal. Dr. Paul

testified that there was no sign of obstruction. Petitioner's lung volumes were normal so there was no sign of restriction (Petitioner's Exhibit 1, p 40).

Dr. Paul testified that the patient usually brings the x-ray films and Dr. Paul reviews them. He testified that the films are usually taken within the last year. He did not know the date of the film that he reviewed regarding Petitioner that he referred to in his report. He testified that it does not matter which opacity type is present. He testified that if one has opacities in his lungs and he is a coal miner, it is usually black lung unless he has some other type of exposure. He testified that he does not pay much attention to profusion because if one has black lung, he has black lung. He testified that profusion does not mean that much. He testified that a lot of times one can have black lung disease in an individual coal miner and not have any abnormality in profusion (Petitioner's Exhibit 1, pp 43-44).

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted chest x-ray of September 13, 2016, for Petitioner. Dr. Smith interpreted the film as positive for pneumoconiosis, profusion 1/0 with P/P opacities in the middle and lower lung zones bilaterally (Petitioner's Exhibit 2).

Records from NIOSH were admitted into evidence. Petitioner underwent chest x-ray screening by NIOSH on May 17, 1974. An A-reader interpreted the film as being completely negative (Respondent's Exhibit 3, p 3). A chest x-ray taken on May 30, 1979, was interpreted by an A-reader and a B-reader as being completely negative (Respondent's Exhibit 3, pp 5-6). A chest x-ray of November 17, 1980, was interpreted by an A-reader and a B-reader as being completely negative (Respondent's Exhibit 3, pp 8-9). A chest x-ray of August 23, 1984, was interpreted by an A-reader and a B-reader as being completely negative (Respondent's Exhibit 3, pp 11, 14). A chest x-ray of October 1, 1987, was interpreted by an A-reader and a B-reader as being completely negative (Respondent's Exhibit 3, pp 16-17). The chest x-ray of June 20, 2000, was interpreted by two B-readers as being completely negative (Respondent's Exhibit 3, pp 20-21).

Dr. Cristopher Meyer reviewed a PA and lateral chest x-ray from Central Illinois Allergy and Respiratory dated September 13, 2016. Dr. Meyer testified that the film was of diagnostic quality. He gave it a quality 3 for overexposure and poor contrast. He testified that there was a calcified granuloma in the right mid zone, and there was a linear parenchymal band at the left lung base. He testified that there were no small opacities or large opacities of pneumoconiosis. His impression was no radiographic findings of coal workers' pneumoconiosis (Respondent's Exhibit 1, pp 41-42). Dr. Meyer testified that the overexposure makes the film darker and severe overexposure could mask small opacities (Respondent's Exhibit 1, pp 42-43). Dr. Meyer testified that the granulomas can be the same size as a single macule of coal workers' pneumoconiosis and can also be the same shape. He testified that the linear parenchymal band can be similar to parenchymal scarring, but it has a different look than parenchymal scarring. Dr. Meyer testified that the linear parenchymal band was a focal process at the left lung base and basilar opacities are not typical of coal workers' pneumoconiosis (Respondent's Exhibit 1, pp 43-44).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1, p 8). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1, pp 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot. Dr. Wiot was part of the original committee that designed the training program which was called the B-reader program (Respondent's Exhibit 1, pp 21-22). Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam (Respondent's Exhibit 1, p 33). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film (Respondent's Exhibit 1, pp 35-36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score (Respondent's Exhibit 1, p 23). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities (Respondent's Exhibit 1, p 29). The distribution of the opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process (Respondent's Exhibit 1, p 24). The last component of the interpretation is the extent of lung involvement or the so-called profusion (Respondent's Exhibit 1, p 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung (Respondent's Exhibit 1, p 31).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records from SIMCA (Respondent's Exhibit 2, p 21). Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease (Respondent's Exhibit 2, p 4). Dr. Castle practiced in Roanoke, Virginia, for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine (Respondent's Exhibit 2, p 7). Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis (Respondent's Exhibit 2, p 8). Dr. Castle has been certified as a B-reader since 1985 (Respondent's Exhibit 2, p 14).

Dr. Castle reviewed a chest x-ray dated September 13, 2016, from Central Illinois Allergy & Respiratory Service. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis. He testified that there was evidence of calcified granulomas and a parenchymal band (Respondent's Exhibit 2, pp 30, 31). Dr. Castle testified that for a proper reading of a chest x-ray for pneumoconiosis, the reader first notes when and where it was taken. Next the reader has to determine the quality of the film. The reader then looks to determine the type of opacity, whether it is small, round and regular or linear and irregular. The reader

compares it to the appropriate standard ILO film to determine the profusion. The reader also determines in which zones of the lung the opacities are located. He testified that the profusion is basically the amount of opacities per volume of lung or the density (Respondent's Exhibit 2, pp 31-32). Dr. Castle testified that profusion is important in interpreting a film for pneumoconiosis because it is the measure that gives the precise definition of how much disease is present in terms of abnormalities per unit volume (Respondent's Exhibit 2, p 33). Dr. Castle testified that the film he reviewed did not reveal emphysema. He testified that the other B-readers did not find emphysema on Petitioner's chest x-ray (Respondent's Exhibit 2, p 35). Dr. Castle testified that Dr. Paul's testimony that if an individual has opacities in his lungs and he was a coal miner, they have to be due to coal mining is absurd. Dr. Castle testified that just because a coal miner or anyone else has opacities does not mean that it is any specific thing. One has to try his best to determine what it is. The most common thing seen in terms of opacities in individuals would be granulomatous disease, particularly in this part of the country where histoplasmosis is endemic. Dr. Castle testified there are numerous other abnormalities that would cause opacities on a chest x-ray (Respondent's Exhibit 2, pp 35-36).

Dr. Castle testified that the methacholine challenge test that Petitioner underwent on September 13, 2016, revealed less than maximum effort. He testified that if one does not have maximum effort, then it does not give an accurate reading on what any changes might be. Dr. Castle agreed with the American Thoracic Society that methacholine challenge testing is more useful in ruling out disease rather than ruling it in (Respondent's Exhibit 2, pp 26-27). Dr. Castle testified that the American Thoracic Society requires a 20% decline in the FEV1 on methacholine challenge to indicate any clinical significance. Dr. Castle testified that he was unable to discern how Dr. Paul's methacholine challenge testing was done. He testified that the American Thoracic Society is very specific in the protocol which is followed if one is utilizing challenge testing. He could not tell from Dr. Paul's testing what exactly he was doing (Respondent's Exhibit 2, pp 27-28). Dr. Castle testified that as a board certified pulmonologist he did not attach any clinical significance to the 10% drop in Petitioner's FEV1 with methacholine challenge. He testified that this is a non-specific finding and does not indicate the presence of hyperactive airways disease. He testified that it is not diagnostic of anything (Respondent's Exhibit 2, p 28).

Dr. Castle testified that Petitioner's diffusion capacity as measured on September 13, 2016, was normal. He testified that a normal diffusing capacity is useful in excluding significant interstitial lung disease such as pneumoconiosis or significant emphysema. Dr. Castle testified that there was not a diagnosis contained in the medical records he reviewed of chronic bronchitis, asthma or hyperactive airways disease (Respondent's Exhibit 2, p 29). Dr. Castle testified that cough is not considered an objective determinant of pulmonary impairment and was not indicative of any pulmonary impairment (Respondent's Exhibit 2, pp 29-30). Dr. Castle testified that based on the spirometry performed on Petitioner on September 13, 2016, there was no evidence of obstruction. He testified that based upon the lung volume testing performed at that time there was no evidence of restriction. He testified that Petitioner's ventilatory function was entirely normal. He testified that based upon that testing the Petitioner was capable of heavy manual labor from a ventilatory standpoint (Respondent's Exhibit 2, p 30). Dr. Castle is familiar with the Guides to the

Evaluation of Permanent Impairment, Sixth Edition. He testified that if he applied Table 5-4 of the Guides to the results of the pulmonary function testing performed on Petitioner, he would fall in class 0 (Respondent's Exhibit 2, pp 30-31).

Dr. Castle testified it is rare for simple pneumoconiosis to progress once exposure ceases. Dr. Castle agrees with the position of the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk from working in currently permissible exposure levels until he reaches retirement age (Respondent's Exhibit 2, p 39). Dr. Castle concluded, based upon a thorough review of all of the data, that Petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust (Respondent's Exhibit 2, p 40). He testified that Petitioner had a significant enough exposure history to coal mine dust to have possibly caused him to develop coal workers' pneumoconiosis if he were a susceptible host. Petitioner did not describe symptoms of significant shortness of breath at rest or with exertion. Furthermore, he did not have any abnormal physical findings which would indicate the presence of an interstitial pulmonary process. Petitioner's physical examination was essentially within normal limits (Respondent's Exhibit 2, p 41).

Dr. Castle testified that studies have shown that as many as 50 percent of long-term coal miners have pathological coal workers' pneumoconiosis that was not appreciated by a radiographic study during their life (Respondent's Exhibit 2, p 61). Dr. Castle testified that coal workers' pneumoconiosis is an x-ray diagnosis except for the caveat about pathology (Respondent's Exhibit 2, p 74) Dr. Castle testified that the abnormality is basically trapped coal dust in a part of the lung which ends up wrapped in scar tissue. He testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring (Respondent's Exhibit 2, p 75).

Medical records of SIMCA were admitted into evidence. Petitioner was seen on March 30, 2015, for a skin issue. His past medical history was positive for allergies. He was noted to be a "never smoker". He denied exercise intolerance, shortness of breath, cough, wheeze and sputum production. On physical examination of the chest the lungs were clear to auscultation (Respondent's Exhibit 4, pp 53-57). Petitioner was seen on May 19, 2015, for follow up on labs. He related fatigue but denied shortness of breath when walking or lying down. He had no cough or wheeze and no sputum production. Physical examination of the chest revealed the lungs to be clear to auscultation. The assessment was essential hypertension, hyperglycemia, hyperlipidemia, BPH, eczema, fatigue and arthritis (Respondent's Exhibit 4, pp 49-53).

Petitioner continued to deny shortness of breath, cough, wheezing and sputum production when seen on December 1, 2015, May 24, 2016, June 7, 2016 and November 23, 2016. His physical examination of the chest on those dates revealed the lungs to be clear to auscultation (Respondent's Exhibit 4, pp 40-49). On June 7, 2016, Petitioner was complaining of increased heart burn and was diagnosed with gastroesophageal reflux disease (Respondent's Exhibit 4, pp

40-42). Petitioner was seen on December 9, 2016, complaining of sore throat with some coughing and a lot of sinus drainage. These symptoms had been present for two days. Petitioner denied shortness of breath. The assessment was sinusitis (Respondent's Exhibit 4, pp 29-32). Petitioner was seen on May 23, 2017, for his first Medicare visit. Review of systems revealed no cough, wheeze or shortness of breath. Physical examination of the chest revealed no dyspnea (Respondent's Exhibit 4, pp 23-29).

Petitioner was seen on September 25, 2017, September 28, 2017, and October 2, 2017, for an insect bite that resulted in cellulitis. No complaints of a respiratory nature were recorded during those visits (Respondent's Exhibit 4, pp 16-23). Petitioner was seen on October 23, 2017, in follow up. He complained of some fatigue. His review of systems revealed no shortness of breath. Physical examination of the chest revealed no dyspnea with the lungs clear to auscultation (Respondent's Exhibit 4, pp 12-16). Petitioner had no cough, wheeze or shortness of breath when seen on December 21, 2017 (Respondent's Exhibit 4, pp 6-9). Petitioner was seen on January 8, 2018, complaining of congestion mainly in his head. His symptoms had been present for two weeks. He had a productive cough. Review of systems revealed no wheeze or shortness of breath. The assessment was viral syndrome. (Respondent's Exhibit 4, pp 3-6). Petitioner was seen on February 27, 2018. He had no cough, wheeze or shortness of breath. Physical examination of the chest revealed no dyspnea (Respondent's Exhibit 4, pp 1-3).

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment with Respondent.

In support of this conclusion the Arbitrator notes the following:

The spirometry performed as part of Dr. Paul's examination was normal. It revealed no sign of obstruction or restriction. Dr. Castle testified that Petitioner did not have any pulmonary impairment based on the testing that he reviewed. Dr. Castle testified that based upon the pulmonary function testing that was performed by Dr. Paul, Petitioner was capable of heavy manual labor from a ventilatory standpoint. Further, in his report of September 13, 2016, Dr. Paul recorded that Petitioner coughed off and on. He did not include chronic bronchitis as a diagnosis in his report.

Dr. Smith, a B-reader, noted the chest x-ray of September 13, 2016, was positive for coal workers' pneumoconiosis. Dr. Smith's finding of opacities in the middle and lower lung zones bilaterally to the exclusion of the upper lung zones was not consistent with Dr. Meyer's testimony that coal workers' pneumoconiosis is generally an upper lung zone predominant process. Dr. Meyer, a B-reader, reviewed the chest x-ray of September 13, 2016, and opined that there was a linear parenchymal band at the left lung base but there was no radiographic findings of coal workers'

pneumoconiosis. Dr. Castle, a B-reader, also reviewed the chest x-ray of September 13, 2016. Dr. Castle opined that there were no parenchymal abnormalities consistent with pneumoconiosis. He testified that there was evidence of a calcified granuloma and a parenchymal band.

The Arbitrator finds the opinions of Dr. Castle and Dr. Meyer to be more persuasive than those of Dr. Paul and Dr. Smith.

Petitioner testified that he was doing pretty well with his breathing. He was not taking, nor had he ever taken, breathing medications. Petitioner indicated that he left work because there were things that changed and he "didn't like the way it was headed and decided that it was a good time to leave." There was no evidence that he left work due to a breathing or pulmonary problem.

In regard to disputed issues (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

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

Lester Furlow,

Petitioner,

vs. NO: 15 WC 10914

Knight Hawk Coal, LLC,

19IWCC0620

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 occupational disease, permanent partial disability, evidentiary error, 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 31, 2018, is hereby affirmed and adopted.

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

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

The 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 2019
TJT:yl
o 11/5/19
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FURLOW, LESTER
Employee/Petitioner

Case# **15WC010914**

KNIGHT HAWK COAL LLC
Employer/Respondent

19IWCC0620

On 5/31/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

19IWCC0620

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

Lester Furlow
Employee/Petitioner

v.

Knight Hawk Coal, LLC
Employer/Respondent

Case # 15 WC 10914

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 12, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On September 27, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $1,573.38.

On the date of accident, Petitioner was 66 years of age, married with 0 dependent child(ren).

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

Based upon the Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

May 27, 2018
Date

MAY 31 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs, heart, pulmonary system and respiratory tracts. The Application alleged a date of last exposure of September 27, 2014, and that Petitioner sustained the occupational disease as a result of inhalation of coal mine dust, rock dust, fumes and vapors for a period in excess of 39 years (Arbitrator's Exhibit 2).

At that time of trial, Petitioner was 70 years old. Petitioner is a high school graduate and went on to receive an associate's degree from Wabash Valley College in Mt. Carmel. While he was working in the mines he took welding and electrical classes. He got his electrical certification and when he was in Illinois, Colorado and Alabama where he had examiner papers. His associate's degree is in agri-business. Petitioner testified that he worked in the coal mines for 38 years with roughly 15 being on the surface and 24 to 25 years underground. In addition to coal dust he was regularly exposed to silica dust, roof bolting glue fumes, diesel fumes and smoke from coal fires.

Petitioner's last date of employment for Respondent in the coal mine was September 27, 2014. He was approximately 66 years old when he left coal mining. His job classification on that date was examiner. He testified that once in a while he would deliver supplies. Petitioner testified that he was exposed to coal dust on his last date of employment in the coal mine. Petitioner testified that he retired on that date. He did not have any employment after the coal mine.

Petitioner started working in the coal mines around 1976 for Freeman Untied in Virden, Illinois. He was hired as a laborer. He was primarily a roof bolter. As a roof bolter, he would set the canopy of the bolter against the top and then drill a hole and insert the glue pins into the roof. The glue pins would be inserted in the hole after it was drilled and then the bolt would be inserted into the hole and sometimes the glue would seep out. He testified that the glue would produce an odor strong enough to take his breath away. He testified that he was exposed to that continually as he was performing the roof bolting process. Petitioner worked at Freeman until May 1978.

Next Petitioner worked at Ziegler 11 mine as a laborer and roof bolter. He would also rock dust. He worked at Ziegler for about three months. He then went to work at Arch Coal at the Captain mine so that he could get on the surface. At Arch Coal he ran a drill. He testified they drilled holes in the ground to put powder in to crack the rock for the excavating machines to dig the rock. He testified that this work sometimes caused a lot of rock dust. He worked on the surface at Arch until February 1993.

He then went underground at the Conant mine. He roof bolted at Conant. He worked there until the end of 1999. Then he went to work for an Arch mine in Colorado. There he roof bolted and ran the coal hauler taking the coal from the face of the mine to the belts. Petitioner also ran a de-gas machine where he would drill above the long wall panels to expel methane gas. Petitioner worked in Colorado until Spring 2002. He then

moved to Alabama and worked in the mines there, where he ran a de-gas machine and roof bolted. Also at times, he worked as mine examiner. As an examiner he would go to different parts of the mine to examine the belt way, travel ways and the face. As an examiner he was looking for any potential problems. He was in all areas of the mine so he was exposed to all of the exposures that were in the coal mine. He worked in Alabama until February 2008 when he moved back to Illinois and went to work for Respondent. He worked for Respondent until he retired in 2014. For Respondent, he roof bolted for a year and a half and then worked as an examiner.

Petitioner first noticed breathing problems at work when he was in Colorado. He noticed that he was not breathing through his nose, but rather was mouth breathing a lot. He testified that would have been around 2000. He testified that from the time he first noticed breathing problems at work until he left the mine, they basically stayed the same. He testified that since leaving the mine his breathing has been about the same.

Petitioner testified that he used to play a lot of golf when he was in Colorado and Alabama. He would walk a lot while playing. Presently if he plays golf, he has to ride because he cannot walk extensively. Petitioner testified that he does not hunt much anymore. He testified that climbing up in deer stands causes breathing problems. Also sometimes he has to walk extensively to an area where he can hunt. Petitioner testified he has difficulty keeping up with his grandchildren because of his breathing problems.

Petitioner's family doctor is Dr. Bilal in Pinckneyville. He goes to the clinic at Marshall Browning. Petitioner testified that he smoked until about five years ago. He started smoking at age 23 or 24 and smoked until about age 65. He testified that at his peak he was smoking a pack and a half per day. In 2013, Petitioner had a kidney removed and had to go through four rounds of chemo to make sure they had gotten everything. Since that time he has developed bladder cancer. About a year and a half prior to trial Petitioner had an aneurysm in his lower abdomen repaired.

Petitioner did not look for work after he left Respondent. Other than spending time with his grandkids; Petitioner spends his time fishing. He fishes mainly at Rend Lake, Kincaid Lake and different strip pits around the Pyramid Park system. When the weather is good he fishes at least once a week or sometimes more often. He testified that he has five or six boats. He testified that the last time he got a deer was in 1993. He tries to golf at least once a week. Petitioner testified that he does yard work around his house and also takes care of his mother-in-law's lot.

Petitioner saw Dr. Glennon Paul on April 22, 2015, at the request of his counsel (Petitioner Exhibit 1, Deposition Exhibit 2). Dr. Paul is the Medical Director of the St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at SIU Medical School (Petitioner's Exhibit 1; p 6). Dr. Paul is the senior physician at the Central Illinois Allergy and Respiratory Clinic. Those physicians specialize in allergy and pulmonary disease. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems (Petitioner's Exhibit 1; p 7).

Dr. Paul is board certified in asthma, allergy and immunology (Petitioner's Exhibit 1; p 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease (Petitioner's Exhibit 1; p 10). Dr. Paul is not an A-reader or a B-reader (Petitioner's Exhibit 1; p 43). Dr. Paul has seen over a hundred individuals at the request of Petitioner's counsel (Petitioner's Exhibit 1; p 38).

Dr. Paul reported that Petitioner had wheezing and coughing at bedtime just about every day which was worse with upper respiratory infections. He noted that Petitioner also had a smoking history (Petitioner's Exhibit 1; p 12). In his report he recorded that Petitioner smoked one pack of cigarettes per day for 25 years (Petitioner's Exhibit 1, Deposition Exhibit No. 2). Dr. Paul testified that his physical examination of Petitioner's chest was normal. Petitioner's pulmonary function studies were within normal limits (Petitioner's Exhibit 1; p 13). Dr. Paul testified that based on all the data that he had on Petitioner, he had coal workers' pneumoconiosis and chronic bronchitis which were both caused by inhalation of coal mine dust. He testified that smoking could also share in the causation of the chronic bronchitis (Petitioner's Exhibit 1; pp 13-14). Dr. Paul testified that if one has chronic bronchitis, the severity of symptoms will wax and wane over time depending on the environment (Petitioner's Exhibit 1; p 14). Dr. Paul testified that in light of the diagnoses of coal workers' pneumoconiosis and chronic bronchitis; Petitioner could not have any further exposure to the environment of a coal mine without endangering his health (Petitioner's Exhibit 1; pp 14-15).

Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. Dr. Paul testified that the scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. He testified that by definition, if one has coal workers' pneumoconiosis, he would have some impairment in the function of his lung at the site of the scarring, whether it could be measured by spirometry or not (Petitioner's Exhibit 1; pp 17-18). Dr. Paul testified that it is possible to have injury or disease in the lung despite having normal pulmonary function test results (Petitioner's Exhibit 1; p 18). Dr. Paul testified that a person could have coal workers' pneumoconiosis and have a normal chest x-ray. He testified that coal workers' pneumoconiosis is something that can be found on both pathology and autopsy and not show up on the chest x-ray. He testified that the negative chest x-ray could never rule out the existence of coal workers' pneumoconiosis (Petitioner's Exhibit 1; p 35).

Dr. Paul testified that when he saw Petitioner he was not taking any breathing medications and did not relate a past history of ever having taken a breathing medication. Dr. Paul did not review any medical records regarding Petitioner (Petitioner Exhibit No. 1; p 38). Dr. Paul noted that Petitioner was not a current smoker, but he did not know when he quit. Dr. Paul testified that symptoms of cough and shortness of breath are something seen with individuals with a significant tobacco use. Dr. Paul testified that Petitioner did not have any wheeze on examination of his chest. Dr. Paul testified that there was no sign of respiratory disease from his exam of Petitioner's chest (Petitioner's

Exhibit 1; p 40). Petitioner did not tell Dr. Paul that he retired when he did on the advice of a physician or that he left work when he did because of a respiratory disease. Dr. Paul testified that on the spirometry that was performed, there was no evidence of obstruction or restriction (Petitioner's Exhibit 1; p 41).

With regard to the diffusion capacity testing that was performed on Petitioner, Dr. Paul did not know what the inhalation time was for the tracer gas. He did not know what the hold time was for the tracer gas. He also did not know what the inspiratory volume was for the tracer gas as compared to Petitioner's largest vital capacity (Petitioner's Exhibit 1; p 42). Dr. Paul did not know the date of the chest x-ray that he interpreted. With regard to the opacity type, he testified that he usually finds they are both round and irregular or a combination of both. Dr. Paul did not know the profusion of the chest x-ray that he reviewed. He testified that he does not check that (Petitioner's Exhibit 1; pp 42-43).

Dr. Henry K. Smith, a board certified radiologist and B-reader, interpreted chest x-ray for Petitioner dated April 21, 2015. He interpreted the chest x-ray as positive for pneumoconiosis; profusion 1/1 with P/S opacities in all lung zones (Petitioner's Exhibit 2).

Dr. Cristopher Meyer reviewed a PA and lateral chest x-ray dated April 21, 2015, from Central Illinois Allergy and Respiratory (Respondent's Exhibit 1; p 41). Dr. Meyer testified that the film was of diagnostic quality. He graded it as quality 2 due to overexposure and being slightly underinflated (Respondent's Exhibit 1; p 41). Dr. Meyer testified that given the low lung volumes, the vessels of the bases were crowded. He testified that there were no small opacities. There were no radiographic findings of coal workers' pneumoconiosis (Respondent's Exhibit 1; pp 41-42). Dr. Meyer testified that CTs are more sensitive for picking up changes of pneumoconiosis than plain films. He testified that this is also true of other diseases such as granulomatous diseases (Respondent's Exhibit 1; pp 41-42).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1; p 8). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1; pp 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which is called the B-reader Program (Respondent's Exhibit 1; pp 21-22). Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam. Dr. Meyer testified that the faculty is typically experienced senior level B-readers (Respondent's Exhibit 1; pp 33-34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film (Respondent's Exhibit 1; pp 35-36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of the small opacities, they are given a letter score (Respondent's Exhibit 1; pp 23). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities (Respondent's Exhibit 1; p 29). The distribution of the opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion (Respondent's Exhibit 1; p 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung (Respondent's Exhibit 1; p 31).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and a chest x-ray regarding Petitioner (Respondent's Exhibit 2; p 21). Dr. Castle is a pulmonologist and is board certified in internal medicine and in the subspecialty of pulmonary disease (Respondent's Exhibit 2; p 4). Board certification in pulmonary disease was first established in 1941 (Respondent's Exhibit 2; p 37). Dr. Castle practiced in Roanoke, Virginia, for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine (Respondent's Exhibit 2; p 7). Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis (Respondent's Exhibit 2; p 8). Dr. Castle has been certified as a B-reader since 1985 (Respondent's Exhibit 2; p 14).

Dr. Castle reviewed a chest x-ray for Petitioner dated April 21, 2015, from Central Illinois Allergy [and Respiratory]. Dr. Castle opined that the film showed no abnormalities consistent with pneumoconiosis. He testified that there was relatively poor inspiration with some crowding of lower lung zones (Respondent's Exhibit 2; p 27). Dr. Castle testified that for a proper reading of the chest x-ray for pneumoconiosis, one needs to note the individual's name, the date of the film needs to be present and the quality of the film needs to be noted. He testified that next one needs to determine whether there are any small opacitities which are classified as P, Q and R and S, T and U. If there are opacities, then the location of those opacities in the various areas of the lung should be recorded as well as the profusion of the opacities. If there are any large opacities, that needs to be recorded as well (Respondent's Exhibit 2; pp 34-35).

Dr. Castle testified that the pulmonary function study by Dr. Paul on April 22, 2015, was a valid study and was entirely normal. He testified that there was no evidence of any obstruction or restriction on that testing. Dr. Castle testified that a diffusing capacity study obtained from Methodist Hospital was also entirely normal. Dr. Castle opined that Petitioner did not suffer from any pulmonary disease or impairment that had occurred as a result of his occupational exposure to coal mine dust (Respondent's Exhibit 2; p 30).

Dr. Castle testified that to have a valid diffusing capacity test, the American Thoracic Society requires that there be inhalation in four seconds or less to total lung capacity, there has to be a breathhold for 10 seconds plus or minus two seconds and exhalation in four seconds or less. The total inhalation and expired volume should be at least 85% of the best vital capacity. Dr. Castle testified that with the testing that was performed by Dr. Paul, he did not have any data to be able to determine whether the diffusion capacity testing met the criteria he described. Dr. Castle agreed with Dr. Paul that scarring of the lung due to dust exposure is permanent and if there is a reduction in the diffusing capacity as a result of that scarring, it would be permanent (Respondent's Exhibit 2; pp 30-31).

Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that if the pulmonary dysfunction table found in the *AMA Guides* is applied to Petitioner, he would be Class 0 impairment (Respondent's Exhibit 2; p 34). Dr. Castle testified that Petitioner had a significant smoking history, having quit the habit in 2013. Dr. Castle testified that if an individual with a significant smoking history ceases that habit, he will continue to suffer from cough, sputum and shortness of breath related to that cigarette smoking. Dr. Castle testified that cough and sputum production will clear up within six months to a year. He testified that shortness of breath related to cigarette smoking will not go away (Respondent's Exhibit 2; pp 32-33). Dr. Castle testified that based upon the valid spirometry for Petitioner and the valid diffusion capacity testing, lung volume testing and the methacholine challenge, from a pulmonary perspective, Petitioner was capable of heavy manual labor (Respondent's Exhibit 2; p 33). Dr. Castle testified that in the records that he reviewed he did not see any evidence of chronic bronchitis. He did not see any findings described as a chronic cough productive of sputum for at least three months of the year for two or more consecutive years. Dr. Castle did not see any evidence of reactive airways disease or asthma in Petitioner (Respondent's Exhibit 2; pp 33-34). Dr. Castle agreed with the American Thoracic Society's statement that an older worker with mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. Dr. Castle testified that it is very unlikely that simple coal workers' pneumoconiosis will be progress once the exposure ceases (Respondent's Exhibit 2; p 36).

Dr. Castle testified that the gold standard for determining the presence of coal workers' pneumoconiosis would be pathologic study rather than radiographic study. He testified that a person could have coal workers' pneumoconiosis despite some people reading his x-rays as negative (Respondent's Exhibit 2; p 49). Dr. Castle testified that there was not any pathologic evidence in the records that he reviewed regarding Petitioner (Respondent's Exhibit 2; p 51). Dr. Castle testified that there are studies that have shown that as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not appreciated by a radiographic study during their lives. (Respondent Exhibit No. 2; pp 55-56). Dr. Castle testified that coal workers' pneumoconiosis is basically an x-ray diagnosis except for the caveat about pathology. (Respondent Exhibit No. 2; pp 59-60). Dr. Castle testified that coal workers'

pneumoconiosis is trapped coal dust in the part of the lung which ends up wrapped in scar tissue. He testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring (Respondent's Exhibit 2; p 61).

The medical records from Center for Medical Arts were admitted into evidence. Petitioner was seen on December 14, 2008, for cold symptoms with congestion in his chest for the past two days. He appeared to have had yellow rhinitis that day with some head congestion. Physical examination of the chest was normal. Physical examination of the lungs showed good airflow. He had mild rhonchi at the end of expiration on the left greater than the right. Petitioner was noted to be a one-half to three-fourths pack per day smoker. The assessment was acute bronchitis (Respondent's Exhibit 4; p 154).

Petitioner was seen on August 7, 2012, for prostate check. On that date his review of systems respiratory was positive for cough, dyspnea and wheezing (Respondent's Exhibit 4; pp 149-151). Petitioner was seen on September 6, 2012, for test results. He continued to be an everyday smoker. His review of systems respiratory was negative for chronic cough, dyspnea and wheezing (Respondent's Exhibit 4; pp 138-140). Petitioner was seen on July 22, 2013, to discuss his pathology results. He continued to smoke approximately 15 cigarettes per day. Petitioner was counseled to stop smoking at that time (Respondent's Exhibit 4; pp 113-114). Petitioner returned to discuss biopsy results on August 5, 2013. Pathology showed urothelial cancer in the renal pelvis and the urine cytology was positive. Petitioner was continuing to smoke at that time. The assessment was now urothelial cancer. Petitioner was released to return to work on August 5, 2013, with no activity restrictions (Respondent's Exhibit 4; pp 100-105). Petitioner underwent a robotic-assisted laproscopic left radical nephroureterectomy and open distal ureterectomy with removal of cuff of bladder on August 16, 2013 (Respondent's Exhibit 4; pp 91-93). Petitioner was seen for post-op visit on September 10, 2013. At that time he was listed as a former smoker stating that he quit in 2013. Review of systems respiratory was negative. Physical examination of chest was described as symmetric and respiratory effort was normal (Respondent's Exhibit 4; pp 77-79). Petitioner was seen on September 16, 2013, for insertion of a port-a-cath for chemotherapy. Review of systems respiratory was negative. On physical examination the lungs were clear to auscultation (Respondent's Exhibit 4; pp 71-73). Petitioner was given a release to return to work without restriction on December 1, 2013 (Respondent's Exhibit 4; p 64).

Petitioner was seen on March 27, 2014, for surveillance cystoscopy. Findings showed no evidence of bladder tumors and bilobar enlarged prostate (Respondent's Exhibit 4; p 49). Petitioner was seen on September 10, 2014, for scrotal swelling that began six months prior. On that date Petitioner was marked as being a heavy tobacco smoker but it was also noted that he quit in 2013. Review of systems respiratory was negative. Physical examination respiratory was normal (Respondent's Exhibit 4; pp 40-43). Petitioner returned on December 16, 2014. His review of systems respiratory remained negative. His physical examination respiratory was also negative (Respondent's Exhibit 4; pp 32-35).

Petitioner was seen on July 24, 2015. His review of systems respiratory was negative for asthma, chronic cough, dyspnea and wheezing (Respondent's Exhibit 4; pp 23-25). Petitioner was seen for port removal on November 3, 2015. It was reported that he had finished his chemotherapy and the port was no longer in use. Physical examination respiratory showed normal auscultation and normal effort. Petitioner returned on November 17, 2015, and had the port physically removed (Respondent's Exhibit 4; pp 10-17). Petitioner was seen on February 15, 2016, for BPH. On that date his review of systems respiratory was negative (Respondent's Exhibit 4; pp 6-9).

The medical records from Cardiothoracic Surgery were admitted into evidence. Petitioner was seen by Dr. John Watson on April 13, 2015, for aortic aneurysm. Petitioner was noted to be a former cigarette smoker and tobacco chewer. Petitioner indicated he quit smoking cigarettes on January 1, 2013. His review of systems respiratory was positive for cough and wheezing. His review of systems respiratory was negative for any accelerated respirations, asthma, dyspnea and frequent upper respiratory infections. The assessment was abdominal aortic aneurysm. Petitioner was to undergo an endograft repair of the abdominal aortic aneurysm (Respondent's Exhibit 5; pp 2-6).

The medical records from Pinckneyville Community Hospital were admitted into evidence. Petitioner was seen in the emergency room on October 13, 2010, complaining of left flank and left groin pain after pulling on a rock at work. The assessment was strained back, abdomen and groin (Respondent's Exhibit 6; p 10). On examination Petitioner's breath sounds were clear and equal (Respondent's Exhibit 6; p 13).

The medical records from Family Medical Center were admitted into evidence. Petitioner was seen on May 13, 2014, with complaint of cold symptoms which had been present for several days. These symptoms included chest congestion, recent cough, ear congestion and stuffiness, nasal congestion and nasal discharge. Review of systems respiratory was positive for recent cough with scant amounts of clear sputum. His O2 saturation on room air was 96%. Physical examination of the chest revealed normal breath sounds without rhonchi, rale or wheeze. The assessment was upper respiratory illness (Respondent's Exhibit 7; pp 28-29).

Petitioner underwent a CT of the chest with contrast on March 27, 2015. The history was bladder cancer. The radiologist's impression was no new/suspicious lung masses or nodules and sequelae of old granulomatous disease (Respondent's Exhibit 7; pp 22-23).

Petitioner was seen on November 5, 2015, with complaint of cold symptoms which had been present for several days. His symptoms included chest congestion, recent cough, ear congestion and stuffiness, nasal congestion and nasal discharge. Review of systems respiratory was positive for recent cough with scant amounts of clear sputum. Petitioner was noted to be a smoker. His O2 saturation on room air was 97%. Physical examination of the chest was normal. The assessment was acute upper respiratory infection (Respondent's Exhibit 7; pp 5-6).

Petitioner was seen on January 9, 2016, with cold symptoms. Same had been present for five days. His symptoms included recent productive cough, ear congestion and stuffiness, nasal congestion, nasal discharge and a moderate amount of sputum. His O2 saturation on room air was 97%. Physical examination of the chest revealed normal breath sounds without rhonchi, rale or wheeze. The assessment was upper respiratory infection (Respondent's Exhibit 7; pp 2-3).

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment with Respondent.

In support of this conclusion the Arbitrator notes the following:

The spirometry performed as part of Dr. Paul's examination was within normal limits. Dr. Castle testified that the pulmonary function study performed by Dr. Paul on April 22, 2015, revealed no evidence of any obstruction or restriction. Dr. Castle testified that a diffusing capacity study obtained from Methodist Hospital was also entirely normal. Dr. Castle opined that Petitioner did not suffer from any pulmonary disease or impairment that had occurred as result of his occupational exposure to coal mine dust. Dr. Paul diagnosed Petitioner with chronic bronchitis based on Petitioner's report that he had wheezing and coughing at bedtime just about every day which was worse with upper respiratory infections. Dr. Paul did not review any treatment records regarding Petitioner. Dr. Castle reviewed medical records regarding Petitioner. Dr. Castle testified that in the records he reviewed he did not see any evidence of chronic bronchitis. Dr. Castle did not see any findings which would be described as a chronic cough productive of sputum for at least three months of the year for two or more consecutive years. Dr. Castle testified that based on Petitioner's objective testing from a pulmonary perspective, Petitioner was capable of heavy manual labor.

Dr. Henry K. Smith, a B-reader and board certified radiologist, interpreted the chest x-ray of April 21, 2015, as positive for coal workers' pneumoconiosis. Dr. Paul is not an A-reader or B-reader. He does not have the special training for interpreting chest x-rays for occupational lung disease that was described by Dr. Meyer. Dr. Meyer and Dr. Castle, B-readers, reviewed Petitioner's chest x-ray of April 21, 2015. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis. Dr. Castle testified that the chest x-ray showed no abnormalities consistent with pneumoconiosis. Dr. Castle testified as to what is required for a proper reading of the chest x-ray for pneumoconiosis. Dr. Paul did not follow that protocol.

The Arbitrator finds the opinions of Dr. Castle and Dr. Meyer to be more persuasive of those of Dr. Paul and Dr. Smith.

Although Petitioner testified that he first noticed breathing problems when working in Colorado in about 2000, a review of the medical records does not support his breathing complaints. Also, Petitioner testified that from the time he first noticed breathing problems in 2000 until he left coal mining in 2014, his problems stayed the same. Petitioner started smoking at age 23 or 24 and smoked until about age 65. The medical records note that on most occasions Petitioner's review of systems respiratory was negative for chronic cough, dyspnea and wheezing. Generally when he did have complaints of cough and chest congestion, he was diagnosed with an acute respiratory condition. No physician related these acute conditions to his coal mine dust exposure. Petitioner testified that he decided to retire on September 27, 2014. There was no evidence that he had a pulmonary or respiratory condition which contributed to his decision to retire.

In regard to disputed issues (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusions of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES McADAMS,

Petitioner,

vs. NO: 16 WC 29623

PRAIRIELAND POWER,

19IWCC0621

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, medical expenses, prospective medical and temporary total disability benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 determines that the appropriate award of prospective medical should be limited to the medical treatment recommended by Dr. Matthew Gornet for treatment of his cervical spine, specifically disc replacement surgery at levels C3-4, C4-5 and C5-6 and reasonable and necessary post-operative care and rehabilitation following therefrom.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 24, 2019 is hereby affirmed and adopted with the foregoing clarification.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical care pertaining to Petitioner's cervical spine, specifically the disc replacement surgery at C3-4, C4-5, and C5-6 recommended by Dr. Gornet, and all reasonable and necessary post-operative care and rehabilitation following therefrom.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the reasonable and necessary medical services as identified in Petitioner's Exhibits 25-33, as provided by Section 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $799.98 per week for 120 1/7 weeks commencing August 19, 2016, through November 30, 2018, as provided for in Section 8 (b) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,000.00. 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 2019
O: 10/29/19
SJM/msb
44

Stephen Mathis

Douglas McCarthy

AUTHORIZATION-SPECIAL CONCURRENCE /DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

McADAMS, JAMES
Employee/Petitioner

Case# **16WC029623**

PRAIRIELAND POWER
Employer/Respondent

19IWCC0621

On 1/24/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

4744 UNSELL SCHATTNIK &PHILLIPS PC
ERIN M PHILLIPS
3 S 16TH ST
WOOD RIVER, IL 62095

1256 HOLTKAMP LIESE ET AL
R KENT SCHULTZ
217 N 10TH ST SUITE 400
ST LOUIS, MO 63101

19IWCC0621

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)

James McAdams
Employee/Petitioner

Case # 16 WC 29623

v.

Consolidated cases: n/a

Prairieland Power
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 Collinsville, on November 30, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident 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 18, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $62,398.44; the average weekly wage was $1,199.97.

On the date of accident, Petitioner was 46 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $83,197.92 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $83,197.92.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 25-33, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the cervical disc replacement surgery recommended by Dr. Matthew Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $799.98 per week for 120 1/7 weeks commencing August 19, 2016, through November 30, 2018, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

January 22, 2019
Date

JAN 24 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claims which alleged he sustained an accidental injury arising out of an in the course of his employment by Respondent on August 18, 2016. According to the Application, the accident occurred "During the course of employment" which caused him to sustain an injury to the "Chest, left leg, left shoulder, left arm, left hand, forehead and head" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related injury, but disputed liability on the basis of causal relationship with regard to the need for cervical surgery as recommended by Dr. Matthew Gornet, one of Petitioner's treating physicians (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in 2011 and worked as a salesman. Petitioner's job duties included selling tractors, tractor equipment, lawn mowers, farm equipment, etc. On August 18, 2016, Petitioner was injured when a grapple fell off the front end loader of the tractor and struck the Petitioner. The accident was reported to Respondent on the day it occurred.

The Petitioner was taken by ambulance to Jersey Community Hospital. A CT of Petitioner's cervical spine was done at the ER which revealed degenerative spurring at C4-C5 and C5-C6 (Petitioner's Exhibit 5).

Petitioner followed up with his primary care physician, Dr. Timothy Lyons, five days later, on August 23, 2016. Petitioner advised Dr. Lyons that a loader bucket flipped over and landed on top of him. In Dr. Lyon's initial assessment stated that Petitioner has a moderate head injury and concussion with mental confusion or disorientation. At that time, Petitioner did not complain of any neck symptoms. On September 2, 2016, Dr. Lyons noted that Petitioner stated he was not feeling better, actually felt worse and Petitioner complained of headaches. Dr. Lyons ordered an MRI of the brain. The MRI was normal, but he referred to a neurologist, Dr. Kama Sherwood for further evaluation (Petitioner's Exhibits 6 and 8).

Petitioner saw Dr. Sherwood on September 20, 2016. Petitioner stated that he was injured at work, a heavy pod about 800 pounds of equipment fell on him at work. Dr. Sherwood's notes indicated stated that while Petitioner initially denied headaches, Petitioner's wife stated that two or three days after the accident, Petitioner began to experience headaches and within a week the headaches increased in intensity. Dr. Sherwood diagnosed Petitioner with a traumatic brain injury, post concussion syndrome and vertigo due to brain injury and ordered physical therapy. (Petitioner's Exhibit 9, page 3)

On September 28, 2016, Petitioner treated at Jersey Community Hospital Physical Therapy for the physical therapy ordered by Dr. Sherwood. Petitioner stated that he was injured at work on August 18, 2016 when a heavy pod fell on him and hit his head. Petitioner complained of pain and headaches (Petitioner's Exhibit 10).

On October 6, 2016, at Petitioner's two week follow up visit with Dr. Sherwood, Petitioner was diagnosed with traumatic brain injury, cervical pain, and cervical radicular pain (Petitioner's Exhibit 9). Petitioner complained of tightness in the neck and with certain movements of his neck, Petitioner experienced a burning sensation radiating into his left shoulder/arm. Dr. Sherwood ordered a cervical spine MRI (Petitioner's Exhibit 9).

On October 14, 2016, the cervical spine MRI was performed. In the MRI report, the history stated that Petitioner had neck pain ever since accident on August 18, 2016. According to the radiologist, the MRI showed disc bulging at C3-C4 and C5-C6 as well as foraminal stenosis at C3-C4, C4-C5, and C5-C6 (Petitioner's Exhibit 12).

When Dr. Sherwood saw Petitioner on October 20, 2016, Petitioner had recurrent neck pain on the left side radiating into the left arm. Petitioner saw Dr. Sherwood on November 8, 2016, and Dr. Sherwood reviewed the MRI findings. Petitioner continued to treat with Dr. Sherwood throughout the period of November, 2016, through June, 2017. Petitioner completed the first session of physical therapy in November, 2016, but Dr. Sherwood referred him back to physical therapy in April, 2017 (Petitioner's Exhibits 9 and 10).

On June 15, 2017, Dr. Sherwood referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon who specializes in spinal surgery. Petitioner first saw Dr. Gornet on July 13, 2017. At that time Petitioner advised Dr. Gornet that on August 18, 2016, he sustained an injury at work when the grapple attachment struck him in the head. Dr. Gornet ordered a cervical MRI scan which was performed on July 13, 2017. According to the radiologist, the MRI revealed disc protrusions at C3-C4, C4-C5 and C5-C6. Dr. Gornet opined there were significant disc fragments not only at C5-C6 but also at C4-C5. Dr. Gornet recommended steroid injections at C4-C5 and C5-C6 on the left as a conservative means of treatment. He indicated that if the injections did not improve the Petitioner's condition, consideration could be given to surgery at C3-C4, C4-C5 and C5-C6 (Petitioner's Exhibits 9, 18, and 19).

Petitioner was seen by Dr. Helen Blake on July 12, 2017. Dr. Blake administered injections at C4-C5 and C5-C6 on July 25, 2017 and August 8, 2017, respectively (Petitioner's Exhibit 3). When Petitioner saw Dr. Gornet on September 14, 2017, Petitioner advised the injections had helped him for a week to 10 days, but he was again experiencing pain (Petitioner's Exhibits 3 and 18).

On September 14, 2017, Dr. Gornet referred Petitioner to Dr. George Paletta, a shoulder specialist to determine if the pain Petitioner was experiencing was related to his shoulder, or if it was related to the cervical spine injury. On September 25, 2017, Petitioner was seen by both Dr. Paletta and Dr. Gornet. Dr. Paletta ordered an MR arthrogram of Petitioner's left shoulder which was performed that same day. Dr. Paletta opined the MR arthrogram revealed some degenerative changes at the AC joint, but that most of Petitioner's left shoulder symptoms originated from his cervical spine problem. Dr. Paletta also recommended Petitioner proceed with the treatment recommended by Dr. Gornet (Petitioner's Exhibits 20 and 21).

Petitioner was again seen by Dr. Gornet on September 25, 2017. At that time, Dr. Gornet recommended disc replacement surgery at C3-C4, C4-C5 and C5-C6 (Petitioner's Exhibit 18).

At the request of the Respondent, Petitioner was examined by Dr. Robert Bernardi, a neurosurgeon, on October 10, 2017. In connection with his examination of Petitioner, Dr. Bernardi reviewed medical records provided by the Respondent. Dr. Bernardi noted Petitioner informed him that he was injured at work on August 18, 2016, when a grapple fell into the Petitioner's lap, causing Petitioner to lose consciousness for approximately five to six minutes. Dr. Bernardi's report stated that the grapple fell into the Petitioner's lap, but when Dr. Bernardi was deposed, he testified that due to the facial lacerations that required suture, the grapple also struck the Petitioner in the head. Dr. Bernardi opined that the accident of August 18, 2016, did not cause or contribute to any of the findings on the diagnostic studies and he was unable to conclude that either Petitioner's neck or low back symptoms were in any away causally related to the work accident. He further noted Petitioner did not have radiculopathy (Respondent's Exhibit 3; pp 43-44; Deposition Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Todd Silverman, a neurologist, on July 25, 2018. In connection with his evaluation of Petitioner, Dr. Silverman reviewed medical records provided to him by the Respondent. At the time of examination, Petitioner advised Dr. Silverman that he was injured at work on August 18, 2016, when a grapple fell directly onto him as he sat in the driver's seat of a tractor. Dr. Silverman noted Petitioner indicated a grapple landed on his head, upper body and legs. Dr. Silverman opined Petitioner's traumatic brain injury and post-concussion syndrome were caused by the work-related injury of August 18, 2016, but those symptoms had resolved and Petitioner was at MMI. Dr. Silverman noted he could not provide an opinion whether the injury on August 18, 2016, caused a prolonged exacerbation of pre-existing psychiatric symptoms because this was beyond the scope of his expertise (Respondent's Exhibit 4; Deposition Exhibit 2).

Dr. Gornet was deposed on September 13, 2018, and his deposition testimony was received into evidence at trial. Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Gornet testified he recommended Petitioner undergo injections at C4-C5 and C5-C6, but that if they did not improve Petitioner's condition, then Petitioner should be considered for disc replacement surgery. Dr. Gornet also stated Petitioner was incapable of working (Petitioner's Exhibit 1; pp 13-14).

Dr. Gornet testified that given the fact that Petitioner already had injections at C4-C5 and C5-C6 that did not provide any long term relief, there was not any other option other than performing surgery. Dr. Gornet stated Petitioner had clear objective pathology that correlated with his subjective complaints. Dr. Gornet testified that there was no indication in the medical record Petitioner had problems with his neck or head prior to the accident. He also testified that the fact the emergency room physician ordered a CT of his cervical spine after head trauma was indicative that there was a concern that Petitioner could have had a neck injury. Dr. Gornet stated that the fact the MRI revealed objective pathology that correlated with Petitioner's subjective complaints created no other explanation other than the fact that the problems in Petitioner's cervical spine were related to the trauma that he experience in connection with the work injury of August 18, 2016 (Petitioner's Exhibit 1).

Dr. Gornet testified that the Petitioner's diagnosis was discogenic neck pain secondary to disc injuries. Dr. Gornet noted Petitioner had mild pre-existing degeneration and mild pre-existing foraminal stenosis, both of which were aggravated by the accident. Dr. Gornet has continued to authorize Petitioner to remain off work and testified Petitioner needs surgery consisting of disc replacement surgery at C3-C4, C4-C5 and C5-C6 (Petitioner's Exhibit 1; pp 26-28).

Dr. Bernardi was deposed on October 12, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Bernardi's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Bernardi testified Petitioner's neck and low back complaints were not related to the accident primarily because when Petitioner was initially treated following the accident, he had no neck or low back symptoms. Further, he stated the MRIs performed after the accident, in particular, the MRI of July 13, 2017, did not reveal any cervical disc pathology (Respondent's Exhibit 3; pp 16-22).

On cross-examination, Dr. Bernardi testified that while his report did not state the grapple hit Petitioner in the head before it hit him in the lap, he noted that because there were facial lacerations when Petitioner was treated at the ER, that the grapple must have struck Petitioner's head as it fell. Dr. Bernardi also testified that when he examined Petitioner, he used the Modified Somatic Perception Questionnaire, which he agreed was developed and used for treatment of low back pain, not cervical spine pain. Dr. Bernardi did concede Dr. Sherwood's record of October 8, 2016, [the record was actually October 6 and October 20, 2016] noted Petitioner had neck symptoms which had been worsening. Dr. Bernardi agreed that pain associated with radicular symptoms from a herniated disc would "wax and wane." Dr. Bernardi also agreed that Petitioner having undergone a CT scan of his neck, was evidence of concern regarding potential problems with the neck because a physician would not exposed the patient to radiation unless there was some possible problem with that part of the anatomy (Respondent's Exhibit 3; pp 34-35, 43-44, 54-56).

As aforestated, Dr. Bernardi opined Petitioner's injuries were not causally related to the accident of August 18, 2016, because Petitioner did not immediately complained of neck pain as he should have based upon the injury. However, Dr. Bernardi agreed that a head injury could interfere with an individual's ability to properly report symptoms. Dr. Bernardi also stated it was his opinion that despite being struck in the head by a grapple, Petitioner did not sustain a significant head injury, but merely a concussion (Respondent's Exhibit 3; pp 52-53).

Dr. Silverman was deposed on October 18, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Silverman's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Silverman testified Petitioner sustained a mild traumatic brain injury or concussion as a result of the accident. He stated Petitioner's current headache symptoms were not related to the accident because Petitioner had them prior to the accident. While Petitioner had headaches following the accident, he had none for approximately one half of a year prior. He testified there was no reason for Petitioner to be symptom free for that period of time and then have a relapse one half of a year afterward (Respondent's Exhibit 4; pp 37-39).

While Dr. Silverman agreed he was a neurologist and not a neurosurgeon, he testified cervical disc surgery was not appropriate. He based this upon his review of the medical records and his review of the MRI report of July, 2017 (Respondent's Exhibit 4; pp 43-44).

On cross-examination, Dr. Silverman agreed that someone working long hours and subjected to stress and anxiety who was predisposed to headaches could be more likely to have them. He noted Petitioner had a history of headaches going back as much as 20 years; however, based upon the records he reviewed, Petitioner last sought treatment in 1994/1995 and did not seek any further treatment until late 2013, early 2014 (Respondent's Exhibit 4; pp 53-54, 69).

Joshua Davis testified on behalf of Petitioner. Davis was present at the accident of August 18, 2016, and stated he was standing approximately one foot behind the right front tire of the tractor in which the Petitioner was seated when the grapple fell off of the loader and struck him. Davis testified the grapple fell off and struck Petitioner in the face and twisted his head around. Davis noted Petitioner's face was bleeding, his mouth was open, his lip had been split, and there was blood everywhere. Davis believed that when the grapple struck Petitioner in the face he thought it had broken his neck and killed him.

At trial, Petitioner testified that the headaches he has experienced subsequent to the accident are different than any headaches he had before. He testified the headaches he now experiences originate in the back part of his head and into his neck area, then he experience pulsating pain that comes down into his left arm. Petitioner has not been able to return to work because of restrictions Dr. Gornet has imposed upon him. Petitioner does want to proceed with the disc replacement surgery recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of August 18, 2016.

In support of this conclusion the Arbitrator notes following:

There was no dispute that Petitioner sustained a work-related injury on August 18, 2016.

Petitioner was examined and treated by Dr. Gornet, an orthopedic surgeon, who has been Petitioner's primary treating surgeon. Dr. Gornet initially treated Petitioner conservatively prior to his recommendation that Petitioner undergo disc replacement surgery. Because the conservative treatment Petitioner received provided him with no permanent relief, Dr. Gornet recommended disc replacement surgery at C3-C4, C4-C5 and C5-C6. Dr. Gornet has opined that Petitioner's neck symptoms are related to the accident of August 18, 2016.

Respondent's Section 12 examiner, Dr. Bernardi, opined that Petitioner's work accident did not cause or contribute to any of the findings on the diagnostic studies and that Petitioner's neck and low back symptoms were not related to the accident of August 18, 2016. His opinion is based primarily on the fact that Dr. Bernardi noted Petitioner did not report any neck pain immediately after the accident in spite of the fact that Dr. Sherwood's records noted Petitioner had worsening neck pain with radiation into the left arm in October, 2016. Dr. Bernardi also agreed that Petitioner having undergone a CT scan of his neck was indicative of him having some neck issues. He also testified a head injury could interfere with an individual's ability to report symptoms.

Respondent's Section 12 examiner, Dr. Silverman is a neurologist and not either an orthopedic surgeon or a neurosurgeon. However, Dr. Silverman opined cervical disc replacement surgery was not appropriate.

Given the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. Bernardi and Dr. Silverman in regard to causality.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 25-33, 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 treatment provided to Petitioner was reasonable and necessary.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the medical treatment recommended by Dr. Matthew Gornet, specifically disc replacement surgery at levels C3-C4, C4-C5 and C5-C6.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 120 1/7 weeks commencing August 19, 2016, through November 30, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been under active medical treatment and Dr. Gornet has opined Petitioner has been unable to work since August 19, 2016.

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

ROBERT WYSE,

Petitioner,

vs. NO: 16 WC 29687

LAKESHORE RECYCLING SYSTEMS,

Respondent.

19IWCC0622

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b) and 8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, temporary total disability, medical expenses and prospective medical care, and being advised of the facts and law, affirms with changes the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

I. FINDINGS OF FACT

A. Background, Prior Treatment, and Accident

On June 8, 2016, Petitioner had been employed by Respondent as a roll-off truck driver for 13 years. Petitioner typically worked 12 hours per day. In addition to driving the roll-off truck, his job duties included hauling, tarping, and securing "boxes" (slang referring to dumpsters and compactors).

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Petitioner's job required him to lift 50- to 80-pound tarps, as well as the "knuckle" which allows a box to be lifted onto a truck. Petitioner was also required to climb in and out of the truck, and occasionally over the truck to hook the box to the truck. He was required to bend or squat when placing knuckles into the receivers of boxes, cleaning up garbage after breaking away a compactor, tarping boxes, and rolling up tarps. He was further required to push or pull doors on the boxes, which could weigh hundreds of pounds.

Petitioner previously sought treatment for right knee pain on March 19, 2009. On suspicion of a meniscal tear, Dr. Gregory Markarian ordered an MRI, which was performed on March 21, 2009. The interpreting radiologist's impression of the MRI was a tear of the posterior horn and body of the medial meniscus, with developing meniscal cysts. On April 15, 2009, Dr. Markarian performed a right knee arthroscopy with partial medical meniscectomy and chondroplasty of the medial femoral condyle. Following courses of outpatient physical therapy and home therapy, Petitioner was discharged from Dr. Markarian's care on February 16, 2010. Petitioner testified he was released for work duty with no restrictions and returned to work for Respondent. Between 2010 and June 8, 2016, Petitioner had no other accidents or treatment involving his right knee. Petitioner also had no problem with his job duties during this time.

On June 8, 2016, Petitioner was sent by Respondent to the suburbs to haul a dumpster overloaded with metal studs. Petitioner attempted to tarp the dumpster, but the tarp became stuck on the studs. He climbed the side of the box with a pole to lift the tarp over the protruding studs. While twisting his body to maneuver the tarp over the studs, Petitioner fell approximately three and one-half feet to the ground, landing partly on concrete and partly on an uneven, grassy area. Petitioner testified that when he fell, he led with his right foot and felt a popping in his right knee upon landing on the uneven surface, which had tire ruts. His left foot trailed, leaving him in a stretched position. Most of Petitioner's weight was on his right foot when he landed. Petitioner testified he gave an account of the accident to his dispatcher and supervisor and requested to go to the medical clinic.

B. Medical Treatment

Later that day, Petitioner was seen by Dr. Peter Sorokin, who obtained X-rays and diagnosed a right knee sprain. Dr. Sorokin prescribed physical therapy and released Petitioner to work with restrictions.

On June 10, 2016, Petitioner saw Dr. Daniel Palyoran for a recheck of his injury. On June 15, 2016, Dr. Palyoran ordered an MRI, which was performed that day. The impression of the interpreting radiologist was: (1) a degenerative disease of the knee, predominantly in its medial compartment with a small joint effusion; (2) a large Baker's cyst; (3) grade IV chondromalacia at the medial femoral condyle and medial tibial plateau; (4) grade II sprain of the anterior cruciate ligament; and (5) Complex grade III tear in the posterior horn and the body of the medial meniscus.

Petitioner was next seen by Dr. Raghu Pulluru on June 16, 2016. Dr. Pulluru examined

Petitioner and the MRI (noting the complex meniscal tear), as well as obtaining new X-rays. He recognized Petitioner's prior surgery, but observed Petitioner was minimally symptomatic prior to the injury, which "likely caused a meniscal tear and may exacerbate the arthritis." Dr. Pulluru prescribed a right knee arthroscopy with partial medial meniscectomy. The doctor's post-operative notes indicate the surgery was performed, along with chondroplasty of the medial femoral condyle, on July 11, 2016.

After the surgery, Dr. Pulluru recommended physical therapy and that Petitioner be restricted to sedentary work. Petitioner visited Athletico for physical therapy sessions from July 14 through September 14, 2016, when he was discharged because his sessions were no longer authorized.

Petitioner testified that Dr. Pulluru released him to return to work for Respondent in August 2016. Petitioner noticed he "wasn't a hundred percent yet."

On August 8, 2016, Petitioner was seen by Dr. Pulluru's assistant, Eric Pomazal. During this visit, Petitioner reported that approximately two weeks earlier, "he was riding his bicycle and took a spill injuring his right hip." Petitioner testified he also scraped the right side of his right knee. According to Petitioner, his knee felt the same except for the pain of the scrape. Pomazal's examination demonstrated "good range of motion at the knee and hip." After discussing the matter with Dr. Pulluru, Pomezal recommended continuing physical therapy.

On September 12, 2016, Dr. Pulluru prescribed a cortisone injection, which he administered the same day. The notes for this visit indicate seeking pre-authorization for a Monovisc injection in the event the cortisone injection failed to provide relief. Petitioner testified the knee felt somewhat better for a few weeks after the cortisone injection.

On September 29, 2016, Petitioner told Dr. Pulluru the cortisone injection did not help much. He also reported he had returned to full-time work duty, working overtime, sometimes 12 hours a day. Dr. Pulluru administered a Monovisc injection on this date. Petitioner testified his knee again felt somewhat better for a few weeks after the injection.

On October 25, 2016, Petitioner informed Dr. Pulluru that the Monovisc injection he received on September 29, 2016 had not relieved his right knee pain. During the October 25 physical examination, Dr. Pulluru recommended total knee replacement surgery.

Petitioner received salary continuation from June 9 through August 15, 2016. Petitioner also received TPD benefits for the period between September 25 through November 19, 2016, when Dr. Pulluru had restricted his hours of work.

C. Current Condition and Activities

Regarding his current condition of ill-being, Petitioner testified he has pain on both the left

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and right sides, as well as some behind the knee, while performing his job duties for Respondent. Petitioner also testified he is slower in his duties than before his injury. He takes Aleve twice daily.

Petitioner testified that he lived an active lifestyle prior to the June 8, 2016 accident. He engaged in numerous activities, including racquetball, softball, and jogging. Petitioner also testified that he does not engage in these activities since the accident.

In June 2016, Petitioner vacationed with his wife and others in North Carolina. Petitioner testified he did not walk much during this trip, driving to various locations and taking brief walks to see the sights.

Petitioner testified that he discussed bicycling with Dr. Pulluru, who advised him it was fine. Petitioner testified Dr. Pulluru endorsed bicycling because exercise was recommended after the surgery, but Petitioner could no longer run for exercise. In addition to the spill Petitioner reported on August 8, 2016, Petitioner testified he participated in a 20.3-mile bicycle ride during an Alaskan vacation in June 2017. Petitioner stated the ride was at a leisurely pace, though some portions were uphill. On July 13, 2017, Dr. Pulluru authored a work status note stating Petitioner was able to bicycle for exercise. Petitioner further testified that when the weather was warm in 2017, he rode his bike as much as 15 miles, three or four times a week.

Petitioner participated in a 5K race on September 25, 2016. Petitioner had signed up for the event in May 2016, prior to the accident. He decided to participate to support his wife, although she finished before him. Petitioner finished 532 out of 772 participants, completing the course in 39 minutes, 23 seconds. Petitioner, who is 6' 5" tall with a long stride, testified he mostly walked the course. His knee felt "okay" because he had recently received a cortisone injection. Petitioner wore a knee brace prescribed by Dr. Pulluru.

Petitioner went deep sea fishing in Mexico from October 14-22, 2016. Petitioner caught a "pretty big" fish, which he hauled to the boat as the fish pulled back somewhat. He did not consider cranking the reel to be physically demanding. According to Petitioner, the crew pulled the fish out of the water. Petitioner testified that his knee pain during the Mexico trip was "probably better because [he] didn't do much."

D. Dr. Raghu Pulluru's Deposition (June 13, 2017)

Dr. Pulluru, a board-certified orthopedic surgeon with a subspecialty in sports medicine, testified by deposition on behalf of Petitioner. Dr. Pulluru testified that when he first examined Petitioner on June 16, 2016, he found a positive McMurray test which is indicative of a meniscal tear. Similarly, his review of Petitioner's MRI showed a complex tear of the medial meniscus, along with some arthritis and a Baker's cyst on the back of the knee. Petitioner's subjective complaints were consistent with Dr. Pulluru's objective findings.

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Dr. Pulluru opined that Petitioner's meniscal tear was related to his injury at work. The injury also exacerbated Petitioner's arthritis, which likely predated the injury, causing it to become symptomatic. Despite the arthroscopy and injections, Dr. Pulluru was unable to return Petitioner to his pre-injury level regarding the arthritis.

Dr. Pulluru also testified that any twisting injury or other injury will catch and shear the meniscus between the two bones and cause a tear. He opined Petitioner needed both the July 11, 2016 surgery and the recommended knee replacement surgery because of the injury. He explained Petitioner was asymptomatic before the injury and symptomatic thereafter. Dr. Pulluru was unable to return Petitioner to an asymptomatic state with conservative measures. He opined that the medical treatment provided to Petitioner was reasonable and necessary. He also recommended total knee replacement surgery based on Petitioner's pain, as well as the arthroscopic and imaging findings.

Dr. Pulluru agreed Petitioner had bone-on-bone degenerative changes since 2009. He also agreed degeneration can cause a torn meniscus. However, Dr. Pulluru explained that in his operative findings, the term "degenerative medial meniscal tear" meant there was a tear associated with degenerative findings, which did not imply causation.

Dr. Pulluru testified he did not believe Petitioner's weight (represented by Respondent's counsel to be 305 pounds) would have caused the meniscal tear. He observed that weight did not appear to have had a major effect on Petitioner's knees in the six or seven years prior to the accident. According to Dr. Pulluru, weight is one of many other issues.

Dr. Pulluru also testified he would advise against jogging if Petitioner was having significant pain and he had significant degenerative changes." Dr. Pulluru stated that significant impact "enforces on the joint and increases your symptoms." He allowed that the activity can aggravate the arthritic condition. However, Dr. Pulluru further testified jogging is not the worst thing someone can do for their knees. He observed there are "a lot of people who jog well into their 60s, 70s, and they do fine," adding "it depends on how any one individual is affected."

Responding to general questions about hiking, Dr. Pulluru testified his recommendation would depend on the extent of the activity and how well Petitioner's knee tolerated it. Dr. Pulluru stated that if the hiking was causing significant knee pain, he would recommend against it. Conversely, if Petitioner could tolerate the hiking and the knee pain was not aggravated, hiking would be preferable to running.

E. Dr. David Fetter's Deposition (October 18, 2017)

Dr. Fetter, a board-certified orthopedic surgeon, testified on behalf of Respondent. Dr. Fetter examined Petitioner at Respondent's request on November 2, 2016. He also reviewed Petitioner's medical records, including the operative report from Petitioner's 2009 knee surgery.

After reviewing the initial medical history of the June 8, 2016 incident, Dr. Fetter testified he did not see any reference to a twisting injury or Petitioner stepping onto uneven ground. Also, the initial records did not indicate an effusion or joint swelling that would be associated with a major knee injury. Dr. Fetter also testified trauma is not required to have a partial tear of the medial meniscus. A degenerative knee condition can often result in degenerative tears or defects.

Dr. Fetter opined there was no causal connection between Petitioner's work injury and his subsequent treatment. Dr. Fetter diagnosed Petitioner with a degenerative knee condition which was not causally related to the June 8, 2016 incident, based on: the medical findings dating back to 2009; the MRI findings; examination findings; and initial evaluation on June 8. Dr. Fetter further opined that if Petitioner underwent total knee replacement surgery, it would not be related to the work incident. In Dr. Fetter's opinion, at the time of his examination, Petitioner was capable of performing his job duties without restrictions.

Dr. Fetter was also questioned about Petitioner's off-work activities. Regarding bicycling, Dr. Fetter stated that "[i]t can be helpful to have your knee moving and with motion." Dr. Fetter also testified that the effect of hiking on someone with Petitioner's knee condition "would depend on really the degree of hiking and what exactly was involved."

Dr. Fetter was further asked whether running a 5K race would aggravate a knee joint with grade 3 or 4 chondromalacia. Dr. Fetter testified that it may. He was also asked whether running a 5K or hiking could aggravate pre-existing arthritis. Dr. Fetter replied: "[A]ggravation is defined in my report as a change objectively, so no, not to aggravation. The correct word would be exacerbation. Could it be a temporary so-called flare-up, that answer would be yes."

II. CONCLUSIONS OF LAW

A. Petitioner's Work-Related Accident and Prospective Medical Care

The Commission affirms the conclusions of the Arbitrator on the issues of accident, causal connection, notice, and prospective medical care. Respondent's Statement of Exceptions focuses on the issues of causal connection and prospective medical care.

The primary issue in dispute is the causal connection between the June 8, 2016 work accident and Petitioner's current condition of ill-being. The record demonstrates that Petitioner, while twisting to adjust a tarp, fell from a box of metal studs he was directed to haul for Respondent. Petitioner's right foot struck the ground first bearing most of Petitioner's weight. Petitioner landed partly on concrete and partly on an uneven, grassy area marked with tire ruts. Petitioner felt a popping in his right knee upon landing on the uneven surface.

Petitioner's treating physician, Dr. Pulluru, consistently opined that Petitioner's condition was caused by the work accident. On June 16, 2016, Dr. Pulluru observed Petitioner was minimally symptomatic prior to the injury, which "likely caused a meniscal tear and may

exacerbate the arthritis." On July 11, 2016, Dr. Pulluru performed a right knee arthroscopy with partial medial meniscectomy, along with chondroplasty of the medial femoral condyle. Dr. Pulluru ultimately opined in his deposition that Petitioner's meniscal tear was related to his injury at work and exacerbated Petitioner's pre-existing arthritis, causing it to become symptomatic.

Dr. Fetter, the Section 12 examiner, opined there was no causal connection between Petitioner's work injury and his subsequent treatment. Dr. Fetter diagnosed Petitioner with a degenerative knee condition dating back to 2009. However, Dr. Fetter testified he did not see any reference to a twisting injury or that Petitioner had stepped onto uneven ground.

Petitioner's treating physician, Dr. Pulluru, had ample opportunities to examine Petitioner and evaluate his physical condition from June 16 through October 25, 2016. In contrast, Dr. Fetter examined Petitioner on one occasion and was unaware of the twisting mechanism or surface areas involved in the accident. This understanding bears directly on whether Petitioner's meniscal tear and advanced degeneration in the knee could have been caused by the accident. It is the function of the Commission to resolve conflicts in medical testimony; greater weight may be attached to the opinion of the treating physician. See *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232 (1992) (citing *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill. 2d 1, 4 (1979)); *Williams v. Advocate South Suburban Hospital*, 15 IWCC 62. Ultimately, in this case, Dr. Pulluru had more complete information relating to Petitioner's mechanism of injury and ongoing right knee condition than that available to Dr. Fetter lending greater weight to Dr. Pulluru's opinions.

Given the record as a whole, we agree with the Arbitrator that Petitioner's current condition of ill-being is causally connected to the June 8, 2016 work accident. Accordingly, the Commission also agrees with the Arbitrator's decision to award the costs of the total knee replacement surgery recommended by Dr. Pulluru, along with all reasonable and necessary treatment associated with such surgery, pursuant to §8 and §8.2 of the Act. As the Arbitrator correctly observed, Dr. Fetter's opinion that Petitioner would not benefit from the surgery due to his weight was not subject to a utilization review. Rather, Dr. Fetter testified that he was "not recommending one way or another," but that Petitioner's weight could be a factor in the success of the surgery.

B. Petitioner's Credibility

The Commission also affirms the conclusion of the Arbitrator that Petitioner was credible, having answered the questions put to him at trial straight-forwardly. The Arbitrator further specifically accounted for Petitioner's off-work activities following the July 11, 2016 right knee surgery, a subject requiring additional findings of fact.

Petitioner lived an active lifestyle prior to the accident, engaging in activities including racquetball, softball, and jogging. Petitioner no longer engages in these activities.

Respondent raises Petitioner's off-work activities to suggest his complaints are

unsubstantiated and the opinions of his physician, Dr. Pulluru, did not account for these activities. The Commission agrees with the Arbitrator that Petitioner's participation in these activities do not affect his credibility.

Regarding bicycling, the record demonstrates that on August 8, 2016, Petitioner informed his physician that he took a spill on his bicycle, and bicycling was not restricted by his physician. Petitioner testified that Dr. Pulluru advised him bicycling was fine. Petitioner's undisputed testimony was that Dr. Pulluru endorsed bicycling because exercise was recommended after the surgery, but Petitioner could no longer run for exercise. Ultimately, Dr. Pulluru authored a work status note stating Petitioner is able to ride a bicycle for exercise. Dr. Fetter testified regarding bicycling that "[i]t can be helpful to have your knee moving and with motion."

Given this record, the Commission concludes that bicycling, whether before or after the August 8, 2016 spill (including Petitioner's June 2017 vacation in Alaska), does not negate Petitioner's knee complaints or provide any reason to discount Dr. Pulluru's opinions.

Responding to general questions about hiking, Dr. Pulluru testified that his recommendation would depend on the extent of the activity and how well Petitioner's knee tolerated it. Dr. Pulluru stated that if Petitioner could tolerate the hiking and the knee pain was not aggravated, hiking would be preferable to running. Similarly, Dr. Fetter testified that the effect of hiking on someone with Petitioner's knee condition "would depend on really the degree of hiking and what exactly was involved."

Given this record, the Commission concludes Petitioner's brief walks during his June 2016 vacation, even if characterized as hiking, do not render the Arbitrator's conclusion regarding causal connection against the weight of the evidence.

The Arbitrator further considered Petitioner's participation in the 5K event on September 25, 2016, when Petitioner had returned to work but remained under Dr. Pulluru's care.

Respondent notes Petitioner told Dr. Pulluru on September 29, 2016 (four days after the 5K event) that the cortisone injection he received on September 12, 2016 did not help much. Petitioner also reported he had returned to full-time work duty, working overtime, sometimes 12 hours a day.

The record demonstrates that Petitioner participated in the 5K event as a pre-existing commitment to support his wife. Petitioner's unrebutted testimony is that he bicycles because he cannot run any more. Almost two years after his accident and almost 19 months after the 5K event, Petitioner was asked at the arbitration hearing, "If the records don't reflect that you were restricted from running, is it your testimony that you are, in fact, restricted?" Petitioner replied that he "just can't do it." Petitioner's complaints in September 2016 may have been affected by the 5K event, but also may have been the product of working as many as 12 hours daily during the period. The activity may have contributed to a temporary exacerbation of symptoms, but Dr. Fetter admitted

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there would be no permanent change in Petitioner's right knee condition. Petitioner's condition remained through the period after the arthroscopy. Accordingly, the Commission concludes this isolated event did not affect the causal connection between Petitioner's accident and his current condition of ill-being.

Lastly, Petitioner went deep sea fishing while vacationing in Mexico in October 2016. Similar to the 5K event, Respondent notes that on October 25, 2016, Petitioner informed Dr. Pulluru that the Monovisc injection he received on September 29, 2016 had not relieved his right knee pain. The record contains less evidence than in respect to the 5K event that Petitioner's fishing trip affected his condition, even temporarily. Indeed, Petitioner testified that his knee pain during the Mexico trip was "probably better because [he] didn't do much." Accordingly, the Commission concludes the fishing did not affect the causal connection between Petitioner's accident and his current condition of ill-being.

The Commission further concludes Petitioner's off-work activities collectively did not affect the causal connection between Petitioner's accident and his current condition of ill-being. Petitioner's unrebutted testimony was that he was advised to exercise following the arthroscopic surgery. Respondent observes that Petitioner was significantly overweight; the record indicates Petitioner was recorded as weighing 300 pounds. In the deposition transcripts, Respondent's counsel questioned Drs. Pulluru and Fetter about the effect Petitioner's weight would have on his condition. Had Petitioner ignored Dr. Pulluru's advice to exercise after the surgery given his body habitus, it is quite likely the point would have been argued in these proceedings. The medical evidence in this case underscores Petitioner's commitment to his rehabilitation in following recommended physical activity to return to MMI following his work-related injury.

Ultimately, the issue remains whether Petitioner's current condition was caused by the work accident of June 8, 2016, as Dr. Pulluru concluded, or a degenerative condition as Dr. Fetter concluded. The Arbitrator gave greater weight to Dr. Pulluru's opinion; the Commission agrees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 2019, is hereby affirmed and adopted with the changes noted above.

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

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

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.

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $49,500.00. 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 19 2019
10/17/19
BNF/kcb
045

Barbara N. Flores

Marc Parker

Dissent

I respectfully dissent from the decision of the majority, which affirmed the Decision of the Arbitrator with explanation. The Arbitrator/Commission found that Petitioner proved the current condition of ill-being of his right knee was caused by a work-related accident and ordered Respondent to authorize and pay for total knee arthroplasty. I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving that the current condition of ill-being of his right knee was causally related to a work-related accident, and denied prospective surgery.

Petitioner alleged injury to his right knee when he stepped down from a dumpster onto uneven ground on June 8, 2016. That same day he presented to Concentra for evaluation. On examination, he had full range-of-motion, full strength, no ecchymosis, and no effusion. An MRI taken June 15th showed degenerative joint disease, small effusion, a large Baker's cyst, Grade IV chondromalacia at the medial femoral condyle and medial tibial plateau, Grade II sprain of the anterior cruciate ligament, and Grade III tear of the posterior horn and the body of the medical meniscus. On July 11, 2016, Dr. Pulluru performed arthroscopic surgery. Intraoperative findings included severe chondromalacia of the medial tibial plateau down to bare bone with posterior Grade III chondromalacia, a 1 centimeter full-thickness chondral defect in the medial femoral condyle over the patella articulation with chondral flaps, and a degenerative tear at the junction of the mid body and posterior horn of the medial meniscus. In October 2016, Dr. Pulluru recommended total knee replacement, which is the subject of this litigation.

The record shows that Petitioner had severe arthritis of the right knee in 2009. At that time he had surgical repair of the medial meniscus and the intraoperative findings included Grade IV chondromalacia in the medical compartment over the medial femoral condyle and a chondral lesion in the medial facet of the patella. Dr. Pulluru opined that Petitioner's current condition of

19IWCC0622

ill-being of his right knee was causally related to the alleged accident on June 8, 2016. However, he assumed that Petitioner was asymptomatic prior to the accident, which was not correct, and he acknowledged that he did not review Petitioner's prior records from 2009. When shown the operative report from 2009, Dr. Pulluru agreed that the intraoperative findings in 2009 were very similar to his in 2016.

In contrast, Respondent's Section 12 medical examiner, Dr. Fetter, reviewed Petitioner's prior medical records. He noted that Petitioner had bone-on-bone degenerative arthritis in 2009 and there was minimal evidence of traumatic injury in the medical examination on the day of the alleged accident. In addition, he noted that Petitioner was obese, fell off his bicycle two weeks after the 2016 arthroscopic surgery, in which he scraped his right knee, and ran a 5 kilometer race in September 2016, a month before Dr. Pulluru recommended arthroplasty. These incidents could have aggravated Petitioner's condition. Dr. Fetter concluded that if Petitioner needed total knee arthroscopy it would be because of the natural progression of his degenerative joint disease and not the alleged work-related accident. In my opinion, the opinion testimony of Dr. Fetter is more persuasive than that of Dr. Pulluru because he had a better understanding of Petitioner's underlying degenerative condition. Also in my opinion, Petitioner suffered at most a temporary exacerbation of his degenerative condition and his accident did not cause the need for arthroscopy.

For the reasons stated above, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving that the current condition of ill-being of his right knee was causally related to a work-related accident, and denied prospective surgery. Therefore, I respectfully dissent from the decision of the majority.

DLS/dw
O-10/17/19

Deborah L. Simpson
Deborah L. Simpson

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

WYSE, ROBERT
Employee/Petitioner

Case# **16WC029687**

LAKESHORE RECYCLING
Employer/Respondent

19IWCC0622

On 1/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS
COUNTY OF DU PAGE)

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

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

Robert Wyse
Employee/Petitioner
v.
Lakeshore Recycling
Employer/Respondent

Case # **16 WC 29687**

19IWCC0622

An *Application for Adjustment 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 Wheaton, on **April 10, 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. [x] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the 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 _____

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Wyse	)	
Petitioner,	)	
vs.	)	**No. 16 WC 29687**
Lakeshore Recycling Systems	)	
Respondent.	)	
	)	**19IWCC0622**

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

This matter proceeded to hearing in Wheaton under the provisions of §19b/§8a on April 10, 2018. The parties agree that on June 8, 2016, Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree petitioner earned $100,457.24 in the year pre-dating the accident and petitioner's average weekly wage, as calculated pursuant to §10, was $1,931.87.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment with respondent;
2. Whether petitioner provided timely notice of the accident to respondent in accordance with the provisions of the Act.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether petitioner is entitled to payment for prospective medical treatment.

STATEMENT OF FACTS

Prior to June 8, 2016, petitioner had been employed by respondent for thirteen years as a roll-off driver and was a member of the Teamsters Union Local 731. As a roll-off driver, his job duties included hauling dumpsters, tarping and securing them. He was required to lift fifty to eighty pounds. He does a lot of walking, bending and squatting in performance his job. He also pushed and pulled doors open and shut, as well as tugged on cable.

Prior to June 8, 2016 he was able to perform this job without problems. Prior to June 8, 2016, he had surgery on his right knee; which was on April 15, 2009 by Dr. Markarian. In 2010, he was released from Dr. Markarian's care. Between 2010 and June 8, 2016, he had no treatment to his right knee and was able to fully perform his job.

On June 8, 2016, petitioner was in the suburbs to pick up a box. The box was overloaded with metal studs sticking out. Petitioner climbed up on the side of the box with a pole to lift the tarp over the metal studs. As he came off the box, he landed partly on concrete and partly on uneven grassy area where the tires had caused ruts. He was up three and a half feet when he came off the box leading with his right foot. As he landed on the uneven surface he felt his right knee pop. He felt pain in his right knee.

He immediately called his dispatcher, Rich Crma by Nextel. He also spoke with roll-off supervisor, Paul Kos via Nextel. This was approximately 3:00 P.M. He asked to go to the clinic.

He filled out an accident report the next day as no one was in [the office] when he returned. Paul Kos was present when petitioner completed the accident report. Petitioner was sent to Concentra. He saw Dr. Sorokin at Concentra; X-rays were done and petitioner was referred to physical therapy. He followed up with Concentra. On June 15, 2016 he was referred for an MRI; performed at Chicago Ridge Medical Imaging on June 15, 2016.

Petitioner was next seen by Dr. Pulluru, with DuPage Medical Group, He first saw Dr. Pulluru on June 16, 2016. Dr. Pulluru performed surgery on July 11, 2016 at Plainfield Surgery Center. He received post-surgical physical therapy at Athletico. He was released to return to work in August, 2016 without restrictions. However, he was not 100%.

On September 12, 2016 petitioner received a cortisone injection. Petitioner received a Monovisc injection on September 29, 2016. On October 25, 2016, Dr. Pulluru recommended a total knee replacement. Petitioner was released to return to work without restrictions on November 22, 2016. He saw Dr. Pulluru on July 13, 2017. He has not yet undergone the recommended total knee replacement; but would like to do so. He now has pain as he does his job and is slower.

Prior to June 8, 2016, petitioner played racquetball and softball, jogged and participated in other activities. Since Jun 8, 2016, he has not been able to participate in these activities. He has taken vacations and does some walking. In September, 2016, he participated in a 5K. He had signed up for it in May, 2016 and participated mainly by walking; in order to support his wife. He had just received a cortisone injection prior to the 5K, so the knee was feeling okay. During the race, he wore a brace prescribed by Dr. Pulluru.

On cross-examination, petitioner admitted he fell off his bike two weeks before his August 8, 2016 Dr. Pulluru visit, scraping his right knee and fell on his right hip. Petitioner admitted he had gone deep-sea fishing and caught a pretty large sail fish in October, 2016. He agreed that when he saw Dr. Pulluru on October 25, 2016 he advised the doctor the Monovisc injection did not help. In June, 2017 he traveled to Alaska and took a 20-mile bike ride.

Occupational Health Centers of Illinois Records (PX.1)

According to these records, petitioner was initially seen by Dr. Sorokin on June 8, 2016 for a right knee injury which was reported as a result of twisting incident while working. X-rays showed mild tricompartmental osteoarthritic changes. The diagnosis was right knee sprain. Physical therapy was order and petitioner was released to return to work with restrictions.

At the June 9, 2018 physical therapy evaluation, petitioner reported the mechanics of the injury was he felt a pop on the inside of his knee cap after stepping down from a box. He reported the previous surgery. Therapy continued through June 15, 2016.

On June 10, 2016 he was seen by Dr. Daniel Paloyan for a recheck of his right knee injury. On June 15, 2016, Daniel Paloyan ordered an MRI.

Chicago Ridge Medical Imaging Record (PX.2)

The June 15, 2016 MRI reported degenerative disease in the medial compartment; Baker's cyst; grade IV chondromalacia at the medial femoral condyle and medial tibial plateau; grade II sprain of the anterior cruciate ligament; complex grade III tear in the posterior horn and the body of the medial meniscus.

Dr. Raghu Pulluru Records (PX.3)

Petitioner was initially seen by Dr. Pulluru on June 16, 2016. Dr. Pulluru concluded petitioner needed arthroscopic surgery for a medial meniscal tear. Petitioner followed up with PA-

C. Eric Pomazal on July 18, 2016, seven days' post op. On August 8, 2016, petitioner reported he had taken a spill while riding his bike two weeks before and injuring his right hip. X-rays were taken of the right hip. Petitioner could fully flex his knee and had no instability and was neurovascularly intact. On September 12, 2016, petitioner reported the physical therapy was discontinued due to lack of workers' compensation coverage. He was having significant amount of pain. Cortisone injection was recommended and administered. On September 29, 2016, petitioner reported little help with the cortisone injection; was having a lot of pain in the knee. A Monovisc injection was administered. He wanted to try full-duty work without overtime. On October 25, 2016, petitioner returned and reported the Monovisc injection did not help. Dr. Pulluru reported the X-rays showed significant medial compartment narrowing and significant degeneration. Dr. Pulluru discussed a total knee replacement.

Dr. Pulluru authored a letter opining that although petitioner's existing arthritis was not caused by the June 8, 2016, accident; however, the accident exacerbated the symptoms now necessitating the knee replacement.

On July 13, 2107, Dr. Pulluru authored a letter indicating it was okay for petitioner to bike for exercise.

Dr. Daniel Hrad Records (PX.4)

Petitioner was seen by Dr. Hrad on June 27, 2016 and July 7, 2016 for pre-op testing.

July 11, 2016 Operative Report (PX.5)

Petitioner underwent right knee arthroscopy for a medial meniscal tear with compartment chondromalacia and patellofemoral chondromalacia by Dr. Pulluru on July 11, 2016.

Athletico Records (PX.6)

Petitioner began physical therapy on July 14, 2016. On September 14, 2016, petitioner was discharged from therapy as further therapy was no longer authorized by workers' compensation, as well as physician's orders. Petitioner complained of increased pain after working 10 to 13 hours a day.

Dr. Raghu Pulluru June 13, 2017 Deposition (PX.8)

Dr. Raghu Pulluru, board certified orthopedic surgeon, testified via deposition in behalf of petitioner. His practice concentrates in treatment of knees and shoulders (6). He first examined petitioner on June 16, 2016, and found a positive McMurray test, which indicative of a meniscal tear (8). Dr. Pulluru performed arthroscopic surgery on July 11, 2016 (9).

Dr. Pulluru reviewed his ongoing treatment (10-14).

Petitioner's ongoing subjective complaints were consistent with Dr. Pulluru's objective findings (15). Dr. Pulluru believed the meniscal tear, necessitating the meniscectomy was caused by the work accident of June 8, 2016 (15). Dr. Pulluru also believed that because petitioner was asymptomatic prior to the work accident of June 8, 2016, the accident necessitated the need for the knee replacement (16).

On cross-examination Dr. Pulluru agreed petitioner had bone on bone degenerative changes dating back to 2009 (22). He also agreed degeneration can cause a torn meniscus (39). Dr. Pulluru confirmed petitioner was asymptomatic prior to the injury and then continued pain since then which is indicative that the injury accelerated petitioner's symptoms. (43).

Medical Bills (PX.9)

Petitioner introduced medical bills, although the stipulation entered by petitioner indicated no known unpaid medical bills.

Dr. David Fetter October 18, 2017 Evidence Deposition (RX.1)

Dr. David Fetter, board certified orthopedic surgeon, testified via deposition in behalf of respondent. Dr. Fetter examined petitioner on November 2, 2016 at respondent's request. Dr. Fetter also reviewed medical records; including the April 16, 2009 operative report.

Dr. Fetter's diagnosis was degenerative knee condition that was not related to the work accident of June 8, 2016 (31). Dr. Fetter based this opinion on the fact that petitioner had confirmed degenerative disease dating back to 2009 (31-32). Dr. Fetter saw no evidence of an acute injury from the June 8, 2016 incident (33). Dr. Fetter did not believe the need for the knee replacement was from the claimed work incident of June 8, 2016 (33-34). Dr. Fetter did not believe petitioner should be restricted in any way (35-36).

Dr. Fetter agreed that a twisting motion could cause a meniscal tear (45).

Dr. Fetter did not believe petitioner would benefit from a total knee replacement given his obesity (57).

Dr. Daniel Hrad Records from October 31, 2007 to August 10, 2010 Records (RX.2)

The records showed petitioner began complaining of right knee pain on October 31, 2007 after jogging. He had pre-op testing by Dr. Hrad on April 8, 2009 prior the the medial meniscectomy. There is no mention of any knee problems in these records after the April 22, 2009 visit.

Dr. Gregory Markarian Records (RX.3)

The March 21, 2009 MRI of petitioner's right knee showed a tear of the posterior horn and body of the medial meniscus with developing meniscal cysts and minimal effusion and tiny Baker's cyst.

Petitioner was evaluated for physical therapy on March 23, 2009 with a history of injuring his right knee a long time ago which healed itself. He reported he started running about five years before and the pain gradually got worse. Arthroscopic surgery was scheduled and performed on April 15, 2009 for right knee meniscus tear plus synovitis and chondromalacia of the medial femoral condyle, grade II to IV chondromalacia over the patellar medial facet and later subluxation tilt.

On November 17, 2009, Dr. Markarian discharged petitioner from therapy. On March 16, 2010, petitioner was doing well and was discharged from doctor's care.

Healthy Driven Plainfield Harvest 5K Run/Walk Records (RX.4 & 5)

The records show petitioner participated in the 5K walk/run on September 25, 2016, with a record of 39 minutes 23 seconds, averaging 12 minutes 41 seconds per mile. He placed 532 out of 772 participants.

Pictures from Pat Wyse's Facebook Page (RX.6)

Photos from the Facebook page of Pat Wyse, purportedly include pictures of petitioner with others in Alaska and Mexico, as well as at a 5K.

19IWCC0622

Lakeshore Recycling Systems Claims Report (RX.7)

Petitioner reported he was tarping a load when tarp got stuck on studs. He climbed on the side rail of box to get a tarp over studs. As he stepped down onto uneven ground, he caught the lip of the driveway and felt a pop in right knee.

His supervisor reported he called in and advised his right foot landed partially on the driveway and partially on the grass causing his knee to bend. He heard a pop and felt a sharp pain. He was able to drive back and then dove directly to Concentra on Ashland.

CONCLUSIONS OF LAW

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

The Arbitrator, having viewed the petitioner and his mannerisms during trial, found he answered the questions straight-forwardly, without hesitation. Thus, the Arbitrator found petitioner to be credible.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

Petitioner was in the course of his employment, when he mounted the box to tarp a load. As he stepped down with his right foot, he caught the edge of the driveway/cement and the grassy area, which petitioner described as having ruts from the tires, with his right foot. This caused his right leg to twist. He felt a pop in his right knee and felt immediate pain.

Based upon the foregoing, the Arbitrator finds petitioner's exposure to a risk, the uneven ground, was greater than that of the general public. Accordingly, the Arbitrator finds petitioner sustained accidental injuries to his right knee as a result of an accident on June 8, 2016 that arose out of and in the course of his employment with respondent.

E. With respect to the issue of whether timely notice of the accident was given to respondent in accordance with the provisions of the Act, the Arbitrator makes the following conclusions of law:

Respondent introduced the report of petitioner's accident that was acknowledged by petitioner's supervisor on June 9, 2016, the day after the accident. This acknowledgement by respondent indicates petitioner provided timely notice of the accident in accordance with the Act.

F. With respect to the issue of whether petitioner's condition of ill-being is causally related to the claimed accidental injuries, the Arbitrator makes the following conclusions of law:

There is no question petitioner had pre-existing arthritis of the right knee and had previously undergone arthroscopic surgery in April, 2009 for a torn medial meniscus of the right knee. However, there is no evidence petitioner received any treatment to the knee after March 16, 2010 until his work accident of June 8, 2016. Furthermore, despite the pre-existing arthritis, petitioner was able to fully perform his job as a roll-off driver for respondent up to the June 8, 2016 accident; working10 to 13 hours a day. This job was physically demanding; requiring him to lift fifty to eighty pounds, and do a considerable amount of walking, bending and squatting.

Petitioner's treating physician, Dr. Pulluru, opined that despite the fact that petitioner had pre-existing arthritis in the right knee, the fact that petitioner was asymptomatic until the work accident of June 8, 2016, and has remained symptomatic now necessitating a total knee

replacement is proof of the causal connection between the work accident of June 8, 2016 and petitioner's right knee condition now requiring knee replacement.

The Arbitrator, relying upon Dr. Pulluru's opinion and the holding in *Sisbro v. Industrial Commission*, 207 Ill.2d 193, finds petitioner's right knee condition, that now requires a total knee replacement, is causally connected to the work accident of June 8, 2016.

The Arbitrator makes this finding, despite the opinion of Dr. Fetter, who did not find petitioner had suffered an acute injury in the work accident of June 8, 2016. Dr. Fetter believed the torn meniscus found on the MRI of was degenerative, even though he acknowledged a twisting injury (to which petitioner testified) can cause a torn meniscus. Furthermore, pursuant to the holding in *International Vermiculite Company v. Industrial Commission*, 77 Ill.2d 1, 204 N.E. 2d 1166 (1979), the Arbitrator is permitted to give greater weight to the opinion of the petitioner's physician.

In reaching this conclusion, the Arbitrator took into consideration the fact that petitioner participated in a 5K race on September 25, 2016, in which he finished 532 out of 772 participants and averaged almost 13 minutes per mile. Dr. Pulluru's records confirm petitioner was having a significant amount of pain as of September 13, 2016 despite having undergone arthroscopic surgery on July 11, 2016.

In addition, the Arbitrator considered petitioner's other activities; included deep-sea fishing, hiking and biking, as well petitioner's fall off his bike on August 8, 2016. There is no evidence these activities contributed to the need for the total knee replacement.

In consideration of all of these factors, the Arbitrator finds petitioner's present right knee condition, for which he needs a total knee replacement was caused by the work accident of June 8, 2016.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator, having found petitioner's right knee condition of ill-being, necessitating a total knee replacement, was caused by the work accident of June 8, 2016, awards the costs of the total knee replacement surgery and all related associated care.

The Arbitrator makes this award despite Dr. Fetter's opinion that due to petitioner's obesity, he would not benefit from a total knee replacement. This opinion was not a utilization review and fell short of finding the total knee replacement was unreasonable or unnecessary. Furthermore, petitioner has exhausted all other conservative treatment without receiving any lasting benefits.

Therefore, the Arbitrator awards the costs of the total knee replacement and all reasonable and necessary treatment associated with said surgery, in accordance with §8 and §8.2 and the medical fee schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ILLINOIS WORKERS' COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DEPARTMENT,

Petitioner,

19IWCC0623

vs.

No: 19 WC 20221
10 INC 112

SHAN F. CHEN, INDIVIDUALLY AND PRESIDENT,
JIA B. CHEN, INDIVIDUALLY AND AS AGENT,
ASIAN BUFFET a/k/a CHINESE BUFFET

Respondents

DECISION AND OPINION ON PETITION FOR
FINES DUE TO INSURANCE NON-COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Department, brings this action, by and through the Office of the Illinois Attorney General, against the above captioned Respondents, alleging violation of Section 4(a) of the Illinois Workers' Compensation Act. Respondents were served with timely and proper notice. (Pet. Group Ex. 1) A hearing was held before Commissioner Maria Portela in Chicago, Illinois on June 7, 2019, and a record was made. Respondents did not appear.

The Commission notes that on April 17, 2019, Respondents, after proper and timely notice, were found to be in default and found to have knowingly and willfully failed to insure their liability to pay compensation in accordance with Section 4(a) of the Act. (Id.)

The Workers' Compensation Commission Insurance Compliance Department Notice of Non-Compliance and Notice of Insurance Compliance Hearing states Chinese Buffet was not in compliance with the requirements of Section 4(a) of the act from 07/20/2005 through 02/18/2010. After considering the entire record, the Commission finds that Respondent knowingly and willfully violated Section 4(a) of the Act and Section 9100.90 of the Rules Governing Practice before the Illinois Workers' Compensation Commission, from 07/20/2005 to 02/18/2010, a period of 1,675 days. The Commission assesses a civil penalty under Section 4 of the Act in the sum of $884,500.00 against Respondents for the reasons set forth below:

19IWCC0623

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Asian Buffet a/k/a Chinese Buffet is an employer under section 3 of the Act:

    a. The Corporation File Detail Report from the Office of the Secretary of State lists Asian Buffet as a corporation. (Pet. Ex 3). The corporation was incorporated on 1/29/2008. (id). However, on 6/12/2009 the Secretary of State dissolved the corporation because the Respondents failed to file an annual report and pay annual franchise tax. (Pet. Ex. 8).
    b. On 4/25/2016, an Arbitration Decision was entered in case 09 WC 21651, in which Respondent was named as Respondent-Employer. The Injured Workers' Benefit Fund ("IWBF") was named as a third party Respondent because it was alleged that Respondent-Employer Asian Buffet did not carry workers' compensation insurance. The Petitioner in that case testified that she worked as a cashier, a delivery person, and a driver for the Respondent-Employer which operated as a restaurant serving food to the general public.
    c. The Automatic Coverage provision of Section 3 of the Illinois Workers' Compensation Act applies because Respondent is in business serving food to the public for consumption on the premises where any employee is at risk of being scalded or burned by hot grease, hot water, hot foods, or other hot fluids, substances or objects. 820 ILCS 305/ Sec. 3

2. Respondent had employees:

    a. In case number 09 WC 21651, the Arbitrator's Decision found that an employee/employer relationship existed between Petitioner Qiurong Patellaro and Respondent-Employer. (Pet. Ex 2). Further, the Commission found that the Employee was injured while working for the Respondent-Employer and ordered the Respondent to pay medical and permanent partial disability to injured Employee.
    b. The IWBF paid $47,000.00 dollars in benefits on behalf of Respondent-Employer to the Petitioner representing compensation for medical bills and permanent partial disability.
    c. Additionally, the Department of Employment Security wage report showed wages for employees. (Pet. Ex. 9).

3. Respondent did not have workers' compensation insurance:

    a. The NCCI report stated that records do not show policy information filed showing proof of workers' compensation insurance for the period of 7/20/2005 to 5/4/2009, and from 1/9/2010 to 2/5/2010. (Pet Ex. 4).
    b. The Office of Self-Insurance records show that no certificate of approval to self-insure was issued by the Illinois Workers' Compensation Commission. (Pet. Ex. 5).
    c. On 2/18/2010 a notice of non-compliance was sent to Respondents. (Pet. Ex. 6).
    d. On 8/25/2016 the Insurance Compliance Division sent Petitioner a notice of insurance compliance hearing for 12/19/2016. (Pet.Ex.7).
    e. Respondent received notice of hearing regarding non-compliance with the mandatory insurance coverage provisions in the Illinois Workers' Compensation Act during the time period of 7/20/2005 to 1/15/2015 through certified mail. The date of hearing was scheduled for April 17, 2019 in New Lenox, IL. Petitioner was also notified that the

19IWCC0623

Commission may asses a civil penalty of up to $500.00 a day pursuant to the Act. (Pet. Group Ex 1).

f. On 4/17/2019 Respondents failed to appear and Commissioner Maria Portela entered an Order of Default. That Order continued the case to 6/17/2019 for a prove-up on the default. (Pet. Ex.7).

g. On 4/25/2019 Respondent received notice of the prove-up on default for 6/17/2019 with the Order of Default from 4/17/19 included. (Pet. Group Ex. 1). Respondent failed to appear on 6/17/19.

4. Therefore, the Commission finds Respondents in violation of the Illinois Workers' Compensation Act. Respondents are operating a business, with employees, and knowingly and willfully disregarding the requirement to possess Workers' Compensation Insurance, even after proper notice.

The Commission can, through this case, deter other businesses from disregarding the insurance laws of this State by applying a severe penalty commensurate with the conduct of the Respondent. For the foregoing reasons, and after considering the entire record, the Commission finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act under Section 3 and was an employer during the periods of non-compliance. The Commission finds that Respondents have knowingly and willfully failed to comply with the requirements of Section 4(a) of the Act and shall be assessed penalties under Section 4(d) of the Act. The Commission finds Respondents knowingly and willfully were in non-compliance with Section 4 of the Act for a period of 1,675 days and shall pay a penalty of $837,500.00 under Section 4 of the Act (1,675 days x $500.00 per day). Additionally, The Commission finds Respondent is liable to the IWBF for $47,000.00 paid on behalf Respondent to Qiurong Patellaro as ordered by the Illinois Workers' Compensation Commission in case 09 WC 021651 on 04/20/2016.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Chinese Buffet, pay to the Illinois Workers' Compensation Commission the sum of $837,500.00 pursuant to Section 4(d) of the Act in addition to the $47,000.00 dollars paid by the IWBF on behalf of Respondent to their injured employee, Qiurong Patellaro.

Bond for the removal of this case 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 21 2019

Maria Elena Portela

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

Kathryn A. Doerries

R: 1/19/18
49

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

MATTHEW W. KIDD,

Petitioner,

19IWCC0624

vs.

NO: 17 WC 23401

W.P. BROMS, INC., AND
CONTINENTAL INDEMNITY CO.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses (including prospective), temporary total disability, penalties and attorneys' fees, and "the two doctor rule," 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 corrects a scrivener's error 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 Arbitrator's decision contains a scrivener's error on page 5 of 13 in the last sentence of paragraph three. It states, "Petitioner testified that he testified that he did not undergo therapy because Respondent refused to authorize it." We hereby remove the repetition of "testified that he" in that sentence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2018, is hereby affirmed and adopted with the correction noted above.

19IWCC0624

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 $1,000.00. 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 2019

Maria Elena Portela

Maria Portela

Thomas J. Tyrrell

Thomas J. Tyrrell

Kathryn A. Doerries

Kathryn A. Doerries

O: 10/22/19
49

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

KIDD, MATTHEW
Employee/Petitioner

Case# **17WC023401**

17WC029464
17WC029465

WP BROMS INC AND CONTINENTAL INDEMNITY COMPANY
Employer/Respondent

19IWCC0624

On 5/9/2018, 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 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:

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

4866 KNELL O'CONNOR & DANIELEWICZ
TORRIE N POPLIN
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

19IWCC0624

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)

Matthew Kidd
Employee/Petitioner

v.

WP Broms, Inc. and Continental Indemnity Company
Employer/Respondent

Case # **17** WC **23401**

Consolidated cases: **17 WC 29464 and 17 WC 29465**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **February 9, 2018 and March 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0624

FINDINGS

On the date of accident, **February 20, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**45,619.60**; the average weekly wage was $**877.30**.

On the date of accident, Petitioner was **35** 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 $**1,129.23** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**1,129.23**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $178.00 to Advocate Occupational Health, as provided in Sections 8(a) and 8.2 of the Act and shall further reimburse Petitioner $670.00 for payments made to Dr. Manfredini and Preferred Open MRI

Respondent shall pay Petitioner temporary total disability benefits of $584.87/week for 2 1/7 weeks, commencing July 21, 2017 through August 4, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $1,129.23 for temporary total disability benefits that have been paid.

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

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

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

Signature of Arbitrator

May 3, 2018
Date

MAY 9 - 2018

ICArbDec19(b)

Statement of Facts

This matter was heard in conjunction with consolidated claims 17 WC 29464 (DOA: 6/10/16) and 17 WC 29465 (DOA: 6/9/17). A single transcript of the hearing was prepared. The Arbitrator has issued separate decisions with respect to each filed claim.

Petitioner Matthew Kidd testified that on June 10, 2016 he was employed by Respondent WP Broms as a long-distance driver and mover. He had been so employed for about five months. He has two years of college and a certification through United Van Lines for moving furniture, loading furniture and driving trucks. His job duties included moving furniture, loading trucks and driving for 10 to 11 hours. He held a Class A CDL license Furniture would be moved with dollies, straps and manpower. He testified that the job was physically demanding. He testified he would average over 60 hours per week. Respondent offered RX 4 with Petitioner's earnings and hours.

Lynn Broms Hillesheim testified that she is Respondent's Vice President. Respondent is a household goods moving company. They do both local and long distance. She is responsible for hiring and distributing assignments with her brother Arnold Broms. They employ between 10 and 15 workers depending on the season. She testified that Petitioner was a driver. He would be in charge of loading, unloading and paperwork. Petitioner began working for Respondent in February 2016.

Ms. Broms Hillesheim testified that Petitioner took time off for personal reasons. She testified he was also seeing his chiropractor when he started working with Respondent so he was given a shorter job or work around that schedule. She testified Petitioner complained of migraines. There were times he could not come to work because the migraines were bad.

Petitioner testified that he had no back pain prior to working for Respondent. He broke his collar bone when he was eleven. He had a head injury and a fractured jaw from falling off the back of a truck in 2006 or 2007. He was treated with anti-nausea pills and had his jaw reset because his TMJ was causing dizziness. Petitioner testified he fully recovered from the experience. He had sought no treatment since 2009. He treatment was with Dr. Gupta at that time. He was diagnosed with a traumatic brain injury. He experienced dizziness with movements of his body.

Petitioner testified that on June 10, 2016, they were delivering an 800-pound gun safe down a flight of stairs into a basement. They were maneuvering it between tight locations and the stairwell. He had a sharp pain in his lower back and pain that went down his right leg. He testified he reported the injury to his supervisor Arnie Broms, the co-owner of Respondent. On June 10, 2016, he finished unloading the truck and delivered a piano.

After he reported to the office, Lynn Broms, a co-owner of Respondent, told him she would pay for a few chiropractic treatments. Ms. Broms Hillesheim testified that he must have said something because they paid for treatment. She testified she told Petitioner if he wanted to go back to his chiropractor, she would pay for it. He was seen by Dr. Furlett. Dr. Furlett's records reflect that Petitioner was seen on June 27, 2016. The Patient Information form states the referral was by Linda Kidd. Petitioner reported low back pain since June 10, 2016. He checked that he has seen a chiropractor. The office note records a history of moving a gun safe. Petitioner complained of pain going down the right leg to the lateral calf. Petitioner was seen thereafter on June 29, 2016 and July 6, 2016. Dr. Furlett diagnosed a sacroiliac sprain, right sided radiculopathy, and sprained ligaments in the thoracic spine. She noted Petitioner was in the acute phase and was to continue with treatment (PX 6).

Petitioner testified he continued to work for Respondent while he received treatment. He continued to work for Respondent after he was released from care without back or right leg pain. He testified he fully recovered from this injury. He had no radiating pain.

He testified he suffered a second work injury on February 20, 2017. He was carrying a 300-pound armoire backwards up the stairs with a subcontractor in Round Rock, Texas. While it was wobbling back and forth and leaning, it caused him to hurt his back. He felt pain in his lower back and on the right side of his lower back and down his leg. He testified he reported the injury immediately after the injury to Lynn Broms. Ms Broms Hillesheim testified he reported this to her. Petitioner testified that when he returned to Illinois, Lynn Broms told him to continue chiropractic treatment. She testified she told him that if he would like to go to his chiropractor they would pay for it.

Petitioner returned to Dr. Furlett on March 15, 2017 with complaints of increased pain and stiffness. He reported the onset 1 ½ to 2 weeks earlier when in Texas for work. He reported he was carrying an armoire with a co-worker who dropped his end and he twisted. On March 20, 2017, Petitioner reported he was still very stiff and sore with radicular symptoms in the right gluts and leg to his ankle. Dr. Furlett recommend he stay off work, but Petitioner reported he could not get away from work. Petitioner continued treatment through April 19, 2017 for complaints in the low back and right leg. Dr. Furlett continued to recommend he take off work to heal and avoid reinjury (PX 6).

Petitioner testified that he told Respondent that the chiropractic was not working and he needed to seek other medical attention. He testified that He saw Dr. Manfredini. Linda Broms made the appointment. Ms. Broms Hillesheim testified that Petitioner told her that the chiropractic was not working and he was getting frustrated. She suggested that if he wanted to see the naprapath that her brother went to that he was welcome to do so. It was up to him. Petitioner went to Dr. Manfredini, a naprapath, on April 20, 2017. The Health History Summary notes he heard about him from Lynn Broms. Petitioner had treatment on April 20, April 26 and May 1, 2017 (PX 7).

Petitioner testified he worked full time for Respondent during his treatment with some days off. He testified that he took about three weeks off due to the injury. It was random days with some periods a week long due to the recommendation from the chiropractor. Petitioner testified that Dr. Furlett did not give him an off-work slip. Ms. Broms Hillesheim testified he did not take any time off work.

Petitioner returned to Dr. Furlett on May 19, 2017. He reported that he had been on cross country moves. Twisting and carrying exacerbated his pain. On June 2, 2017, Dr. Furlett discussed advanced imaging if there was no progress. Petitioner was seen again on June 4, 2017 (PX 6).

Petitioner testified that on June 9, 2017 he was carrying and loading a grand piano in Washington, D.C. He was pushing the piano into the truck on a dolly and it was falling over when he felt sharp pain in his back. He testified that he reported it immediately afterward to Lynn Broms. Ms. Broms Hillesheim testified that she does not remember him reporting the injury. She testified he did call from the east coast to complain about the neighborhood and locking his keys in the truck. She testified that Petitioner requested a few days to visit his grandmother in Michigan.

Petitioner saw Dr. Furlett on June 14, 2017 with continuing low back pain. He was again advised to take off work. He had additional treatment through June 23, 2017. During that visit, Petitioner reported an episode of

dizziness and vomiting at home after lying down. He advised Dr. Furlett cervical rotation with his head flexed caused dizziness. Dr. Furlett insisted that he be taken to the emergency room (PX 6).

Petitioner testified that he went to Alexian Brother Medical Center emergency room on June 23, 2017 for dizziness after his chiropractic manipulation of his neck. The dizziness was more extreme than that he had previously experienced. He testified that he was diagnosed with vertigo due to a crystal dislocation. The Alexian Brothers records have a history of symptoms beginning in his bed yesterday when he turned his head. He noted a prior motor vehicle accident 10 years earlier with intermittent vertigo and headaches. This episode is no different today than his previous symptoms. Petitioner was discharged and referred to Dr. Gupta for a neurological consult (PX 8).

Petitioner saw Dr. Furlett on June 26, 2017 for continued back and right leg pain. Dr. Furlett records Petitioner stated the ER doctor assured him the symptoms were not related to his low back. Dr. Furlett ordered an MRI. The June 29, 2017 MRI impression was L4-5 disc bulging and L5-S1 disc bulging with a 3.5 mm central protrusion. The facet articulations appear unremarkable with no evidence of degenerative change, the neural foramen appears patent. Petitioner continued to treat with Dr. Furlett through July 17, 2017 (PX 6). Petitioner testified he stopped seeing Dr. Furlett because Respondent refused to pay for any more appointments. Ms. Broms Hillesheim testified that she stopped paying because the chiropractor was telling her that she did not know what else she could do. Dr. Furlett's records state that the claim was being transferred to the comp. carrier (PX 6).

Petitioner saw Dr. Gupta on July 7, 2017. The notes reflect the reason for the consult was low back pain after injury at work. He notes that Petitioner has seen a chiropractor and a naprapath. He has no insurance. The employer is paying for the visit. Petitioner's main concern is to have Dr. Gupta review the MRI, describe what symptoms may or may not be caused by his back pain and make recommendations for the next step. He notes the ER visit after the chiropractor but states that there was no cervical adjustment made. Petitioner reported the dizziness is fully recovered. Dr. Gupta's neurological examination was normal. Petitioner had a normal gait. He diagnosed back pain with sciatica. He stated that his back pain is not likely related to his dizziness, bowel, rectal or bladder complaints. He recommended physical therapy (PX 9). Petitioner testified that he testified that he did not undergo the therapy because Respondent refused to authorize it.

Petitioner saw Dr. Ramon Castillo on July 21, 2017. He testified that the insurance adjuster made the appointment. The records of Advocate Occupational Medicine reflect a single appointment on July 21, 2017 (PX 10). The records do not include the name of the 'company" or employer. Petitioner provided a history of the lower back pain for 5 months since carrying an armoire upstairs. The pain is stabbing with numbness on the anterior lateral aspect of the thighs and lateral aspect of the lower legs and to the toes. Dr. Castillo diagnosed a strain with low back pain and radiculopathy. He took Petitioner off work and instructed him to see a spine specialist (PX 10).

Petitioner was seen by Dr. Singh on August 3, 2017. Petitioner testified Dr. Singh refused to examine him. Dr. Singh's records reflect that Petitioner was seen for a consultation. The records reflect the referring doctor was Dr. Castillo. The report was addressed to the adjuster Tara Jackson. Petitioner reported the injury on February 20, 2017 while carrying furniture up the stairs. He reported pain in his neck, mid and low back rated 8-9/10. The report documents a physical examination with normal reflexes and strength. Dr. Singh diagnosed a cervical and lumbar muscular strain with L4-5 and L5-S1 degenerative disc disease. He released Petitioner to return to work without restrictions. He found Petitioner at MMI with no further treatment needed. He stated the

Petitioner presented with malingering behavior. The MRI revealed no stenosis. The exam was essentially normal (PX 19).

Petitioner testified he called Respondent to schedule himself back to work, but was told they could not employ him in the condition he was. He testified he made a second attempt but was told that they would not take him back because he had a lawsuit against them. Petitioner testified he was still having pain in his lower back, his right hip, his buttocks, and pain in the testicles and groin area. Ms. Broms Hillesheim testified she spoke with Petitioner around July 17, 2017 to discuss returning him to light duty work. Petitioner was saying he was not capable of doing anything. He could not stand or sit for any length of time. The company was very busy at that time. She was told by the chiropractor that she did not know why the treatment was not working. As he testified, she spoke with Petitioner again after Petitioner was released to full duty on August 3, 2017. He was upset and crying, saying he had to come back to work but was still in pain and did not know what he could do. She said how do we do this if you are still in so much pain.

Petitioner saw Dr. Carl Graf on August 25, 2017. His mom found Dr. Graf. He testified that he called the chiropractor to ask for a referral. He already had the appointment. Dr. Furlett did not refer him. He testified she told him the insurance company would not honor it. Dr. Furlett's records contain notes of a phone call on August 23, 2017. The appointment was already set. The record notes Petitioner is now represented. Dr. Furlett told him she was unable to give a referral that would help with the insurance company (PX 6).

On August 25, 2017, Petitioner reported the February 20, 2017 accident to Dr. Graf. He told Dr. Graf his pain was 8-9/10. The physical examination noted normal strength, sensation and reflexes. Straight leg raise was negative. No tenderness was noted. There were no cervical complaints. The pain diagram that Petitioner prepared notes that he felt a stabbing pain in the groin area, an aching pain along the spine from the neck to the tailbone and into the shoulders, a stabbing, burning, aching and pins and needles in the right-sided low back region into the SI joint, right gluts, and into his right leg. He also noted pins and needles in both hands. He rated his pain at 7-8/10. Dr. Graf read the MRI as demonstrating degenerative disc at L4-5 and L5-S1. There is an annular tear at L4-5 with a central disc herniation at L5-S1. His assessment was low back pain with radiculopathy. He noted low back and right radiating leg pain. His pain appears to be mediated from the right SI joint on examination. Patient is not currently at MMI. He started a Medrol dose pack and took Petitioner off work. He recommended physical therapy and a right sided sacroiliac joint injection (PX 11).

On September 22, 2017, Dr. Graf's physical examination remained unchanged. He recommended a lumbar epidural steroid injection. On October 20, 2017, Dr. Graf notes the Workers Compensation denial. His recommendations remain the same. He states that the right leg pain is secondary to the SI joint dysfunction and is corroborated by the physical examination. He notes that the SI joint does not appear to have been evaluated during the IME. Petitioner remained off work (PX 11).

Petitioner began physical therapy on October 26, 2017 (PX 11). On October 30, 2017, Dr. Forowycz performed a right sacroiliac joint injection. His examination report notes moderate to severe point tenderness over the right SI joint and tenderness over L4-L5 midline, He noted positive straight leg raise at 5 degrees (PX 11). Petitioner continued with physical therapy. He noted only some minor relief in his pain. On November 21, 2017, Dr. Graf noted that Petitioner had dramatic pain relief after the sacroiliac joint injection and improvement with therapy and ordered a second SI joint injection which was performed on Nov. 27, 2017. Dr. Forowycz noted that Petitioner has substantial improvement after 3 days, but over the last 1-2 weeks, the pain has

begun to return (Px. 11). Petitioner continued with physical therapy. He initially noted improvement from the second injection, but advised that the pain increased (PX 11).

On December 15, 2017, Petitioner reported great improvement. His back pain is much less. The physical examination was neurologically normal with negative straight leg raise. Dr. Graf diagnosed sacroiliitis. He recommended continued physical therapy and an SI joint injection (PX 11). Petitioner continued physical therapy and underwent a third right SI injection on January 8, 2018 (PX 11). On January 26, 2018, Dr. Graf noted that the third SI joint injection provided Petitioner great relief resulting in less SI joint pain with less frequency. Petitioner complained of pain with radiation from the back to the buttocks. Physical examination was completely normal. Dr. Graf stated that he had concerns about Petitioner returning to work where he would have to do heavy moving and continued to keep him off work. He ordered physical therapy with less frequency and a lumbar epidural steroid injection which Petitioner underwent on February 5, 2018 (PX 11). On February 27, 2018, Dr. Graf gave Petitioner work restrictions in the light physical demand level (PX 20).

Petitioner was examined by Dr. Zelby on October 11, 2017 at Respondent's request (RX 1, Zelby 2). Dr. Zelby testified by evidence deposition on January 17, 2018 (RX 1). Dr. Zelby testified to the history provided of accidents on February 20 and June 9, 2017. The history included a 2016 back injury while carrying a gun safe with no symptoms into the lower extremities. The pain went away with chiropractic care (RX 1, Zelby 2). Dr. Zelby testified that the physical examination noted tenderness even with non-physiologic light touch. Straight leg raise was positive for back pain only, Gait was slow and antalgic. Petitioner said he was only able to ambulate with a single-post cane. Dr. Zelby testified that there was no medical basis for it as it relates to his spine and nervous system. Dr. Zelby noted inconsistent pain behavior with pain on superficial light lough, pain on simulation and non-anatomic sensory changes.

Dr. Zelby reviewed the records of Dr. Furlett, Dr. Manfredini, Dr. Singh, the Occupational Med Clinic, and Dr. Gupta. He did not recall seeing records from Dr. Graf. He reviewed the actual MRI films. His review of the MRI noted a minuscule bulging disc at L4-5 and a small chronic annular tear. At L5-S1 there was a broad-based bulging disc that partially extended into the ventral epidural fat along with a chronic partial thickness annular tear. there was no stenosis. The findings were not acute or post-traumatic. They were typical for the normal aging of the spine. He testified that an acute tear would be bright. You could see it for six months. A degenerative disc can be aggravated, but absent an acute abnormality, it is not possible (RX 1).

Dr. Zelby's impression was that Petitioner had mild lumbar degenerative disc disease and had sustained a lumbar strain. He had an essentially normal neurological exam except for a sensory loss inconsistent with any spinal condition. His subjective complaints cannot be corroborated with any objective findings. He testified that Petitioner's subjective complaints appeared related to symptom amplification. He opined that there was no evidence that the underlying degenerative condition was exacerbated, aggravated or accelerated in any way as a consequence of the reported work injuries. He had no radicular findings on examination and nothing on the MRI would result in a radiculopathy (RX1).

Dr. Zelby opined that Petitioner's treatment was protracted and excessive. He required no more that 8-12 chiropractic visits. He required no additional diagnostics and is not a candidate for any invasive treatment because he has no condition that would be treated by injections. He opined that Petitioner was at maximum medical improvement by April or May 2017 for the February 20, 2017 incident and by August or September for the June 2017 incident. Petitioner could return to his regular employment without restrictions. Dr. Zelby disagreed that a treating doctor is in a better position to judge cause and nature of the injury (RX 1).

Petitioner testified he has been off work since August 25, 2017. He would undergo a second lumbar epidural procedure if it was approved. He cannot do chores around the house, walk his dog regularly or drive. He does not feel he can go back to work. He feels he is about 70%. On March 19, 2018, Petitioner testified that Dr. Graf released him to return to light duty on February 27, 2018. He attempted to return to work. He sent the work status report to Respondent by email. He has not received any response from Respondent. If light work was offered by Respondent, he would accept it. Ms. Broms Hillesheim testified she would accommodate his restrictions if she had something available for him, but there is nothing at present. It is their slow season. It usually picks up in the summer.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified to a specific incident on February 20, 2017. He testified that he was carrying a 300-pound armoire backwards up the stairs and while it was wobbling back and forth and leaning, it caused him to hurt his back. He felt pain in his lower back and on the right side of his lower back and down his leg Petitioner testified that he reported this incident to Respondent. Ms. Broms Hillesheim confirmed the reporting of the accident. The records of Dr. Furlett contain the consistent history. Petitioner has included this incident in his subsequent histories as well. The Arbitrator finds that this incident occurred based upon the undisputed evidence submitted, all of which corroborates Petitioner's testimony. The incident described occurred during employment and at a place where Petitioner was performing his employment duties, and while a he fulfilled those duties. The risk of carrying a heavy item up the stairs is a risk connected with the employment and involves a causal connection between the employment and the accidental injury.

Although Petitioner testified to an earlier June 10, 2016 back injury (See the decision in the consolidated case 17 WC 29464), Petitioner had been working full duty for over 7 months and had not had any treatment since July 2016. His own testimony and the history he provided to Dr. Zelby stated that he was fully recovered from that injury. He had no radiating pain. He began the ongoing course of care only after the injury on February 20, 2017

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on February 20, 2017.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). Based upon the Arbitrator's decision in 17 WC 29464, the Arbitrator finds that any condition of ill being that started with the February 20, 2017 accident is causally related to that injury. Petitioner has alleged a subsequent accident on June 9, 2017 (as addressed in the decision in the consolidated case 17 WC 29645). As discussed in that matter, the Arbitrator notes that Petitioner was under active treatment from March 2017 through June 4, 2017 before leaving on the east coast trip where Petitioner alleges he was reinjured. The Arbitrator notes the Respondent denies receiving any notice of this subsequent injury and Petitioner did not mention it in the medical records of Dr. Furlett even though she saw Petitioner within days of the incident. It is not reflected in the medical records of Dr. Manfredini, Dr. Gupta, Dr. Castillo, Dr. Singh or Dr. Graf. The Arbitrator finds that to the extent Petitioner's condition ill-being is causally related to his employment, that it is related to the February 20, 2017 accident.

The dispute in this matter is what exactly is the nature of that condition of ill being. The parties agree with the initial medical treatment from Dr. Furlett and Dr. Manfredini. Dr. Furlett provided chiropractic care for a diagnosis of a sacroiliac sprain, right sided radiculopathy, and sprained ligaments in the thoracic spine. Dr. Manfredini was treating acute lumbar pain. Petitioner has alleged treatment for dizziness beginning in June 2017 and further treatment for his low back and right leg complaints with Dr. Graf. Respondent has relied on the opinions of Dr. Singh and Dr. Zelby.

In evaluating the medical opinions, the Arbitrator must determine the weight to be given to Petitioner's testimony, histories and subjective complaints. Having observed the Petitioner and compared his testimony to the documentary evidence and the testimony of Ms. Broms Hillesheim, the Arbitrator notes multiple inconsistencies which create doubt as to the Petitioner's credibility.

Petitioner's testimony consistently slants or varies the facts to create a more favorable narrative. He testified he consistently worked in excess of 60 hours per week, but his time records clearly document that this is a gross exaggeration. He testified that he was completely recovered after the July 2016 treatment by Dr. Furlett despite her records stating he was still in the acute phase of recovery. Petitioner testified and told Dr. Graf the employer sent him to a chiropractor but Dr. Furlett's records note the referral was from his mother. Ms. Broms Hillesheim's testimony as to the circumstances surrounding the choices of Dr. Furlett and Dr. Manfredini are more credible. Her testimony as to the conversations with Petitioner concerning medical treatment and work status are more credible that his testimony.

As more fully detailed below, Petitioner's testimony concerning the June 23, 2017 dizziness is completely contradicted by the medical records. As also addressed below, the Petitioner's presentation and subjective complaints are inconsistent between Dr. Graf, Dr. Zelby and physical therapy. As more fully addressed in the decision in consolidated case 17 WC 29465, his testimony concerning the claimed June 9, 2017 work accident is contradicted by all the treating medical records and the testimony of Ms. Broms Hillesheim. The Arbitrator must consider the lack of credibility of the Petitioner in evaluation the medical evidence and opinions.

The Arbitrator finds that the treatment for dizziness at Alexian Brothers Medical Center is not causally related to the accident. Petitioner presented no medical opinion finding causal connection, Dr. Gupta stated that the back pain was not likely related to the dizziness. The remaining evidence completely contradicts Petitioner's testimony. Contrary to Petitioner's testimony, on June 23, 2017, Dr. Furlett noted Petitioner reported he spent four hours in the bath tub vomiting after he turned his head to the side while lying down. Dr. Furlett states Petitioner was in a supine position and rotated his head producing a dizzy sensation. Petitioner's testimony that she was manipulating his neck is contradicted by Dr. Gupta's note stating he notes the ER visit after the chiropractor but states that there was no cervical adjustment made. The Arbitrator also notes that Petitioner never testified he sustained a neck injury. Petitioner's testimony is that he told the ER that he was having dizziness due to a chiropractic manipulation but the Alexian Brothers Medical Center history is that his vertigo symptoms started when he was lying in his bed yesterday when he turned his head triggering his symptoms. Petitioner testified he suffered a traumatic brain injury 10 years ago but he fully recovered from this injury. Petitioner told the emergency room physician he gets intermittent vertigo and headaches due to a motor vehicle incident 10 years ago. Petitioner testified the dizziness and nausea he experienced in the emergency room was different than the symptoms he had with his prior head injury. However, Petitioner stated in the emergency room this incident is no different than his previous symptoms and Ms. Broms Hillesheim testified Petitioner would call off work for a number of reasons including migraines.

Petitioner saw Dr. Gupta on July 7, 2017. Despite his testimony that this was follow up on the dizziness. Dr. Gupta's records are clear that the purpose of the visit was a low back consult, Dr. Gupta noted normal reflexes, sensation and strength. Petitioner had a normal gait. Straight leg raise was negative. He reviewed the MRI and recommended only physical therapy. He did not provide an off-work slip.

Dr. Castillo saw Petitioner only two weeks later. He now presented with a slow gait with minimal limp. He had intact sensation but strength is diminished. He had positive straight leg raise. Dr. Castillo took Petitioner off work and referred him to Dr. Singh for a consultation. Dr. Singh noted a normal examination and found malingering behavior and released Petitioner at MMI to regular work without restrictions.

Dr. Graf began treating Petitioner on August 25, 2017. His physical examination is completely normal for strength, reflexes, sensation. Straight leg raise is negative. Gait is normal. Petitioner can squat and raise up with no difficulty. Dr. Graf notes that Petitioner has significant pain. His September 22, 2017 recommendation for an injection is "given his ongoing pain," despite a continued normal physical examination. When Petitioner was examined by Dr. Zelby on October 11, 2017, only a few weeks later, the physical examination noted tenderness even with non-physiologic light touch. Straight leg raise was positive for back pain only, Gait was slow and antalgic. Petitioner said he was only able to ambulate with a single-post cane. He could not squat. Dr. Zelby noted inconsistent pain behavior with pain on superficial light lough, pain on simulation and non-anatomic sensory changes. While Petitioner also presents with significant pain behaviors to Dr. Forowycz on October 30, 2017, Dr. Graf's physical examination on November 21, 2017 is again completely benign. Dr. Graf treated Petitioner for a diagnosis of sacroiliitis. As of the January 26, 2018 examination, Petitioner has noted improvement in the SI joint but now advances radiation into the buttocks. Despite a completely benign physical examination, Dr. Graf now discusses radicular pain and is recommended a standard epidural injection. Both Dr. Singh and Dr. Zelby have opined that this is unreasonable and unnecessary. They both opine that Petitioner is presenting with nonorganic pain complaints and is at MMI and able to return to work without restrictions.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Having reviewed the evidence and considered the weight to be given to Petitioner's testimony and subjective complaints, the Arbitrator finds the opinions of Dr. Singh and Dr. Zelby persuasive. The Arbitrator finds that Dr. Singh saw Petitioner on referral for a consultation, not a Section 12 examination. His opinions agree with Dr. Zelby as to Petitioner's condition. The Arbitrator notes the inconsistent presentation of Petitioner, particularly to medical providers other than Dr. Graf. His presentation varies widely in short time frames. This evidence taken in conjunction with the numerous inconsistencies in his testimony on multiple issues demands that his subjective presentation be questioned.

Dr. Graf consistently records a normal physical examination with no deficits in strength, reflexes or sensation. He records normal gait, the ability to squat and negative straight leg raise. His recommendations for treatment are based upon the ongoing and severe complaints of pain. Given the totality of the evidence presented, these opinions and recommendations are unpersuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that as a result of the accident on February 20, 2017, he suffered a condition of ill-being in his low back as diagnosed by Dr. Singh and Dr. Zelby. Said condition of ill-being reached maximum medical improvement as of Dr. Singh's release to return to work on August 3, 2017. Petitioner's claimed condition of ill being thereafter is not causally related to the accident on February 20, 2017.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission, 409 Ill. App. 3d 258,267* (1st Dist., 2011). Based upon the Arbitrator's finding with respect to Causal Connection, only bills for treatment found causally connected would be awarded. Petitioner submitted bills claimed as PX 12-18. The Arbitrator has reviewed this exhibit in conjunction with the medical records and other evidence and finds as follows:

The Arbitrator finds the treatment and bills of Dr. Manfredini, Preferred Open MRI, and Advocate Occupational Health are reasonable, necessary and causally related to the accident on February 20, 2017. Petitioner paid $320.00 to Dr. Manfredini and $350.00 to Preferred Open MRI for which he is entitled to reimbursement. Respondent is responsible for the $178.00 bill to Advocate Occupational Medicine.

Based upon the Arbitrator's finding with respect to Casual Connection, the billing of Alexian Brothers Medical Center and MEA-Elk Grove for the June 23, 2017 treatment is denied. Based upon the Arbitrator's finding with respect to Causal Connection that the opinions of Dr. Zelby and Dr. Singh are persuasive, the treatment and billing of and out-of-pocket expenses incurred after August 3, 2017 are denied.

Respondent has raised the additional issue of Petitioner exceeding his choices of physicians under Section 8(a) or the Act. The Arbitrator has reviewed the testimony and medical records and finds as follows:

Petitioner's first choice was Dr. Furlett. Dr. Manfredini was on the recommendation of Respondent, but Petitioner chose to treat there based upon the testimony of Ms. Broms Hillesheim. Dr. Gupta was Petitioner's clear second choice. While the initial referral was from the Emergency Room, that related to care for his dizziness. When Petitioner chose to focus on his low back, that constituted his choice. Dr. Castillo and the referral to Dr. Singh were a choice by Respondent's carrier for treatment. Dr. Graf would therefore be outside of the chains of referral as either the third or fourth choice, a fact clearly recognized by Petitioner and his counsel as demonstrated by the efforts to get a referral from Dr. Furlett.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $178.00 to Advocate Occupational Health, as provided in Sections 8(a) and 8.2 of the Act and shall further reimburse Petitioner $670.00 for payments made to Dr. Manfredini and Preferred Open MRI.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Causal Connection and Medical, including the finding that the opinions of Dr. Singh and Dr. Zelby as to the condition of ill-being, necessary medical treatment and maximum medical improvement were persuasive, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he is entitled to prospective medical treatment.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

The parties stipulated that Petitioner was paid temporary compensation from his disability by Dr. Castillo on July 21, 2017 through August 4, 2017 when he was released to return to unrestricted work by Dr. Singh, a period of 2 1/7 weeks. RX 3 documents the stipulated payment of $1,129.23. Based upon the Arbitrators findings with respect to Causal Connection and Medical, including finding the opinions of Dr. Singh and Dr. Zelby as to the condition of ill-being, necessary medical treatment and maximum medical improvement were persuasive, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he is entitled further temporary compensation.

Based upon the record as a whole the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is entitled to temporary total disability benefits for 2 1/7 weeks, commencing July 21, 2017 through August 4, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $1,129.23 for temporary total disability benefits that have been paid.

In support of the Arbitrator's decision with respect to (M) Penalties, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Causal Connection, Medical, Prospective Medical and Temporary Compensation, the Arbitrator finds that Respondent's denials in this matter were in good faith and were reasonable and based upon substantial evidence. The Petition for Penalties is 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

MATTHEW W. KIDD,

Petitioner,

19IWCC0625

vs.

NO: 17 WC 29464

W.P. BROMS, INC., AND
CONTINENTAL INDEMNITY CO.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, and "the two doctor rule," 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 corrects a scrivener's error 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 Arbitrator's decision contains a scrivener's error on page 5 of 9 in the last sentence of paragraph three. It states, "Petitioner testified that he testified that he did not undergo therapy because Respondent refused to authorize it." We hereby remove the repetition of "testified that he" in that sentence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2018, is hereby affirmed and adopted with the correction noted above.

19IWCC0625

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 by Respondent for the removal of this cause to the Circuit Court because no award was made. The 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 2019

Maria Elena Portela

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

O: 10/22/19
49

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

KIDD, MATTHEW
Employee/Petitioner

Case# **17WC029464**

17WC023401
17WC029465

WP BROMS INC AND CONTINENTAL INDEMNITY COMPANY
Employer/Respondent

19IWCC0625

On 5/9/2018, 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 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:

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

4866 KNELL O'CONNOR & DANIELEWICZ
TORRIE N POPLIN
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

19IWCC0625

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Matthew Kidd
Employee/Petitioner

v.

WP Broms, Inc. and Continental Indemnity Company
Employer/Respondent

Case # **17** WC **29464**

Consolidated cases: **17 WC 23401 and 17 WC 29465**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **February 9, 2018 and March 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0625

FINDINGS

On the date of accident, **June 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**45,619.60**; the average weekly wage was $**877.30**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HIS CURRENT CONDITION OF ILL BEING IS CAUSALLY CONNECTED TO THE ACCIDENT ON JUNE 10, 2016, COMPENSATION IS DENIED WITH RESPECT TO THIS MATTER. PETITIONER'S ENTITLEMENT TO BENEFITS IS FURTHER ADDRESSED IN THE DECISIONS IN THE CONSOLIDATED CASES 17 WC 23401 AND 17 WC 29465.

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

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

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

Signature of Arbitrator

May 3, 2018
Date

ICArbDec19(b)

MAY 9 - 2018

Statement of Facts

This matter was heard in conjunction with consolidated claims 17 WC 23401 (DOA: 2/20/17) and 17 WC 29465 (DOA: 6/9/17). A single transcript of the hearing was prepared. The Arbitrator has issued separate decisions with respect to each filed claim.

Petitioner Matthew Kidd testified that on June 10, 2016 he was employed by Respondent WP Broms as a long-distance driver and mover. He had been so employed for about five months. He has two years of college and a certification through United Van Lines for moving furniture, loading furniture and driving trucks. His job duties included moving furniture, loading trucks and driving for 10 to 11 hours. He held a Class A CDL license Furniture would be moved with dollies, straps and manpower. He testified that the job was physically demanding. He testified he would average over 60 hours per week. Respondent offered RX 4 with Petitioner's earnings and hours.

Lynn Broms Hillesheim testified that she is Respondent's Vice President. Respondent is a household goods moving company. They do both local and long distance. She is responsible for hiring and distributing assignments with her brother Arnold Broms. They employ between 10 and 15 workers depending on the season. She testified that Petitioner was a driver. He would be in charge of loading, unloading and paperwork. Petitioner began working for Respondent in February 2016.

Ms. Broms Hillesheim testified that Petitioner took time off for personal reasons. She testified he was also seeing his chiropractor when he started working with Respondent so he was given a shorter job or work around that schedule. She testified Petitioner complained of migraines. There were times he could not come to work because the migraines were bad.

Petitioner testified that he had no back pain prior to working for Respondent. He broke his collar bone when he was eleven. He had a head injury and a fractured jaw from falling off the back of a truck in 2006 or 2007. He was treated with anti-nausea pills and had his jaw reset because his TMJ was causing dizziness. Petitioner testified he fully recovered from the experience. He had sought no treatment since 2009. He treatment was with Dr. Gupta at that time. He was diagnosed with a traumatic brain injury. He experienced dizziness with movements of his body.

Petitioner testified that on June 10, 2016, they were delivering an 800-pound gun safe down a flight of stairs into a basement. They were maneuvering it between tight locations and the stairwell. He had a sharp pain in his lower back and pain that went down his right leg. He testified he reported the injury to his supervisor Arnie Broms, the co-owner of Respondent. On June 10, 2016, he finished unloading the truck and delivered a piano.

After he reported to the office, Lynn Broms, a co-owner of Respondent, told him she would pay for a few chiropractic treatments. Ms. Broms Hillesheim testified that he must have said something because they paid for treatment. She testified she told Petitioner if he wanted to go back to his chiropractor, she would pay for it. He was seen by Dr. Furlett. Dr. Furlett's records reflect that Petitioner was seen on June 27, 2016. The Patient Information form states the referral was by Linda Kidd. Petitioner reported low back pain since June 10, 2016. He checked that he has seen a chiropractor. The office note records a history of moving a gun safe. Petitioner complained of pain going down the right leg to the lateral calf. Petitioner was seen thereafter on June 29, 2016 and July 6, 2016. Dr. Furlett diagnosed a sacroiliac sprain, right sided radiculopathy, and sprained ligaments in the thoracic spine. She noted Petitioner was in the acute phase and was to continue with treatment (PX 6).

Petitioner testified he continued to work for Respondent while he received treatment. He continued to work for Respondent after he was released from care without back or right leg pain. He testified he fully recovered from this injury. He had no radiating pain.

He testified he suffered a second work injury on February 20, 2017. He was carrying a 300-pound armoire backwards up the stairs with a subcontractor in Round Rock, Texas. While it was wobbling back and forth and leaning, it caused him to hurt his back. He felt pain in his lower back and on the right side of his lower back and down his leg. He testified he reported the injury immediately after the injury to Lynn Broms. Ms Broms Hillesheim testified he reported this to her. Petitioner testified that when he returned to Illinois, Lynn Broms told him to continue chiropractic treatment. She testified she told him that if he would like to go to his chiropractor they would pay for it.

Petitioner returned to Dr. Furlett on March 15, 2017 with complaints of increased pain and stiffness. He reported the onset 1 ½ to 2 weeks earlier when in Texas for work. He reported he was carrying an armoire with a co-worker who dropped his end and he twisted. On March 20, 2017, Petitioner reported he was still very stiff and sore with radicular symptoms in the right gluts and leg to his ankle. Dr. Furlett recommend he stay off work, but Petitioner reported he could not get away from work. Petitioner continued treatment through April 19, 2017 for complaints in the low back and right leg. Dr. Furlett continued to recommend he take off work to heal and avoid reinjury (PX 6).

Petitioner testified that he told Respondent that the chiropractic was not working and he needed to seek other medical attention. He testified that He saw Dr. Manfredini. Linda Broms made the appointment. Ms. Broms Hillesheim testified that Petitioner told her that the chiropractic was not working and he was getting frustrated. She suggested that if he wanted to see the naprapath that her brother went to that he was welcome to do so. It was up to him. Petitioner went to Dr. Manfredini, a naprapath, on April 20, 2017. The Health History Summary notes he heard about him from Lynn Broms. Petitioner had treatment on April 20, April 26 and May 1, 2017 (PX 7).

Petitioner testified he worked full time for Respondent during his treatment with some days off. He testified that he took about three weeks off due to the injury. It was random days with some periods a week long due to the recommendation from the chiropractor. Petitioner testified that Dr. Furlett did not give him an off-work slip. Ms. Broms Hillesheim testified he did not take any time off work.

Petitioner returned to Dr. Furlett on May 19, 2017. He reported that he had been on cross country moves. Twisting and carrying exacerbated his pain. On June 2, 2017, Dr. Furlett discussed advanced imaging if there was no progress. Petitioner was seen again on June 4, 2017 (PX 6).

Petitioner testified that on June 9, 2017 he was carrying and loading a grand piano in Washington, D.C. He was pushing the piano into the truck on a dolly and it was falling over when he felt sharp pain in his back. He testified that he reported it immediately afterward to Lynn Broms. Ms. Broms Hillesheim testified that she does not remember him reporting the injury. She testified he did call from the east coast to complain about the neighborhood and locking his keys in the truck. She testified that Petitioner requested a few days to visit his grandmother in Michigan.

Petitioner saw Dr. Furlett on June 14, 2017 with continuing low back pain. He was again advised to take off work. He had additional treatment through June 23, 2017. During that visit, Petitioner reported an episode of

dizziness and vomiting at home after lying down. He advised Dr. Furlett cervical rotation with his head flexed caused dizziness. Dr. Furlett insisted that he be taken to the emergency room (PX 6).

Petitioner testified that he went to Alexian Brother Medical Center emergency room on June 23, 2017 for dizziness after his chiropractic manipulation of his neck. The dizziness was more extreme than that he had previously experienced. He testified that he was diagnosed with vertigo due to a crystal dislocation. The Alexian Brothers records have a history of symptoms beginning in his bed yesterday when he turned his head. He noted a prior motor vehicle accident 10 years earlier with intermittent vertigo and headaches. This episode is no different today than his previous symptoms. Petitioner was discharged and referred to Dr. Gupta for a neurological consult (PX 8).

Petitioner saw Dr. Furlett on June 26, 2017 for continued back and right leg pain. Dr. Furlett records Petitioner stated the ER doctor assured him the symptoms were not related to his low back. Dr. Furlett ordered an MRI. The June 29, 2017 MRI impression was L4-5 disc bulging and L5-S1 disc bulging with a 3.5 mm central protrusion. The facet articulations appear unremarkable with no evidence of degenerative change, the neural foramen appears patent. Petitioner continued to treat with Dr. Furlett through July 17, 2017 (PX 6). Petitioner testified he stopped seeing Dr. Furlett because Respondent refused to pay for any more appointments. Ms. Broms Hillesheim testified that she stopped paying because the chiropractor was telling her that she did not know what else she could do. Dr. Furlett's records state that the claim was being transferred to the comp. carrier (PX 6).

Petitioner saw Dr. Gupta on July 7, 2017. The notes reflect the reason for the consult was low back pain after injury at work. He notes that Petitioner has seen a chiropractor and a naprapath. He has no insurance. The employer is paying for the visit. Petitioner's main concern is to have Dr. Gupta review the MRI, describe what symptoms may or may not be caused by his back pain and make recommendations for the next step. He notes the ER visit after the chiropractor but states that there was no cervical adjustment made. Petitioner reported the dizziness is fully recovered. Dr. Gupta's neurological examination was normal. He diagnosed back pain with sciatica. He stated that his back pain is not likely related to his dizziness, bowel, rectal or bladder complaints. He recommended physical therapy (PX 9). Petitioner testified that he testified that he did not undergo the therapy because Respondent refused to authorize it.

Petitioner saw Dr. Ramon Castillo on July 21, 2017. He testified that the insurance adjuster made the appointment. The records of Advocate Occupational Medicine reflect a single appointment on July 21, 2017 (PX 10). The records do not include the name of the 'company" or employer. Petitioner provided a history of the lower back pain for 5 months since carrying an armoire upstairs. The pain is stabbing with numbness on the anterior lateral aspect of the thighs and lateral aspect of the lower legs and to the toes. Dr. Castillo diagnosed a strain with low back pain and radiculopathy. He took Petitioner off work and instructed him to see a spine specialist (PX 10).

Petitioner was seen by Dr. Singh on August 3, 2017. Petitioner testified Dr. Singh refused to examine him. Dr. Singh's records reflect that Petitioner was seen for a consultation. The records reflect the referring doctor was Dr. Castillo. The report was addressed to the adjuster Tara Jackson. Petitioner reported the injury on February 20, 2017 while carrying furniture up the stairs. He reported pain in his neck, mid and low back rated 8-9/10. The report documents a physical examination with normal reflexes and strength. Dr. Singh diagnosed a cervical and lumbar muscular strain with L4-5 and L5-S1 degenerative disc disease. He released Petitioner to return to work without restrictions. He found Petitioner at MMI with no further treatment needed. He stated the

Petitioner presented with malingering behavior. The MRI revealed no stenosis. The exam was essentially normal (PX 19).

Petitioner testified he called the employer to schedule himself back to work, but was told they could not employ him in the condition he was. He testified he made a second attempt but was told that they would not take him back because he had a lawsuit against them. Petitioner testified he was still having pain in his lower back, his right hip, his buttocks, and pain in the testicles and groin area. Ms. Broms Hillesheim testified she spoke with Petitioner around July 17, 2017 to discuss returning him to light duty work. Petitioner was saying he was not capable of doing anything. He could not stand or sit for any length of time. The company was very busy at that time. She was told by the chiropractor that she did not know why the treatment was not working. As he testified, she spoke with Petitioner again after Petitioner was released to full duty on August 3, 2017. He was upset and crying, saying he had to come back to work but was still in pain and did not know what he could do. She said how do we do this if you are still in so much pain.

Petitioner saw Dr. Carl Graf on August 25, 2017. His mom found Dr. Graf. He testified that he called the chiropractor to ask for a referral. He already had the appointment. Dr. Furlett did not refer him. He testified she told him the insurance company would not honor it. Dr. Furlett's records contain notes of a phone call on August 23, 2017. The appointment was already set. The record notes Petitioner is now represented. Dr. Furlett told him she was unable to give a referral that would help with the insurance company (PX 6).

On August 25, 2017, Petitioner reported the February 20, 2017 accident to Dr. Graf. He told Dr. Graf his pain was 8-9/10. The physical examination noted normal strength, sensation and reflexes. Straight leg raise was negative. No tenderness was noted. There were no cervical complaints. The pain diagram that Petitioner prepared notes that he felt a stabbing pain in the groin area, an aching pain along the spine from the neck to the tailbone and into the shoulders, a stabbing, burning, aching and pins and needles in the right-sided low back region into the SI joint, right gluts, and into his right leg. He also noted pins and needles in both hands. He rated his pain at 7-8/10. Dr. Graf read the MRI as demonstrating degenerative disc at L4-5 and L5-S1. There is an annular tear at L4-5 with a central disc herniation at L5-S1. His assessment was low back pain with radiculopathy. He noted low back and right radiating leg pain. His pain appears to be mediated from the right SI joint on examination. Patient is not currently at MMI. He started a Medrol dose pack and took Petitioner off work. He recommended physical therapy and a right sided sacroiliac joint injection (PX 11).

On September 22, 2017, Dr. Graf's physical examination remained unchanged. He recommended a lumbar epidural steroid injection. On October 20, 2017, Dr. Graf notes the Workers Compensation denial. His recommendations remain the same. He states that the right leg pain is secondary to the SI joint dysfunction and is corroborated by the physical examination. He notes that the SI joint does not appear to have been evaluated during the IME. Petitioner remained off work (PX 11).

Petitioner began physical therapy on October 26, 2017 (PX 11). On October 30, 2017, Dr. Forowycz performed a right sacroiliac joint injection. His examination report notes moderate to severe point tenderness over the right SI joint and tenderness over L4-L5 midline, He noted positive straight leg raise at 5 degrees (PX 11). Petitioner continued with physical therapy. He noted only some minor relief in his pain. On November 21, 2017, Dr. Graf noted that Petitioner had dramatic pain relief after the sacroiliac joint injection and improvement with therapy and ordered a second SI joint injection which was performed on Nov. 27, 2017. Dr. Forowycz noted that Petitioner has substantial improvement after 3 days, but over the last 1-2 weeks, the pain has

begun to return (Px. 11). Petitioner continued with physical therapy. He initially noted improvement from the second injection, but advised that the pain increased (PX 11).

On December 15, 2017, Petitioner reported great improvement. His back pain is much less. The physical examination was neurologically normal with negative straight leg raise. Dr. Graf diagnosed sacroiliitis. He recommended continued physical therapy and an SI joint injection (PX 11). Petitioner continued physical therapy and underwent a third right SI injection on January 8, 2018 (PX 11). On January 26, 2018, Dr. Graf noted that the third SI joint injection provided Petitioner great relief resulting in less SI joint pain with less frequency. Petitioner complained of pain with radiation from the back to the buttocks. Physical examination was completely normal. Dr. Graf stated that he had concerns about Petitioner returning to work where he would have to do heavy moving and continued to keep him off work. He ordered physical therapy with less frequency and a lumbar epidural steroid injection which Petitioner underwent on February 5, 2018 (PX 11). On February 27, 2018, Dr. Graf gave Petitioner work restrictions in the light physical demand level (PX 20).

Petitioner was examined by Dr. Zelby on October 11, 2017 at Respondent's request (RX 1, Zelby 2). Dr. Zelby testified by evidence deposition on January 17, 2018 (RX 1). Dr. Zelby testified to the history provided of accidents on February 20 and June 9, 2017. The history included a 2016 back injury while carrying a gun safe with no symptoms into the lower extremities. The pain went away with chiropractic care (RX 1, Zelby 2). Dr. Zelby testified that the physical examination noted tenderness even with non-physiologic light touch. Straight leg raise was positive for back pain only, Gait was slow and antalgic. Petitioner said he was only able to ambulate with a single-post cane. Dr. Zelby testified that there was no medical basis for it as it relates to his spine and nervous system. Dr. Zelby noted inconsistent pain behavior with pain on superficial light lough, pain on simulation and non-anatomic sensory changes.

Dr. Zelby reviewed the records of Dr. Furlett, Dr. Manfredini, Dr. Singh, the Occupational Med Clinic, and Dr. Gupta. He did not recall seeing records from Dr. Graf. He reviewed the actual MRI films. His review of the MRI noted a minuscule bulging disc at L4-5 and a small chronic annular tear. At L5-S1 there was a broad-based bulging disc that partially extended into the ventral epidural fat along with a chronic partial thickness annular tear. there was no stenosis. The findings were not acute or post-traumatic. They were typical for the normal aging of the spine. He testified that an acute tear would be bright. You could see it for six months. A degenerative disc can be aggravated, but absent an acute abnormality, it is not possible (RX 1).

Dr. Zelby's impression was that Petitioner had mild lumbar degenerative disc disease and had sustained a lumbar strain. He had an essentially normal neurological exam except for a sensory loss inconsistent with any spinal condition. His subjective complaints cannot be corroborated with any objective findings. He testified that Petitioner's subjective complaints appeared related to symptom amplification. He opined that there was no evidence that the underlying degenerative condition was exacerbated, aggravated or accelerated in any way as a consequence of the reported work injuries. He had no radicular findings on examination and nothing on the MRI would result in a radiculopathy (RX1).

Dr. Zelby opined that Petitioner's treatment was protracted and excessive. He required no more that 8-12 chiropractic visits. He required no additional diagnostics and is not a candidate for any invasive treatment because he has no condition that would be treated by injections. He opined that Petitioner was at maximum medical improvement by April or May 2017 for the February 20, 2017 incident and by August or September for the June 2017 incident. Petitioner could return to his regular employment without restrictions. Dr. Zelby disagreed that a treating doctor is in a better position to judge cause and nature of the injury (RX 1).

Petitioner testified he has been off work since August 25, 2017. He would undergo a second lumbar epidural procedure if it was approved. He cannot do chores around the house, walk his dog regularly or drive. He does not feel he can go back to work. He feels he is about 70%. On March 19, 2018, Petitioner testified that Dr. Graf released him to return to light duty on February 27, 2018. He attempted to return to work. He sent the work status report to Respondent by email. He has not received any response from Respondent. If light work was offered by Respondent, he would accept it. Ms. Broms Hillesheim testified she would accommodate his restrictions if she had something available for him, but there is nothing at present. It is their slow season. It usually picks up in the summer.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified to a specific incident on June 10, 2016 delivering an 800-pound gun safe down a flight of stairs into a basement. While maneuvering it between tight locations and the stairwell, he had a sharp pain in his lower back and pain that went down his right leg. Petitioner testified that he reported this incident to Respondent. Ms. Broms Hillesheim confirmed the reporting of the accident. The records of Dr. Furlett contain the consistent history. Petitioner has included this incident in his subsequent histories as well. The Arbitrator finds that this incident occurred based upon the undisputed evidence submitted. This incident occurred during employment and at a place where Petitioner was performing his employment duties, and while a he fulfilled those duties. The risk of carrying a heavy item down the stairs is a risk connected with the employment and involves a causal connection between the employment and the accidental injury.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on June 10, 2016.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Petitioner testified he provided notice to Arnie Broms, the co-owner of Respondent. He testified that after he reported to the office, Lynn Broms, a co-owner of Respondent, told him she would pay for a few chiropractic treatments. Ms. Broms Hillesheim testified that he must have said something because they paid for treatment.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he provided notice of the accident on June 10, 2016 to Respondent within the time limits provided in the Act.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *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). 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).

Petitioner testified he had no prior back problems before the June 10, 2016 accident. Thereafter, he sought treatment with Dr. Furlett with complaints of back pain going down the right leg to the lateral calf. Petitioner was seen thereafter on June 29, 2016 and July 6, 2016. Dr. Furlett diagnosed a sacroiliac sprain, right sided radiculopathy, and sprained ligaments in the thoracic spine. Although she noted Petitioner was in the acute phase and was to continue with treatment, Petitioner testified he was released from care without back or right leg pain. He testified he fully recovered from this injury. He had no radiating pain. He provided a similar history to Dr. Zelby.

Petitioner sought no further medical treatment and continued to work full time including overtime at his heavy physical job for almost 8 months until his subsequent accident on February 20, 2017. Only thereafter did he begin a course of treatment with additional diagnoses, lost time and recommended additional treatment (as more fully addressed in the decision in consolidated cases 17 WC 23401 and 17 WC 29465).

As more fully addressed in the decision in consolidated case 17 WC 23401, the Arbitrator finds that the Petitioner's subsequent condition of ill-being is related to that incident, rather that the June 10, 2016 accident.

Based upon the record as a whole, the Arbitrator finds that Petitioner sustained a sacroiliac sprain, right sided radiculopathy, and sprained ligaments in the thoracic spine, which condition of ill-being reached maximum medical improvement as of July 6, 2016. Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill being is causally related to the accidental injuries sustained on June 10, 2016.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Prospective Medical, (L) Temporary Compensation, and (M) Penalties, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, the claims for Medical, Prospective Medical, Temporary Compensation are moot with respect to the June 10, 2016 accident. The issues will be further addressed in the decision in consolidated cases 17 WC 23401 and 17 WC 29465.

Based upon the Arbitrator's finding with respect to Causal Connection, Respondent has paid all benefits owed with respect to the accident on June 10, 2016. The Petition for Penalties is therefore denied with respect to this matter.

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

MATTHEW W. KIDD,

Petitioner,

19IWCC0626

vs.

NO: 17 WC 29465

W.P. BROMS, INC., AND
CONTINENTAL INDEMNITY CO.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses (including prospective), notice, temporary total disability, penalties and attorneys' fees, and "the two doctor rule," 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 corrects a scrivener's error 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 Arbitrator's decision contains a scrivener's error on page 5 of 9 in the last sentence of paragraph three. It states, "Petitioner testified that he testified that he did not undergo therapy because Respondent refused to authorize it." We hereby remove the repetition of "testified that he" in that sentence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2018, is hereby affirmed and adopted with the correction noted above.

19IWCC0626

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 by Respondent for the removal of this cause to the Circuit Court because no award was made. The 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 2019

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn A. Doerries

O: 10/22/19
49

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

KIDD, MATTHEW
Employee/Petitioner

Case# **17WC029465**

17WC029464
17WC023401

WP BROMS INC AND CONTINENTAL INDEMNITY COMPANY
Employer/Respondent

19IWCC0626

On 5/9/2018, 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 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:

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

4866 KNELL O'CONNOR & DANIELEWICZ
TORRIE N POPLIN
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

19IWCC0626

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)

Matthew Kidd
Employee/Petitioner

v.

WP Broms, Inc. and Continental Indemnity Company
Employer/Respondent

Case # **17** WC **29465**

Consolidated cases: **17 WC 29464 and 17 WC 23401**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **February 9, 2018 and March 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 9, 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.

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

In the year preceding the injury, Petitioner earned $**45,619.60**; the average weekly wage was $**877.30**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT ON JUNE 9, 2017 AND FURTHER FAILED TO PROVE THAT HIS CURRENT CONDITION OF ILL BEING IS CAUSALLY CONNECTED TO ANY INCIDENT OCCURRING ON JUNE 9, 2017, PETITIONER CLAIM FOR COMPENSATION FOR JUNE 9, 2017 IS DENIED.

PETITIONER'S ENTITLEMENT TO BENEFITS IS FURTHER ADDRESSED IN THE DECISION IN THE CONSOLIDATED CASE 17 WC 23401.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 3, 2018
Date

MAY 9 - 2018

ICArbDec19(b)

Statement of Facts

This matter was heard in conjunction with consolidated claims 17 WC 23401 (DOA: 2/20/17) and 17 WC 29464 (DOA: 2/20/17). A single transcript of the hearing was prepared. The Arbitrator has issued separate decisions with respect to each filed claim.

Petitioner Matthew Kidd testified that on June 10, 2016 he was employed by Respondent WP Broms as a long-distance driver and mover. He had been so employed for about five months. He has two years of college and a certification through United Van Lines for moving furniture, loading furniture and driving trucks. His job duties included moving furniture, loading trucks and driving for 10 to 11 hours. He held a Class A CDL license Furniture would be moved with dollies, straps and manpower. He testified that the job was physically demanding. He testified he would average over 60 hours per week. Respondent offered RX 4 with Petitioner's earnings and hours.

Lynn Broms Hillesheim testified that she is Respondent's Vice President. Respondent is a household goods moving company. They do both local and long distance. She is responsible for hiring and distributing assignments with her brother Arnold Broms. They employ between 10 and 15 workers depending on the season. She testified that Petitioner was a driver. He would be in charge of loading, unloading and paperwork. Petitioner began working for Respondent in February 2016.

Ms. Broms Hillesheim testified that Petitioner took time off for personal reasons. She testified he was also seeing his chiropractor when he started working with Respondent so he was given a shorter job or work around that schedule. She testified Petitioner complained of migraines. There were times he could not come to work because the migraines were bad.

Petitioner testified that he had no back pain prior to working for Respondent. He broke his collar bone when he was eleven. He had a head injury and a fractured jaw from falling off the back of a truck in 2006 or 2007. He was treated with anti-nausea pills and had his jaw reset because his TMJ was causing dizziness. Petitioner testified he fully recovered from the experience. He had sought no treatment since 2009. He treatment was with Dr. Gupta at that time. He was diagnosed with a traumatic brain injury. He experienced dizziness with movements of his body.

Petitioner testified that on June 10, 2016, they were delivering an 800-pound gun safe down a flight of stairs into a basement. They were maneuvering it between tight locations and the stairwell. He had a sharp pain in his lower back and pain that went down his right leg. He testified he reported the injury to his supervisor Arnie Broms, the co-owner of Respondent. On June 10, 2016, he finished unloading the truck and delivered a piano.

After he reported to the office, Lynn Broms, a co-owner of Respondent, told him she would pay for a few chiropractic treatments. Ms. Broms Hillesheim testified that he must have said something because they paid for treatment. She testified she told Petitioner if he wanted to go back to his chiropractor, she would pay for it. He was seen by Dr. Furlett. Dr. Furlett's records reflect that Petitioner was seen on June 27, 2016. The Patient Information form states the referral was by Linda Kidd. Petitioner reported low back pain since June 10, 2016. He checked that he has seen a chiropractor. The office note records a history of moving a gun safe. Petitioner complained of pain going down the right leg to the lateral calf. Petitioner was seen thereafter on June 29, 2016 and July 6, 2016. Dr. Furlett diagnosed a sacroiliac sprain, right sided radiculopathy, and sprained ligaments in the thoracic spine. She noted Petitioner was in the acute phase and was to continue with treatment (PX 6).

Petitioner testified he continued to work for Respondent while he received treatment. He continued to work for Respondent after he was released from care without back or right leg pain. He testified he fully recovered from this injury. He had no radiating pain.

He testified he suffered a second work injury on February 20, 2017. He was carrying a 300-pound armoire backwards up the stairs with a subcontractor in Round Rock, Texas. While it was wobbling back and forth and leaning, it caused him to hurt his back. He felt pain in his lower back and on the right side of his lower back and down his leg. He testified he reported the injury immediately after the injury to Lynn Broms. Ms Broms Hillesheim testified he reported this to her. Petitioner testified that when he returned to Illinois, Lynn Broms told him to continue chiropractic treatment. She testified she told him that if he would like to go to his chiropractor they would pay for it.

Petitioner returned to Dr. Furlett on March 15, 2017 with complaints of increased pain and stiffness. He reported the onset 1 ½ to 2 weeks earlier when in Texas for work. He reported he was carrying an armoire with a co-worker who dropped his end and he twisted. On March 20, 2017, Petitioner reported he was still very stiff and sore with radicular symptoms in the right gluts and leg to his ankle. Dr. Furlett recommend he stay off work, but Petitioner reported he could not get away from work. Petitioner continued treatment through April 19, 2017 for complaints in the low back and right leg. Dr. Furlett continued to recommend he take off work to heal and avoid reinjury (PX 6).

Petitioner testified that he told Respondent that the chiropractic was not working and he needed to seek other medical attention. He testified that He saw Dr. Manfredini. Linda Broms made the appointment. Ms. Broms Hillesheim testified that Petitioner told her that the chiropractic was not working and he was getting frustrated. She suggested that if he wanted to see the naprapath that her brother went to that he was welcome to do so. It was up to him. Petitioner went to Dr. Manfredini, a naprapath, on April 20, 2017. The Health History Summary notes he heard about him from Lynn Broms. Petitioner had treatment on April 20, April 26 and May 1, 2017 (PX 7).

Petitioner testified he worked full time for Respondent during his treatment with some days off. He testified that he took about three weeks off due to the injury. It was random days with some periods a week long due to the recommendation from the chiropractor. Petitioner testified that Dr. Furlett did not give him an off-work slip. Ms. Broms Hillesheim testified he did not take any time off work.

Petitioner returned to Dr. Furlett on May 19, 2017. He reported that he had been on cross country moves. Twisting and carrying exacerbated his pain. On June 2, 2017, Dr. Furlett discussed advanced imaging if there was no progress. Petitioner was seen again on June 4, 2017 (PX 6).

Petitioner testified that on June 9, 2017 he was carrying and loading a grand piano in Washington, D.C. He was pushing the piano into the truck on a dolly and it was falling over when he felt sharp pain in his back. He testified that he reported it immediately afterward to Lynn Broms. Ms. Broms Hillesheim testified that she does not remember him reporting the injury. She testified he did call from the east coast to complain about the neighborhood and locking his keys in the truck. She testified that Petitioner requested a few days to visit his grandmother in Michigan.

Petitioner saw Dr. Furlett on June 14, 2017 with continuing low back pain. He was again advised to take off work. He had additional treatment through June 23, 2017. During that visit, Petitioner reported an episode of

dizziness and vomiting at home after lying down. He advised Dr. Furlett cervical rotation with his head flexed caused dizziness. Dr. Furlett insisted that he be taken to the emergency room (PX 6).

Petitioner testified that he went to Alexian Brother Medical Center emergency room on June 23, 2017 for dizziness after his chiropractic manipulation of his neck. The dizziness was more extreme than that he had previously experienced. He testified that he was diagnosed with vertigo due to a crystal dislocation. The Alexian Brothers records have a history of symptoms beginning in his bed yesterday when he turned his head. He noted a prior motor vehicle accident 10 years earlier with intermittent vertigo and headaches. This episode is no different today than his previous symptoms. Petitioner was discharged and referred to Dr. Gupta for a neurological consult (PX 8).

Petitioner saw Dr. Furlett on June 26, 2017 for continued back and right leg pain. Dr. Furlett records Petitioner stated the ER doctor assured him the symptoms were not related to his low back. Dr. Furlett ordered an MRI. The June 29, 2017 MRI impression was L4-5 disc bulging and L5-S1 disc bulging with a 3.5 mm central protrusion. The facet articulations appear unremarkable with no evidence of degenerative change, the neural foramen appears patent. Petitioner continued to treat with Dr. Furlett through July 17, 2017 (PX 6). Petitioner testified he stopped seeing Dr. Furlett because Respondent refused to pay for any more appointments. Ms. Broms Hillesheim testified that she stopped paying because the chiropractor was telling her that she did not know what else she could do. Dr. Furlett's records state that the claim was being transferred to the comp. carrier (PX 6).

Petitioner saw Dr. Gupta on July 7, 2017. The notes reflect the reason for the consult was low back pain after injury at work. He notes that Petitioner has seen a chiropractor and a naprapath. He has no insurance. The employer is paying for the visit. Petitioner's main concern is to have Dr. Gupta review the MRI, describe what symptoms may or may not be caused by his back pain and make recommendations for the next step. He notes the ER visit after the chiropractor but states that there was no cervical adjustment made. Petitioner reported the dizziness is fully recovered. Dr. Gupta's neurological examination was normal. He diagnosed back pain with sciatica. He stated that his back pain is not likely related to his dizziness, bowel, rectal or bladder complaints. He recommended physical therapy (PX 9). Petitioner testified that he testified that he did not undergo the therapy because Respondent refused to authorize it.

Petitioner saw Dr. Ramon Castillo on July 21, 2017. He testified that the insurance adjuster made the appointment. The records of Advocate Occupational Medicine reflect a single appointment on July 21, 2017 (PX 10). The records do not include the name of the 'company" or employer. Petitioner provided a history of the lower back pain for 5 months since carrying an armoire upstairs. The pain is stabbing with numbness on the anterior lateral aspect of the thighs and lateral aspect of the lower legs and to the toes. Dr. Castillo diagnosed a strain with low back pain and radiculopathy. He took Petitioner off work and instructed him to see a spine specialist (PX 10).

Petitioner was seen by Dr. Singh on August 3, 2017. Petitioner testified Dr. Singh refused to examine him. Dr. Singh's records reflect that Petitioner was seen for a consultation. The records reflect the referring doctor was Dr. Castillo. The report was addressed to the adjuster Tara Jackson. Petitioner reported the injury on February 20, 2017 while carrying furniture up the stairs. He reported pain in his neck, mid and low back rated 8-9/10. The report documents a physical examination with normal reflexes and strength. Dr. Singh diagnosed a cervical and lumbar muscular strain with L4-5 and L5-S1 degenerative disc disease. He released Petitioner to return to work without restrictions. He found Petitioner at MMI with no further treatment needed. He stated the

Petitioner presented with malingering behavior. The MRI revealed no stenosis. The exam was essentially normal (PX 19).

Petitioner testified he called Respondent to schedule himself back to work, but was told they could not employ him in the condition he was. He testified he made a second attempt but was told that they would not take him back because he had a lawsuit against them. Petitioner testified he was still having pain in his lower back, his right hip, his buttocks, and pain in the testicles and groin area. Ms. Broms Hillesheim testified she spoke with Petitioner around July 17, 2017 to discuss returning him to light duty work. Petitioner was saying he was not capable of doing anything. He could not stand or sit for any length of time. The company was very busy at that time. She was told by the chiropractor that she did not know why the treatment was not working. As he testified, she spoke with Petitioner again after Petitioner was released to full duty on August 3, 2017. He was upset and crying, saying he had to come back to work but was still in pain and did not know what he could do. She said how do we do this if you are still in so much pain.

Petitioner saw Dr. Carl Graf on August 25, 2017. His mom found Dr. Graf. He testified that he called the chiropractor to ask for a referral. He already had the appointment. Dr. Furlett did not refer him. He testified she told him the insurance company would not honor it. Dr. Furlett's records contain notes of a phone call on August 23, 2017. The appointment was already set. The record notes Petitioner is now represented. Dr. Furlett told him she was unable to give a referral that would help with the insurance company (PX 6).

On August 25, 2017, Petitioner reported the February 20, 2017 accident to Dr. Graf. He told Dr. Graf his pain was 8-9/10. The physical examination noted normal strength, sensation and reflexes. Straight leg raise was negative. No tenderness was noted. There were no cervical complaints. The pain diagram that Petitioner prepared notes that he felt a stabbing pain in the groin area, an aching pain along the spine from the neck to the tailbone and into the shoulders, a stabbing, burning, aching and pins and needles in the right-sided low back region into the SI joint, right gluts, and into his right leg. He also noted pins and needles in both hands. He rated his pain at 7-8/10. Dr. Graf read the MRI as demonstrating degenerative disc at L4-5 and L5-S1. There is an annular tear at L4-5 with a central disc herniation at L5-S1. His assessment was low back pain with radiculopathy. He noted low back and right radiating leg pain. His pain appears to be mediated from the right SI joint on examination. Patient is not currently at MMI. He started a Medrol dose pack and took Petitioner off work. He recommended physical therapy and a right sided sacroiliac joint injection (PX 11).

On September 22, 2017, Dr. Graf's physical examination remained unchanged. He recommended a lumbar epidural steroid injection. On October 20, 2017, Dr. Graf notes the Workers Compensation denial. His recommendations remain the same. He states that the right leg pain is secondary to the SI joint dysfunction and is corroborated by the physical examination. He notes that the SI joint does not appear to have been evaluated during the IME. Petitioner remained off work (PX 11).

Petitioner began physical therapy on October 26, 2017 (PX 11). On October 30, 2017, Dr. Forowycz performed a right sacroiliac joint injection. His examination report notes moderate to severe point tenderness over the right SI joint and tenderness over L4-L5 midline, He noted positive straight leg raise at 5 degrees (PX 11). Petitioner continued with physical therapy. He noted only some minor relief in his pain. On November 21, 2017, Dr. Graf noted that Petitioner had dramatic pain relief after the sacroiliac joint injection and improvement with therapy and ordered a second SI joint injection which was performed on Nov. 27, 2017. Dr. Forowycz noted that Petitioner has substantial improvement after 3 days, but over the last 1-2 weeks, the pain has

begun to return (Px. 11). Petitioner continued with physical therapy. He initially noted improvement from the second injection, but advised that the pain increased (PX 11).

On December 15, 2017, Petitioner reported great improvement. His back pain is much less. The physical examination was neurologically normal with negative straight leg raise. Dr. Graf diagnosed sacroiliitis. He recommended continued physical therapy and an SI joint injection (PX 11). Petitioner continued physical therapy and underwent a third right SI injection on January 8, 2018 (PX 11). On January 26, 2018, Dr. Graf noted that the third SI joint injection provided Petitioner great relief resulting in less SI joint pain with less frequency. Petitioner complained of pain with radiation from the back to the buttocks. Physical examination was completely normal. Dr. Graf stated that he had concerns about Petitioner returning to work where he would have to do heavy moving and continued to keep him off work. He ordered physical therapy with less frequency and a lumbar epidural steroid injection which Petitioner underwent on February 5, 2018 (PX 11). On February 27, 2018, Dr. Graf gave Petitioner work restrictions in the light physical demand level (PX 20).

Petitioner was examined by Dr. Zelby on October 11, 2017 at Respondent's request (RX 1, Zelby 2). Dr. Zelby testified by evidence deposition on January 17, 2018 (RX 1). Dr. Zelby testified to the history provided of accidents on February 20 and June 9, 2017. The history included a 2016 back injury while carrying a gun safe with no symptoms into the lower extremities. The pain went away with chiropractic care (RX 1, Zelby 2). Dr. Zelby testified that the physical examination noted tenderness even with non-physiologic light touch. Straight leg raise was positive for back pain only, Gait was slow and antalgic. Petitioner said he was only able to ambulate with a single-post cane. Dr. Zelby testified that there was no medical basis for it as it relates to his spine and nervous system. Dr. Zelby noted inconsistent pain behavior with pain on superficial light lough, pain on simulation and non-anatomic sensory changes.

Dr. Zelby reviewed the records of Dr. Furlett, Dr. Manfredini, Dr. Singh, the Occupational Med Clinic, and Dr. Gupta. He did not recall seeing records from Dr. Graf. He reviewed the actual MRI films. His review of the MRI noted a minuscule bulging disc at L4-5 and a small chronic annular tear. At L5-S1 there was a broad-based bulging disc that partially extended into the ventral epidural fat along with a chronic partial thickness annular tear. there was no stenosis. The findings were not acute or post-traumatic. They were typical for the normal aging of the spine. He testified that an acute tear would be bright. You could see it for six months. A degenerative disc can be aggravated, but absent an acute abnormality, it is not possible (RX 1).

Dr. Zelby's impression was that Petitioner had mild lumbar degenerative disc disease and had sustained a lumbar strain. He had an essentially normal neurological exam except for a sensory loss inconsistent with any spinal condition. His subjective complaints cannot be corroborated with any objective findings. He testified that Petitioner's subjective complaints appeared related to symptom amplification. He opined that there was no evidence that the underlying degenerative condition was exacerbated, aggravated or accelerated in any way as a consequence of the reported work injuries. He had no radicular findings on examination and nothing on the MRI would result in a radiculopathy (RX1).

Dr. Zelby opined that Petitioner's treatment was protracted and excessive. He required no more that 8-12 chiropractic visits. He required no additional diagnostics and is not a candidate for any invasive treatment because he has no condition that would be treated by injections. He opined that Petitioner was at maximum medical improvement by April or May 2017 for the February 20, 2017 incident and by August or September for the June 2017 incident. Petitioner could return to his regular employment without restrictions. Dr. Zelby disagreed that a treating doctor is in a better position to judge cause and nature of the injury (RX 1).

Petitioner testified he has been off work since August 25, 2017. He would undergo a second lumbar epidural procedure if it was approved. He cannot do chores around the house, walk his dog regularly or drive. He does not feel he can go back to work. He feels he is about 70%. On March 19, 2018, Petitioner testified that Dr. Graf released him to return to light duty on February 27, 2018. He attempted to return to work. He sent the work status report to Respondent by email. He has not received any response from Respondent. If light work was offered by Respondent, he would accept it. Ms. Broms Hillesheim testified she would accommodate his restrictions if she had something available for him, but there is nothing at present. It is their slow season. It usually picks up in the summer.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (F) Causal Connection, 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 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

Petitioner testified to a work accident on June 9, 2017 while moving a piano. he claims to have reported this to Ms. Broms. As more fully discussed in the decision in consolidated case 17 WC 23401, the Arbitrator finds the Petitioner's testimony not credible based upon the contradiction with the medical histories, medical records and the testimony of Ms. Broms Hillesheim.

Although Petitioner testified to a specific June 9, 2017 accident and testified that he told Dr. Furlett about this injury, Dr. Furlett's medical record from June 14, 2017, does not record the new injury. On July 7, 2017, Dr. Gupta includes a history of a work injury about two months ago while rotating a piece of furniture with a co-worker at work. The mechanism of injury described at this appointment is inconsistent with how Petitioner described the events of the June 9, 2017 injury but is consistent with the February 20, 2017 accident reported. The timing of the injury is inaccurate. On July 21, 2017, Advocate Occupational Health has a history of lower back pain for almost 5 months. This is consistent with Petitioner's February 20, 2017 injury. Petitioner never mentioned an injury that occurred around June 9, 2017. On August 3, 2017, Dr. Kern Singh's history is that on February 20, 2017, he was carrying furniture up the stairs when he felt a sharp pain. Petitioner did not mention an injury that occurred around June 9, 2017. Petitioner only reported the February 20, 2017 accident to Dr. Graf. Given the complete contradiction of Petitioner's testimony by the medical histories provided, the Arbitrator finds that Petitioner failed to prove he sustained an accident on June 9, 2017.

Petitioner has alleged a prior accident on February 20, 2017 which is the subject of consolidated claim 17 WC 23401. As discussed in that matter, the Arbitrator notes that Petitioner was under active treatment from March 2017 through June 4, 2017 before leaving on the east coast trip where Petitioner alleges he was reinjured. The Arbitrator notes Ms. Broms Hillescheim denies receiving any notice of the injury on June 9, 2017 and Petitioner did not mention it in the medical records of Dr. Furlett even though she saw Petitioner within days of the incident. It is also not reflected in the medical records of Dr. Manfredini, Dr. Gupta, Dr. Castillo, Dr. Singh or Dr. Graf. Petitioner presented no medical opinion that any condition of ill-being was related to an accident

on June 9, 2017. The Arbitrator therefore also finds that Petitioner's current condition ill-being is not causally related to any injury claimed on June 9, 2017.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment on June 9, 2017 and further failed to prove by a preponderance of the evidence that any condition of ill being is causally connected to a work injury on June 9, 2017.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Prospective Medical, (L) Temporary Compensation, and (M) Penalties, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the claims for Medical, Prospective Medical, Temporary Compensation are moot with respect to the June 9, 2017 claim. The issues will be further addressed in the decision in consolidated cases 17 WC 23401 and 17 WC 29464.

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, no benefits are owed with respect to the claim of accident on June 9, 2017. The Petition for Penalties is therefore denied with respect to this matter.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ILLINOIS WORKERS' COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DEPARTMENT,

Petitioner,

19IWCC0627

vs.

No: 18 WC 27951
12 INC 204

JOHN COLLIER, INDIVIDUALLY AND PRESIDENT,
JANE COLLIER, INDIVIDUALLY AND SECRETARY,
AND SUN TOWING, INC.

Respondents

DECISION AND OPINION ON PETITION FOR
FINES DUE TO INSURANCE NON-COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Department, brings this action, by and through the Office of the Illinois Attorney General, against the above captioned Respondents, alleging violation of section 4(a) of the Illinois Workers' Compensation Act (the "Act"). Proper and timely notice was provided to Respondents. *See* Transcript of Proceedings, pp.10-16 (hereinafter "T. 10-16"); 29-30; 36 and Petitioner's Exhibit 2. A hearing in this insurance compliance case was held on November 14, 2016, before Commissioner Charles DeVriendt and a record was made. No one appeared on behalf of Respondents.

Petitioner alleges Respondents knowingly and willfully lacked workers' compensation coverage from July 20, 2005 through November 30, 2011 in violation of Section 4(a) of the Illinois Workers' Compensation Act. Petitioner seeks the maximum fine allowed under the Act, $500.00 per day for each of the 2,325 days Sun Towing did business and failed to provide coverage for its employees. Petitioner seeks a total fine of $1,162,500.00.

The Workers' Compensation Commission Insurance Compliance Department Notice of Non-Compliance and Notice of Insurance Compliance Hearing states Sun Towing was not in

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compliance with the requirements of section 4(a) of the Act from July 20, 2005 through November 30, 2011. After considering the entire record, the Commission finds that Respondents knowingly and willfully violated Section 4(a) of the Act and Section 9100.100 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission from July 20, 2005 through November 30, 2011. The Commission finds, after reasonable notice and hearing, Respondents knowingly and willfully failed or refused to comply with the provisions of Section 4(a) of the Act and Section 9100.100(b) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission. The Commission assesses a civil penalty under Section 4 of the Act in the sum of $1,162,500.00 against Respondents for the reasons set forth below:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner presented Don Johnson, a lead investigator for the Insurance Compliance Department of the Illinois Workers' Compensation Commission, as a witness at the hearing on November 14, 2016.

2. Investigator Johnson enforces state law by attempting to make sure every employee in the state of Illinois is covered by Workers' Compensation Insurance. T. 7. Investigator Johnson has been performing compliance work investigating companies for 9 years. T. 8.

3. As part of his investigations, Investigator Johnson accesses the database of the National Council on Compensation Insurance (NCCI), and secures records from the Illinois Department of Employment Security, Illinois Department of Revenue, and the office of Self Insurance. T. 8.

4. Investigator Johnson testified there was an injury in a case involving an employee of Sun Towing and an Injured Workers' Benefit Fund award was paid by the Fund to injured employee Cleo Smith. T. 9; *See* Petitioner's Exhibit 3.

5. Mr. and Mrs. Collier, from Chicago Ridge, Illinois, were the owners of Sun Towing. T. 9.

6. Investigator Johnson researches with the Office of Self Insurance in all of his investigations. T. 16. Sun Towing was not self-insured through the state of Illinois. T. 17-18; Petitioner's Exhibit 5.

7. Records from the Illinois Secretary of State show Sun Towing was incorporated in November 1995 with a declaration of 1,000 common shares of stock. T. 19. Both John and Jane Collier signed as incorporators of the business. T. 20; *See* Petitioner's Exhibit 6.

8. Illinois Secretary of State records show the purpose of Sun Towing's business was to provide towing services. T. 20.

9. On March 10, 2014, Sun Towing changed its corporate name from Sun Towing to ST Liquidation. T. 20.

10. Investigator Johnson obtains records from the Illinois Department of Revenue in his investigations because these documents can show a company is operating, paying taxes, and can occasionally show how many employees a company has. T. 22. Investigator Johnson learned that in 2008 Sun Towing had total income subject to withholding of $29,400.00. T. 22. In 2009, Sun Towing had total income subject to withholding of $30,000.00. T. 22. In 2010 Sun Towing had total income subject to withholding of $27,000.00. T. 23. Investigator Johnson found these round numbers suspicious. T. 23; *See* Petitioner's Exhibit 4.

11. Investigator Johnson also sought records from the Illinois Department of Employment Security in this case. *See* Petitioner's Exhibit 8; T. 25. Investigator Johnson learned Sun Towing declared employees in 2009. T. 25-26. Cleo Smith was named as an employee in the first quarter of 2009. T. 26. Cleo Smith was the petitioner in the Injured Workers' Benefit Fund case involving Sun Towing. T. 26; *See* Petitioner's Exhibit 3. Five employees were declared as employees, in fact, in the first quarter of 2009. T. 26. In the second quarter of 2009 Sun Towing declared five employees, as well. T. 26-27. In addition, Sun Towing declared five employees in the third quarter of 2009 and four employees in the final quarter of 2009. Finally, Sun Towing declared five employees in the third quarter of 2009 and four employees in the final quarter of 2009. T. 27 - 28. Investigator Johnson also found it suspicious that the payroll amounts from the Illinois Department of Employment Security exceeded what was reported to the Illinois Department of Revenue as total income subject to withholding. T. 28.

12. The Commission takes judicial notice of the Injured Workers' Benefit Fund decision in Cleo Smith vs. John and Jane Collier, jointly and severally, doing business as Sun Towing and the State Treasurer as ex-officio custodian of the Injured Workers' Benefit Fund. *See* Petitioner's Exhibit 3.

13. Investigator Johnson learned from NCCI that Sun Towing and John and Jane Collier had no proof of Workers' Compensation Insurance from July 20, 2005 to November 30, 2011. T. 31-32. *See* Petitioner's Exhibit 9. This length of time without insurance amounts to 2,325 days of noncompliance with the workers' compensation insurance laws of this state. This is a period of six years, four months and 11 days.

14. Investigator Johnson testified he sent a Notice of Non-Compliance to Sun Towing on December 26, 2013. T. 34; Petitioner's Exhibit 11. Investigator Johnson also sent a Notice of Informal Conference. 34-35. John and Jane Collier never appeared at any informal conference. T. 35; *See* Petitioner's Exhibit 12.

15. Investigator Johnson testified the state did pay out the Injured Workers' Benefit Fund award to injured employee Cleo Smith. T. 36.; *See* Petitioner's Exhibit 3. Investigator Johnson testified that payout amounted to approximately $34,000.00. T. 36.

16. According to Investigator Johnson, from the time of subpoena service in Columbia, Tennessee on October 26, 2015 to the time of trial, neither John nor Jane Collier contacted the Insurance Compliance Department. T. 37.

The Commission now analyzes Sun Towing's liability under Section 4(a) of the Act, which requires all employers of at least one employee who come within the provisions of Section 3 of the Act, and any other employer who shall elect coverage under Section 2 of the Act, to provide workers' compensation insurance for the protection of their employees. 820 ILCS 305/4. Common law liability of employers to injured employees has been replaced in this state by the workers' compensation system.

The evidence in this case shows Sun Towing had numerous employees reported to the Illinois Department of Employment Security. *See* Petitioner's Exhibit 8. The Commission has no doubt that Sun Towing was operating a towing business with employees, bringing it within the automatic coverage provisions of the Act as "[a]ny business or enterprise in which electric, gasoline or other power-driven equipment is used in the operation thereof." 820 ILCS 305/3(15). The Commission also finds Sun Towing was engaged in carriage by land with their tow trucks. 820 ILCS 305/3 (3); *See* Petitioner's Exhibit 3. Sun Towing was a business operating in this State required to have workers' compensation insurance and the provisions of the Act apply automatically and without election in this case.

Under Section 4(a) of the Act, a respondent may elect to apply for approval as a self-insurer, insure his liability to pay such compensation in some insurance carrier authorized to do such insurance business in the State or make other provision, satisfactory to the Commission for the securing of the payment of compensation provided for in the Act. The Respondents in this case did not seek to obtain self-insurer status, obtain traditional workers' compensation insurance or make other provisions with the Commission.

Turning to Sun Towing's knowing violation of section 4(a) of the Act and the appropriate penalty amount to assess. Any reasonable trier-of-fact can conclude Sun Towing would have known, by operating a tow truck business, that it needed to provide workers' compensation insurance for its employees. The Injured Workers' Benefit Fund case involving employee Cleo Smith shows, by a preponderance of the evidence, that Sun Towing had employees when it was operating its towing business. Further, it is clear Sun Towing was operating its business until at least December 31, 2011 because it was reporting income at that time to the Illinois Department of Revenue. *See* Petitioner's Exhibit 4. The Commission notes the Insurance Compliance Department is only seeking to impose a civil penalty through November 30, 2011.

The Commission cannot tolerate, nor allow this State to endure, a tow truck business that operates without insurance.

In considering the appropriate penalty against Respondents, evidence to be considered includes the period of over six years of non-compliance, the injury and subsequent payment to Cleo Smith and John and Jane Collier's continued avoidance of these Insurance Compliance proceedings. The Commission has also considered the rationale offered by Investigator Johnson in support of imposing a larger civil fine. *See* T. 36.

The Commission can, through this case, deter other businesses, and especially tow truck businesses, from disregarding the insurance laws of this State by exacting a severe penalty commensurate with the conduct of Sun Towing. For the foregoing reasons, and after considering

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the entire record, the Commission finds that Respondents were operating under and subject to the Illinois Workers' Compensation Act under Section 3 and was an employer during the periods of non-compliance from July 20, 2005 through November 30, 2011, as denoted in Section 1 of the Act. The Commission finds that Respondents have knowingly and willfully failed to comply with the requirements of Section 4(a) of the Act and shall be assessed penalties under Section 4(d) of the Act. The Commission finds Respondents knowingly and willfully were in noncompliance with Section 4 of the Act from at least July 20, 2005 to November 30, 2011, a period of 2,325 days and shall pay a fine of $500.00 per day for a total penalty of $1,162,500.00 under Section 4(d) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents, John Collier, Individually and as President of Sun Towing, Inc., Jane Collier, Individually and as Secretary of Sun Towing, Inc., and Sun Towing, Inc., pay to the Illinois Workers' Compensation Commission the sum of $1,162,500.00 pursuant to Section 4(d) of the Act.

Bond for the removal of this case 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 21 2019

María Elena Portela

María E. Portela

Thomas J. Tyrrell

Thomas J. Tyrrell

Kathryn A. Doerries

Kathryn A. Doerries

R: 11/14/16
49

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

PATTY MATTINGLY,

Petitioner,

vs.

NO: 13 WC 11683

NORTH AMERICAN LIGHTING, INC.,

19IWCC0628

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability (TTD) benefits, and permanent partial disability (PPD) 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.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission modifies the Arbitrator's Decision with respect to Petitioner's right knee condition, and finds instead that Petitioner's current condition of ill-being as to her right knee is

causally related to the November 28, 2012 undisputed work accident. The Arbitrator found that Petitioner's current condition of ill-being was not related to the November 28, 2012 work injury, but was instead related to an intervening injury that Petitioner sustained at home on January 12, 2013. Thus, the Arbitrator found causal connection only up to January 11, 2013.

> To obtain compensation under the Act, an employee must establish by a preponderance of the evidence a causal connection between a work-related injury and the employee's condition of ill-being. (citation omitted) Every natural consequence that flows from a work-related injury is compensable under the Act unless the chain of causation is broken by an independent intervening accident. (citation omitted) Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred 'but for' the original injury. (citation omitted) Thus, when an employee's condition is weakened by a work-related accident, a subsequent accident, whether work related or not, that aggravates the condition does not break the causal chain. (citation omitted) 'For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition.' (citation omitted) As long as there is a 'but for' relationship between the work-related injury and subsequent condition of ill-being, the first employer remains liable. (citation omitted).

PAR Elec. v. Ill. Workers' Comp. Comm'n, 2018 IL App (3d) 170656WC, ¶ 63.

The Commission finds that the January 12, 2013 accident at Petitioner's home did not sever causal connection for Petitioner's right knee condition. Immediately prior to her re-injury, Petitioner was actively treating with Dr. Brower, Respondent's company doctor; she was undergoing physical therapy; and, she continued to report tenderness along the medial aspect and into the posterior knee. Petitioner's right knee remained edematous, she ambulated with a slight limp, and experienced discomfort with range of motion. Although Petitioner was working without restriction prior to January 12, 2013, Petitioner reported having pain, and she noticed that she was a little slower at work and walked differently.

Petitioner testified credibly of increased pain immediately after the January 12, 2013 accident at home. Specifically, Petitioner testified to increased pain that lasted approximately two minutes. "And after a little bit it went back to what I had been accustomed to, just the regular pain." (T.26). However, Petitioner's "regular pain" was not insignificant. Petitioner testified that during this time period prior to January 12, 2013, "The knee just wasn't coming back. The pain seemed to be getting a little bit more consistent. Nothing was really relieving me at that time." (T.25). Dr. Paletta's opinion was undercut by Petitioner's testimony; Dr. Paletta, Respondent's Section 12 examiner, had indicated that Petitioner had been doing relatively well, working full duty, until the second injury that occurred at home. Petitioner in fact was not doing well. The

Commission notes that the Arbitrator relied on Dr. Brower, in part, to cut off causal connection, indicating that Petitioner's need for increased intervention occurred after January 12, 2013. However, Dr. Brower testified that based on Petitioner's symptoms prior to January 12, 2013, he had suspected Petitioner had a meniscal tear, but he did not want to order an MRI until Petitioner failed conservative care. Dr. Brower wanted Petitioner to first try medication and some physical therapy.

Thus, the evidence demonstrated that Petitioner's right knee, prior to January 12, 2013, was in a weakened state as a result of the work-related accident in November 2012. Petitioner's injury involved more than a knee strain. She had meniscus pathology as well as underlying arthritis. As of January 12, 2013, Petitioner had not completely recovered from the November 28, 2012 work accident, she was in fact actively treating for that injury, and had not yet reached maximum medical improvement. Therefore, the subsequent injury at home did not sever the chain of causation. Petitioner's injury on January 12, 2013 would not have occurred but for the original injury in November 2012. Accordingly, the Commission finds that the November 28, 2012 accident remained a cause of Petitioner's subsequent condition of ill-being.

The Commission further writes that one of the key issues in this claim revolved around whether the actual mechanism of injury on November 28, 2012 caused the meniscal tear. The Arbitrator found that Petitioner sustained nothing more than a right knee strain on November 28, 2012, and that the January 12, 2013 accident at home caused the meniscal tear.

In reviewing the evidence in its entirety and resolving the conflicting physician opinions in the record, the Commission finds Dr. Ulrich, Petitioner's treating orthopedic surgeon, more persuasive than Drs. Brower and Paletta. Drs. Brower and Paletta's opinions denying causation was based on a limited understanding of the mechanism of injury on November 28, 2012. Dr. Ulrich, on the other hand, understood that Petitioner had been moving parts at work and felt a pop in her right knee after stepping laterally, twisting, and turning. The Commission finds that Dr. Ulrich's testimony was consistent with his medical records and Petitioner's testimony and demonstration at arbitration. Petitioner testified that after putting together LED lights for certain headlights, she took a step to the side and turned to put the finished product into a tote. The Commission finds Petitioner's testimony credible and that the record demonstrated that Petitioner's description of the accident was consistent, and her explanation at arbitration regarding having to side step and turn was reasonable and corroborated by the record as a whole. Dr. Ulrich opined that this mechanism of injury was consistent with a medial meniscal tear. Dr. Ulrich further opined that the work injury was a causative factor for surgery. The Commission further notes that the emergency room records from Paris Community Hospital, dated the same date as the work injury, indicated that Petitioner exhibited limited active range of motion due to pain; there was effusion in the medial aspect of the right knee and posterior aspect; Petitioner also had mild swelling and tenderness. These findings were all consistent with a meniscal injury.

The Commission additionally notes that while the Arbitrator's Decision primarily focused on Petitioner's mechanism of injury on November 28, 2012 and whether Petitioner's movements could have caused the meniscal tear, the record demonstrated that both Dr. Brower and Dr. Paletta believed that Petitioner's meniscal injury pre-existed the accident. Dr. Brower had diagnosed Petitioner on December 11, 2012 with degeneration of the medial meniscus secondary to

osteoarthritis. Dr. Paletta testified that Petitioner's meniscal tear pre-existed the November 28, 2012 accident. Thus, if Petitioner's meniscal tear had been pre-existing, as was Petitioner's arthritis in the right knee, the same argument may be made for both conditions. Petitioner had no treatment or complaints related to her right knee, or any issues performing her full duties for Respondent, prior to November 28, 2012. The Commission can reasonably infer that as a result of the November 28, 2012 work accident, Petitioner's pre-existing right knee arthritis and meniscal issue was either aggravated or exacerbated and rendered symptomatic. Dr. Paletta conceded on this point at his deposition. Dr. Paletta testified on cross-examination that the November 28, 2012 work accident exacerbated Petitioner's pre-existing meniscal condition. "Based on the history, and based on the medical records, and based on the way I would use the term 'exacerbation,' meaning an increase in symptoms without a change in the underlying condition of the knee, I would agree that she had an increase, reported an increase in symptoms." (RX8, pgs. 67-68).

In light of the foregoing, the Commission modifies the Arbitrator's Decision with respect to Petitioner's right knee condition, and finds that Petitioner's current condition of ill-being as to her right knee is causally related to the November 28, 2012 undisputed work accident. As the Commission finds causal connection for Petitioner's current condition of ill-being, the Commission further awards the reasonable and necessary medical bills as detailed in Petitioner's Exhibits 6 through 9, as well as TTD benefits from March 18, 2013 through May 28, 2013 (10 2/7 weeks). Respondent disputed liability on the basis of no causal connection.

The Commission further finds that Petitioner is entitled to PPD benefits of 20% loss of use (LOU) of the right leg. The Arbitrator considered the five factors under Section 8.1b of the Act and awarded Petitioner 5% LOU of the right leg for her right knee strain. The Commission, having reviewed and reweighed the evidence in this matter, finds the PPD award to be insufficient. The Commission weighed the five factors listed under Section 8.1b of the Act as follows:

(i) Impairment Rating: The Commission gives no weight to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: Following her right knee surgery on March 18, 2013, Petitioner returned to her regular duties with Respondent in May 2013. She continued to work for Respondent until April 4, 2016, when she was terminated for reasons unrelated to the work injury. Since February 2017, Petitioner has been working in home health care. The Commission finds that Petitioner's new employment was unrelated to the November 28, 2012 work injury and gives this factor little weight.

(iii) Petitioner's Age: Petitioner was 54 years old on the accident date; the Commission gives this factor no weight as there is no evidence in the record that Petitioner's age had any effect on the level of permanent partial disability.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: Based on the Commission's finding of causal connection for Petitioner's current condition of ill-being, as stated above, the Commission finds that

Petitioner sustained more than a right knee strain on November 28, 2012. The evidence demonstrated that the November 28, 2012 work accident aggravated Petitioner's meniscal pathology and underlying arthritis. Petitioner necessitated diagnostic imaging, medication, physical therapy, and surgery.

Specifically, on March 18, 2013, Dr. Ulrich performed a partial medial meniscectomy, chondroplasty of the patella and medial condyle with abrasion arthroplasty of the medial tibial plateau. The operative report noted a Grade 4 arthritic area also on the medial plateau. Petitioner's post-operative diagnoses were medial meniscal tear of the right knee, Grade 3 chondrosis of the medial condyle and patellofemoral joint. Petitioner then underwent three Euflexxa injections to the right knee. Despite treatment, Petitioner continued to experience intermittent pain in her right knee. She experienced difficulty with sleeping and standing for long periods of time. A hinged knee brace was recommended and it was suggested that Petitioner would need a total knee arthroplasty in the future.

At the Section 12 examination with Dr. Paletta on September 30, 2013, Dr. Paletta noted that Petitioner lacked some flexion compared to the left knee, she had mild peripatellar tenderness, and mild patellofemoral crepitance. Petitioner also exhibited moderate medial joint line tenderness. X-rays of the right knee were taken at the Section 12 examination and demonstrated degenerative changes involving the medial and patellofemoral compartments. There was also some mild joint space narrowing and osteophyte formation. Dr. Paletta diagnosed Petitioner with symptomatic medial compartment and patellofemoral compartment degenerative joint disease of the right knee, and status post arthroscopy with partial medial meniscectomy.

As of the date of arbitration, Petitioner stated that she continued to have swelling and pain, but that it was manageable. The Commission assigns this factor great weight.

In light of the foregoing, with no single enumerated factor being the sole determinant of disability, the Commission finds that a PPD award of 20% LOU of the right leg is more appropriate and in line with the totality of the evidence in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed December 27, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and causally related medical bills pertaining to the right knee, as detailed in Petitioner's Exhibits 6 through 9 totaling $21,305.83, pursuant to Section 8(a) of the Act and to be adjusted in accord with the medical fee schedule provided in Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to credit for medical bills paid through its group medical plan for which credit may be allowed 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.

19IWCC0628

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $404.00 per week for 10 2/7 weeks, commencing March 18, 2013 through May 28, 2013, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $363.60 per week for 43 weeks, because the injuries sustained caused 20% loss of use of the right leg, as provided in Section 8(e) of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,200.00. 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 21 2019

D. Douglas McCarthy

DDM/pm
O: 11-6-19
052

Stephen J. Mathis

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 rely on the Arbitrator's detailed findings and would affirm and adopt the Arbitrator's Decision in its entirety.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MATTINGLY, PATTY
Employee/Petitioner

Case# **13WC011683**

NORTH AMERICAN LIGHTING INC
Employer/Respondent

19IWCC0628

On 12/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0157 ASHER & SMITH
CRAIG SMITH
1119 N MAIN ST PO BOX 340
PARIS, IL 61944

5791 LAW OFFICE OF STEPHEN A CARTER
PO BOX 934
MINOOKA, IL 60447

19IWCC0628

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

PATTY MATTINGLY,
Employee/Petitioner

v.

NORTH AMERICAN LIGHTING, INC.,
Employer/Respondent

Case # **13** WC **11683**

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 **Urbana**, on **11/20/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident 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 _____

On **11/28/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being as it relates to her right leg/knee ***is*** causally related to the accident on 11/28/13 through 1/11/13.

In the year preceding the injury, Petitioner earned $**31.512.00**; the average weekly wage was $**606.00**.

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

Petitioner ***has*** received all reasonable and necessary medical services through 1/11/13.

Respondent ***has or will*** pay all appropriate charges for all reasonable and necessary medical services for petitioner's right knee/leg through 1/11/13.

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**2,965.34** in nonoccupational indemnity benefits in the form of short term disability benefits, for a total credit of $**2,965.34**.

ORDER

The petitioner's current condition of ill-being as it relates to petitioner's right leg/knee is causally related to the injury on 11/28/12 through 1/11/13.

Respondent shall pay all reasonable and necessary medical services for petitioner's right leg/knee from 11/28/12 through 1/11/13. Respondent is not responsible for any medical expenses related to petitioner's right leg/knee after 1/11/13 given that the arbitrator finds the petitioner's current condition of ill-being as it relates to her right leg/knee is not casually related to the injury on 11/28/12 after 1/11/13, due to an intervening injury on 1/12/13.

Respondent shall be given a credit for medical benefits that have been paid for the right leg/knee from 11/28/12 through 1/11/13, 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 no temporary total disability benefits as provided in Section 8(b) of the Act given that the period of time petitioner is claiming temporary total disability benefits is after 1/11/13, the last day petitioner's right leg/knee condition is causally related to the injury petitioner sustained on 11/28/13, due to an intervening injury on 1/12/13.

Respondent shall pay Petitioner permanent partial disability benefits of $363.60/week for 10.75 weeks, because the injuries sustained caused the 5% loss of the right leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

12/13/18
Date

ICArbDec p. 2

DEC 27 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 54 year old subassembly operator, sustained an accidental injury to her right leg/knee that arose out of and in the course of her employment by respondent on 11/28/12. Petitioner's job entailed grabbing a raw product from the rack on her right, placing it in her workstation, assembling and wrapping the product, and then placing it in a tote on the finished goods rack to her left. She testified that her job required a lot of twisting and turning because of her workstation configuration and her coworkers working so close behind her.

Petitioner testified at trial that while performing this task on 11/28/12 she injured her right knee when she went to place the product in the tote on the finished good rack. Petitioner testified that after she completed assembling a product she twisted to the left to put the product in the tote on the shelf and felt a very loud pop in her right knee, followed by pain and swelling in her right knee. Following this injury she notified her boss and was taken to the first aid room by a first responder.

In the first aid room she completed an accident report. Petitioner testified that "sidestep" to her meant taking a step to the side and turning so as not to be in the way of the worker behind her. She testified that at the time of the injury, after assembling the product, she took a step, turned to the finishing rack and then put the part in the tote on the rack. She testified that she sidestepped with her left leg and then twisted and turned with her right leg. She also testified that "pop" and "ping" mean the same thing to her.

Petitioner completed an Accident Report. She reported that she "build LED and side step to put in tote. Felt a ping in the back of the right knee. Started to swell and call a first responder." She complained of right knee swelling and discomfort.

After she completed her accident report the first responder suggested that she go to the emergency room. Petitioner called her husband and he took her to the emergency room at Paris Community Hospital. Petitioner gave a history to the nurse of "stepped sideways and felt sudden pain in back of right knee this am at work (NAL), pain has gotten a little worse since this am". Petitioner gave a history to the doctor of "stepped on the side and resulted in acute pain, back of the right knee, which worsens progressively and radiated to the medial aspect of the knee, no fall, no h/o arthritis or bakers cyst. Was able to walk on the knee, did not felt that knee is going to away, did feels that knee is swollen and has dull pain now on scale of 1-10 as 7 or 8." Petitioner complained of pain in back of right knee radiating to medial side and down leg. Mild swelling was noted in the right medial knee. X-rays of the right knee revealed osteoarthritis and joint effusion. Petitioner was diagnosed with a knee sprain. She was given an ACE wrap and prescription for ibuprofen. She reported that this was a new problem. She was discharged and instructed to go to Occupational Health for drug test before leaving hospital.

On 11/29/12 petitioner presented to Dr. Phipps at Paris Community Hospital Family Medical Center. Dr. Phipps noted that petitioner "took a step, felt a 'pop' in back of knee. Pain with some discomfort and swelling." Dr. Phipps noted full range of motion of the right knee, minimal swelling, and small effusion. He assessed a strain of the right knee. He recommended ice, ACE bandage and Aleve. Dr. Phipps released petitioner to full duty work without restrictions as of 11/30/12.

Petitioner testified that when she returned to her regular duty job she took it a little slower and walked a little different. She testified that after work her knee would hurt and she would ice and elevate it at home. Petitioner testified that she continued working her regular duty job through the early part of December 2012.

On 12/11/12 petitioner presented to Dr. Brower at MOHA, the company clinic in the plant. She gave a history of "working at her LED station and took a side step to the left, developed sudden pain along the left distal thigh, medial knee area." She stated that her right knee swelled immediately. Petitioner was continued on regular duty. Dr. Brower examined petitioner and noted that given the relatively nontraumatic mechanism of injury, just a small side step, that petitioner most likely had some degeneration of the medial meniscus secondary to osteoarthritis. Dr. Brower prescribed prednisone. He also recommended some range of motion exercises.

On 12/18/12 petitioner was again seen at MOHA, but by Jennifer Frank, APN. Petitioner continued with complaints of some tenderness along the medial aspect of the right knee, and into the posterior knee. She reported that the prednisone upset her stomach so she stopped taking it. She stated that she was using Aleve. An examination revealed tenderness about the right knee and some swelling. Petitioner demonstrated good range of motion. Petitioner was assessed with right medial knee pain, and prescribed Mobic and physical therapy onsite. Frank noted that petitioner was doing her regular job.

On 1/8/13 petitioner saw Patricia Quint, FNP-BC at MOHA. Petitioner reported persistent pain in her right knee. Petitioner reported that she was "turning and pivoting at her station when she felt a sharp pulling sensation on the posterior aspect of the knee." She rated her pain at 6.5/10. She complained of a burning sensation to the back of her knee. The physical therapy order needed to be rewritten. It was, and petitioner was prescribed therapy 2-3 times a week for 4 weeks. An examination revealed no instability. She had full range of motion with discomfort. Petitioner reported significant discomfort in her posterior cruciate ligament. Minimal edema was noted. Petitioner was tender to palpation along the medial aspect and in the posterior medial aspect. Petitioner was continued on regular duty and therapy was reordered.

Between 1/8/13 and 1/22/13 petitioner underwent 5 sessions of physical therapy. On 1/9/13 petitioner reported that her right knee was "singing" to her. She reported knee pain at a 9/10. Petitioner reported pain with exercises. On 1/10/13 petitioner reported that her right knee pain woke her up during the night. She also reported a pulling in her hamstrings and calf. She rated her pain at a 6/10.

On 1/12/13 petitioner was at home clearing dishes. She testified that she stepped wrong or twisted her right knee and had an "AAH HAA" moment. She testified at trial that this increased pain lasted only 2 minutes before her pain returned to baseline.

Petitioner worked her regular job on 1/13/13 and then underwent another physical therapy session. On 1/17/13 petitioner reported her right medial pain as an 8/10. She stated that she was not able to bend her knee much. She also reported that on Saturday she got up to clear dishes and her right knee popped. She reported some burning/tingling in her right medial knee and pain down her right medial calf. Exercises were limited due to petitioner's right knee pain. Petitioner reported increased pain with increased gait difficulty since her right knee popped on Saturday.

On 1/22/13 petitioner underwent another physical therapy session. It was noted that petitioner was unable to do her exercises because she was unable to lie flat due to the pain in her back. She reported her right knee seemed to be getting worse since it "popped" on 1/12/12 (sic) while clearing dishes from the table. She also reported that her pain was significantly worsening, and was so severe that she would even be willing to go to the emergency room to receive an injection for her relief, even though she does not typically enjoy receiving injections. The therapist noted that there was a limited treatment intolerance secondary to the pain.

On 1/22/13 petitioner presented to Quint at MOHA for her ongoing knee pain. She apologized for missing her last appointment because she was ill. She reported that her right knee pain had significantly worsened. She stated that her pain was pretty severe in physical therapy that morning. She stated that her lower back was beginning to bother her because she was compensating for her right knee. She reported a back injury in June of 2012 but stated that the pain resolved and she had been pain free until now. She gave a history of clearing dishes from her table at home on 1/12/13 and felt a pop in her right knee. She reported that since then her pain had been significantly worse. An examination revealed extreme tenderness to palpation over the knee particularly on the medial aspect; increased edema to the knee generally; no instability; negative anterior and posterior drawer test; and negative instability noted with varus and valgus maneuvers. An MRI was ordered.

On 1/29/13 petitioner followed up with Dr. Brower at MOHA. Petitioner reported that her right knee was getting worse. She reported trouble bending it, and burning along the medial aspect of the knee when she tried

to flex it. She stated that she was taking Aleve plus 2 Tylenol every 4 hours. Petitioner was able to fully extend the knee but could only flex it approximately 90 degrees. She had marked tenderness medially. No swelling posteriorly. Dr. Brower assessed right medial knee pain, most likely a medial meniscal degenerative tear. He did not believe her current symptoms were related to her job activities, given that she was merely taking a small lateral step, which does not put any pressure on the knee joints. He recommended Diclofenac gel applied 4x a day to the right knee. He reviewed the x-ray of the right knee and noted that it showed moderate joint effusion in the supra patellar bursa, and vertebral spurs involving the articular margin medially of the femur and tibia, consistent with osteoarthritis.

On 2/5/13 petitioner saw Sandra Elliott, APN-C at MOHA. She reported that her symptoms were unchanged. She stated that she was waiting for the MRI to be approved and was working her regular duty job without problems. She denied any knee locking, catching, or giving way. She reported that the knee would occasionally pop. Petitioner was examined and continued on regular work status. She was prescribed Tramadol every 6 hours as needed for pain.

On 2/15/13 petitioner presented to the office of Dr. Ulrich at UAP Clinic in Terra Haute, Indiana. Petitioner testified that she had heard of Dr. Ulrich and knew him. Petitioner was examined by Billie Thurman, NP. Petitioner gave a history of stepping laterally at work one day and had a pop in her knee and pain laterally and on the knee cap. She also stated that at work she was moving some of her parts and felt a loud pop in her knee. She stated that since then she has had severe pain and swelling. She reported that she was getting to the point where she was having a difficult time finishing her job because of the increased pain and swelling. She stated that the Tramadol makes her sleepy. She also stated that she had tried therapy in the past without relief. She complained of frequent catching and locking. An examination revealed mild effusion; mild edema along the popliteal joint; slight Baker's cyst palpable; pain and tenderness more prominent on the medial joint line; increase in pain with positive medial MacMurray's; mild patellofemoral crepitus with range of motion; and ambulating with a stiff antalgic gait. Thurman's impression was right knee pain, moderate right knee osteoarthritis, and right knee effusion. Thurman noted that the injury was consistent with twisting and turning. An MRI of the right knee was ordered.

On 2/15/13 petitioner underwent an MRI of her right knee. The impression was tearing to the interior surface of the anterior horn of the medial meniscus with degenerative changes of the medial compartment and subchondral marrow edema of the medial tibial plateau, and grade I sprain of the MCL.

On 3/12/13 petitioner was examined by Dr. Ulrich. Dr. Ulrich noted that the MRI showed a right medial meniscus tear, osteoarthritis of the right knee and right knee pain. He noted that the anterior medial meniscal

tear of the right knee was causing petitioner's catching and locking. She had complaints of right knee pain over the anterior medial aspect right in the area of the medial meniscal tear. Dr. Ulrich recommended an arthroscopy.

On 3/18/13 petitioner underwent a right knee partial medial meniscectomy, chondroplasty patella, chondroplasty medial condyle with abrasion arthroplasty of the medial tibial plateau performed by Dr. Ulrich. He also noted that there was a Grade 4 area on the medial platueau. Petitioner followed-up with Dr. Ulrich and Thurman post-operatively on 4/1/13 and 4/15/13. On 4/15/13 petitioner still had mild effusion, and pain directly over the medial joint. Stiffness was noted. Dr. Ulrich performed an injection into the right knee. On 4/22/13 and 4/29/13 petitioner underwent injections into the right knee.

On 5/14/13 petitioner returned to Dr. Ulrich. X-rays showed moderate degenerative changes along the medial condyle and joint space was maintained. She reported pain in her right knee most of the time. She stated that she could not tell a difference since the surgery. Dr. Ulrich noted that petitioner had compartment osteoarthritis with Grade 4 changes. She stated that she noticed a big difference with the Euflexxa. She told Dr. Ulrich that she wanted to return to her regular duty work. Dr. Ulrich recommended a varus unloading brace to see if the medial compartment could be unloaded. He released her to her regular duty work.

On 5/28/13 petitioner returned to her regular duty job. She testified that her right knee was better, but tender. At trial petitioner testified that when she returned to work she noticed more fatigue, and her right leg was swollen and painful. She testified that she wanted to sit and cry it was so bad.

Petitioner follow-up with Dr. Ulrich for right knee complaints on 6/11/13. On that day she reported her pain at a 0 on a scale of 10. However, she also stated that she was starting to have a burning sensation similar to the sensation she had prior to the surgery along the medial quadriceps. She stated that she was starting to walk to the side because of the knee pain. She reported difficulty standing. An examination revealed minimal edema and no pain in the medial joint line. Dr. Ulrich continued her on the unloader brace.

On 7/19/13 petitioner returned to Thurman. She complained of pain when walking and increased pain at night. She stated that she could not wear her knee brace due to swelling. She reported difficulty working. She stated that her right hip was starting to bother her with the way she was working. She stated that she had no relief with Tylenol or Advil. She complained of swelling in her lower extremity and ankle. An examination revealed mild effusion, and pain and tenderness mostly along the medial joint line. Thurman stated that she could work as tolerated. He recommended a knee hinged brace for support. He noted that she would be more comfortable doing more of a sitdown, sedentary type work. He also noted that she would need to continue

follow-up with either steroids or Euflexxa. He was of the opinion petitioner would need a total knee arthroplasty in the future.

On 7/19/13 Dr. Ulrich drafted a letter to whom it may concern. It included a review of her diagnosis and treatment to that point.

On 9/30/13 petitioner underwent a Section 12 examination performed by Dr. George Paletta, at the request of the respondent. In addition to his examination, Dr. Paletta took a history from the petitioner, and reviewed medical records from the emergency room, imaging studies, and her treating physicians. Petitioner reported that she works standing at a table and the work is done at about waist level in front of her. She stated that finished goods have to move from right to left. She lifts the finished goods from the left side of the table to load the finished goods onto a rack. She stated while she was doing her job in the normal fashion on 11/28/12 she stepped to move some of the finished product onto the rack or into tote and felt a pop or pain in her right knee. She stated "I think when it happened it just twisted." She reported that she felt a pop in the posterior aspect of the knee. On examination, petitioner's right knee range of motion was 0 to 120 degrees; she lacked some flexion when compared to the left; mild peripatellar tenderness; mild patellofemoral crepitance; moderate medial joint line tenderness; and her neutral to slight varus alignment was partly correctable with valgus load. Petitioner complained of mild discomfort in her knee. She stated that she could tolerate it so she did not feel that she was ready for a knee replacement. She stated that overall things were reasonably tolerable. She noted intermittent medial sided pain. She was of the opinion that the surgery helped somewhat, but not dramatically. She was very clear she was not interested in a knee replacement at that time. She also stated that she was not terribly interested in additional injections as she did not feel that the viscosupplementation helped her significantly.

Following his examination, petitioner's history, and record review, Dr. Paletta's impression was symptomatic medical compartment and patellofemoral compartment degenerative joint disease of the right knee, and status post arthroscopy with partial medical meniscectomy. Dr. Paletta opined that petitioner had moderately severe medial compartment and moderate patellofemoral compartment degenerative changes, that were clearly longstanding and preexisting, and not in any way related to the incident that occurred on 11/28/12. He was of the opinion that it did not appear as if there was a significant meniscus tear that would have resulted from that incident. He was of the opinion that it was a relatively minor incident without the typical forced flexion or load and rotation that one would expect from a meniscus tear. He further noted that petitioner did relatively well after that event and was able to do her job until a second incident happened at home. Dr. Paletta was of the opinion that petitioner had increasing problems from that point forward. He noted that petitioner

admitted that her symptoms were significantly worse thereafter and that really prompted additional treatment that eventually led to her surgical treatment. Dr. Paletta was of the opinion that her ongoing symptoms were related to her underlying preexisting degenerative joint disease. He opined that the work incident on 11/28/12 did not cause any significant meniscal pathology. He was of the opinion that it was more likely that the incident that occurred at home in January of 2013 was the incident that led to an increase in symptoms requiring additional treatment. He believed a total knee arthroplasty would be a reasonable option if her symptoms were intolerable, however, the petitioner stated that her symptoms were tolerable and she did not want to consider a knee replacement. Dr. Paletta was of the opinion that if petitioner eventually needed a knee replacement it would be as a result of her underlying osteoarthritis. He was of the opinion that petitioner could work full duty as tolerated. He recommended continued symptomatic treatment for her osteoarthritis. He was also of the opinion that petitioner had reached maximum medical improvement as a result of the work injury on 11/28/12.

On 9/4/14 the evidence deposition of Dr. Paletta was taken on behalf of the respondent. Dr. Paletta opined that the work accident of November of 2012 was not a causative factor and was not related to her ongoing knee problems. He opined that her right knee problems were related to her underlying condition. He further opined that the mechanism of injury was not typical or sufficient to cause the reported meniscus tear, and she was not a candidate for any additional surgery short of a total knee replacement and that if she did require additional surgery it is due to her underlying degenerative condition of the knee.

Dr. Paletta was of the opinion that the ultimate diagnosis as revealed in the operative report of degenerative joint disease of the right knee, with advanced chondromalacia of the patella in the medial compartment, with associated degenerative tear of the medial meniscus, is multifactorial and can be related to age, genetics, weight, microtrauma, or history of previous trauma, all which play into the development of osteoarthritis. Dr. Paletta noted that petitioner's chondromalacia was at Grade 3 and Grade 4 on the operative and Grade 4 means that there is bone on bone and the cartilage is worn away. Grade 3 means that the cartilage is at least 50% worn away. He was of the opinion that the operative findings were worse than were predicted by the MRI. Dr. Paletta was of the opinion that a degenerative type tear suggests longstanding chronicity. Dr. Paletta was of the opinion that for an acute meniscus tear the mechanism of injury is a load on the knee with some flexion and some rotation or angular force on the knee as it twists or pivots, accompanied by an angular load on the knee that compresses and shears on the meniscus trapping it between the thighbone and the shinbone resulting in the tear of the meniscus. He was of the opinion that it is rare that compression alone will result in an acute chondral injury, since there usually has to be some shear mechanism to get an acute chondral injury. He was of the opinion that petitioner had a degenerative osteoarthritic condition that would take years to develop.

Dr. Paletta was of the opinion that in an acute meniscus tear of the medial meniscus or an acute chondral injury the pain would be localized primarily to that portion of the knee with swelling. However, petitioner had a more diffuse degenerative condition which included pathology involving the patellofemoral compartment, and the medial compartment, and intermittent swelling, as well as crepitance. Dr. Patella opined that it was more likely than not that petitioner's right knee was symptomatic prior to the injury on 11/28/12 due to the Grade 4 chondromalacia she had on her MRI. Dr. Paletta did not believe the injury on 11/28/12 aggravated petitioner's preexisting degenerative condition since there was no material change in the underlying condition of the knee, or permanent change to the underlying condition of the knee.

Dr. Paletta was also of the opinion that petitioner's history as to the mechanism of the injury was not consistent over time, in that there was increasing detail with respect to her history the further out she got from the initial injury. Dr. Paletta did not believe the mechanism of injury petitioner provided him would be competent or typical for the type of flexion-rotation injury that would usually cause a meniscus tear. Dr. Paletta was of the opinion that all medical providers petitioner saw on 11/28/12 and 11/29/12 saw nothing that would warrant an MRI, injections, surgeries, or assistive devices. Dr. Paletta opined that mild swelling and pain are consistent with a degenerative process. Dr. Paletta was of the opinion that petitioners' symptoms after the dish incident were new and/or different than before the dish incident, and were incapacitating. He also noted that it was not until after this incident that an MRI of the right knee was ordered, and she reported catching or locking in her right knee. Dr. Paletta was of the opinion that it was not until after the dish incident did petitioner have symptoms and physical findings suggestive of a meniscal tear. These symptoms and findings included pain more medially, complaints of mechanical symptoms, specific tenderness along the medial joint line, and a positive MacMurray sign on the medial side of the knee, which is one of the signs that is suggestive of a meniscus tear. Dr. Paletta opined that the symptoms after the 11/28/12 injury and her physical exam were not consistent with a meniscal tear.

On cross examination, Dr. Paletta opined that there was no evidence of an acute meniscus tear or an acute chondral injury, but rather an increase in her symptoms as she reported. Dr. Paletta stated that there are medical records between 11/28/12 through 1/8/13 that include records that state she has swelling, and that her symptoms had not changed from 12/18/12 through 1/8/13. He noted that petitioner's complaints on 1/8/13 included some pain and a burning sensation, which she reported a month and a half earlier. Physical therapy was also recommended at that time. Dr. Paletta was of the opinion that the varus stress test results on 1/8/13 were where her arthritic changes and complex meniscus tear were. He was of the opinion that on 1/8/13 petitioner had a longstanding tear in her right meniscus that was there prior to 11/28/12. Dr. Paletta agreed that the incident on

11/28/12 exacerbated petitioner's preexisting degenerative condition in her right knee, and caused an increase in her symptoms.

On redirect examination Dr. Paletta stated that petitioner did not describe a pivoting injury to Dr. Phipps, Dr. Brower or at the emergency department. Dr. Paletta did not relate petitioner's need for surgery to the work incident or the dish incident, but rather to her arthritis. He was of the opinion that she was headed for surgery regardless of either incident. However, he further testified that petitioner's symptoms, physical exams and all treatment up to the dish incident were not suggestive of a surgical problem or one that even warranted advanced imaging such as an MRI. He testified that this did not occur until after the dish incident.

On redirect examination Dr. Paletta testified that regardless of what petitioner's symptoms were after the injury on 11/28/12 no part of this injury led to, caused, aggravated, or exacerbated the condition to the point where once could connect the surgery to the injury on 11/28/12.

On 6/2/15 the evidence deposition of Dr. Brower, a family medicine and occupational medicine doctor, was taken on behalf of the respondent. Dr. Brower is respondent's company doctor. He was of the opinion that the typical mechanism for a meniscal tear is a fall, a torqueing type injury, or a twisting type injury. He testified that when you are 54 all you have to do is get up out of a chair, and that is enough of a force to cause a meniscal tear. Dr. Brower testified that the operative report noted a degenerative meniscal tear, and that aging and gravity cause degenerative meniscal tears. Dr. Brower noted significant arthritis on the x-ray taken on the date of injury. He was of the opinion that it is more likely than not that petitioner was symptomatic at the time of the injury on 11/28/12. Dr. Brower testified that on 12/11/12 although he suspected petitioner had a degenerative meniscal tear based on her symptoms, he noted that petitioner reported no locking, catching or a feeling that the knee was going to slip out. Dr. Brower opined that the alleged injury she described did not cause or contribute to the meniscal tear, and that the mechanism of injury she described did not cause or contribute to the underlying arthritis because there is no stress involved in a side step. Dr. Brower was of the opinion that the swelling petitioner had when he saw her could have been due to her underlying arthritic condition, and the work injury may not have been a factor in the swelling. Dr. Brower was of the opinion that petitioner's symptoms after the dish incident were worse. Dr. Brower opined that any total knee replacement would not be causally related to the injury on 11/28/12. Dr. Brower testified that respondent could have accommodated just about any restrictions petitioner had.

On cross examination Dr. Brower opined that the injury on 11/28/12 could not have temporarily aggravated her condition.

Petitioner testified that she continued working for respondent until 4/4/16. Petitioner had worked 12 ½ years for respondent. On that day petitioner was walked out because she had been off work and had no more time off to use because of her husband being sick. Petitioner testified that since she was released from care she continued to have some swelling, and is not pain free. She testified that she took ibuprofen, and ices and wraps her right knee when it is really bad.

On 12/8/16 the evidence deposition of Dr. Gary Ulrich, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Ulrich opined that the history of twisting at work is consistent with a medial meniscal tear and the need for surgery. He opined that his post operative diagnosis was consistent with the medial meniscus tear. Dr. Ulrich testified that the injections into petitioner's knee were for her arthritis. He opined that petitioner's arthritis existed prior to the injury, and the work injury exacerbated it. He noted that on 7/19/13 when Thurman last examined petitioner that the possibility of a total knee arthroplasty was noted. He opined that a total knee replacement that may be needed in the future could be as a result of the aggravation and/or injury on 11/28/12.

On cross examination Dr. Ulrich stated that he was not aware that petitioner treated with any other providers before she came to see him, other than the referral from Dr. Phipps. He did not see Dr. Phipps, Dr. Paletta or Dr. Brower's records. He was not aware that petitioner's complaints changed over time. He testified that the only accident history had was in the record on 2/15/13. He testified that he relied on what Thurman stated and wrote with respect to the mechanism of injury. He noted that he was not aware if petitioner was symptomatic or asymptomatic prior to the injury on 11/28/12. He testified that arthritis or articular cartilage wear can occur acutely or as a function of time and over the years. He stated that Grade 4 is the most severe loss of articular cartilage, and tends to be very symptomatic because nerve endings are exposed and there is bone on bone. He stated that grade 4 is complete loss of the articular cartilage. Dr. Ulrich noted Grade 3 chondromalacia under the kneecap, Grade 3 arthritis on the end plate for the medial femoral condyle, Grade 3 lesion on the bottom of the medial femoral condyle, and Grade 4 lesion on top of the medial tibial plateau. Dr. Ulrich was of the opinion that medial findings could correlate with lateral complaints.

Dr. Ulrich testified that he did not see the accident report petitioner filled out. He also did not see the emergency room records, and did not know if restrictions were placed on petitioner by the emergency room or Dr. Phipps. Dr. Ulrich was unaware that the accident history at the emergency room, in the accident report, and to Dr. Phipps and Dr. Brower were all similar and reflect that petitioner simply sidestepped. He noted that the comment section of his report on 2/15/13 notes that petitioner simply stepped laterally. He testified that he believed that petitioner's complaint of catching and locking, and increased pain and swelling appeared to be part of the whole history of symptoms since November of 2012. Dr. Ulrich testified that petitioner never told him

about an incident that may have caused increased pain or a change in her symptoms, other than the injury on 11/28/12. Dr. Ulrich testified that he was only interested in his history and physical as it was presented at the time of his evaluation. Dr. Ulrich testified that he had no way of knowing whether petitioner's right knee complaints changed in degree after the alleged incident at home while she was clearing dishes. He stated that he had no record of any injury at home. Dr. Ulrich admitted that petitioner's osteoarthritis and degenerative conditions were mentioned during her postoperative treatment plan, but not specifically stated as an aggravation from the injury. Dr. Ulrich noted that although petitioner was instructed to follow up 3-4 months after her 7/19/13 appointment she did not return. Dr. Ulrich testified that he has no way of knowing what petitioner's right knee condition presently is, and what future treatment is needed, since he had not seen her since 2013.

In February of 2017 petitioner began working in the home healthcare field. She stated that she still works in this field. She testified that still has pain and swelling in her right knee, and has difficulty getting up off the floor and needs to grab onto something to get up. Petitioner has not sought any treatment since she was released from care by Dr. Ulrich in May of 2013. Petitioner denied any problems or treatment for her right knee prior to 11/28/12.

On 11/3/17 Dr. Paletta drafted a letter to Stephen Carter, respondent's attorney, after receiving a letter from him dated 8/14/17. Included with the letter was a copy of his deposition transcript of 9/4/14, Dr. Brower's deposition transcript of 6/2/15, and Dr. Ulrich's deposition testimony of 12/8/16. After reviewing all these documents Dr. Paletta was of the opinion that his opinions had not changed. He was of the opinion that Dr. Brower and Dr. Ulrich's testimony reinforced his original opinions, specifically as it calls into question the petitioner's credibility concerning the alleged mechanism of injury, and his opinion the petitioner's right knee condition was not caused, and is not related to the work injury. Dr. Paletta believed that Dr. Ulrich's history regarding the mechanism of injury appeared to be based more on hearsay, than on any direct report from the petitioner given to him directly. He was of the opinion that Dr. Ulrich did not review any of the medical records from the emergency room or other treating physicians documenting the reported mechanism of injury. He noted that there was nothing contained in Dr. Ulrich's deposition that in any way changes his opinions articulated in the IME report or his evidence deposition.

On 12/29/17 a second deposition of Dr. Paletta was taken on behalf of respondent. Dr. Paletta opined that reviewing the depositions of Dr. Ulrich and Dr. Brower reinforced his opinion that petitioner's meniscus tear was not related to the work injury, that petitioner's underlying knee condition was neither caused by nor related to the work injury, and that the surgery was not related to the work injury. Dr. Paletta questioned the credibility of petitioner because her accident history changed over time and became more detailed and robust the further

she got out from the initial injury. Dr. Paletta finds the most accurate history tends to be the one given closest to the time of the injury. He viewed petitioner's changing accident history to be consistent with secondary gain. Dr. Paletta was of the opinion that Dr. Ulrich's opinions were not based on a complete record from the time of injury up to his examination. Dr. Paletta was of the opinion that petitioner was demonstrating a pretty clear example of the natural history of progressive osteoarthritis, and once the symptoms reach the point where petitioner can't tolerate it anymore, then a joint replacement would be appropriate. However, the need for that replacement would be as a consequence of the natural history and progression of her osteoarthritis and not a result of her work injury. Dr. Paletta was of the opinion that if there had been an aggravation, acceleration or exacerbation of her preexisting condition as a result of the injury, she would have already had a knee replacement. He opined that given the severity of her arthritis and Dr. Ulrich's finding during surgery, petitioner would more likely than not end up with a knee replacement at some point. Dr. Paletta was of the opinion that the natural history of osteoarthritis is a slowly progressive condition with waxing and waning episodes of symptoms. He opined that the natural progression of her arthritis is what will cause petitioner to have a total knee replacement. Dr. Paletta opined that petitioner sustained a knee strain as a result of the injury on 11/28/12 that resolved before the surgery was performed.

On cross examination Dr. Paletta testified that one cannot tell from an MRI scan or arthroscopy when the meniscus tear occurred, but it is his belief and opinion that dish incident either caused the meniscus tear or caused an aggravation of the meniscus pathology that was previously asymptomatic. He then testified that based on the history petitioner provided him and the mechanism of injury as it relates to the dish incident that the dish incident resulted in symptoms related to the underlying meniscus tear. He could not opine that the dish incident is when petitioner's meniscal tear occurred. Dr. Paletta was of the opinion that meniscus tears are more common in people with osteoarthritis, and activities that put pressure on knees, such as just a rotation of the knee can cause a meniscal tear.

Dr. Paletta opined that regardless of what the cause or the aggravation of the meniscal tear was, it has nothing to do with the need for a knee replacement. He was of the opinion that the need for a knee replacement is the natural progression of the osteoarthritis. He opined that the initial injury, no matter how petitioner described it, was not a competent mechanism for tearing a meniscus or aggravating arthritis.

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

Petitioner alleges that her current condition of ill-being as it relates to her right knee is causally related to the injury on 11/28/12. Respondent disputes, and claims that petitioner's current condition of ill-being as it relates to her right knee is only causally related to the injury on 11/28/12 until 1/11/13.

One of the key issues in this case revolves around the actual mechanism of injury. Petitioner provided an accident history to multiple providers that over time evolved and ended up being vastly different at trial than it was most contemporaneous to the injury on 11/28/12.

On 11/28/12, shortly after the injury, petitioner provided her first accident history in the form of an accident report she completed. She wrote that she "built LED and side step to put in tote. Felt a ping in back of right knee. Started to swell." She was then taken to the hospital and provided her next two accident histories. To the nurse she reported "stepped sideways and felt sudden pain in back of right knee this am at work (NAL), pain has gotten a little worse since this am." To the doctor she stated "stepped on the side and resulted in acute pain, back of the right knee, which worsens progressively and radiated to the medial aspect of the knee." She reported that she could walk and did not feel the knee was going to give way. None of the three accident histories provided on the day of the injury include a history of twisting her right knee.

The next day, petitioner presented to her primary care doctor, Dr. Phipps. Her accident history was noted as "took a step, felt a "pop" in back of knee." Petitioner had minimal swelling, but had full range of motion. Again, there is no history of any twisting or turning of the right knee. This brings the total to 4 accident histories provided by petitioner on the day of and day after the injury that include no twisting injury.

Petitioner's next treatment is on 12/11/12 with Dr. Brower at the company clinic. Petitioner provides a history of "working at her LED station and took a side step to the left, developed sudden pain along the left distal thigh and medial knee area." This is now 5 accident histories that do not include a twisting or turning motion with her right knee. At the conclusion of this examination Dr. Brower noted that given the relatively nontraumatic mechanism of injury, just a small step, that petitioner most likely had some degeneration of the medial meniscus secondary to osteoarthritis. On 12/18/12 petitioner continued to complain of right knee pain along the medial aspect with some swelling. She also continued to demonstrate good range of motion.

On 1/8/13 petitioner returned to MOHA and for the first time gave a different accident history. On this date she reported that she was "turning and pivoting at her station when she felt a sharp pulling sensation on the posterior aspect of the knee." She rated her pain at a 6.5/10. An examination revealed no instability and continued full range of motion. She was continued on regular duty.

On 1/9/13 petitioner reported knee pain of 9/10 at therapy. Then on 1/10/13 she reported that it was back to a 6/10.

Petitioner then reports that on 1/12/13 she was at home clearing dishes and she stepped wrong and twisted her right knee resulting in an "Ahh Haa" moment. At trial she testified that this increase in pain lasted only two

minutes. However, the credible medical records indicate otherwise. When petitioner returned to therapy on 1/17/13 she gave a history of getting up to clear her dishes on Saturday and her right knee "popped". She reported that her pain was at an 8/10, and she was unable to bend her knee much. Prior to this petitioner had full range of motion of her right knee. Petitioner's exercises were also limited for the first time due to pain in her right knee. She also reported increased pain with increased gait difficulty since her right knee "popped" on Saturday.

Five days later on 1/22/13 she returned to MOHA and reported that her knee pain had significantly worsened, and her low back was beginning to hurt because she was now compensating for her right knee pain, which was never a problem before the twisting and "popping" injury at home while clearing dishes on 1/12/13. Contrary to petitioner's testimony at trial that 2 minutes after the injury on 1/12/13 at home her right knee condition returned to baseline, the arbitrator notes that petitioner reported on 1/22/13 that since the injury on 1/12/13 her right knee pain had been significantly worse. It was only at this point that an MRI of the right knee was ordered. Petitioner continued to report that her right knee was getting worse. She stated that she was having trouble bending it, which was not her complaint prior to 1/12/13, when she had full range of motion. At this time Dr. Brower noted that he did not believe petitioner's current symptoms were related to her job activities, given that she was merely taking a small lateral step, which he was of the opinion did not put any pressure on the knee joints. He noted that the x-rays revealed findings consistent with osteoarthritis.

Dr. Brower was of the opinion that it is more likely than not that petitioner was symptomatic at the time of the injury on 11/28/12 as it relates to her right knee. He opined that the alleged injury petitioner reported occurring on 11/28/12 did not cause or contribute to the meniscal tear, and that the mechanism of injury she described did not cause or contribute to the underlying arthritis because there is no stress involved in a side step. Dr. Brower was of the opinion that the swelling petitioner had when he saw her could have been due to her underlying arthritic condition, and the work injury may not have been a factor in the swelling. Dr. Brower was of the opinion that petitioner's symptoms after the dish incident were worse. He then opined that any total knee replacement would not be causally related to the injury on 11/28/12.

On 2/15/13 petitioner presented to Dr. Ulrich's office. She gave Thurman, Dr. Ulrich's nurse practitioner, a history of "stepping laterally at work one day and had a pop in her knee and pain laterally and on the knee cap." The arbitrator notes that this history is not consistent with the accident histories most contemporaneous to the injury. She provided no history of the incident on 1/12/13, nor did she ever mention that she twisted or turned her right knee. Given that petitioner did not provide a history of the incident on 1/12/13, Thurman noted that the injury on 11/28/12 was consistent with twisting and turning. By the time petitioner saw Dr. Ulrich on

3/12/13 she was reporting catching and locking, which she never reported before 1/12/13. She also did not provide him with a history of the incident on 1/12/13 or the worsening of her condition since that date. She also never provided Dr. Ulrich with any treating records from 11/28/12 through 3/12/13.

In addition to failing to provide Dr. Ulrich or Thurman with a history of twisting/turning injury on 1/12/13, as well as the failure to provide them with any treatment records from 11/28/12 through 3/12/13, the petitioner provided an accident history at trial on 11/21/18 that included a twisting, turning, popping injury on 11/28/12 that was inconsistent with all medical records and accident reports most contemporaneous to the injury. Based on these significant inconsistencies, the arbitrator finds the petitioner's testimony at trial, and her accident histories after 12/11/13 as they pertain to the injury on 11/28/12 to be less than credible, and self serving.

Petitioner would like the arbitrator to rely on the opinions of Dr. Ulrich in determining whether or not her current condition of ill-being as it relates to her right knee is causally related to the injury she sustained on 11/28/12. However, given that petitioner provided Dr. Ulrich and Thurman with an accident history inconsistent with those most contemporaneous with the injury, did not provide Dr. Ulrich with her treatment records from any other providers beginning 11/28/12, and also did not share with Dr. Ulrich the incident on 1/12/13 and the fact that her right knee symptoms worsened significantly after that incident, the arbitrator finds Ulrich's opinions less than persuasive given that they are not based on the entire credible record.

The arbitrator next looks at the casual connection opinions of Dr. Paletta. Dr. Paletta examined petitioner on 9/30/13. Petitioner reported that she stepped to move some of the finished product onto the rack or into a tote and felt a pop or pain in her right knee. She then went further and reported "I think when it happened it just twisted." Again, the arbitrator finds petitioner provided a history that was partially inconsistent with the accident histories provided most contemporaneous to the injury.

Dr. Paletta not only examined petitioner, but he also reviewed the medical records dating back to 11/28/12. He opined that petitioner had moderately severe medial compartment and moderate patellofemoral compartment degenerative changes, that were clearly longstanding and preexisting, and not in any way related to the injury on 11/28/12. He opined that it does not appear that there was a meniscus tear that would have resulted from the injury on 11/28/12. He opined the injury on 11/28/12 was a relatively minor incident without the typical forced flexion or load and rotation that one would expect from a meniscus tear. He also noted that petitioner was able to continue to work until after the intervening injury on 1/12/13, after which she experienced significant worsening symptoms with her right knee that prompted additional diagnostic tests and surgery. He noted that it was significant that the operative findings were worse than the MRI showed and that a degenerative

type tear suggests longstanding chronicity. Dr. Paletta was of the opinion that for an acute meniscus tear the mechanism of injury is a load on the knee with some flexion and some rotation or angular force on the knee as it twists or pivots, accompanied by an angular load on the knee that compresses and shears on the meniscus trapping it between the thigh bone and the shin bone resulting in the tear of the meniscus. Given the fact that Dr. Paletta took the time to not only examine petitioner, but to review the entire credible medical record, the arbitrator finds Dr. Paletta's opinions more persuasive.

Based on the opinions of Dr. Paletta and Dr. Brower, the arbitrator finds its significant that when petitioner was going from the workstation to the rack, regardless of whether she side stepped or twisted, the load would have been on her left leg, not her right leg, thus making it unlikely that any tear to right knee would have been caused by the injury on 11/28/12 given that the load when she turned was on her left leg, not her right. The arbitrator also finds it significant when petitioner provided her mechanism of injury to various healthcare providers regarding the "dish incident" on 1/12/13 she specifically reported that the load was on her right leg when she twisted her right leg/knee, and this resulted in a significant change in her symptoms and the need for additional medical treatment, diagnostic tests, and ultimately surgery. Based on the credible evidence, the arbitrator finds the petitioner's testimony that within 2 minutes after the intervening incident on 1/12/13 her right knee was back to how it was before the incident, unsupported by the credible records, thus bringing the petitioner's credibility into question.

Based on the above, as well as the credible record, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that her current condition of ill-being as it relates to her right leg is causally related to the injury on 11/28/12 after 1/11/13. The arbitrator further finds the petitioner's current condition of ill-being as it relates to her right leg is causally related to the intervening accident petitioner sustained at home on 1/12/13 when she twisted her right knee placing dishes away and experienced a significant increase in her symptoms and physical findings that were new or different than before 1/12/13, and were also incapacitating, thus resulting in the need for additional treatment including injections, and a recommended surgery that had not been recommended prior to the incident on 1/12/13.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner's condition of ill-being as it relates to her right leg/knee only causally related to the injury on 11/28/12 through 1/11/13, the arbitrator finds all treatment for petitioner's right leg/knee through 1/11/13 was reasonable and necessary to cure or relieve petitioner from the effects of her injury on

11/28/12. The arbitrator finds all treatment to petitioner's right leg/knee after 1/11/13 causally related to the intervening injury she sustained to her right leg/knee on 1/12/13.

The arbitrator finds the respondent has or will pay all reasonable and necessary medical expenses related to petitioner's right leg/knee from 11/28/12 through 1/11/13. The arbitrator bases this opinion on the opinion of Dr. Paletta that petitioner was at maximum medical improvement with respect to the right knee strain she sustained as a result of the injury on 11/28/12 in early January of 2013, before the intervening accident on 1/12/13.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The petitioner claims she is entitled to temporary total disability benefits from 3/18/13 through 5/28/13. Having found the petitioner's condition of ill-being as it relates to her right leg/knee only causally related to the injury on 11/28/12 through 1/11/13, and the claimed period of temporary total disability benefits is after this date, the arbitrator finds the petitioner is not entitled to any temporary total disability benefits.

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

For injuries that occurred after 9/1/11, according to 820 ILCS 305/8.1B(b) the Commission shall base its determination of permanent partial disability based upon five factors including an AMA report, the occupation of the injured employee, the age of the employee at the time of injury, the employee's future earning capacity and evidence of disability corroborated by treating medical records.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA rating was offered into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the petitioner was a subassembly operator at the time of the injury. Between 11/28/12 and 1/11/13 petitioner continued to perform her regular duty job. It was not until after the intervening injury on 1/12/13 that petitioner lost any time from work. For these reasons the arbitrator gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 54 years old at the time of the accident. Following the injury on 11/28/12 petitioner continued working her full duty work without restrictions until the intervening accident on 1/12/13. Therefore, the arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that the petitioner offered no evidence regarding her future earnings capacity based solely on her condition as of

1/11/13. As of that date petitioner was working full duty without restrictions and her earnings capacity remained unchanged. Therefore, the arbitrator gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds petitioner the petitioner was diagnosed with a right knee strain on 11/28/12 following the injury. Petitioner had complaints of some discomfort and swelling. On 11/29/12 Dr. Phipps also diagnosed petitioner with a strain of the right knee. On 1/8/13 petitioner reported persistent pain in her right knee. An examination revealed no instability, and she had full range of motion with discomfort. Only minimal edema was noted. She was continued on regular duty. Petitioner continued to complain of right knee pain until 1/12/13 when she sustained an intervening accident and her symptoms in her right knee increased significantly and she experienced increased gait difficulty. Petitioner herself reported on 1/22/13 that after the intervening incident in 1/12/13 her pain worsened significantly, and was so severe that she would even be willing to go to the emergency room to receive an injection for her relief. Her pain continued to worsen and she also complained of low back pain due to overcompensating for her right knee pain. It was only at this point that an MRI was ordered, petitioner underwent injections in her right knee and a surgery to her right knee.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that prior to 1/11/13 the petitioner continued to work her regular duty job and had only been diagnosed with a right knee strain. Petitioner had complaints of some discomfort and swelling and was in therapy before the intervening injury on 1/12/13. As a result, the arbitrator finds the petitioner sustained a permanent partial disability to the extent of 5% loss of use of his right leg pursuant to Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Johnson Barnes,

Petitioner,

vs. NO: 18WC 17580

Total Airport Service,

Respondent.

19IWCC0629

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, prospective medical, temporary total disability, fees, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 14, 2019, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 1 2019
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DDM/jrc
052

D. Douglas McCarthy
Douglas McCarthy

Stephen J. Mathis
Stephen Mathis

L. Elizabeth Coppoletti
L. Elizabeth.Coppoletti

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

JOHNSON BARNES, JACQUELINE
Employee/Petitioner

Case# **18WC017580**

TOTAL AIRPORT SERVICE
Employer/Respondent

19IWCC0629

On 2/14/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0243 JAMES ELLIS GUMBINER & ASSOC
CHRIS COOPER
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

1454 THOMAS & PORTELA
DANA DJOKIC
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS	)	___Injured Workers' Benefit Fund (4(d)
	)SS	___Rate Adjustment Fund (8(g)
COUNTY OF COOK	)	___Second Injury Fund (8(e)18)
	)	_X_None of the above

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

Jacqueline Johnson Barnes, Case #: **18 WC 17580**

Employee/Petitioner,
-vs-

19IWCC0629

Total Airport 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 **Robert M. Harris**, on **November 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._X_ Was timely notice of the accident given to Respondent?
F._X_ Is Petitioner's current condition of ill-being causally related to the injury?
G.___ What were Petitioner's earnings?
H.___ What was Petitioner's age at the time of the accident?
I.___ What was Petitioner's marital status at the time of the accident?
J._X_ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K._X_ Is Petitioner entitled to any prospective medical care?
L._X_ What temporary benefits are in dispute?
___TPD ___Maintenance _X_TTD
M._X_ Should penalties or fees be imposed upon Respondent?
N.___ Is Respondent due any credit?
O.___ Other_____

FINDINGS

On the date of accident **April 24, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year next preceding the accident, Petitioner earned **$23,346.96**; the average weekly wage was ***$448.98***.

On the date of accident, Petitioner was ***56*** years of age, ***single*** with ***5*** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for 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 of ***$0.00***.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $299.32 per week for a period of 2-4/7 weeks, from May 21, 2018 through her release from treatment for her compensable cyst on June 7, 2018, as provided under Section 8(b).

Respondent shall pay Petitioner medical expenses under Section 8(a) and the commission fee schedule under 8.2 for all medical care and treatment rendered to her **relating solely to her aggravated pre-existing sebaceous cyst**; any and all other claims for payment and authorization for medical care and treatment, past, present and future, are denied, including specifically the prospective treatment recommended by Dr. Murtaza. Only Petitioner's pre-existing aggravated sebaceous cyst is causally related to this claim.

This Decision will not serve as a bar to further proceedings that are not inconsistent with this decision.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for 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 Robert M. Harris

February 14, 2019
Date

FINDINGS OF FACT:

The Arbitrator heard the testimony of five (5) witnesses (including Petitioner) and has reviewed the various exhibits that were introduced into evidence.

Petitioner testified she was employed by Respondent and that on April 24, 2018, she was working in a warehouse (Arb. Tran. p. 12). Petitioner testified she went to retrieve materials and was in the process of walking between 2 forklifts when they began to back-up. Petitioner testified she turned to try to avoid the forklifts by turning but was struck by the forklift that was driven by Cordell Gaines. Petitioner testified the forklifts had just started to back up and that neither driver was looking back when she was struck on the back. Petitioner testified she did not fall down but that it was a jolt and that she felt a burning and pressure on her back (Arb. Tran p. 13 – 15). Petitioner testified the driver (Cordell) was wearing earbuds (Arb. Tran. p. 16) and he stopped when she screamed. Petitioner testified she told Cordell that he hit her and she was going to report the incident to a supervisor; however, she testified that she could not find him (Arb. Tran. p. 16). Petitioner testified that she worked the remainder of the day (Arb. Tran. p. 17).

Cordell Gaines testified for Respondent (Arb. Tran. p. 176 – 201). Gaines testified he no longer works for Respondent and he was terminated in October, 2018 for unknown reasons unrelated to this incident (Arb. Tran. p. 177). Gaines testified he remembered this incident (Arb. Tran. p. 179). Gaines denied ever hitting Petitioner (Arb. Tran. p. 179 & 186). Gaines testified that he had started to back up when he saw the petitioner (Arb. Tran. p. 180) and braked to avoid her. Gaines testified he got off the forklift and asked her if he had hit her and if she was all right (Arb. Tran. p. 181 & 198). Gaines testified Petitioner denied being hit and denied being injured in the incident. Gaines testified that if he had hit her, he would have felt it (Arb. Tran. p. 187). Gaines also testified he was not wearing earbuds because it was against Respondent's safety policies (Arb. Tran. p. 179). Gaines testified that while there was noise, he would have heard Petitioner had she screamed (Arb. Tran. p. 187). Gaines testified that though that the petitioner worked for several days after this incident (Arb. Tran. p. 187).

Torrence Sumerlin, Petitioner's supervisor, testified (Arb. Tran. p. 144 – 175). Sumerlin denied Petitioner ever reported a work accident (Arb. Tran. p. 147) and, as a result, he never completed an incident report (Arb. Tran. p. 147). Sumerlin testified he was always available during work hours (Arb. Tran. p. 149) and if he was not there, Petitioner could report to another supervisor (Arb. Tran. p. 156). Sumerlin testified he did not recall receiving a voice mail message but acknowledge receiving a text message in late May, 2018 (Arb. Tran. p. 160 – 172). Sumerlin testified he did not fill out an incident report after that contact because the information was vague as to when and what happened (Arb. Tran. p. 172).

Petitioner testified she also reported this incident to Robert Allbright (Arb. Tran. p 57). Allbright admitted he received a telephone call from Petitioner where they initially discussed FMLA issues but then Petitioner "told me that she was injured." (Arb. Tran. Pp. 92-94). Allbright admitted Petitioner explained that she had a knot in her back and

her doctor said "it was possibly because she got bumped by a forklift." (Arb. Tran. p. 94 – 95). Allbright admitted Petitioner told him, "...she was hit by a forklift." (Arb. Tran. p. 95).

Petitioner first sought medical treatment on April 29, 2018 when she went to Ingalls hospital (Pet. Ex #3). These records indicate Petitioner reported a cyst on her back and a bump that she had for 11 years and that it had worsened since she was struck by a forklift 2 days earlier (4/27/18) when she was hit by a forklift at work. Petitioner was not taken off work at this visit.

Petitioner next saw Dr. Richardson at U of I (Pet. Ex. # 2) on May 2 when she again reported being struck by a forklift at work on April 27, 2018. This initial treatment was for the cyst on Petitioner's back (Pet. Ex #2 & 3). These records do not show Petitioner was taken off work.

The first records indicating when Petitioner was authorized off work is from Dr. Richardson at U of I dated May 21, 2018 (Pet. Ex #2). The note under "Plan" indicates, "...rest from work till next wound check." This same notation is also found in records dated May 23 and May 29. The records entry dated June 7 indicates, "...will defer return to work assessment to workers; comp physician." However, there is no such further assessment found regarding Petitioner's resolved cyst and return to work status.

Petitioner testified (Ar. Tran. p. 68) she first complained of neck/should/back complaints when she went to Dr. Murtuza approximately one month after the alleged accident (Pet. Ex #1). He performed an injection and is now recommending a second injection (Pet. Ex #1 & Arb. Tran. p. 33)

Respondent had Petitioner examined by Dr. Monaco pursuant o Section 12 (Resp. Ex #1 & 2). Dr. Monaco opined Petitioner had a pre-existing cyst that was aggravated by the claimed incident on April 24, 2018. Dr. Monaco opined Petitioner's claimed back/neck injuries, which if they exist, are not related to the alleged work incident (Resp. Ex #1 & 2).

CONCLUSIONS OF LAW:

Although the Arbitrator finds Petitioner's testimony/evidence at times was inconsistent with other evidence and testimony, she appeared credible overall.

With regard to the issue of "C," Accident, "E," Notice, and "F," Causal Connection, the Arbitrator finds the following facts and draws the following conclusions:

The petitioner has the burden of proving each and every element of her claim. *Parro v. Industrial Comm.*, 260 IllApp3rd 551, 196 IllDec 695, 630 NE 2nd 860 (1st D., 1993). An award cannot be based upon speculation, guess or conjecture. Here, Petitioner claims she should be awarded TTD through the date of hearing and medical care, both past and future. The evidence regarding these disputed issues is conflicting; nonetheless, the Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on April 24, 2018. **The Arbitrator emphasizes that her compensable injuries as a result of this accident are limited to only an aggravation of her pre-existing sebaceous cyst on her back.**

Petitioner claims she was struck by a forklift while working for Respondent on April 24, 2018. The Arbitrator finds Petitioner's testimony, Allbright's testimony and the histories found in the medical records (while not entirely consistent) are sufficient to support and prove her accident claim by a bare preponderance of the evidence.

That is, Petitioner's testimony, Allbright's testimony, and the flawed histories in the medical records all corroborate and support Petitioner's claim (to a greater or lesser extent) that she sustained an accident at work on April 24, 2018 when she was mildly struck by a forklift driven by co-worker Gaines.

There is indeed conflicting and inconsistent evidence in the record. However, the preponderance of the evidence supports her claim that Petitioner sustained an accident which only aggravated her pre-existing sebaceous cyst on her back and caused an infection; the evidence leads the Arbitrator to find and conclude that **the minor forklift contact with her body did not cause or contribute to any injury to any other body part,** and, to that extent, all claims related to any body part other than the cyst are therefore denied.

In that regard, the Arbitrator places considerable emphasis, weight and reliance on the expert medical opinions of Dr. Monaco, as found in his September 11, 2018 Section 12 report (RX1) and his November 9, 2018 addendum. Dr. Monaco reviewed the relevant evidence and he noted and took into account the conflicting and inconsistent evidence in the record when he offered his well-reasoned and supported opinions. The Arbitrator adopts these opinions.

The Arbitrator notes Petitioner was unclear on when she believes this incident occurred. The medical records indicate she has been confused about the date of the claimed accident from the first time she sought treatment. The initial medical records from both Ingalls Hospital and Dr. Richardson both indicate that Petitioner reported that the accident occurred on April 27, 2018. Petitioner's explanation for this discrepancy is that the medical providers erred in recording her history. It is debatable whether this is a credible explanation, but Respondent's expert Dr. Monaco seemed to not be influenced by this when he nonetheless found an accident occurred on April 24, 2018.

Petitioner claims she was struck by a forklift driven by Cordell Gaines. Petitioner claims Gaines was not looking where he was going and that he was wearing earbuds when the incident occurred. Gaines denied all of this testimony. The Arbitrator notes Gaines would obviously not want to admit he hit Petitioner, as that could expose him to potential liability beyond this claim. Therefore, he had obvious incentive to testify in Respondent's favor and deny he hit Petitioner. The fact that he testified in Respondent's favor is significant. This weighs heavily in diminishing his credibility.

Petitioner claims she attempted to report this accident; this claim has some credibility. Sumerlin testified that he was on the floor or in the supervisor's shack the entire shift on the day of the claimed occurrence and Petitioner could have reported this accident to him. The Arbitrator finds Petitioner's claim that she was unable to report the claimed incident is credible, as Sumerlin has an incentive to testify on behalf of his current employer.

Petitioner claims she reported this accident to Robert Allbright and Allbright, to his credit, admitted and confirmed Petitioner discussed an accident with him when she was hit by a forklift. Allbright, Respondent's witness, honestly corroborated Petitioner's trial testimony and confirmed she reported the forklift incident to him.

The Arbitrator agrees with Dr. Monaco and finds the accident as described was not a competent mechanism of injury to cause Petitioner to sustain all the injuries alleged (neck, back and shoulder) and for which she received treatment.

Petitioner's physical contact with the forklift was slight, minor. This conclusion is based on the opinions of Dr. Monaco, on which the Arbitrator places reliance and adopts. While there was testimony about speed, the Arbitrator does not believe that the forklift could have been moving fast. At worst, the testimony indicates the forklift had a top speed of 7 mph. Since the forklift had just started, the Arbitrator finds it highly doubtful that it had reached its top speed at the time of the claimed physical contact with Petitioner. This conclusion is supported by the fact that it appears from the testimony the forklift stopped almost immediately. While Petitioner claims the forklift jarred her and she felt a burning sensation, the Arbitrator is not clear how the engine of the forklift could have been hot enough to cause any real harm if it had just started, nor is he persuaded this even occurred. The Arbitrator is not persuaded to conclude this incident caused or aggravated any condition of ill-being other than aggravating Petitioner's pre-existing cyst, as Dr. Monaco opines.

Further, as Dr. Monaco highlights, there is no reference to treatment for the alleged neck, should and back found in the initial medical records. Petitioner admitted her first complaints about these problems did not occur until when she went to Dr. Murtaza 4 – 5 weeks later. The Arbitrator finds that if these conditions were related to the alleged incident on April 24, 2018, Petitioner complaints would have started within days of that incident, not weeks later. Dr. Monaco supports this conclusion.

Further, the Arbitrator emphasizes and highlights Petitioner did not obtain an expert medical causation opinion to support its claims nor did Petitioner obtain an expert medical opinion to specifically attempt to rebut Dr. Monaco's expert opinions. Therefore, the absence of any counter or rebuttal expert causation opinion significantly weakens Petitioner's case.

For all of these reasons, and after a careful review of the record, the Arbitrator finds and concludes Petitioner proved by a preponderance of the evidence she sustained accidental injuries arising out of and in the course of her employment with Respondent on April 24, 2018 relating to only an aggravation – now fully resolved and healed – of her pre-existing sebaceous cyst.

With regard to the issues of "J," Medical and "K," Prospective Medical, the Arbitrator finds the following facts and conclusions:

The Arbitrator finds and concludes the only medical care and treatment related to this claim concerns the aggravation of the pre-existing infected sebaceous cyst. Petitioner needed no further medical care or treatment for the cyst after the date of her Section 12 examination with Dr. Monaco on September 11, 2018. All other medical care and treatment not related to her cyst, and all bills relating to same, are therefore denied. Respondent shall pay for all medical care and treatment relating to Petitioner's pre-existing sebaceous cyst pursuant to Section 8 and the medical fee schedule in 8.2.

Further, Petitioner's request for any and all prospective medical care and treatment is denied. As noted above, the Arbitrator finds and concludes that only Petitioner's aggravated pre-existing cyst condition is related to this accident and that condition needs no further medical care or treatment, as indicated in Dr. Monaco's Section 12 examination of September 11, 2008.

With regard to the issues raised in "L," TTD, the Arbitrator finds the following facts and draws the following conclusions:

Petitioner was temporarily totally disabled for the period of May 21, 2018 through June 7, 2018, being a period of 2-4/7 weeks, based on the records of treating physician Dr. Richardson who kept Petitioner off work ("rest from work") during this period.

With regard to the issues raised in "M," Penalties, the Arbitrator finds the following facts and conclusions:

Petitioner is not entitled to any fees or penalties, for the reasons set forth below:

There were many evidentiary inconsistencies and contradictions in the records and the testimony at trial, as well as delays in making this claim; this leads the Arbitrator to conclude that Respondent was reasonably justified in denying this claim. Some medical records (as noted above) do not indicate an April 24, 2018 date of accident. Some of Respondent's witnesses offered testimony against Petitioner. Further,

Respondent placed reasonable and objective reliance on the opinions of its Section 12 examiner Dr. Monaco, who prepared a comprehensive report, with opinions based on a review of extensive records.

Therefore, penalties and fees are not warranted in this claim.

Robert M. Harris

Arbitrator Robert M. Harris

Dated: February 14, 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPage)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fred Robertson,
Petitioner,
vs.

NO: 17WC7438

UPS,
Respondent.

19IWCC0630

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 7, 2019, is hereby affirmed and adopted.

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

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

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

DATED: NOV 21 2019
o111319
DDM/jrc
052

D. Douglas McCarthy
Douglas McCarthy

Stephen J. Mathis
Stephen Mathis

Kathryn A. Doerries
Kathryn A. Doerries

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

ROBERTSON, FRED
Employee/Petitioner

Case# **17WC007438**

17WC007437

UPS
Employer/Respondent

19IWCC0630

On 2/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2932 LAW OFFICE OF KUGIA & FORTE PC
MARTIN V KUGIA
711 W MAIN ST
WEST DUNDEE, IL 60118

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

STATE OF ILLINOIS)
) SS
COUNTY OF DU PAGE)

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

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

Fred Robertson
Employee/Petitioner
v.
UPS
Employer/Respondent

Case # 17 WC 7438
Consolidated case: 17 WC 7437

19IWCC0630

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Wheaton**, on **February 21, 2018**. Proofs were reopened and reclosed in **Geneva** on **March 15, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

On this date, Petitioner ***did 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 an accident.

In the year preceding the injury, Petitioner earned **$68,959.17;** the average weekly wage was **$1,567.25**

On the date of accident, Petitioner was **44** years of age, **single** with **no** dependent child.

Respondent ***does not owe*** 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 $**12,005.76** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on August 14, 2017, or any other date, that arose out of and in the course of his employment with respondent.

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

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

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

Christine Moy

Signature of Arbitrator

January 30, 2019

Date

IC ArbDec19(b) p. 2

FEB 7 - 2019

-BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fred Robertson	)	
Petitioner,	)	
vs.	)	**No. 17 WC 7437 & 17 WC 7438**
UPS	)	
Respondent.	)	**19IWCC0630**
	)	

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

This matter proceeded to hearing under the provisions of §19b/§8a in Wheaton on February 21, 2018. Proofs were reopened and closed on March 15, 2018 in Geneva. The parties agree that on May 19, 2016 and August 14, 2017, the petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner's wages, in the year pre-dating the claimed accidents were $68,959.17; and his average weekly wage, calculated pursuant to §10 was $1,567.25. (The parties stipulated that the issue of unpaid medical is reserved for future hearings.)

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner gave respondent notice of the accident within the time limits set in the Act.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether petitioner is entitled to payment for prospective medical treatment.
5. Whether petitioner is due TTD.

STATEMENT OF FACTS

Petitioner, Fred Robertson Testimony

Petitioner began his employment with respondent as a package handler in 1989. He became a driver in 1994. He worked as a driver until 2016. As a driver, he made100 to 130 deliveries and 15 to 20 pickups per day. He handled 500 to 600 packages daily. His deliveries included farm equipment, that that could weigh up to 150 pounds. He also delivered medical supplies that weighed up to 70 pounds; which he had to lift up onto a dock. He also delivered school books in boxes that weighed up to 45 pounds; and could be from 50 to 200 boxes depending upon the time of year. Other items included telephone equipment, ladders, cones, barbecue grills, lawn mowers, tile and spools of wire. These items had to be carried by hand. He did a lot of bending and reaching.

Petitioner testified that in November 2015, he began to have pain in neck or back. He testified he told Rob McAllister, who reportedly advised him "okay, it is noted". He also told Toni Lobocki and Nikki Pietrangeli, as well as Dave Kearns.

Petitioner worked until March, 2016, when he said the pain became really bad. He was under the care of Dr. Graf for a work-related neck injury. Dr. Graf was not authorized to provide treatment to his back. In May, 2016, he spoke with Liberty Mutual [adjuster] regarding his neck injury only.

He went to Insearch in April, 2016 for counseling for depression, anxiety and pain. His last day worked was March 31, 2016. He stopped working in order to seek treatment for his neck, back and headaches.

He saw his family doctor, Dr. Cynthia Palmisano on May 19, 2016 due to back, pain around his waistline and neck. He was prescribed Norco. Petitioner called Brant Hughes on May 16, 2016 at 12:19 P.M. to advise he needed treatment for his back and Liberty Mutual would not pay. Hughes advised he would get back to petitioner. Petitioner followed upon with Hughes on June 23, 2016 and August 2, 2016. On August 2, 2016 Brant advised petitioner he did not know anything about an injury report.

Petitioner went to Physicians Immediate Care on August 3, 2016. He was examined, diagnosed with a strain and prescribed anti-inflammatory. He went to Momentum for physical therapy; but he received no physical therapy to his lower back.

He saw Dr. Kuo on October 7, 2016, who wanted petitioner to follow up after an MRI that was done on October 16, 2016. On October 28, 2016 he returned to Dr. Kuo after obtaining the MRI. Dr. Kuo ordered physical therapy and injections. Petitioner was not able to obtain physical therapy or the injections as his health insurance ran out and the workers' compensation insurance would not cover it.

Petitioner next saw orthopedic surgeon, Dr. Dixon, on March 6, 2017. He recommended physical therapy, injections and surgery. He followed up with his family doctor.

Petitioner testified he was in pain, he has problems sleeping, rolling over and laying down. He was prescribed hydrocodone.

He confirmed his neck injury occurred in 2012. From 2012 to November 2015 he worked full time. He had prior minor back strains for which he had only physical therapy and chiropractor treatment in 1996 and 2005. He denied having lower back problems or prior MRIs.

He sought counseling for two months for headaches.

On cross examination, he stated that on March 31, 2016, he decided he wanted to file a report and seek medical treatment. He agreed he had open medical for his neck injury.
He confirmed he was off work from July 12, 2014 until September, 2014 was off work for non-workers' compensation related condition. In September, 2014 he returned to work until November, 2015.

The date of accident of November 13, 2015 was chosen by Brent Hughes. There was no specific incident in November, 2015. He was just having pain in neck and back pain.

Petitioner confirmed he was on vacation for two weeks beginning on November 16, 2015. On November 17, 2015 he went to see Dr. Palmisano. Dr. Randt removed a growth from his backs Petitioner worked the full peak season once he returned to work after his vacation. He worked until March 31, 2016, at which time he went to Dr. Palmisano. Thereafter, he saw Mr. Kenny, at Insearch, until May 26, 2016.

Petitioner confirmed he signed the disability form identified as Respondent Exhibit 8. Petitioner confirmed he received 26 weeks of disability starting in April, 2016.

He confirmed he saw Dr. Graf on April 25, 2016

He confirmed he called the adjuster at Liberty Mutual on May 10, 2016. He obtained a cervical MRI on May 26, 2016. By August 16, 2016 he was done with physical therapy.

On redirect, he confirmed no accident reports were completed for any of the claimed cases. He testified he did no physical activity during his November, 2015 vacation.

Amy Little Testimony

Amy Little, who is an adjuster with Liberty Mutual for 21 years and handles respondent's account for Liberty Mutual, testified in behalf of respondent. She confirmed that she spoke with petitioner on May 10, 2016, which was memorialized in Respondent's Exhibit 10.

Little provided authorization for the cervical MRI and reopened the file for petitioner's neck claim. Petitioner told Little he had prior claim open for medical [for his cervical spine] and started having pain in November-December.

Therese Johnk [of Liberty Mutual] also documented her conversations with petitioner on May 11, 2016 and August 5, 2016. According to the documentation, it was on August 5, 2016 that petitioner advised of the November, 2015 accident.

On cross-examination, Little testified she assumed it was petitioner's neck he was talking about, although he did not specify, as he was talking about his June, 2010 injury that involved only his neck. According to the notes in Respondent's Exhibit 11, petitioner reported the back injury of November, 2015 to respondent in August, 2016.

Nikki Pietrangeli Testiomny

Nikki Pietrangeli, respondent's labor manager, testified in behalf of respondent. She handles the negotiating between the union and respondent. She was overall manager at respondent's Aurora center. She testified that a report is made of an injury, even if minor.

Pietrangeli testified she did not recall a November, 2015 conversation with petitioner regarding his lower back. Pietrangeli did not recall petitioner ever telling her of his [lower back] injury.

On cross examination, Pietrangeli agreed petitioner's supervisors in November, 2015 were Rob McAllister, Toni Lobocki and herself. Pietrangeli testified she first learned petitioner was making a claim for his lower back a couple of months before the hearing.

The proper way to report a claim would be for petitioner reporting it to Robert McAllister, his supervisor, and then McAllister would complete the first report of injury. To Pietrangeli's knowledge, petitioner never discussed this with McAllister.

Brant Hughes Testimony

Brant Hughes, respondent's business manager for 17 years, testified in behalf of respondent. He testified he is now in charge of the Beverly Center in Bedford Park; having moved into this position in August, 2017. He had been a lead man. He would see that the injured worker gets medical treatment. He began in Aurora in February, 2016. On May 18, 2106, petitioner called to say he had neck pain under a previous claim.

Hughes confirmed that Respondent's Exhibit 11 is an email exchange between himself and Cummings on May 11, 2016 regarding petitioner's claim. The communication confirmed petitioner had reached out to Joy Crotser. Hughes did not recall any conversation petitioner had with him on June 23, 2016. Hughes said that petitioner advised him during a discussion on August 3, 2016 that he [petitioner] had told everyone in November, 2015, in respondent's center, that his back was hurting. During this August 3, 2016 conversation, Hughes told petitioner to come in for him to go to Physicians Immediate Care.

On cross examination Hughes confirmed petitioner never mentioned back pain.

Petitioner, Fred Robertson Rebuttal Testimony

On rebuttal, petitioner said he told Adjuster Little about both his neck; she denied authorization for treatment for his back.

He confirmed he reached out to Joy Crotser, who is another manager, in order to get treatment for his back.

Illinois Orthopaedic Network/Dr. Geoffrey Dixon Records (PX.1)

Petitioner was initially seen by Dr. Dixon on March 6, 2017. The history provided was that he was a driver for respondent and initially injured in 2010 and underwent a cervical disk replacement. He recovered completely and returned to work. In November or December, 2015 he had an onset of mid and low back pain; reported it to his supervisor and continued working until he no longer could tolerate it. He continued working until March, 2016, when he could no longer work. He received physical therapy in September or October, 2016. His pain was predominantly in his mid and low back; he denied radiating pain.

Dr. Dixon reported the MRI demonstrated a broad-based herniated disc at L5-S1 compressing the nerve root.

Dr. Dixon recommended conservative treatment of physical therapy and injections, as well as the possibility of surgical intervention of micro lumbar decompression and discectomy.

Momentum Physical Therapy Records (PX.2)

Petitioner was evaluated for physical therapy on September 12, 2016. The history provided was last year original onset of neck and low back pain. Under subjective it reads: "Insidious onset of pain-no specific incident that brought it on." Petitioner received physical therapy and work conditioning/hardening until November 7, 2016.

Dr. Cynthia Palmisano Records (PX.3)

According to these records petitioner was first seen on April 16, 2016. On that date, Dr. Palmisano discussed seeing a counselor; she also mentioned neck pain. The records continue through December 14, 2017. (For the most part, these records were illegible.)

From the records that could be deciphered, there was ongoing mention of petitioner's neck and thoracic spine. It appears the first mention of petitioner's lower back was not until September 29, 2016. Thereafter, petitioner obtained an MRI of the thoracic and lumbar spine; which showed degenerative disc changes along with diffuse L5-S1 disc bulge, as well as right paracentral disc herniation.

Petitioner was also receiving counseling for depression and post-traumatic stress disorder. Dr. Palmisano kept petitioner off work for medical reasons; without any specificity of the medical reason.

Insearch Counseling Center Records (PX.4)

The records of Mark Kenny, MS, LCPC are for counseling from April 11, 2016 through May 26, 2016. Petitioner related he has chronic pain in his neck and lower back. Petitioner related that the doctors were not listening to him and his employer was giving him the run around. He also related he was doing community service due to tickets he had received.

Physicians Immediate Care Records (PX.5)

Petitioner was first seen on August 3, 2016. He related he had mid-back pains since November, 2015. There was no specific injury that occurred that caused the pain. The diagnosis was thoracic spine pain.

Dr. Geoffrey R. Dixon August 14, 2017 Deposition (PX.6)

Dr. Geoffrey Dixon, board certified neurosurgeon, testified via deposition in behalf of petitioner. Dr. Dixon examined petitioner on March 6, 2017 (8). In conjunction with the exam, he reviewed the MRI films, which revealed a broad-based disc herniation at L5-S1 (9-10). Dr. Dixon determined petitioner's occupation as a truck driver for respondent could have caused the herniated disc at the L5-S1 level (15).

Dr. Kuo/MK Orthopaedics Records (PX.7)

Petitioner was initially seen by Dr. Kuo on October 7, 2016. The history recited was that petitioner was being evaluated for neck, thoracic and low back pain. Petitioner indicated that about a year ago he was working his job for respondent and randomly felt increase in pain. He further indicated he was working his normal route when he was injured. He previously had a cervical disc replacement by Dr. Charles Graf. The X-rays showed a calcified disc at L5-S1. Dr. Kuo recommended petitioner continue physical therapy. He was kept off work and advised to follow up after obtaining an MRI.

Petitioner returned on October 28, 2016 with the MRIs taken on October 13, 2016. Dr. Kuo noted a L5-S1 right lateral recess herniated nucleus pulposus.

Dr. Kuo's diagnosis was right leg radiculopathy secondary to herniated nucleus pulposus at L5-S1; degenerative disc diseases at L5-S1; and back pain, likely secondary to a work-related injury. Dr. Kuo recommended physical therapy; if no benefit than injections were recommended.

Reports of Petitioner's Claimed Work Injuries and Reporting Procedures (RX.1).

The list includes petitioner's injuries, including some for his lower back, from January 24, 1991 through January 6, 2005 as well as on September 17, 2010. Petitioner signed an on-time injury reporting commitment on January 4, 2012.

10 WC 44587 Lump Sum Settlement Contract (RX.2)

Petitioner entered into a settlement agreement approved on October 18, 2012 for the cervical spine; leaving medical rights for treatment of the cervical spine.

Dr. Matthew Colman November 22, 2017 Deposition (RX.3)

Dr. Matthew Colman, board certified orthopaedic surgeon, testified in behalf of respondent. After reviewing records and imaging studies, Dr. Colman examined petitioner on June 28, 2017 and authored a report which was allowed into evidence as part of the deposition (8-9). Petitioner's exam was normal, with the exception of midline thoracic spine tenderness (14). Dr. Colman noted the MRI showed a degenerative disc at [L5-S1] with a small right sided paracentral disc herniation at [L5-S1] that hit the nerve and was causing symptoms (15).

Dr. Colman opined that petitioner's diagnosis and complaints were not unreasonable; however, he could not attribute the condition to any specific work-related injury due to lack of medical documentation and petitioner's reporting over time (16). On cross-examination, Dr.

Colman reaffirmed the reason for questioning causation to a work accident was due to the lack of documentation as to when it occurred (31-32).

Dr. Colman believed the appropriate treatment would include physical therapy and injections and may lead to surgery (17).

Tutor Chiropractic Healthcare Records (RX.4)

Petitioner received chiropractic treatment for his mid to lower back from various times beginning in 1995 to 2005.

Teamcare Application (RX.8)

Petitioner and Dr. Palmisano completed a short-term disability application due to anxiety/ fatigue beginning on March 30, 2016.

Mark Kenny of Insearch Counseling Center on May 14, [2016] Report (RX.9)

Mark Kenny report a report indicating petitioner was being seen for stress-related depression and post-traumatic stress disorder.

May 10, 2016 Amy Little of Liberty Mutual Journal Entry (RX.10).

According to the note by Amy Little, she was contacted by petitioner regarding his 2010 (cervical) injury for which he had open medical. The notes reflect petitioner has seen Dr. Graff (sic) a few weeks before, who had ordered an MRI. Petitioner advised it began in November-December. There was no new accident.

Therese Johnk Journal Entry of May 11, 2016 and August 5, 2016 (RX.11)

Johnk was contacted by petitioner regarding TTD benefits and was advised that portion of the claim had been closed out.

The entry includes communication between Tim Cummings and Brant Hughes discussing petitioner's present complaints and his disability for personal issues.

Petitioner communicated with Johnk about his pain in the middle of his back between shoulder blades. He reportedly advised Nikki, Dave and Rob at the time. He was doing his regular job.

Dr. Charles Graf Records (Introduced on March 15, 2018)

Petitioner was seen by Dr. Graf on April 25, 2016 with headaches and neck pain with activity that started in November/December. He had a cervical disc arthroplasty in 2012.

Petitioner returned to Dr. Graf on June 10, 2016 after obtaining a cervical MRI, but not a CT scan. Diagnosis was cervical radiculopathy. Dr. Graf reiterated the need for the CT scan. Petitioner returned on July 27, 2016 after the CT scan was completed. Physical therapy and possible injections were recommended. He returned on September 2, 2016 with ongoing neck complaints. On October 19, 2016, petitioner advised he had dramatic improvement after physical therapy.

CONCLUSIONS OF LAW

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

C. With respect to the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

It is undisputed petitioner's position as delivery driver with respondent required him to lift and carrying heavy items and that his workload significantly increased in November to December. However, by his own admission, petitioner agreed he was doing his regular job and he could not pinpoint exactly when he started feeling pain in his lower back; other than indicating it started in November or December, 2015 Furthermore, he was on vacation for two weeks during this same period; starting on November 16, 2015.

The earliest mention of lower back pain in any of records was in Mark Kenney's April 11, 2016 records. Petitioner reported he was having chronic low back and neck pain but his complaints were being ignored by his employer and treating doctor.

The records of Dr. Graf, which begin on April 25, 2016, failed to mention any lower back complaints; the complaints were centered in his neck. Most notably, when he saw the doctors at Physicians Immediate Care on August 3, 2016 as a referral by respondent, petitioner's complaints were of pain to the thoracic region and not the lower back. The first mention of low back pain is found in the medical records of his family doctor, Dr. Palmisano, on September 29, 2016. There was no explanation given in these records (PX.3, p.52).

It was not until petitioner was seen by Dr. Kuo on October 7, 2016 that petitioner even hinted that his low back pain was related to his work. However, petitioner's statement to Dr. Kuo falls short of proving accident as he stated to Dr. Kuo that about a year ago he was working his normal job for respondent and randomly felt an increase in pain [in his lower back].

Although Dr. Dixon, who examined petitioner on March 6, 2017, testified that petitioner's duties as respondent's package delivery driver could have caused the herniated disc at the L5-S1 level, this opinion was based upon an inaccurate hypothetical of petitioner's medical history.

Not lost on the Arbitrator is the fact that it was not until petitioner learned he was not eligible to receive temporary total disability for his cervical problem, as that portion of the case was closed, that he recalled the lower back pain that began in November-December, 2015.

The Arbitrator considered and agrees with Dr. Colman's assessment, that although petitioner's diagnosis and complaints were not unreasonable; petitioner could not attribute the condition to any specific work-related injury, lacked medical documentation of a low back injury and questioned the reporting over time of the low back condition.

The Arbitrator also considered the fact that petitioner amended both Applications for Adjustment of Claim for dates to work around the notice issue and to fit his narrative for a work-related accident.

Based upon the evidence taken as a whole, the Arbitrator finds petitioner failed to prove by a preponderance of the evidence that he suffered an injury to his lower back, repetitive or otherwise, in a work accident that arose out of and in the course of his employment with respondent on November 13, 2015, May 1, 2016, May 19, 2016, August 14, 2017, or any other date.

As the Arbitrator determined petitioner did not sustain accidental injuries to his lower back from a work related accident, his case is dismissed and all other issues are moot.

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

Fred Robertson,
Petitioner,
vs.

NO: 17WC 7437

19IWCC0631

UPS,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 7, 2019, is hereby affirmed and adopted.

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

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

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

DATED: NOV 21 2019
o111319
DDM/jrc
052

D Douglas McCarthy
Douglas McCarthy

Stephen J. Mathis
Stephen Mathis

Kathryn A. Doerries
Kathryn A. Doerries

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

ROBERTSON, FRED
Employee/Petitioner

Case# **17WC007437**

17WC007438

UPS
Employer/Respondent

19IWCC0631

On 2/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2932 LAW OFFICE OF KUGIA & FORTE PC
MARTIN V KUGIA
711 W MAIN ST
WEST DUNDEE, IL 60118

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

STATE OF ILLINOIS)
) SS
COUNTY OF DU PAGE)

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

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

Fred Robertson
Employee/Petitioner

v.

UPS
Employer/Respondent

Case # 17 WC 7437
Consolidated case: 17 WC 7438

19IWCC0631

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Wheaton**, on **February 21, 2018**. Proofs were reopened and reclosed in **Geneva** on **March 15, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident **May 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 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 an accident.

In the year preceding the injury, Petitioner earned **$68,959.17;** the average weekly wage was **$1,567.25**

On the date of accident, Petitioner was **44** years of age, **single** with **no** dependent child.

Respondent ***does not owe*** 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 **$12,005.76** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on May 19, 2016, or any other date, that arose out of and in the course of his employment with respondent.

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

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

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

Christine Moy

Signature of Arbitrator

January 30, 2019
Date

IC ArbDec19(b) p. 2

FEB 7 - 2019

-BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fred Robertson	)	
Petitioner,	)	
vs.	)	**No. 17 WC 7437 & 17 WC 7438**
UPS	)	
Respondent.	)	
	)	**19IWCC0631**

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

This matter proceeded to hearing under the provisions of §19b/§8a in Wheaton on February 21, 2018. Proofs were reopened and closed on March 15, 2018 in Geneva. The parties agree that on May 19, 2016 and August 14, 2017, the petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner's wages, in the year pre-dating the claimed accidents were $68,959.17; and his average weekly wage, calculated pursuant to §10 was $1,567.25. (The parties stipulated that the issue of unpaid medical is reserved for future hearings.)

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner gave respondent notice of the accident within the time limits set in the Act.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether petitioner is entitled to payment for prospective medical treatment.
5. Whether petitioner is due TTD.

STATEMENT OF FACTS

Petitioner, Fred Robertson Testimony

Petitioner began his employment with respondent as a package handler in 1989. He became a driver in 1994. He worked as a driver until 2016. As a driver, he made100 to 130 deliveries and 15 to 20 pickups per day. He handled 500 to 600 packages daily. His deliveries included farm equipment, that that could weigh up to 150 pounds. He also delivered medical supplies that weighed up to 70 pounds; which he had to lift up onto a dock. He also delivered school books in boxes that weighed up to 45 pounds; and could be from 50 to 200 boxes depending upon the time of year. Other items included telephone equipment, ladders, cones, barbecue grills, lawn mowers, tile and spools of wire. These items had to be carried by hand. He did a lot of bending and reaching.

Petitioner testified that in November 2015, he began to have pain in neck or back. He testified he told Rob McAllister, who reportedly advised him "okay, it is noted". He also told Toni Lobocki and Nikki Pietrangeli, as well as Dave Kearns.

Petitioner worked until March, 2016, when he said the pain became really bad. He was under the care of Dr. Graf for a work-related neck injury. Dr. Graf was not authorized to provide treatment to his back. In May, 2016, he spoke with Liberty Mutual [adjuster] regarding his neck injury only.

He went to Insearch in April, 2016 for counseling for depression, anxiety and pain. His last day worked was March 31, 2016. He stopped working in order to seek treatment for his neck, back and headaches.

He saw his family doctor, Dr. Cynthia Palmisano on May 19, 2016 due to back, pain around his waistline and neck. He was prescribed Norco. Petitioner called Brant Hughes on May 16, 2016 at 12:19 P.M. to advise he needed treatment for his back and Liberty Mutual would not pay. Hughes advised he would get back to petitioner. Petitioner followed upon with Hughes on June 23, 2016 and August 2, 2016. On August 2, 2016 Brant advised petitioner he did not know anything about an injury report.

Petitioner went to Physicians Immediate Care on August 3, 2016. He was examined, diagnosed with a strain and prescribed anti-inflammatory. He went to Momentum for physical therapy; but he received no physical therapy to his lower back.

He saw Dr. Kuo on October 7, 2016, who wanted petitioner to follow up after an MRI that was done on October 16, 2016. On October 28, 2016 he returned to Dr. Kuo after obtaining the MRI. Dr. Kuo ordered physical therapy and injections. Petitioner was not able to obtain physical therapy or the injections as his health insurance ran out and the workers' compensation insurance would not cover it.

Petitioner next saw orthopedic surgeon, Dr. Dixon, on March 6, 2017. He recommended physical therapy, injections and surgery. He followed up with his family doctor.

Petitioner testified he was in pain, he has problems sleeping, rolling over and laying down. He was prescribed hydrocodone.

He confirmed his neck injury occurred in 2012. From 2012 to November 2015 he worked full time. He had prior minor back strains for which he had only physical therapy and chiropractor treatment in 1996 and 2005. He denied having lower back problems or prior MRIs.

He sought counseling for two months for headaches.

On cross examination, he stated that on March 31, 2016, he decided he wanted to file a report and seek medical treatment. He agreed he had open medical for his neck injury.
He confirmed he was off work from July 12, 2014 until September, 2014 was off work for non-workers' compensation related condition. In September, 2014 he returned to work until November, 2015.

The date of accident of November 13, 2015 was chosen by Brent Hughes. There was no specific incident in November, 2015. He was just having pain in neck and back pain.

Petitioner confirmed he was on vacation for two weeks beginning on November 16, 2015. On November 17, 2015 he went to see Dr. Palmisano. Dr. Randt removed a growth from his backs Petitioner worked the full peak season once he returned to work after his vacation. He worked until March 31, 2016, at which time he went to Dr. Palmisano. Thereafter, he saw Mr. Kenny, at Insearch, until May 26, 2016.

Petitioner confirmed he signed the disability form identified as Respondent Exhibit 8. Petitioner confirmed he received 26 weeks of disability starting in April, 2016.

He confirmed he saw Dr. Graf on April 25, 2016

He confirmed he called the adjuster at Liberty Mutual on May 10, 2016. He obtained a cervical MRI on May 26, 2016. By August 16, 2016 he was done with physical therapy.

On redirect, he confirmed no accident reports were completed for any of the claimed cases. He testified he did no physical activity during his November, 2015 vacation.

Amy Little Testimony

Amy Little, who is an adjuster with Liberty Mutual for 21 years and handles respondent's account for Liberty Mutual, testified in behalf of respondent. She confirmed that she spoke with petitioner on May 10, 2016, which was memorialized in Respondent's Exhibit 10.

Little provided authorization for the cervical MRI and reopened the file for petitioner's neck claim. Petitioner told Little he had prior claim open for medical [for his cervical spine] and started having pain in November-December.

Therese Johnk [of Liberty Mutual] also documented her conversations with petitioner on May 11, 2016 and August 5, 2016. According to the documentation, it was on August 5, 2016 that petitioner advised of the November, 2015 accident.

On cross-examination, Little testified she assumed it was petitioner's neck he was talking about, although he did not specify, as he was talking about his June, 2010 injury that involved only his neck. According to the notes in Respondent's Exhibit 11, petitioner reported the back injury of November, 2015 to respondent in August, 2016.

Nikki Pietrangeli Testiomny

Nikki Pietrangeli, respondent's labor manager, testified in behalf of respondent. She handles the negotiating between the union and respondent. She was overall manager at respondent's Aurora center. She testified that a report is made of an injury, even if minor.

Pietrangeli testified she did not recall a November, 2015 conversation with petitioner regarding his lower back. Pietrangeli did not recall petitioner ever telling her of his [lower back] injury.

On cross examination, Pietrangeli agreed petitioner's supervisors in November, 2015 were Rob McAllister, Toni Lobocki and herself. Pietrangeli testified she first learned petitioner was making a claim for his lower back a couple of months before the hearing.

The proper way to report a claim would be for petitioner reporting it to Robert McAllister, his supervisor, and then McAllister would complete the first report of injury. To Pietrangeli's knowledge, petitioner never discussed this with McAllister.

Brant Hughes Testimony

Brant Hughes, respondent's business manager for 17 years, testified in behalf of respondent. He testified he is now in charge of the Beverly Center in Bedford Park; having moved into this position in August, 2017. He had been a lead man. He would see that the injured worker gets medical treatment. He began in Aurora in February, 2016. On May 18, 2106, petitioner called to say he had neck pain under a previous claim.

Hughes confirmed that Respondent's Exhibit 11 is an email exchange between himself and Cummings on May 11, 2016 regarding petitioner's claim. The communication confirmed petitioner had reached out to Joy Crotser. Hughes did not recall any conversation petitioner had with him on June 23, 2016. Hughes said that petitioner advised him during a discussion on August 3, 2016 that he [petitioner] had told everyone in November, 2015, in respondent's center, that his back was hurting. During this August 3, 2016 conversation, Hughes told petitioner to come in for him to go to Physicians Immediate Care.

On cross examination Hughes confirmed petitioner never mentioned back pain.

Petitioner, Fred Robertson Rebuttal Testimony

On rebuttal, petitioner said he told Adjuster Little about both his neck; she denied authorization for treatment for his back.

He confirmed he reached out to Joy Crotser, who is another manager, in order to get treatment for his back.

Illinois Orthopaedic Network/Dr. Geoffrey Dixon Records (PX.1)

Petitioner was initially seen by Dr. Dixon on March 6, 2017. The history provided was that he was a driver for respondent and initially injured in 2010 and underwent a cervical disk replacement. He recovered completely and returned to work. In November or December, 2015 he had an onset of mid and low back pain; reported it to his supervisor and continued working until he no longer could tolerate it. He continued working until March, 2016, when he could no longer work. He received physical therapy in September or October, 2016. His pain was predominantly in his mid and low back; he denied radiating pain.

Dr. Dixon reported the MRI demonstrated a broad-based herniated disc at L5-S1 compressing the nerve root.

Dr. Dixon recommended conservative treatment of physical therapy and injections, as well as the possibility of surgical intervention of micro lumbar decompression and discectomy.

Momentum Physical Therapy Records (PX.2)

Petitioner was evaluated for physical therapy on September 12, 2016. The history provided was last year original onset of neck and low back pain. Under subjective it reads: "Insidious onset of pain-no specific incident that brought it on." Petitioner received physical therapy and work conditioning/hardening until November 7, 2016.

Dr. Cynthia Palmisano Records (PX.3)

According to these records petitioner was first seen on April 16, 2016. On that date, Dr. Palmisano discussed seeing a counselor; she also mentioned neck pain. The records continue through December 14, 2017. (For the most part, these records were illegible.)

From the records that could be deciphered, there was ongoing mention of petitioner's neck and thoracic spine. It appears the first mention of petitioner's lower back was not until September 29, 2016. Thereafter, petitioner obtained an MRI of the thoracic and lumbar spine; which showed degenerative disc changes along with diffuse L5-S1 disc bulge, as well as right paracentral disc herniation.

Petitioner was also receiving counseling for depression and post-traumatic stress disorder. Dr. Palmisano kept petitioner off work for medical reasons; without any specificity of the medical reason.

Insearch Counseling Center Records (PX.4)

The records of Mark Kenny, MS, LCPC are for counseling from April 11, 2016 through May 26, 2016. Petitioner related he has chronic pain in his neck and lower back. Petitioner related that the doctors were not listening to him and his employer was giving him the run around. He also related he was doing community service due to tickets he had received.

Physicians Immediate Care Records (PX.5)

Petitioner was first seen on August 3, 2016. He related he had mid-back pains since November, 2015. There was no specific injury that occurred that caused the pain. The diagnosis was thoracic spine pain.

Dr. Geoffrey R. Dixon August 14, 2017 Deposition (PX.6)

Dr. Geoffrey Dixon, board certified neurosurgeon, testified via deposition in behalf of petitioner. Dr. Dixon examined petitioner on March 6, 2017 (8). In conjunction with the exam, he reviewed the MRI films, which revealed a broad-based disc herniation at L5-S1 (9-10). Dr. Dixon determined petitioner's occupation as a truck driver for respondent could have caused the herniated disc at the L5-S1 level (15).

Dr. Kuo/MK Orthopaedics Records (PX.7)

Petitioner was initially seen by Dr. Kuo on October 7, 2016. The history recited was that petitioner was being evaluated for neck, thoracic and low back pain. Petitioner indicated that about a year ago he was working his job for respondent and randomly felt increase in pain. He further indicated he was working his normal route when he was injured. He previously had a cervical disc replacement by Dr. Charles Graf. The X-rays showed a calcified disc at L5-S1. Dr. Kuo recommended petitioner continue physical therapy. He was kept off work and advised to follow up after obtaining an MRI.

Petitioner returned on October 28, 2016 with the MRIs taken on October 13, 2016. Dr. Kuo noted a L5-S1 right lateral recess herniated nucleus pulposus.

Dr. Kuo's diagnosis was right leg radiculopathy secondary to herniated nucleus pulposus at L5-S1; degenerative disc diseases at L5-S1; and back pain, likely secondary to a work-related injury. Dr. Kuo recommended physical therapy; if no benefit than injections were recommended.

Reports of Petitioner's Claimed Work Injuries and Reporting Procedures (RX.1).

The list includes petitioner's injuries, including some for his lower back, from January 24, 1991 through January 6, 2005 as well as on September 17, 2010. Petitioner signed an on-time injury reporting commitment on January 4, 2012.

10 WC 44587 Lump Sum Settlement Contract (RX.2)

Petitioner entered into a settlement agreement approved on October 18, 2012 for the cervical spine; leaving medical rights for treatment of the cervical spine.

Dr. Matthew Colman November 22, 2017 Deposition (RX.3)

Dr. Matthew Colman, board certified orthopaedic surgeon, testified in behalf of respondent. After reviewing records and imaging studies, Dr. Colman examined petitioner on June 28, 2017 and authored a report which was allowed into evidence as part of the deposition (8-9). Petitioner's exam was normal, with the exception of midline thoracic spine tenderness (14). Dr. Colman noted the MRI showed a degenerative disc at [L5-S1] with a small right sided paracentral disc herniation at [L5-S1] that hit the nerve and was causing symptoms (15).

Dr. Colman opined that petitioner's diagnosis and complaints were not unreasonable; however, he could not attribute the condition to any specific work-related injury due to lack of medical documentation and petitioner's reporting over time (16). On cross-examination, Dr.

Colman reaffirmed the reason for questioning causation to a work accident was due to the lack of documentation as to when it occurred (31-32).

Dr. Colman believed the appropriate treatment would include physical therapy and injections and may lead to surgery (17).

Tutor Chiropractic Healthcare Records (RX.4)

Petitioner received chiropractic treatment for his mid to lower back from various times beginning in 1995 to 2005.

Teamcare Application (RX.8)

Petitioner and Dr. Palmisano completed a short-term disability application due to anxiety/ fatigue beginning on March 30, 2016.

Mark Kenny of Insearch Counseling Center on May 14, [2016] Report (RX.9)

Mark Kenny report a report indicating petitioner was being seen for stress-related depression and post-traumatic stress disorder.

May 10, 2016 Amy Little of Liberty Mutual Journal Entry (RX.10).

According to the note by Amy Little, she was contacted by petitioner regarding his 2010 (cervical) injury for which he had open medical. The notes reflect petitioner has seen Dr. Graff (sic) a few weeks before, who had ordered an MRI. Petitioner advised it began in November-December. There was no new accident.

Therese Johnk Journal Entry of May 11, 2016 and August 5, 2016 (RX.11)

Johnk was contacted by petitioner regarding TTD benefits and was advised that portion of the claim had been closed out.

The entry includes communication between Tim Cummings and Brant Hughes discussing petitioner's present complaints and his disability for personal issues.

Petitioner communicated with Johnk about his pain in the middle of his back between shoulder blades. He reportedly advised Nikki, Dave and Rob at the time. He was doing his regular job.

Dr. Charles Graf Records (Introduced on March 15, 2018)

Petitioner was seen by Dr. Graf on April 25, 2016 with headaches and neck pain with activity that started in November/December. He had a cervical disc arthroplasty in 2012.

Petitioner returned to Dr. Graf on June 10, 2016 after obtaining a cervical MRI, but not a CT scan. Diagnosis was cervical radiculopathy. Dr. Graf reiterated the need for the CT scan. Petitioner returned on July 27, 2016 after the CT scan was completed. Physical therapy and possible injections were recommended. He returned on September 2, 2016 with ongoing neck complaints. On October 19, 2016, petitioner advised he had dramatic improvement after physical therapy.

CONCLUSIONS OF LAW

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

C. With respect to the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

It is undisputed petitioner's position as delivery driver with respondent required him to lift and carrying heavy items and that his workload significantly increased in November to December. However, by his own admission, petitioner agreed he was doing his regular job and he could not pinpoint exactly when he started feeling pain in his lower back; other than indicating it started in November or December, 2015 Furthermore, he was on vacation for two weeks during this same period; starting on November 16, 2015.

The earliest mention of lower back pain in any of records was in Mark Kenney's April 11, 2016 records. Petitioner reported he was having chronic low back and neck pain but his complaints were being ignored by his employer and treating doctor.

The records of Dr. Graf, which begin on April 25, 2016, failed to mention any lower back complaints; the complaints were centered in his neck. Most notably, when he saw the doctors at Physicians Immediate Care on August 3, 2016 as a referral by respondent, petitioner's complaints were of pain to the thoracic region and not the lower back. The first mention of low back pain is found in the medical records of his family doctor, Dr. Palmisano, on September 29, 2016. There was no explanation given in these records (PX.3, p.52).

It was not until petitioner was seen by Dr. Kuo on October 7, 2016 that petitioner even hinted that his low back pain was related to his work. However, petitioner's statement to Dr. Kuo falls short of proving accident as he stated to Dr. Kuo that about a year ago he was working his normal job for respondent and randomly felt an increase in pain [in his lower back].

Although Dr. Dixon, who examined petitioner on March 6, 2017, testified that petitioner's duties as respondent's package delivery driver could have caused the herniated disc at the L5-S1 level, this opinion was based upon an inaccurate hypothetical of petitioner's medical history.

Not lost on the Arbitrator is the fact that it was not until petitioner learned he was not eligible to receive temporary total disability for his cervical problem, as that portion of the case was closed, that he recalled the lower back pain that began in November-December, 2015.

The Arbitrator considered and agrees with Dr. Colman's assessment, that although petitioner's diagnosis and complaints were not unreasonable; petitioner could not attribute the condition to any specific work-related injury, lacked medical documentation of a low back injury and questioned the reporting over time of the low back condition.

The Arbitrator also considered the fact that petitioner amended both Applications for Adjustment of Claim for dates to work around the notice issue and to fit his narrative for a work-related accident.

Based upon the evidence taken as a whole, the Arbitrator finds petitioner failed to prove by a preponderance of the evidence that he suffered an injury to his lower back, repetitive or otherwise, in a work accident that arose out of and in the course of his employment with respondent on November 13, 2015, May 1, 2016, May 19, 2016, August 14, 2017, or any other date.

As the Arbitrator determined petitioner did not sustain accidental injuries to his lower back from a work related accident, his case is dismissed and all other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA MARTINEZ REYES,

Petitioner,

vs. NO: 17 WC 14484

MACNEAL HOSPITAL,

Respondent.

19IWCC0632

DECISION AND OPINION ON REVIEW

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

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission vacates the Arbitrator's Decision with respect to the award of vocational rehabilitation services and maintenance benefits. The Commission notes that Petitioner's treating physician, Dr. Sclamberg, recommended a functional capacity evaluation (FCE) following her surgeries. The Petitioner, however, was unable to obtain the FCE as noted by the record. As an FCE was not performed, Dr. Sclamberg provided Petitioner with permanent restrictions following his September 24, 2018 examination. The Commission finds that many of Dr. Sclamberg's permanent restrictions are unrelated to Petitioner's use of her hands or her actual job duties as a registered nurse. Absent the FCE, the Commission is unable to determine Petitioner's actual restrictions as it relates to her ability to perform her job duties. As the Commission has affirmed the Arbitrator's Decision with respect to accident and causal connection, the Commission finds that Petitioner is entitled to an FCE as recommended by Dr. Sclamberg. At the conclusion of the FCE, the Commission finds that Petitioner is entitled to a vocational assessment.

The Commission affirms the award of TTD from August 2, 2017 through September 24, 2018, and further awards Petitioner TTD benefits from September 25, 2018 through December 13, 2018 in lieu of maintenance benefits. The Arbitrator had awarded maintenance benefits from September 25, 2018 through December 13, 2018, the hearing date. The Commission finds, however, that this period is better classified as Temporary Total Disability, or TTD. "When determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of a work-related injury *and whether the employee is capable of returning to the work force*." *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 146 (2010) (emphasis added). Having found that Petitioner is entitled to an FCE, as recommended by Dr. Sclamberg, to determine Petitioner's actual restrictions as it relates to her ability to perform her job duties, the Commission finds that Petitioner's condition has yet to stabilize pending the recommended FCE. The Commission, therefore, finds that Petitioner is entitled to TTD and not maintenance, and awards TTD from August 2, 2017 through December 13, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed February 27, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and causally related medical bills of $79,621.35, pursuant to Section 8(a) of the Act and to be adjusted in accord with the medical fee schedule provided in Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $164.95 for medical bills paid through its group medical plan for which credit may be allowed 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.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of vocational rehabilitation services and maintenance benefits are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to a functional capacity evaluation (FCE) and a vocational assessment following the FCE.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $1,048.74 per week for 71 2/7 weeks, commencing August 2, 2017 through December 13, 2018, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 21 2019

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/pm
O: 11-13-19
052

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

REYES, MARIA MARTINEZ
Employee/Petitioner

Case# **17WC014484**

MacNEAL HOSPITAL
Employer/Respondent

19IWCC0632

On 2/27/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
SUSAN E WALSH
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARIA MARTINEZ REYES
Employee/Petitioner

v.

MACNEAL HOSPITAL
Employer/Respondent

Case # **17 WC 14484**

Consolidated cases: **N/A**

19IWCC0632

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 13, 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 **Vocational Rehabilitation**

19IWCC0632

FINDINGS

On the date of accident, **March 27, 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 **$81,802.24**; the average weekly wage was **$1573.12**.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit of **$164.95** for benefits paid by BCBS under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,048.74/week** for **59-6/7th** weeks, commencing **8/2/17** through **9/24/18**, as provided in **Section 8(b)** of the Act.

Respondent shall pay Petitioner maintenance benefits of **$1,048.74/week** for **11-3/7th** weeks, commencing **9/25/18** through **12/13/18**, as provided in **Section 8(a)** of the Act.

Respondent shall pay reasonable and necessary medical services of **$79,621.35**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of **$164.95** for medical benefits that have been paid by BCBS, 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 provide vocational rehabilitation services to Petitioner pursuant to Section 8(a) of the Act, including any and all incidental care thereto.

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

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

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

Signature of Arbitrator

2-27-2019
Date

ICArbDec19(b)

FEB 27 2019

19IWCC0632

FINDINGS OF FACT

Maria Martinez Reyes ("Petitioner") testified in March 2017 she was employed by MacNeal Hospital as a registered nurse. She had been so employed for 25 years in the Breast Care Center. Petitioner had been working in that department for five years. She was a full-time employee working 40 hours per week. T:9-10. Petitioner testified her hours changed from part-time to full-time in March 2015. T: 11.

Petitioner testified her job duties were split between data entry and assisting with procedures or biopsies. She testified in March 2017 she was doing about 31 hours per week of data entry and the rest of the time she was doing biopsies. T:11-12.

Petitioner testified with data entry, she needed to enter a patient's recommendations from a radiologist into a computer system. She would be clicking, putting information from the paper into the computer, sending out certification letters, entering treatment plans, putting the doctor's final recommendations for information into the patient's record, doing data entry, gathering data entry for the radiologist as far as cancer positive patients to build a report for them, and other things including receptionist, calling, answering phone calls and filing (pp. 12-13. Petitioner testified she used both of her hands constantly when doing data entry T: 13.

As to how many hours per day Petitioner was performing data entry, she testified it was split. On Mondays, Tuesdays and Wednesdays, she would do anywhere from 4-1/2 to 5 hours of data entry. On Thursdays and Fridays, she would do a full 8 hours of data entry T:13. Petitioner testified she got a lunch break of 30 to 45 minutes each day T:14.

Petitioner also testified that her other job was assisting with biopsies. She would confront the patient, assist the patient to the biopsy room, set up trays for the procedures, draw the medications and situate the patient the way the doctor wanted her to be positioned. She would also assist in obtaining or putting the sample into the sample container. T:14-15.

Petitioner testified that once the doctor was done with the procedure, she would have to hold pressure on the breast to prevent any bleeding from the biopsy site. She testified she did that several different ways depending on where the incision site was. She indicated that she would have her right hand pressing down on top of her left-hand T:15. Petitioner also sometimes held her hand in a fist with the upper portion of the hand facing forward as opposed to sideways. She also testified she sometimes used the distal portion of her index, middle and ring fingers to apply the pressure T:16. Petitioner demonstrated she sometimes held her hand straight out with the lateral side of her hand on her thigh T:17. Petitioner testified during March 2017, she would be involved in anywhere from 15 to 18 breast biopsies per week T:17.

Petitioner testified that the amount of pressure she applied would vary depending on whether the patient was on blood thinners, or actively bleeding, or depending on the radiologists' request. She testified the least amount of time she would hold pressure on the breast after a biopsy would be 20 minutes and the most would be about an hour to an hour and 15 minutes T:18. Petitioner testified the MRI biopsies would require an hour and 15 minutes of pressure because they involve quite a bit more needles. T:18-19.

Petitioner testified on Monday March 13, 2017 she arrived for work between 8:30 and 9:00 a.m. She began the day doing data entry T: 20. Petitioner testified that she started getting right wrist pain that day. For the next two weeks she continued working full time and performed the same job duties. T:21. During that two-week period, Petitioner testified she noticed her left wrist acting up, getting numb, tingling and wrist pain.

On March 27, 2017, Petitioner testified she reported this to Anna Sulik, who sent Petitioner to Julie Denson, of Employee Health. Denson made out a report and told Petitioner to go to Clearing Clinic. T: 22. The report, dated March 27, 2017, was created at 12:26pm. Px8. The document identified the incident date as 3/13/2017, the time start at 8am and event time at 10a. Data entry was identified as the job task. The phrase

"repetitive motion" is used 3 times in the report and is identified as the cause. The description noted "employee c/o of pain to right hand since late February. C/O tingling to left hand fingers 1-3 x 1 week."

On March 27, 2017, after finishing her shift, Petitioner went to Clearing Clinic where she informed the doctor that she was entering data into the computer and felt sharp pain in her right thumb, wrist and forearm, left thumb and fingers. T:22-22, Px1. She was feeling tingling and numbness. Petitioner was diagnosed with radial styloid tenosynovitis and advised to wear braces at night and at work and to ice both of her wrists for 15 minutes, four times per day. She was prescribed Ibuprofen and occupational therapy.

Petitioner initiated her occupational therapy at MacNeal Rehabilitation Services on April 3, 2017. The history she gave the therapist was consistent with what she testified to at trial. The records reflect Petitioner had twelve therapy visits with the last visit being on May 8, 2017. Px2. Petitioner returned to the Clearing Clinic on April 6, 2017, April 11, 2017 and May 2, 2017. Her complaints were the same on all three visits. At the final visit on May 2, 2017, Petitioner was referred to a hand specialist. Px1.

On May 10, 2017 Petitioner underwent an EMG/NCV at Neurologic Care Associates. Px3. The test was normal but suggestive of Petitioner's symptoms being of a musculoskeletal basis. The clinical note from the doctor stated it was likely she has overuse type of tendinitis in the wrist and fingers and there might be slight contribution from the periscapular spasm with referred pain and paresthesias.

On May 22, 2017, Petitioner was seen by Dr. Steven Sclamberg of Chicago Pain & Orthopedic Institute. Petitioner was complaining of pain in both wrists along the radial side with the right being worse. Px3. Dr. Sclamberg reviewed the EMG/NCV and diagnosed Petitioner with bilateral de Quervain's tenosynovitis, right greater than left. Dr. Sclamberg recommended a first dorsal compartment release on the right with an injection to the left wrist. He also restricted her work to no more than 5 pounds with repetitive duty.

On June 29, 2017, Respondent had Petitioner examined by Dr. Peter Hoepfner. Dr. Hoepfner reviewed various medical records and also diagnosed Petitioner with bilateral de Quervain's tenosynovitis. He also found Petitioner's complaints of numbness and tingling in her hands and at the wrist to be consistent with a diagnosis of mild bilateral carpal tunnel syndrome. Dr. Hoepfner opined that Petitioner's work was insufficiently forceful or repetitious to be the cause of the carpal tunnel syndrome or tendinitis and that more likely personal health factors and natural history were the etiology for her complaints. He also opined that Petitioner's treatment to date was reasonable and necessary but not related to the accident. He opined she may need a repeat cortisone injection and possibly de Quervain's release.

Petitioner returned to Dr. Sclamberg on July 17, 2017 still complaining of pain in her right wrist which was greater than in the left wrist. Dr. Sclamberg continued to recommend the first dorsal compartment release on the right. On August 7, 2017, Petitioner returned to Dr. Sclamberg still complaining of pain in both wrists, right greater than the left. She also had numbness and tingling in her first and third fingers bilaterally. Dr. Sclamberg reviewed the IME report and disagreed with the causal connection opinion of Dr. Hoepfner. Dr. Sclamberg opined there was sufficient radial and ulnar deviation in her job and also sustained forceful use based on what Petitioner described to him and recommended she continue with restricted work. He also continued to recommend surgery.

On September 8, 2017, Petitioner returned to Dr. Sclamberg with the same complaints. She informed him that the injection did not help. Dr. Sclamberg continued to recommend surgery. On September 11, 2017, Dr. Sclamberg performed a release of the first dorsal compartment for de Quervain's tenosynovitis on the right wrist. Px3. Petitioner returned to Dr. Sclamberg on September 25, 2017 and was noted to be doing well but still having some pain in her left wrist. Dr. Sclamberg recommended therapy which Petitioner began on October 2, 2017 at ATI. Px4. ATI noted a history of data entry and applying pressure in biopsy procedures.

On November 6, 2017, Petitioner returned to Dr. Sclamberg with complaints of pain over her incision but no numbness and tingling. She was also having complaints of pain in her left wrist with lifting. Dr. Sclamberg continued to recommend therapy. On December 4, 2017, Petitioner returned to Dr. Sclamberg still having some issues with the scar tissue on her right wrist and complaints of pain in her left wrist. Dr. Sclamberg continued to recommend therapy and prescribed a topical for her scar sensitivity. He also recommended a left first dorsal compartment release. Px3.

On January 11, 2018, Petitioner returned to ATI for her final therapy session. Petitioner underwent 45 therapy sessions between October 2, 2017 and January 11, 2018. Px4. On January 15, 2018, Petitioner returned to Dr. Sclamberg with the same complaints as from her prior visit. Dr. Sclamberg made the same treatment recommendations. On February 26, 2018, Petitioner returned to Dr. Sclamberg advising the right wrist was doing much better. She still had the same pain complaints regarding her left wrist. Dr. Sclamberg continued to recommend surgery for the left wrist.

On March 26, 2018, Dr. Sclamberg performed a first dorsal compartment release on the left wrist. Px3. On April 9, 2018, Petitioner returned to ATI for her second round of therapy. Px4. On June 11, 2018, Petitioner underwent MRIs to both of her wrists at Preferred Open MRI. Mild tenosynovitis and minimal fluid within the distal radial ulnar joint were noted on the right wrist. The left wrist MRI revealed a tiny dorsal metacarpal ganglion. Px3. On June 25, 2018, Petitioner returned to ATI for her final therapy visits. She underwent 31 therapy sessions between April 9, 2018 and June 25, 2018. Px4. Petitioner returned to Dr. Sclamberg on September 10, 2018 advising she was not experiencing any numbness or tingling. Dr. Sclamberg's PA, Melanie Coderre, recommended an FCE.

On September 24, 2018, Petitioner returned to Dr. Sclamberg and was examined by Coderre. Coderre reviewed the MRIs. Petitioner informed Coderre that she was unable to obtain the FCE. Coderre and Sclamberg completed a physical capacity form which noted restrictions for Petitioner's hands. Dr. Sclamberg opined that Petitioner was unable to use her hands for repetitive actions such as simple grasping, pushing and pulling and fine manipulating. There were other restrictions noted on the form which have nothing to do with Petitioner's work-related injury. Px3.

Petitioner testified she continued working for MacNeal until August 3, 2017. T:27. She testified she started doing light-duty work for MacNeal on June 1, through August 2, 2017. T:28. Petitioner testified after she was released by Dr. Sclamberg, she began looking for work. Petitioner identified job search records that she completed reflecting where she applied for work. Px6. She testified no one offered her a job. T:29. Petitioner testified that she still has sharp and burning pain in her wrists, but it is worse on the right.

On cross-examination, Petitioner testified she spoke to Julie Denson, the employee health manager, on March 27, 2017. T:32. Petitioner testified she informed Denson that she had been experiencing pain to both wrists. Petitioner denied telling Denson that she had been experiencing pain in her right hand since late February. She testified she had been experiencing a little tingling, numbness but not pain. She also testified she informed Denson about tingling and pain to her wrists. Petitioner denied any pre-existing conditions. Petitioner specifically denied having diabetes or being a smoker. T:33-34.

Petitioner also testified she informed Denson that she performed 4-1/2 to 5 hours of data entry on Mondays, Tuesdays and Wednesdays and 8 hours on Thursdays and Fridays. She testified she informed Denson that the remainder of her days she was applying pressure to the biopsy sites. T:34.

Petitioner identified Rx1as being a list of her job duties and job description which contained dates of when she started doing certain jobs. Petitioner was not really sure if she provided that same description of her job duties to Dr. Sclamberg. T:36. Petitioner testified she provided Dr. Hoepfner and Dr. Sclamberg a verbal description of her job duties which was similar but did not contain as much detail as the written one.

Petitioner testified with regard to data entry, she clicks, scrolls and types in. The amount of typing depends on errors on the patient sheets and the doctor's recommendations. She testified she had to type the doctor's recommendation regardless of whether or not it contained an error. T:40. Petitioner testified that typing could involve a sentence or two or could be more extensive. T:41. Petitioner testified that patients on blood thinners were told not to take them 5 days prior to the biopsy but they would still have bleeding after a biopsy. Petitioner denied a patient would be taken to the emergency room due to bleeding after more than 15 minutes. T:44.

Petitioner testified she is looking for any type of position she can find such as customer service, order taking, nursing, sitter or technician. She did not submit any applications but made phone calls to the prospective employers. T:45.

On re-direct examination, Petitioner testified there would be bleeding with every type of breast biopsy. She testified she never sent any patients to the emergency room for bleeding. T:48. Petitioner testified that if the Respondent were to offer her a position to return to work for them within her restrictions, she would accept it. Petitioner also testified she would accept help in finding suitable employment within her restrictions if that were offered to her by the Respondent. On re-cross examination, Petitioner testified that many of the restrictions placed upon her by Dr. Sclamberg have nothing to do with her wrists. T:49. On questioning from the Arbitrator, Petitioner testified that when she performed the data entry job, she was seated at a desk. Originally, she indicated her wrists would be hanging while typing and that she had two screen computers. She would have to move the mouse with her right hand. Petitioner also testified that she asked the manager about fixing that situation because she felt it was a problem that she was typing that way and an ergonomic person came in and switched the area around. That occurred in April 2017. T:51-52.

Testimony of Julie Denson

Julie Denson testified on behalf of the Respondent. Denson testified she is currently employed for MacNeal Hospital. She testified she would be there 9 years next month and that her job title is Manager of Employee Health. Her job duties include all pre-employment screenings, doing the annual flu vaccines and a large portion performing Workers' Compensation case managing. T:55-57.

Denson identified Rx2 as her notes after she talks to an employee following the initial injury. She testified if the employee has not completed an injury report, they do that together and it is noted. She identified her signature under the typed portion of the report. T:58. Denson testified she documented Petitioner's job duties being Mondays through Thursdays for 4-1/2 to 5 hours spent performing data entry with the remainder of the time being spent holding pressure on breast biopsy sites. Fridays was spent entirely performing data entry. T:60. Denson also testified that Petitioner told her she felt the issues with her hands and fingers were work related. T:60-61.

On cross-examination, Denson testified that Px8 is the injury report that is generated when it is entered into their system. T:63. Denson did not question anything Petitioner told her about her job duties. T:64. Upon questioning by the Arbitrator, Denson testified that she did hand write something on May 3, 2017 and she also spoke with Petitioner after May 3, 2017. Denson testified there is another set of notes with accommodations and stuff like that that they document. T:65-66.

On re-cross examination, Denson testified that she was the one who made the work accommodations for Petitioner based on the doctor's restrictions. Denson testified that Petitioner gave the restrictions to her unless they were faxed by the clinic. Denson would then send it to her manager or director Anna stating Petitioner may work with the following restrictions. Denson would lay them out and asked if they were able to accommodate those restrictions. T:67-68.

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Testimony of Anna Sulik

Respondent then presented Anna Sulik. Sulik testified she has been employed with the Respondent for 35 years. She is currently Director of Cardiac Rehab, Diagnostic Cardiology, Nuclear Medicine, Pain Management Clinic, Mammography Department, Ultrasound Department and Wound Care. She has been in this position for 6 years. Her job duties include overseeing departments, making sure they follow guidelines, protocols, standards, resolve any employee issue, any physician issue, but mainly it is to take care of employees and processes. T:69-70. On March 13, 2017, Petitioner was a nurse in the mammography department and Sulik was director over that department. Petitioner's direct supervisor was a lead tech and would have been Joann Baker. T:72.

Sulik testified that she had reviewed Rx1 which was the job description Petitioner completed. T:72-73. Sulik was asked about the various times spent holding pressure as stated on Rx1. According to Rx1, fine needle aspiration was 5 minutes but Sulik testified no holding pressure was required because it is very thin needle. T: 76. As for ultrasound biopsies requiring 15 minutes of holding pressure, Sulik testified it would be from "3 to 5 minutes for ultrasound biopsies, max 10 minutes. That's it. 15 minutes. It's quick." T:77. Regarding stereo or vacuum biopsies, Sulik testified 3 to 5 minutes, 10 minutes max. She disagreed with 20 to 25 minutes on Rx1. T: 78. Sulik also disagreed with holding pressure for up to an hour and 15 minutes and testified in that case, the patient would be sent to the emergency room. T:80. Sulik also disagreed with the amount of pressure applied being from 35 to 40 lbs. She also, however, testified there is no standard on how many pounds of pressure you need to apply although she stated the standard is gentle and constant pressure. T:81.

Sulik demonstrated her way of holding pressure was just with 3 fingers although some people use their palm. She testified 2 hands would be too much pressure but that some might do it. Sulik admitted there are really no guidelines on how to hold the pressure. T:95, 104-106. Sulik also testified that when Petitioner finally agreed to assist with MRI biopsies, she probably did a handful and that the average time of applying pressure would be 45 minutes due to the larger needle. T:96. Sulik agreed that for an ultrasound biopsy, there could be a situation where it would be longer than 10 minutes. T:113. Sulik testified she did not observe Petitioner applying pressure. T:106. She also agreed that a radiologist might sometimes ask the nurse to extend time for pressure after a biopsy and that the nurse would have to follow the instructions and direction of the radiologist T:115. Sulik also agreed there would be times when the Petitioner might be finished applying pressure in one room and then would have to go into another room immediately thereafter. T:116. On re-direct examination, Sulik testified that on average 80% of their biopsies would be 10 minutes max with the other 20% being 15 minutes. T:118.

Sulik testified biopsies are performed on patients on blood thinners but the patient is told to discontinue blood thinner medications prior to the biopsy. Sulik disagreed about every patient bleeding. Sulik testified that when you stop anticoagulants for 5 days, your blood clotting level goes to normal and you are considered a normal patient. There would not, therefore, be any situation that would require holding pressure for an hour and 15 minutes. T:79.

When asked about being allowed only 3 to 5 minutes rest between procedures, as stated in Rx1, Sulik testified they do not have designated rest time between patients. They have lunch breaks. The techs do not get rests between patients nor do the nurses. T:82-83. Regarding pushing and pulling a 7-foot lead door, Sulik testified Petitioner was never expected to be in the room during the biopsy but that it was her choice unless they had a Spanish speaking patient. Regarding the lead shield used in biopsy procedures, Sulik testified the door was 6-feet in size, on wheels and was moved 10 inches in direction, 20-25 times. T:84. Petitioner was not expected to move the shield but could. Sulik also testified that 4-6 images or x-rays were obtained, meaning the shield would be moved no more than 6 times.

Sulik testified that post biopsy procedure for Petitioner was holding pressure. If bleeding stopped, petitioner would have applied Steri-Strips and an occlusive dressing before sending the patient home. T:86

Sulik testified after she saw Petitioner for the second time with braces, it was decided to put her on data entry. T:114. Sulik also testified that she did have occasions to observe Petitioner doing her data entry and that she would see her keyboarding. T:115.

Regarding data entry, Sulik testified that Petitioner performed that task from 9:00 to 11:30 before going to lunch. She would come back at 12:30 and then do biopsies until 2:30 or 3:30. Petitioner would then clean up the rooms. From 3:30 to 5:00 she did data entry and Sulik disagreed with Petitioner's testimony that Petitioner performed data entry for 4-1/2 to 5 hours per day. T:87.

Sulik disagreed with the amount of typing Petitioner did. Sulik testified Petitioner would be seated, using a normal keyboard and would use a mouse to click thru approximately 5 fields. Petitioner would click, choose an option from the drop-down menu and move onto the next patient. Sulik testified Petitioner would only type if notes needed to be entered and if a doctor's recommendation was not one of the options from the drop-down menu. Petitioner also needed to type in the results of the biopsies. T:90-91, 96. Sulik confirmed Petitioner issued certification letters but only would have been required to type in the patient's name. Sulik testified the letters were templates Petitioner could choose from. T:92. Sulik testified Petitioner would have to fill out the green slip with the patient's address which was necessary for certified letters.

Sulik agreed that Petitioner filed her own packets that she created for patients although Sulik suggested it was not necessary as everything was electronic. T:93. Sulik testified that on Thursdays and Fridays, Petitioner might have to perform 8 hours of data entry each day. T:94. Sulik further testified that the hospital did an ergonomic study in March or April 2017 which was sparked by seeing Petitioner with her wrist brace. Sulik testified that about a week later, she could not remember if she saw Petitioner with one or two wrist braces and asked Petitioner what was going on. Petitioner replied, "you know, my wrists really hurt." T: 97.

Sulik testified when an employee has any type of injury, she will send them to Employee Health. Sulik testified Petitioner informed her that she is following up with Employee Health. Sulik was concerned with how Petitioner was performing biopsies with the wrist braces and asked how she puts gloves on them. Sulik testified Petitioner replied, "I'm taking them off, but I'm not – I don't remember for 100%, but I'm taking them off." Sulik testified a few days later, Petitioner informed her she could not do biopsies any more, so the decision was to remove her from biopsy and do data entry for the whole day. T:98. Sulik testified that what she found unusual about the Denson's report was concerning Petitioner's work injury is the fact that Petitioner was wearing 2 braces and she was wondering how she could perform her job. This would have been either late March or April 2017. T:101-102, See Rx2.

Sulik testified received complaints from techs and radiologists that Petitioner was taking too long in the room, but she did not know if it was because Petitioner was talking to the patient or if she was applying pressure but that it seemed like it was applying the pressure from what she stated. T:107.

On rebuttal, Petitioner testified with fine needle biopsy aspirations, she had to apply pressure for 5 minutes. She testified there were no biopsy procedures she was involved in where she did not have to apply pressure. T:122-123.

Regarding the 7-foot lead shield door, Petitioner agreed it could be 6 feet. She testified she needed to push and pull that door to allow the tech to come to the computer area. She also needed to push and pull that door to protect them from radiation when they were taking images of the patient. Petitioner agreed there was a typo in Rx1 and that that it was not 20 to 24 times per procedure that she had to push and pull on the lead door but 10 to 24 times. T:123-124.

On rebuttal cross-examination, Petitioner testified she agreed that the time required to apply pressure with a fine needle biopsy was 5 minutes. She also testified she disagreed with Sulik regarding the number of images per patient. Petitioner testified it could be anywhere from 9 or 10 which would be the least amount. She would have to push and pull the lead door so the tech could do her job taking the images. T:127-128. Petitioner

testified that while it might only be a couple of sentences, she had to type in doing data entry, it was per patient and there were stacks of backlogs that she had to do. T:131.

Petitioner also testified there was typing involved and drop-down boxes involved with data entry but because the computers were not interfaced or communicating, she had to type into her MRS screen the radiologist's interpretation which was in the chart. T:133. Petitioner also disagreed with Sulik's testimony that she only performed 3 MRI biopsies while at MacNeal. Petitioner testified there were way more than 3 and that she held pressure on all of them. T:136.

Following testimony, Petitioner's attorney made a Motion to Amend the Application to reflect an accident date of March 27, 2017 to conform to the proofs and to conform to the first date of medical treatment. There being no objection from Respondent, the Arbitrator granted the Motion to Amend the Application.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner, Sulik and Denson all testified at trial. The Arbitrator had an opportunity to observe each Petitioner's testimony and finds that Petitioner was very credible in her description of her work duties, when and how she reported her incident and symptoms, the course of treatment she had and her current attempts to seek work. The Arbitrator also observed Sulik and found her to be credible and knowledgeable in her duties and the scope of some of the areas of employment under her supervision. However, the factual dispute as to the length of time and amount of pressure applied during breast biopsies is resolved in favor of Petitioner, as Petitioner was the one who had direct and credible knowledge of this part of her job. In addition, the Arbitrator resolves the factual dispute over the amount of typing performed in favor of Petitioner for the same reason. The Arbitrator also observed Denson and found her also to be credible and candid in all of her testimony.

ISSUE (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
ISSUE (F) Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator incorporates the foregoing findings of fact as though fully set forth herein. The issue of accident was placed into dispute by the parties. Based on the record, Petitioner alleges repetitive trauma based on two primary sources of activities she repeatedly identified and which were discussed at length during the trial. These were the data entry performed at her desk and the application of pressure with her hands following biopsy procedures. *See also*, T:11. Extensive testimony was provided by the witnesses as to what these activities entailed, the lay out of the areas in which the activities took place, the duration, nature and extent of such activities.

Following Petitioner reporting her symptoms, Denson completed a Workers' Compensation worksheet consisting of the information provided to her by Petitioner. Px8. "Repetitive motion" is noted 3 times and is identified as the cause. The job task identified is data entry. The description noted right hand pain since late February and tingling to the left hand that was present for 1 week. Denson also completed a typed note that petitioner first noticed right hand, thumb and wrist radiating to the forearm since late February. Rx2. Denson wrote that Petitioner noticed an increase in pain on 3/13/17. Petitioner also complained of left numbness. Petitioner gave Dr. Hoepfner at the time of her June 2017 Section 12 exam a similar history – that on March 13th she noticed right wrist symptoms after performing data entry and also began noticing left wrist symptoms. Rx3:8. She related to Dr. Hoepfner that her symptoms were present since February. Likewise, Petitioner disclosed to Concentra, Dr. Sclamberg and ATI that she performed both data entry and biopsy assistance. The Arbitrator finds that Petitioner gave a credible, honest and consistent history of the onset and duration of her symptoms.

At trial, there was extensive testimony over Petitioner's job duties. The parties do not dispute that Petitioner's job duties involved both data entry and the application of pressure following breast biopsies.

Regarding the data entry duties, Petitioner testified that in March 2017, she performed 31 hours of data entry per week. T:11. Specifically, on Mondays, Tuesday and Wednesdays she did 4.5-5 hours of data entry. On Thursdays and Fridays, she did full days of data entry. She further alleged the data entry work, which included working with a mouse and keyboarding, was for up to 2 hours continuously. See, Rx1. Petitioner said she used her hands constantly when doing data entry. In rebuttal, Petitioner related that her data entry included clicking, scrolling, inputting data into the system and for certified letters using the keyboard. Sulik contended the amount of typing Petitioner had to do was significantly less than the extent to which Petitioner testified. Sulik, however, did not dispute that Petitioner had typing. On the other hand, Denson wrote that Petitioner related that her job duties were Monday thru Thursday 4.5-5 hours spent performing data entry but that only Fridays were spent performing data entry all day. Rx2. The remainder of the time is spent holding pressure for breast biopsies. *Id.* The Arbitrator finds that Denson's notations are otherwise consistent with Petitioner's trial testimony and the information Petitioner disclosed on Rx1. Clearing Clinic noted Petitioner was entering data into the computer when she noticed pain to the right thumb, wrist and forearm. Px1. MacNeal noted Petitioner related she had to *type* constantly. Px2 (Emphasis added). Dr. Sclamberg also documented that Petitioner performed data entry work and noted Petitioner demonstrated radial and ulna deviation as well as wrist extension and flexion. Px3. ATI also noted Petitioner performed data entry. Px4. The Arbitrator finds Petitioner's description of her data entry duties credible over the facts alleged by Sulik for this particular job.

As to the biopsy duties, Sulik gave conflicting testimony as to the amount of time pressure is applied, testifying that it was 3-5 minutes max but also as high as 45 minutes. She further agreed there is no guideline on how to apply pressure or how much pressure to apply. Sulik admitted she never observed Petitioner applying pressure in this setting. Denson noted that the remainder of Petitioner's non-data entry time was spent holding pressure for breast biopsies. Rx2. MacNeal noted petitioner related that she was also required to apply pressure with both hands constantly. Px2. Dr. Sclamberg noted Petitioner applied pressure anywhere from 5-60 minutes with short breaks in between patients. Px3. ATI noted petitioner assisted with biopsy procedures. Px4. The Arbitrator weighs this disputed fact in favor of Petitioner has she had direct knowledge of how much pressure she applied, how she used her fingers and hands to apply pressure and for how long.

In order to obtain compensation under the Act in a repetitive trauma claim, an employee must point to a date on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Durand v. Indus. Comm'n*, 224 Ill.2d 53, 64 (Il. 2006). The date of injury in a repetitive trauma claim is the date in which the injury manifests itself. *Id.* at 67. In determining the manifestation date, courts have typically set the manifestation date on the day the employee requires medical treatment or the date in which the employee can no longer work. *Id.* at 72.

The Arbitrator concludes that the preponderance of the evidence supports a conclusion that Petitioner's data entry activities, which were undisputedly part of her employment duties resulted in accidental injuries arising out of and in the course of her employment and which manifested on March 27, 2017. Petitioner and Sulik both confirmed Petitioner's job duties included data entry, thereby satisfying the employment risk associate with the arising out of analysis. The histories contained in Denson's report, the incident report, Concentra, MacNeal, Dr. Sclamberg and ATI all identify data entry as either a cause or as associated with her symptoms. Rx1-2, Px1-4.

Petitioner credibly testified she performed data entry work 4.5-5 hours per day and that Thursdays and Fridays were exclusively data entry. Petitioner also disclosed this in her self-reported job description. Rx1. Despite Sulik disagreeing Petitioner performed 4.5-5 hours of data entry work, the Arbitrator assigns less weight to Sulik's estimation as she neither worked alongside Petitioner on a daily basis nor testified she ever observed Petitioner performing data entry. Sulik also did not refute Petitioner's testimony that she performed exclusively data entry on Thursdays and Fridays. Petitioner testified her data entry included mousing, keyboarding and

inputting data using the keyboard. She also described entering data, scrolling, clicking, copying and pasting, reaching for the mouse, filing and stapling. Rx1. The Arbitrator finds these activities of data entry are sufficiently repetitive to constitute an accident arising out of and in the course of that employment. While petitioner also points to the application of pressure in post-biopsy procedures, the Arbitrator places less weight on this activity as sufficiently repetitive based on Petitioner's own description at the time of the accident that she was performing data entry when she noticed her symptoms. Nevertheless, the Arbitrator places some weight on Petitioner's testimony and her medical records in favor of corroborating the application of pressure as a potential contributing cause.

The Arbitrator further concludes that Petitioner's accidental injuries were sustained in the course of her employment. Petitioner's unrebutted testimony was that on Monday March 13th, she clocked into work and began performing data entry work. T:19-20. She noticed right wrist pain but kept working. Eventually, she reported her symptoms to Sulik and Denson on March 27th.

As to causation, Dr. Sclamberg opined Petitioner's bilateral de Quervain's tenosynovitis was related to her work duties. Px3. In his August 7, 2017 office note, Dr. Sclamberg reviewed a job description prepared by Petitioner and, based on Petitioner's demonstrating how she performed her job, Dr. Sclamberg opined that her job was the cause of her de Quervain's tenosynovitis and carpal tunnel symptoms. Dr. Sclamberg believed there was sufficient radial and ulnar deviation in Petitioner's job as well as sufficient sustained forceful use.

Dr. Hoepfner, while in agreement with the diagnosis and treatment, disagreed as to the cause of Petitioner's conditions. Rx3. The doctor attributed Petitioner's condition to personal health factors and natural etiology. The doctor concluded Petitioner's work was insufficiently forceful or repetitious to cause bilateral de Quervain's tenosynovitis as well as bilateral carpal tunnel syndromes. The Arbitrator must place less weight on Dr. Hoepfner's opinions. In so doing, the Arbitrator notes that Dr. Hoepfner did not review medical records beyond May 10, 2017 and only reviewed handful of records. He did not have the benefit of reviewing Denson's report, the incident report, MacNeal Rehab records or the initial records from Dr. Sclamberg. Rx2, Px8. These records existed at the time he performed his evaluation. Further, Dr. Hoepfner only cited as the history of her illness to include clicking and mousing – he did not weigh or consider the typing noted throughout the record. Rx3:4. Finally, Dr. Hoepfner's conclusion that Petitioner's condition is related to personal health factors and a natural etiology, this conclusion is in contrast to his finding that Petitioner's past medical history was unremarkable. In addition, Dr. Hoepfner failed to identify what those personal health factors or etiologies were.

Having weighed all evidence including the medical opinions in this case, the Arbitrator adopts the opinions of Dr. Sclamberg and finds that his opinions are more persuasive than those of Dr. Hoepfner. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being involving both of her hands and wrists is causally connected to the accident of March 27, 2017. In so concluding, the Arbitrator finds that Petitioner's data entry duties were a causative factor in the development of Petitioner's current condition of ill-being. This is consistent with Petitioner's testimony that she first noticed right wrist pain on March 13th and that she then also noticed left wrist pain. Further, this conclusion is consistent with Petitioner's statements to Denson, which were timely memorialized in the incident report and in Denson's notes. See, Rx2, Px8.

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 as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that the medical services provided to Petitioner for her bilateral de Quervain's tenosynovitis have been both reasonable and necessary and that Respondent has not yet paid all appropriate charges for same. Petitioner placed into evidence the following medical bills:

Chicago Pain & Orthopedic Institute	$ 13,025.22
Accredited Ambulatory Care	$ 32,015.92
Preferred Open MRI	$ 3,000.00
Skypoint Medical Center	$ 368.00
ATI	$ 23,988.58
Ashland Health	$ 863.28
RX Development	$ 2,678.18
Injured Workers Rx	$ 3,682.17
	$79,621.35

The record shows Petitioner undertook the aforementioned treatment in order to treat her bilateral de Quervain's tenosynovitis. The medical bills submitted properly correspond to the medical treatment contained in the record. Respondent objected to the medical bills based on causation, reasonableness and necessity. As of the date of Dr. Hoepfner's exam, the doctor agreed that all treatment up until then had been reasonable and necessary. He further concluded that Petitioner had not exhausted conservative care, recommending she may benefit from a second injection and if necessary, a first dorsal compartment release. Causation aside, Dr. Hoepfner did not dispute the need for additional care and the treatment that was in fact administered was consistent with Dr. Hoepfner's conclusions in this regard. The Arbitrator finds that the medical bills referenced above for treatment Petitioner received were both reasonable and necessary as well as causally related to the injury.

Respondent shall pay reasonable and necessary medical services of **$79,621.35**, 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 by BCBS, 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?

The Arbitrator incorporates the foregoing findings of fact as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner is entitled to TTD for her time off of work as a result of these injuries. Petitioner is claiming temporary total disability benefits from August 3, 2017 through September 24, 2018. From a review of Dr. Sclamberg's records, there are work status notes contained therein to justify Petitioner receiving temporary total disability for this period. Petitioner had testified that her last day worked was August 2, 2017 and that for a period of time prior to August 2, Respondent had been accommodating her work restrictions. Respondent shall pay Petitioner temporary total disability benefits of **$1,048.74/week** for **59-6/7th** weeks, commencing **8/2/17** through **9/24/18**, as provided in Section 8(b) of the Act.

Petitioner also seeks maintenance benefits from September 25, 2018 through December 13, 2018. Ax1. Petitioner reached MMI as of September 24, 2018 and was given permanent work restrictions from Dr. Sclamberg. There is no indication that Petitioner's permanent work restrictions were able to be accommodated by Respondent or that Respondent presented any evidence challenging the validity of the permanent work restrictions. Petitioner testified to a job search she performed on her own. Petitioner placed into evidence as Px6 job search records covering the period October 15, 2018 through December 10, 2018. Contained in those records are 86 job contacts made by Petitioner. Petitioner testified she has not been offered any work since she last worked for the Respondent on August 2, 2017. Therefore, Respondent shall pay Petitioner maintenance benefits of **$1,048.74/week** for **11-3/7th** weeks, commencing **9/25/18** through **12/13/18**, as provided in Section 8(a) of the Act.

ISSUE (K) ***Is Petitioner entitled to any prospective medical care?***
ISSUE (O) ***Other – Vocational Rehabilitation***

The Arbitrator incorporates the foregoing findings of fact as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner is entitled to vocational rehabilitation services.

On October 3, 2018, Petitioner filed a Petition for Vocational Rehabilitation pursuant to Section 8(a) of the Act. Px7. The basis of the request concerned Petitioner's permanent restrictions precluding her from returning to work for the Respondent in her former capacity. Since being released by Dr. Sclamberg, Petitioner has been diligently looking for work within her restrictions albeit unsuccessfully.

Because Petitioner is unable to resume her prior job duties, the Arbitrator orders the Respondent to comply with Section 9110.10 of the Rules of the Commission and to provide vocational rehabilitation services to Petitioner.

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

KENNETH BRITT,

Petitioner,

vs. NO: 18 WC 3627

GRANITE CITY SCHOOL DISTRICT,

Respondent.

19IWCC0633

DECISION AND OPINION ON REVIEW

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

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission modifies the Arbitrator's Decision with respect to Petitioner's left knee condition, and instead finds that Petitioner's current condition of ill-being as to his left knee is causally related to the January 19, 2018 undisputed work accident.

The Arbitrator stated that Petitioner had a long history of left knee problems, and one month before the January 19, 2018 accident, his primary care physician noted that Petitioner would likely need a knee replacement. Notwithstanding Petitioner's pre-existing left knee issues, the Arbitrator awarded medical bills for the left knee through February 5, 2018. The Arbitrator also added that Petitioner's left knee injury, resulting from the January 19, 2018 accident, would have resolved by March 23, 2018. On March 23, 2018, Dr. George Paletta, a board-certified orthopedic surgeon who evaluated and treated Petitioner, indicated that the left knee was normal. (PX3). However, Petitioner had been undergoing physical therapy for his left knee from January 22, 2018 through August 1, 2018, and underwent bilateral knee injections on July 26, 2018 with Dr. Mark Eavenson. (PX2). Dr. Paletta explained at his August 2018 deposition that he did not want to recommend any left knee surgery just yet because he wanted to address Petitioner's left shoulder, which was also injured in the January 19, 2018 accident. "Just in case after surgery on the knee he happens to need to be on crutches for a little while, I don't want him to be on crutches immediately after any shoulder surgery." (PX8, pgs. 17-18).

The prior medical records in evidence related to Petitioner's left knee indicate that Petitioner last treated for his left knee around June 2008. (RX10). Then on September 19, 2017, his primary care physician noted that Petitioner had knee pain that was triggered by back pain; Petitioner's back pain radiated into his left knee and thigh. His diagnosis was chronic left-sided low back pain with left-sided sciatica. (RX14). Petitioner's low back condition is unrelated to this workers' compensation claim. Thereafter, Petitioner's left knee complaints appear again following the January 19, 2018 accident. There were objective findings of trauma; on January 19, 2018, left knee x-rays were ordered which revealed large joint effusion indicating internal derangement, as well as tricompartmental degenerative changes of the left knee that were moderate in the medial compartment and mild in the lateral and patellofemoral compartments. Petitioner was diagnosed with left knee contusions and effusion. (PX1).

Dr. Eavenson then noted on January 22, 2018, that Petitioner's left knee was swollen and he had medial/lateral joint line tenderness; apprehension test, valgus stress test, and drawer test were all positive. Based on these findings, Dr. Eavenson diagnosed Petitioner with internal derangement of the left knee with possible medial meniscus and ACL tear. (PX2).

Petitioner completed an MR arthrogram of the left knee on February 1, 2018. The impression revealed a partially resected medial meniscus with a recurrent undersurface tear of the posterior horn of the meniscal remnant. There was also a Grade 4 chondrosis of the medial femoral trochlear surface and peripheral medial femoral condyle, as well as a Grade 2 tear of the ACL origin. (PX2; PX6). Dr. Paletta noted on February 5, 2018 some left knee peripatellar tenderness; Petitioner also had pain in the posterior aspect of the left knee with forced flexion, as well as moderate patellofemoral crepitus. (PX3; PX8, pg. 11). Dr. Paletta took x-rays of Petitioner's left knee on February 5, 2018 which revealed some mild degenerative changes of the medial

compartment and patellofemoral compartment. Dr. Paletta found no advanced osteoarthritic changes in the left knee; these findings appeared similar to a May 2008 MRI. (PX3; RX10).

Dr. Paletta also reviewed the January 24, 2018 MRI of the left knee; compared to the February 1, 2018 MR arthrogram, he did not note any recurrent tear. There was also evidence of medial compartment degenerative changes with Grade 3 chondrosis of the medial tibial plateau and femoral condyle. There was also minimal signal abnormality in the ACL consistent with possible mild strain. (PX3; PX6; PX8, pg. 13). Dr. Paletta diagnosed Petitioner with left knee medial compartment degenerative joint disease. (PX3). Dr. Paletta had testified that although the meniscus was abnormal, it looked consistent with old changes from a previous knee surgery. "I diagnosed him with increase in symptoms related to arthritis of the inside of the knee with reactive effusion or swelling. I did not think there was evidence of an obvious meniscus tear at that point." (PX8, pg. 13). Dr. Paletta opined that Petitioner's left knee condition was causally related to the January 2018 work accident. "While it is clear that the DJD was long standing and preexisting, it was asymptomatic up until the time of the fall. He has evidence of persistent effusion." (PX3; PX8, pg. 15).

Respondent's Section 12 examiner, Dr. Christopher Kostman, indicated that as of March 14, 2018, Petitioner was exhibiting left knee medial joint line tenderness bilaterally, range of motion was mildly restricted bilaterally, and Petitioner had some patellofemoral crepitance to knee range of motion bilaterally. (RX6, pg. 11). Dr. Kostman took x-rays of Petitioner's left knee and reviewed the January 24, 2018 MRI of the left knee. (RX6, pgs. 12, 18-20). He, like Dr. Paletta, diagnosed Petitioner with left knee degenerative joint disease. However, Dr. Kostman did not believe Petitioner's left knee condition was causally related to the January 19, 2018 accident. He stated that Petitioner's left knee findings were consistent with longstanding degenerative arthritis. (RX6, pgs. 22-23).

Based on the evidence in its entirety, the Commission finds that Petitioner's current left knee condition is causally related to the January 19, 2018 accident. Respondent does not dispute accident as its relates to the left knee, and the chain of events and evidence in the record supports that Petitioner's left knee had been aggravated in the January 19, 2018 fall; Petitioner had objective evidence of injury including left knee contusions, effusion, and swelling as of January 19, 2018. Petitioner was off work, and necessitated diagnostic tests, physical therapy, and injections. Following the January 19, 2018 accident, Petitioner's complaints, symptoms, and findings were consistent and continuous. As such, the Commission further awards all reasonable, necessary, and causally related medical bills pertaining to the left knee, as well as prospective treatment as may be recommended or reasonably required to cure or relieve Petitioner's left knee condition from the effects of the accidental injury. Petitioner is also entitled to TTD from January 20, 2018 through October 3, 2018 (or 36 5/7 weeks). The Commission finds that Respondent is entitled to credit for TTD previously paid to Petitioner in the amount of $9,891.90, covering January 25, 2018 through May 9, 2018. By its stipulation and Brief, Respondent disputed causal connection on the issue of benefits, but not the reasonableness or necessity of the treatment rendered, nor the TTD time period.

19IWCC0633

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 7, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and causally related medical bills pertaining to the left knee, pursuant to Section 8(a) of the Act and to be adjusted in accord with the medical fee schedule provided in Section 8.2 of the Act. The Commission affirms the Arbitrator's Decision that medical benefits for the left shoulder and left elbow after February 5, 2018 are denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective treatment as may be recommended or reasonably required to cure or relieve Petitioner's left knee condition from the effects of the accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $659.46 per week for 36 5/7 weeks, commencing January 20, 2018 through October 3, 2018, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $9,891.90 for temporary total disability benefits that have been paid.

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

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

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

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

DATED: NOV 21 2019

D. Douglas McCarthy

DDM/pm
O: 10-29-19
052

Stephen J. Mathis

SPECIAL CONCURRENCE/DISSENT

I concur with all aspects of the Majority's opinion other than its award of benefits regarding Petitioner's left knee. I respectfully dissent as to this award. I would affirm and adopt the Arbitrator's well-reasoned opinion in its entirety.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

BRITT, KENNETH
Employee/Petitioner

Case# **18WC003627**

GRANITE CITY SCHOOL DISTRICT
Employer/Respondent

19IWCC0633

On 1/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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PO BOX 99
E ALTON, IL 62024

2396 KNAPP OHL & GREEN
MATTHEW M TERRY
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EDWARDSVILLE, IL 62025

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)

KENNETH BRITT
Employee/Petitioner

v.

GRANITE CITY SCHOOL DISTRICT
Employer/Respondent

Case # 18 WC 3627

Consolidated cases: _____

19IWCC0633

An *Application for Adjustment 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 **10/3/18**. 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, **1/19/18**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**51,433.20**; the average weekly wage was $**989.19**.

On the date of accident, Petitioner was **49** years of age, *married* with **0** children under 18.

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

Respondent shall be given a credit of $**9,891.90** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**9,891.90**.

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

ORDER

Petitioner failed to prove his current conditions of ill-being for his left shoulder, left elbow, or left knee are causally related to the accident. Therefore, medical benefits for the left shoulder, left elbow, and left knee after February 5, 2018 are denied. In addition, Petitioner failed to prove a compensable claim for his right knee and failed to prove his current condition of ill-being for his right knee is causally related to the accident so medical benefits for the right knee are denied in their entirety. Lastly, temporary total disability benefits are denied in their entirety. See attached Addendum to Arbitration Decision.

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

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

Signature of Arbitrator

12/31/18
Date

ICArbDec19(b)

JAN 7 - 2019

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KENNETH BRITT
Employee/Petitioner

v. Case # 18 WC 3627

GRANITE CITY SCHOOL DISTRICT
Employer/Respondent

19IWCC0633

ADDENDUM TO ARBITRATION DECISION

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim alleging injuries to his left shoulder, left elbow, and left knee when he "tripped on concrete block" on January 19, 2018. (AX 2).

Petitioner is a custodian for Respondent and has been a custodian for Respondent for approximately 16 years. (T.9).

LEFT SHOULDER

It is undisputed Petitioner suffered a left shoulder injury in a motor vehicle accident (MVA) at Horseshoe Lake State Park on May 5, 2010 and filed a lawsuit against the State of Illinois in the Illinois Court of Claims for that MVA. (T.14-19, RX 1, RX 2, RX 3).

Dr. George Paletta treated Petitioner's left shoulder after that MVA, as well as after the instant accident, and Dr. Paletta testified in his August 22, 2018 deposition for the instant claim that if Petitioner had continuous left shoulder complaints after that MVA then the January 19, 2018 work injury would not be a causative factor in Petitioner's left shoulder condition. (PX 8-32-33). Here, the evidence is clear Petitioner's left shoulder complaints continued after that MVA based on Petitioner's deposition testimony and trial testimony from his Illinois Court of Claims case. (RX 1-39, RX 2-51, RX 2-60).

Petitioner began treating with Dr. Paletta for his left shoulder after that MVA on January 12, 2011. (RX 8, PX 3). Petitioner eventually underwent left shoulder surgery with Dr. Paletta on February 10, 2011 and during the February 10, 2011 surgery Dr. Paletta debrided Petitioner's labrum, debrided Petitioner's partial-thickness rotator cuff tear, and performed a subacromial decompression, bursectomy, and acromioplasty, among other procedures. (RX 9, PX 4).

Dr. Paletta released Petitioner on May 18, 2011 but, based on Petitioner's deposition testimony from November 25, 2014, Petitioner continued to have left shoulder complaints after his release from Dr. Paletta on May 18, 2011. (PX 3-23-25, RX 1). The following is the exchange between Petitioner and the Respondent's attorney in that deposition (RX 1-39):

Q: With regard to the left shoulder injury we've talked briefly about that, you've had surgery?

A: Yes.

Q: You went through physical therapy?

A: Yes.

Q: Have you recovered from your shoulder injury?

A: No, not totally.

Q: What is still wrong with you shoulder?

A: It hurts me every night, I can't hardly sleep, between it and my neck, I mean a lot of misery, a lot of pain.

(RX 1-39).

When initially asked about this deposition testimony at trial of the instant claim on cross-examination, Petitioner claimed he was "almost positive at that point I was over the shoulder issue. The pain I was having was due to my neck." However, when Respondent's counsel read the deposition transcript to Petitioner at trial, Petitioner admitted those were his left shoulder complaints as of November 25, 2014. (T.31, 34). In addition, Petitioner was still taking muscle relaxers for his left shoulder as of November 25, 2014. (T.32, 34-35; RX 1-41). Furthermore, Petitioner testified in his deposition at length regarding things he could no longer do (hunting, fishing, side jobs, extended amounts of bending over or hammering or reaching over his head) and things he could do but was limited (forward weight lifting, reaching over his head, mowing his yard) because of his left shoulder. (RX 1-42-44).

The ongoing left shoulder complaints after the May 18, 2011 release from Dr. Paletta are further evidenced by the records from Petitioner's visit with his primary care physician on November 6, 2012 wherein his primary care physician stated "part of this is from the neck and part of it is from the shoulder itself." The note further states "it hurts to sleep and he awakens in marked pain." (RX 14-1-7).

Throughout direct examination and cross-examination at the trial of the instant claim Petitioner testified that only his neck continued to cause him difficulties and his left shoulder did not cause him difficulties after the MVA. (T.36). However, the following is the exchange

between Petitioner and his attorney at the trial of his Illinois Court of Claims case on October 11, 2017 (RX 2-51):

Q: The difficulties that you have today, are they related to your neck and shoulder?

A: Yeah, I mean they play into each other, yes, sir.

(RX 2-51).

The following is an additional exchange between Petitioner and his attorney at the trial of his Illinois Court of Claims case on October 11, 2017 (RX 2-60):

Q: All right. So the difficulties – I am correct when I state, and I don't want to put words in your mouth, you just tell me, that when we're talking about the difficulties and your ability to do things and not ability to do things, and things you can't do that you used to be able to do, that is because of the difficulty and the problems that you're having with regard to your neck and your shoulder, is that correct?

A: Yes, . . .

(RX 2-60).

Petitioner testified at the trial of his Illinois Court of Claims case on October 11, 2017 at length regarding the things he had difficulties doing due to the MVA. For example, he testified he was able to perform his job duties for the Granite City School District but he has difficulties bending over and cleaning desktops, as well as pain "every day." (RX 2-51, RX 2-7-8). In addition, he testified he can no longer do heavy work such as "carpentry work, gettin' down on the ground, rollin' around under a car, workin' on anything like that. Workin' over – like under the hood of a car, workin' bent over for a long period of time. . . overhead work kills me, havin' to tilt my head back and lookin' up, and like trying to hammer overhead or anything like that, that's bad. That really hurts." (RX 2-53-54). Furthermore, Petitioner testified the hardest things he has to deal with on a daily basis was "living with the pain every day" and "not being able to get a decent night's sleep." (RX 2-57). This was the condition of Petitioner's left shoulder less than 3 months before the instant accident.

As for the instant claim, Petitioner first presented for medical treatment on January 19, 2018 at the emergency room at Gateway Regional Medical Center (GRMC). He was diagnosed with a contusion of his left shoulder and discharged. (PX 1). He presented to Dr. Paletta on February 5, 2018 at which time he was diagnosed with a partial thickness rotator cuff tear of his left shoulder with possible focal full thickness tear. (PX 3-21). Petitioner eventually underwent another left shoulder surgery with Dr. Paletta on August 7, 2018 in a nearly identical procedure as the February 10, 2011 surgery Dr. Paletta performed because in the August 7, 2018 surgery Dr. Paletta again debrided Petitioner's labrum, debrided Petitioner's partial-thickness rotator cuff tear, and performed a subacromial decompression, bursectomy, and acromioplasty. (PX 5, PX 4).

Petitioner testified at trial of the instant claim on direct examination that after January 19, 2018, but before the August 7, 2018 left shoulder surgery, his left shoulder "was killing me. I couldn't hardly sleep at night. It was aching and throbbing constantly. I mean, it hurt pretty much all the time, and very limited, weak, real weak." (T.26-27). This testimony is nearly identical to the deposition testimony from November 25, 2014 and the trial testimony from October 11, 2017. Specifically the fact he could not hardly sleep at night due to his left shoulder complaints were the same complaints made on November 25, 2014 and October 11, 2017. (RX 1-39, RX 2-57). Petitioner also testified at trial of the instant claim on direct examination that he did not seek medical care from any other physicians for his left shoulder from May 18, 2011 to January 19, 2018 but the fact he did not seek medical care for his left shoulder during that time frame is insignificant based on his testimony on November 25, 2014 and October 11, 2017 because he had continued left shoulder complaints at those times without seeking medical treatment.

Dr. Paletta was deposed in the Illinois Court of Claims case on December 22, 2017 and testified Petitioner suffered a large tear of the labrum in the MVA and further testified that because Petitioner had a partial thickness rotator cuff tear he was potentially more susceptible to additional rotator cuff problems in the future. (RX 3-12, 3-15). Dr. Paletta confirmed this in his August 22, 2018 deposition for the instant claim. (PX 8-27, 8-28, 8-34). In fact, Dr. Paletta further testified in his August 22, 2018 deposition that one does not need to have a specific event to have future rotator cuff pathology that may require an additional surgery as one can have progression of the condition and the likelihood of having future rotator cuff pathology that may require surgical intervention increases with time and age. (RX 8-34-35). This is significant in the instant claim as the same area of the rotator cuff (supraspinatus) that was debrided in 2018 was debrided in 2011. Furthermore, Dr. Paletta testified the subacromial decompression, bursectomy, and acromioplasty is basically removing scar tissue and spurs, which are either due to the prior surgery or age. (PX 8-35).

Dr. Paletta's causation opinion for the left shoulder in the instant claim was based on Petitioner's history of not having any significant problems with his left shoulder over the last seven years but Dr. Paletta admitted that his opinions regarding causation could change if that history is inaccurate. (RX 8-30-31). The evidence at trial shows that history is, in fact, inaccurate and Dr. Paletta admitted on cross-examination that the complaints or problems Petitioner mentioned during his deposition and trial of his Illinois Court of Claims case were significant complaints or problems. (RX 8-31-33). Dr. Paletta also testified in his August 22, 2018 deposition that if Petitioner had continuous left shoulder complaints (which, again, are evidenced by Petitioner's deposition and trial testimony from the Illinois Court of Claims case) then the January 19, 2018 work injury would not be a causative factor in Petitioner's left shoulder condition. (RX 8-32-33).

Petitioner underwent a Section 12/IME with Dr. Chris Kostman, a board-certified orthopedic surgeon specializing in extremity surgeries, on March 14, 2018 and Dr. Kostman was deposed on September 5, 2018. (RX 6). Dr. Kostman reviewed all of the significant left shoulder records in the instant claim including, but not limited to, the deposition transcript from November 25, 2014, the trial transcript from October 11, 2017, Dr. Paletta's prior medical records (including the color operative photographs from the February 10, 2011 surgery), and Dr.

Paletta's current medical records (including the color operative photographs from the August 7, 2018 surgery). Dr. Kostman diagnosed Petitioner with a partial thickness rotator cuff tear with possible full thickness component, AC joint degenerative arthritis, circumferential labral tearing, and status post biceps tenodesis. (RX 6-92). It was Dr. Kostman's opinion that the January 19, 2018 accident was not a cause of, or did not permanently aggravate, any of these diagnoses but were rather the natural progression of those conditions following the February 10, 2011 left shoulder surgery with Dr. Paletta. (RX 6-21-22, RX 6-92-93). Lastly, Dr. Kostman testified that based on Petitioner's deposition testimony and trial testimony in his Illinois Court of Claims case that Petitioner had ongoing left shoulder problems or complaints as of October 11, 2017 then Petitioner would more likely than not continue to have those left shoulder complaints after October 11, 2017 unless he sought and underwent treatment for his left shoulder. (RX 6-26-27).

LEFT ELBOW

Petitioner testified at trial that his left elbow is "fine." (T.12, 25). While Dr. Paletta initially diagnosed Petitioner with posttraumatic ulnar neuritis of his left elbow. Dr. Paletta made no recommendations for any treatment besides possibly night splints and, based on Petitioner's trial testimony, it does not appear that even night splints are warranted. In addition, Dr. Kostman found Petitioner did not suffer any injury to his left elbow from the January 19, 2018 accident. (RX 6-22-23, RX 6-93-94).

LEFT KNEE

On December 18, 2017 – approximately one month before this alleged accident – Petitioner presented to his primary care physician with left knee pain and the record states "sees Ortho and was told he likely needs knee replacement soon." (RX 14-8).

Petitioner has a long history of left knee problems dating back well before January 19, 2018. (RX 10, RX 11, RX 12, RX 13-1-2). In fact, Petitioner has undergone three prior left knee surgeries – on October 4, 2001, January 20, 2003, and March 7, 2007. (RX 11, RX 12, RX 13-1-2). After the October 4, 2001 surgery he continued to have left knee problems and eventually underwent the January 20, 2003 left knee surgery with Dr. Forbes McMullin. (RX 10-4-10, RX 12). After the January 20, 2003 surgery he was released on March 3, 2003 and instructed to return on a prn basis but returned with pain and swelling to his left knee on June 4, 2003. (RX 10-11-13). At the time of the June 4, 2003 visit Dr. McMullin thought Petitioner was getting osteoarthritis in his left knee and scheduled Petitioner for a series of Supartz injections. (RX 10-13). Petitioner underwent five Supartz injections to his left knee from June 11, 2003 through July 9, 2003. (RX 10-14-18). On October 8, 2003 Petitioner returned to Dr. McMullin and Dr. McMullin stated Petitioner may need a knee replacement in the future on the left side. (RX 10-19). On February 21, 2007 Petitioner returned to Dr. McMullin following another workers' compensation accident on February 7, 2007 and Petitioner eventually underwent the March 7, 2007 left knee surgery with Dr. McMullin. (RX 10-21-24, RX 13-1-2). Again, Petitioner continued to have problems and underwent four Orthovisc injections to his left knee from July 27, 2007 through August 15, 2007. (RX 10-34-38). Then, Petitioner returned to Dr. McMullin on May 8, 2008 and underwent four more Orthovisc injections to his left knee through June 4, 2008. (RX 10-42-49).

In addition, Petitioner has two prior settlements for his left knee. 03 WC 974 settled for 25% of the left leg (RX 5-3-6) and 07 WC 9245 settled for 39% of the left leg (RX 5-7-8).

As for the instant claim, when Petitioner first presented to Dr. Paletta on February 5, 2018 he was diagnosed with medial compartment degenerative joint disease of his left knee with acute increase in symptoms with reactive effusion. (PX 3-21). Of note, Dr. Paletta was of the opinion there did not appear to be any ligament injury or evidence of recurrent meniscus tear and Dr. Paletta said there was no indication for surgical treatment of the left knee. (PX 3-21-22). Dr. Paletta recommended aspiration and injection of the knee and starting a Medrol Dosepak. (PX 3-21). Petitioner returned to Dr. Paletta on March 23, 2018 at which time Dr. Paletta examined Petitioner's left knee and Petitioner's left knee was basically normal on examination. (PX 3-6). Dr. Paletta confirmed this in his August 22, 2018 deposition. (PX 8-26-27).

Lastly, Dr. Kostman reviewed all of the significant left knee records in the instant claim including, but not limited to, the December 18, 2017 note from Petitioner's primary care physician, the three prior operative reports, and all of Dr. McMullin's records. (RX 6). Of note, Dr. Paletta reviewed none of these left knee records. Dr. Kostman also reviewed the actual radiographic study from the January 24, 2018 MRI of Petitioner's left knee and diagnosed Petitioner with left knee degenerative joint disease. (RX 6-94, RX 6-23-24). It was Dr. Kostman's opinion the findings on the MRI scan of Petitioner's left knee from January 24, 2018 were consistent with his longstanding degenerative arthritis in his left knee and did not identify evidence of an impact injury or new injury to the left knee. (RX 6-94, RX 6-23-24). Dr. Kostman was further of the opinion this alleged accident was not a cause of, and did not permanently aggravate, Petitioner's left knee degenerative joint disease but rather the findings were consistent with longstanding degenerative arthritis in Petitioner's left knee. (RX 6-94-95, RX 6-23-24).

RIGHT KNEE

Petitioner did not allege an injury to his right knee on his Application for Adjustment of Claim but, based on his trial testimony and Dr. Paletta's medical records, is now alleging an injury to his right knee in addition to the injuries to his left shoulder, left elbow, and left knee. (AX 2). However, the medical records do not support an injury to his right knee.

Petitioner has an even longer history of right knee problems than left knee problems and, similar to his left knee, his problems date back well before January 19, 2018. (RX 10, RX 13-3). Petitioner has undergone at least one prior right knee surgery – on July 18, 2007 with Dr. McMullin. (RX 13-3). On August 29, 2017 Dr. McMullin noted Petitioner has significant arthritis in his right knee and Dr. McMullin recommended hyaluronic acid (Orthovisc) injections if the symptoms recurred. (RX 10-40). Petitioner's symptoms recurred and he underwent four Orthovisc injections to his right knee from May 8, 2008 through June 4, 2008. (RX 10-42-49).

In addition, Petitioner has two prior settlements for his right knee. 97 WC 8056 settled for 10% of the right leg (RX 5-1-2) and 07 WC 9245 settled for 20% of the right leg (RX 5-7, 5-9).

As for the instant claim, Petitioner testified at trial that he "slammed" his right knee into the floor and "both knees were hurting really bad." (T.12). However, when Petitioner first presented for medical treatment on January 19, 2018 at the emergency room at GRMC he had no right knee complaints. (PX 1). In fact, Petitioner's extremities were examined and the doctor noted a grossly normal examination of the extremities besides the left shoulder and left knee. (PX 1-12-13). Petitioner also testified at trial that when he went to the emergency room at GRMC his right knee was "starting to swell" but, again, this testimony is contradicted by the medical records presented at trial. (T.24, PX 1-12-14).

When Petitioner presented for medical treatment on January 22, 2018 at Multicare Specialists and there was no mention of any right knee complaints. (PX 2-351-365). Petitioner was referred by Multicare Specialists to Dr. Paletta and first presented to Dr. Paletta on February 5, 2018 at which time he not only made no mention of any right knee complaints – Dr. Paletta examined his right knee and Dr. Paletta's examination of the right knee was normal. (PX 3-19). Dr. Paletta confirmed this in his August 22, 2018 deposition. (PX 8-37). In fact, Dr. Paletta testified that based on Petitioner's complaints and his examination of Petitioner right knee on February 5, 2018, it was his opinion based upon a reasonable degree of medical certainty that Petitioner did not suffer any injury to his right knee in the fall on January 19, 2018. (PX 8-38).

The first mention of any right knee complaints was on February 19, 2018 at Multicare Specialists but Petitioner claimed his right knee pain was due to "the way he's been walking due to left knee pain." (PX 2-312). This history is in contrast to the history Petitioner gave Dr. Paletta on March 21, 2018 that his right knee problems began on January 19, 2018 from a fall at work. (PX 3-8). Petitioner claimed to Dr. Paletta at the March 23, 2018 visit that he also had some right knee pain after the fall on January 19, 2018 but "did not think much about it at that time." However, again, Dr. Paletta examined Petitioner's right knee on February 5, 2018 and found a normal examination of Petitioner's right knee. (PX 3-5). In addition, Petitioner's claim that he "did not think much about it at that time" is in contrast to his own trial testimony mentioned above wherein he states he "slammed" his right knee into the floor and "both knees were hurting really bad" and his right knee was "starting to swell" on January 19, 2018. (T.12, T.24).

TEMPORARY TOTAL DISABILITY

Petitioner claimed TTD from January 20, 2018 through October 3, 2018, a total of 36 5/7 weeks. (AX 1). Respondent disputed liability for any TTD but paid $9,891.90 in TTD. (AX 1, RX 4-1). In addition, the parties stipulated at trial that Respondent is entitled to an 8(j) credit for any short-term disability paid by IMRF and Respondent is entitled to a credit for all net sick or vacation that's been paid to Petitioner against TTD, provided Petitioner's sick or vacation days or time is credited back to him. (T.8).

MEDICAL BILLS

Petitioner claimed medical bills totaling $75,334.94 at trial. (PX 7). Respondent disputed liability for any medical bills but paid $8,219.43 in medical. (AX 1, RX 4). In

addition, the parties stipulated at trial that Respondent is entitled to an 8(j) credit for any medical bills paid by group. (T.7).

CONCLUSIONS OF LAW

Issues (C) and (F): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and is Petitioner's current condition of ill-being causally related to the injury?

Petitioner failed to prove his current conditions of ill-being for his left shoulder, left elbow, or left knee are causally related to the accident. In addition, Petitioner failed to prove a compensable claim for his right knee and failed to prove his current condition of ill-being for his right knee is causally related to the accident.

As for the left shoulder, it is clear Petitioner had ongoing left shoulder complaints after his release by Dr. Paletta on May 18, 2011 based on Petitioner's deposition testimony on November 25, 2014 and his trial testimony on October 11, 2017 from his Illinois Court of Claims case. (RX 1, RX 2, RX 8). At trial of the instant claim Petitioner attempted to claim that his ongoing complaints after his release by Dr. Paletta on May 18, 2011 were due entirely to his neck but a cursory and comprehensive review of the entire evidence presented at trial shows otherwise.

Petitioner testified in his November 25, 2014 deposition that he had not totally recovered for his left shoulder injury in that his left shoulder hurt him "every night" and he "can't hardly sleep" due to his left shoulder pain. (RX 1-39). This testimony is even more significant in that Petitioner, despite these complaints, confirmed he was no longer treating for his left shoulder and had not gone to another doctor for his left shoulder. Id. In addition, Petitioner testified in his November 25, 2014 deposition that he was still taking muscle relaxers for his left shoulder at that time and he testified at length regarding the things he could no longer do or could do but was limited due to his left shoulder issues. (RX 1-41-44).

Petitioner's trial testimony on October 11, 2017 clearly shows Petitioner's difficulties were due to his neck and his left shoulder, not just his neck. (RX 2-51, RX 2-60). In addition, and consistent with his November 25, 2014 deposition testimony, Petitioner testified at length regarding the things he could no longer do or could do but was limited due to his left shoulder issues. (RX 2-7-8, RX 2-51, RX 2-53-54). Furthermore, Petitioner testified that he had pain "every day" and was still not able to "get a decent night's sleep." (RX 2-57).

The November 6, 2012 note from Petitioner's primary care physician further supports Petitioner's ongoing left shoulder complaints after his release by Dr. Paletta on May 18, 2011 in that the note said "part of this is from the neck and part of it is from the shoulder itself." The note further states 'it hurts to sleep and he awakens in marked pain." (RX 14-1-7). The Arbitrator finds this note of extreme significance because this note confirms Petitioner's ongoing complaints after his release from Dr. Paletta in 2011 were due to Petitioner's neck and left shoulder, not merely Petitioner's neck as Petitioner claimed at trial.

On August 7, 2018 Petitioner underwent another left shoulder surgery with Dr. Paletta in a nearly identical procedure that Dr. Paletta performed on February 10, 2011. (PX 4, PX 5). In both surgeries Dr. Paletta debrided Petitioner's labrum, debrided Petitioner's partial-thickness rotator cuff tear, and performed a subacromial decompression, bursectomy, and acromioplasty. Id.

At trial of the instant claim Petitioner testified on direct examination that his main complaint after January 19, 2018 but before the August 7, 2018 surgery was he "couldn't hardly sleep at night" – which was the same main left shoulder complaint in his November 6, 2012 primary care physician note, his November 25, 2014 deposition testimony, and his October 11, 2017 trial testimony. (T.26-27, RX 1-39, RX 2-57).

Dr. Paletta's causation opinion for the left shoulder is based on an inaccurate history from Petitioner (not having any significant problems with his left shoulder in the seven years before the January 19, 2018 accident) and Dr. Paletta testified on cross-examination that his opinions regarding causation for the left shoulder could change if that history is inaccurate. (PX 8-30-31). That history is, in fact, inaccurate based on Petitioner's deposition and trial testimony from his Illinois Court of Claims case. (RX 1, RX 2). Dr. Paletta further testified on cross-examination that if Petitioner had continuous left shoulder complaints (which, again, are evidenced by Petitioner's deposition and trial testimony from his Illinois Court of Claims case) then the January 19, 2018 work injury would not be a causative factor in Petitioner's left shoulder condition. (RX 2-32-33). Respondent's Section 12/IME Dr. Kostman was of the opinion the January 19, 2018 accident was not a cause of, or did not permanently aggravate, Petitioner's left shoulder based on his review of all of the records (including the deposition testimony and trial testimony) so the Arbitrator finds Dr. Kostman's opinions on causation to be more persuasive than Dr. Paletta.

As for the left elbow, Petitioner's left elbow is "fine" according to his trial testimony. (T.12, 25). In addition, Petitioner basically underwent no treatment to his left elbow and he is not scheduled to undergo any treatment to his left elbow. (PX 3). Furthermore, Dr. Kostman found Petitioner did not suffer any injury to his left elbow from the January 19, 2018 accident. (RX 6-22-23, RX 6-93-94).

As for the left knee, Petitioner presented to his primary care physician approximately one month before the January 19, 2018 accident with left knee pain and it was noted Petitioner would likely need a knee replacement. (RX 14-8). In addition, Petitioner has a long history of left knee problems dating back nearly 20 years before January 19, 2018 and he underwent three prior left knee surgeries. (RX 10, RX 11, RX 12, RX 13-1-2). Based on all of the evidence presented at trial, the Arbitrator finds the January 19, 2018 accident failed to change any condition of Petitioner's left knee. This is supported by Petitioner's long history of left knee problems, his significant arthritis in his left knee which is undisputed by several orthopedic surgeons, and his left knee complaints to his primary care physician approximately one month before the January 19, 2018 accident. However, assuming Petitioner suffered some injury to his left knee on January 19, 2018, any injury he would have suffered resolved as of March 23, 2018 when Dr. Paletta examined Petitioner's left knee and his left knee was basically normal upon examination. (PX 3-6).

As for the right knee, Petitioner failed to allege an injury to his right knee on his Application for Adjustment of Claim. (AX 2). In any event, the medical records do not support an injury to his right knee.

Petitioner has a long history of right knee problems dating back approximately 20 years before January 19, 2018 and he underwent at least one prior right knee surgery. (RX 10, RX 13-3). In addition, Petitioner's trial testimony is in stark contrast to the medical records as Petitioner testified he "slammed" his right knee into the floor and "both knees were hurting really bad" on January 19, 2018. (T.12). However, the first record of treatment for the instant claim was on January 19, 2018 at the emergency room at GRMC and this record is not only devoid of any right knee complaints but reveals that the doctor examined Petitioner's extremities and the doctor noted a grossly normal examination (besides the left shoulder and left knee mentioned above). (PX 1-12-13). Petitioner also claimed at trial that when he went to the emergency room at GRMC his right knee was "starting to swell" but this testimony is inconsistent with the medical records. Petitioner had no right knee complaints when he presented to Multicare Specialists on January 22, 2018 – contrary to Petitioner's trial testimony. (PX 2-351-365).

When Petitioner presented to Dr. Paletta on February 5, 2018 he was given at least two opportunities to tell Dr. Paletta of these apparent right knee complaints. (PX 3-19). However, he not only failed to do so, Dr. Paletta examined Petitioner's right knee on February 5, 2018 and Dr. Paletta's examination of Petitioner's right knee was normal. Id. In addition, Dr. Paletta testified in his deposition that based on Petitioner's complaints and his examination of Petitioner's right knee on February 5, 2018, it was his opinion based upon a reasonable degree of medical certainty that Petitioner did not suffer any injury to his right knee in the fall on January 19, 2018. (PX 8-38).

In conclusion, the Arbitrator finds Petitioner failed to prove his current conditions of ill-being for his left shoulder, left elbow, or left knee are causally related to the accident. In addition, Petitioner failed to prove a compensable claim for his right knee and failed to prove his current condition of ill-being for his right knee 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?

Having found that Petitioner failed to prove his current conditions of ill-being for his left shoulder, left elbow, or left knee are causally related to the accident, medical benefits for the left shoulder, left elbow, and left knee after February 5, 2018 are denied.

In addition, having found that Petitioner failed to prove a compensable claim for his right knee and failed to prove his current condition of ill-being for his right knee is causally related to the accident, medical benefits for the right knee are denied.

Issue (L): Is Petitioner entitled to temporary total disability benefits?

Having found that Petitioner failed to prove his current conditions of ill-being for his left shoulder, left elbow, or left knee are causally related to the accident, temporary total disability benefits are denied.

In addition, having found that Petitioner failed to prove a compensable claim for his right knee and failed to prove his current condition of ill-being for his right knee is causally related to the accident, temporary total disability benefits are denied.

12/31/18
DATE

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

ROBERT BONDS, JR.,

Petitioner,

vs. NO: 16 WC 29952

MATTESON ELEMENTARY SCHOOL #159,

Respondent.

19IWCC0634

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, temporary total disability, and permanent partial disability, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 23, 2019 is hereby affirmed and adopted.

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

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

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

19IWCC0634

DATED: NOV 21 2019

DDM/tdm
O: 11/13/19
052

Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BONDS, ROBERT
Employee/Petitioner

Case# **16WC029952**

15WC039538

MATTESON ELEMENTARY SCHOOL #159
Employer/Respondent

19IWCC0634

On 1/23/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0598 LUSAK & COBB
RONALD COBB
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

1120 BRADY CONNOLLY & MASUDA PC
NICHOLAS A RUBINO
10 S LASALLE ST SUITE 900
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

Robert Bonds,
Employee/Petitioner

v.

Matteson Elementary School #159,
Employer/Respondent

Case # **16** WC **29952**

Consolidated cases: **15 WC 39538**

19IWCC0634

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 13, 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 **September 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 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 $**24,990.68**; the average weekly wage was $**480.59**.

On the date of accident, Petitioner was **61** 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 $**0.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**2,189.94** for other benefits, for a total credit of $**2,189.94.**

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

ORDER:

Because the Arbitrator finds Petitioner did not sustain an accident that arose out of and in the course of his employment for Respondent, and further finds Petitioner's condition of ill-being not causally connected to any alleged work accident for Respondent, the Arbitrator denies all benefits.

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

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

Signature of Arbitrator

January 23, 2019
Date

JAN 2 3 2019

MEMORANDUM IN SUPPORT OF
ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT BONDS,
Employee/Petitioner

v. Case No.: 16 WC 29952

MATTESON ELEMENTARY SCHOOL #159, 15 WC 39538
Employer/Respondent

I. STATEMENT OF FACTS:

Testimony of Petitioner:

Petitioner testified he worked for Respondent in a dual capacity, as a mail carrier and custodian. (T. 8). Petitioner testified he worked in that capacity as of September 14, 2015. (T. 8). On that date, Petitioner testified he was tasked with moving batteries on the loading dock of the elementary school. (T. 21). Petitioner testified the batteries were dropped of by a separate delivery driver. (T. 22; T. 82). During direct examination, Petitioner testified his job then required him to move the delivered batteries approximately 15-20 feet. (T. 23). However, during cross examination, Petitioner testified he only had to move batteries, 8 to 10 feet. (T. 82).

Petitioner testified he had to lift and carry the batteries across the loading dock. (T. 22-23). Petitioner admitted he was working alone on September 14, 2015. (T. 81). Petitioner admitted no one could confirm he was lifting batteries, twisting, pushing, or pulling on the date of the reported accident. (T. 81). Petitioner testified while moving the aforementioned batteries on the aforementioned date he felt a severe shock through his lower back, and down his legs. (T. 23). Petitioner testified he finished his job duties that morning, moving the remaining cases of batteries. (T. 25).

Petitioner testified he finished working his entire shift that day. (T. 25). During cross examination, Petitioner testified the alleged accident occurred at 9:00 A.M., so he worked another five hours on September 14, 2015. (T. 86). Petitioner testified he completed all tasks he "was supposed to do." (T. 25). Specifically, Petitioner was able to complete his mail run, and climb into and out of his truck. (T. 26). Petitioner testified he sought medical treatment the following day for his low back pain at an urgent care clinic. (T. 29).

On cross examination, Petitioner testified he was truthful and honest with all his physicians, both prior to and subsequent to September 14, 2015. (T. 88-89). Petitioner admitted he informed the urgent care clinic he "had a back sprain about five years ago." (T. 89) Petitioner admitted he only informed the urgent care clinic (on September 15, 2015) he had physical therapy for his condition and it resolved. (T. 89). Petitioner denied informing the urgent care clinic he had a history of osteoarthritis or that he was currently taking Mobic. (T. 90).

During direct examination, Petitioner acknowledged he had low back pain prior to September 14, 2015. (T. 33). Petitioner testified he had treatment, including injections, in 2013 and 2014. (T. 34). On further questioning from counsel, Petitioner clarified he had injection treatment, on and off, between July 2013 and June 2014. (T. 34). Petitioner testified he did not have "epidurals or other back treatment from June 2014 until...September 14, 2015." (T. 34-35). During that time, Petitioner testified he had "some mild pain...some pain going down my leg." (T. 35).

Petitioner admitted to a medical appointment two weeks prior to September 14, 2015. (T. 36). Petitioner testified he treated with Dr. Patel on September 1, 2015. (T. 36). Petitioner testified he saw Dr. Patel for "stomach problems" or GERD. (T. 36-37). Petitioner admitted he had "some back pain" as of that date, but no severe back pain. (T. 37). Petitioner admitted he

"requested...Prednisone" for a "flare-up of inflammation." (T. 37). Petitioner testified even as of September 1, 2015, he had "some shooting pain" down his leg. (T. 39). During cross examination, Petitioner attempted to deny seeking treatment for his back on that date. (T. 105). However, Petitioner then admitted he had three chief complaints on September 1, 2015, including diabetes, medication refills, and sore throat. (T. 106). Petitioner testified he sought an eye exam for diabetes, Prednisone for leg/back pain and also complained of a scratchy throat. (T. 106-107).

Petitioner testified after his reported accident, he first sought treatment with an orthopedic specialist on December 4, 2015. (T. 107). Petitioner testified he gave a history of no medical treatment for seventeen (17) months prior to his accident. (T. 108). He also informed Dr. Rinella he did not have any symptoms of back pain for seventeen months. (T. 108). Petitioner admitted he did not inform Dr. Rinella he sought Prednisone for leg and back pain only two (2) weeks before his alleged accident. (T. 108).

Petitioner testified he underwent a L2-S1 laminectomy and a L4-S1 transforaminal lumbar interbody fusion on March 8, 2016. (T. 46). Petitioner testified he underwent a second fusion from L1 through S1 on November 22, 2016. (T. 57-58). After Petitioner's second surgery, he was released from the hospital, but testified he had to return due to "[his] stomach." (T. 60). Petitioner testified he was re-admitted to Silver Cross Hospital through the emergency room for 4 days. (T. 60). However, on cross examination, Petitioner admitted this hospitalization because he had problems with his gastrointestinal tract. (T. 123). Petitioner admitted he was treated for his stomach during that hospitalization. (T. 125).

Petitioner testified regarding his reported condition after his second operation. (T. 65). Petitioner testified as of May 3, 2017, he had "shooting pain," and "nerve pain." (T. 65).

Petitioner testified the final time he sought treatment with a physician was October 11, 2018. (T. 69). Petitioner alleged he continued to experience "complications" from his condition. (T. 70). Petitioner complained of tightness in his ankles, spasms, and sleeping difficulties. (T. 70-71). Petitioner alleged the spasms travel to his toes. (T. 71). Petitioner testified Dr. Rinella (on October 11, 2018) referred Petitioner for trigger point injections for "nerve pain." (T. 71-72). Petitioner testified Dr. Rinella provided him with permanent restrictions of no lifting more than 5-10 pounds frequently, and up to 20 pounds occasionally. (T. 72). Petitioner testified he could not perform overhead lifting, or climb ladders. (T. 73). As of the time of trial, Petitioner reported he also continued to experience pain in his lower back and legs. (T. 78). Petitioner testified he used a cane because his legs go out on him and he has fallen. (T. 79).

During cross examination, Petitioner testified regarding his visit on October 10, 2018, as well as his two visits preceding that date, or August 3, 2017 and November 9, 2017. Petitioner denied informing Dr. Rinella his lower extremity symptoms resolved. (T. 118). Petitioner also testified he believed Dr. Rinella had addressed his work status at those visits. (T. 117-118). Petitioner also admitted despite testified regarding current nerve pain, that he also discussed with his physician that he may have diabetic neuropathy. (T. 121).

During cross examination, petitioner testified further regarding the nature of his pre-existing lumbar spine condition. (T. 91). Petitioner testified "I've always had some back pain." (T. 91). Petitioner admitted he had lumbar spine pain as far back as June 2011. (T. 93). Shortly before that, Petitioner denied having complained of low back pain to Dr. Patel on June 12, 2013. (T. 91). However, Petitioner admitted to having an MRI of his lumbar spine on May 2, 2013. (T. 92).

Petitioner testified that as early as June 2011 his "spine pain became so severe [he] had symptoms of pain in [his] bilateral legs." (T. 94). Petitioner testified he believed he had pain complaints radiating into his legs as early as June 2011. (T. 94). However, Petitioner then testified he could not recall whether his back pain was so severe his legs gave out on him. (T. 94). Petitioner admitted he sought treatment with an orthopedic surgeon, Dr. Payne, in June 2013. (T. 95).

Petitioner denied that he was informed he had a herniation in his lumbar spine as early as May 2013. (T. 92-93). However, Petitioner then admitted he recalled Dr. Roland informed him of a disk herniation in his back in June 2013. (T. 95-96). Petitioner admitted Dr. Roland treated him for lumbar spine pain radiating into his bilateral legs. (T. 96). Petitioner testified he recalled having burning pain in his legs in June 2013, but could not recall whether he had tingling. (T. 97).

Petitioner then testified he received six (6) injections into his lumbar spine between July 2013 and April 24, 2014. (T. 99). Petitioner acknowledged he requested injections, and Dr. Roland informed him he had to wait for treatment, because he too many injections in a short period of time. (T. 100). Petitioner acknowledged he returned to Dr. Roland after the sixth injection continuing to complain of low back pain radiating into his bilateral legs. (T. 100). Petitioner testified he did not recall informing Dr. Roland he only had a 10% improvement of his lumbar spine symptoms. (T. 101). Petitioner admitted during that time he was experiencing pain with activity. (T. 101). At that visit, Petitioner admitted he received a prescription for Neurontin and Ibuprofen. (T. 102). Petitioner testified he also received a prescription for physical therapy. (T. 103).

Apart from his lumbar spine condition, Petitioner testified he was diagnosed with diabetes while under the care of Dr. Patel and sought treatment with Dr. Patel for the condition. (T. 103). Petitioner testified this occurred in June 2014, and resulted in being prescribed Metformin. (T. 103). During that same time, from June 2014 and moving onward with his treatment, that Dr. Patel "might have" continued to prescribe Mobic. (T. 104). Petitioner admitted his knowledge that Mobic was a painkiller, and a "super strong medication. (T. 104; T. 107). Petitioner admitted he had also previously received a prescription for Prednisone. (T. 105).

Exhibits Admitted at Trial:

Respondent's Exhibit #1:

Respondent's Exhibit #1 consisted of Petitioner's September 1, 2015 office visit record with Dr. Sunil Patel. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of causation.

Petitioner presented to Dr. Patel with complaints of low back and leg pain. Petitioner specifically requested Prednisone from Dr. Patel, and specifically requested it as a refill of medication. (RX1). The Arbitrator finds the record directly contradicted the testimony of Petitioner. Petitioner testified he presented to Dr. Patel for treatment to his stomach; however the record does not list stomach problems as one of Petitioner's three chief complaints for the office visit. (RX1).

Moreover, the Arbitrator finds Petitioner's testimony that this was an "auto-renewal" lacked credibility, as Dr. Patel specifically indicates Petitioner requested the refill of medication. (RX1). The record further confirms that Petitioner had a chronic lower back condition. (RX1).

Respondent's Exhibit #2:

Respondent's Exhibit #2 consisted of the evidence deposition transcript of Dr. Babak Lami, Respondent's Section 12 Medical Examiner. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of causation.

Dr. Lami testified he initial performed an examination of Petitioner on November 2, 2015. (RX2, p. 8). Dr. Lami testified Petitioner reported a work accident on September 14, 2015, while lifting cases of batteries for Respondent. (RX2, p. 9.). Dr. Lami testified Petitioner reported he felt sharp pain in his lower back, but continued to work. (RX2, p. 9). Dr. Lami testified Petitioner reported by the next day he was experiencing pain mainly in his lower back but radiating into his bilateral legs posteriorly. (RX2, p. 10). Dr. Lami testified he asked Petitioner whether he had any previous lumbar spine injury or treatment. (RX2, p. 10). In response, Petitioner reported he had some back pain a year and a half prior. (RX2, p. 10). Petitioner reported he had only undergone physical therapy and chiropractic visits and had no symptoms for a year a half. (RX2, p. 14). Dr. Lami testified Petitioner specifically denied having any injections previously. (RX2, p. 15).

Dr. Lami testified as of the time of his original examination, he opined Petitioner suffered from lumbar spinal stenosis and degenerative changes to the lumbar spine. (RX2, p. 13). Dr. Lami testified the MRI findings he reviewed from October 20, 2015 were unrelated to Petitioner's alleged work accident. (RX2, p. 13). However, Dr. Lami testified he believed Petitioner's work accident aggravated his underlying condition. (RX2, p. 13).

Subsequently, Dr. Lami testified he was able to review additional medical evidence after performing his original examination. (RX2, p. 16). Dr. Lami reviewed records from 2013 and 2014 from Dr. Donald Roland. (RX2, p. 16). Dr. Lami also reviewed Petitioner's May 2, 2013

MRI examination of Petitioner's lumbar spine. (RX2, p. 17). Dr. Lami opined after reviewing these additional medical records his opinions changed as it related to causation relative to the September 14, 2015 claimed work accident. (RX2, p. 18). Dr. Lami opined the basis for his change in opinions dealt with Petitioner's credibility, reliability, and accuracy of his previous medical treatment and history pertaining to his lumbar spine. (RX2, p. 19).

Dr. Lami also testified concerning the impact of the prescription for prednisone and Petitioner's diabetic condition. (RX2, p. 54). Dr. Lami opined, "prednisone is not your ibuprofen or anti-inflammatory most people know about...someone asking for prednisone [a] few days before the incident, if someone who was completely aware of his back condition knows the medication...so he was symptomatic even a few days before the incident." (RX2, p. 54). Dr. Lami further opined, "the treatment Dr. Patel said is consistent with someone in a lot of pain because giving someone who has diabetes, which you don't give prednisone...Dr. Patel must have figured out the risk-benefits ratio...so much pain he has, he's willing to give steroids to someone who has diabetes." (RX2, p. 57).

Respondent's Exhibit #3:

Respondent's Exhibit #3 consisted of Petitioner's medical treatment records at Franciscan Health Olympia Fields. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of causation.

Petitioner underwent an MRI examination on October 20, 2015. The MRI examination only revealed a diffuse disc bulge at L3/4 with moderate spinal canal stenosis. The radiologist opined "the previously described disc extrusion is no longer seen." (PX). At levels L4/5 and L5/S1, the moderate levels of stenosis were consistent with Petitioner's pre-existing MRI examination.

Respondent's Exhibit #4:

Respondent's Exhibit #4 consisted of Petitioner's medical treatment records at Pain Treatment Centers of Illinois. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of causation.

The Arbitrator notes Petitioner underwent a significant course of interventional pain management. On July 2, 2013, Petitioner underwent a lumbar epidural steroid injection at L4-5. On July 16, 2013, Petitioner underwent a second LESI to the same level. On both October 9, 2013 and November 6, 2013, Petitioner underwent a transforaminal epidural steroid at L3 through S1. On April 24, 2014, Petitioner underwent another lumbar epidural steroid injection performed at L4-5. On June 25, 2014, Petitioner returned for a post-injection follow up examination and reported only a 10% improvement in symptoms since last ESI.

Respondent's Exhibit #5:

Respondent's Exhibit #5 consisted of Petitioner's employment resignation from his employment with Respondent. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of claimed entitlement to temporary total disability benefits.

Petitioner also testified he no longer works because he was "let go" by the District on December 3, 2016. (T. 80). The resignation letter clearly confirms that Petitioner voluntarily resigned from his employment with Respondent. (RX5). Petitioner provided no evidence to support the contention he was "let go," and did not dispute the admissibility or validity of the resignation letter offered into evidence. The Arbitrator finds this evidence shows Petitioner's testimony was clearly suspect as it relates to credibility.

Respondent's Exhibit #6:

Respondent's Exhibit #6 consisted of Petitioner's September 15, 2015 office visit at Ingalls Occupational Health. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of causation.

At Petitioner's office visit, Petitioner reported a history of previous injury in the form of a back sprain "5 years ago." Petitioner reported to the physician the injury resolved after only receiving physical therapy. Petitioner admitted to a history of osteoarthritis, and was taking Mobic for occasional back pain. However, he did not report that he recently was prescribed Prednisone.

The Arbitrator finds Petitioner's history provided to Ingalls Occupational Health conflicts with his trial testimony and the other medical evidence submitted at trial. Petitioner admitted he suffered from chronic low back pain as early as June 2011, and Petitioner admitted he sought treatment much greater than physical therapy. Petitioner admitted he sustained his 6th lumbar spine injection in February 2014.

Respondent's Exhibit #7:

Respondent's Exhibit #7 consisted of Petitioner's December 4, 2015 office visit with Dr. Anthony Rinella. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of causation.

At this office visit, Petitioner reported a work accident on September 14, 2015. Petitioner reported prior epidural steroid injections 17 months prior to the accident. However, Petitioner reported he had no treatment, and no symptoms over the 17 month time frame until his alleged accident. (RX7).

The Arbitrator finds this contradicts both Petitioner's testimony and other medical treatment records. Petitioner testified after his last injection and until his alleged accident, that he had "some mild pain...some pain going down my leg." (T. 35). Moreover, treatment records from Dr. Roland, Petitioner indicated he only had a 10% improvement of his symptoms after the last injection provided. Petitioner requested additional injections during this time, but was informed by Dr. Roland he could not undergo additional injections. Finally, it bears repeating that the Petitioner sought a prescription for Prednisone just prior to the alleged accident, even though he was a diabetic and it would raise his blood glucose levels.

Respondent's Exhibit #8:

Respondent's Exhibit #6 consisted of Petitioner's May 3, 2013 Lumbar Spine MRI at Olympia Field MRI. The Arbitrator finds the record instructive as to the credibility of Petitioner, and regarding the issue of causation.

Petitioner underwent an MRI examination on May 2, 2013 at Franciscan Health Olympia Fields. The MRI revealed (1) a disc herniation and inferior extrusion at L3/4 causing moderate to severe spinal stenosis, severe in the left hemicanal, (2) a small central disc herniation component at L4/5 with moderate central zone spinal stenosis; (3) multilevel bilateral neural foraminal stenosis at L2/3, L3/4, L4/5, and L5/S1, multilevel facet arthropathy, (4) and a broad based disc bulge at L5/S1 contract both S1 nerve roots.

Evidence Deposition of Dr. Rinella:

The Arbitrator finds Dr. Rinella's Evidence Deposition instructive on the issue of Petitioner's credibility. Moreover, the Arbitrator finds Dr. Rinella's opinions as to Petitioner's condition of ill-being and the issue of causation unreliable as he admittedly did not have an

accurate picture of Petitioner's medical history relative to his pre-existing lumbar spine condition.

Dr. Rinella opined and admitted he had not reviewed any of Petitioner's pre-existing medical treatment records prior to his December 4, 2015 examination. (Rinella Dep. Transcript, p. 22). Dr. Rinella never reviewed the medical treatment records of Dr. Roland or Dr. Patel. (*Id.*, p. 23). Dr. Rinella never reviewed or had the opportunity to compare Petitioner's pre-alleged accident and post-alleged accident MRI examinations. (*Id.*, p. 24). Additionally, Dr. Rinella opined he was unaware Petitioner had sought medical treatment on September 1, 2015, less than two weeks prior to his alleged accident. (*Id.*, p. 28).

Dr. Rinella opined Petitioner suffered from a right-sided disc herniation at L5/S1 with severe canal stenosis from L3/4 and L4/5 and moderate central stenosis at L2/3. (*Id.*, p. 32). Dr. Rinella opined relative to Petitioner's treatment thirteen days prior to his alleged accident, specifically indicating, "...[t]hat is could be a very mild issue which would have been self-regulated and gone away and not led to two major spine surgeries, or it may be on par." (*Id.*, p. 42). Dr. Rinella admitted the basis for Petitioner being recommended to undergo surgery was his complaint of pain. (*Id.*, p. 47). Dr. Rinella admitted this complaints of pain are solely a subjective consideration. (*Id.*, p. 47).

Dr. Rinella testified regarding the September 1, 2015 office note during re-direct examination. (*Id.*, p. 55). Dr. Rinella testified during re-direct examination Petitioner treated for a sore throat and diabetes, but did not mention the lumbar spine treatment. (*Id.*, p. 55). However, on re-cross examination, Dr. Rinella was forced to admit the chief complaint on the medical record indicated Petitioner presented for leg/back pain, wants prednisone. (*Id.*, p. 58).

CONCLUSIONS OF LAW

C. Whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent?

It is well established that the petitioner bears the burden of proof that an incident arose out of and in the course of a risk connected to her employment. Union Stark v. Industrial Commission, 56 Ill.2d 272, 277, 307 N.E.2d 119 (1974); Dodson v. Industrial Commission, 308 Ill.App.3d 572, 720 N.E.2d 275 (1999). In the present case, the Arbitrator finds that Petitioner did not establish his alleged accidental injuries arose out of and in the course of his employment for Respondent.

The Arbitrator must judge the credibility of the witnesses, including Petitioner, who testified at trial. The Arbitrator had significant concerns with the credibility of Petitioner's testimony. The Arbitrator finds the following contributed to his finding as to the issue of credibility.

The Arbitrator notes multiple instances where Petitioner's testimony was clearly contradicted by evidence submitted by both parties:

- Petitioner testified he sought treatment on September 1, 2015 for a stomach problem; however, the record utilized by both parties indicates Petitioner had no complaints of stomach problems during the aforementioned visit.
- Petitioner testified he cannot recall taking Mobic prior to his alleged accident date; however, petitioner's pre-existing treatment records confirm it was prescribed even as recent as September 1, 2015.
- Petitioner testified he was honest and truthful with his treating and examination physicians; however, a review of the records of Ingalls Occupational Health, Dr. Anthony Rinella, and Dr. Babak Lami revealed Petitioner did not provide a truthful history concerning the nature of his lumbar spine condition.

In addition to the issue of credibility, the Arbitrator finds Petitioner had no objective change in his medical condition prior to or after his alleged accident on September 14, 2015. Petitioner underwent an MRI examination on May 2, 2013 at Franciscan Health Olympia Fields. The MRI revealed (1) a disc herniation and inferior extrusion at L3/4 causing moderate to severe spinal stenosis, severe in the left hemicanal, (2) a small central disc herniation component at L4/5 with moderate central zone spinal stenosis; (3) multilevel bilateral neural foraminal stenosis at L2/3, L3/4, L4/5, and L5/S1, multilevel facet arthropathy, (4) and a broad based disc bulge at L5/S1 contract both S1 nerve roots.

Petitioner's MRI examination from after Petitioner's alleged accident on October 20, 2015, which was performed at the same facility, actually revealed a less severe nature of lumbar degeneration. The MRI examination only revealed a diffuse disc bulge at L3/4 with moderate spinal canal stenosis. The radiologist opined "the previously described disc extrusion is no longer seen." (PX). At levels L4/5 and L5/S1, the moderate levels of stenosis were consistent. The Arbitrator finds that the alleged accident clearly did not cause an aggravation, acceleration, or exacerbation or Petitioner's objective condition of his lumbar spine as indicated and confirmed by the MRI examinations.

The issue left to determine relative to causation was whether Petitioner's subjective complaints were aggravated, accelerated, or exacerbated by the alleged work accident, and whether Petitioner's physician's recommendation for surgery were sufficient to find a causal relationship under the Act.

The Arbitrator again notes the concerns relative to Petitioner's credibility as it relates to his subjective complaints. As it relates to the fact that Petitioner was recommended for and

underwent surgery subsequent to the alleged accident date, the Arbitrator finds that fact alone is insufficient to prove causation.

The Arbitrator finds Petitioner had a lengthy course of medical treatment with his primary care physician, Dr. Patel, and a pain management physician, Dr. Roland, both of whom new the nature and extent of his lumbar spine condition. Petitioner further admitted during trial he had previously seen an orthopedic physician, Dr. William Payne, on referral of Dr. Patel. However, after Petitioner's alleged accident, he sought orthopedic treatment with Dr. Anthony Rinella. Petitioner testified the treatment was sought as a result of a recommendation from a friend. Moreover, after Petitioner's alleged accident, Petitioner failed to provide a complete history of his medical condition when treating with Ingalls Occupational health and Dr. Rinella.

Finally, the Arbitrator opines that he did not place great weight on the testimony of Petitioner's treating physician, Dr. Rinella. Dr. Rinella admitted he never reviewed the medical records of treatment pre-dating Petitioner's alleged accident, and never compared the results of the objective findings including the MRI examinations. The Arbitrator has already noted he finds is persuasive that Petitioner actually improved from an objective standpoint when reviewing the MRI examinations.

Dr. Rinella also opined his surgical recommendations were based solely on Petitioner's pain complaints, which he admits are completely subjective in nature. The Arbitrator finds Petitioner did not testify credibly and Petitioner subjective complaints are suspect relative to his condition. As such, the Arbitrator finds that Petitioner's lumbar spine and any subjective pain complaints were not caused by any alleged accident from September 14, 2015, but were a pre-existing condition Petitioner suffered from for over four to five years prior to his accident.

Petitioner made numerous admissions throughout trial that he always had low back and leg pain even prior to his alleged accident.

F. Whether Petitioner's condition of ill-being was causally connected to his injury.

The Arbitrator finds Petitioner's current condition of ill-being is not causally connected to his alleged work accident from September 14, 2015. The Arbitrator finds Petitioner did not sustain an objective change in his medical condition relative to his lumbar spine as the result of purported lifting lithium batteries while working for Respondent. The Arbitrator bases this finding on a review of Petitioner's medical treatment records; notably, Petitioner's MRI examination from May 2, 2013 compared to Petitioner's post-accident MRI examination from October 20, 2015. The Arbitrator finds Petitioner's lumbar spine had actual improved in terms of the nature of the herniation and degenerative process.

In addition, the Arbitrator finds Petitioner's subjective complaints relative to his lumbar spine and the allegation his condition "worsened" from a pain complaints perspective after his alleged accident lacked credibility. Petitioner repeatedly provided a history of medical treatment and subjective complaints to his physicians, which were inconsistent with his trial testimony and a review of his pre-existing treatment records. Petitioner admitted during the trial he always had back pain, meaning before and after the accident. Petitioner admitted he had leg pain and symptoms of radiating pain in his lower extremity both prior to and after the alleged accident. Petitioner alleged there was a worsening of his symptoms after the alleged accident, but the Arbitrator finds no evidence to support such a contention other than the Petitioner's testimony, which the Arbitrator finds lacks credibility.

Finally, the Arbitrator again notes Dr. Rinella's opinions were not given great weight as to the issue of causation. However, the Arbitrator focuses on Dr. Rinella's acknowledgement

that Petitioner's surgery was only recommended due to his subjective pain complaints. These pain complaints lacked credibility based on the Arbitrator's assessment of Petitioner. As such, the Arbitrator finds no causal relationship between Petitioner's condition of ill-being and the alleged work accident from September 14, 2015.

J. Whether Petitioner's medical services were reasonable and necessary?

As the Arbitrator finds Petitioner did not sustain an accident that arose out of and in the course of his employment for Respondent, and does not suffer from a condition or ill-being causally connected to his employment for Respondent, the Arbitrator finds Petitioner is not entitled to any medical benefits concerning his lumbar spine treatment.

K. Whether Petitioner is due temporary total disability benefits?

As the Arbitrator finds Petitioner did not sustain an accident that arose out of and in the course of his employment for Respondent, and does not suffer from a condition or ill-being causally connected to his employment for Respondent, the Arbitrator finds Petitioner is not entitled to any temporary total disability benefits.

L. What is the nature and extent of the injury?

As the Arbitrator finds Petitioner did not sustain an accident that arose out of and in the course of his employment for Respondent, and does not suffer from a condition or ill-being causally connected to his employment for Respondent, the Arbitrator finds Petitioner is not entitled to any permanent partial disability benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT EPPENSTEIN,

Petitioner,

vs. NO: 17 WC 026410

LANGLOIS ROOFING,

Respondent.

19IWCC0635

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability and an evidentiary ruling 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).

I. Evidentiary Ruling

Section 9030.70, titled Rules of Evidence, of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, provides, "The Illinois Rules of Evidence shall apply to all proceedings before the Commission, either upon Arbitration or Review, except to the extent they conflict with the Act, the Workers' Occupational Diseases Act [820ILCS 310], or the Rules Governing Practice Before the Workers' Compensation Commission (50 Ill. Adm. Code

Chapter VI)." 50 Ill. Adm. Code 9030.70(a) (2016). Rule 802 of the Illinois Rules of Evidence provides, "Hearsay is not admissible except as provided by these rules, by other rules prescribed

by the Supreme Court, or by statute as provided in Rule 101." *Ill. R. Evid. 802*. Unless an exception applies, hearsay is inadmissible. *People v. Sorrels*, 389 Ill.App.3d 547, 553, 906 N.E.2d 788, 329 Ill. Dec. 590 (2009). Foundation and hearsay are separate grounds for objection. See *National Wrecking Company v. The Industrial Commission*, 352 Ill. App.3d 561,816 N.E.2d 722, 287 Ill. Dec. 755 (1st Dist. 2004). If a document is admissible pursuant to an exception to the hearsay rule, the proponent must still lay an adequate foundation for its admission into evidence. *Raithel v. Dustcutter, Inc.*, 261 Ill. App. 3d 904, 908, 634 N.E.2d 1163, 199 Ill. Dec. 809 (1994).

Respondent objected to the admission of Petitioner's Fee Schedule Analysis on the basis of hearsay and further reserved all objections to the admission of the document. Petitioner did not cite an exception to the hearsay rule allowing for its admissibility nor did Petitioner present a witness to lay a foundation for the document. The Arbitrator admitted the Petitioner's Fee Schedule Analysis over Respondent's objections.

The Commission finds Petitioner's Fee Schedule Analysis should not have been admitted into evidence. The Respondent objected to its admission based on hearsay grounds and Petitioner did not cite any exception to the hearsay rule which would allow for its admission. In addition, the document should also have been excluded based on Respondent's foundation objection. The preparer of the Fee Schedule Analysis from Petitioner's attorney's office was not present at the arbitration hearing to testify regarding the document. Respondent had no opportunity to cross-examine the preparer on their qualifications to prepare such an analysis, to review the method of calculation or to verify the accuracy of the document. Thus, the Arbitrator erred in admitting the Petitioner's Fee Schedule Analysis.

Therefore, the Commission modifies the Decision of the Arbitrator to exclude Petitioner's Fee Schedule Analysis from the evidence considered and, in so doing, strikes any references made by the Arbitrator in his decision as it relates to the excluded document. Excluding the Fee Schedule Analysis also necessitates the vacating of the $121,243.06 awarded to Petitioner as compensation for medical expenses incurred as the Arbitrator relied on Petitioner's Fee Schedule Analysis to arrive at that figure. The Commission instead awards the medical bills pursuant to Section 8(a) and Section 8.2 of the Act pursuant to the Fee Schedule.

II. Scrivener's Errors

The Commission further modifies the Decision of the Arbitrator to correct two scrivener's errors found on page 17 of the Decision of the Arbitrator.

The first scrivener's error is found in the sentence, "The Petitioner claims that he has been totally disabled from work from September 23, 2016 through April 13, 2017." The evidence, including Petitioner's testimony, indicates he was released to unrestricted work on April 3, 2017.

The Commission, therefore, corrects the sentence to read, "The Petitioner claims that he has been totally disabled from work from September 23, 2016 through April 3, 2017," noting these dates correspond with the day after the September 22, 2016 19(b-1) arbitration hearing and continuing through the day Petitioner returned to work.

The second scrivener's error is found in the sentence, "In support of this claim, the Petitioner presented off-work slips from his treating physicians, a valid Functional Capacity Evaluation, and a full duty release dated April 13, 2017." Petitioner's treating physician, Dr. Cary Templin, allowed Petitioner to return to work with no restrictions and provided Petitioner a work status report to that effect on April 3, 2017, not April 13, 2017. The Commission, accordingly, corrects the sentence to read, "In support of this claim, the Petitioner presented off-work slips from his treating physicians, a valid Functional Capacity Evaluation, and a full duty release dated April 3, 2017."

With the exception of the above-referenced modifications, the Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,106.01 per week for a period of 98-1/7 weeks, commencing August 8, 2017 through June 25, 2019, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses under the Fee Schedule as provided under §8(a) and §8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 21 2019
KAD/mav
O:10/11/19
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portella

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19 (b-1) ARBITRATOR DECISION

EPPENSTEIN, ROBERT
Employee/Petitioner

Case# **17WC026410**

15WC029997

ALL SEALANTS AND LANGLOIS ROOFING
Employer/Respondent

19IWCC0635

On 7/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 1,433.0 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and
3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MITCH HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

4234 RIPES NELSON BAGGOT KALOBRATSO
PETER DONAHUE
605 E DEVON AVE SUITE 110
ITASCA, IL 60143

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b-1)

Robert Eppenstein
Employee/Petitioner
v.
All Sealants and Langlois Roofing
Employer/Respondents

Case # **17** WC **26410**
Consolidated cases: **15WC029997**

19IWCC0635

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **4/25/2019**. Respondent Langlois Roofing filed a *Response* on **5/13/2019**. The Honorable **Michael Glaub**, Arbitrator of the Commission, held a pretrial conference in Waukegan, IL on **5/17/2019**. The matter was continued for trial on **6/14/2019** for trial in the city of **Rockford**. The *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* was withdrawn on **6/14/2019** and was refiled on **6/25/2019**. This matter was heard for trial on **6/25/2019**, in the city of **Chicago**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES VS. LANGLOIS ROOFING

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, **8/8/2017**, 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 **$15,263.05**; the average weekly wage was **$1,659.02**.

On the date of accident, Petitioner was **36** 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 **$55,541.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$19,766.00** for other benefits **(PPD Advance)**, for a total credit of **$75,307**.00

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

ORDER

SEE COMPANION DECISION RORBERT EPPENSTEIN V. ALL SEALANTS & LANGLOIS ROOFING, 15 WC 29997

Respondent LANGLOIS ROOFING shall pay reasonable and necessary medical services of $121,243.06 which represents the amount owed per the Illinois Fee Schedule as provided in Sections 8(a) and 8.2 of the Act.

The Section 10 average weekly wage is $1,659.02.

Respondent LANGLOIS ROOFING shall pay Petitioner temporary total disability benefits of $1,106.01/week for 98 & 1/7 weeks, commencing 8/8/2017 through 6/25/2019, as provided in Section 8(b) of the Act.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter $ **1,433.00** or the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

July 25, 2019
Date

ICArbDec19(b-1) p. 2

JUL 26 2019

FINDINGS OF FACTS

The consolidated case, 15 WC 29997, was tried pursuant to §19(b) of the Act on August 22, 2016 and on September 22, 2016. The Arbitrator adopts the findings of fact and conclusions of law made in that case and incorporates those findings and conclusions herein. The Commission decision is now the *law of the case* and is binding on this arbitrator unless overturned by an upper court. As a matter of procedure, the complete Transcript at Arbitration from 15 WC 2997 was included with this current transcript, identified as Joint Exhibit 1. The Arbitrator notes that the 19b decision awarding benefits to petitioner in 15 WC 2997 is currently pending before the Illinois Appellate Court on Respondent All Sealant's appeal (hereinafter: All Sealants). The arbitrator pre-tried these cases on May 17, 2019 and denied Respondent Langlois Roofing's motion to dismiss the 19(b-1).

PETITIONER'S PRE-INJURY JOB DUTIES

The Petitioner testified that he is a journeyman roofer and a member of the Local 11 roofer's union. His job duties included tearing off existing roofing, moving materials and ladders, unloading roofing materials from trucks, and affixing roofing materials to the roof. He testified that his job required him to lift 5-gallon glue buckets weighing 40-50 lbs. without assistance. He was required to manipulate ladders weighing from 60-80lbs. He was required to lift materials weighing more than 100 lbs. with the assistance of other roofers. He was occasionally required to lift up to 300 lbs. as a group.

PETITIONER'S TREATMENT AFTER SEPTEMBER 22, 2016

Proofs closed in the prior 19(b) hearing, 15 WC 2997, on September 22, 2016. Since that date, the Petitioner continued attending physical therapy at ATI Physical Therapy. (PX 10, 10a, 10b). He returned to see Dr. Cary Templin, his treating orthopedic surgeon, on October 28, 2016. (PX 3, 3a). The Petitioner reported mild lower back pain with resolved leg pain. *Id.* Dr. Templin ordered the Petitioner to continue in physical therapy before advancing to work conditioning. The Petitioner returned to ATI Physical Therapy and began work conditioning.

The Petitioner presented to Dr. Templin again on December 9, 2016. He reported pain in his back that increased with work conditioning but was overall doing well. Dr. Templin ordered additional work conditioning, noted that the Petitioner was weaning off of pain medications with the aid of his pain management doctor, and ordered the Petitioner off of work. (PX 3, 3a). The Petitioner continued work conditioning at ATI Physical Therapy and continued to follow up with Dr. Najera, his pain management physician. He reported that work conditioning was causing him a lot of discomfort and described non-radiating back pain. Dr. Najera described the Petitioner's condition as a nerve injury. He ordered the Petitioner to follow up after seeing Dr. Templin. (PX 9, 9a)

After completing several weeks of work conditioning, the Petitioner returned to Dr. Templin on January 20, 2017. He reported 4/10 pain in his back. Dr. Templin noted that the Petitioner had plateaued in work conditioning and ordered a functional capacity evaluation. The FCE took place on February 16, 2017. The FCE was valid. It documented that the Petitioner's capabilities met the level stated by the DOT but fell below his self-stated level. (PX 3, 3a, 10, 10a, 10b, 14)

The Petitioner followed up with Dr. Templin on February 22, 2017. Dr. Templin released the Petitioner to work per the FCE restrictions of medium level work. He ordered the Petitioner to perform a home exercise program and return for X-rays in 3 months. The Petitioner presented to Dr. Najera on March 10, 2017. Dr. Najera noted 4/10 back pain improving with rest. He noted that the Petitioner was looking for work and was ready to wean off of his narcotic pain medications. The Petitioner testified that he contacted Dr. Templin's office on April 3, 2017 and

requested a work release allowing him to return to full duty.. Dr. Templin issued a report releasing the Petitioner to regular work with no restrictions as of April 4, 2017. (PX 3, 3a, 9, 9a). The Petitioner testified that at the time he was released to full duty work, he was feeling great and was not taking any pain medications.

The Petitioner returned to Dr. Templin on July 24, 2017. The Petitioner testified that he was doing "excellent" at that time and that his lower back was not affecting his ability to perform his duties as a roofer. Dr. Templin performed low back X-rays on this date. Dr. Templin noted "He is doing clinically well; however, I am concerned on the x-ray that there may be some evidence of loosening. I would like to get a CT scan to ensure that he is fused. He will see me back in follow-up after the CT scan is completed." (PX 3, 3a)

PETITIONER'S PHYSICAL CONDITION AFTER FULL-DUTY RELEASE

The Petitioner testified that he returned to the roofing trade after his full-duty release from Dr. Templin. His first assignment through Local 11 was as a journeyman roofer with Gleuth Brothers. He worked in this position for 3 weeks before starting work with the Respondent, Langlois Roofing (hereinafter: Langlois). The Petitioner was employed as a Local 11 journeyman roofer for Langlois. The Petitioner worked 8 hours per day 5 days per week. If there was inclement weather, roofing work could not be completed, and the Petitioner would not report for duty. The Petitioner testified that he worked overtime for Langlois, because once a roof is open, all roofers are required to be present until it is sealed. The Petitioner testified that he may have used one sick day to care for his special-needs children during the 11 weeks he was employed by Langlois.

AUGUST 8, 2017 INJURY

The Petitioner testified that he was injured on August 8, 2017 while working for Langlois. He was moving insulation and several rolls of roofing materials from the far end of a roof to an area that had just been torn up. He testified that these rolls weighed over 200lbs and that he was lifting them with his colleagues, Bill and Pat. He held a roll on top of his right shoulder with his right arm wrapped around the roll. While moving the third or fourth roll with Bill and Pat, the Petitioner slipped on a slippery drain. He testified that his feet slid out from under him and he hit his buttocks and lower back on the roof. He was bent over with the roll of materials on top of him. He required one of his colleagues to help get the roll off of him. After this fall, he experienced pain in his right shoulder, chest, low back, and neck, and testified that arms were also very sore. He felt "body-slammed to the roof."

THE PETITIONER'S MEDICAL TREATMENT

The Petitioner presented to Silver Cross Hospital on the same day as his fall. While at Silver Cross, he underwent a CT scan of his lower back and x-rays of his chest and right shoulder (PX 8). The Petitioner testified that he complained of injuries to his right shoulder and low back with chest tenderness and pain. Medical records from Silver Cross Hospital indicate that he reported a slip and fall injury while holding a 300lb roll of roofing liner over his right shoulder. The Petitioner slipped in water and was complaining of right shoulder pain, right chest wall pain, and low back pain. (PX 8).

The Petitioner returned to Silver Cross Hospital on August 13, 2017. At that time, the Petitioner reported right shoulder pain, right lower rib pain, and back pain. He reported that he was prescribed a Medrol Dosepak, Meloxicam, and a muscle relaxant without relief. His rib pain was aggravated by certain movements and deep breaths. (PX 8). The Petitioner returned to Hinsdale Orthopedics on August 16, 2017. He reported not having any pain leading up to this new work injury, but reported experiencing increased pain in his lower and mid back, neck, and right shoulder. Records from Hinsdale Orthopedics indicate that the Petitioner's symptoms stemmed from the

work injury. The Petitioner was prescribed physical therapy and was referred to Dr. Abusharif for pain management and to Dr. Burra for his shoulder. He was ordered off of work. (PX 3, 3a).

Dr. Burra saw the Petitioner on August 21, 2017. In his records, Dr. Burra noted pain with abduction and elevation of the arm, popping noises in the Petitioner's shoulder, and neck pain and paresthesias radiating distally to the Petitioner's elbow. Dr. Burra diagnosed a right shoulder SLAP tear, rotator cuff contusion, biceps tendinitis, impingement, and AC joint contusion. Dr. Burra further noted that the Petitioner's "presentation is complex as usually is the case when there is an involvement of his cervical spine as well as his shoulder." He opined that the Petitioner demonstrated neurological changes with diminished sensation. Dr. Burra ordered an MRI arthrogram and ordered the Petitioner off of work. (PX 3, 3a)

On August 22, 2017, the Petitioner underwent an MRI of his thoracic spine. On August 27, 2017, the Petitioner underwent an MRI Arthrogram of his right shoulder. The MRI Arthrogram indicated SLAP-type tears of the superior labrum, mild biceps tendinosis, and moderate acquired anterior down sloping of the acromion. He underwent an MRI of his cervical spine on August 30, 2017. The cervical MRI showed a small central to left paramedian disc herniation at C5-6. Finally, the Petitioner underwent an EMG/Nerve Conduction Study on August 30, 2017. (PX 3, 3a).

The Petitioner followed-up with Dr. Burra on September 6, 2017. At that time, Dr. Burra noted no qualitative change in symptoms. He diagnosed Petitioner with a right shoulder SLAP lesion, rotator cuff contusion, biceps tendinitis and impingement, and a nondisplaced fracture of the left 6th rib. Dr. Burra opined "it is my opinion to a reasonable degree of medical and surgical certainty, that the entirety of his ill-being of his right shoulder is connected to this work-related injury where he was carrying the 350-pound in a 90 degree abducted external rotated position when he fell." Dr. Burra prescribed surgery once the rib fracture was settled. (PX 3, 3a) .

The Petitioner next presented to Dr. Abusharif at the Pain Treatment Centers of Illinois. Dr. Abusharif noted neck pain involving the right hand, shoulder, and cervical spine. He also noted lumbar radiculitis. He noted that the Petitioner was attending physical therapy at ATI. The Petitioner returned to Dr. Abusharif on September 12, 2017. At that time Dr. Abusharif performed a cervical epidural steroid injection. He noted that the Petitioner tolerated the procedure well and was discharged home. (PX 9, 9a)

On September 26, 2017 the Petitioner underwent an MRI of his lumbar spine. He returned to see Dr. Templin on September 29, 2017. Dr. Templin noted that the Petitioner had been doing well and that prior to his injury on August 8, 2017, the petitioner had been working at full duty without restrictions and was at MMI. At the time of his appointment with Dr. Templin, the Petitioner reported 8/10 lower back pain extending into the right lower extremity, but not down the leg. Dr. Templin noted that the Petitioner needed a labral repair in his right shoulder. Dr. Templin opined that the Petitioner's fall at work aggravated the lower back: "CT scan shows evidence of what appears to be a stable pseudoarthrosis which has been aggravated by his fall injury of 8/8/2017. That being said, given the pseudoarthrosis and his pain level at this point in time, my recommendation would be for a revision posterior fusion." He recommended that the Petitioner undergo shoulder surgery before attempting back surgery. The Petitioner was ordered to stay off work. (PX 3, 3a). He returned to Dr. Abusharif for a third cervical epidural steroid injection on November 2, 2017. Dr. Abusharif noted a 40% interval improvement to injection. (PX 9, 9a)

Dr. Burra performed a right shoulder arthroscopy with SLAP lesion repair and subacromial bursectomy on the Petitioner's on November 16, 2017. Dr. Burra's post-operative diagnosis was a SLAP lesion and subacromial bursitis in the right shoulder. Following the surgery, Dr. Burra ordered the Petitioner to attend physical therapy, which occurred with Athletico Physical Therapy. The Petitioner returned to Hinsdale Orthopedics on November 28,

2017, where he was instructed to continue using a sling until he was 6 weeks post-operative and to follow-up in 4 weeks. He was ordered to stay off of work. (PX 3, 3a, 11, 14).

The Petitioner saw Dr. Abusharif for follow-up on December 14, 2017. Dr. Abusharif noted a 100% reduction in the Petitioner's neck complaints after the injection and that the neck pain was manageable at this time. He reported that the Petitioner recently had right shoulder surgery and was planning to have lower back surgery in 6 months. (PX 9, 9a)

The Petitioner continued physical therapy and returned to Dr. Burra on January 2, 2018. At that time, Dr. Burra reported that he was progressing well with his shoulder. He was compliant with wearing his sling, attending physical therapy, and performing his home exercises. The Petitioner was advised to discontinue wearing his sling and to continue with physical therapy. He remained off of work. Dr. Burra's physician's assistant next saw the Petitioner on February 13, 2018. At that time, the Petitioner reported improved pain and that he was progressing well. Dr. Burra released the Petitioner to return to work with restrictions of no manual use of the right arm, but noted that he would likely remain off of work due to Dr. Templin's restrictions for the Petitioner's low back.

The Petitioner returned to Dr. Burra's office on March 13, 2018. He reported that his shoulder was pain-free, but was awaiting authorization for low back surgery. The Petitioner complained of numbness and tingling into his right fingers. Dr. Burra noted continued rotator cuff strength deficits on clinical examination and ordered additional physical therapy and home exercises. Dr. Burra maintained the same work restrictions. (PX 3, 3a)

On March 15, 2018, the Petitioner again saw Dr. Abusharif. He reported pain involving the low back, right buttock, and right thigh. Dr. Abusharif diagnosed the Petitioner with inadequately-controlled lumbar radiculitis. He noted that the Petitioner was awaiting authorization for lumbar spinal surgery. (PX 9, 9a)

The Petitioner next saw Dr. Burra on April 9, 2018. During that visit, he indicated that he was pain-free in his shoulder. Dr. Burra noted a discrepancy between the listed DOT requirement of a medium physical demand requirements of a roofer and the Petitioner's self-reported requirements of lifting unilaterally up to 150lbs. At that time, the Petitioner's primary limiting factor was his lumbar spine. Dr. Burra stated that "[a]t the time of injury, he was clearly lifting a load much greater than 50 lbs that is mentioned in the DOT, and this gentleman understands his job, and he indicates to me that he routinely has to lift loads up to 150lbs or higher." Dr. Burra recommended work conditioning, but stated that the Petitioner could not complete work conditioning until treatment of the lumbar spine was completed. Barring work conditioning, the Petitioner was at MMI for his shoulder with a 10lb weight-lifting limit, and pending completion of a functional capacity evaluation or work conditioning. (PX 3, 3a).

In April 2018, the Petitioner received 2 letters from respondent about light duty. (RX 7). Petitioner testified to certain facts, claiming light duty was not offered. He was not released by Dr. Templin at the time. (PX 3, 3a, PX 23) Respondent called the office manager of Langlois, Sara Hankey, as a witness. Ms. Hankey claimed that Langlois had offered the Petitioner light duty, but he had refused to work. After a review of Respondent Langlois's employment file and an off-the-record discussion, the parties agreed on the record that petitioner had turned in an off-work note from September 2017 stating he was not released to work in April 2018. After receiving the light duty note and discussing with Ms. Hankey, the Petitioner returned to Dr. Templin in April 2018. A new FCE was ordered and Dr. Templin released him with restrictions for his lower back per the FCE.

The parties agreed on the record "no additional effort was made by respondent to bring petitioner back to work after the Petitioner provided his updated records with reference to the FCE and Dr. Templin's more recent work note." (TA 6-25-19 @ 163-164) (PX 3, 3a, PX 15, 23 RX 7, RX 10).

The Petitioner returned to Dr. Burra's office on June 6, 2018. He mild soreness from time to time in his shoulder, and the FCE was reviewed. Dr. Burra's physician's assistant noted that the Petitioner was not working because his work was unable to accommodate his restrictions. The physicians' assistant noted mild rotator cuff deficits on clinical examination. The Petitioner was released with restrictions per the FCE and counseled to continue treating with Dr. Templin and to continue his home exercises. (PX 3, 3a, 15)

Dr. Templin saw the Petitioner for follow-up on June 11, 2018. At that time, he reported pain across the lower back and into the right buttock. Dr. Templin opined that the Petitioner had permanent restrictions per the FCE and to return for a follow-up CT scan if his symptoms worsened. The Petitioner returned to Dr. Templin's office on July 25, 2018. He indicated that he tried increasing his activities within the FCE limits but has had progressively increasing pain across is lower back and upper buttock. The Petitioner was sent for a new CT scan to assess the continued pseudoarthrosis. The petitioner testified that one of the activities that caused increased pain was riding a bicycle, but he denied any injury from bike riding. (PX 3, 3a, TA 6-25-19 @ 58).

On July 21, 2018, Respondent Langlois conducted surveillance on the Petitioner, which showed him squatting and riding a bicycle with his son. The Petitioner testified that squatting was not restricted in his FCE, and that riding a bicycle was part of his physical therapy routine. He testified that after riding the bike with his son, his back was sore, but that soreness was common after he had conducted other household activities such as doing dishes or changing his five-year-old disabled daughter's diapers. The Petitioner testified that he did not injure his back from riding a bicycle. [JS1]

Dr. Burra's physician's assistant examined the Petitioner on August 8, 2018. At that time, the Petitioner reported that his shoulder was doing well. He was off of work due to his employer being unable to accommodate his work restrictions. The physicians' assistant noted that the Petitioner was limited due to his lumbar spine. The Petitioner's restrictions per the FCE were to be permanent unless the Petitioner underwent further intervention with the lumbar spine. (PX 3, 3a).

The Petitioner saw Dr. Abusharif on August 9, 2018. Dr. Abusharif noted that the Petitioner reported 7/10 pain in the lumbar spine and that the lumbar spinal surgery had not yet been approved. The Petitioner returned on September 13, 2018. He reported 6/10 pain in his right buttock, lumbar spine, and radiating pain to his right posterior thigh. (PX 9, 9a).

Dr. Templin saw the Petitioner on September 17, 2018. The Petitioner told Dr. Templin that he had back pain of 2/10 at rest and 6/10 with increasing activity. Dr. Templin reviewed the Petitioner's CT scan and noted that it was indeterminate for fusion: "there is a cleft through the bone mass within the interbody cage device. There is improvement of the previous haloing of the screws but there does appear to be still some evidence of a space around the anterior instrumentation into L5 as well as the posterior instrumentation." Dr. Templin recommended an exploration and possible revision of the previous fusion. The Petitioner testified he agreed to the surgery because he had not been working and was concerned about his pain interfering with his duties as a father. The Petitioner stated that Dr. Templin told him he should not need to take pain medications following his surgery. (PX 3, 3a).

The Petitioner returned to Dr. Abusharif on November 15, 2018. At that time, he reported 7/10 pain in his back. Dr. Abusharif refilled the patient's medications. (PX 9, 9a).

On December 6, 2018, the Petitioner presented to Dr. Pacis for pre-surgery clearance, which he received. The Petitioner was also cleared by Dr. Templin. Dr. Templin operated on the Petitioner's lower back on January 2, 2019. Dr. Templin diagnosed an L5-S1 spondylolisthesis and an L5-S1 nonunion. He performed a revision posterolateral union. The Petitioner was kept overnight at Presence St. Joseph Medical Center and discharged home on January 4, 2019. (PX 3, 3a, 13, 22).

The Petitioner returned to Dr. Templin on February 12, 2019. At that time, Dr. Templin indicated that he found motion at L5-S1 during surgery, so he had to put in bilateral pedicle screws and perform a revision fusion. The Petitioner was doing well, had pain of 3/10, and was off of pain medications. Dr. Templin ordered the Petitioner to return in 6 weeks to start physical therapy. Dr. Templin's physician's assistant saw the Petitioner on March 26, 2019. The Petitioner was doing well and reported 2/10 pain completely in his back. He was ordered to attend physical therapy and kept off of work. The Petitioner began physical therapy at ATI Physical Therapy on April 2, 2019. The Petitioner saw Dr. Templin for follow-up on May 7, 2019. . He had been attending therapy and reported 1/10 pain. Dr. Templin noted that the Petitioner was improving and ordered him to finish physical therapy and advance to work conditioning program. He imposed 5-10lb lifting restrictions with limitations on sitting, standing, walking, and bending. The Petitioner continued physical therapy at ATI Physical Therapy. (PX 3, 3a, 10, 10a, 10b).

PETITIONER'S CURRENT CONDITION

At the time of hearing, the Petitioner testified that he is still in physical therapy, which he attends three times a week. He testified that he still has restrictions from Dr. Templin, which state he cannot lift greater than 5-10 pounds outside of supervised lifting during physical therapy, that he can stand and walk as comfort allows, and that he can participate in limited bending. The Petitioner stated that he plans to go back into work hardening, but has been feeling well while engaging in therapy. He anticipates that work hardening will begin after his next appointment with Dr. Templin if everything is going well. The Petitioner testified that prior to his surgery, his low back limited his ability to do dishes and do activities with his special-needs children. He testified that he needs to change his 5-year-old daughter's diapers but could not pick her up. The Petitioner stopped taking narcotics in the last few months. He has a State of Illinois Department of Public Health-issued medical marijuana card. (PX 24) The Petitioner testified that he uses CBD oil, which contains minimal THC, every day to help with pain. He also takes cannabis with THC a couple of nights every week, but does not drive when he has taken a product that contains THC.

The Petitioner testified that he was previously an every-day smoker, and quit smoking when Dr. Templin advised him to do so in advance of first fusion surgery. He disagreed with medical records that indicated he was a smoker after he quit in December of 2015 or January of 2016. The Petitioner noted that after his surgery, in the summer of 2017 while working at Langlois roofing, he did occasionally smoke 1-5 cigarettes per week, but completely stopped permanently following that summer. The Petitioner hypothesized that some of the medical records may have incorrectly stated he was a smoker because he had been a smoker when he completed the intakes at a facility and they had not been updated since. He disagrees with any medical records indicating smoking after his first fusion surgery. The Petitioner agreed with the records that stated he is not a smoker since before his first surgery. He disagreed with a record that stated he was never a smoker. (*See* PX 31 through 40).

The Petitioner testified that he currently has light duty restrictions from Dr. Burra and Dr. Templin, and has been "looking around" for employment that fits these restrictions. He has not engaged in Vocational Rehabilitation but has taken a Spanish class on his own at night.

TESTIMONY OF SARAH HANKEY

The Arbitrator heard testimony from Sarah Hankey, the office manager for Langlois. Ms. Hankey has been in this position for four years, and completes HR, project management, payroll, and other administrative duties in this role. Ms. Hankey testified that she is familiar with the Petitioner and has known him since he was hired in 2017.

Ms. Hankey testified that employees may be entitled to overtime pay if they work more than 8 hours in a day and must finish the job they started. However, she stated that overtime is infrequent, and that individuals volunteer for it, as it is in high demand. She stated that she does not believe overtime to be mandatory. She did not testify he lost time work due to personal reasons.

The rest of her testimony about light duty is not relevant as the parties agreed the respondent ultimately did not offer light duty to him. (TA 6-25-19 @ 163-164).

TESTIMONY OF ROBERT WICKS & VIDEO SURVEILLANCE

The Arbitrator also heard testimony from Robert Wicks. Robert Wicks testified that he is a senior investigator with Con Data Consultants. Mr. Wicks testified that he conducted surveillance on the Petitioner on July 21, 2018, March 11, 2019, and March 13, 2019. He stated that he observed the Petitioner riding a bike with his son on July 21, 2018, and that he was running errands with his children on March 11, 2019 and March 13, 2019. He did not observe the Petitioner using any visible orthopedic devices, nor did he observe anything unusual.

The Arbitrator viewed the video surveillance taken by Mr. Wicks. The video footage shows the Petitioner riding a bike, walking, standing, entering and existing his vehicle over three days. The Arbitrator has considered this footage in reaching his opinions. (RX 11, 12).

The Petitioner testified that he reviewed the surveillance, and that the video from July 21, 2018 shows him squatting. He testified that he was not restricted from squatting. The video further showed the Petitioner riding a bicycle with his son for 30-45 minutes. He testified that his back was sore after biking and he could not ride a bike without taking pain medications. He testified that he did not injure himself while riding a bike. He testified that he was riding a bike in physical therapy at the time of the surveillance. He would be given a choice between riding an exercise bike for 10 minutes or power-walking on a treadmill. The Petitioner testified that the March 11, 2019 surveillance shows him walking. He testified that his doctors told him that he was supposed to be up and walking.

EVIDENCE DEPOSITION TESTIMONY

The Arbitrator reviewed testimony from Dr. Cary Templin, the Petitioner's treating physician, as well as the Respondents' §12 Examiners: Dr. Julie Wehner, Dr. Carl Graf, and Dr. Bruce Summerville.

EVIDENCE DEPOSITION OF DR. CARY TEMPLIN

Dr. Cary Templin testified that he is an orthopedic surgeon who specializes in spinal treatments. He performs approximately 350 spinal surgeries every year. Dr. Templin treated and performed surgery on Petitioner, who went through rehabilitation, returned to work, had another injury, and eventually required a revision fusion of his back. Dr. Templin saw the Petitioner 13 times from September 2016 through December 2018. Dr. Templin testified to a reasonable degree of medical and surgical certainty that the Petitioner's treatment was reasonable, necessary, and causally related to his work injury. (PX 17, p. 5, 10-23).

Dr. Templin saw the Petitioner on September 1, 2016, when he reported pain at a 5 out of 10 and was continuing physical therapy. He reported pain at a 4 out of 10 on October 28, 2016, with no leg pain and only mild lower back pain with unchanged X-rays, with similar results at his appointments on December 9, 2016 and January 20, 2017. On February 16, 2017, Petitioner underwent a capacity evaluation, which Dr. Templin viewed as valid, meaning that Petitioner was giving his full effort during the examination. Petitioner's condition remained stable on February 22, 2017, when he reported pain at a 3 out of 10 with no leg pain and good X-rays with no neurological concerns. The FCE indicated that Petitioner could return to work with medium duty. (PX 17, p. 10-12).

Dr. Templin stated that Petitioner was working full duty as of his appointment on July 24, 2017 and that he had no pain and was doing well, despite potential loosening of screws shows on his X-rays. Dr. Templin believes that Petitioner's screws came loose as a result of his bones not properly growing together, which may present without symptoms. (PX 17, p. 12).

Dr. Templin testified that he saw the Petitioner on August 16, 2017, following the fall Petitioner had at work on August 8, 2017. The Petitioner stated that he was carrying a heavy roll of material on his shoulder when he slipped and fell. He reported a shoulder injury and pain in his mid and lower back and his shoulder at a 7 or 8 out of 10. Dr. Templin reviewed Petitioner's CT scan, which showed evidence of a nonunion at L5-S1, known as a pseudoarthrosis. Dr. Templin testified that a pseudoarthrosis can be aggravated, exacerbated, or accelerated by trauma, such as a fall. After his August 2017 appointment, Dr. Templin recommended physical therapy and shoulder treatment with Dr. Burra. Petitioner was kept out of work following this appointment. (PX 17, p 14-15).

On September 29, 2017, Dr. Templin saw the Petitioner again. The Petitioner was still complaining of pain at an 8 out of 10 in his shoulder, neck, and back. The Petitioner's lumbar MRI showed open neurologic regions with L5-S1 instrumentation, and his CT scan from August 8, 2017, showed a loosening of the screws at L5-S1. At this point, Dr. Templin planned to revise the fusion, following a shoulder surgery ordered by Dr. Burra. (PX 17, p. 16-17).

On April 10, 2018, however, Petitioner's pain in his lower back had improved to a 4 out of 10, and he was no longer experiencing pain in his neck, upper back, or shoulder, so Dr. Templin decided to avoid surgery until an additional FCE was complete. Following the FCE, Dr. Templin determined that the Petitioner could return to work with the restrictions contained in the FCE, with plans to follow up at a later date. (PX 17, p. 18-19).

The Petitioner returned to Dr. Templin on June 11, 2018. At that time, the Petitioner reported a progressive increase in lower back pain when he attempted to reach his FCE limits. Dr. Templin ordered a repeat a CT scan and testified that the Petitioner's pain was related to his pseudoarthrosis. (PX 17, p. 19-20).

Dr. Templin testified that he reviewed the CT scan and found evidence of loosening of the screws. He recommended surgery with possible revision fusion. Dr. Templin performed this surgery on January 2, 2019. Dr. Templin testified that this surgery was the most definitive way to treat a non-union. (PX 17, p. 21-23).

Dr. Templin was testified about his observations during the surgery. He testified that the screws in the Petitioner's back were not as tight as he would have liked, which shows that the Petitioner has pseudoarthrosis. The surgery was without complication. Dr. Templin testified that he recommends that the Petitioner undergo two to three months of physical therapy beginning ten weeks after surgery, and then to begin work conditioning six months after surgery.. Dr. Templin stated that he would need to wait and see regarding any work restrictions the Petitioner may need. (PX 17, p. 24-25).

Dr. Templin was questioned regarding the findings of Langlois's §12 Examiner, Dr. Graf. Dr. Templin testified that he disagreed with Dr. Graf's opinions. Dr. Templin testified that Petitioner had an initial injury, for which he was treated and rehabilitated, and then he returned to work and was tolerating full duty. Dr. Templin opined that the Petitioner's pseudoarthrosis was stable and asymptomatic until it was aggravated by the August 2017 injury. Dr. Templin further testified that he could not tell whether the Petitioner would have needed revision absent the trauma in August 2017. Dr. Templin stated that he would not recommend treatment for asymptomatic pseudoarthrosis Dr. Templin opined that the Petitioner's treatment from August 2017 to present was reasonable, necessary, and causally related to the August 2017 injury, and that the work restrictions imposed upon him were similarly causally related to the same injury. (PX 17, p. 29-31).

Dr. Templin stated that the Petitioner will require therapy and work conditioning and was unable to return to work immediately following surgery (PX 17, p. 32). Dr. Templin believes Petitioner could return to work in a sedentary capacity once he begins physical therapy, but would be unable to make a determination on Petitioner's ability to return to work without restrictions until he had completed physical therapy, an FCE, and work conditioning (PX 17, p. 32).

Dr. Templin testified that the Petitioner's subjective complaints were consistent with his objective findings on physical examination, review of imaging studies, surgical findings, and mechanism of injury. Dr. Templin stated that if Petitioner's pseudoarthrosis had remained pain-free and he was functioning well, he would not have performed a revision surgery. (PX 17, p. 62, 64).

Cross-Examination by Respondent Langlois

On cross-examination, Dr. Templin agreed that it is possible that the Petitioner will have a full recovery without restrictions. He stated that the Petitioner would be on sedentary light duty for 10 to 12 weeks while undergoing physical therapy, that he would not be able to work while undergoing work conditioning, and that he could potentially return to work at full duty six to seven months post-surgery, assuming his fusion is successful. Dr. Templin agreed that the Petitioner did not have a herniated disc, spinal stenosis, or fracture as a result of his August 8, 2017 injury. Dr. Templin agreed that Petitioner had back pain at a 2 out of 10 in July of 2017, one year following the first fusion surgery, and had no leg pain. Dr. Templin agrees that the Petitioner had a pseudoarthrosis on August 8, 2017. (PX 17, p. 35, 37-40, 55).

Dr. Templin stated that excessive motion, smoking, poor calcium metabolism, hypothyroidism, hypoparathyroidism, and Vitamin D deficiency can all be causes of a nonunion or pseudoarthrosis. He agreed that the Petitioner reported smoking at his appointment on January 20, 2017, and that he advised the Petitioner to quit smoking.. (Petitioner disputes smoking, *see* PX 30-40). (PX 17, p. 43).

After reviewing Petitioner's FCEs from before and after his August 2017 injury, Dr. Templin noted that Petitioner's above the shoulder lifting was significantly lower, and his chair to floor lifting and carrying were both about 10% lower with the April 2018 FCE than at the February 2017 FCE. (PX 17, p. 47).

Dr. Templin testified that the Petitioner's pseudoarthrosis was not the same on July 24, 2017 as it was on May 11, 2018, because Petitioner was working full duty with minimal problems in July of 2017 but was struggling with medium-duty work in May of 2018. (PX 17, p. 47).

Cross-Examination by Respondent All Sealants

On cross-examination by Respondent All Sealants, Dr. Templin agreed that the Petitioner was working without restrictions as a roofer in April, May, June, and July of 2017. Dr. Templin agreed that after his July 24, 2017 examination, he was concerned about haloing in the Petitioner's screw, but he was not concerned about the Petitioner's ability to work without restriction. Dr. Templin opined that the Petitioner's fall was a competent cause of low back pain both in the face of a nonunion and without a nonunion, and that the Petitioner's fall was a competent cause of making asymptomatic pseudoarthrosis symptomatic. Dr. Templin based this opinion upon the Petitioner's report that he was carrying heavy weight and slipped and fell, which placed significant torsion and load upon the spine, which can irritate a stable pseudoarthrosis. Dr. Templin further stated that fibrous tissues can stabilize pseudoarthrosis, and that these fibrous tissues can be irritated with torsion and load on the spine, such as from a fall. He stated that a less stable pseudoarthrosis is shown with loosened screws, which would indicate more motion. (PX 17, p. 56-57, 59, 60).

Dr. Templin testified that the Petitioner was not a candidate for pseudoarthrosis surgery in July 2017. Dr. Templin reported a significant change in the Petitioner's subjective complaints following the August 8, 2017 incident, which were consistent with his diagnostic findings. (PX p. 69-70).

EVIDENCE DEPOSITIONS OF DR. CARL GRAF, Retained by Langlois Roofing.

The Arbitrator reviewed the evidence deposition transcripts of Dr. Carl Graf. (RX 1, 2 & 3). Dr. Graf testified that he questioned the Petitioner regarding his previous injury in August 2015, and also questioned Petitioner's pain, which he stated was a 7 to 8 out of 10 in the whole body but mostly the right shoulder, left flank, and chest due to a rib fracture. (RX 1, p. 10). Dr. Graf specifically saw Petitioner in order to treat his low back, and not his cervical spine. (RX 1, p. 12).

Dr. Graf testified that the Petitioner exhibited nonorganic pain signs on evaluation and that these raised questions of the Petitioner's true subjective complaints. Despite these signs, Dr. Graf diagnosed the Petitioner with a low back pseudoarthrosis. Dr. Graf stated that smoking is the most recognized reason for a nonunion of any bony fusion, fracture healing, or otherwise, as it impedes bone growth. Dr. Graf testified that patients for lumbar fusions are approximately more likely to have a nonunion if they are a smoker. (RX 1, p. 16, 18, 20-21).

Dr. Graf agreed with Dr. Templin's finding that Petitioner radiographically showed a non-fusion on July 24, 2017. Dr. Graf opined that the Petitioner's pseudoarthrosis/non-union was a pre-existing condition that was in no way related to the August 8, 2017 claimed injury. Over objection from Petitioner and Respondent All Sealants, Dr. Graf stated that there was no significant change in Petitioner's low back condition between July 24, 2017 and August 8, 2017. The Arbitrator notes that this opinion was not contained in Dr. Graf's reports prepared before the deposition. Nevertheless, the Arbitrator will consider Dr. Graf's opinion over objection. (RX 1, p. 24-25, 29).

Dr. Graf stated that beyond pseudoarthrosis, there was no need for additional surgery for the Petitioner, and he would not recommend any additional treatment. Dr. Graf opined that the Petitioner's low back condition dated back to 2013. Over objection under *Ghere* and the 48-hour rule, Dr. Graf stated that Petitioner's two FCEs are almost completely identical, so he should be able to return to work at the medium physical demand level. Again, the Arbitrator notes that this opinion was not contained in Dr. Graf's reports prepared before the deposition. Nevertheless, the Arbitrator will consider Dr. Graf's opinion over objection. (RX 1, p. 30, 38).

Cross-Examination by Petitioner

On cross-examination, Dr. Graf agreed that a nonunion is a known complication for lumbar fusion. Dr. Graf testified that a pseudoarthrosis can be symptomatic or asymptomatic. Dr. Graf agreed that revision fusion is an appropriate treatment for symptomatic pseudoarthrosis. He further opined that an asymptomatic or mildly symptomatic pseudoarthrosis could be aggravated by trauma, a slip and fall, or a slip and fall with hundreds of pounds falling on top of someone. Dr. Graf agreed that it is possible that the addition of hundreds of pounds falling on top of someone may make it more likely for that individual to get injured. (RX 1, p. 55-57).

Dr. Graf agreed that a pseudoarthrosis can be a pain generator.. Dr. Graf testified that the mechanism that causes pain in pseudoarthrosis is non-fusion or loosening of hardware, where the goal is to fuse the spine level so there is no motion. Dr. Graf admitted that, before the August 2017 injury, the Petitioner was working at the very heavy physical demand level according to the Department of Labor's definitions. The cutoff for heavy labor is typically 100 pounds, and that Petitioner stated in a questionnaire that he was crushed when carrying a roll that weighed 300 pounds. (RX 2, p. 87-88, 90; RX 1, p. 63).

Dr. Graf was also questioned about non-organic pain signs. Dr. Graf agreed that non-organic pain signs bring forward a question about subjective complaints, but do not explicitly show that there is not an organic basis for the patient's pain. Dr. Graf admitted that the Petitioner has an organic basis for his low back pain: the pseudoarthrosis. Dr. Graf did not think that the Petitioner was malingering. (RX 1, p. 68; RX 2, p. 108-109).

Cross-Examination by Respondent All Sealants

Dr. Graf testified that the Petitioner had similar low back issues in the past, which were resolved after back surgery on May 4, 2016. Dr. Graf agreed that, hypothetically, it is possible for Petitioner's injury to have aggravated a lumbar spine that had been previously operated on but does not believe that to be the case here. His opinion is based on finding no radiographic changes from before and after the August 2017 injury. (RX 2, p. 94-95).

EVIDENCE DEPOSITION OF DR. JULIE WEHNER, Retained by All Sealants.

The Arbitrator further considered the evidence deposition of Dr. Julie Wehner. (All Sealants RX 1). Dr. Wehner was retained by All Sealants pursuant to §12 of the Act to do a record review for the second injury. The Arbitrator notes that Dr. Wehner previously examined the Petitioner and had testified regarding the August 2015 injury.

Dr. Wehner testified that she examined the Petitioner on November 9, 2015, and conducted a records review on October 1, 2018. She testified that the Petitioner reported a new work injury on August 8, 2017, when he slipped and fell on his buttocks while carrying a roll of material on his shoulder that weighed approximately 350 pounds. Dr. Wehner testified that she reviewed the Petitioner's medical records from Concentra, Hinsdale Orthopedics, Dr. Templin, and ATI, along with a §12 report from Dr. Graf, an FCE, work conditioning notes, MRIs, and X-rays. She could not recall if she reviewed records from Silver Cross Hospital. (All Sealants RX 1, p. 8-15, 17).

Dr. Wehner testified that the revision fusion surgery recommended by Dr. Templin was causally connected to Petitioner's August 8, 2017 work injury. Dr. Wehner relied upon Dr. Templin's lack of recommendation of work restrictions or surgery prior to August 8, 2017 to draw this conclusion. Dr. Wehner testified the Petitioner's increased pain could have been attributed to his pseudoarthrosis. (All Sealants RX 1, p. 19-23).

Cross Examination by Langlois

On cross-examination by Langlois, Dr. Wehner agreed that she only examined Petitioner once, on November 9, 2015. Dr. Wehner testified that she conducts IMEs almost exclusively for respondents. Dr. Wehner agreed that it has been "a while" since she conducted a surgery for pseudoarthrosis in the lumbar spine, and that she has not done many revision surgeries for pseudoarthrosis. Dr. Wehner was unaware that Petitioner had undergone a revision surgery on January 2, 2019. (All Sealants RX 1, p. 25, 27-28).

Over Petitioner's counsel and Respondent All Sealants' counsel's objections that it was beyond the scope of direct examination, counsel requested that Dr. Wehner review the operative report from Petitioner's January 2, 2019 fusion revision surgery. The Arbitrator overrules the objection and will consider Dr. Wehner's testimony. Dr. Wehner stated that there was no indication in the report of a herniated disc, or spinal stenosis. (All Sealants RX 1, p. 28).

Dr. Wehner agreed that Petitioner's X-ray from July 24, 2017 showed haloing around one of the screws in the fusion, which may indicate non-fusion. Dr. Wehner stated that there was no indication of pseudoarthrosis, but it could be inferred from the loosening of the screws. Dr. Wehner agreed that smoking can cause a fusion surgery to fail, but stated that there is no indication Petitioner was a smoker. (All Sealants RX 1, p. 32, 36, 39).

Cross Examination by Petitioner

On cross-examination by the Petitioner, Dr. Wehner agreed that her October 2018 report states that Petitioner "clearly sustained a new injury on August 8, 2017," and states that this is still an accurate representation of her opinion. Dr. Wehner states that she based her opinion that the Petitioner sustained a new injury by looking at the mechanism of injury, the Petitioner's significant increase in pain, the Petitioner's prescription of narcotic medications, and the new radiographic finding of a loosening screw at the prior fusion site. (All Sealants RX 1, p. 40-41, 45).

EVIDENCE DEPOSITION OF DR. SUMMERVILLE, Retained by Respondent Langlois

The Arbitrator finally considered the evidence deposition testimony of Langlois' §12 Examiner, Dr. Bruce Summerville. (RX 4 & 5). Dr. Summerville is a board-certified orthopedic surgeon who specializes in general orthopedics with a subspecialty in arthritis and joint replacement. He treats hips, knees, shoulders and nonoperative spinal patients. Dr. Summerville examined the Petitioner on July 26, 2018. He noted a history of injury where the Petitioner and a coworker were carrying a roll of roofing materials. The Petitioner was using his right shoulder with his arm up and holding onto the material when he slipped and fell in a puddle, but kept his arm on the roofing material to maintain control of it. (RX 4, p. 4-7).

Dr. Summerville reported that the Petitioner had undergone shoulder surgery. The Petitioner's shoulder examination was relatively normal with mild tenderness at the T1 transverse process level, but with no significant findings in his cervical spine. Dr. Summerville noted that the Petitioner's shoulders had nearly symmetrical range of motion, but that the Petitioner's right shoulder hung slightly lower than the left. Dr. Summerville noted that Petitioner's arthroscopy portals were healed, and had no redness, warmth, or swelling. The Petitioner exhibited no tenderness to the shoulder, had normal strength of his shoulder muscles, and did not have any positive results on special tests to look for specific diagnoses. Dr. Summerville found some loss of internal rotation in Petitioner's right shoulder relative to his left, but states that he had normal strength and sensation with no abnormal flexion, abduction, or external rotation. Dr. Summerville diagnosed Petitioner with an acute posttraumatic superior labrum anteroposterior (SLAP) tear. (RX 4, p. 7-10, 14).

Dr. Summerville opined that Petitioner's right shoulder subacromial bursitis and subsequent subacromial bursectomy were unrelated to his August 8, 2017 injury. Regarding Petitioner's cervical spine, Dr. Summerville opined that the Petitioner sustained an irritation, exacerbation, or aggravation of a degenerative condition of his cervical spine as a result of the work injury. Dr. Summerville opined that the Petitioner's right shoulder injury was causally related to the August 8, 2017 accident. (RX 4, p. 14-15, 17).

Dr. Summerville testified that the Petitioner reached maximum medical improvement for his right shoulder as of July 26, 2018. Dr. Summerville opined that Petitioner reached maximum medical improvement on his cervical spine on December 14, 2017, based off his report of a 100% reduction of pain after his third cervical epidural steroid injection. Dr. Summerville testified that the Petitioner does not require needed additional treatment or work restrictions after April 9, 2018 for the shoulder and after December 14, 2017 for the cervical spine. (RX 4, p. 18-20).

Dr. Summerville finally stated that he did not believe Petitioner needed work hardening or work conditioning in regard to his cervical spine or his shoulder, and would not recommend it for someone who is pain free and does not have a clinical lack of strength or range of motion. Dr. Summerville stated that Petitioner's dynamometer reading and heart rate are consistent with full effort on his FCE, and that the FCE does not report any specific work restrictions to the right shoulder or neck. (RX 4, p. 49-50, 56-57).

Cross-Examination by All Sealants

On cross-examination by All Sealants, Dr. Summerville agreed that he did not examine Petitioner's low back and does not hold any opinions regarding Petitioner's low back. (RX 4, p. 21).

Cross-Examination by Petitioner

On cross-examination, Dr. Summerville admitted that the mechanism of injury that the Petitioner reported could be a competent mechanism of injury to cause an aggravation of a low back condition. Dr. Summerville stated that Petitioner's sagging shoulder could be involuntary or voluntary positional, or it could represent a nerve problem or atrophy of the muscles, though he did not find atrophy on examination. He stated that sagging or drooping is not a known side effect of a surgically repaired SLAP tear. (RX 4, p. 25)

Dr. Summerville agreed that, because the Petitioner is required to lift upwards of 150 pounds by himself at his job, it would fall into the very heavy physical demand letter from the Department of Labor's Dictionary of Occupational Titles. Dr. Summerville agreed that Petitioner may have difficulty with progressive work-specific lifting given his history of prior L5-S1 fusion, hardware fracture, and multiple cervical disc herniations. Dr. Summerville stated that he does not view work conditioning for the Petitioner to be absolutely necessary, though it would not be harmful. Dr. Summerville agreed that Dr. Burra wanted to hold off on work conditioning until the Petitioner's lumbar spine issues were addressed, but that Petitioner was otherwise at MMI for his shoulder. He agreed that the Petitioner's lumbar spine affected Athletico's ability to progress him with work-related lifting during his shoulder physical therapy. (RX 4, p. 31, 35-36, 39, 46).

Dr. Summerville had no opinions regarding causation on Petitioner's low back. Dr. Summerville he did not see evidence of malingering or symptom magnification in the Petitioner. (RX 4, p. 62-63).

CONCLUSIONS OF LAW: EPPENSTEIN v. ALL SEALANTS

I. Whether the Petitioner's Condition of Ill-Being was Causally Related to the Work Injury?

The Arbitrator notes the Arbitrator and Commission found his lumbar spine condition and lumbar spine fusion to be related to the accident of August 31, 2015 against All Sealants. TTD and medical was awarded under Section 19b of the Act through the close of proofs, September 22, 2016. (PX 1 & 2). The arbitrator is bound by the Commission's decision as it is the *law of the case*. No Court has overturned the Commission decision to date. The decision now is pending in the Illinois Appellate Court on All Sealants Appeal. (Arb Exh 1)

The Arbitrator concludes that the Petitioner's treatment from September 23, 2016 through August 7, 2017 was a continuation of the medical treatment ordered by the Petitioner's treating physicians and awarded by the Illinois Workers' Compensation Commission. (PX 1 & 2).

As will be discussed in the Conclusions of Law: Eppenstein v. Langlois, the Petitioner suffered a second injury arising out of and in the course of his employment on August 8, 2017 to his lumbar spine, and other body parts.

Based on the above, as well as the Petitioner's credible testimony and his treating medical records, the Arbitrator finds that the Petitioner's condition of ill-being from September 23, 2016 through August 7, 2017 is causally related to his August 31, 2015 work injury.

II. Whether the Medical Services Provided to the Petitioner were Reasonable and Necessary?

The Arbitrator finds that the medical services provided to the Petitioner from September 23, 2016 through August 7, 2017 were reasonable, necessary, and causally related to the August 31, 2015 work injury. The Arbitrator bases this decision on the Petitioner's credible testimony regarding his injury and treatment, the medical records from the Petitioner's treating physicians, and the testimony provided by Dr. Templin. The Petitioner has established causation as to his physical therapy, work hardening, visits with his orthopedic surgeon and pain management physician, functional capacity evaluation, and radiographic imaging studies from September 23, 2016 through August 7, 2017.

III. Whether the Respondent has Paid All Appropriate Charges for All Reasonable and Necessary Medical Treatment?

Having found that the Petitioner's medical treatment from September 23, 2016 through August 7, 2018 was reasonable, necessary, and causally related to the August 31, 2015 work injury, the Arbitrator finds that the Respondent has not paid all appropriate charges for all reasonable and necessary medical treatment.

The Arbitrator has reviewed the list of bills prepared by Petitioner's counsel, the fee schedule analysis prepared by Petitioner's counsel, and the itemized bills themselves. (PX 21). The Arbitrator has further reviewed the accompanying treating medical records, the testimony of Dr. Templin, the testimony of the Petitioner regarding the Petitioner's medical treatment. The Arbitrator further finds that the Petitioner's fee schedule analysis accurately states the appropriate charges for the Petitioner's reasonable and necessary medical treatment. The Arbitrator provided both respondent until July 5, 2019 to submit a fee schedule analysis. Respondent All Sealants agreed with petitioner's, but the date August 8, 2017 was removed from the bills as that is for the second accident.

Provider	Date(s) of Treatment	Charged Amount	Fee Schedule
ATI Physical Therapy	9/28/2016 – 2/16/17	$42,870.34	$17,689.35

Hinsdale Orthopedics	10/28/2016 – 7/24/2017	$1,709.00	$1,131.79
Pain Treatment Centers of Illinois	10/28/2016 – 3/10/2017	$892.77	$473.03
	Total:	**$45,472.11**	**$19,294.17**

The Arbitrator therefore awards $19,294.17 to be paid by All Sealants. This is the amount owed per the Illinois Fee Schedule.

IV. Whether the Petitioner is Entitled to Temporary Total Disability Benefits?

The Arbitrator finds that the Petitioner is entitled to TTD benefits. The Petitioner claims that he has been totally disabled from work from September 23, 2016 through April 13, 2017. In support of this claim, the Petitioner presented off-work slips from his treating physicians, a valid Functional Capacity Evaluation, and a full duty release dated April 13, 2017. The Arbitrator further relies upon the deposition testimony of Dr. Cary Templin, the treating records and the findings of the Commission awarding TTD benefits through September 22, 2016.

The Arbitrator notes that the parties have stipulated that the Petitioner's § 10 Average Weekly Wage is $1,603.50. Accordingly, the Petitioner's TTD rate is $1,069.01. This is the same rate contained in the IWCC decision. (PX 1 & 2).

Accordingly, the Arbitrator awards additional TTD benefits to be paid by All Sealants for the period of September 23, 2016 through April 13, 2017 (29 weeks x $1,069.01/week). The arbitrator notes TTD was claimed from 9/1/2015 through 4/13/17 on the stipulation sheet (Arb. Exh. 1). The Commission has already awarded TTD from 9/1/2015 through 9/22/16, for which respondent was given a credit of $28,252.16 for TTD previously paid. (PX 1 & 2; Arb. Exh. 1) There is no evidence that any additional TTD was paid by respondent All Sealants since the closing of proofs on 9/22/16. Therefore, the total due and owing in TTD by All Sealants when considering the Commission decision and the additional 29 weeks awarded here is the period of 9/1/15 through 4/13/17 at $1,069.01 per week x 84 3/7 weeks = $90,245.82 [JS2]less the credit of $28,252.16 for a net $61,993.66 in TTD owed and awarded through 4/13/17.

CONCLUSIONS OF LAW: EPPENSTEIN v. LANGLOIS ROOFING

I. Whether the Petitioner's Current Condition of Ill-Being is Causally Related to the Injury?

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to his work injury of August 8, 2017. The Arbitrator notes the following in particular support of this finding: (1) the Petitioner's credible testimony regarding his pre-injury and post-injury symptoms; (2) the Petitioner's credible and detailed account of his August 8, 2017 work injury; (3) the Petitioner's pre-injury and post-injury treating records; (4) Dr. Templin, Dr. Burra, and Dr. Abusharif's treating medical records and surgical records; (5) Dr. Templin and Dr. Wehner's causation opinions; (6) Dr. Burra's causation opinions contained in his treating medical records; (7) Dr. Summerville's causation opinions; (8) Dr. Graf's agreement that the Petitioner's mechanism of injury could possibly be sufficient to cause an aggravation of a pre-existing pseudoarthrosis; and (9) the Petitioner's denial of any injuries after his August 8, 2017 work injury. (10) The fact that petitioner was working full duty for respondent performing very heavy work until he injured the lower back on August 8, 2017, sustaining direct trauma to his lumbar spine.

It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work related accident aggravated or accelerated the pre-existing 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. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 204-05 (2003). It is axiomatic that employers take their employees as they find them; even when an employee has a pre-existing condition which makes 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 a causative factor. *Id.* at 205. An employee need only prove that some act or phase of his employment was a causative factor of the resulting injury, the mere fact that he might have suffered the same disease, even if not working, is immaterial. *Twice Over Clean, Inc. v. Indus. Comm'n*, 214 Ill.2d 403, 414 (2005).

The Arbitrator reviewed and considered the Petitioner's pre-injury records. These records demonstrate that the Petitioner had a pre-existing condition and underwent surgery to treat his condition in his lower back. The testimony and reports of Dr. Templin, Dr. Wehner, and Dr. Graf also reflect that the Petitioner had pseudoarthrosis in his lower back before his injury on August 8, 2017. Each of the testifying doctors, including Dr. Summerville, agree that the Petitioner's mechanism of injury, falling carrying a heavy weight, was sufficient to cause an aggravation of a previously asymptomatic pseudoarthrosis.

The Arbitrator is also persuaded by the Petitioner's testimony that he was able to return to work full duty for several months before his injury in August 2017. It appears he was in good health, functioning at a heavy physical demand level for Respondent Langlois before the August 8, 2017 accident. The Petitioner's testimony mirrors the treating medical records: that he had little-to-no pain in his lower back before the fall while carrying heavy roofing materials.

Furthermore, the Arbitrator notes Langlois's argument that the Petitioner's condition was caused by smoking. The Arbitrator finds the Petitioner's testimony credible on this regard. The Petitioner testified that he quit smoking before his first fusion and disagreed with records reflecting him smoking after that, and agreed with the records indicating he had stopped smoking. (PX 30-40). The Petitioner further indicated that he would occasionally smoke while working at Langlois roofing (1-5 cigarettes per week). Furthermore, the Arbitrator notes that the Petitioner's handwritten records indicate that he was a non-smoker. The Arbitrator finds the Petitioner's testimony credible. The Arbitrator is persuaded by the Petitioner's testimony that, while he was once a smoker, the history kept repeating through the records. There was also a clear trauma to his lower back. He was highly functional until

he fell on August 8, 2017, suffering significant trauma. There is no persuasive evidence here that smoking caused a medical condition in his lower back.

The Arbitrator also considered the surveillance footage. The Arbitrator finds the Petitioner's testimony credible that he did not sustain an injury while riding a bike. The Arbitrator further relied upon the Petitioner's treating medical records. For example, on July 25, 2018 the Arbitrator notes that Dr. Templin reported that the Petitioner had pain while trying to be more active within the limitations of the Functional Capacity Evaluation. The biking is consistent. (PX 3, 3a). Respondent provided no medical opinion suggesting he suffered a new injury riding a bicycle.

The Arbitrator finds Dr. Templin and Dr. Wehner persuasive. The Arbitrator does not find Dr. Graf to be persuasive. Dr. Graf testified that he based his opinion on no changes being present in the Petitioner's radiographic studies from before to after the injury. The Arbitrator finds the testimony of Dr. Templin more persuasive. Dr. Templin's testimony and treating medical records indicate that he found movement in the fusion site at the time of surgery; a clear indication of a pseudoarthrosis. (PX 17).

Finally, the Arbitrator notes that both Dr. Summerville, Langlois's §12 Examiner, and Dr. Burra, the Petitioner's treating shoulder surgeon, opined that the Petitioner sustained an injury to his shoulder arising out of and in the course of his employment. The Arbitrator further adopts the opinion of Dr. Summerville finding that the Petitioner sustained an injury to his cervical spine as a result of the work injury. (RX 4).

To summarize, the Arbitrator finds the current condition of the Petitioner's right shoulder, herniated cervical disc, fractured left 6th rib and lower back to be related to the accident of August 8, 2017. He was at MMI and back to work full duty prior to August 8, 2017. The direct trauma to his body, carrying very heavy weight on his right shoulder, slipping and falling, caused these injuries. The trauma to the right shoulder led to the right shoulder injury and surgery by Dr. Burra. The lower back injury was reported on the date of accident. The injury caused an aggravation and acceleration of the pre-existing stable pseudoarthrosis at L5-S1, and was a cause of the lumbar surgery of January 2, 2019 performed by Dr. Templin. As it relates to the August 31, 2015 accident, the August 8, 2017 accident represents an intervening superseding accident to the lumbar spine. All treatment after August 8, 2017 is related to the August 8, 2017 accident. All treatment between August 31, 2015 and August 7, 2017 is related to the August 31, 2015 accident.

The Arbitrator also finds that the Petitioner is not at maximum medical improvement for the right shoulder and lower back as it relates to the August 8, 2017 accident. He has not completed physical therapy for the lower back following the January 2, 2019 lumbar fusion. He has not completed work conditioning ordered by Dr. Burra for the right shoulder because he was waiting to have the lower back treated. (PX 3, 3a)

II. What Were the Petitioner's Earnings?

The Arbitrator finds that the Petitioner's earnings in the year proceeding his injury were $15,263.05 and that the Petitioner's average weekly wage was $1,659.02. The Arbitrator notes the following in particular support of this finding: (1) the Petitioner's pay records in evidence (PX 18); (2) the Petitioner's credible testimony regarding the hours he worked and was required to work; and (3) the testimony of Sarah Hankey that the usual work week for roofers at Langlois is 40 hours per week.

In *Sylvester v. Indus. Comm'n,* 107 Ill. 2d 255 (2001), the Supreme Court stated:

> [S]ection 10 [of the Illinois Workers' Compensation Act] provides four different methods for calculating average weekly wage. (1) By default, average weekly wage is "actual earnings" during the 52-week period preceding the date of injury, illness or disablement, divided by 52. (2) If the employee lost five or more calendar days during that 52-week period, "whether or not in the same week," then the employee's earnings are divided not by 52, but by "the number of weeks and parts thereof remaining after the time so lost has been deducted." **(3) If the employee's employment began during the 52-week period, the earnings during employment are divided by "the number of weeks and parts thereof during which the employee actually earned wages."** (4) Finally, if the employment has been of such short duration or the terms of the employment of such casual nature that it is "impractical" to use one of the three above methods to calculate average weekly wage, "regard shall be had to the average weekly [***8] amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer." 107 Ill.2d at 230-31.

The Arbitrator finds that the appropriate method for calculating the Petitioner's average weekly wage is method **(3)** mentioned above. The Petitioner testified that he started working for Langlois in May 2017. His regular work week was 8 hours per day, 5 days per week. If the Petitioner worked a 22-hour week, he would have worked 3 days. A 35-hour week was 4-5 days. He worked 5 days per week unless he was sent home due to weather. Overtime started after an 8 hour day. The Petitioner testified that overtime was mandatory if the roof was open. Once a roof was opened, every roofer was required to stay until the roof was re-sealed. Sarah Hankey testified that overtime was not mandatory, but agreed that it was possible that workers would have to stay to complete work and seal the roof. Based on the testimony and evidence, the Arbitrator concludes that the Petitioner's overtime was mandatory and will be included at the straight time rate.

Based on all of the evidence and testimony in this case, including the Petitioner's wage records contained in Petitioner's Exhibit 18, the Arbitrator calculates the Petitioner's average weekly wage as follows:

Period Ending	Gross	Hours	Days	Weeks	Wage Excluding Overtime Premium
5/20/2017	$917.40	22	3	0.6	$917.40
6/3/2017	$1,502.28	35.01	4	0.8	$1,480.92
6/10/2017	$1,834.34	42.24	5	1.0	$1,786.75
6/17/2017	$1,082.46	25.45	3	0.6	$1,076.53
6/24/2017	$1,629.81	38.53	5	1.0	$1,629.82
7/1/2017	$1,690.31	39.96	5	1.0	$1,690.31
7/8/2017	$1,529.42	36.05	5	1.0	$1,529.42
7/15/2017	$1,283.11	30.05	4	0.8	$1,283.11
7/22/2017	$1,485.59	35.12	5	1.0	$1,485.59
7/29/2017	$1,405.01	32.94	4	0.8	$1,393.37
8/5/2017	$1,023.04	23.40	3	0.6	$989.83
TOTALS:	**$15,382.78**	**360.75**	**46**	**9.2**	**$15,263.05**

Total Earnings Under Section 10:	**$15,263.05**
Total Weeks and Parts Thereof Worked:	**9.20**
Section 10 Average Weekly Wage:	**$1,659.02**
Temporary Total Disability Rate:	**$1,106.01**

The Arbitrator hereby finds that the Petitioner's average weekly wage pursuant to §10 of the Workers' Compensation Act was $1,659.02

III. Whether the Medical Services Provided to the Petitioner were Reasonable and Necessary?

The Arbitrator finds that the medical services provided to the Petitioner following his August 8, 2017 work injury were reasonable, necessary, and causally related to the August 8, 2017 work injury. The Arbitrator bases this decision on the Petitioner's credible testimony regarding his injury and treatment, the medical records from the Petitioner's treating physicians, and the testimony provided by Dr. Templin, Dr. Wehner, and Dr. Summerville. The Petitioner has established causation as to his physical therapy, work hardening, visits with his orthopedic surgeons and pain management physician, epidural steroid injections, medications, surgeries, functional capacity evaluation, and radiographic imaging studies following his August 2017 work injury.

The Arbitrator notes that Dr. Templin testified that the Petitioner's medical treatment for his low back condition was reasonable, necessary, and causally related to the work injury. (PX 3, 3a, 4, 17). Dr. Wehner agreed with Dr. Templin's assessment, offering the opinion that the need for the Petitioner's revision surgery was causally related to his August 2017 work injury. (All Sealants RX 1). The Arbitrator further notes that Langlois's §12 Examiner, Dr. Graf, also agreed that the proposed revision surgery was reasonable to treat a symptomatic pseudoarthrosis, although he disagreed as to cause of the symptomatic pseudoarthrosis. (RX 1 & 2).

The Arbitrator further relies upon the Petitioner's treating medical records, particularly the records of Dr. Abusharif, in determining that the treatment for the Petitioner's neck condition was reasonable, necessary, and causally related to the work injury. (PX 3, 3a, 9, 9a). The Arbitrator also relies upon the opinion of Dr. Summerville, Langlois's §12 Examiner, who opined that the Petitioner sustained an injury, exacerbation, or aggravation to his cervical spine and reached maximum medical improvement with regard to the cervical spine after he completed cervical epidural steroid injections with Dr. Abusharif. (RX 4).

The Arbitrator relies upon the Petitioner's treating records of Dr. Burra and Dr. Templin in finding the treatment for the Petitioner's right shoulder to be reasonable, necessary, and causally related to his August 2017 work injury. The Arbitrator further relies upon the opinion of Dr. Summerville, who opined that the Petitioner's right shoulder condition was causally related to the work injury of August 2017.

Based on the foregoing, the Arbitrator finds that the Petitioner's treatment to the right shoulder, neck, lower back and chest to date have been reasonable, necessary, and causally related to the August 8, 2017 work injury.

IV. Whether the Respondent has Paid All Appropriate Charges for All Reasonable and Necessary Medical Treatment?

Having found that the Petitioner's medical treatment from August 8, 2017 to present has been reasonable, necessary, and causally related to the August 8, 2017 work injury, the Arbitrator further finds that the Respondent has not paid all appropriate charges for all reasonable and necessary medical treatment. The Arbitrator has reviewed the list of bills prepared by Petitioner's counsel, the fee schedule analysis prepared by Petitioner's

counsel, and the itemized bills themselves. (PX 21). The arbitrator allowed petitioner's fee schedule analysis into evidence at arbitration. The arbitrator gave both respondents until July 5, 2019 to submit their own fee schedule analysis to petitioner's attorney. Respondent, Langlois Roofing, communicated with this arbitrator via email on July 5, 2019 indicating they would not be submitting their own fee schedule analysis and are maintaining their objections. Respondent, All Sealants, agreed with petitioner's calculations.

The arbitrator notes PX 21 chart created by petitioner's attorney erroneously contained the Silver Cross Hospital bill for August 8, 2017 as part of the All Sealants claim, when it should have been part of the Langlois Roofing claim.

The Arbitrator has further reviewed the accompanying treating medical records, the testimony of Dr. Templin, Dr. Wehner, Dr. Graf, Dr. Summerville, and the testimony of the Petitioner regarding the Petitioner's medical treatment. The Arbitrator further finds that the Petitioner's fee schedule analysis accurately states the appropriate charges for the Petitioner's reasonable and necessary medical treatment.

The Arbitrator therefore awards the following medical bills:

Provider	Date(s) of Treatment	Total Original Charges	Fee Schedule	Lesser Fee Schedule or Negotiated Rate
Advanced Midwest Radiology	8/13/17 – 11/13/17	$97.00	$231.92	$97.00
Assoc. Pathologists of Joliet	12/11/18 - 1/3/19	$285.00	$376.40	$285.00
ATI Physical Therapy	8/17/17 - 6/13/19	$18,512.08	$8,617.24	$8,617.24
EM Strategies	8/13/17	$685.00	$292.32	$292.32
Hinsdale Orthopedics	8/16/17 - 5/7/19	$38,158.00	$22,764.31	$22,764.31
Joliet Radiological	12/11/18	$38.00	$99.70	$38.00
Pain Treatment Centers of IL	9/7/17 - 2/21/19	$20,691.45	$10,152.50	$10,152.50
Pain Treatment Surgical Suites	10/19/17 - 11/2/17	$6,965.67	$3,241.48	$3,241.48
Presence St. Joseph Medical Ctr.	12/11/18 - 2/2/19	$105,745.98	$72,770.19	$72,770.19
Silver Cross Hospital	8/8/17 - 11/13/17	$5,694.35	$2,985.02	$2,985.02
	Totals:	**$196,872.53**	**$121,531.08**	**$121,243.06**

The arbitrator therefore awards $121,243.06 for medical bills which is at the Illinois fee schedule rate pursuant to Section 8(a) and 8.2.

V. Whether the Petitioner is Entitled to Temporary Total Disability Benefits?

Having already found that the Petitioner's current condition of ill-being is causally related to his August 2017 work injury, the Arbitrator finds that the Petitioner is entitled to TTD benefits. The Petitioner claims that he has been totally disabled from work from August 8, 2017 through June 25, 2019, the date of hearing. In support of this claim, the Petitioner presented off-work slips from his treating physicians. The Arbitrator further relies upon the treating records of Dr. Burra and Dr. Templin. Dr. Burra only allows him to lift 10 lbs with the right shoulder / arm as of April 9, 2018. He has not been released by Dr. Burra because of the lower back. He was not able to complete work conditioning due to the lower back which has delayed him reaching MMI on the right shoulder. Dr. Summerville did not agree, but the arbitrator finds Dr. Burra's position more persuasive. He is now in physical

therapy for the lower back. He should start work conditioning soon. His current PT treats the right shoulder and the lower back. The arbitrator finds the light duty job offer in April 2017 a non-issue. (RX 7). After he returned to Dr. Templin and obtained a light duty release the respondent, Langlois, did not take him back to work within his physical restrictions. The light duty job offer is not a basis to withhold TTD under these facts and per the stipulation of the parties made on the record. (TA 6/25/19 @ 163-164).

Accordingly, the Arbitrator finds that the Petitioner has been totally disabled from work from August 8, 2017 through June 25, 2019. The Arbitrator awards the following TTD benefits:

August 8, 2017 through June 25, 2019 (98 & 1/7 weeks x $1,106.01/week): $108,543.82.

The Arbitrator also notes that the Petitioner filed a Penalties Petition against Langlois but withdrew the Penalties Petitioner at the time of trial. In consideration of withdrawing this Penalties Petitioner, Langlois agreed, on the record, to pay a PPD advance of $19,766.00 to petitioner. The Arbitrator awards Langlois a credit of $19,766.00 even though it had not been paid at the time of the hearing on June 25, 2019. The petitioner has the right to challenge this if in fact the advance is never paid by respondent following the hearing of June 25, 2019.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT EPPENSTEIN,

Petitioner,

vs. NO: 15 WC 029997

ALL SEALANTS, INC.,

Respondent.

19IWCC0636

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses and temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 corrects the Decision of the Arbitrator which inconsistently awarded temporary total disability benefits for two different time periods as a result of his August 31, 2015 accident. The ***Order*** awarded temporary total disability benefits commencing September 1, 2015 through April 3, 2017. The ***Conclusions of Law***, however, awarded temporary total disability benefits commencing September 23, 2016 through April 3, 2017. The latter time period is found to be more appropriate as Petitioner had previously been awarded temporary total disability benefits in the November 7, 2016 19(b) Arbitration Decision in this matter, for the time period commencing September 1, 2015 through September 22, 2016. Thus the Commission corrects the date for which temporary total disability benefits were awarded in the ***Order*** section to make it consistent with the ***Conclusions of Law*** section, namely September 23, 2016 through April 3, 2017.

19IWCC0636

Save for the above-referenced correction, the Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,069.01 per week for a period of 27-4/7 weeks, commencing on September 23, 2016 through April 3, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act, 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 $19,294.17 for medical expenses under §8(a) and §8.2 of the Act.

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

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's condition of ill-being as of August 8, 2017 is not causally related to Petitioner's August 31, 2015 accident.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

NOV 21 2019

DATED:
KAD/mav
O: 10/22/19
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19 (b-1) ARBITRATOR DECISION

EPPENSTEIN, ROBERT
Employee/Petitioner

Case# **15WC029997**

17WC026410

ALL SEALANTS
Employer/Respondent

19IWCC0636

On 7/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 1558.20 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and

3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MITCH HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL R EGAN
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
19(b-1)

Robert Eppenstein
Employee/Petitioner

v.

All Sealants
Employer/Respondent

Case # **15** WC **29997**

Consolidated cases: **17 WC 26410**

19IWCC0636

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **April 25, 2019, re-filed on June 14, 2019, and re-filed on June 25, 2019**. Respondent filed a *Response* on **May 6, 2019**. The Honorable **Michael Glaub**, Arbitrator of the Commission, held a pretrial conference on **May 17, 2019 and June 14, 2019**, and a trial on **June 25, 2019**, in the city of **Chicago**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, **8/31/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$83,382.00**; the average weekly wage was **$1,603.50**.

On the date of accident, Petitioner was **34** years of age, *married* with **2** dependent children.

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

Respondent shall be given a credit of **$28,252.16** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$28,252.16**.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $19,294.17, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,069.01/week for 82-4/7 weeks, commencing 9/1/15 through 4/3/17, as provided in Section 8(b) of the Act.

As of 8/8/17, Petitioner's condition of ill-being is not related to the accident date 8/31/15. Petitioner sustained a new accident on 8/8/17, the subject of the decision in the companion case, 17 WC 26410

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter **$1,558.20** or the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Signature of Arbitrator

Date 25, 2019

JUL 26 2019

Eppenstein v. All Sealants
15 WC 29997

INTRODUCTION

This matter was previously heard as a 19(b) trial before Arb. Erbacci on August 22, 2016, and on September 22, 2016. Arbitrator Erbacci filed his decision on November 7, 2016. (Px 1) Respondent filed a Petition for Review, and the Illinois Workers' Compensation Commission filed a Decision and Opinion on Review on April 12, 2018. (Px 2) The parties have represented to this Arbitrator that said case is now on appeal, pending in the Appellate Court, Third District, Workers' Compensation Division, in case number 3-19-0110WC. (Ar. Ex 1, Transcript, hereinafter "T." p. 8)

Subsequent to the last trial, and during the pendency of that litigation, Petitioner returned to work for a different employer, Langlois Roofing, and has alleged accidental injuries arising out of and in the course of his employment by that employer on August 8, 2017, and which is the subject of 17 WC 26410.

This Arbitrator heard testimony for those events occurring after the closure of proofs in this case on September 22, 2016 and after the alleged second accident on August 8, 2017.

STATEMENT OF FACTS

Petitioner testified that subsequent to the last date of Arbitration, he remained under Dr. Templin's care. (T. p. 16) Petitioner saw Dr. Templin on October 28, 2016, December 9, 2016, January 20, 2017, February 22, 2017, and July 24, 2017, prior to the second claimed accident. (T. p. 16, Px 3) Petitioner agreed that he also continued to receive treatment at Pain Treatment Centers of Illinois. (T. p. 16) Their records reflect Petitioner was seen on October 28, 2016, December 30, 2016, and March 10, 2017.

Petitioner testified that he also remained in physical therapy for his low back, which had started prior to the last hearing. (T. p. 17) Petitioner testified that in December 2016, he progressed in to work conditioning. (T. p. 17, Px 10) Petitioner testified that he completed his work conditioning in February, 2017. (T. p. 17) Petitioner also underwent a Functional Capacity Evaluation on February 16, 2017. (Px 14)

Petitioner testified that he spoke with Dr. Templin in February 2017 about returning to work as a roofer. Petitioner testified that Dr. Templin felt Petitioner was more than capable of returning to work as a roofer. (T. p. 17)

On April 3, 2017, Petitioner testified that Dr. Templin gave him a release to return to work full duty, without restriction. (T. p. 18, Px 3) Petitioner testified that he was feeling great, and was not on any pain medications. (T. p. 19) Petitioner testified that he telephoned Dr. Templin and asked to be released to full activities and this was granted. (T. p. 18)

Petitioner testified that he returned to work as a journeyman roofer at Gluth Brothers in Indiana. They had a job in Chicago that lasted about three weeks. (T. p. 19) After this job ended, he obtained employment with the co Respondent, Langlois Roofing, as a journeyman roofer. In this employment he

tore off roofs, moved materials, loaded trucks, unloaded trucks, moved ladders; everything that was expected to be done by a roofer. He lifted rolls of material that could weigh up to 300 pounds. (T. p. 20)

Petitioner testified that lifting rolls of material could take 2 or 3 people. Petitioner testified that ladders weighed between 60 and 80 pounds. (T. p. 21)

Petitioner testified that while working for Langlois Roofing, he worked 8 hours per day, 5 days per week, depending on weather. (T. pp. 21-23) Petitioner testified that he also worked overtime for Langlois Roofing. (T. pp. 23-24)

On July 24, 2017, Petitioner saw Dr. Templin. (Px 3) Dr. Templin's records reflect that Petitioner had no leg pain. His back showed 2 over 10 pain. Petitioner testified that Dr. Templin asked what his back pain was when working, and Petitioner advised it could be up to a 2, but that he was not having pain at the time. Nor was he taking narcotic pain medication. (T. p. 103)

Dr. Templin's records do reflect that Petitioner complained of mild pain with flexion-extension through the lumbar spine. Straight leg raise was negative. (Px 3)

X-rays did show some haloing around the central screw extending in to L5 with a few degrees of motion on flexion, extension. Dr. Templin expressed concern over these findings and recommended a CT scan. However, he noted that Petitioner was doing well, and he would simply be observed. Dr. Templin noted that Petitioner had been working full duty for a number of months and would remain on full duty work at that time. (Px 3)

Petitioner testified that at the time of this visit on July 24, 2017, he was going great. He did not think his low back was affecting his ability to do his job as a roofer. (T. 25)

On August 8, 2017, Petitioner testified that he was injured while working for Langlois Roofing. (T. p. 26) Petitioner testified that he was helping to move insulation rolls from the far end of the roof to where they had just tore off. Petitioner testified that he was on the back end of the roll, which he was carrying with two others. Petitioner testified he was balancing it on his right shoulder. Petitioner estimated the weight of the roll to be easily over 200 pounds. Petitioner testified that he was near a drain which was very slippery, and his feet slid out from under him and he landed on his butt. The roll was still on his shoulder, and he ended up bent over with the roll on top of him. (T. pp. 26-27) Petitioner testified that he knew right away that he was hurt. (T. p. 28)

Petitioner presented to Silver Cross Hospital on August 8, 2017, where he complained of right shoulder, low back and right chest wall pain. (Px 8) Petitioner underwent a CT scan of the lumbar spine. The radiologist described no definite significant acute fracture deformity or gross dislocation, but noted results were degraded due to surgical hardware. (Px 8) Petitioner was diagnosed as having injuries to his ribs, right shoulder, and low back. For purposes of this decision, the Arbitrator is only going to concentrate on the low back injuries.

Petitioner saw Dr. Templin's PAC, Kelly Burgess, on August 16, 2017. (Px 3) He was seen for evaluation of his neck, mid and lower back. He reported an injury at work on August 8, 2017 while working as a roofer. He slipped and fell while carrying a roll of material with another person. He complained of low back pain with some radiation to his buttock. Ms. Burgess referred Petitioner to Dr. Abusharif for pain management. She took him off work as well. (Px 3)

On September 27, 2017, Petitioner underwent an MRI of his lumbar spine. (Px 3) Petitioner saw Dr. Templin in follow up for his low back on September 29, 2017. He reported a consistent history of accident. He now reported 8/10 low back pain that extended somewhat to his right leg but did not radiate down the leg. Dr. Templin also commented upon the CT scan performed in the emergency room on August 8, 2017. He felt it showed evidence of migration of the screw in the anterior cage as well as loosening of the L4-5 screw on the right side from his posterior instrumentation. He noted a stable pseudoarthrosis through the interbody cage. Dr. Templin further commented:

> [Petitioner) is status post L5-S1 fusion, had been returned to work full duty without restrictions and was at maximum medical improvement. He has now fallen aggravated this (*sic*). CT scan shows evidence of what appears to be a stable pseudoarthrosis and his pain level at this point in time, my recommendation would be for a revision posterior fusion....He will undergo his shoulder surgery first as this will aid in his rehabilitation from back surgery, and will see me once surgery is approved....He remains off work at this point. (Px 3)

Dr. Templin wrote two reports (Px 4 & 5)and testified by evidence deposition. (Px 17). In his reports, and in his testimony Dr. Templin noted that Petitioner was working full duty after the first surgery and was asymptomatic prior to the accident of August 8, 2017. The Petitioner had a pseudoarthrosis as a result of his first surgery; however Petitioner was asymptomatic until he fell on August 8, 2017. This fall rendered Petitioner clinically symptomatic, resulting in increasing low back pain. Dr. Templin opined the accident of August 8, 2017 was the proximate cause of the current condition of ill-being in the low back as his pain drastically worsened from what it had been prior to the injury. (Px 4) Dr. Templin further noted during his testimony that Petitioner was doing fine and might never have needed treatment. (Px 17, p. 30) Dr. Templin opined that the August 8, 2017 accident caused low back pain which required further treatment. (Px 17, p. 31)

At the request of Respondent All Sealants, Dr. Julie Wehner performed a medical records review on October 1, 2018. Dr. Wehner testified by evidence deposition. (Rx All Sealants 1). Dr. Wehner opined:

> Dr. Templin's notes clearly identify the August 8, 2017 date as a new onset of symtomatology and the cause of the need for the revision of his fusion. He clearly sustained a new injury on August 8, 2017, significant enough to include multiple other body parts, and significant enough to cause increased symptoms requiring him to be off work and new recommendations for a revision of his previous fusion. Without the new injury on August 8, 2017, there was no indication to from (*sic*) his symptoms to indicate a need for work restrictions or for surgery. (Rx All Sealants 1, Ex 2)

Dr. Graf examined the Petitioner at the request of Respondent Langlois Roofing, and his deposition was taken over two dates. (Rx Langlois 1 and 2). Dr. Graf testified that the pseudoarthrosis was not caused by the accident of August 8, 2017. (Rx Langlois 1, p. 25) Dr. Graf testified over objection that the pseudoarthrosis was neither aggravated nor accelerated by the work accident of August 8, 2017. (Rx 1, pp. 26 – 28) Dr. Graf's reports do not reflect that he provided any opinion as to aggravation or acceleration of the pseudoarthrosis (Rx Langlois 3), and the Arbitrator therefore sustains the objections made pursuant to *Ghere v. Industrial Commission*, 278 Ill.App. 3d 840 (1996).

On January 4, 2019, Petitioner underwent surgery to his lumbar spine. (Px 22) The surgical report reflects that Petitioner had "a previous history of L5-S1 fusion. Initially, he did very well after surgery, however was injured when he fell holding something extremely heavy and reinjured his back. He had previously been diagnosed with a stable pseudoarthrosis, but developed back pain and given his continued complaints of pain, elected to proceed with a revision posterolateral fusion after exploration of fusion." (Px 22)

At the time of trial, Petitioner testified that he remained in physical therapy. (T. p. 61) He had work restrictions of lifting no more than 10 pounds. (T. p. 62) Petitioner thought he would start work conditioning in the next 10 days. (T. p. 63)

Petitioner testified that he was not taking narcotic pain medications at the time of trial. (T. p. 63) However, he had obtained a medical marijuana card which he felt worked better than narcotic pain medication. (T. pp. 63, 64)

CONCLUSIONS OF LAW

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

As noted at the outset, the case against Respondent All Sealants is pending in the Appellate Court. The Arbitrator recognizes that the initial decision against Respondent All Sealants is not final. Nevertheless, based upon the testimony and the evidence, the Arbitrator concludes that the Petitioner's condition of ill-being in the lumbar spine from the date of September 23, 2016 through August 7, 2016 is causally related to the accident of August 31, 2015. There is no evidence or testimony to demonstrate that the Petitioner's condition of ill-being in the lumbar spine is not related to the accident of August 31, 2015. The Arbitrator is further obligated to follow the law of the case as it is presented to him.

However, the Arbitrator finds that the Petitioner was involved in a new accident on August 8, 2017, while working for Langlois Roofing, which is the subject matter of the litigation in 17 WC 26410. The Arbitrator finds that the against of August 8, 2017, with regard to the low back, was one such that it broke the chain of causation between the condition in the low back and the accident of August 31, 2015 while employed by Respondent All Sealants.

The evidence is clear that prior to August 8, 2017, Petitioner had been released to return to his previous level of employment by his surgeon, Dr. Templin. Petitioner had been engaged in his previous level of employment as a journeyman roofer, for at least 14 weeks prior to the accident of August 8, 2017. Petitioner testified that he was not having issues with regard to his low back in his return to work as a journeyman roofer. The accident of August 8, 2017, was a significant one. It is unrebutted that the

claimant was carrying a roll of insulation in excess of 200 pounds when he slipped and fell, landing on his buttocks, and experiencing low back pain that he was not experiencing prior to the accident. He made immediate complaints of low back pain, and sought immediate medical care in the emergency room for same.

While it is true that Dr. Templin felt that Petitioner might have some non union issues in the lumbar fusion on July 24, 2017, Dr. Templin did not restrict the Petitioner in any fashion after this office visit, and it is clear from Dr. Templin's testimony that he didn't think Petitioner would need any restrictions, or medical treatment, other than a CT scan to check the integrity of the fusion.

The treating physician, Dr. Templin, opined that the accident of August 8, 2017, aggravated the Petitioner's condition, causing Petitioner to once again have pain, and once again require treatment in the form of surgery. Dr. Wehner agreed with Dr. Templin's assessment. The Arbitrator is persuaded by the opinions and testimony of Dr. Templin and Dr. Wehner.

Dr. Graf only indicated that the pseudoarthrosis was not caused by the accident of August 8, 2017. Dr. Graf tried to opine that the pseudoarthrosis was not aggravated or accelerated by the accident. The Arbitrator has stricken this opinion pursuant to *Ghere v. Industrial Commission*, 278 Ill.App. 3d 840 (1996). However, even if this testimony were allowed to stand, the Arbitrator does not find it persuasive. It is clear from the testimony and the evidence that the accident of August 8, 2017, was a significant trauma; it also caused a significant shoulder injury that required surgery and caused a rib fracture, in addition to reinjuring the low back.

It is clear that Petitioner's symptoms changed after the accident of August 8, 2017. He went from feeling great and able to work as a journeyman roofer, to have low back pain that radiated to his buttock and leg (but not down it) that prohibited him from working. Petitioner now also required another lumbar surgical procedure, something he did not require before the accident. These are all factors that were deemed important in *National Freight Industries v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120043WC, ¶¶29 -32.

Additionally, Petitioner had been back to work as a journeyman roofer for two different employers in a physically demanding capacity for several weeks to months, all without apparent issue. The Arbitrator finds this to be a significant factor, and notes that the Commission has found this to be a significant factor in determining a causal relationship. In *Zarate v. Kankakee Nursery*, 17 IWCC 643 and 17 IWCC 644, the Commission found that claimant's return to work full duty in a physical job was an important factor to consider in concluding the second accident was the cause of claimant's condition of ill-being and need for surgery ***despite there being a surgical recommendation prior to the second accident which claimant refused (emphasis added).***

Finally, the Arbitrator finds this matter from the recent decision in *Par Electric v. Ill. Workers' Comp. Comm'n*, 2018 IL App (3d) 170656WC. In *Par Electric*, claimant testified his shoulder was weak and painful. 2018 IL App (3d) 170656WC ¶12. Further the treating doctor, Dr. Li, opined that the shoulder condition was "a result of his original injury from June 2014 and subsequent surgery." 2018 IL App (3d) 170656WC ¶16. In the instant case, the Petitioner testified that he felt "great" prior to the accident of August 8, 2017. Petitioner felt that his low back was not an issue when it came to him performing the duties of a journeyman roofer prior to the accident of August 8, 2017. Additionally, Dr. Templin, the treating surgeon, opined that the August 8, 2017, accident caused an aggravation and acceleration of

Petitioner's condition and that the August 8, 2017, accident was the basis for the need for revision surgery to the low back.

The evidence herein clearly supports the Arbitrator's conclusion that Petitioner's current condition of ill-being in the lumbar spine is related to accident of August 8, 2017; the chain of causation between the condition in the lumbar spine and the accident of August 31, 2015 was broken by the accident of August 8, 2017.

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

As noted at the outset, the case against Respondent All Sealants is pending in the Appellate Court. The Arbitrator recognizes that the initial decision against Respondent All Sealants is not final. Nevertheless, based upon the testimony and the evidence, the Arbitrator concludes that Petitioner is entitled to medical benefits for services incurred prior to August 8, 2017. These bills are as follows:

1. ATI Physical Therapy for treatment from 9/28/16 through 2/16/17, which the parties have agreed total $17,689.35 after application of the medical fee schedule.
2. Hinsdale Orthopedics for treatment from 10/28/16 through 7/24/17, which the parties have agreed total $1,131.79 after application of the medical fee schedule.
3. Pain Treatment Center of Illinois for treatment 10/28/16 through 3/10/17, which the parties have agreed total $473.03 after application of the medical fee schedule.

This denial of medical benefits after August 7, 2017, is based upon the Arbitrator's conclusion regarding causal relationship above.

L. What temporary benefits are in dispute? TTD

As noted at the outset, the case against Respondent All Sealants is pending in the Appellate Court. The Arbitrator recognizes that the initial decision against Respondent All Sealants is not final. Nevertheless, based upon the testimony and the evidence, the Arbitrator concludes that Petitioner is entitled to temporary total disability benefits prior to the accident of August 8, 2017 as follows:

1. The Commission previously awarded benefits through September 22, 2016 as claimed on the Request for Hearing by Petitioner.
2. The Arbitrator awards additional TTD benefits from September 23, 2016 until April 3, 2017. Dr. Templin released Petitioner to full duty work activities effective April 4, 2017. (Px 3)

The denial of TTD benefits after August 8, 2017, is based upon the Arbitrator's conclusion regarding causal relationship above.

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

Virgen Balbaneda,

Petitioner,

19IWCC0637

vs.

NO. 15WC023562

Artisan Bread Company, et al.; Illinois State Treasurer as Ex Officio Custodian of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Petitioner and the Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issue of permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 4, 2019 is hereby affirmed and adopted.

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

19IWCC0637

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents 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 either 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 22 2019
SJM/sj
o-10/9/2019
44

Stephen J. Mathis

Douglas D. McCarthy

SPECIAL CONCURRENCE

I concur with the outcome reached by the majority in affirming the Arbitrator's award of 60% loss use of the hand under Section 8(e) of the Act. I write separately as I arrive at this result utilizing a different explanation of the relevance and weight of the factors contained in Section 8.1b. *820 ILCS 305/8.1b(b)* (West 2014).

Section 8.1b(b)(i) – level of impairment

Neither party submitted a Section 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. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101), I assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner sustained injury while performing her duties as food preparer for Respondent. Following her injury, Petitioner was unable to return to work for Respondent. Moreover, Petitioner was unable to return to work in certain jobs, Uber driver and banquet server, which she performed prior to her injury. I find this factor weighs in favor of an increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 57 years old on the date of accident. I observe Petitioner is relatively older, and as such, will therefore have more difficulty with the effects of her injury in as she must rely on her non-dominant hand. I find this factor weighs in favor of an increased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner was unable to return to work in her pre-injury capacity. Petitioner testified she obtained employment at reduced earning capacity. Moreover, Petitioner was unable to return to work in certain jobs, Uber driver and banquet server, which she performed prior to her injury. I find this factor weighs in favor of an increased permanence.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Following her injury, Petitioner eventually underwent a revision amputation to her right thumb with a full thickness skin graft. On January 25, 2016, Dr. Wiedrich evaluated Petitioner who stated "she is doing well and using the thumb normally." Dr. Wiedrich advised Petitioner was able to "use her hand for whatever she fells she is capable and comfortable doing." PX19. Petitioner testified she continues to experience pain and difficulties with grabbing, scrubbing, cutting, and lifting heavy objects. T. 26. I find this weighs in favor of a decreased permanence.

For the reasons stated above, I concur with the result reached by the majority.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BALBANEDA, VIRGEN
Employee/Petitioner

Case# **15WC023562**

19IWCC0637

ARTISAN BREAD COMPANY ET AL ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

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

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

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19IWCC0637

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

Virgen Balbaneda,
Employee/Petitioner

Case # **15** WC **23562**

v.

Artisan Bread Company, et al.; Illinois State Treasurer as *Ex-Officio* Custodian of the Injured Workers' Benefit Fund,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **February 28, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Insurance**

FINDINGS

On **July 03, 2015**, 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 earned **$20,800.00**; the average weekly wage was **$400.00**.
On the date of accident, Petitioner was **57** years of age, ***single*** with **1** dependent children.
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 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-Employer is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent-Employer shall pay Petitioner reasonable and necessary medical expenses pursuant to Section 8(a) and 8.2 of the Act (fee schedule) of Petitioner's claim of $72,033.77 to Northwestern Medicine; $20,343.00 to Northwestern Medicine Physicians; $158.55 to St. Anthony Hospital; and $123.00 to St. Anthony Physicians.

Respondent-Employer shall be given a credit for all medical benefits that have been paid. Respondent-Employer has not proven entitlement to any credit as provided in Section 8(j) of the Act.

Respondent-Employer shall pay Petitioner Temporary Total Disability benefits pursuant to Section 8(b) of the Act of $266.67/week for 18-6/7 weeks, because Petitioner remained off work due to her injuries during the period 07/04/2015 – 11/12/2015.

Respondent-Employer shall pay Petitioner permanent partial disability benefits of $253.00/week for a period of **123 weeks**, because the injuries caused Petitioner to sustain permanent partial loss of use of her **right hand** under Section 8(e)9 to the **extent of 60% thereof**.

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 office of 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 Injury Workers' Benefit Fund.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

June 3, 2019
Dated

JUN 4 - 2019

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
MEMORANDUM OF DECISION OF ARBITRATOR

Virgen Balbaneda,	)	**Case No. 15 WC 23562**
	)	
Petitioner,	)	**Chicago, IL**
	)	
v.	)	
	)	
Artisan Bread Company, et al.; Illinois State Treasurer as *Ex-Officio Custodian* of the Injured Workers' Benefit Fund	)	
	)	
Respondents.	)	

STATEMENT OF FACT

An Application for Adjustment of Claim was filed by Petitioner, Virgen Balbaneda, seeking relief under the Illinois Workers' Compensation Act from Respondent-Employer, Artisan Bread Company, et al. This action sought further relief from the Illinois Workers' Benefit Fund (IWBF) because Respondent-Employer allegedly did not maintain workers' compensation insurance covering the date of accident. A hearing was held before Arbitrator Robert M. Harris on February 28, 2019 in Chicago, Illinois. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as *ex-officio custodian* of the IWBF, and participated in the proceeding.

I. FINDINGS OF FACT

The proceedings were conducted through the services of a sworn Spanish-English interpreter. The witness testified through interpretation.

Petitioner's Direct Testimony

Petitioner Virgen Balbaneda testified in his case-in-chief. Petitioner lives in Chicago, Illinois. She was born on January 3, 1958. On July 3, 2015, she was 57 years old, single, and had one minor child. Petitioner was employed by Artisan Bread Company, which was a bakery. The business served food on its premises, and its employees regularly used handcutting instruments

and slicing machines. The bakery employees were also regularly in danger of being scalded or burned by hot food and hot fluids, substances and objects.

Petitioner testified she originally learned of the job opening around January 2015. The driver for the bakery told her that they were looking for someone to work in the bakery. On January 6, 2015, Petitioner met with the bakery's owner, Nicola "Nic" Addante who hired her. The bakery located on West Chicago Avenue, in Chicago, Illinois, had several bakeries working out of the one address. At the bakery, Petitioner typically would take bread from the oven, pack bread, and slice and cut the bread. Nic Addante and the bakery owned and provided the equipment and tools that Petitioner used during the course of her work. Nic Addante also instructed Petitioner regarding what work she was to complete, although her direct supervisor was an individual named Napoleon. Napoleon typically arrived at the bakery after Petitioner had already started working. Petitioner was paid in cash by Nic Addante at a rate of $10 per hour. Petitioner worked 40 hours per week. Petitioner worked overnight: her shift began at 6:00 p.m. each day, and ended at 3:00 a.m. She did not receive medical insurance from Respondent-Employer.

On July 2, 2015, Petitioner testified she arrived at the bakery located at 1461 W. Chicago Avenue, in Chicago, Illinois, at 6:00 p.m., for her overnight shift. Petitioner's supervisor, Napoleon, directed Petitioner to cut some bread. The machine used to cut the bread, however, was stopping suddenly while in use. Each time the machine stopped, Napoleon came over and pushed a button on the machine. The machine would start up again, only to once more suddenly stop. After about five times of coming over to restart the machine, Napoleon told Petitioner that if she machine stopped again, she should push the button herself to restart it. The machine did stop again, this time with a loaf of bread stuck about half way into it. Petitioner pushed the button on the machine and went to pull out the lodged bread. The machine activated, and caught Petitioner's thumb on her right hand, severing it. As Petitioner removed the bread, she saw her thumb go flying. Petitioner grabbed a roll of paper to absorb the blood that was coming from her severed thumb. A large portion of Petitioner's thumb had been cut off by the machine; her index finger and middle fingers were also lacerated but remained attached to her hand. The accident occurred at approximately 2:00 a.m. on the morning of July 3, 2015.

Petitioner testified she immediately informed Napoleon of the accident. An ambulance transported Petitioner to Northwestern hospital, where surgery was performed at approximately 2:15 a.m. to reattach the thumb and address the injuries to her other fingers.

On July 9, 2015, Petitioner followed up in the Emergency Room at St. Anthony's Hospital for difficulties she was having with the injury. The remainder of her medical treatment for the injuries occurred at Northwestern Medicine. Petitioner underwent a follow-up surgery at Northwestern Hospital on August 7, 2015 to remove the reattached thumb from the right hand and implant a skin graft from her right hip. Petitioner also received physical therapy at Northwestern. Petitioner's treating doctor also recommended that Petitioner seek treatment for depression relating to the amputation of her thumb, which she underwent at Cook County hospital. Petitioner received restrictions from her doctor relating to her injury. Petitioner was ultimately released from treatment on November 12, 2015. Continued medical service was denied after this date due to Petitioner's lack of insurance. Petitioner was off work with a doctor's note from July 4, 2015 through November 12, 2015. From November 13, 2015 through December 11, 2017, Petitioner received no further medical treatment for the injuries. On December 12, 2017, Petitioner returned to her treating doctor in order to be fitted with a thumb prosthesis. The prosthesis, however, was denied due to lack of insurance. Petitioner received no additional medical treatment or follow-ups after that date. Petitioner never received any payments for her time off work. The medical bills incurred to treat the injury total approximately $92,658.32; Respondent-Employer has not paid any of those bills. To date, no one has paid any of the outstanding medical bills.

The mobility in Petitioner's right hand is at 20 percent of normal.[1] Only the little finger and ring finger move OK. The thumb amputation removed her thumb from immediately above the proximal joint – the joint closest to the palm of the hand. Petitioner has no movement in the remainder of the joint. Petitioner is right-handed, and she cannot perform many tasks using just her left hand. Petitioner cannot write with her left hand. She has difficulty with grabbing soap, scrubbing her back, cutting, and lifting heavy things. Finger movement in the hand is greatly reduced, as is range-of-motion. Petitioner cannot hold things in her hand. She has had to try to learn to perform more tasks with her left hand. Petitioner can no longer make a fist with her right hand: she can close the little and ring fingers all the way to the palm of the hand, but her index and middle fingers only close about half way to the palm. When lifting objects, Petitioner feels intense pain from the remainder of her thumb to her right shoulder. Petitioner can no longer open jars with her right hand and cannot use her right hand to turn doorknobs. Petitioner has sustained no

[1] Petitioner based the 20 percent figure on her own assessment/opinion from comparing her right hand function to her left hand function. Per Petitioner, 100% mobility would be the ability to move all fingers.

subsequent injuries to the right hand or thumb. She had no previous complaints or difficulties with the right hand prior to the accident.

Petitioner currently works as a companion for a company that works with the State of Illinois. Petitioner is sent to assist individuals in their homes. She makes $200 per week and does not perform any heavy work in this role. She primarily sits and keeps her client company. Petitioner started as a companion on September 15, 2018. Prior to beginning this work, Petitioner tried to drive for Uber, which she did do for a short time. Petitioner had to cease working for Uber, however, because it hurt too much to move her arm while driving. Petitioner also tried to sell health products, but this did not work out because she was too inexperienced at sales. Petitioner speaks little English, but she understands more than she can speak.

Petitioner's Testimony on Cross-Examination

The tools that Petitioner used while employed at the bakery were predominantly knives and a saw machine to cut bread.

After the accident, Petitioner informed the treating emergency medical personnel about rodents in the bakery. She told them that the bakery had rats, so when the machine cut off her thumb, she was afraid that the rats would find and eat the severed finger.

Petitioner did not remember the exact timing or duration of the physical therapy treatment she received at Northwestern. Petitioner underwent about one month of treatment for depression due to her work situation. Prior to the accident, Petitioner had never experienced any kind of diagnosed medical problem with her right hand, such as carpal tunnel syndrome.

At her current job as a companion, Petitioner sees two clients. She arrives at the home of the first client at 8:00 a.m. Petitioner assists this client in dressing, helps the client brush her teeth by handing her certain items, combs her hair, helps her put makeup on, assists her from the bedroom to the living room, and prepares and serves her breakfast. She then accompanies the client in watching TV and listening to music. Petitioner sees this client for four hours during the day.

Petitioner attempted to ask Respondent-Employer for her old job back. Approximately two months after the accident, Petitioner went and knocked on the door at the bakery location, but no one answered. The bakery was no longer in business.

Petitioner's Responses to Questions from the Arbitrator

Six months prior to working at the bakery, Petitioner worked as an Uber driver. Before working as an Uber driver, Petitioner held a position serving at banquets in a golf club.

While Petitioner was at the hospital following the accident, the bakery's owner, Nic Addante, visited her. He told Petitioner not to worry, that he and insurance would pay for everything. Petitioner has not seen him since.

Petitioner's Medical History

Petitioner's medical records show that on July 3, 2015, she was admitted to the Emergency Department at Northwestern Memorial Hospital in Chicago, Illinois. (Petitioner's Exhibit "Pet. Ex." 19). Petitioner arrived at the hospital via Chicago Fire Department ambulance. The ambulance note that Petitioner suffered a traumatic right thumb amputation from a bread machine. The wound was cleanly cut; the missing digit was recovered at the scene of the accident and wrapped in a wet gauze and placed between ice packs by the EMS personnel. No other injuries are noted to have been sustained. (Pet. Ex. 19).

The Emergency Department notes indicate that Petitioner relayed the following history: that she was working at a bread factory and that around 2:00 a.m, she saw a rodent, jumped up and stuck her hand in the bread cutter. (Pet. Ex. 19, pg. 38 of 254). They note that the bleeding was controlled at the scene. (Pet. Ex. 19). X-rays were taken at the hospital showing that the amputation of the thumb occurred at the level of the mid-diaphysis of the proximal phalanx, and that there was no evidence of any fracture or dislocation. (Pet. Ex. 19).

Surgery was performed at Northwestern hospital to reattach the thumb. Petitioner underwent an irrigation and debridement of the right thumb, followed by its reimplantation. Dr. Thomas Wiedrich performed the procedure. (Pet. Ex. 19). The surgical notes indicate that Petitioner suffered a complete amputation of the right thumb at the level of the proximal phalynx, as well as a two-centimeter laceration to the right index finger on the palmar side, with no flexor tendon involvement. The amputated portion of the thumb included the IP joint and distal thumb. (Pet. Ex. 19). The procedure involved a digital block with bupivicane and libo to control the pain. At the time of the procedure, Petitioner displayed full range of motion in the unaffected digits and denied numbness, paresthesias, or weakness. (Pet. Ex. 19).

Petitioner was discharged from Northwestern on July 5, 2015. Petitioner was given prescriptions for Herapin sodium, docusate-senna, and hydrocodone (Norco). (Pet. Ex. 19).

Petitioner followed up with Dr. Wiedrich on July 6, 2015. At this time, Petitioner remained off work. Dr. Wiedrich performed splint and dressing changes on the wound. (Pet. Ex. 19).

On July 9, 2015, Petitioner presented to the Emergency Department at St. Anthony Hospital for an incision check. (Pet. Ex. 20 and 21). Petitioner's daughter had been cleaning the wound with hydrogen peroxide and became concerned when some of the solution landed on the skin. (Pet. Ex. 20 and 21). The treating medical personnel advised Petitioner to follow up with her primary care physician, and discharged Petitioner. (Pet. Ex. 20 and 21).

Petitioner next followed up with Dr. Wiedrich on July 13, 2015. Dr. Wiedrich noted that at ten days post-reimplantation, the thumb displayed areas of questionable viability, but that there was no sign of infection. (Pet. Ex. 19). Petitioner's pain levels remained stable. (Pet. Ex. 19). Dr. Wiedrich instructed Petitioner to complete home exercises of two-to-three repetitions for each exercise, two-to-three times per day. Dr. Wiedrich also instructed Petitioner to follow up with an occupational therapist. (Pet. Ex. 19).

Petitioner's next appointment with Dr. Wiedrich occurred on July 20, 2015. Dr. Wiedrich noted that the thumb now displayed minimal viable tissue over the volar aspect of the right thumb, as well as dry gangrene. Dr. Wiedrich stated that the thumb needed to be removed. (Pet. Ex. 19). At a pre-operative appointment on July 30, 2015, Dr. Wiedrich discussed the thumb removal with Petitioner, explaining that the procedure would include a skin graft from Petitioner's groin. (Pet. Ex. 19). Petitioner consented to undergoing the thumb removal and skin graft. (Pet. Ex. 19).

The thumb removal procedure occurred on August 7, 2015, after Petitioner attended a pre-operative appointment on August 6. (Pet. Ex. 19). Petitioner's preoperative diagnosis was necrosis after attempted reimplantation of the right thumb. (Pet. Ex. 19). Petitioner displayed skin with necrosis, acute and chronic inflammation, and granulation in the tissue; bone with acute osteomyelitis was also indicated. (Pet. Ex. 19). Dr. Wiedrich performed the revision amputation to Petitioner's right thumb, as well as a full-thickness skin graft from her right groin. (Pet. Ex. 19). Petitioner was given prescriptions for Dilaudid, Norco, and Colace. (Pet. Ex. 19).

After the amputation procedure, Petitioner followed up with Dr. Wiedrich several times as her wound healed. (Pet. Ex. 19). At Petitioner's November 12, 2015 appointment, Dr. Wiedrich noted that Petitioner displayed full range of motion in her digits, and good flexion of the MP joint in the thumb. Petitioner's last regular appointment with Dr. Wiedrich occurred on November 25, 2015. (Pet. Ex. 19). Petitioner saw Dr. Wiedrich once more on January 25, 2016. Dr. Wiedrich noted that the amputation stump was non-tender and supple, and displayed excellent MP joint motion. (Pet. Ex. 19). Dr. Wiedrich noted that they were waiting on a prosthesis for the thumb, but

that in the interim, Petitioner was able to use her right hand for whatever she felt capable and comfortable doing. Dr. Wiedrich instructed Petitioner to follow up in four months. (Pet. Ex. 19).

Petitioner saw Dr. Wiedrich again on December 12, 2017, at Northwestern Medicine Center for Surgery of Hand. (Pet. Ex. 22). Dr. Wiedrich gave Petitioner a referral for a prosthesis for the thumb, with the comment that "This patient requires occupational therapy as a medical necessity for optimum recovery;" as part of that occupational therapy prescription, Dr. Wiedrich referred Petitioner to the use of a Pillet prosthesis for the thumb. (Pet. Ex. 22).

Petitioner's medical records indicate that she began occupational therapy at Northwestern on July 6, 2015 and continued through November 25, 2015. (Pet. Ex. 19). Petitioner underwent therapy approximately one-to-two times per week during this period. (Pet. Ex. 19).

In a note dated July 6, 2015, Dr. Wiedrich first placed Petitioner off work, retroactively effective from July 2, 2015. (Pet. Ex. 19).

The last note from Dr. Wiedrich indicating that Petitioner remained off work is dated September 30, 2015. (Pet. Ex. 19). In the July 6 noted, Dr. Wiedrich also stated that Petitioner would reach Maximum Medical Improvement (MMI) in six months. A note dated July 13, 2015 revised that to MMI in six months to one year, which was again revised to six months in a note dated August 20, 2015. (Pet. Ex. 19).

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

A. Was Respondent-Employer operating and subject to the Illinois Workers' Compensation Act?

Petitioner testified that on the date of the accident, she worked for Respondent-Employer, which was a bakery. The bakery served food on its premises. In the course of employment, she and the other employees regularly used and/or handled handcutting and slicing machines, including knives and a bread-slicing machine. Petitioner also retrieved bread from an oven. Petitioner and the other employees were exposed to the dangers of being scaled by hot machinery and liquids. The Arbitrator finds these conditions sufficient to subject Respondent-Employer to the automatic coverage provisions of Section 3 of the Illinois Workers' Compensation Act.

B. Was there an employer-employee relationship?

The existence of an employment relationship is a prerequisite for any award of benefits under the Act. There is no specific litmus test for determining whether an employer-employee relationship exists. Instead, there are multiple factors to consider when assessing the nature of the relationship between the parties. *Ware v. Indus. Comm'n.*, 318 Ill. App. 3d 1117, 1122 (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with materials and equipment; and (7) whether the employer's general business encompasses the person's work. *See Robertson v. Indus. Comm'n.*, 866 NE.2d 191, 200 (Ill. 2007). No single factor is determinative and finding an employer-employee relationship rests upon the totality of the circumstances. *Roberson*, 866 NE.2d at 200.

Petitioner testified that she was hired by Nicola Addante, owner of Respondent-Employer business, on January 6, 2015. Mr. Addante owned and provided the tools and equipment that Petitioner used when performing her job duties at the bakery. Mr. Addante also instructed Petitioner in which tasks she was to perform. Petitioner also had a direct supervisor, Napoleon, who provided instruction to Petitioner. Petitioner maintained set work hours established by Respondent-Employer. Respondent-Employer paid Petitioner directly for her work, in cash.

After considering the totality of the circumstances, the Arbitrator finds that an employer-employee relationship did exist between Petitioner and Respondent-Employer. The Arbitrator notes no contrary evidence was presented.

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

Petitioner bears the burden of proving all of his case by a preponderance of the evidence. *Chicago Rotoprint v. Industrial Comm'n.*, 157 Ill.App.3d 996 (1987). To be compensable under the Act, an injury must "arise out of" and be "in the course of" the employee's employment. *Kochilas v. Industrial Comm'n*, 274 Ill.App.3d 1088, 1090 (1995). The burden of establishing that the injury "arose out of" and was "in the course of" the employment rests with the applicant. *Rockford Cabinet Co. v. Industrial Comm'n.*, 295 Ill. 332, 335 (1920).

Petitioner testified that on the date of accident, she was working her overnight shift at the bakery. She was using the bread slicing machine, which had been malfunctioning over the course of the night. At the instruction of her supervisor, Napoleon, when the machine once again malfunctioned and stopped running, Petitioner pushed a button that would start it up again. Petitioner saw, however, that about half a loaf of bread was stuck in the machine. When Petitioner went to dislodge the bread, the machine started up again, severing her thumb.

The Arbitrator notes that the circumstances of the accident as testified to by Petitioner in court, differ from the accident history given by Petitioner to the emergency medical personnel who treated her on the day it occurred. Emergency department notes from Northwestern indicate that Petitioner stated she had seen a rat on the workplace premises, jumped up, and in so doing, stuck her hand in the slicing machine, severing the thumb. When asked in court about any statements made to emergency personnel regarding rodents, Petitioner stated that she told the treaters that she had been afraid that rats would find and eat her severed thumb.

The discrepancies in Petitioner's recounting of the accident call into question the overall accuracy of Petitioner's statements. In each version of the story, however, the severing of the thumb occurred on Respondent-Employer's premises while Petitioner was performing work-related tasks assigned to her by Respondent-Employer. The Arbitrator therefore finds that, inconsistencies notwithstanding, an accident did occur that arose out of and in the course of Petitioner's employment with Respondent-Employer. The Arbitrator notes no contrary evidence was presented refuting accident.

D. What was the date of the accident?

Petitioner testified that the accident occurred on July 3, 2015. Petitioner's testimony is supported by medical records and there is no evidence to the contrary. Thus, the Arbitrator finds the accident occurred on July 3, 2015. The Arbitrator notes no contrary evidence was presented.

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

Petitioner testified that her immediate supervisor, Napoleon, was present on Respondent-Employer's premises the night of the accident, and had interacted with Petitioner directly prior to the accident. Petitioner further stated that immediately after the accident, she informed Napoleon of its occurrence. Petitioner also testified that Nicola Addante visited her at the hospital while she

was still being treated for the injury, and that they discussed her condition. The Arbitrator finds that timely notice of the accident was given to Respondent-Employer. The Arbitrator notes no contrary evidence was presented.

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

Petitioner testified that her right thumb was severed when the bread slicing machine she used at work malfunctioned. An attempt to reattach the thumb was made, but a couple of weeks into the healing process, the thumb had to be removed to the PIP joint due to its turning necrotic. In court, the Arbitrator observed that Petitioner is missing that portion of her thumb to the PIP joint. Petitioner's medical records corroborate Petitioner's testimony, and there is no evidence that Petitioner was missing any portion of her right thumb prior to the July 3, 2015 accident. The Arbitrator therefore finds that Petitioner's current condition of ill-being is casually related to the injury sustained on July 3, 2015. The Arbitrator notes no contrary evidence was presented.

G. What Were Petitioner's Earnings?

Petitioner testified that while she worked for Respondent-Employer, she made $10 per hour and worked forty hours per week. Respondent-Employer paid Petitioner in cash. There being no evidence presented to the contrary, the Arbitrator finds that on the date of accident, Petitioner earned $400.00 per week. The Arbitrator notes no contrary evidence was presented.

H. What Was Petitioner's Age at the Time of Accident?

Petitioner testified that she was born on January 3, 1958. Medical records submitted by Petitioner corroborate her testimony. As such, the Arbitrator finds that on July 3, 2015, Petitioner was 57 years old.

I. What Was Petitioner's Marital Status at the Time of Accident?

Petitioner testified that at the time of the accident, she was not married. Petitioner's testimony remains unrebutted and is supported by information contained in Petitioner's medical records. As such, the Arbitrator finds that on July 3, 2015, Petitioner's marital status was "single."

J. Were Medical Services Provided to Petitioner Reasonable and Necessary? Did Respondent-Employer Pay for All Reasonable and Necessary Medical Services?

Medical Services

Immediately following the accident, Petitioner was taken by ambulance to the Emergency Department at Northwestern Hospital. The wounds to her right hand was treated, and the right thumb was surgically reattached. Petitioner remained in the hospital for two days.

Petitioner underwent follow up care with Dr. Thomas Wiedrich. While initially the reattachment of the thumb seemed to take, after approximately two weeks, the reattached portion of the thumb became necrotic and gangrenous. Dr. Wiedrich advised that due to its deteriorating condition, the reattached portion of the thumb would have to be removed. The reattached portion of the thumb was surgically removed on August 7, 2015.

Petitioner continued to have regular follow-up appointments with Dr. Wiedrich through November 2015. She also had one final appointment with Dr. Wiedrich in January 2016. She did see Dr. Wiedrich once again in December 2017, where he gave her a referral for a thumb prosthesis. Due to insurance reasons, however, Petitioner never obtained the prosthesis.

Following both the original thumb reattachment procedure and the thumb removal surgery, Petitioner underwent a course of Occupational Therapy to regain functionality in her right hand and thumb. Petitioner attended Occupational Therapy approximately once a week through November 2015. Petitioner was also given home exercises to perform.

The Arbitrator finds that the treatments sought by Petitioner immediately after the accident, and in the following months, were reasonable and necessary. All treatments received by Petitioner directly related to the treatment of Petitioner's right hand and thumb. The Arbitrator finds no evidence that Petitioner has sought out or received excessive or unnecessary treatment. The Arbitrator notes no contrary evidence was presented.

Medical Expenses

Petitioner tendered to the court several exhibits for medical bills incurred as a result of the July 03, 2015 accident. Petitioner testified that Respondent-Employer has not paid any of these bills. The Arbitrator finds that Respondent-Employer has not paid any of Petitioner's medical expenses related to the July 03, 2015 accident. The Arbitrator notes no contrary evidence was presented.

K. Temporary Total Disability

Petitioner testified that following the July 3, 2015 accident, she was unable to work. She further testified that she stopped treating for the injury in November 2015. Petitioner's medical records and off-work notes corroborate her testimony. As such, the Arbitrator finds that Petitioner is entitled to 18-6/7 weeks of Temporary Total Disability at the applicable rate. The Arbitrator notes no contrary evidence was presented.

L. What Is the Nature and Extent of Petitioner's Injury?

Pursuant to Section 8.1(b) of the Illinois Workers' Compensation Act, for accidents occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. 820 ILCS 305/8.1(b). The criteria to be considered include: (i) the reported level of impairment pursuant to the physician's findings per the American Medical Association's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. *Id.*

Regarding criterion (i), no AMA Impairment Rating was rendered, and therefore, this factor can be given no weight in determining the nature and extent of Petitioner's disability.

Regarding criterion (ii), Petitioner is currently employed as a companion/home care aide. Petitioner began in this position in September of 2018. Prior to the accident, Petitioner worked as an Uber driver and as a server at banquets. The Arbitrator gives this factor great weight.

Regarding criterion (iii), Petitioner was 57 years old at the time of the injury. The Arbitrator gives this factor some weight.

Regarding criterion (iv), as previously stated, Petitioner testified that she currently works as a home companion/aide. Following the accident, she attempted to drive for Uber, but was unable to do so due to pain in her right arm. She also attempted to sell health products but was not successful due to inexperience. In her current role, Petitioner makes $200 per week. While she primarily sits with her clients to keep them company, she is also able to perform aid tasks such as assisting in dressing, teeth brushing, hair combing, make application, and movement from different rooms in the residence. Petitioner prepares and serve breakfast for her clients. Petitioner is currently 61 years old; at the current official U.S. retirement age of 66.5 years, as provided by the

Social Security Administration, Petitioner can be expected to work for approximately 5.5 more years. The Arbitrator gives this factor great weight.

Regarding criterion (v), Petitioner testified that she only has full functionality in the little and ring fingers of her right hand. She cannot fully close her middle or index fingers to the palm; in court, Petitioner demonstrated that those fingers only close about half way. The right thumb is clearly and visibly missing to the PIP joint. Petitioner testified that she has no movement in the remainder of the joint. Petitioner further stated that she is right handed, and that she has been unable to learn to perform many tasks with her left hand to compensate. Petitioner cannot write with her left hand, and has difficulties with grabbing, scrubbing, cutting, and lifting heavy objects. Petitioner testified that the range of motion in the hand is greatly reduced, and that she cannot really hold things in her hand. Petitioner cannot open jars and cannot turn doorknobs with her right hand. When she does attempt to lift objects with the hand, she feels pain.

In his final treatment note from January 25, 2016, Dr. Wiedrich noted that the amputation site at the right thumb displayed excellent MP joint motion. Dr. Wierdich opined that Petitioner was able to use her right hand for whatever she felt "capable and comfortable" doing. This medical evidence is rather ambiguous and unclear; **while Petitioner certainly has permanent limitations and restrictions, the extent of these are not defined**. It is not clear whether Petitioner can engage in and perform her usual and customary occupation or indeed if she is restricted from any particular activities or occupation - **it is not helpful to a permanency determination when a treating physician and surgeon opaquely opines his patient is able to use her right hand for whatever she felt "capable and comfortable" doing, a very subjective, amorphous and vague concept.**

The Arbitrator gives this factor greatest weight.

Upon consideration of all factors, the Arbitrator finds that Petitioner has sustained the permanent partial loss of use of her right hand under Section 8(e)9 to the extent of 60% thereof, or (123 weeks).

M. Other: Insurance and Liability of the IWBF

The Arbitrator finds that the NCCI certifications tendered by Petitioner as Petitioner's Exhibit 17 prove that on July 03, 2015, Respondent lacked workers' compensation insurance.

Robert M. Harris

Arbitrator Robert M. Harris

June 3, 2019

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

David Hendy,

Petitioner,

vs. NO. 02WC029522

Thatcher Engineering,

Respondent.

19IWCC0638

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 24, 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 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 22 2019
SJM/sj
o-11/13/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENDY, DAVID
Employee/Petitioner

Case# **02WC029522**

THATCHER ENGINERING
Employer/Respondent

19IWCC0638

On 2/24/2017, 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 0.67% 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:

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

1109 GAROFALO SCHREIBER ET AL
STEVEN SCARLATI
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

19IWCC0638

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

David Hendy
Employee/Petitioner

v.

Thatcher Engineering
Employer/Respondent

Case # **02** WC **29522**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **December 13, 2016 and January 17, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 15, 2002**, 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 established causation only as to a right hand condition that stabilized as of July 2, 2002. Petitioner did not establish causation as to any claimed current condition of ill-being, right hand or otherwise.

In the year preceding the injury, Petitioner earned **$62,000.00**; the average weekly wage was **$1200.00**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **0** dependent children.

Right hand treatment through July 2, 2002 was reasonable, related and necessary.

Respondent ***paid in part*** appropriate charges for all reasonable and necessary medical care for the right hand.

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

Petitioner's Application improperly alleged both a specific trauma of January 15, 2002 and an occupational exposure to asbestos. Section 7020.20 (b) provides that an Application for Adjustment of Claim must be limited to one accident or claim. At the initial hearing, the Arbitrator allowed Petitioner to proceed only with the specific trauma claim, noting that the 25-year statute of limitations applicable to claims alleging asbestos exposure had not yet expired.

In the remaining specific trauma claim, the Arbitrator awards Petitioner the following, subject to Respondent's preserved Section 5(b) rights: 1) temporary total disability benefits of $800.00/week for 23 1/7 weeks, commencing January 22, 2002 through July 2, 2002, as provided in Section 8(b) of the Act; and 2) outstanding medical expenses, if any, relating to right hand treatment rendered through July 2, 2002. The Arbitrator awards no permanency benefits and declines to find Respondent liable for penalties and/or fees.

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

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

Molly C Mason

Signature of Arbitrator

2/24/17
Date

FEB 24 2017

David Hendy v. Thatcher Engineering
02 WC 29522

Procedural History and Preliminary Ruling

This case has been pending for fifteen years. A related personal injury case [David Hendy v. TBMK Joint Venture, et al., 09 L 14624] was settled for $100,000 some time ago, with Respondent preserving its lien rights. T. 12/13/16, pp. 19-21.

In the summer of 2016, during one of several off the record discussions, the Arbitrator informed the parties that the case would be subject to dismissal if trial did not begin before the end of the year. The parties agreed to a trial date of December 13, 2016. On that date, it came to light that Petitioner's claim was hybrid in nature in that he was alleging both specific traumatic injuries stemming from an accident of January 15, 2002 and an occupational lung disorder stemming from general claimed exposure to asbestos and silica at the same jobsite where the accident occurred. In reliance on Commission rules and giving consideration to the 25-year statute of limitations applicable to the potential occupational disease claim, the Arbitrator determined that Petitioner could proceed only with his specific trauma claim and would have to file a separate Application with respect to the alleged exposure claim. T. 12/13/16, pp. 5-7, 9-11. Petitioner's counsel agreed that the accident was not a cause of the claimed lung injury but objected to the Arbitrator's ruling. T. 12/13/16, pp. 9-11.

Summary of Disputed Issues in the Specific Trauma Claim

There is no dispute that Petitioner sustained an accident while working for Respondent on January 15, 2002. Petitioner claims this accident resulted in injuries to multiple body parts, including his right hand, abdomen, neck, back and hip. Respondent maintains the accident caused only a right hand injury, citing the histories in the initial medical records from Concentra and the Veterans Administration. The parties agree that Respondent paid certain medical expenses relating to right hand treatment rendered at Concentra. T. 12/13/16, pp. 11, 13. The disputed issues include causation, other medical expenses, temporary total disability from January 26, 2002 through April 1, 2008, permanency and penalties/fees. Arb Exh 1.

Arbitrator's Findings of Fact Relative to Specific Trauma Claim

Petitioner testified he was born on August 17, 1958. He initially obtained an associate's degree in pre-law and went on to obtain a bachelor's degree of science in occupational safety and health. In June 1983, he successfully completed an 81-hour basic training program in Kentucky and was certified as an emergency medical technician. PX 47-C. In June 1987, he successfully completed a continuing education course in "asbestos control procedures" offered by the Veterans Administration in Birmingham, Alabama. PX 47-A. In 1990, he received a certificate after completing an eight-hour course in "supervisor training for hazardous waste operations" offered by Bechtel National, Inc. PX 47-B. In May 1992, he obtained a master's

degree in occupational safety and health from Murray State University. T. 12/13/16, pp. 29-31. PX 47-E.

Petitioner testified he is a certified welder [PX 47-G and 47-H] and a journeyman carpenter. He has attended a number of classes in the field of occupational safety and health, including the OSHA-sponsored "9000 series" geared toward federal inspectors and safety professionals. T. 12/13/16, pp. 31-32.

Petitioner testified he was certified as an ambulance driver. At one point, he served on a fire department. T. 12/13/16, p. 32.

Petitioner testified he is a member of Local 578, the pile drivers union. T. 12/13/16, p. 33.

Petitioner testified that, at some point prior to the accident, he attended a union meeting and learned Respondent was hiring. Over Respondent's objection, he testified he got in touch with Respondent's dispatcher and was sent to Soldier Field to work. T. 12/13/16, pp. 34-35. He began working for Respondent at the Soldier Field jobsite around November 25, 2001. T. 12/13/16, p. 39. [Respondent paycheck stubs in PX 16 reflect Petitioner worked 32 regular hours and 10.50 overtime hours the week ending November 20, 2001, 32 regular hours and 2.50 overtime hours the week ending November 27, 2001, 35 regular hours and .50 overtime hours the week ending December 4, 2001, 24 regular hours and 2.50 overtime hours the week ending December 11, 2001, 37 regular hours and 1.50 overtime hours the week ending December 18, 2001 and 18 regular hours and 2 overtime hours the week ending December 25, 2001. PX 16 does not include any paychecks from January 2002.] He had worked as a pile driver for other entities in the past. Earlier in 2001, he had worked as a pile driver for Kenny Construction. T. 12/13/16, p. 40.

Petitioner testified he had both pile driving and safety-related responsibilities at the Soldier Field jobsite. He indicated Respondent assigned the safety-related responsibilities to him after he presented his 30-hour OSHA training certificate. T. 12/13/16, pp. 35-36. At the jobsite, he attended meetings with safety and project management as well as general safety meetings that all workers had to attend. T. 12/13/16, p. 37.

Petitioner testified that, in general, pile drivers operate heavy equipment to lay foundations or break up excavations. He described pile driving as very heavy work. He indicated pile drivers have to be "like Olympic bodybuilders" in that they are required to deal with thousands of pounds. A pile driver has to be able to support his weight in order to climb up onto structures and maneuver objects that are being hoisted into the air. Those objects, which typically hang from cables, "may weigh thousands and thousands of pounds." T. 12/13/16, p. 39.

Petitioner testified he felt good, could move and was "stronger than [he] had ever been in his life," as of mid-January 2002, prior to the accident. T. 40.

Petitioner acknowledged being involved in a motor vehicle accident in 1979, while serving in the military. He testified he injured "the medulla in the neck" in this accident and underwent traction for this condition. He also "had some low back problems" and underwent "extensive therapy" as a result of this accident. T. 12/13/16, p. 41.

Petitioner's pre-accident medical history is complex. Records in RX 1 reflect he underwent X-rays of the cervical spine, both shoulders and right hip at the Jesse Brown Veterans Administration Medical Center (hereafter "JBVAMC") on June 23, 1997. The cervical spine X-rays were negative. The shoulder X-rays revealed an "old avulsion fracture of the left clavicle." The right hip X-rays showed a deformity of the femoral head, with the radiologist indicating that "ischemic necrosis should be considered." RX 1, pp. 114-116. Petitioner also underwent a psychiatric evaluation in June 1997. This evaluation is not in evidence. Pulmonary function studies performed on June 25, 1998 were normal. Dr. Das Gupta certified Petitioner for unrestricted respirator usage the same day. PX 19. Petitioner underwent MRI scans of his right shoulder and both hips at JBVAMC on July 22, 1997. The interpreting radiologist interpreted the right shoulder images as consistent with impingement and possible partial tearing of the proximal fibers of the supraspinatus tendon. He interpreted the hip images as showing a very small amount of fluid in the left hip joint, "which may be upper limits of normal," and no defects involving the femoral head or hip joints. RX 1, pp. 111-113. It appears Petitioner underwent a right inguinal hernia repair at JVAMC on December 29, 1998, although no operative report is in evidence. RX 1, p. 929. Petitioner underwent an exploratory laparotomy and appendectomy at JBVAMC on June 19, 1999. Before undergoing this surgery, he provided a history of 24 hours of severe epigastric pain which had kept him awake and indicated he had experienced "similar but less intense pain intermittently over the past several months." RX 1, pp. 155-156, 159-160, 928. On September 21, 1999, Petitioner complained of various problems, including "right hip discomfort" for which he had seen Dr. Jantra in the past. Petitioner requested a follow-up appointment with this physician. RX 1, p. 922. On February 5, 2001, Petitioner complained of an intermittent productive cough since a West Side VA Emergency Room visit of December 24, 2000. Petitioner indicated he had been diagnosed with uvelitis on that date. RX 1, p. 919.

Petitioner testified that, on January 15, 2002, shortly before the accident, he was working in an excavation trench at the north end of the Soldier Field project. Very large beams were being placed as piles. Petitioner testified each beam weighed at least 8,000 pounds. Some of the beams were 95 feet long. The biggest might have been 114 feet long. T. 12/13/16, pp. 41-42.

Petitioner testified he "walked out" of the jobsite after the accident and went home. T. 12/13/16, p. 55. After arriving home, he noticed swelling in his hands and stomach. Pulling on the bar caused the muscles inside his stomach to "actually rip." He had never noticed similar abdominal swelling in his stomach before. T. 12/13/16, pp. 55-57. His "whole body was swelling and sore." T. 12/13/16, p. 55.

Petitioner testified he got up "really early" the following day and reported to the jobsite as required. He "got ahold of James McCormick, the superintendent, who [he had] worked safety with" and told him he had been injured. Petitioner testified he told McCormick his body "was swelled up." He also showed McCormick his hands. Both of his hands were swollen "like baseballs" but it was his dominant right hand that was "predominantly messed up." Petitioner denied ever experiencing similar hand swelling in the past. T. 12/13/16, p. 58.

Petitioner testified he was sent from the jobsite to Concentra, where he saw Dr. Israel. Petitioner testified he told Dr. Israel he was in pain, his body was swelling and he was having trouble breathing. He testified he also told the doctor "that the pain from the hand had radiated up through to [his] neck." T. 12/13/16, p. 61. He believes Dr. Israel ordered chest and arm X-rays. T. 12/13/16, pp. 62-64. Dr. Israel also ordered hand therapy, imposed work restrictions and referred him to Rush Orthopedic. T. 12/13/16, pp. 64-65. Petitioner testified he called Rush but was not able to confirm an appointment.

Dr. Israel's note of January 16, 2002 reflects that Petitioner "began to feel pain and swelling" while he was "using a kicker bar to push a 98-foot H beam." The doctor noted that "specifically, [Petitioner] developed pain and swelling in the right hand." He described the right hand pain as "located on the dorsal aspect" and non-radiating. He also noted that Petitioner reported developing a productive cough a week earlier "which he attributed to inhaling dust particles at work."

On right hand examination, Dr. Israel noted "minimal swelling and moderate tenderness over the distal halves of the fourth and fifth metacarpal bones," a full range of motion of the MCP joints, no ecchymosis or erythema and normal muscle strength.

On chest examination, Dr. Israel noted clear breath sounds bilaterally, good air movement and no rales, stridor or wheezes.

Dr. Israel ordered X-rays of the right hand and chest. He advised Petitioner that, on preliminary reading, both sets of films were negative.

With respect to the right hand, Dr. Israel diagnosed tenosynovitis. He described this condition as work-related and prescribed therapy three times per week for one week. He prescribed Naproxen, dispensed a 2-inch Ace bandage and released Petitioner to restricted duty with no lifting over 20 pounds and no pushing/pulling over 20 pounds of force. He directed Petitioner to return to Concentra on January 18, 2002.

Dr. Israel attributed Petitioner's cough to "an upper respiratory tract infection which is not work related." He directed Petitioner to see his personal physician for this problem. RX 2.

A "second reading report" concerning the X-rays indicates that the interpreting radiologist noted "no active pulmonary process" on the chest films and "no fracture, dislocation or bone destruction" on the right hand films. RX 2.

Petitioner testified that, after seeing Dr. Israel, he returned to the jobsite, the same day, and presented the restriction to the job superintendent, who discarded it. T. 65-66. He resumed working. He testified he was "hurt worse" as a result. His neck pain increased, his grip was weak and he felt soreness in his trapezius. T. 67. He cannot recall all of his symptoms, due to the passage of many years, but he believes he was also experiencing "hip popping" at that time. T. 68. He performed light duty in the sense that he "held his right arm back while lifting" but continued performing all of his regular pile driver tasks. T. 71. In the days that followed, he obtained assistance from co-workers.

Petitioner offered into evidence, with no objection from Respondent, a two-page "accident investigation report" prepared by David Cooper, a safety director. The report is dated January 17, 2002. In the report, Cooper described Petitioner as a pile driver who had worked at the Soldier Field jobsite for four months. Cooper stated that "over exertion" contributed to the accident. He indicated Petitioner was "pushing a hickey bar to position a 8' H-beam some 8,000 pounds to set at point #183." He listed three eyewitnesses: Donald Schwemin (who he identified as Petitioner's supervisor), Paul Walters and Wally Rodgers (who he identified as an "operator"). In response to a question asking whether a specific procedure existed for the task Petitioner was performing, Cooper stated: "5 pile drivers in a crew, when one leaves early the beam tender should join the crew." He also stated a third party could possibly have contributed to the accident, indicating the "task usually requires 2 men." In response to a question asking whether equipment was used and functioned properly, he stated: "hickey bar pipe was a little small to grip." In response to a question asking whether any unsafe physical/environmental conditions existed, Cooper wrote: "yes – physical 8,000 beam has to be set in place." Cooper listed "Dr. Israel" as the attending physician. PX 15.

The Concentra records reflect that Petitioner returned to the clinic on January 22, 2002 and again saw Dr. Israel. The doctor noted that Petitioner reported "less pain in the right hand" and described the pain as "precipitated by applying pressure over the 4th and 5th MCP joints." The doctor indicated that Petitioner had started therapy and was "working within the duty restrictions."

On right hand re-examination, Dr. Israel noted minimal swelling and tenderness overlying the distal halves of the fourth and fifth metacarpal bones and a full range of motion in the fourth and fifth MCP joints. He described Petitioner's grip strength as normal. He reapplied the tensor bandage, recommended daily warm soaks at home and changed the restrictions to no lifting over 40 pounds and no pushing or pulling over 40 pounds of force. He directed Petitioner to return on January 29, 2002. RX 2.

Petitioner also went to the Emergency Room at Lakeside VA on January 22, 2002. A triage nurse described Petitioner's chief complaints as follows:

> "Exposed to silicon dust at work and have R hand swelling/
> discomfort even tho work doctor said I could go back to work."

The nurse noted right hand edema. He also noted that Petitioner brought chest and right hand X-ray films with him. At discharge, Petitioner was instructed to take Motrin, rest his right hand and avoid straining, heavy use/lifting. RX 1, pp. 911-913.

An Emergency Room progress note "addenda" dated January 22, 2002 reads as follows:

> " Pt looking to initiate care and also for R hand pain secondary to injury at work. Wrote him a note saying he should have light duty. Also pt has some possible exposures and mild SOB. CXR with questionable interstitial pattern."

Dr. Sidhaye, the author of this note, recommending follow up and pulmonary function studies. RX 1, p. 908.

A "late entry" addendum dated January 23, 2002 reads as follows:

> "43 yr old man with history of personality disorder here for evaluation of right hand and sob/cough for 1-2 weeks. Says that he hurt his hand pushing a very heavy cart ('it was 8000 lbs.') and that X-rays done at the clinic where he works were negative. Wants a letter for work stating that he should be on light duty. Says that his hand is slightly swollen today because he's been forced to resume his regular duties at work. No deficits in range of motion or strength. Also with mild sob and cough which he attributes to silicon exposure at work – whitish sputum, no f/c, no uri symptoms."

Dr. Hasan, the apparent author of this note, noted mild swelling along the dorsum of the right hand laterally. He interpreted chest X-rays ("from outside clinic") as showing a "mild diffuse interstitial pattern, right greater than left." He described hand X-rays as showing no fracture. He diagnosed "right hand strain" and "poss[ible] interstitial lung disease due to inhalation of unknown substance." He prescribed Ibuprofen and recommended that Petitioner follow up in urgent care/general medicine for scheduling of pulmonary function studies. RX 1, p. 908.

Petitioner went to the Emergency Room at Westside VA on January 23, 2002 and complained of a "productive cough of whitish sputum for the past week" and shortness of breath which he attributed to a "large amount of dust around where he works." The examining physician, Dr. Gowhari, noted that Petitioner requested a chest X-ray and inhalers. On chest examination, Dr. Gowhari noted minimal expiratory wheezing bilaterally. He obtained chest X-rays and interpreted them as showing "no clear infiltrates or masses." He attributed Petitioner's symptoms to "reactive airway disease secondary allergens including dust at work." He recommended that Petitioner wear a mask at work. He also noted that Petitioner had been

seen at the Lakeside VA facility earlier that day, where a doctor recommended pulmonary function studies. RX 1, p. 907.

Petitioner testified he last worked at the Soldier Field jobsite on January 25, 2002. Respondent laid him off on that date. Petitioner testified he was still on light duty when he was laid off. T. 72. That same day, he saw Dr. Agrawal, a primary care physician, at a VA facility. The doctor noted that Petitioner complained of a productive cough, episodes of shortness of breath improved with Albuterol, and continued pain "since his hand injury." The doctor indicated that Petitioner requested a chest CT scan, citing "silica dust exposure for three months." He described Petitioner as becoming "very upset" after he suggested that Petitioner wait for a pulmonary evaluation and pulmonary function studies. He "strongly recommended" a cardiac stress test but noted that Petitioner "adamantly refused." He referred Petitioner "to ortho" for his right hand pain. RX 1, p. 905.

Petitioner testified that, after being laid off, he talked to his union business agent and "did try to get other work later on." T. 72. Starting around February 18, 2002 he worked as a pile driver for a different employer, Lorig, for one to three days. During that time, he "mostly stood around." He needed help just to get his tools. He stopped working for Lorig because he was physically unable to perform his assigned duties. He could not hold or position objects that weighed "hundreds and hundreds of pounds." He was required to weld but he could not sit and weld for more than 30 minutes at a time. T. 105-106.

Petitioner returned to Concentra on February 1, 2002 and again saw Dr. Israel. The doctor noted that Petitioner was still complaining of "on and off pain in the right hand exacerbated by active flexion of the 4th MCP joint." He also noted that Petitioner was continuing to perform restricted duty and engage in physical therapy.

On right hand re-examination, Dr. Israel noted "minimal swelling and tenderness over the 4th metacarpophalangeal joint," a full range of motion of the joint, no erythema or ecchymosis and normal grip strength.

Dr. Israel obtained repeat right hand X-rays. He advised Petitioner the preliminary X-ray reading was negative. He directed Petitioner to see a hand surgeon at Midwest Orthopedics "at the earliest convenient time." He also told Petitioner to continue his exercises and return to Concentra on February 8th. RX 2.

Petitioner also underwent treatment at a VA facility on February 1, 2002, where he saw Drs. Kulkarni and Smith. The note reflects that Petitioner complained of a chronic cough with associated shortness of breath which he attributed to "exposure to dust at work." On examination, Dr. Kulkarni described Petitioner's chest as clear to auscultation bilaterally. She recorded the following:

> "States he is unable to obtain material safety data sheet from employer as he was laid off a week ago."

She also noted that Petitioner was scheduled to undergo pulmonary function studies on March 11th. RX 1, p. 903.

A mental health case manager's note of February 1, 2002 reads as follows:

> "Extremely demanding about documentation concerning exposure to silica dust. However, refuses to say where or how he was exposed. Will only say that he was @ a construction [site]. Reports chief of medicine instructed him to decline to answer."

RX 1, pp. 903-904.

Petitioner also saw Dr. Nam, an orthopedic surgeon, at a VA facility on February 1, 2002. Dr. Nam described Petitioner as "present[ing] with right hand tenderness dorsum after injuring approx. 14 days ago while pushing object, no direct trauma, X-rays taken at outside hospital, negative per patient." On right hand examination, Dr. Nam noted some tenderness in the dorsum of the fourth metacarpal "versus extensor tendon" with no laceration and a full range of motion in the fingers. He diagnosed "right hand dorsum contusion." He directed Petitioner to "rest hand and progress prn." RX 1, pp. 902-903.

Petitioner saw a different orthopedic surgeon, Dr. Hoepfner, at a VA facility on February 15, 2002. Petitioner testified that, as of this date, he was still experiencing extreme stomach swelling. His stomach resembled that of a character in the Alien movie. He was also experiencing severe back and hip problems. He felt as if a disc was moving inside his neck. His right hand was still swollen but the swelling had gone down.

Dr. Hoepfner recorded the following history on February 15, 2002:

> "Gentleman presents with right hand tenderness dorsum after injuring approx. one month ago while pushing object. No direct trauma. X-rays taken at outside hospital negative per patient. Patient states pain is improving but is aggravated by heavy labor at work."

On right hand examination, Dr. Hoepfner noted minimal tenderness to palpation over the fourth metacarpal, a full range of motion in all fingers and full extensor tendon strength.

Dr. Hoepfner also examined Petitioner's right hip. His note sets forth no history as to the origin or duration of any right hip complaints. He noted a full range of right hip motion "without pain at endpoint."

Dr. Hoepfner indicated he reviewed "old" right hip X-rays dating back to June 1997. He interpreted them as showing some flattening of the femoral head and no joint space narrowing.

Dr. Hoepfner diagnosed a right hand dorsum contusion. He issued a handwritten note stating:

> "Mr. Hendy has a right hand injury. He is not to push/pull greater than 50 pounds for next 4 weeks."

The note is dated February 15, 2002. PX 41.

Petitioner underwent pulmonary function testing at VA Lakeside on March 11, 2002. The report states that Petitioner put forth "poor effort" and "was unable to produce acceptable and reproducible spirometry data." The evaluator also noted: "pulse ox ra 95%." PX 2.

On March 27, 2002, Petitioner went to a VA urgent care facility and complained of left-sided throat pain, chest congestion for five days and "lung problem for 3 mos." Petitioner indicated he had been taking Amoxicillin "that he had left over" for four days and Erythromycin for one day. Dr. De Jesus noted rhonci in the left base on chest examination. He ordered chest X-rays which showed "no infiltrate." He provided Petitioner with cough syrup and lozenges. PX 1.

Later in the day on March 27, 2002, Petitioner saw Dr. Cuttica at a different general medicine VA clinic and again complained of a productive cough and sore throat. The doctor noted a past medical history of "chronic R hip arthritis? States sec/2 service injury" along with "arthritic changes in neck" and ringing in the ears. On examination, the doctor noted a lesion on Petitioner's tonsil. He recommended that Petitioner return in three weeks. He noted that Petitioner had no smoking history and reported a "recent work exposure to silicon." PX 2.

A VA orthopedic clinic note dates April 5, 2002 reflects that Petitioner complained of pain in his right hip, "controlled with Ibuprofen," and "pain of dorsum of rt hand from previous injury, improving." The provider, Dr. Unis, went on to state that "upon further questioning, does have intermittent low back pain as well." He indicated that Petitioner denied leg symptoms and reported putting on weight and "now not able to exercise." On right hand examination, Dr. Unis noted minimal tenderness to palpation over the interval between the fourth and fifth metacarpal, good grip strength and full extensor tendon strength. On hip examination, he noted mild pain with range of motion, apparently unilaterally [the note is difficult to read]. He obtained right hip X-rays, which showed no evidence of fracture, slight flatteninging of the medial portion of the right femoral head which "may represent old trauma" and "slight hypertrophic bony changes of the lesser trochanter of the right femur." Petitioner also underwent pelvis X-rays, with the radiologist indicating that AVN [avascular necrosis] "cannot be excluded", based on the slight flattening of the medial portion of the right femoral head, and that a right hip MRI should be done "if clinically indicated." PX 2. Dr. Unis stated he

found Petitioner's complaints consistent with a back rather than hip problem. He recommended bridging exercises, to be performed at home, and Ibuprofen. PX 2.

On April 30, 2002, Petitioner saw Dr. Philip at JBVAMC, with the doctor recording the following history:

> "44 yr old male patient with chronic low back pain since 1979, 1980. He stated that the pain [in] the low back started after a MVA while in service. He was seen and evaluated by Dr. Jantra in 1997 and had therapy here. He does not report any significant benefit from therapy. He also reports that the pain is aggravated last weekend by lifting approx 30 lbs weighing boxes. He stated he was discharged from service and he was told he had spondylosis. He also has pain in lt wrist medially since 1980 s/p MVA while in service. H/o injury to rt hand in 1/02. Pain in rt wrist is aggravated by lifting weights. Has h/o DJD of LS spine. No radiating pain except has pain in rt hip."

On examination, Dr. Philip described Petitioner's lungs as clear and his gait as normal. She noted "no tenderness over spine" and negative straight leg raising. She noted a slightly decreased range of trunk motion in forward flexion.

Dr. Philip's impression was "chronic low back pain – r/o LS radiculopathy rt." She prescribed one to two therapy sessions and a trial of a TENS unit for the low back. She also recommended EMG/NCS testing and an orthopedic follow-up. RX 1, pp. 289-290. PX 2.

A VA social work progress note dated May 1, 2002 reflects that Petitioner requested "references to employment and job re-training services." The note also reflects that a social worker provided Petitioner with telephone numbers and addresses for various VA and Illinois offices.

Petitioner saw Dr. Philip again on May 16, 2002. The doctor described Petitioner as "still having chronic low back pain and right hand pain." She described Petitioner as "ambulating independently." On right hand re-examination, she again noted tenderness in the fourth web space between the fourth and fifth fingers, along with mild edema of the hand. She recommended orthopedic follow-up and EMG/NCV testing. At Petitioner's request, she signed an insurance-related form that describes Petitioner as having "chronic back pain" and "new" right hand pain since January 14, 2002. The form reflects that Petitioner was totally disabled from January 15, 2002 to July 31, 2002 and that his return to work date was "indefinite." PX 2.

Petitioner underwent an initial physical therapy evaluation at a VA facility on May 30, 2002, with the therapist noting a diagnosis of "lumbar DJD, low back pain since 1979." The therapist prescribed home exercises "for cervical, low back and LE." He provided Petitioner with tubing to be used to perform these exercises. PX 2.

On July 2, 2002, Dr. Phillip noted that Petitioner was still experiencing right hand and right hip pain. She further noted that Petitioner declined the previously recommended EMG/NCV testing. RX 1, pp. 885-886.

A JBVAMC pulmonary clinic note dated August 15, 2002 reflects that recent pulmonary function studies were "uninterpretable due to poor quality." The examining physician described Petitioner as "insistent that he has silica and asbestos in his lungs" and wanting a "biopsy to prove it." The physician stated she "assured [Petitioner] that we do NOT see anything on his cxr and a blind biopsy would be unindicated and unsafe." She went on to state that Petitioner "suggested the radiologist had an agenda and intentionally under-read his film." After Petitioner continued to express concern "about dying from silica/asbestos exposure," she recommended he return in six months for a follow-up chest X-ray. She indicated Petitioner "left abruptly, stating he is receiving sub-standard care." RX 1, p. 884.

A VA orthopedic clinic note of August 16, 2002 reflects that Petitioner complained of low back pain, right hip pain/popping, neck pain, right shoulder pain and "abdominal growth." Dr. Quinby directed Petitioner to schedule an MRI "of lower joints" and see a general surgeon "for evaluation of abdominal hernia." PX 2.

A JBVAMC general surgery progress note dated August 22, 2002 reflects that Petitioner complained of "sharp, stabbing pain in epigastric area gradually worsening since beginning of the year, during work at construction site." Dr. Swaroop diagnosed diastasis "likely secondary to recent weight gain."

A JBVAMC general surgery progress note dated September 10, 2002 reflects that Petitioner "began to notice pain in the inguinal area in January" after performing "intensive construction work" the previous winter. On examination, a medical student palpated a hernia in the right inguinal area. He noted Petitioner was scheduled to undergo a hernia repair on October 17, 2002. RX 1, pp. 865-867.

An otolaryngology progress note also dated September 10, 2002 reflects that Petitioner complained of tinnitus and "sudden" worsening of bilateral hearing loss while "pile driving" in January. A staff nurse recommended a yearly audiogram. RX 1, pp. 867-868.

Petitioner underwent a hip MRI at a VA facility on September 30, 2002. The radiologist noted small effusions bilaterally, no evidence of avascular necrosis and a "focal hypointense signal in the right hip just medial to the fovea." He indicated he did not know whether this area of focus represented a torn ligament. He could not rule out a subcortical bulging fracture of the right femur. PX 2.

Petitioner underwent a mesh right inguinal hernia repair at JBVAMC on October 17, 2002. Postoperatively, he was discharged with instructions to avoid lifting anything heavier than a phone book for six weeks. PX 2.

On December 2, 2002, Petitioner saw Dr. Cremer at a VA facility. The doctor noted a past medical history of various complaints that "seem to be tied, at least in [Petitioner's] mind, to work-related injury or exposure." He noted current complaints of chronic left lower leg cramping and an inner upper lip mucosal growth. He also indicated that Petitioner wanted him to change a form previously completed by Dr. Cuttica so as to reflect a longer period of disability. He stated he "reviewed ortho and PM & R notes and was unable to find evidence of this." He "explained to [Petitioner] that in good conscience [he] could not fill out the form with the dates [he] wanted [the doctor] to include." RX 1, p. 835.

On February 3, 2003, Dr. Levandovsky of the VA "assured [Petitioner] that his hernia repair was intact" and completed another disability form, indicating Petitioner "may have some limitation for heavy labor but [was] not disabled to perform regular work." RX 1, p. 832.

On February 11, 2003, Dr. Philip noted questionable tenderness in the fourth webspace of Petitioner's right hand. She also noted that Petitioner was "still" refusing EMG/NCV testing. RX 1, p. 830.

On September 15, 2003, Dr. Agrawal issued a VA memo form addressed "to whom it may concern," stating as follows:

> "Mr. David Hendy has had severe neck pain and is currently undergoing evaluation. He is allowed to do light work such as computer work but should not engage in any lifting or strenuous activity for now."

PX 30.

On August 3, 2004, Dr. Lipman of the Lakeside VA Mental Health Clinic noted that Petitioner had contacted her and was requesting that "all psychiatric diagnoses" be removed from his chart. RX 1, p. 709.

A JBVAMC general medicine note dated October 8, 2004 sets forth the following history:

> "46 y/o male with h/o cervical disc disease who thinks he reinjured his neck while lifting a fax machine on Wednesday. Pain started Wednesday and has escalated. Pain at posterior neck L sided greater than right. No hand weakness. He indicates he feels like something is grinding at back of neck but this not a new sensation."

Dr. Pittman, the author of the note, also stated that Petitioner "indicates he is self-employed as a safety salesman that requires him to pick up heavy items." On examination, Dr. Pittman noted 5-/5 strength on the left, good grip strength and mild tenderness with palpation of the

cervical paraspinal region. He diagnosed a muscular neck strain and recommended follow up with physical medicine for neck exercises. RX 1, pp. 695-696.

A JBVAMC general medicine note dated November 5, 2004 reflects that Petitioner reported reinjuring his neck "lifting a heavy fax machine." The provider, a medical resident, noted that Petitioner had missed physical therapy appointments in the past. He recommended re-enrollment. He also informed Petitioner he needed to focus on Petitioner's reported medical problems rather than "spending all of our time talking about his insurance forms and workers' comp." RX 1, pp. 688-689.

Petitioner underwent a cervical spine MRI at JBVAMC on December 3, 2004. The interpreting radiologist noted "degenerative disc disease at C4-5, C5-6 and C6-7 with subligamentous disc herniations more prominently at C5-6 and C6-7." RX 1, pp. 645-646.

A JBVAMC physical medicine note of March 18, 2005 reflects a history of "chronic neck pain" that "began many years ago" and "really flared in 2002 when patient was working construction." The evaluating physician described Petitioner as "very emotional and angry at times in the room about his neck pain" and refusing to perform certain neck movements because he felt it would bring on his pain. The physician offered formal physical therapy but indicated Petitioner declined this option and only wanted to have moist heat applied. The physician also recommended that Petitioner "follow up with psychiatric services since the many stressors in his life are likely contributing to his pain complaints also." RX 1, pp. 654-655.

On April 19, 2005, Petitioner saw Dr. Tara Sanft at JBVAMC. The doctor noted a history of "untreated depression" and "chronic neck pain." She indicated that Petitioner described his neck pain as worsening and dated his depression back to a "neck injury in 2002." She stated that Petitioner had discontinued formal physical therapy due to pain and did not want to undergo a psychiatric evaluation or try anti-depressants. She directed Petitioner to start taking Robaxin rather than Cyclobenzaprine for his neck pain and continue his home exercises. She also encouraged Petitioner to undergo a psychiatric evaluation and re-enroll in formal physical therapy. RX 1, p. 646.

On September 22, 2005, Dr. Smushkin of the VA reviewed cervical and dorsal spine MRI films with Petitioner. She attributed Petitioner's cervical disc disease to trauma "during service and MVA." She recommended weight loss and pain control, versus surgery. She indicated that Petitioner would not likely benefit from surgery "as pain also has a significant psychiatric/psychosocial component." RX 1, pp. 601-603.

On August 4, 2006, Dr. Ryan of the VA indicated he did not view Petitioner's neck pain as work-related. On October 20, 2006, Dr. Ryan analyzed the treatment rendered since the work accident and was able to link only the right hand injury to that event. He addressed causation as to the other claimed conditions as follows: "I cannot be certain that the injury exacerbated/caused [Petitioner's] neck pain, hip pain, back pain or hernia, due to the delay from the injury to the onset of symptoms." RX 3.

Petitioner began a course of intermittent care with Dr. Stamelos, an orthopedic surgeon, on October 12, 2006. See below for a summary of the doctor's 2013 deposition testimony.

A JBVAMC orthopedic surgery progress note of July 6, 2007 reflects that Petitioner complained of right foot pain (which he attributed to ill-fitting shoe inserts), left shoulder pain and "multiple complaints relating to his spine." The examining physician, Dr. Marecek, noted that Petitioner felt his spine problems were "all sequelae from an incident in which a 4-ton beam fell on him at work." Petitioner requested a cane. On examination, Dr. Marecek noted a decreased range of cervical spine motion, a positive Lhermitte's sign, a full range of shoulder motion and decreased sensation on the left in "ax/med/rad/uln distrib[ution]." He recommended that Petitioner obtain new shoe inserts and continue his spinal rehabilitation program. RX 1, pp. 448-449. A subsequent note, dated July 6, 2007, reflects Petitioner was given a standard cane. RX 1, pp. 447-448. Petitioner testified he continues to use this cane.

A JBVAMC physical therapy note of July 13, 2007 reflects that Petitioner complained of 8-10/10 pain in his neck, both shoulders, upper back and lower back "since 1979" secondary to an injury he sustained when he was in the military. RX 1, p. 437.

The Arbitrator notes that Petitioner claims temporary total disability benefits through April 1, 2008. Arb Exh 1.

One of Petitioner's treating physicians, Dr. Stamelos, testified that Petitioner was involved in a motor vehicle accident in June 2008. The doctor also testified he had a "complete chart" concerning the treatment he rendered to Petitioner following this accident. Petitioner did not acknowledge this accident on direct examination. The doctor's chart was marked as Dep Exhibit 3 at his 2013 deposition. Respondent did not object to this exhibit but it is not attached to the deposition transcript. PX 7.

Petitioner testified he worked part-time at Dawson Technical Institute during the summer of 2008. He worked as an adjunct professor. He taught welding. He left the job in August 2008 in order to undergo some kind of surgery.

A telephone triage note dated June 24, 2010, authored by a VA provider, reflects that Petitioner reported injuring his back 8 ½ years earlier and experiencing increased back pain and bilateral arm weakness at 10:30 AM the previous day, June 23, 2010, after being "assaulted by police" and "forced into a police car, by mistake." The note goes on to state that the provider directed Petitioner to come to a VA Emergency Room and that Petitioner did in fact seek care at a VA facility and was started on Vicodin. Gee Dep Exh 4.

On January 4, 2012, Dr. Israel testified at a discovery deposition in the common law action, 09 L 14624. PX 14. Petitioner offered this deposition into evidence, with no objection from Respondent.

Dr. Israel testified he has been practicing occupational medicine since 1979. He is not board certified. He is employed by Concentra Medical Center. PX 14, pp. 5-6. He primarily treats musculoskeletal injuries. PX 14, p. 6. He sometimes refers patients to orthopedic surgeons or neurologists. PX 14, pp. 6-7.

Dr. Israel testified he does not independently recall Petitioner. Records from Concentra show he saw Petitioner three times, on January 16 and 22, 2002 and February 1, 2002. PX 14, pp. 7-8. He has never seen Petitioner since February 1, 2002. PX 14, pp. 8, 12. He has been informed he gave a deposition in another case involving Petitioner [David Hendy v. Soldier Field Joint Venture, 03 L 9037] but he does not recall this. He gave this deposition in 2005, in connection with an accident of January 15, 1992 [sic]. PX 14, pp. 9-11. [No transcript concerning this deposition is in evidence.] At that deposition, he testified he recommended hand therapy for Petitioner but Petitioner attended only one therapy session, on January 16, 2002. He further testified Petitioner called after that session and cancelled the remaining appointments because he was going to work. PX 14, p. 13.

Dr. Israel testified that, when he first saw Petitioner, on January 16, 2002, Petitioner complained only of his right hand and a cough. He noted swelling and tenderness primarily on the dorsum, or back, of Petitioner's right hand. Petitioner reported experiencing this pain while using a kicker bar to move a heavy beam. Based on this history, he viewed Petitioner's right hand problem as a sprain or contusion that stemmed from a work injury. He obtained right hand X-rays, which were negative. PX 14, p. 19. As of January 16, 2002, it was his expectation that the hand problem would resolve in three to four weeks. PX 14, p. 18. He viewed the cough as a non-work-related condition. PX 14, pp. 13-14. At the second visit, on January 22, 2002, Petitioner mentioned only his hand and reported improvement. At the third visit, Petitioner reported additional improvement but was still complaining of some right hand discomfort. PX 14, p. 20. He referred Petitioner to a hand specialist but does not know whether Petitioner ever saw a specialist. PX 14, pp. 20-21. As of that last visit, he did not know whether the swelling and discomfort in Petitioner's right hand would resolve over time. PX 14, p. 22. If Petitioner testified that his right hand symptoms resolved shortly after that last visit, that would surprise him. He imposed work restrictions but did not take Petitioner off work. PX 14, pp. 24-25. If he testified at his prior deposition that he did not anticipate any hand disability, he would still testify in the same manner. PX 14, p. 25.

Dr. Israel testified that, at no time between January 16 and February 1, 2002 did Petitioner complain to him of neck, back, hip or groin pain. PX 14, pp. 27-28. It was his assistant who first spoke with Petitioner and recorded his history and complaints. He then spoke with Petitioner and confirmed the mechanics of the injury. PX 14, pp. 28-29. There is nothing in the records that reflects Petitioner described being caught by the beam and "wildly flung around like a wet noodle." PX 14, pp. 29-30.

Dr. Israel testified that any worker injured at the Soldier Field project would first be sent to Concentra. The name "Dick Strenquist" sounds familiar to him. He believes Strenquist was

the foreman at the Soldier Field project. PX 14, p. 31. Typically, an injured worker would report the injury to Strenquist who would, in turn, send the worker to Concentra. There is no indication in his records that this did not happen in Petitioner's case. PX 14, p. 32. He has no recollection of Petitioner complaining about pain in the right side of his body, including his arm, neck and back, or him telling Petitioner he was going to send Petitioner elsewhere for care because Soldier Field management was "shutting down" his treatment. PX 14, p. 32. If a worker complained to him of neck or back pain, he would "usually" record that in his chart. PX 14, p. 33. He would not ignore such complaints. PX 14, p. 34.

Dr. Israel testified he did not discharge Petitioner from care at the point at which he referred Petitioner to a hand specialist. Petitioner simply never returned to see him. PX 14, p. 37.

Dr. Israel testified there is no way to verify a patient's subjective complaints. You have to rely on the patient's honesty. PX 14, p. 36.

Under cross-examination, Dr. Israel testified he initially diagnosed tenosynovitis of the right hand. He provided Petitioner with an Ace wrap and prescribed Naproxen and physical therapy. He initially imposed a 20-pound lifting restriction. Petitioner would have thereafter undergone an initial therapy evaluation. The therapist would typically perform hot and cold applications and have the patient perform exercises, such as squeezing a ball. At the second visit, on January 22, 2002, he increased Petitioner's lifting to 40 pounds. As far as he knows, Petitioner was performing his job as of that date. PX 14, p. 41. The hand specialist he referred Petitioner to was at Rush. PX 14, pp. 41-42. If Petitioner had, for some reason, missed an appointment with the specialist, he would have wanted Petitioner to reschedule. If Petitioner had refused to reschedule, that would have been contrary to his directions. PX 14, p. 42. Petitioner would have completed a form at Concentra, giving preliminary information about himself. All Concentra patients are required to do this. PX 14, pp. 44-45. On January 16, 2002, he called Strenquist but did not reach him. He left Strenquist a message concerning his hand and pharyngitis diagnoses. Strenquist would have been aware that Petitioner was alleging his cough stemmed from dust exposure at work. PX 14, p. 46.

Dr. Israel identified Dep Exhibit 5 as a note prepared by Karla Webbers, a Concentra nurse. He testified he has never previously seen this note. Webbers signed this note. **[The Arbitrator notes that this note was not offered into evidence at Dr. Israel's deposition and is not attached to the deposition transcript.]**

Dr. Israel testified he initially anticipated Petitioner would fully recover from his hand injury but Petitioner had not fully recovered by February 1, 2002.

Dr. Israel conceded that the type of work activity Petitioner described, i.e., using a kicker bar to move a beam, could "possibly" cause a neck or back injury. Petitioner did not, however, complain to him of his neck or back. PX 14, pp. 48-49. He has seen situations in which a Concentra patient has reported a work accident and then later experienced an onset of neck

and back symptoms. PX 14, pp. 49-50. He obtained chest and right hand X-rays. He performed an initial, or "wet" reading, of these X-rays and then sent the films out to be read by a radiologist. PX 14, p. 50. Dr. Dalia is the radiologist who read Petitioner's films. PX 14, pp. 50-51. The Naproxen he prescribed could have taken away pain in "whatever part" of Petitioner's body.

On redirect examination, Dr. Israel testified that the "hard" Concentra file concerning Petitioner is in storage. The treatment occurred eleven years ago. Petitioner did not complain to him of neck, back, hip or groin pain and he has no opinion that the accident Petitioner described resulted in injuries to any of these body parts. PX 14, p. 52.

Petitioner testified that, due to his disabled veteran status, the Veterans Administration hired him to work as an industrial hygienist in October 2012. This was the first full-time job he held after the work accident. T. 117. On October 25, 2012, he began working at the Jesse Brown VA facility. He continued working at this facility until July 2013. He was in a lot of pain throughout this period and had difficulty performing his assigned duties.

On November 28, 2012, Dr. Shanker of the VA examined Petitioner's abdomen, noting the previous hernia repair and the presence of a "large diastasis recti." She explained to Petitioner that a diastasis recti "is not a hernia but a separation of the rectus muscles causing protrusion upon increased abdominal pressure." She recommended against surgery, noting that an operation "would have more complications than benefits." She indicated she gave Petitioner a note stating the condition "should not have an effect on his working and that he should be able to perform all activities normally." RX 1, pp. 172-173.

JBVAMC Emergency Room progress notes dated January 26, 2013 reflect that Petitioner reported developing "worsening" of his chronic low back pain after being on his feet for several hours earlier that day while working as a "fit tester." On examination, Dr. Okwuosa noted that Petitioner appeared comfortable and exhibited no neurological deficits. He theorized that Petitioner's increased back pain was attributable to prolonged standing and bending. He administered a Toradol injection and recommended that Petitioner follow up with his personal care physician. RX 1, pp. 312-313.

A JBVAMC "telephone encounter note" of February 1, 2013 reflects that Petitioner complained of right hip pain secondary to a back injection performed the previous week. The provider recommended that Petitioner present at the JBVAMC Emergency Room in two to three days since his personal care physician was based at Hines rather than Jesse Brown. The provider also recommended that Petitioner apply heat or cold packs to his hip in the interim. RX 1.

A JBVAMC optometry note dated February 20, 2013 reflects that Petitioner requested a letter "justifying" dry eye syndrome "as a need for a larger computer screen at work." Dr. Adamo, the attending optometrist, indicated that, when he recommended that Petitioner enlarge the font size, Petitioner "reported that he was unable to complete his work and be

successful with that set up." Adamo also noted that Petitioner reported feeling as if he "needs to quit his job" due to perceived lack of support from the Veterans Administration in "helping [him] be successful in [his] work environment." RX 1, p. 301.

JBVAMC Emergency Room nursing notes dated February 28, 2013 reflect that Petitioner complained of "back pain persisting since the 18th of January and worsening." Petitioner rated his pain at 8/10 and "c/o a lot of movement while doing his job." Petitioner reported seeing a personal care physician at Hines [VA] for chest, neck and back pain. He requested a referral to a pain clinic and reported having recently undergone MRIs. RX 1, p. 298.

On March 1, 2013, Petitioner saw Dr. Pitzele at the Emergency Room at JBVAMC, with the doctor noting a history of "chronic back pain" that had worsened one day earlier. The doctor described the pain as "in bilateral paraspinal thoracic regions" with "no radiation." He noted that Petitioner reported experiencing "similar pain in the past, including three recent visits to the ED for the same symptoms." He stated that Petitioner reported being able to walk but was experiencing pain "with any movement."

Dr. Pitzele diagnosed "acute-on-chronic lumbago." He saw no evidence of cord compression or neurological sequelae. He indicated that Petitioner was already on pain medication and was "primarily [there] to obtain long term work release." He advised Petitioner he would have to see his primary physician to obtain such a release. RX 1, pp. 293-294.

At Respondent's request, Dr. Ghanayem conducted a Section 12 examination of Petitioner on May 20, 2013. In his examination report, Dr. Ghanayem described Petitioner's gait and cervical spine range of motion as normal. He noted multiple areas of muscular discomfort to palpation in the neck, mid-back and lower back. Based on his review of the initial treatment records (particularly Dr. Philip's note of April 30, 2002), he opined that the work accident caused a right hand injury and was not the cause of the neck and back complaints Petitioner began voicing months after the accident. He attributed those complaints to Petitioner's 1979 service-connected injury. He expressed no opinions as to right hand permanency, if any. RX 5.

Dr. Stamelos testified by way of evidence deposition on August 30, 2013, having previously given a discovery deposition in November 2011 in Petitioner's common law case. Stamelos Dep Exh 5. Dr. Stamelos testified he obtained board certification in orthopedic surgery in 1983. PX 8 at 5. He has been in practice for 36 years. He devotes half of his time to spinal issues. PX 8 at 6.

Dr. Stamelos testified that, in connection with the deposition, he reviewed Petitioner's MRIs along with "massive" Veterans Administration records. PX 8 at 7.

Dr. Stamelos conceded that medical records are only as reliable as the patient's history. PX 8 at 7.

Dr. Stamelos testified he first saw Petitioner on October 12, 2006. On that date, Petitioner provided a history of the January 15, 2002 work accident. Specifically, Petitioner told him he "strained his neck, dorsal spine, ribs and lower back" while using enormous force to move a very heavy pylon that was hanging from a crane. PX 8 at 9. Petitioner was wearing a cervical collar. Petitioner's ribs had healed but he was still experiencing severe pain in his upper and lower extremities, hips and back. Petitioner was experiencing "pseudoparaylsis" at night, meaning he remained still while lying in bed "because he feared different movements would bring more pain." PX 8 at 11.

Dr. Stamelos testified he next saw Petitioner on September 9, 2008. He prescribed Valium as a muscle relaxant. Petitioner did not return thereafter until October 15, 2009. Petitioner attributed the gap to undergoing care at the Veterans Administration. PX 8 at 11-12. Dr. Stamelos testified he contemplated discharging Petitioner from his care at that time because his visits had been so irregular. Petitioner's MRIs all showed "considerably advanced severe degenerative disease." Over Respondent's Ghere-based objection, Dr. Stamelos testified that the MRIs showed the results of a problem that "more likely than not came from an injury in and about" 2002. The MRIs show conditions that have transitioned from acute to chronic. PX 8 at 14-15.

Dr. Stamelos testified he also reviewed the Concentra records. He described these records as "very interesting," noting they do not mention spine complaints. He testified he "confronted" Petitioner about this, with Petitioner explaining that, initially, he had only "soreness" but no pain in his spine. PX 8 at 18. Dr. Stamelos testified this "supports the possibility" that Petitioner had an annular tear or inter-disc pressure, which "takes a while to hurt." When asked how long it would take for an annular tear to create symptoms, Dr. Stamelos responded that it could take up to a week. PX 8 at 18. A disc rupture, in contrast, would cause an immediate onset of horrible pain. A delay in symptoms is the "only explanation" for Petitioner's failure to promptly seek back care. Petitioner did promptly seek care at Concentra but that was "for his hands, not his back." PX 8 at 19-20.

Dr. Stamelos testified he has reviewed Dr. Hoepfner's note of February 15, 2002. In his opinion, Petitioner "could have strained his hip" at the time of the work accident but his hip symptoms "could also be referred pain from the spine." He added, "it depends on the history the patient gives." PX 8 at 20. The L5 nerve root innervates the hip. The May 30, 2002 VA note prompts him to conclude that Petitioner had "significant spinal involvement somewhere in his life around that time." The pain would not have to be of acute onset or constant. PX 8 at 24.

Dr. Stamelos testified he would not perform a fusion on Petitioner. Petitioner needs something for his pain, such as radiofrequency ablation, to "knock out the nerves in the annulus," but not surgery. Petitioner could also benefit from a dorsal spine stimulator, which creates a low electric current and blocks pain to the brain. PX 8 at 25-26.

Dr. Stamelos testified that, based on the history Petitioner provided, the only credible cause of the spinal pain is the work accident. PX 8 at 29.

Dr. Stamelos testified that Petitioner is capable of working, subject to a 20-pound lifting limitation, but cannot return to construction, due to his spine. PX 8 at 29, 32. He imposed the 20-pound restriction as of Petitioner's first visit, in 2006. PX 8 at 29-30. Unless Petitioner undergoes treatment, the restriction would be permanent. PX 8 at 31. If Petitioner underwent a procedure, he might ultimately be able to lift up to 30 pounds. PX 8 at 32.

Dr. Stamelos testified Petitioner "has a definite T7-T8 herniation" but is not a candidate for surgery for this condition "based on the present criteria," since he does not have neurological deficits. PX 8 at 33. The mechanism of injury Petitioner described "is a competent cause for the injuries he has" but he does not know anything about Petitioner's pre-accident condition. PX 8 at 34. There is no radiographic evidence that the accident caused annular tears and herniations. "You [would need] to do an MRI a few weeks after the injury" to find such evidence. PX 8 at 36.

Under cross-examination, Dr. Stamelos testified that a now deceased attorney whose last name was Shuldiner referred Petitioner to him. Shuldiner told him about Petitioner's job injury and asked him to evaluate Petitioner. Petitioner's history was "all over the place."

Dr. Stamelos testified that Petitioner was involved in a serious motor vehicle accident on June 5, 2008. He treated Petitioner following this accident. PX 8 at 43. He stopped treating Petitioner in 2009, either when Shuldiner died or Petitioner stopped coming to his office. PX 8 at 43. Petitioner did not see him on a consistent basis. PX 8 at 43. Petitioner primarily used the VA. PX 8 at 43. Everything he put in his initial October 12, 2006 office note is "based 100% on [Petitioner's] history." PX 8 at 44. On that date, Petitioner wore a cervical collar and his hernia was visible. Petitioner did not bring any medical records with him. He asked Petitioner to bring him information "so [he] could at least be objective." PX 8 at 47. He last saw Petitioner in 2013. Petitioner appeared without an appointment, seeking causation-related opinions. Petitioner informed him of two more recent injuries he had sustained in his then-current industrial hygienist job. PX 8 at 53. He did not want to assist Petitioner with his Department of Labor claims but told Petitioner he would be comfortable stating that the Department of Labor hired him knowing he had pre-existing back conditions. PX 8 at 54. The two most recent injuries aggravated Petitioner's pre-existing conditions. PX 8 at 58. When he first saw Petitioner in 2006, Petitioner denied having any serious injuries before the January 15, 2002 accident. Petitioner specifically denied having any serious injuries while serving in the military. PX 8 at 59.

Dr. Stamelos recalled giving a discovery deposition in November 2011 but did not recall all of the questions he answered at that time. He will stand by whatever testimony he gave. PX 8 at 64. After being reminded that he testified Petitioner should have related neck symptoms immediately after the work accident, he stated: "He should have but he didn't. I don't know why." He went on to state that Petitioner's hand symptoms would not have been indicative of a radicular condition since "it would be too soon to be complaining about hand symptoms the day after the so-called injury." PX 8 at 64. "It would not fit the pattern of disc injuries

[Petitioner] is suffering from." PX 8 at 65. He could never understand why Petitioner did not make a big deal about his claimed spine injuries. There is no reason why Petitioner would not have told his providers his neck was sore. PX 8 at 66. Petitioner is a "mysterious individual" who has "all kinds of issues." PX 8 at 68. He is familiar with the concept of secondary gain. When he was deposed in November 2011, he conceded that Petitioner was "desperate to get his claim accepted." PX 8 at 70. He has a "complete chart" concerning Petitioner's June 2008 motor vehicle accident. PX 8 at 76. He acknowledges that, at the November 2011 deposition, he testified that Petitioner's right hip problem had nothing to do with the work accident. It is his opinion that Petitioner's hip pain is referred from the back. PX 8 at 88.

On redirect, Dr. Stamelos testified that the 2008 and 2011 accidents aggravated Petitioner's pre-existing condition. PX 8 at 92-93. "Sporadic" as his treatment of Petitioner was, he believes "there seems to be some relation" between Petitioner's condition as of 2013 and the January 15, 2002 work accident. PX 8 at 93. To a reasonable degree of medical and surgical certainty, Petitioner was, as of 2013, still suffering the effects of that accident. PX 8 at 94.

[The Arbitrator notes that Dr. Stamelos' records concerning the treatment he rendered to Petitioner after the June 2008 motor vehicle accident were marked as Stamelos Dep Exhibit 3 at his 2013 evidence deposition. Petitioner did not object to the admission of these records into evidence (PX 8 at 92) but the records are, in fact, not attached as an exhibit to the deposition transcript.]

Dr. Gee testified by way of evidence deposition on January 24, 2014. Dr. Gee is a board certified internal medicine physician. Gee Dep Exh 1. He has seen Petitioner at the VA and has prescribed Norco for him. PX 11 at 6. Petitioner suffers from chronic neck and back pain. Petitioner attributes this pain to a work accident. PX 11 at 5.

Dr. Gee could not recall exactly when he first saw Petitioner. PX 11 at 8. [The Arbitrator sustained Respondent's Ghere-based objections to testimony concerning the doctor's opinions relating to Petitioner's claimed asbestos exposure, etc.] He believes he placed Petitioner under restrictions to avoid any heavy lifting or exertion. PX 11 at 16. Those restrictions stem from Petitioner's chronic neck and back pain. He would not recommend that Petitioner perform construction work. PX 11 at 17. He believes Petitioner has cervical stenosis. He last saw Petitioner on November 12, 2013, based on his note. Gee Dep Exh 4. Another note shows Petitioner was using an Albuterol inhaler for asthma. He does not know whether Petitioner's asthma was aggravated by any occupational exposure. PX 11 at 20. A Jessie Brown VA note of January 22, 2002 shows Petitioner was on Albuterol. PX 11 at 32. He has no opinion as to whether this was due to any occupational exposure. PX 11 at 33, 34, 39. That is outside of his area of competence. PX 11 at 39. One of Petitioner's chest X-rays showed interstitial markings. He cannot say whether those markings are permanent. PX 11 at 44. They could result from various things. PX 11 at 44-45.

Under cross-examination, Dr. Gee testified he would refer a patient claiming an occupational dust exposure to a pulmonologist. PX 11 at 46. Petitioner never mentioned such an exposure to him. PX 11 at 47. Exposure to any dust can aggravate asthma. PX 11 at 48. He does not know whether Petitioner's neck and back issues stem from the work accident. PX 11 at 49. The sole basis for his understanding that Petitioner's neck and back pain started on January 15, 2002 is Petitioner's verbal history. PX 11 at 52, 57-58. He is not an expert on work-related conditions. PX 11 at 59. He is familiar with the concept of "secondary gain." PX 11 at 64. He agrees that the letter of May 6, 2008 is an example of a patient demonstrating secondary gain behavior. PX 11 at 70. Petitioner's behavior has been typical of someone exhibiting secondary gain. PX 11 at 71. Petitioner's preoccupation with disability forms and letters is very common secondary gain behavior. PX 11 at 71-72. He is not aware that Petitioner's records document neck and back pain dating back to 1979. PX 11 at 76. He did not review any records predating 2002. PX 11 at 79. He has prescribed cervical collars. They are to be worn for no more than one month. PX 11 at 80. He has seen Petitioner wearing such a collar on numerous occasions. PX 11 at 81. He agrees that Petitioner's condition is degenerative and will progress. PX 11 at 81. Petitioner has, at times, been a non-compliant patient. PX 11 at 84.

On redirect, Dr. Gee testified it is still his opinion that the work accident caused or aggravated Petitioner's neck condition. PX 11 at 86.

Petitioner testified he worked for FEMA between March 2014 and July 2014. During this time, he had "problems in the field." He could not go up or down hills and was unable to move objects.

On June 4, 2014, Dr. Gee of Hines VA Hospital issued a letter addressed "to whom it may concern" indicating that Petitioner, his patient, "suffers from chronic neck and back pain" and requires a companion dog to move heavier items for him. PX 44.

Dr. Park testified in this case, by way of evidence deposition, on April 23, 2015. Dr. Park identified Park Dep Exhibit 1 as her CV. She testified she is board certified in neurology. She is also co-director of the sleep lab at Hines VA Hospital. PX 7, pp. 4-5.

Dr. Park testified she first saw Petitioner on September 19, 2003. On that date, she saw Petitioner at Hines VA Hospital. Petitioner told her he had been experiencing neck and low back pain for about 21 months, since a work accident. PX 7, pp. 7-8. Specifically, Petitioner told her he was pulling and pushing, while dealing with an 8,000-pound beam, when he heard a pop in his hip and leg. Petitioner related that the task he was performing at the time of the accident was a "two-man job" but that he was performing the task by himself because another worker failed to show up. PX 7, p. 10. Petitioner went on to relate that, a few minutes after the accident, he began experiencing swelling in his right hand, numbness in the left side of his neck and progressively worsening neck and back pain. PX 7, p. 10.

Dr. Park testified that, as a physician, she has to "totally trust" what her patient tells her. PX 7, p. 13.

Dr. Park testified that, on initial examination, Petitioner was "very anxious" but his mental status score was normal. Petitioner's strength was also normal. Sensory examination was abnormal in that Petitioner had a decrease to pinprick on the left side of his neck. PX 7, p. 16. She assessed Petitioner as having neck pain associated with intermittent numbness around the left eye, a sensory deficit of the left side of the neck and possible C3-C4 radiculopathy. She recommended a head MRI, a head and neck angiogram and a neck CT scan. Petitioner's previous cervical spine MRI of August 29, 2003 was abnormal in that it showed osteopenic changes with a subligamentous herniation at C3-C4 and moderate central stenosis at C5-C6. PX 7, p. 18. Petitioner's right hip MRI of September 30, 2003 was also abnormal in that it showed focal findings just medial to the fovea and a questionable ligament tear. PX 7, p. 19. Petitioner underwent another cervical spine MRI in October 2003. That MRI showed normal spine alignment and a small protrusion at C5-C6 with no cord compression or stenosis. PX 7, p. 21. She has no information about Petitioner's pre-accident condition but, if he had back pain before the work accident, "maybe certainly more likely that something happened events after January '02." PX 7, pp. 22-23. She saw Petitioner 21 months after the work accident. Sometimes an injury "doesn't come right away." PX 7, p. 24. "Most likely" there is a connection between the work accident and Petitioner's condition but it is "not definite." PX 7, p. 25. She does not believe that surgery is indicated for Petitioner. PX 7, p. 26. After she saw Petitioner, she had some telephone contact with him in November and December 2003. PX 7, p. 29. She did not actually see Petitioner again until 2011. At that Petitioner was "basically [a] pain man" with "chronic pain syndrome." She last saw Petitioner on April 13, 2015. She believes Petitioner has cervical lordosis but, because she has no pre-accident records, she cannot state with certainty that the accident contributed to or caused this condition. PX 7, pp. 36-37. Petitioner cannot return to work as a pile driver due to the pain in his neck and entire spine. Petitioner cannot bend or lift anything. PX 7, p. 39.

Under cross-examination, Dr. Park testified she reviewed some of the VA records. PX 7, p. 45. If the history Petitioner gave to the providers he saw shortly after the work accident is different from the history he gave her, that would raise a question in her mind as to the accuracy of the history he gave her. She "kind of sorted out" the VA records "very quickly." PX 7, p. 50. She does not know when after the work accident Petitioner first mentioned hip pain. PX 7, pp. 57-58. She is a neurologist. She does not focus on psychiatric care. PX 7, p. 59.

On redirect, Dr. Park testified there is no definite answer to the question of when a person would first feel pain following a back and neck accident. It depends on the person's activity level. PX 7, pp. 52-53. In reviewing the VA records, she read some of Dr. Gee's notes but focused primarily on the MRI results. PX 7, p. 64.

Under re-cross, Dr. Park conceded she does not have information concerning the histories Petitioner provided shortly after the work accident. PX 7, p. 65.

Dr. Ghanayem, Respondent's Section 12 examiner, testified by way of evidence deposition on September 2, 2015. The transcript reflects that Petitioner attended this deposition. The doctor's testimony was consistent with his previous report. He indicated he had no opinions concerning Petitioner's claimed hip injury.

Petitioner testified he worked at VA Hines Hospital from December 29, 2015 until July 2016. [He did not indicate exactly what type of job he held.] He left this job due to his work-related injuries. He was in severe pain and could not push a cart. T. 115-117.

Petitioner testified his condition has not improved. He believes he would pose a safety risk if he resumed pile driving due to the weights involved in that job. Over time, he has looked for other lighter work, primarily desk jobs. [PX 48, a multi-page exhibit, contains a lengthy alphabetical list of businesses, military divisions and governmental agencies Petitioner claims to have contacted while looking for work, along with the dates of contact. The dates range from August 2004 to January 2017. The first page of PX 48 reflects that Petitioner also searched for work through unions, including Local 578, from 2002 to 2016. No actual letters, E-mails, applications or other search-related documents appear in the exhibit.] Before the accident, he operated a "family business" called the Chicago Safety Institute. He has continued operating this business since the accident but his injuries have prevented him from earning the kind of income from the business he feels he could have otherwise earned. His injuries and numerous medical appointments have prevented him from being able to travel to meet with clients and "commit to grants." He is limited to teaching safety-related courses at his residence.

Petitioner testified his injuries have also prevented him from pursuing other occupations for which he is technically qualified. He is unable to perform welding because he would have to sit for extended periods. T. 108. He cannot perform carpentry because that job would require him to operate impact drills. His neck and back pain prevent him from being able to perform a safety hygienist job. T. 112. When he tried to work as a safety hygienist, at the VA, he "had a lot of problems" performing his assigned duties. T. 112. He stopped working in this capacity in July 2013. T. 115.

Petitioner testified he was a member of Local 578, the Commercial Divers and Pile Drivers Union. As of the accident, he earned $29.00 per hour per the union contract. If he could still work as a pile driver, he would now be earning $49.00 per hour, he believes. T. 126.

Petitioner testified that, since the accident, no physician has released him to pile driving or carpentry. No physician has found him to be at maximum medical improvement. In 2003, Dr. Park, a neurologist, told him he would not reach maximum medical improvement.

At the initial hearing of December 13, 2016, the parties agreed to have Dr. Khuans of the VA testify for Petitioner, out of order, before cross-examination of Petitioner. Dr. Khuans testified he became licensed in Illinois in 1976. He has been based at the Jessie Brown VA facility, or its predecessors, for 40 years. T. 148. He obtained board certification in internal medicine in 1976. T. 149.

Dr. Khuans testified he reviewed Petitioner's VA chart along with Dr. Park's deposition in preparation for his court appearance. T. 149-150. [After Respondent raised a Ghere-based objection, Petitioner's counsel conceded he did not provide Respondent with any information concerning the opinions Dr. Khuans formulated after reviewing Dr. Park's deposition. The Arbitrator viewed this objection as valid and allowed the doctor to testify as to opinions he formulated before reviewing this deposition. T. 156.] He also reviewed his own August 2005 discovery deposition. T. 159. It is difficult for him to state when he last saw Petitioner as a patient. Petitioner "stops in to talk to [him] about his medical problems" but not based on scheduled appointments. Petitioner has his own primary care physician. He has never recommended any treatment for Petitioner. T. 170. The VA records he reviewed show that Petitioner had service-connected spinal issues before 2002. T. 171. Those service-related issues made Petitioner more susceptible to suffer an injury in January 2002. T. 172. He does not know whether they made Petitioner more susceptible to further disability. T. 172. An inguinal hernia can be painful. It would more likely than not be disabling for a construction worker. T. 174. Based on the information Petitioner gave him, Petitioner injured his hip in January 2002. T. 175. A foveal ligament tear is "like a hip strain." It can be painful and disabling. T. 175-176. It is his opinion that the right inguinal hernia Petitioner underwent after the work accident was related to that accident. When Petitioner first met his hernia surgeons, he told them the hernia "happened on the job." T. 180. The lifting and exertion Petitioner put forth on January 15, 2002 caused the right hip ligament tear. T. 182. That lifting and exertion could have aggravated pre-existing neck and back pain. T. 183. He does not know whether Petitioner is still suffering from the ligament tear. T. 184. He recalls the letters he issued in 2003, 2004 and 2005, in connection with Petitioner. The letters were true and accurate when written. T. 185. The opinions they contain remain his opinions. T. 186.

Under cross-examination, Dr. Khuans testified he reviewed the treatment records that were created shortly after the accident. He conceded the right hip did not become an issue until "later in 2002." T. 190. Petitioner was "focused on pulmonary and hand" immediately after the accident. T. 191. The post-accident records that mention neck and back complaints reflect that Petitioner attributed those complaints to his service-related motor vehicle accident. T. 192. He would agree with his prior deposition testimony that there is "no way to know" whether Petitioner's neck pain was causally related to the work accident. T. 194-195. He would also agree with his prior testimony that Petitioner's hip, neck and back pain stemmed from the service-related incident in 1979. T. 196. Petitioner had a car accident in 2004 but he did not have the records concerning this because Petitioner treated for the accident at Hines VA rather than Jessie Brown VA. T. 199. Petitioner has a degenerative disc process that will progress, regardless of injury. T. 199. Petitioner has never asked him to change his records but he has seen entries in the VA chart indicating Petitioner asked other physicians to do this. T. 201. He is not a proponent of cervical collars and doubts he would have recommended Petitioner wear a collar. T. 201.

On redirect, Dr. Khuans testified he reviewed Dr. Hoepfner's note of February 15, 2002, referencing a right hip complaint. T. 202. What he knows about the work accident is that Petitioner was moving a very heavy beam. He does not know all of the details. T. 203.

Under re-cross, Dr. Khuans testified he does not recall whether Petitioner underwent hip care before the work accident. T. 205.

The case was then continued to January 17, 2017, by agreement of the parties.

Under cross-examination, at the continued hearing, Petitioner testified his occupations as of the accident were pile driver and safety professional. He was a member of the pile drivers union. His union occasionally sent him to jobs. With respect to his employment by Respondent, he cannot recall whether he learned of the job from a co-worker or his union's business agent. If he was assigned to a job and the job came to an end, he would not go back to the union to seek work. Instead, he would wait for a call.

Petitioner testified he was using a pry bar to stabilize a beam at the time of the accident. As a crane lowered the beam, he used the bar to direct the beam. The beam was made of steel. It was about 3 feet long and ¾ inch around. It had a piece welded onto it.

Petitioner testified he is alleging the accident resulted in multiple injuries. Specifically, he injured his right hand, cervical spine, low back, groin, sciatic nerve and stomach. His stomach was "ripped" when the bar struck his abdomen. He experienced an immediate onset of pain and swelling in the right side of his body. He was not immediately aware of the extent of all of his injuries. "Some diagnostics had to be done by the VA" before he gained this awareness. His wife rendered treatment to him on the day of the accident. He saw Dr. Israel at Concentra the following day. By that time, all of his problems were evident. It was a nurse from TBMK, the joint venture in charge of the Soldier Field job, who sent him to Concentra. He told Dr. Israel and his assistant about using the bar. He also told Dr. Israel he was experiencing pain and swelling in his right hand and neck. The doctor observed his right hand swelling. He also told the doctor about his exposure to asbestos and silica. If the doctor's note states that he reported having had a productive cough for one week, that "sounds inaccurate." He did not use the term "dorsal" when describing his right hand pain to the doctor. The doctor did not touch his hand. He used the term "sharp" to describe the degree of neck pain he was experiencing. Dr. Israel told him he could only undergo treatment for his hand. If the doctor's January 16, 2002 note describes only a right hand injury, the note is "probably wrong." If the doctor's next note, of January 22, 2002, states he reported improvement, that could be correct with respect to his right hand but he complained about his arm. Before the January 22nd visit, he was performing exercises for his right hand by manipulating a "putty ball." Concentra told him it could treat only what Respondent authorized. Concentra did treat his cough and he did undergo chest X-rays there.

Petitioner acknowledged seeing Dr. Hassan and another physician at a VA Emergency Room on January 22, 2002. He complained of shortness of breath on that date. The doctors

looked at his X-ray and recommended further work-up. Petitioner testified that "you can't treat for just anything you like at the VA." He also testified that "you can't give any history you want at the VA" because you see specialists and not generalists. On January 22, 2002, he told VA personnel about the work accident. He complained of pain in his low back and trapezius. He also complained that his right hand was "swollen like a baseball." It was not until January 25, 2002, when he saw a general medicine physician at the VA, that he complained about his abdomen. If the Concentra records of February 1, 2002 mention only his right hand, the records are "incomplete." He was referred to Dr. Nam by another doctor. He saw Dr. Nam, an orthopedic surgeon, on February 1, 2002. He complained to the doctor about his back as well as his hand. If the doctor's records mention only the right hand, it's in the context of the phrase "no direct trauma." He did not tell Dr. Nam his right hand was improving. It was on February 15, 2002, when he saw a different VA orthopedic surgeon, Dr. Hoepfner, that he complained of his right hip. He described his problems to Dr. Hoepfner "in detail," mentioning his back and pelvis. The VA had "old" right hip X-rays available as of his visit to Dr. Hoepfner. He had undergone right hip treatment at the VA in the past, before the accident. Before he saw Dr. Hoepfner, he provided a history to an intake person. Dr. Hoepfner would not have had all of the information concerning the work accident. He does not recall telling Dr. Hoepfner about his abdomen. He does not think Dr. Hoepfner's note is incorrect. After seeing Dr. Hoepfner, he returned to the VA on several occasions for treatment of congestion and a throat problem. His next orthopedic visit was on April 5, 2002, when he saw Dr. Unis. He described the work accident to Dr. Unis. If the doctor's note does not mention the accident, it "should have, but it's not a mistake." He complained of right hip pain and intermittent low back pain. The doctor recommended he continue taking Ibuprofen. On April 30, 2002, he saw Dr. Phillips at the VA. He would have to refresh his memory in order to be able to state whether he provided a history of the work accident to Dr. Phillips. He complained of his cervical spine. If the doctor's note states he reported having "chronic" low back pain since 1979, that is a reference to pre-existing back problems dating back to a service-connected accident. He does not recall undergoing physical therapy at the VA in 1997. He drew a picture of his back for Dr. Phillips and she recommended physical therapy. He acknowledged telling Dr. Phillips he had further aggravated his back the previous weekend when he lifted 30-lb. boxes. At that point, every activity, including lifting only 10 pounds, aggravated his back. "However you spin it," it was the work accident that caused his back problem. He recovered fully from the back problem he had in 1979.

Petitioner testified he did not refuse to undergo an EMG study for his right hand. Rather, the doctors at the VA told him an EMG was "optional" and he said he did not like it.

In response to a question asking whether he went to the VA in December 2002 in order to have his records changed to show a different period of disability, Petitioner testified he requested records anytime he went to the VA. He does not recall the VA refusing to do what he asked. He got Dr. Khuans to write letters on his behalf. If his records indicate he secured a causation-related report from Dr. Ryan, they are correct. If the VA records mention referrals, they are correct. He did see doctors at the referral of other doctors.

Petitioner maintained that, after Concentra referred him to Rush, the physicians at Rush would not see him. If Dr. Cohen's note states that he simply failed to appear, it is not accurate.

In response to a question asking whether his first visit to a VA medical facility occurred on January 22, 2002, Petitioner initially responded by saying he went to the VA "one or two times" before that date. He then stated he did not seek care at the VA "at all" during the ten years preceding the work accident. When asked whether he went to the VA for care on eighteen occasions between 1995 and 2001, he stated he could not recall.

On redirect, Petitioner clarified he was involved in a motor vehicle accident in 1979, while serving in the military. After this accident, he was able to resume working as a pile driver. Before the work accident of January 15, 2002, he was "stronger than [he] had ever been." A January 17, 2002 report concerning his work accident is incorrect in that it mentions "the wrong crane operator." His superintendent would have been required to complete a separate report. This report is missing.

Under re-cross, Petitioner identified PX 15 as a report concerning his work accident. His handwriting does not appear on this report. David Cooper completed this report. There is another report that is missing. It was Wally Stalaga who was operating the crane at the time of the work accident. Petitioner identified PX 21 as an incident report signed by a receptionist at Concentra. No one at Respondent completed this report. It describes his injury as a right hand sprain. The union contract called for him to create a report.

Arbitrator's Credibility Assessment

Petitioner was less than forthright with respect to some of the medical treatment he underwent before the work accident. In response to a question asking whether he had ever had a right-sided hernia before the accident, he stated, "I don't know – not to have surgery where it hurt like that." T. 76. According to the VA records, Petitioner underwent a right inguinal hernia repair on December 29, 1998, only two years before the accident.

Petitioner was also not forthcoming about several post-accident events, including a June 2008 motor vehicle accident that Dr. Stamelos alluded to during his deposition and a June 2010 altercation with police officers.

Respondent views the work accident of January 15, 2002 as causing only a right hand contusion while Petitioner maintains it resulted in significantly disabling injuries to multiple body parts. Petitioner contends that the post-accident records from Concentra mention only a right hand injury because Respondent decreed that Concentra could not address any of his other claimed injuries. The Arbitrator accepts that Petitioner did not choose to go to Concentra and that Respondent sent him there. But even if the Arbitrator went a step further and accepted the premise that Respondent controlled the parameters of care rendered at Concentra, the central problem in this case would not be solved. Dr. Israel of Concentra did address more than just a hand problem in that he evaluated Petitioner's respiratory complaints.

Moreover, within one week of the accident, Petitioner was also undergoing care with various individuals at the Veterans Administration, a medical provider of his own selection. The VA notes of January 22 and 23, 2002 set forth a history of the accident and document only a right hand injury. On February 15, 2002, a month after the accident, Dr. Hoepfner mentioned the right hip as well as the right hand but he did not link the hip to the accident. Just as significantly, he did not note any hip abnormalities on examination. On April 30, 2002, Dr. Philip noted spinal complaints and indicated Petitioner attributed those complaints to his 1979 service-connected motor vehicle accident.

Petitioner is no shrinking violet. During pre-trial discussions and the two hearings, he did not hesitate to make his opinions known. In fact, the Arbitrator had to frequently caution him not to insert himself in the proceedings when he was not testifying. The Arbitrator believes that, if he experienced an abrupt onset of severe pain in his neck, back, right hip, along with "ripping" of his abdomen at the time of the accident, as he testified, he would have mentioned this to his VA providers. The Arbitrator, having combed through hundreds of pages of medical records, concludes that Petitioner did not begin to link body parts other than his right hand to the accident until the latter part of 2002, at which point he had been laid off and needed help with insurance paperwork.

That Petitioner has thoroughly convinced himself that the accident is the cause of his various ailments, is abundantly clear. He has not, however, convinced the Arbitrator.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed accident of January 15, 2002 and his various claimed current conditions of ill-being?

Having assessed Petitioner's credibility and reviewed the entire record, the Arbitrator finds that Petitioner established causation only as to a right hand condition of ill-being that stabilized on July 2, 2002, the date Petitioner declined to undergo previously recommended EMG/NCV testing. In making this finding, the Arbitrator relies primarily on the initial histories in the Concentra and VA records, the history Dr. Philip recorded on April 30, 2002 and the causation-related opinions voiced by Dr. Israel, Dr. Ryan of the VA and Respondent's examiner, Dr. Ghanayem. Of all of the physicians who commented on causation in this case, it appears that Drs. Israel, Ryan and Ghanayem had the best grasp of the histories Petitioner provided during the weeks following the accident. Of the physicians who testified, Dr. Israel was the only one who actually interacted with Petitioner during those weeks.

Petitioner seemed to view the accident report (PX 15) as supporting his claim that he injured more than his right hand. The report does confirm that Petitioner was dealing with a very heavy object and that the crew was likely down one worker. Ultimately, however, it is consistent with a hand injury in that the author described the hickey bar as being "a little small to grip."

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria E. Lule-Saavedra,

Petitioner,

vs. NO. 15 WC026709

Accurate Personnel,

Respondent.

19IWCC0639

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

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

19IWCC0639

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 22 2019
SJM/sj
o-11/13/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

DISSENT

I respectfully dissent from the Majority's Decision as I believe the evidence establishes that Petitioner sustained a compensable right knee injury. The Petitioner testified that she was working without issue on July 23, 2015 when she felt a pop in her right knee and back with pain extending into her neck while supporting a television. She informed her manager of the incident and that she now had pain in her right knee, back and neck from the incident. No evidence was presented showing that the Petitioner had ever experienced any prior issues with her right knee.

Petitioner was referred by her employer to Alexian Brothers for treatment on July 27, and she reported having right knee pain and that the knee would give out. On August 3, she was seen by her family physician, Dr. Barnabas. Following an examination, he diagnosed her with internal derangement of the right knee. An MRI on August 14 was interpreted as showing a torn medial meniscus, with the radiologist also noting effusion. Upon referral from Dr. Barnabas, the Petitioner saw an orthopedic surgeon, Dr. Poepping, on September 2. His exam showed medial joint line pain as well as a positive McMurray's test. After an injection and physical therapy failed to provide any long-term relief, Dr. Poepping on December 14 recommended knee surgery.

In summary, she had a traumatic event wherein she noted immediate knee pain while lifting a heavy object. No evidence was presented showing any prior knee problems. She had a steady stream of treatment after the accident with objective evidence of a torn medial meniscus. After trying conservative treatment, her treating orthopedist recommended surgery. I believe she

19IWCC0639

has proven a causal relationship between the accident and the knee injury and is entitled to receive the treatment prescribed by Dr. Poepping.

D. Douglas McCarthy

Douglas D. McCarthy

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

LULE-SAAVEDRA, MARIA E
Employee/Petitioner

Case# **15WC026709**

ACCURATE PERSONNEL
Employer/Respondent

19IWCC0639

On 7/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% 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:

2234 CHEPOV & SCOTT LLC
NICHOLAS CLIFFORD
5440 N CUMBERLAND AVE STE 150
CHICAGO, IL 60656

2623 McANDREWS & NORGLE LLC
EDWARD JORDAN
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

19IWCC0639

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)

Maria E. Lule-Saavedra
Employee/Petitioner

v.

Accurate Personnel
Employer/Respondent

Case # **15** WC **26709**

Consolidated cases: **N/A**

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

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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, **July 23, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$1,461.00**; the average weekly wage was **$269.11**.

On the date of accident, Petitioner was **38** 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 **$1,693.30** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$1,693.30**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $319.00 to Alexian Brothers Medical Center, $400.00 to Dr. Barnabas, $875.00 to Total Athleticare, $1,894.38 to Lakeshore MRI, $2,109.22 to ATI Physical Therapy, and $500.00 to Dr. Erickson, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any bills paid.

Respondent shall pay Petitioner temporary total disability benefits of $269.11/week for 8 5/7 weeks, commencing August 3, 2015 through October 2, 2015, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $1,693.30 for temporary total disability benefits that have been paid.

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

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

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

Signature of Arbitrator

July 25, 2018
Date

ICArbDec19(b)

JUL 27 2018

Statement of Facts

Petitioner Maria Lule Saavedra testified in Spanish through an interpreter. She testified that prior to the accident on July 23, 2015, she had surgery on her lower back. It was about 13 or 14 years ago. She testified that she had no pain in her lower back after that surgery. She testified that she was employed through Respondent Accurate Personal, a temporary agency. She began working for Respondent on April 9, 2015. On May 14, 2015, Petitioner completed an Essential Job Functions Worksheet indicating that she could stand for long periods, lift and carry up to 25 pounds regularly and reach overhead with 10-25 pounds. She denied any condition or injury that would have an effect on her capacity to perform her job responsibilities and denied any back problems or back injuries (RX 8). At the time of her accident, she had been placed at Micro Systems for 3 to 4 weeks. Her job duties were to take televisions out of the boxes, place them on a table, clean them, wrap them up and return them to the packaging. Depending on the condition of the televisions, she would work on between 12 and 30 sets per day.

Petitioner testified that she sustained an accident at work on July 23, 2015. It happened almost upon the completion of her workday. She had no problems with work duties before the accident. On that day, she had worked on about 25 televisions. Petitioner was taking a heavy 60-inch television out of a cart with another worker. The television was in the cart about a foot off the ground. The cart had barriers three to four feet off the ground. The television needed to be lifted over the barriers. The table was about waist high and 15 feet away. While taking the television to the table, she had to twist around. While supporting the television, she popped her knee, her back and pain went up into her neck. Petitioner testified that a Micro System manager arrived and she told him she was in pain from the television in her knee, her back and her neck. Petitioner testified she attempted to stretch and fell on her knees.

Petitioner went home and used hot towels and pills for the pain. The accident took place on a Thursday. She did not work on Friday. Petitioner testified she asked to go to a doctor on Monday. Respondent sent her to Alexian Brothers. Petitioner testified that she received a superficial examination. Petitioner was seen at Alexian Brothers Medical Group on July 27, 2015 by Dr. Lyman (PX 1). Petitioner provided a history of lifting a TV with another person when she felt pain in the right low back. She reported tingling in the right hand and fingers about 10 minutes later and weakness in her right leg. She stated her right knee would give out. Hand written notes include the history of the prior lumbar disc herniation in 2006. Petitioner had left leg radicular pain at that time. Afterward she reported mild low back pain with no radiation occurs when lifting (PX 1).

The Visit Notes document a detailed physical examination. Posture was normal. Petitioner got up from the chair once using her hands and once without using assistance. The doctor notes that Petitioner rotated her torso to put clothing on a chair without problem, reaction or complaint. Gait was normal. Petitioner had complaints of back pain with heel walking and back and right knee pain on squatting. Strength noted poor effort with stuttering motion. Knee range of motion was full, with good strength. Straight leg raise was negative seated, but with complaints of back pain only when supine. When the right hip is rotated even slightly, she complains of increased right low back pain. Reflexes are normal. Back range of motion is full, with complaints of right low back pain. The neck range of motion is full, with no complaints of pain. Waddell is positive for passive pelvis rotation. Petitioner reported tenderness to even light palpation over the entire right back from the base of the neck and trapezius to T10 and the entire lumbar back, right buttock and hip. Sensation is normal. Petitioner also had extensive complaints in the right hand, fingers and arm (PX 1).

Dr. Lyman notes that when Petitioner was waiting for her papers, she walked down the hall quite normally and was pleasant and smiling. Yet she continued to report 10/10 pain. His impression was that her complaints were grossly diffuse and pain level was inconsistent. He felt that the findings on examination were not consistent or anatomic. He suggested conservative therapy to see if there is any improvement or if the complaints become more localized, consistent and anatomic. If not, he suggested an IME (PX 1). The diagnosis was lumbar strain and right elbow strain. Petitioner was returned to work with restrictions and sent for physical therapy. She was given a follow up appointment for August 3, 2015 (PX 1).

She sought treatment with Dr. Barnabas at Herron Medical Center on August 3, 2015 (PX 2). She reported the history of accident and complained of pain in the right side including her neck, back, right knee, shoulder and hand. She described the pain in her back as 5-6/10. She reported pain that goes down her right leg. She also had pain in the knee, but thinks that is due to the pain in the back. She reported that she had surgery on her lower back about 10 years prior. Physical examination noted cervical paraspinal muscle spasm with painful range of motion and loss of strength. Petitioner reported painful range of motion in the right shoulder. She had painful range of motion and tenderness in the thoracic and lumbar spine. Dr. Barnabas notes loss of strength on the right with positive right straight leg raise. The examination of the right knee was normal. The assessment was multiple conditions of the cervical, thoracic and lumbar spine, right shoulder and right knee. Petitioner was referred for X-rays, referred to physical therapy and was restricted from working. Dr. Barnabas noted that if she was not improved in 2-3 weeks, she can come back for MRIs (PX 2, p 1-3).

Petitioner began physical therapy at Total Athleticare on August 4, 2015. Petitioner had four visits through August 7, 2015. Petitioner was diagnosed with strains to the lumbar spine, thoracic spine, lesions of the cervical spine and shoulder pain. Petitioner underwent chiropractic and physical therapy without any significant gains (PX 3). On August 5, 2015, Petitioner complained of extreme pain. Forward flexion, neck range of motion and knee range of motion were all listed as painful. Strength and reflexes were normal. Petitioner was diagnosed with a cervical sprain/strain and cervicalgia, a lumbar sprain/strain and lumbago, right knee internal derangement and right shoulder impingement syndrome (PX 2, p 4).

Petitioner underwent MRIs at Lakeshore Open MRI on August 14, 2015 to the right shoulder, right knee, and the lumbar spine (PX 4). The records note referral from Dr. Barnabas. The MRI of the right shoulder noted an intact rotator cuff with rotator cuff tendonitis and impingement (PX 4, p 1). The MRI of the lumbar spine noted post-surgical changes at L5-S1 with no disc herniations (PX 4, p 2). The MRI of the right knee noted a tear of the posterior horn of the medial meniscus (PX 4, p 3).

On August 17, 2015, Dr. Barnabas ordered two more weeks of therapy (PX 2, p 6). Petitioner testified that she switched physical therapy providers to ATI on the instructions of the workers' compensation insurance carrier. She participated in seven sessions of physical therapy at ATI from August 20, 2015 through September 3, 2015. The discharge summary notes continued pain in the mid back, on the right side of her neck to her shoulder and down her arm to her hand. She reported no improvement with therapy (PX 5).

Petitioner testified Dr. Barnabas referred her to Dr. Poepping. She saw Dr. Poepping on September 2, 2015. Dr. Poepping's Patient Face Sheets notes the referral (PX 8). The office notes do not reflect a referring physician. Petitioner testified Dr. Poepping treated her for the knee and the arm. Petitioner reported that she was injured at work on July 23, 2015 when she was carrying a 50-inch plasma television. Petitioner complained of pain in her back, neck, right shoulder and right knee. She feels she is getting worse. Physical examination records tenderness in the neck, right shoulder, low back and medial joint line of the right knee.

She had weakness of the rotator cuff and positive Neer's and Hawkin's testing at the shoulder. There was a positive McMurray test on the right knee. Dr. Poepping reviewed Petitioner's MRIs. He diagnosed neck pain, lumbar degenerative disc disease, right shoulder pain, and a right medial meniscal tear. He recommended Petitioner be off work, continue physical therapy, and undergo an MRI of the cervical spine. (PX 8, p 1-2).

Petitioner underwent a MRI of her thoracic spine and cervical spine on September 4, 2015 at Lakeshore Open MRI (PX 4). The thoracic spine MRI noted a 3-4mm posterior disc protrusion/herniation (PX 4, p 4). The cervical spine MRI showed an annular disc bulge at C5-6 with a posterior disc protrusion at C6-7, and herniation at T1-2 (PX 4, p 5). Petitioner saw Dr. Barnabas on September 4, 2015. She stated that therapy made her back worse. Her examination was unchanged. Dr. Barnabas noted a plan for her to see Dr. Poepping and go for a neurosurgical consultation. The patient will see Dr. Giannoulias (PX 8). He kept Petitioner off work through October 2, 2015 (PX 2, p 12).

Petitioner saw Dr. Erickson on September 9, 2015 for her neck and back (PX 10). Physical examination noted cervical and lumbar pain radiating to the right side. She had loss of grip strength and clumsiness in the right hand. He notes she does not seem to be magnifying her symptoms. He performed SSEP tests which noted mild delay in C5-C7. He recommended injections and additional physical therapy (PX 10, p 1-2).

Dr. Poepping provided an injection to the right knee on September 21, 2015 (PX 8, p 4). Petitioner saw Dr. Vargas on referral from Dr. Erickson on September 25, 2015. Dr. Vargas noted Petitioner's history of injury and treatment and her increasing complaints. She described her pain as a constant electrical-like shooting pain in her mid and lower back and radiating into both buttocks and her lower extremities. Her neck pain radiates into both upper extremities with tingling. After examination, Dr. Vargas recommended Petitioner undergo bilateral L5-S1 epidural steroid injections, and possible cervical spine injections. He stated that the course of care was reasonable, necessary and causally related to the accident.

Petitioner saw Dr. Barnabas on September 25, 2015. He noted the consultation with Dr. Vargas for injections. His examination noted 5/5 strength in the upper and lower extremities (PX 2, p 9). Dr. Vargas performed two bilateral L5-S1 epidural steroid injections on October 9, 2015 (PX 12, PX 13). Petitioner saw Dr. Erickson on October 21, 2015. He noted the injections were not effective. SSEP testing of the lower extremities noted delay at S1. He recommended further lumbar injections and an MRI with contrast of the lumbar spine. He noted no indication at present for surgical intervention (PX 10, p 3, PX 11, p 2). Dr. Vargas performed additional lumbar injections on October 23, 2015 (PX 12, PX 13). Petitioner testified that the injections were not helpful. Petitioner underwent a lumbar CT scan on October 30, 2015. The CT scan revealed a 2-3 mm left sided bulge at L4-5 and postsurgical changes at the L5-S1 level with right laminectomy and discectomy changes. A broad-based posterior soft tissue structure appeared to indent the thecal sac measuring approximately 3-4 mm with mild bilateral neuroforaminal narrowing greater on the left. The radiologist opined that this might represent postsurgical epidural scarring with granulation tissue changes, but disk herniation could not be excluded. (PX 14, p 1-2).

Petitioner returned to Dr. Poepping on October 19, 2015. He discussed knee surgery, but recommended therapy first. On November 2, 2015, Dr. Poepping noted the second lumbar injection did not help. Petitioner requested a different pain management specialist. Petitioner also complained of wrist pain and was given a wrist brace (PX 8). Petitioner had therapy at ATI from November 18, 2015 through December 18, 2015 (PX 5). Dr. Poepping injected the right elbow on November 16, 2015. He recommended right knee arthroscopic surgery (PX 8, p 8). Dr. Poepping has continued to recommend surgery and has kept Petitioner on a 5-pound

lifting restriction. She was last seen on June 8, 2016 (PX 8). Petitioner testified she has seen Dr. Poepping in October 2017. Petitioner testified she wants to proceed with surgery.

Petitioner testified that Dr. Poepping referred her to Dr. Kalina because Dr. Vargas was not helping her. Petitioner testified that she only saw Dr. Kalina two times, on November 18, 2015 and December 5, 2015. Dr. Kalina recommended Petitioner take pain medication and restricted her from work. Dr. Kalina referred Petitioner see Dr. Sokolowski (PX 15). Petitioner testified that Dr. Kalina prescribed creams. They were not helpful.

Petitioner first saw Dr. Sokolowski on November 23, 2015 with complaints of pain in her neck, right shoulder, right buttock and right leg, and right knee. Physical examination revealed a mildly positive sagittal profile and restoration to neutral reproduced concordant back pain with radiation to the right. She had a positive right sided straight leg raise with reproduction of radiation. She had tenderness to palpation of her lumbar spine at L5-S1 and her back pain increased with flexion beyond 40 degrees. Strength and sensation were intact. Spurling sign was positive to the right for reproduction of right sided arm pain. Following review of the MRI studies, Dr. Sokolowski diagnosed Petitioner with cervical and lumbar pain and radiculopathy. He noted a combination of discogenic pain and facet joint mediated pain at L5-S1. He discussed the option of an L5-S1 fusion.

On December 14, 2015, Dr. Sokolowski sent Petitioner for provocative discography to confirm her pain generator. He also restricted her from working (PX 16, p 6-7). On February 2, 2016, Dr. Sokolowski noted that he did not have the report of the discogram but that Dr. Kalina confirmed that L5-S1 was the pain generator. Dr. Sokolowski recommended a fusion surgery at L5-S1 (PX 16, p 11-12). Petitioner continued follow up with Dr. Sokolowski. Petitioner last treated with Dr. Sokolowski on March 9, 2018. He continues to recommend fusion surgery at L5-S1 (PX 16, p 28). Petitioner testified she wants to proceed with the surgery. Petitioner has been restricted from working by Dr. Sokolowski. (PX 16).

Dr. Poepping testified by evidence deposition taken December 20, 2016 (PX 18). Dr. Poepping reviewed his treatment records and Dr. Verma's IME report. Dr. Poepping testified to his history and medical examinations and treatment. He did not provide any treatment regarding Petitioner's lumbar spine, cervical spine or shoulder. He noted a positive McMurray's test in the right knee. This is a test for meniscal pathology. Petitioner's right knee MRI showed a medial meniscus tear and was consistent with his examination. Dr. Poepping diagnosed a meniscal tear based on Petitioner's mechanism of injury, his examination and the MRI findings. Dr. Poepping testified that there was a causal connection between Petitioner's alleged mechanism of injury of twisting and his diagnosis of a right knee medial meniscus tear, and recommended surgery that was causally related to the accident. Dr. Poepping testified that the surgery is both diagnostic and treatment (PX 18).

On cross-examination, Dr. Poepping stated that he did not review any medical records other than his chart and Dr. Verma's report. He did not review the Alexian Brothers Medical Center records. He testified that he believed that Petitioner was referred to G&T Orthopedics by Dr. Vargas and/or Windy City Pain Management. He had worked as an independent contractor for Windy City for two to three months. Dr. Poepping stated that the history taken is important in formulating a diagnosis. If the history is inaccurate or incomplete, it might change his opinions. The classic mechanism for a meniscus tear is a weight-bearing twisting injury. All meniscal tears are not attributed to an acute injury. They could be degenerative. Dr. Poepping stated that, assuming it was documented correctly, it would be important that Petitioner's initial presentation to Alexian

Brothers Medical Center did not reference any knee pain or twisting mechanism. He stated that the emergency room history is sometimes not the greatest, but it would also depend on the treating doctor's representation of the history provided (PX 18).

Dr. Verma testified by evidence deposition taken January 18, 2017 (RX 3). Dr. Verma is a board-certified orthopedic surgeon who focuses his practice on knee and shoulder treatment. Dr. Verma testified that he examined Petitioner on October 2, 2015. He testified to the history he took. He testified that he did not see a specific mechanism. It was atypical that she had such diffuse complaints of pain that involved her entire right side. His examination of the right knee noted somewhat of a limp, but when he observed her when she was not looking, she did not have any limp or abnormal gait. Her physical examination was objectively normal with the exception of subjective tenderness that was difficult to rectify from an anatomic consideration or specific injury. Dr. Verma testified his review of the MRI was normal. While there was some signal within the meniscus, it was appropriate age-related degeneration. There were no significant findings of meniscal pathology such as joint effusion. His diagnosis was atypical subjective complaints of pain. He did not see any anatomic basis for Petitioner's right knee pain based upon a clinical examination, review of medical records, Petitioner's history and the MRI films. He stated that Petitioner's symptoms were grossly out of proportion. They do not correspond to either of the pathologies he noted. Dr. Verma testified that the alleged mechanism of injury did not relate to the global nature of Petitioner's alleged injuries and subjective complaints and that her pain complaints were very inconsistent. He opined that the conditions of ill-being in the right knee and right shoulder are not causally related to the injury. He stated Petitioner was at maximum medical improvement and could return to work. Dr. Verma testified that a twisting mechanism would be consistent with a tear. A direct impact to the knee typically would not. Nothing in the history provided by Petitioner and in the medical records reviewed showed anything consistent with a twisting mechanism (RX 3).

Dr. Mark Sokolowski testified by evidence deposition taken January 9, 2017 (PX 19). Dr. Sokolowski testified that he reviewed his records, the MRI studies and the reports of Dr. Verma and Dr. Goldberg. He began treatment of Petitioner on November 23, 2015 on referral from a pain specialist. He testified that his physical examination at that time showed positive right straight leg raise for radicular symptoms and increased back pain with flexion, which are consistent with discogenic pain, pain of the disc, axial back pain. Petitioner had negative motor and sensory examination. He did not find Petitioner was faking or exaggerating. His review of the lumbar MRI noted the prior laminectomy at L5-S1 and disc desiccation with up/down neural foraminal stenosis. She had impingement from the floor and ceiling being closer to one another. He did not recommend injections or physical therapy at that time. Petitioner said she was returned to work full duty and wanted to try to make that return despite her symptoms (PX 19).

He treated Petitioner six additional times through December 20, 2016 for her neck and back complaints. He also provided a shoulder injection in December 2016. Petitioner reported consistent symptoms that were getting worse. He reviewed the CT scan which he testified showed clear up/down neural foraminal stenosis. He recommended a discogram which Dr. Kalina said showed concordant pain at L5-S1 and negative controls at the other tested levels. Dr. Sokolowski prescribed an L5-S1 fusion. He opined that Petitioner's lumbar spine and cervical spine conditions were causally related to the injury based upon Petitioner's physical examination, the MRI findings, the CT scan and discogram. He testified that his recommended treatment was reasonable and necessary. He also opined that Petitioner should have an EMG of the upper extremities to evaluate the shoulder and neck complaints. He testified that Petitioner's lumbar spine diagnosis was lumbar pain and lumbar radiculopathy caused by the work injury. The disc degeneration at L5-S1 had been rendered

symptomatic by the work injury. Dr. Sokolowski testified that the recommendation for the L5-S1 fusion was due to Petitioner's axial back pain, and not radiculopathy or any radicular symptoms (PX 19).

Dr. Sokolowski testified to his review of Dr. Goldberg's report. He testified that the diagnosis of a lumbar strain or sprain is reasonable at two months after the accident. He stated that Dr. Goldberg did not have the benefit of the CT scan or the discogram. Dr. Sokolowski agrees with the reading of the MRI showing disc degeneration without herniation at L5-S1. He agrees that Petitioner does not have horizontal compression caused by a herniation (PX 19).

Dr. Edward Goldberg testified by evidence deposition taken January 9, 2017 (RX 2). Dr. Goldberg is a board-certified orthopedic surgeon who specializes in lumbar and cervical spine conditions. Dr. Goldberg testified he examined Petitioner on September 18, 2015. Petitioner complained of low back and mid thoracic pain. She denied neck pain, radicular pain and any loss of motor function. He testified to review of medical records. His review of the lumbar MRI was some disc degeneration with annular bulging at L5-S1 without herniation. This was consistent with the prior surgery or normal aging. Petitioner's physical examination was normal. There was no evidence of stenosis or pathology at any other level. He noted the MRIs or the cervical and thoracic spine were normal. He diagnosed a lumbar strain causally related to the accident. He testified Petitioner did not require any interventional treatment. Epidurals were not required because she had no radicular complaints. He felt Petitioner needed two more weeks of therapy and should return to work with a 25-pound lifting restriction for those two weeks. Dr. Goldberg testified that the results of a CT and discography could be relevant to his diagnosis. He testified that up/down neural foraminal stenosis did not exist on the MRI. Petitioner had no leg pain so clinically it was not present and/or symptomatic (RX 2).

Petitioner testified that she has worked since the accident for Respondent, Kelly Services and US Staffing. She worked in a toothbrush factory for 3 to 4 weeks putting pieces into a machine. She testified when she was rotated to loading boxes, she was not able because they were too heavy. She worked assembling car stereos at Motorola for one day. She testified it was heavy to operate the drill. She testified she worked in a print shop for 3 to 4 weeks loading cards into boxes. The assignment finished. She testified the walking affected her knee and back. She also worked one day with auto parts. She testified that the bending was tough. She testified she applied for work at three or four other offices in 2015 or 2016.

Employment records indicate Petitioner applied for work at Kelly Services as a temporary worker on December 28, 2015 indicating she was available on December 29, 2015. She worked 8 hour days from January 4, 2016 through February 10, 2016 and April 27, 2016 (PX 9). Petitioner worked at US Staffing from May 27, 2016 through June 18, 2016, working up to 40 hours per week and six hours on September 17, 2016 (RX 10).

Petitioner testified that she continues to experience regular pain in her back, neck, and right knee that has gotten worse since the accident. She testified that her injuries make it difficult to lift household items and make it difficult for her to sleep. She testified that she has increased back pain from sitting or standing for long periods and that her knee pain makes it difficult for her to walk. She performs child care for her three children. She wears a knee brace. She does not use a cane

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. The parties have stipulated that Petitioner sustained an accident on July 23, 2015 while moving a heavy television set. The parties stipulated that Petitioner's complaints in the right elbow are not causally connected to the accident. The Respondent further disputes that Petitioner's current alleged conditions of ill-being in her neck, right shoulder and arm, lower back and right knee are causally connected to the accident. Petitioner has presented the treating records and the testimony of Dr. Poepping and Dr. Sokolowski. Respondent has offered the records of Dr. Lyman at Alexian Brothers Medical Center and the testimony of Dr. Goldberg and Dr. Verma.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

In evaluating the opinions, diagnoses, treatment, and recommendations for further care by the various experts, the Arbitrator notes that an important component in their decisions was an evaluation of Petitioner's history and subjective complaints advanced. Therefore, the Arbitrator's assessment of the credibility of the Petitioner's subjective presentation is an important factor in determining the weight to be given to the various medical opinions. The Arbitrator notes that Petitioner's presentation has been inconsistent and varied during her testimony and the course of her medical care.

Petitioner's description of the accident has shifted during the course of her care. While she has always reported pain while lifting a heavy television set, there is no twisting reported at the emergency room. She reported to Dr. Barnabas that while lifting a TV, the weigh shifted and she felt pain in her right side. Again, no twisting is mentioned. She told Dr. Erickson that she fell slightly and felt a cracking sensation in the neck and low back. Soon thereafter she noted right arm and right knee pain. She said she fell later the same day because of weakness. She testified she fell when she tried to stretch. She reported to Dr. Poepping that she twisted while carrying the TV. She told Dr. Kalina that she was lifting a TV when she felt sudden onset of right shoulder, right knee, right elbow, neck and low back pain. Dr. Sokolowski's history is that she needed to carry the TV around a pole and, because of the height difference with her co-employee, she developed acute onset

of pain in her back, neck, right arm and right leg. In Dr. Verma's history, she told him that the co-worker lifted the TV higher that she did and the force came on her right side with sudden onset of pain in her low back, neck, right arm and entire right leg. She then fell on her right knee while stretching.

There are other discrepancies in the records and testimony. The Arbitrator notes, that told Dr. Erickson she weighed 180 pounds at that time of the accident, but Dr. Barnabas' records note her weight only days after the accident as 195 pounds. Dr. Erickson records her weight in September 2015 as 245 pounds. Dr. Sokolowski's initial November 2015 record has a self-reported weight of 200 pounds.

RX 8, which notes it was electrically signed by Petitioner, denies a prior back injury. Yet Petitioner admits she had surgery to her low back in 2006. She testified that the surgery resolved her back pain, but the hand-written notes from Alexian Brothers state that afterward she reported mild low back pain with no radiation occurs when lifting. Petitioner reported that Dr. Lyman performed a superficial examination, but the records document a detailed physical with notation of extensive subjective complaints, examination of multiple body parts and observations during her stay.

Petitioner's subjective presentation including the location, nature and intensity of her pain has not been consistent with a clinical diagnosis. Dr. Lyman questioned Petitioner's subjective complaints. He documented multiple pain behaviors despite a basically negative physical examination. His impression was that her complaints were grossly diffuse and pain level was inconsistent. He felt that the findings on examination were not consistent or anatomic. Dr. Verma did not see any anatomic basis for Petitioner's right knee pain based upon a clinical examination, review of medical records, Petitioner's history and the MRI films. He stated that Petitioner's symptoms were grossly out of proportion. They do not correspond to either of the pathologies he noted. Dr. Goldberg finds no objective evidence to support Petitioner' subjective complaints of back pain. Both Dr. Verma and Dr. Goldberg read the MRI studies as showing degenerative changes consistent with the aging process or Petitioner's prior back surgery.

Petitioner's complaints also vary from doctor to doctor and visit to visit. As noted above, Petitioner did not advance right knee complaints at Alexian Brothers other that noting her leg gave out. The diagnosis was a lumbar strain. She told Dr. Barnabas that her right leg symptoms were from her back. Petitioner's complaints of radiating pain in her arms and legs are inconsistent. Dr. Erickson notes prominent neck pain and paresthesia in the fingers of the right hand on September 9, 2015. On September 18, 2015, Dr. Goldberg notes Petitioner did not complain of any radicular complaints and no neck pain at all. While Dr. Sokolowski diagnosed lumbar radiculopathy, he testified that Petitioner has principally axial back pain. The surgery he is proposing is not for radiculopathy.

Petitioner's post-accident job history is also inconsistent with the medical presentation. Despite being either placed on very limited lifting restrictions or being taken completely off work, Petitioner has returned to multiple jobs since her injury. The job duties she described are inconsistent with the medical limitations. These temporary assignments were with various agencies. The Arbitrator does not find Petitioner's testimony concerning the physical problems that she encountered while performing the job assignment persuasive.

The Arbitrator observed the Petitioner during her testimony and based upon these observations and upon the voluminous inconsistencies noted above, the Arbitrator does not find the Petitioner's presentation credible with respect to the exact mechanism of accident testified to, the medical history provided, and her subjective complaints. Considering the medical opinions in this light, the Arbitrator finds the opinions of Dr. Verma and

Dr. Goldberg supported by the credible treating records and diagnostic testing and more persuasive that those of Dr. Poepping and Dr. Sokolowski.

Dr. Verma's physical examination was objectively normal with the exception of subjective tenderness that was difficult to rectify from an anatomic consideration or specific injury. Dr. Verma testified the MRI was normal. While there was some signal within the meniscus, it was appropriate age-related degeneration. There were no significant findings of meniscal pathology such as joint effusion. His diagnosis was atypical subjective complaints of pain. He did not see any anatomic basis for Petitioner's right knee pain based upon a clinical examination, review of medical records, Petitioner's history and the MRI films. He opined that the conditions of ill-being in the right knee and right shoulder are not causally related to the injury. Dr. Poepping based his opinion of causation on the history of a twisting injury which is not documented in the initial medical records but rather in Petitioner's subsequent histories. He did not review the initial medical treatment records. His opinion on the existence of a meniscus tear is in part dependent on Petitioner's subjective presentation.

Dr. Sokolowski's opinions on diagnosis, causation and treatment are similarly based upon Petitioner's subjective presentation, which the Arbitrator has discounted due to the multiple inconsistencies noted above. While he testified that the discogram is an important element in his recommendation and diagnosis, he admits he did not review the test but rather relied on a telephone call from Dr. Kalina. Dr. Kalina's records do not contain this important element. Dr. Goldberg noted multiple subjective complaints inconsistent with his objective examination findings. His review of the lumbar MRI was some disc degeneration with annular bulging at L5-S1 without herniation. This was consistent with the prior surgery or normal aging. Petitioner's physical examination was normal. He noted the MRIs of the cervical and thoracic spine were normal. He diagnosed a lumbar strain causally related to the accident. He testified Petitioner did not require any interventional treatment. epidurals were not required because she had no radicular complaints. He felt Petitioner needed two more weeks of therapy and should return to work with a 25-pound lifting restriction for those two weeks. The Arbitrator also notes that Dr. Erickson also felt that Petitioner was not a surgical candidate at the time of his examination despite her presentation to him with significantly greater subjective complaints.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that, as a result of the accidental injury sustained on July 23, 2015, she suffered a lumbar strain as opined by Dr. Goldberg. Petitioner failed to prove she suffered any other conditions of ill-being alleged in the low back, right leg and knee, right arm and shoulder, or neck causally connected to the accident.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). In determining the reasonableness and necessity of treatment, the Commission also has considered whether the records demonstrate subjective or objective improvement or whether the treatment failed to provide demonstrable benefit. *Hugo Alvarez v AMI Bearings*, 16 IWCC 0408; *Nelson Centeno v. Minute Men*, 13 IWCC 0914, affirmed *Centeno v. Illinois Workers' Compensation Commission*, 2016 IL App (2d) 150575WC-U; 2016 Ill. App. Unpub. LEXIS 1261. Based upon the Arbitrator's

finding with respect to Causal Connection, only treatment for the condition of ill-being diagnosed by Dr. Goldberg of a lumbar strain would be causally connected.

Petitioner has submitted alleged unpaid medical bills in PX1 through PX17. Having reviewed the billing and medical records admitted, the Arbitrator finds the following unpaid bills are reasonable, necessary and causally connected:

Alexian Brothers Medical Center (PX 1): $319.00
Dr. Barnabas (PX 2): The Arbitrator finds the office visits are reasonable, necessary and causally related ($400.00). The additional charges for medications are denied. The records do not document the prescriptions and there is no evidence that they provided any improvement.
Total Athleticare (PX 3): $875.00
Lakeshore Open MRI: The charges for the 8/14/15 lumbar spine MRI are reasonable, necessary and causally related ($1,894.38). The remaining charges for the shoulder, knee and cervical and thoracic spine are denied. PX 9 is a duplicate billing for the cervical and thoracic MRIs denied herein.
ATI Physical Therapy: The charges for therapy from 8/20/15 through 9/3/15 are reasonable, necessary and causally related ($2,109.22). The subsequent therapy from 11/18/15 through 12/18/15 is denied as not reasonable, necessary or causally related.
Dr. Erickson (PX 10): The initial consult on 9/9/15 was reasonable, necessary and causally related ($500.00). Per Dr. Goldberg's persuasive opinion that Petitioner would reach MMI with two additional weeks of therapy, the return visit on 10/21/15 and the CT scan ordered are denied.

The Arbitrator finds the remaining bills are denied for the reasons as follows:
Ashland Health (PX 6): The Arbitrator finds no prescription written for this 8/21/18 series of prescriptions: Petitioner testified she did not know of any treatment at this facility and no records were admitted into evidence to support these charges.
Dr. Poepping (PX 8) and Windy City Medical (PX 7): Based on the Arbitrator's finding with respect to Causal Connection and the persuasive opinion of Dr. Verma, these charges for treatment to the right knee are denied. The Arbitrator also notes an unreasonable $400.00 charge by Windy City for transportation.
Lake County Neuromonitoring (PX 11), River North Pain Management (PX 12), Lakeshore Surgery Center (PX 13), Edgebrook Open MRI (PX 14), Dr. Kalina (PX 15), Dr. Sokolowski (PX 16), Prescription Partners (PX 17): These charges are for treatment found unreasonable, unnecessary and not causally related by Dr. Goldberg's persuasive opinion. The Arbitrator notes that Dr. Goldberg specifically stated that injections were not reasonable and further the records confirm that they provided no improvement.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $319.00 to Alexian Brothers Medical Center, $400.00 to Dr. Barnabas, $875.00 to Total Athleticare, $1,894.38 to Lakeshore MRI, $2,109.22 to ATI Physical Therapy, and $500.00 to Dr. Erickson, as provided in Sections 8(a) and 8.2 of the Act. Per the Request for Hearing form (Arb. Ex. 1), Respondent shall receive credit for any bills paid.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Causal Connection and Medical and the persuasive opinions of Dr. Goldberg and Dr. Verma, Petitioner's request for prospective medical care including lumbar fusion, cervical injections, and arthroscopic right knee surgery are denied.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. To show entitlement to TTD benefits, claimant must prove not only that she did not work, but that she was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 666 N.E.2d 827, 217 Ill. Dec. 158 (1996).

Petitioner was first placed on restricted duty by Dr. Lyman on July 27, 2015. There was no testimony or evidence of whether she worked between that date and August 3, 2015 when Dr. Barnabas took her off work. Petitioner is seeking temporary compensation beginning August 3, 2015 (Arb. Ex. 1B). Based upon the Arbitrator's finding with respect to Causal Connection and Dr. Goldberg's persuasive opinion, the Arbitrator finds that at the time of Dr. Goldberg's examination on September 18, 2015, Petitioner was restricted to work with a 25-pound lifting restriction and in need of additional treatment for two more weeks of therapy. Her job for Respondent required lifting heavy TV sets and would not be within the restrictions. No evidence was offered that Petitioner was offered work within her restrictions by Respondent. Dr. Goldberg opined that Petitioner would be maximum medical improvement two weeks following his examination and could return to her regular work as of that date.

The evidence supports this opinion. Petitioner worked multiple jobs beginning in January 2016. Despite being under work restrictions from her treating doctors, Petitioner worked up to 40 hours per week. She also testified that she would have worked a full-time job during this time and also applied for other jobs in 2016. Petitioner's testimony detailing why she stopped each of the jobs was unpersuasive. Petitioner did not show that she was unable to work. Her work activity supports Dr. Goldberg's opinion that she would be at maximum medical improvement and able to resume regular work activities two weeks after his examination which would be as of October 2, 2015.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that she was entitled to temporary total compensation beginning August 3, 2015 through October 2, 2015, a period of 8 5/7 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☐ 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

Fredy E. Mejia,

Petitioner,

vs.

NO: 17 WC 13529

Arthur Schuman Midwest, LLC;
Metro Staff, Inc.,

19IWCC0640

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal relationship, average weekly wage, medical expenses including prospective care, and temporary total disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator regarding case number 17 WC 13529 (D/A- 03/21/17) as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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).

Average Weekly Wage

Pursuant to Section 10 of the Act, overtime hours are explicitly excluded in calculating an employee's average weekly wage. *820 ILCS 305/10* (West 2013). "Overtime includes those hours in excess of an employee's regular weekly hours of employment that he or she is not required to work as a condition of his or her employment or which are not part of a set number of hours consistently worked each week. *Airborne Express, Inc. v. Illinois Workers' Compensation Commission*, 372 Ill. App. 3d 549, 554, 865 N.E.2d 979 (2007).

Petitioner testified he worked twelve-hour shifts, five to seven days a week. T. 28-29. Petitioner's testimony, though, is not supported by his wage records. The wage records evidence Petitioner consistently worked 40 hours per week not 60 hours. PX22; RX2. Moreover, the wage records evidence Petitioner worked varying overtime hours ranging from 5.25 hours to 24.76 hours. The hours are not consistently worked each week, and Petitioner provided no testimony that he was required to work overtime hours.

The Commission finds Petitioner's overtime hours are excluded pursuant to Section 10 of the Act. As such, the Commission finds Petitioner's average weekly wage to equal $354.42. The Commission calculates the average weekly wage as follows: 1) Petitioner worked for 29 weeks prior to his date of accident, 09/04/16 through 03/22/17; 2) for the period of 09/4/16 through 10/12/16, 211.5 hours were worked at an hourly rate of $9.25 totaling $1956.38; 3) for the period of 10/19/16 through 3/22/17, 875.99 hours were worked at an hourly rate of $9.50 totaling $8321.91; and 4) total wages earned equals $10,278.29 divided by 29 weeks worked equaling $354.42.

Medical Expenses

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The same standard applies to prospective medical care. *Homebrite Ace Hardware v. The Industrial Commission*, 351 Ill. App. 3d 333, 814 N.E.2d 126 (2004).

Having affirmed and adopted the Arbitrator's finding as to accident and causation, the Commission awards the outstanding medical expenses contained in PX16, PX17, PX18, PX19, and PX20 pursuant to Section 8(a) and 8.2 of the Act. The Commission further awards prospective medical treatment as recommended by Dr. Atluri, specifically the left shoulder surgical procedure and attendant follow-up care.

Temporary Total Disability Benefits

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Further "[t]he dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [citation omitted]." *Mechanical Devices v. The Industrial Commission*, 344 Ill. App. 3d 752, 759, 800 N.E.2d 819 (2003).

Petitioner continues to be disabled due to his left shoulder condition and has yet to reach maximum medical improvement. Additionally, Petitioner testified since June 30, 2017, Respondent was unable to accommodate his restrictions. As such, Petitioner is awarded temporary total disability benefits for a period of 30 and 4/7 weeks from June 30, 2017 through

19IWCC0640

January 29, 2018, the date of hearing. The award of prospective temporary total disability benefits is stricken. *820 ILCS 305/19(b)* (West 2013).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator regarding 17 WC 13529 filed March 19, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 30 and 4/7 weeks, representing June 30, 2017 through January 29, 2018, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary, and causally related medical expenses incurred in the care and treatment of Petitioner's left shoulder injury as detailed in Petitioner's Exhibits 16, 17, 18, 19, and 20, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent provide and pay for the prospective medical treatment as recommended by Dr. Atluri.

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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 22 2019
LEC/maw
o07/17/19
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen J. Mathis

D. Douglas McCarthy

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MEJIA, FREDY E
Employee/Petitioner

Case# **17WC013529**

17WC019712

ARTHUR SCHUMAN MIDWEST LLC METRO STAFF INC
Employer/Respondent

19IWCC0640

On 3/19/2018, 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 1.85% 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:

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

2284 LAW OFFICE OF LAWRENCE COZZI
MARK ZAPF
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

0159 FRANCIS J DISCIPIO LAW OFFICE
1200 HARGER RD
SUITE 500
OAK BROOK, IL 60521

STATE OF ILLINOIS)

)SS.

COUNTY OF DuPage)

☐ Injured Workers' Benefit Fund (§4(d))

☐ Rate Adjustment Fund (§8(g))

☐ Second Injury Fund (§8(e)18)

☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

19(b)

FREDY E. MEJIA Case # 17 WC 13529

Employee/Petitioner

v. Consolidated cases: 17 WC 19712

ARTHUR SCHUMAN MIDWEST, LLC; METRO STAFF, 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 **Ketki STEFFEN**, Arbitrator of the Commission, in the city of **Wheaton, Illinois**, 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

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

H. ☐ What 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 **Prospective medical treatment**

FINDINGS

On the date of accident, **3/21/17**, 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 $**18,676.80**; the average weekly wage was $**491.49**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **1** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services. Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**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

On **March 21, 2017**, Petitioner sustained an injury to his left shoulder, forearm, elbow, and wrist that arose out of and in the course of employment with Respondents.

Respondent shall pay to Petitioner the following unpaid reasonable and necessary medical expenses owed to: **(1) Hand to Shoulder Associates, a/k/a Hand Surgery Associates – $708.00; (2) Northwest Radiology Associates – $734.00; (3) Physicians Immediate Care – $1,676.11; (4) Physicians Immediate Care Physical Therapy – $891.00; and (5) ATI Physical Therapy – $23,470.57**; pursuant to the Medical Fee Schedule.

Respondent shall pay Petitioner temporary total disability benefits of $327.66/week for **30-3/7** weeks for the period of: **6/30/2017 to 1/29/2018** (the date of the hearing), as provided in Section 8(a) of the Act.

Respondent shall authorize the reasonable and necessary medical treatment, specifically the left shoulder arthroscopy surgical procedure, recommended by **Dr. Atluri**.

Petitioner's request for penalties under Sec. 16, **§19(l) and under §19(k) 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.

KSSteffen — March 13, 2018

Signature of Arbitrator — Date

ICArbDec19(b)

MAR 19 2018

Ghere Ruling

On October 16, 2017, Petitioner was examined by Dr. Neal, Respondents' §12 retained expert, for the June 28, 2017 right shoulder and wrist work related injury. Dr. Neal's October 16, 2017 §12 report was emailed to Petitioner's counsel on Thursday, November 16, 2017 3:56 p.m., approximately 22 hours prior to the deposition. Respondents failed to tender the §12 report to Petitioner's counsel 48-hours prior to the deposition. Petitioners counsel proceeded to fully participate in the deposition and stated that Petitioner was able to prepare for the deposition, inspite of the late notice. Petitioner did make a Ghere objection. The Arbitrator denies Petitioner's request to disregards the October 16, 2017 §12 report itself and strikes all testimony regarding the §12 report from the deposition transcript.

FACTUAL HISTORY

Petitioner, Fredy E. Mejia, a 29-year old, testified that he was an employee of Metro Staff, Inc. working at Arthur Schuman Midwest, LLC, at the time of his March 21, 2017 work injury and his June 28, 2017 work injury (Tr. pgs. 23-24; 44). Petitioner testified that he worked as a machine operator for Respondents for approximately seven (7) months prior to his first work injury on March 31, 2017 (Tr. pgs. 24, 73).

Petitioner operated a machine that made cheese, cookies and crackers for Respondents. Petitioner's duties were to ensure the machine was constantly moving so the oven would not stop (Tr. pgs. 24-26, 28). To do this, he constantly pushed and pulled a plastic board used to dispense cheese into molds with his left arm (Tr. pgs. 24-26, 28). The plastic board he pushed and pulled with his left arm was not equipped with any gripping device such as a handle or lever (Tr. pg. 26). While using his left arm to

operate the machine, he simultaneously used his right arm to pour 8-10 lb. bags of cheese into the vat and used a stick to break up the clusters (Tr. pgs. 24-26, 28).

Petitioner testified that the machine operated on two different speeds, slow and fast. The slow mode required Petitioner to push and pull the board in one-second intervals, while the fast mode required him to push and pull at a much faster and constant rate (Tr. pgs. 27-28). Petitioner testified that he worked 12-hour shifts, 5-7 days per week (Tr. pgs. 28-29). Petitioner's testimony regarding his work schedule is corroborated by the pay stubs entered into evidence as Petitioner's Exhibit Group 22 (Px. Group 22).

a) MARCH 21, 2017 INJURY:

Petitioner testified that he was an employee of Metro Staff, Inc. while working at Arthur Schuman Midwest, LLC when he suffered a work related injury on March 21, 2017 when operating the cheese cracker machine (Tr. pgs. 23-24). Petitioner testified and indicated that after pouring asiago cheese into the vat, it became difficult to push or pull the board he used to operate the machine. The board then became stuck, and he felt a pop in the left shoulder when trying to push the board (Tr. pgs. 29-30). Petitioner felt immense pain to his left shoulder radiating down to his left elbow and arm and was unable to pull the board back (Tr. pg. 30).

Petitioner testified that following his injury, he notified Nelson, the company supervisor at Arthur Schuman. Nelson took over Petitioner's post operating the machine, and Petitioner was sent to pick up garbage for the remainder of the shift (Tr. pgs. 31- 32). The following day, he reported the injury to Claudia at Metro Staff (Tr. pg. 31). Petitioner testified that Nelson told him to continue working because they did not have enough labor, which Petitioner did for a couple of weeks following his March 21,

2017 work injury (Tr. pg. 32). His pain continued, and Petitioner testified that eventually Claudia from Metro Staff, Inc. initiated an injury report and sent him to the doctor (Tr. pg. 33).

On April 11, 2017, Dr. Wollin at Physicians Immediate Care initially saw Petitioner (Px. 13). Petitioner explained to Dr. Wollin how he injured his left shoulder, forearm, elbow and left wrist on March 21, 2017 (Tr. pgs. 33-34). Dr. Wollin noted in his records:

> "Patient states he was working on a machine and for the last 3 weeks due to repetitive movement. The pain is from his left wrist up to his left shoulder with pain focusing on the shoulder. ... Patient has been doing repetitive work with left arm pulling a machine continuously 8 hours a day, now has pain in left shoulder mostly, with also pain in the left elbow and left wrist ..." (Px. 13).

Dr. Wollin examined and took x-rays of Petitioner's left shoulder, elbow and wrist, while noting that Petitioner's pain was from the left wrist up to his left shoulder with greater pain to the shoulder (Px. 13). Dr. Wollin noted tenderness and swelling over the left forearm and to the lateral epicondylitis of the left elbow, tenderness to left deltoid muscle and reduced left shoulder range of motion with pain (Px. 13). Petitioner further testified that Dr. Wollin gave him work restrictions of no lifting more than 10 lbs. and no pushing or pulling with the left arm (Tr. pg. 34). Dr. Wollin ordered Petitioner to avoid: strong gripping with the left hand, to limit repetitive motion with left hand, no lifting over shoulder and no pushing/pulling greater than 10 lbs. and to wear a splint (Px. 13).

Petitioner followed up with Dr. Wollin who noted that he had the same pain in the left shoulder, forearm, elbow and wrist for which he placed the same work restrictions and ordered physical therapy for the left shoulder and wrist (Px. 13). Petitioner participated in the physical therapy program without relief or decrease in pain to the left shoulder, forearm, elbow or wrist (Px. 13).

On May 11, 2017, Petitioner was seen by Dr. Atluri from Hand-to-Shoulder Associates (Tr. pg. 36). He explained to Dr. Atluri how his injury to his left wrist, forearm, elbow and shoulder occurred (Tr. pg. 36). Dr. Atluri noted in his records:

> "Patient reports a left upper extremity injury from March 2017. He states he was using a cheese machine at work for a 12-hour shift. He states this involved gripping with his left hand and pushing and pulling rapidly with his left arm, while pouring cheese into the machine with his right upper extremity. He states that the machine kept getting stuck due to the consistency of the cheese. He states that he developed severe pain in his left shoulder, as well as pain in his left forearm extending into his radial wrist. ... The symptoms have worsening [sic]. Pain has been present for 1 month. Onset was sudden following an accident at work. " (Px. 13).

Dr. Atluri's medical note further indicates that the onset of Petitioner's left shoulder pain was sudden following an accident at work (Px. 13). Dr. Atluri examined the left wrist, forearm and elbow, and noted tenderness at the radial tunnel and the extensor carpi radialis brevis muscle with tendon origin, left lateral elbow pain with grip test, pain with resisted wrist extension test, and pain with resisted forearm supination (Px. 14). An examination of the left shoulder presented global tenderness, limited range of motion with guarding and stiffness (Px. 14). Petitioner tested positive for the Hawkin's and Yergason's sign (Px. 14). Dr. Atluri ordered x-rays. The x-rays revealed a left reduced glenohumeral joint (Px. 14). Dr. Atluri diagnosed Petitioner with a left radial nerve compression and left shoulder joint derangement (Px. 14). He gave Petitioner no use of the left arm work restrictions and ordered an MRI arthrogram of the left shoulder (Px. 14). After May 11, 2017, Petitioner could no longer work as a machine operator and instead worked in a light duty position, performing all his work tasks with the use of his right arm (Tr. pgs. 44-45).

The June 9, 2017 MRI arthrogram showed a left shoulder glenoid labral tear at the anterior and anterior inferior labrum (Px. 15). On June 13, 2017, Dr. Atluri noted

that Petitioner had failed conservative treatment and recommended a left shoulder arthroscopy with a labral repair and possible biceps tenodesis (Px. 15).

Petitioner continued to treat with Dr. Atluri. Physical therapy was ordered for the left shoulder to maintain Petitioner's shoulder motion. Petitioner attended physical therapy at ATI Physical Therapy (Px. 21). The November 21, 2017 physical therapy notes indicate that Petitioner:

> Patient continues to present with impairments involving strength, pain, these deficits limit patient's ability to perform these tasks: lifting overhead, overhead tasks: sustained/repetitive, using heavy machinery/ power tools (Px. 21).

After examination of the left upper extremity, Dr. Atluri noted that Petitioner had functional improvements of the left elbow, forearm, and wrist/hand with therapy but not of the left shoulder, he discontinued physical therapy and again ordered the left shoulder arthroscopy procedure for the labral tear (Px. 14). On January 2, 2018, Dr. Atluri continued to give Petitioner work restrictions of no use of left arm and noted that the surgery was pending approval (Px. 14).

Petitioner testified that he did not undergo surgery for the left shoulder superior labral tear because the insurance company did not approve it (Tr. pg. 39). Petitioner testified that he continues to experience left forearm and elbow pain (Tr. pgs. 40-41). Petitioner still cannot raise his left arm high, he cannot help with the house chores and cannot help at the supermarket like before which he was able to do before the March 21, 2017 work injury (Tr. pgs. 41-42). Petitioner testified that he did not have any pains in his left shoulder or left elbow before March 21, 2017 (Tr. pg. 59). Petitioner further testified that he would undergo the left shoulder surgical procedure if it was approved by workers' compensation (Tr. pg. 40).

b) JUNE 28, 2017 INJURY:

Petitioner testified that on June 28, 2017, he was working light duty at Arthur Schuman Midwest, LLC while still employed by Metro Staff, Inc. (Tr. pg. 44). Petitioner testified that he did not work as a machine operator after 5/11/17 due to the no use of the left arm restrictions imposed by Dr. Atluri (Tr. pg. 45). Petitioner testified that he performed various functions at work but only with his dominant right arm due to the left arm restrictions (Tr. pgs. 44-45, 51).

Petitioner testified that one of his functions was to lift and pull pallets carrying cheese from the freezer with a pallet jack; and he would place the pallets next to the machines for the machine operators (Tr. pgs. 44-45). Petitioner testified that he would also pull and push pallets carrying boxed cheese crackers that weighed about 720 lbs. with the use of either a manual or electric pallet jack to an area where he would have to seal each individual box (Tr. pgs. 33-34, 75). Petitioner further testified that he had to pass each box through a nylon seal machine manually (Tr. pgs. 44-45).

Petitioner testified that on June 28, 2017, he felt strong pain to his right shoulder when pulling and pushing a manual pallet jack, and that due to all the repetitive movements he had developed a cyst on his right wrist (Tr. pgs. 45-47, 75). Petitioner further testified that the cyst was like a small ball that caused him pain when he would want to move his right wrist (Tr. pgs. 46-47).

Petitioner testified that he notified his supervisor, Nelson, of his work injury on June 28, 2018 (Tr. pg. 47). On June 30, 2017, Petitioner notified Estella from Metro Staff of the work injury to the right arm; and Estella sent Petitioner to Physicians Immediate Care that same day (Tr. pgs. 47-48).

On June 30, 2017, Dr. Wollin examined Petitioner's right shoulder and wrist and noted the following in his records:

> "Patient states he is having right wrist and shoulder pain now since he has to primarily use this arm instead of his left which he injured previously. He has been using his right arm only to work, starting 2 days ago he developed pain to his right posterior shoulder and to the dorsum of his right wrist." (Px. 13).

Dr. Wollin's medical records indicate that Petitioner's right wrist and shoulder pain complaints had a gradual onset, and that the pain was worse when working (Px. 13). On examination, Dr. Wollin noted tenderness to the right supraspinatus tendon and over the right trapezius muscle, a tender rotator cuff and biceps tendon, and tenderness to mid dorsum wrist and extensor tendon with a ganglion cyst over the dorsum wrist (Px. 13). Dr. Wollin ordered physical therapy for the right shoulder and right wrist, gave Petitioner work restrictions of no lifting over shoulder greater than 0 lbs., to limit repetitive motion with right hand, to wear splint, and prescribed Deltasone to reduce the inflammation (Px. 13).

On July 14, 2017, Dr. Wollin recommended that Petitioner continue physical therapy for the right wrist and shoulder and ordered an MRI of the right shoulder (Px. 13). Physicians Immediate Care's activity log regarding the right shoulder MRI notes that the facility received a call on July 20, 2017 from the worker's comp. adjuster stating the claim was disputed and that nothing would be authorized "for now" (Px. 13).

On July 28, 2017, Dr. Wollin noted that Petitioner had right shoulder pain upon abduction and pronation of the right shoulder with sharp pain present at the lateral to anterior aspect of shoulder with radiation to the neck and down to the forearm with a tingling sensation in his fingers (Px. 13). Dr. Wollin also noted that approval for both the right shoulder MRI and physical therapy was pending (Px. 13). Dr. Wollin's notes indicate that Petitioner wanted to continue therapy as it was helping his right forearm and wrist pain (Px. 13).

On August 3, 2017, Petitioner was seen by Dr. Boersma at Physicians Immediate Care (Px. 13). Dr. Boersma's August 3, 2017 records document right shoulder and deltoid pain, severe tenderness over bone and muscle and over dorsal and palmar wrist, severe tenderness over the right palm and muscles, reduced dorsiflexion, volar flexion, radial and ulnar flexion, reduced forearm pronation and supination with pain (Px. 13). He prescribed Petitioner Mobic (Px. 13). Dr. Boersma ordered no exercise of the right arm or wrist/hand, avoid strong gripping, limit repetitive motion with right hand, no lifting over shoulder and no lifting from waist to shoulder greater than 5 lbs. (Px. 13). Based on the physical examination, Dr. Boersma also recommended a right shoulder MRI and pain management evaluation (Px. 13). On August 11, 2017, Petitioner was given work restrictions of no exercise of the right arm or wrist/hand, limit repetitive motion of right hand/arm and shoulder, and was told to consider a right shoulder steroid injection (Px. 13).

Petitioner testified that he told his treating physician, Dr. Atluri, about his right arm injury and complaints, but Dr. Atluri could not treat him without authorization from the insurance company (Tr. pg. 73). The July 6, 2017 medical note indicates that Dr. Atluri requested authorization to treat the right shoulder and wrist injury; however the workers' compensation insurance carrier denied it (Px. 14).

Petitioner further testified that he underwent physical therapy for only a few weeks but was unable to receive any further treatment because the workers' compensation insurance denied further treatment and denied authorization for the right shoulder MRI (Tr. pgs. 51-52). Petitioner testified that Metro Staff, Inc. and Arthur Schuman Midwest, LLC were unable to accommodate the work restrictions imposed by Dr. Wollin (Tr. pgs. 48-49). Petitioner testified that he continues to have right shoulder

pain (Tr. pg. 52). He cannot use his right arm without experiencing pain over the top of the shoulder or wrist pain. Petitioner testified that he has not worked since June 30, 2017 and has not received any temporary total disability benefits since said date (Tr. pgs. 51-52).

FINDINGS/ANALYSIS

WITH RESPECT TO ISSUE C, ISSUE E AND ISSUE F – DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENTS?

WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENTS?

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

THE ARBITRATOR FINDS AS FOLLOWS:

a) MARCH 21, 2017 INJURY:

The medical records corroborate Petitioner's testimony that he suffered a work injury on March 21, 2017 while he was working as a machine operator as an employee of Metro Staff, Inc., working at the Arthur Schuman Midwest, LLC plant. Furthermore, Petitioner's description of injury, of operating a machine that required him to constantly and forcefully push a board with his left upper extremity, is consistently reflected in Dr. Atluri and Dr. Wollin's medical records admitted into evidence and in his testimony.

On June 21, 2017, Petitioner was examined by Dr. Neal, Respondents' §12 retained expert. Dr. Neal testified that he asked Petitioner to remove the brace from his left forearm, wrist, and hand and to remove his shirt (Rx. 1, pg. 15). Dr. Neal further testified that Petitioner unbuttoned his shirt using only his right hand and kept his left arm very still and at his side (Rx. 1, pg. 15). Dr. Neal testified that Petitioner's left upper extremity movement was tremendously guarded (Rx. 1, pg. 16). Dr. Neal also testified that there was a greater examination of the left shoulder in comparison to the

left elbow, forearm or wrist, while noting that left wrist range of motion was painful (Rx. 1, pg. 57). Moreover, Dr. Neal agreed that the MRI arthrogram demonstrated evidence of a superior labral tear (Rx. 1, pg. 59).

Dr. Neal testified that an acute labral tear could be the result of a traumatic injury of an outstretched arm (Rx. 1, pg. 63). Moreover, Dr. Neal agrees that a shoulder labrum tear can occur if a person dislocates their shoulder as a result of a work related activity (Rx. 1, pgs. 64-65). Dr. Neal testified that he did not read Petitioner's job description, did not know how much force Petitioner had to apply while operating the cookie machine, or how often Petitioner had to push and pull with his left shoulder (Rx. 1, pgs. 70-71).

Dr. Neal testified that a labral tear would elicit pain located superiorly and anteriorly (Rx. 1, pg. 60). Further, Dr. Neal testified that a person with a labral tear injury could have pain placing their arm in overheard or elevated positions (Rx. 1, pg. 66). Dr. Neal's observations and examination of Petitioner's left upper extremity are consistent with his medical opinions regarding the symptomology of a labral tear. However, Dr. Neal concluded that Petitioner did not suffer a March 21, 2017 work related injury based on his observations and the arthrogram report.

The Arbitrator discounts Dr. Neals opinion because it fails to account for the fact that the Petitioner had no prior left shoulder, elbow, forearm or wrist injuries and no medical treatment to said body parts prior to the March 21, 2017 work injury. The Arbitrator also notes that Petitioner worked as a machine operator, a physically demanding job that required Petitioner to use constant force to push and pull a plastic board with his left arm, while he simultaneously used his right arm to pour cheese into the vat during his 12-hour shift. The Arbitrator notes that Petitioner was required to

work 12-hour shifts, 5-7 days per week for approximately seven months prior to the work injury. The mechanism of the injury corroborated Petitioner's subjective complaints and his treating physicians diagnosis. Therefore, the Arbitrator finds that Petitioner sustained a work related injury on March 21, 2017 when he forcefully pushed the board on the machine which resulted in a left shoulder labral tear and left radial nerve compression. The Arbitrator notes that although Dr. Neal does not find causation, he does not disagree with the objective findings of a labral tear. His notes do not show that Petitioner was exaggerating his symptoms or that there was a disconnect between Petitioner's subjective complaints and the objective medical findings. Therefore, the Arbitrator affords less weight to IME Dr. Neal opinion.

The Arbitrator also finds that Petitioner reported his injury to Nelson, the plant supervisor at Arthur Schuman Midwest, LLC, on the same day, and reported the injury to Claudia from Metro Staff, Inc., the following day. This further strengthen Petitioner's claim that he suffered a work injury. There is no evidence to refute Petitioner's testimony as to notice. Therefore, Respondents' claim that there was no notice given to the employer regarding the March 21, 2017 injury is denied. The Arbitrator specifically notes that medical authorization was given by a Metro Staff employee, Marisol Glaser, on April 10, 2017 which is contained in the Physician Immediate Care medical records admitted into evidence. The Arbitrator finds notice was given since Petitioner's medical treatment for the work injury was authorized by his employer.

The Arbitrator finds that, looking at the totality of the evidence, the opinions of Petitioner's treating physicians, Dr. Prasant Atluri, orthopedic surgeon, and Dr. Wollin, the Physicians Immediate Care physician, are more credible than the opinion of Respondents' retained medical expert, Dr. Neal. Dr. Neal's testimony that a person

suffering from a labral tear injury would have pain placing their arm in overhead or elevated positions coupled with the fact that he agrees that the arthrogram shows that Petitioner has a labral tear is inconsistent and disingenuous with his conclusory opinion that Petitioner did not suffer a work injury on March 21, 2017. Specifically, the Arbitrator notes that Dr. Neal also observed that Petitioner's left shoulder movement was guarded and accepted that Petitioner has subjective medical findings of a labral tear. Dr. Neal's failure to account for Petitioner's mechanism of injury weakens his final opinion.

The Arbitrator finds that Petitioner testified consistently with the medical records. Accordingly, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment with Respondents. Further, the Arbitrator finds the Petitioner's current condition of ill-being (left shoulder, elbow, forearm and wrist) is causally related to his work injury of March 21, 2017, and that timely notice was unequivocally given to Respondents.

As an additional note, the Arbitrator finds the Petitioner to be credible on the issue of the mechanism of the injury. The Petitioner was involved in repetitive type work but also suffered a specific accident. He testified that on March 21, 2017 he was constantly and forcefully pushing a board with his left arm when he was injured. In the Arbitrator's estimation Petitioner's testimony that he was involved in repetitive work but that the traumatic injury occurred on a specific day does not diminish his credibility. The Arbitrator notes that Petitioner's descriptions of his work injury to Dr. Atluri and Dr. Wollin's are consistent with his testimony.

b) JUNE 28, 2017 INJURY:

After the March 21, 2017 injury to his left extremity, Petitioner continued to work using his dominant right arm. On June 28, 2017, Petitioner was operating a pallet jack.

The pallet jack at the employer's business was either manual or electric and the operated the pallet jack to deliver cheese to the operators. Petitioner also operated a nylon seal machine to seal the cheese. Petitioner claims that he injured his right shoulder when operating a manual pallet jack on June 28, 2017. He claims that he develoved a cyst on his right wrist. (Tr. pgs. 45-47, 75). Petitioner testified that he notified his supervisor, Nelson, of his work injury on June 28, 2018 (Tr. pg. 47). On June 30, 2017, Petitioner notified Estella from Metro Staff of the work injury to the right arm; and Estella sent Petitioner to Physicians Immediate Care that same day (Tr. pgs. 47-48).

On June 30, 2017, Dr. Wollin examined Petitioner's right shoulder and wrist and noted the following in his records:

> "Patient states he is having right wrist and shoulder pain now since he has to primarily use this arm instead of his left which he injured previously. He has been using his right arm only to work, starting 2 days ago he developed pain to his right posterior shoulder and to the dorsum of his right wrist." (Px. 13).

Dr. Wollin's medical records indicate that Petitioner's right wrist and shoulder pain complaints had a gradual onset, and that the pain was worse when working (Px. 13). On examination, Dr. Wollin noted tenderness to the right supraspinatus tendon and over the right trapezius muscle, a tender rotator cuff and biceps tendon, and tenderness to mid dorsum wrist and extensor tendon with a ganglion cyst over the dorsum wrist (Px. 13). Dr. Wollin ordered physical therapy for the right shoulder and right wrist, gave Petitioner work restrictions of no lifting over shoulder greater than 0 lbs., to limit repetitive motion with right hand, to wear splint, and prescribed Deltasone to reduce the inflammation (Px. 13).

Approval for both the right shoulder MRI and physical therapy (besides a few sessions) was denied. On August 3, 2017, Petitioner was seen by Dr. Boersma at Physicians Immediate Care (Px. 13). Dr. Boersma's records document right shoulder and deltoid pain, severe tenderness over bone and muscle and over dorsal and palmar wrist, severe tenderness over the right palm and muscles, reduced dorsiflexion, volar flexion, radial and ulnar flexion, reduced forearm pronation and supination with pain (Px. 13). Dr. Boersma also recommended a right shoulder MRI and pain management evaluation (Px. 13). On August 11, 2017, Petitioner was given work restrictions of no exercise of the right arm or wrist/hand, limit repetitive motion of right hand/arm and shoulder, and was told to consider a right shoulder steroid injection (Px. 13).

Petitioner testified that the employer could not accommodate his restrictions so he could not return to work. He has not worked since June 30, 2017 and has not received any temporary total disability benefits since said date (Tr. pgs. 51-52). Petitioner requests the MRI, pain management and physical therapy as recommended by his physicians Dr. Wollin and Dr. Boersma.

The Respondent argues that the Petitioner's did not suffer a work accident and therefore is not entitled to any benefits (TTD or medical) because he has given inconsistent accounts of how his injury occurred. The Respondent points to the lack of specificity of whether the Petitioner suffered repetitive trauma injury or a specific date injury. The Respondent also points out that the Petitioner's testimony about the weight of the box of cheese that Petitioner said he was holding during his accident is inconsistent. (10 lbs. vs. 18 lbs) Although the Arbitrator concedes that there are minor inconsistencies in Petitioner's testimony and that his account of his injury included both,

repetitive trauma as well as specific injury, the Arbitrator does not find the same as detrimental to Petitioner's case.

This is mainly so because the medical records corroborate Petitioner's testimony that he suffered a work injury on June 28, 2017 as a result of having no use of the left upper extremity; and he could only perform his job duties with the use of his right upper extremity. Petitioner's description of injury is consistently reflected in the medical records admitted into evidence and in his testimony.

On October 16, 2017, Petitioner was examined by Dr. Neal, Respondents' §12 retained expert, for the June 28, 2017 right shoulder and wrist work related injury. Petitioner argues that Dr. Neal's testimony regarding the June 28, 2017 work related injury should be given little to no deference. Dr. Neal testified that he did not know how long Petitioner had exclusively used the right upper extremity at work during his 12-hour shifts prior to the June 28, 2017 work injury (Rx. 1, pgs. 81-82). Dr. Neal testified that he did not know that Petitioner operated a pallet jack and also did not know how much weight or force Petitioner had to apply to maneuver it (Rx. 1, pgs. 82-83). Dr. Neal agrees that repetitive injuries can cause ganglion cysts (Rx. 1, pgs. 77-79). Dr. Neal testified that he believed an MRI of the right shoulder would be useful to explain Petitioner's symptomology; and he would not disagree if someone wanted to order it (Rx. 1, pgs.84).

The Arbitrator gives greater deference to the opinions of the two treating physicians than that of Respondents' §12 examiner based on the totality of the evidence. The Arbitrator notes that Petitioner had no prior right shoulder, forearm, or wrist/hand injuries and no medical treatment to said body parts prior to the June 28, 2017 work injury. The Arbitrator notes that Petitioner was working for Metro Staff, Inc.,

at Arthur Schuman Midwest, LLC, with work restrictions of no strong gripping with the left hand, to limit repetitive motion with left hand, no over the shoulder lifting, and no pushing/pulling greater than 10 lbs. since April 2017. The Arbitrator notes that prior to the June 28, 2017 work related injury, Petitioner was working with only his right arm due to the no use of the left arm work restrictions imposed by Dr. Atluri since May 11, 2017.

Petitioner reported his injury to Nelson the plant supervisor at Arthur Schuman Midwest, LLC, immediately following the incident. Petitioner also reported the June 28, 2017 injury to Estela an employee from Metro Staff, Inc. Respondents' assertion that there was no notice given to Respondents regarding the June 28, 2017 injury is without merit. Petitioner's medical records contain a medical authorization given by two Metro Staff, Inc., employees, Monique Edwards and Marisol Glaser, on 6/30/2017. Based on the totality of the above evidence, notice was clearly provided.

The Arbitrator finds that Petitioner testified credibly coupled with the medical records. Therefore, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment with Respondents on June 28, 2017. Further, the Arbitrator finds the Petitioner's current condition of ill-being (right shoulder, forearm and wrist/hand) is causally related to the gradual work injury of June 28, 2017, and that timely notice was unequivocally given to Respondents.

WITH RESPECT TO ISSUE G – WHAT WERE PETITIONER'S EARNINGS?

THE ARBITRATOR FINDS AS FOLLOWS: The Arbitrator finds Petitioner credible and finds that he worked 12-hour shifts on average 5-7 days per week and earned $9.50/hour. The Arbitrator finds that the Petitioner worked an average of 60-84 hours per week, and that there were weeks in which Petitioner worked less than five (5) days. The Arbitrator finds that Petitioner's pay stubs entered into evidence accurately reflect

that overtime was consistent and required, and that Petitioner worked for approximately nine (9) months before the June 28, 2017 work injury.

Where the employment prior to the injury extended over a period of less than 52 weeks the method of dividing the earnings during that period by the number of weeks and parts thereof shall be followed. 820 ILCS 305/10. Petitioner's pay stubs document that he worked 38 out of the 52 weeks in the year prior to his work accident. Therefore, the Arbitrator finds that Petitioner earned $18,676.80, and pursuant to §10 of the Act, Petitioner's average weekly wage is $491.49 ($18,676.80 ÷ 38 = $491.49).

WITH RESPECT TO ISSUE J – WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAVE RESPONDENTS PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

THE ARBITRATOR FINDS AS FOLLOWS: The Arbitrator incorporates her findings of ISSUE C, ISSUE E, and ISSUE F into ISSUE J herein.

Petitioner currently has numerous medical bills, listed below, that have not been paid by Respondents since they dispute that Petitioner suffered work injuries on March 21, 2017 and on June 28, 2017. The Arbitrator has already determined liability in the form of causal connection between Petitioner's March 21, 2017 and June 28, 2017 work injuries and his current condition of ill-being.

Exhibit	Medical Provider	Amt. of Bill
Px# 16	Hand to Shoulder Associates, a/k/a Hand Surgery Associates	$ 708.00
Px# 17	Northwest Radiology Associates	734.00
Px# 18	Physicians Immediate Care	1,676.11
Px# 19	Physicians Immediate Care Physical Therapy	891.00
Px# 20	ATI Physical Therapy	23,470.57
	TOTAL	$ 27,479.68

The Arbitrator has reviewed Petitioner's medical records and bills and finds that these bills were unpaid by the workers' compensation carrier, and that the medical

records document that the only services that Petitioner received were for problems associated with the March 21, 2017 and the June 28, 2017 work injuries.

The Arbitrator finds that the medical expenses are consistent with the medical treatment reflected in the medical records for such services. The Arbitrator specifically notes the medical treatment received by Petitioner was reasonable and necessary to treat his March 21, 2017 and June 28, 2017 work injuries. Based upon the medical records admitted into evidence along with Petitioner's unrebutted testimony, the Arbitrator orders Respondents to pay Petitioner the reasonable and necessary medical expenses (Px. 16, Px. 17, Px. 18, Px. 19, & Px. 20) incurred in the care and treatment which medical bills total $27,479.68. All awarded medical bills are to be paid subject to the fee schedule.

WITH RESPECT TO ISSUE K – IS PETITIONER ENTITLED TO PROSPECTIVE MEDICAL CARE? THE ARBITRATOR FINDS AS FOLLOWS:

PROSPECTIVE MEDICAL RELATING TO MARCH 21, 2017 INJURY:

The Arbitrator notes that Petitioner had no prior left shoulder, elbow, forearm or wrist injuries and no medical treatment to said body parts prior to the March 21, 2017 work injury. The Arbitrator also notes that Petitioner worked as a machine operator, a physically demanding job, working 12-hour shifts, 5-7 days per week for approximately seven (7) months prior to the work injury.

The Arbitrator finds that, when looking at the totality of the evidence, the opinions of Petitioner's treating physicians, Dr. Prasant Atluri, orthopedic surgeon, and Dr. Wollin, the Physicians Immediate Care physician, are more credible than the opinions of Respondents' retained medical expert, Dr. Neal. Further, the Arbitrator finds that Dr.

Neal's opinions and diagnosis regarding the left shoulder, forearm, elbow and wrist to be conflicting to the objective observations, his medical expertise and his testimony in which he admits that Petitioner has a left shoulder labral tear. The Arbitrator finds that Petitioner testified credibly coupled with the medical records.

Accordingly, the Arbitrator found that the Petitioner's current condition of ill-being (left shoulder, elbow, forearm and wrist) is causally related to his work injury of March 21, 2017, and that Petitioner continues to have pain to the left shoulder.

Since the Arbitrator finds liability in favor of Petitioner, she also finds the prospective medical issue, *i.e.* the left shoulder surgery recommended by Dr. Atluri, in favor of Petitioner. Therefore, Respondents are ordered to authorize and pay for the medical expenses related to the surgery recommended by Dr. Atluri.

PROSPECTIVE MEDICAL RELATING TO JUNE 28, 2017 INJURY:

The Arbitrator notes that Petitioner had no prior right shoulder, forearm, or wrist/hand injuries and no medical treatment to said body parts prior to the June 28, 2017 gradual work injury. The Arbitrator finds that the opinions of the two physicians from Physicians Immediate Care, Dr. Boersma, DO and Dr. Wollin, are more credible and disregards Dr. Neal's testimony regarding the right upper extremity work related injury due to a *Ghere* violation in the October 16, 2017 §12 report. In the alternative, the Arbitrator notes that Dr. Neal testified that Petitioner did not suffer a right upper extremity work related injury, but agreed that an MRI of the right shoulder would be useful to explain Petitioner's symptomology and would not disagree if someone wanted to order it.

The Arbitrator finds that Petitioner testified credibly coupled with the medical records. Further, the Arbitrator finds the Petitioner's current condition of ill-being (right

shoulder, forearm and wrist/hand) is causally related to his gradual work injury of June 28, 2017. Since the Arbitrator finds liability in favor of Petitioner, he also finds the prospective medical issue, *i.e.* physical therapy for the right wrist and shoulder and the right shoulder MRI recommended by both Dr. Wollin and Dr. Boersma. Therefore, Respondents are ordered to authorize and pay for the medical expenses related to the right upper extremity, right shoulder MRI and and physical therapy as recommended by Petitoner's treating doctors.

WITH RESPECT TO ISSUE L – WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator has already determined Petitioner's AWW is $491.49. Therefore, Petitioner's TTD rate is $327.66/wk. The Arbitrator further finds that Petitioner has not been released back to work; and no treating physician has stated that Petitioner is at MMI of either the left or the right upper extremity. The medical records demonstrate Petitioner has work restrictions of no use of the left arm, and limited repetitive motion of the right arm, hand and wrist, avoid strong gripping, no lifting over the shoulder and no lifting from waist to shoulder greater than 5 lbs. which Respondents did not accommodate.

The Arbitrator finds that while Respondents rely on the opinion of its §12 examiner as its basis for denying Petitioner's temporary total disability, Respondents no longer have a good faith basis to deny said benefits given that this Arbitrator found that the deposition testimony regarding the October 16, 2017 §12 report to be a *Ghere* violation. As such, Respondents have effectively waived any and all reasonable basis to deny Petitioner temporary total disability benefits. Accordingly, the Arbitrator finds that there is no medical basis for Respondents' refusal to pay Petitioner's temporary total disability benefits which he is entitled to as provided in Section 8(a) of the Act.

Moreover, the Arbitrator finds Petitioner's testimony of continued bilateral upper extremity limitations coupled with the medical records, and his work status restrictions that he is not able to work, credible.

Therefore, the Arbitrator finds that based on the medical records admitted into evidence, Petitioner's unrebutted testimony, along with the Arbitrator's findings of causal connection between Petitioner's March 21, 2017 and June 28, 2017 work injuries, Petitioner is entitled to temporary total disability benefits from: June 30, 2017 through January 29, 2018 (the last date of hearing) which represents **30-3/7 weeks.** The Arbitrator orders Respondents to pay Petitioner a total of **$9,970.23** (30-3/7 weeks x $327.66) in back temporary total disability benefits. The Arbitrator also finds that Petitioner is entitled to temporary total disability benefits from January 30, 2018 through the present and orders Respondents to issue Petitioner's temporary total disability benefits, so long as Respondent is unable to accommodate Petitioner's work restrictions.

WITH RESPECT TO ISSUE M – IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO ISSUE M - SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENTS?

The Arbitrator has already determined liability in the form of causal connection between Petitioner's March 21, 2017 and June 28, 2017 work injuries and his current condition. The Arbitrator finds that the Respondents relied on the opinion of its §12 examiner as its basis for denying Petitioner's medical treatment, recommended surgery and TTD benefits. Although the Arbitrator disagreed with the Dr. Neal's final opinion, the Arbitrator finds that the Respondents had a good faith basis to deny liability. The Arbitrator does not find, based on the totality of the evidence that the Respondents

actions were unreasonable or vexatious. Therefore, the Arbitrator denies penalties under Sections 16, 19 (l) and 19(k).

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

FREDY E. MEJIA,

Petitioner,

vs. NO: 17 WC 19712

ARTHUR SCHUMAN MIDWEST, LLC;
METRO STAFFING, INC.,

19IWCC0641

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal relationship, average weekly wage, medical expenses including prospective care, and temporary total disability benefits, and being advised of the facts and law, reverses the Decision of the Arbitrator regarding case number 17 WC 19712 (D/A- 06/28/17), as stated below, but does incorporate the Arbitrator's factual findings as part of the Commission's decision. The Commission finds Petitioner failed to prove he sustained an accidental injury arising out of his employment on June 28, 2017 and failed to prove his condition of ill-being as it relates to his right shoulder is causally related to the alleged accident. All benefits are denied.

Average Weekly Wage

Pursuant to Section 10 of the Act, overtime hours are explicitly excluded in calculating an employee's average weekly wage. *820 ILCS 305/10* (West 2013). "Overtime includes those hours in excess of an employee's regular weekly hours of employment that he or she is not required to work as a condition of his or her employment or which are not part of a set number of hours consistently worked each week." *Airborne Express, Inc. v. Illinois Workers' Compensation Commission*, 372 Ill. App. 3d 549, 554, 865 N.E.2d 979 (2007).

Petitioner testified he worked twelve-hour shifts, five to seven days a week. T. 28-29. Petitioner's testimony, though, is not supported by his wage records. The wage records evidence Petitioner consistently worked 40 hours per week not 60 hours. PX22; RX2. Moreover, the wage records evidence Petitioner worked varying overtime hours ranging from 5.25 hours to 24.76 hours. The hours are not consistently worked each week, and Petitioner provided no testimony that he was required to work overtime hours.

The Commission finds Petitioner's overtime hours are excluded pursuant to Section 10 of the Act. As such, the Commission finds Petitioner's average weekly wage to equal $358.94. The Commission calculates the average weekly wage as follows: 1) Petitioner worked for 41 weeks prior to his date of accident, 09/04/16 through 06/28/17; 2) for the period of 09/4/16 through 10/12/16, 211.5 hours were worked at an hourly rate of $9.25 totaling $1956.38; 3) for the period of 10/19/16 through 6/28/17, 1343.19 hours were worked at an hourly rate of $9.50 totaling $12,760.31; and 4) total wages earned equals $14,716.69 divided by 41 weeks worked equaling $358.94.

Accident/Causation

To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that he sustained an accidental injury arising out of and in the course of his employment. *820 ILCS 305/1(d)*. Both elements must be present to justify compensation. *First Cash Financial Services v. Industrial Commission*, 367 Ill. App. 3d 102, 105, 853 N.E.2d 799 (2006). The parties do not dispute the incident in question occurred while Petitioner was in the course of his employment; rather, the dispute is whether the injury arose out of his employment.

The requirement that the injury arise out of the employment concerns the origin or cause of the claimant's injury. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). The occurrence of an accident at the claimant's workplace does not automatically establish the injury "arose out of" the claimant's employment. *Parro v. Industrial Commission*, 167 Ill. 2d 385, 393, 657 N.E.2d 882 (1995). Rather, "[t]he 'arising out of' component is primarily concerned with causal connection" and is satisfied when the claimant has "shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro, Inc.*, 207 Ill. 2d at 203.

Further, as the Court noted in *Peoria County Bellwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." "There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet the legal definition of 'repetitive.'" *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 192, 825 N.E.2d 773 (2005).

It is not the Commission's job to determine whether the job duties are sufficiently repetitive to establish compensability. Instead our job is to determine whether the evidence of the Petitioner's job duties supports the medical opinions offered on the issue of causation. The Petitioner's testimony and evidence submitted at arbitration were conflicting as to whether he was claiming injury from a single trauma or from gradual overuse of the right shoulder.

Petitioner testified he sustained a discrete accidental injury to his right shoulder on June 28, 2017. T.44. Petitioner testified due to his prior left arm injury, he was forced to use only his right arm while performing his work duties. T.45. Petitioner explained while bringing a pallet to the nylon machine, he felt a pain in his right shoulder. T.47. On cross-examination, Petitioner reaffirmed he sustained a specific injury to his shoulder on June 28, 2017. T. 65.

Petitioner's testimony as to a discrete injury is not borne out by the medical records. On June 30, 2017, Petitioner presented to Physicians Immediate Care (PIC) complaining of pain in his right arm which he reported as a gradual onset. Petitioner denied any specific injury. Petitioner was diagnosed with a right wrist and shoulder sprain. On July 7, 2017, Petitioner was reevaluated at PIC and complained of right shoulder and wrist joint pain. Petitioner again denied a specific injury instead he associated his pain to his repetitive work activities. PX13.

On July 6, 2017, Petitioner presented to Dr. Atluri complaining of both left and right shoulder pain. Petitioner attributed his right shoulder pain to the work he performed while on light duty. Again, Petitioner failed to provide any history of a discrete accident. PX14.

On October 16, 2017, Dr. Neal evaluated Petitioner for a second time pursuant to Section 12 of the Act at Respondent's request. Petitioner provided a history of injury to his right shoulder and denied any specific accident but instead, attributed his shoulder pain to his general work activities. RX1, p.31.

The Arbitrator found the discrepancy between Petitioner's trial testimony regarding a discrete injury and the medical histories memorializing a repetitive trauma injury minimal and not detrimental to his case. The Commission views the evidence differently and finds such discrepancy significant and fatal. Petitioner testified he sustained a discrete injury, but there is no medical documentation which supports such an injury. Petitioner provided little testimony as to the method or manner of his specific job duties. Moreover, Petitioner failed to offer any evidence in support of a repetitive trauma theory of recovery. See *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 477, 510 N.E.2d 502 (1987) ("Furthermore, in the 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").

The only causation opinion offered is that of Dr. Neal. Dr. Neal testified Petitioner's "activities in general overall or as a process over time or along the lines of either repetitive trauma or compensatory, it would be my opinion that his were not of those origins because like his other side, I do believe they are psychogenic in origin." RX1, p.38. The Commission affords significant

weight to Dr. Neal's opinion and finds Petitioner failed to prove he sustained an accident which arose out of his employment and failed to prove a causal relationship regarding his current condition of ill-being.

Evidentiary Ruling

The parties offered their respective exhibits into evidence. Petitioner objected, in part, to Respondent's Exhibit 1, the evidence deposition of Dr. Neal. Petitioner's objection was predicated on the 48-hour rule, arguing the October 16, 2017 report was not provided to her timely, relying on *Ghere v. Industrial Commission,* 278 Ill. App. 3d 840, 663 N.E.2d 1046 (1996). The Arbitrator overruled the objection and the exhibit was admitted, but Dr. Neal's testimony as to the report was stricken. The Commission finds Dr. Neal's testimony in toto should be admitted. Petitioner's counsel stated on the record despite her late notice of report, she was prepared to proceed with the deposition and did so. As such, the Commission finds Petitioner was not prejudiced.

All benefits are denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator regarding 17 WC 19712 filed March 19, 2018, is hereby reversed as Petitioner failed to prove accident and causal relationship for the claimed right shoulder injury on June 28, 2017.

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

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2).* Based upon the denial of compensation herein, no bond is set by the Commission.

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

DATED: NOV 22 2019

Douglas McCarthy

LEC/DDM/tdm
O: 7/17/19
43

Stephen Mathis

SPECIAL CONCURRENCE

I concur with all aspects of the majority's opinion other than the analysis utilized as it relates to the issues of accident/causation. I write separately as I arrive at my decision utilizing a different analysis.

As the majority aptly notes on page three of its decision, "The Petitioner's testimony and evidence submitted at arbitration were conflicting as to whether he was claiming injury from a single trauma or from a gradual overuse of the right shoulder." Even such, the majority finds "It is not the Commission's job to determine whether the job duties are sufficiently repetitive to establish compensability."

The majority in arriving at its decision seems to confuse a repetitive trauma theory of recovery with an overuse theory of recovery originating from the March 21, 2017 injury to Petitioner's left shoulder. In the present matter, Petitioner filed an Application for Adjustment of Claim alleging a discrete second accident occurring on June 28, 2017 claiming injury to his right shoulder, arm, hand, and wrist. Again, the evidence is conflicting regarding a specific accident versus a gradual onset. I concur with the majority that the evidence does not support a finding of a specific accident. However, unlike the majority, I find it is the Commission's duty pursuant to Section 19(e) of the Act to determine whether Petitioner's job duties were sufficiently repetitive to establish a claim under a repetitive trauma theory of recovery. To make such a determination, the Commission may review the evidence or lack thereof concerning the method and manner of Petitioner's job duties. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993).

As the majority noted, Petitioner provided little testimony as to the method and manner of his job duties, and no medical evidence supporting a repetitive trauma theory of recovery. As such Petitioner failed to prove he sustained an accident which arose out of his employment for

either a specific accident or under a repetitive trauma theory of recovery. Petitioner further failed to prove a causal relationship regarding his current condition of ill-being.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

MEJIA, FREDY E
Employee/Petitioner

Case# **17WC019712**
17WC013529

ARTHUR SCHUMAN MIDWEST LLC METRO STAFF INC
Employer/Respondent

19IWCC0641

On 3/19/2018, 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 1.85% 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:

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

0159 FRANCIS J DISCIPIO LAW OFFICE
1200 HARGER RD
SUITE 500
OAK BROOK, IL 60521

2284 LAW OFFICE OF LAWRENCE COZZI
MARK ZAPF
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

STATE OF ILLINOIS)

)SS.

COUNTY OF DuPage)

☐ Injured Workers' Benefit Fund (§4(d))

☐ Rate Adjustment Fund (§8(g))

☐ Second Injury Fund (§8(e)18)

☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

19(b)

FREDY E. MEJIA

Employee/Petitioner

v.

Case # 17 WC 19712

Consolidated cases: 17 WC 13529

ARTHUR SCHUMAN MIDWEST, LLC;

METRO STAFF, INC.;

Employer/Respondent

19IWCC0641

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki STEFFEN**, Arbitrator of the Commission, in the city of **Wheaton, Illinois**, 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. ☒ Did an accident 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 **Prospective medical treatment**

FINDINGS

On the date of accident, **3/21/17**, 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 $**18,676.80**; the average weekly wage was $**491.49**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **1** dependent child.

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

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

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

ORDER

On **June 28, 2017**, Petitioner sustained an injury to his right shoulder and wrist that arose out of and in the course of employment with Respondents.

Respondent shall pay to Petitioner the following unpaid reasonable and necessary medical expenses owed to: **(1) Hand to Shoulder Associates, a/k/a Hand Surgery Associates – $708.00; (2) Northwest Radiology Associates – $734.00; (3) Physicians Immediate Care – $1,676.11; (4) Physicians Immediate Care Physical Therapy – $891.00; and (5) ATI Physical Therapy – $23,470.57**; pursuant to the Medical Fee Schedule.

Respondent shall pay Petitioner temporary total disability benefits of $327.66/week for **30 3/7** weeks for the period of: **6/30/2017 to 1/29/2018** (the date of the hearing), as provided in Section 8(a) of the Act.

Respondent shall authorize the reasonable and necessary medical treatment, specifically the right shoulder MRI and physical therapy for the right shoulder and wrist, recommended by **Dr. Wollin and Dr. Boersma**.

Petitioner's request for penalties under sec. 16, **§19(l) and under §19(k) 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.

KSSteffen March 13, 2018

Signature of Arbitrator Date

ICArbDec19(b)

MAR 19 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MEJIA, FREDY E
Employee/Petitioner

Case# **17WC013529**

17WC019712

ARTHUR SCHUMAN MIDWEST LLC METRO STAFF INC
Employer/Respondent

19IWCC0641

On 3/19/2018, 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 1.85% 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:

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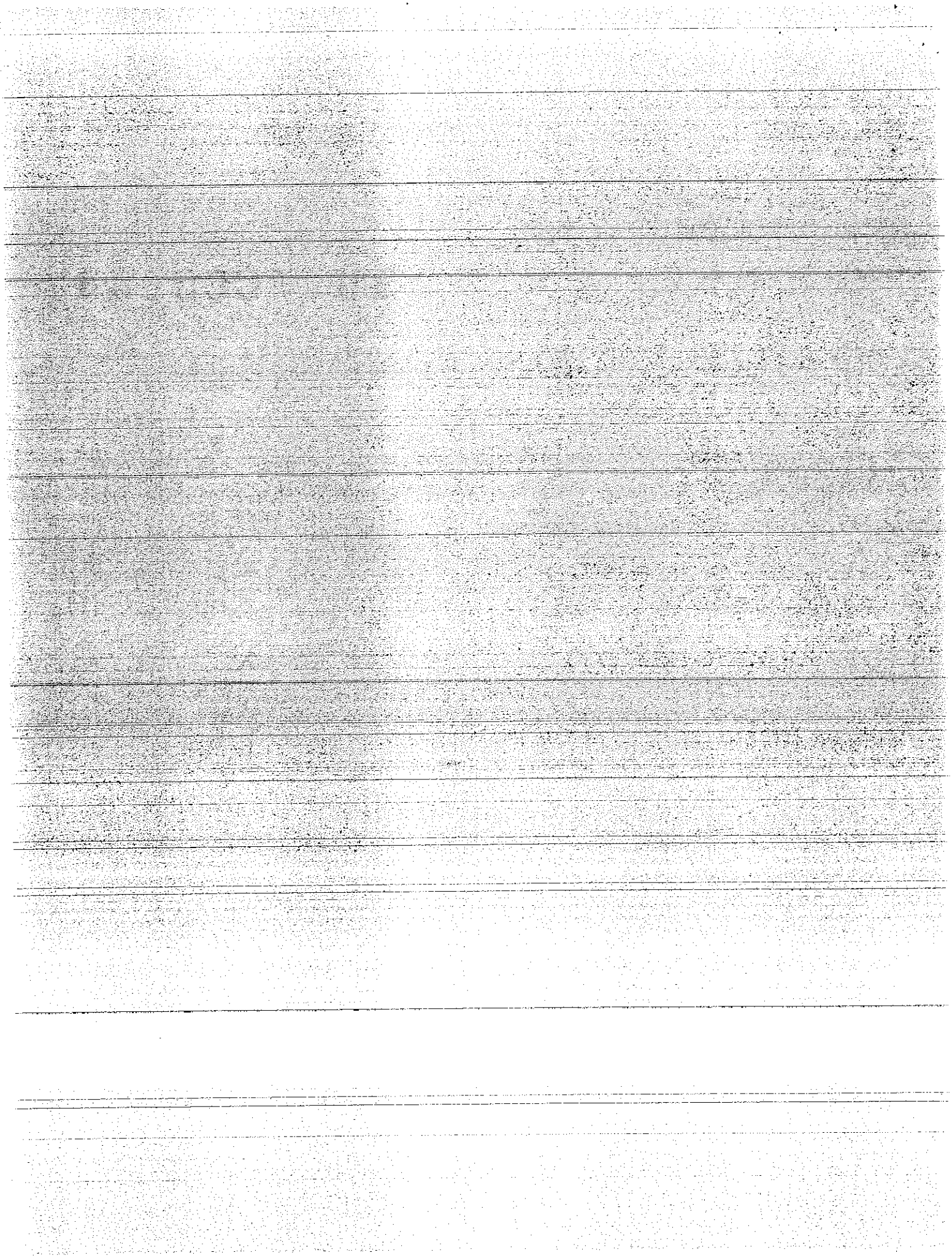

STATE OF ILLINOIS)

)SS.

COUNTY OF DuPage)

☐ Injured Workers' Benefit Fund (§4(d))

☐ Rate Adjustment Fund (§8(g))

☐ Second Injury Fund (§8(e)18)

☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

19(b)

FREDY E. MEJIA

Case # 17 WC 13529

Employee/Petitioner

v.

Consolidated cases: 17 WC 19712

ARTHUR SCHUMAN MIDWEST, LLC; METRO STAFF, 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 Ketki STEFFEN, Arbitrator of the Commission, in the city of Wheaton, Illinois, 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

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

H. ☐ What 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 **Prospective medical treatment**

FINDINGS

On the date of accident, **3/21/17**, 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 $**18,676.80**; the average weekly wage was $**491.49**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **1** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services. Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**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

On **March 21, 2017**, Petitioner sustained an injury to his left shoulder, forearm, elbow, and wrist that arose out of and in the course of employment with Respondents.

Respondent shall pay to Petitioner the following unpaid reasonable and necessary medical expenses owed to: **(1) Hand to Shoulder Associates, a/k/a Hand Surgery Associates – $708.00; (2) Northwest Radiology Associates – $734.00; (3) Physicians Immediate Care – $1,676.11; (4) Physicians Immediate Care Physical Therapy – $891.00; and (5) ATI Physical Therapy – $23,470.57**; pursuant to the Medical Fee Schedule.

Respondent shall pay Petitioner temporary total disability benefits of $327.66/week for **30-3/7** weeks for the period of: **6/30/2017 to 1/29/2018** (the date of the hearing), as provided in Section 8(a) of the Act.

Respondent shall authorize the reasonable and necessary medical treatment, specifically the left shoulder arthroscopy surgical procedure, recommended by **Dr. Atluri**.

Petitioner's request for penalties under Sec. 16, **§19(l) and under §19(k) 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.

KSSteffen — March 13, 2018

Signature of Arbitrator — Date

ICArbDec19(b)

MAR 19 2018

Ghere Ruling

On October 16, 2017, Petitioner was examined by Dr. Neal, Respondents' §12 retained expert, for the June 28, 2017 right shoulder and wrist work related injury. Dr. Neal's October 16, 2017 §12 report was emailed to Petitioner's counsel on Thursday, November 16, 2017 3:56 p.m., approximately 22 hours prior to the deposition. Respondents failed to tender the §12 report to Petitioner's counsel 48-hours prior to the deposition. Petitioners counsel proceeded to fully participate in the deposition and stated that Petitioner was able to prepare for the deposition, inspite of the late notice. Petitioner did make a Ghere objection. The Arbitrator denies Petitioner's request to disregards the October 16, 2017 §12 report itself and strikes all testimony regarding the §12 report from the deposition transcript.

FACTUAL HISTORY

Petitioner, Fredy E. Mejia, a 29-year old, testified that he was an employee of Metro Staff, Inc. working at Arthur Schuman Midwest, LLC, at the time of his March 21, 2017 work injury and his June 28, 2017 work injury (Tr. pgs. 23-24; 44). Petitioner testified that he worked as a machine operator for Respondents for approximately seven (7) months prior to his first work injury on March 31, 2017 (Tr. pgs. 24, 73).

Petitioner operated a machine that made cheese, cookies and crackers for Respondents. Petitioner's duties were to ensure the machine was constantly moving so the oven would not stop (Tr. pgs. 24-26, 28). To do this, he constantly pushed and pulled a plastic board used to dispense cheese into molds with his left arm (Tr. pgs. 24-26, 28). The plastic board he pushed and pulled with his left arm was not equipped with any gripping device such as a handle or lever (Tr. pg. 26). While using his left arm to

operate the machine, he simultaneously used his right arm to pour 8-10 lb. bags of cheese into the vat and used a stick to break up the clusters (Tr. pgs. 24-26, 28).

Petitioner testified that the machine operated on two different speeds, slow and fast. The slow mode required Petitioner to push and pull the board in one-second intervals, while the fast mode required him to push and pull at a much faster and constant rate (Tr. pgs. 27-28). Petitioner testified that he worked 12-hour shifts, 5-7 days per week (Tr. pgs. 28-29). Petitioner's testimony regarding his work schedule is corroborated by the pay stubs entered into evidence as Petitioner's Exhibit Group 22 (Px. Group 22).

a) MARCH 21, 2017 INJURY:

Petitioner testified that he was an employee of Metro Staff, Inc. while working at Arthur Schuman Midwest, LLC when he suffered a work related injury on March 21, 2017 when operating the cheese cracker machine (Tr. pgs. 23-24). Petitioner testified and indicated that after pouring asiago cheese into the vat, it became difficult to push or pull the board he used to operate the machine. The board then became stuck, and he felt a pop in the left shoulder when trying to push the board (Tr. pgs. 29-30). Petitioner felt immense pain to his left shoulder radiating down to his left elbow and arm and was unable to pull the board back (Tr. pg. 30).

Petitioner testified that following his injury, he notified Nelson, the company supervisor at Arthur Schuman. Nelson took over Petitioner's post operating the machine, and Petitioner was sent to pick up garbage for the remainder of the shift (Tr. pgs. 31-32). The following day, he reported the injury to Claudia at Metro Staff (Tr. pg. 31). Petitioner testified that Nelson told him to continue working because they did not have enough labor, which Petitioner did for a couple of weeks following his March 21,

2017 work injury (Tr. pg. 32). His pain continued, and Petitioner testified that eventually Claudia from Metro Staff, Inc. initiated an injury report and sent him to the doctor (Tr. pg. 33).

On April 11, 2017, Dr. Wollin at Physicians Immediate Care initially saw Petitioner (Px. 13). Petitioner explained to Dr. Wollin how he injured his left shoulder, forearm, elbow and left wrist on March 21, 2017 (Tr. pgs. 33-34). Dr. Wollin noted in his records:

> "Patient states he was working on a machine and for the last 3 weeks due to repetitive movement. The pain is from his left wrist up to his left shoulder with pain focusing on the shoulder. ... Patient has been doing repetitive work with left arm pulling a machine continuously 8 hours a day, now has pain in left shoulder mostly, with also pain in the left elbow and left wrist ..." (Px. 13).

Dr. Wollin examined and took x-rays of Petitioner's left shoulder, elbow and wrist, while noting that Petitioner's pain was from the left wrist up to his left shoulder with greater pain to the shoulder (Px. 13). Dr. Wollin noted tenderness and swelling over the left forearm and to the lateral epicondylitis of the left elbow, tenderness to left deltoid muscle and reduced left shoulder range of motion with pain (Px. 13). Petitioner further testified that Dr. Wollin gave him work restrictions of no lifting more than 10 lbs. and no pushing or pulling with the left arm (Tr. pg. 34). Dr. Wollin ordered Petitioner to avoid: strong gripping with the left hand, to limit repetitive motion with left hand, no lifting over shoulder and no pushing/pulling greater than 10 lbs. and to wear a splint (Px. 13).

Petitioner followed up with Dr. Wollin who noted that he had the same pain in the left shoulder, forearm, elbow and wrist for which he placed the same work restrictions and ordered physical therapy for the left shoulder and wrist (Px. 13). Petitioner participated in the physical therapy program without relief or decrease in pain to the left shoulder, forearm, elbow or wrist (Px. 13).

On May 11, 2017, Petitioner was seen by Dr. Atluri from Hand-to-Shoulder Associates (Tr. pg. 36). He explained to Dr. Atluri how his injury to his left wrist, forearm, elbow and shoulder occurred (Tr. pg. 36). Dr. Atluri noted in his records:

> "Patient reports a left upper extremity injury from March 2017. He states he was using a cheese machine at work for a 12-hour shift. He states this involved gripping with his left hand and pushing and pulling rapidly with his left arm, while pouring cheese into the machine with his right upper extremity. He states that the machine kept getting stuck due to the consistency of the cheese. He states that he developed severe pain in his left shoulder, as well as pain in his left forearm extending into his radial wrist. ... The symptoms have worsening [sic]. Pain has been present for 1 month. Onset was sudden following an accident at work." (Px. 13).

Dr. Atluri's medical note further indicates that the onset of Petitioner's left shoulder pain was sudden following an accident at work (Px. 13). Dr. Atluri examined the left wrist, forearm and elbow, and noted tenderness at the radial tunnel and the extensor carpi radialis brevis muscle with tendon origin, left lateral elbow pain with grip test, pain with resisted wrist extension test, and pain with resisted forearm supination (Px. 14). An examination of the left shoulder presented global tenderness, limited range of motion with guarding and stiffness (Px. 14). Petitioner tested positive for the Hawkin's and Yergason's sign (Px. 14). Dr. Atluri ordered x-rays. The x-rays revealed a left reduced glenohumeral joint (Px. 14). Dr. Atluri diagnosed Petitioner with a left radial nerve compression and left shoulder joint derangement (Px. 14). He gave Petitioner no use of the left arm work restrictions and ordered an MRI arthrogram of the left shoulder (Px. 14). After May 11, 2017, Petitioner could no longer work as a machine operator and instead worked in a light duty position, performing all his work tasks with the use of his right arm (Tr. pgs. 44-45).

The June 9, 2017 MRI arthrogram showed a left shoulder glenoid labral tear at the anterior and anterior inferior labrum (Px. 15). On June 13, 2017, Dr. Atluri noted

that Petitioner had failed conservative treatment and recommended a left shoulder arthroscopy with a labral repair and possible biceps tenodesis (Px. 15).

Petitioner continued to treat with Dr. Atluri. Physical therapy was ordered for the left shoulder to maintain Petitioner's shoulder motion. Petitioner attended physical therapy at ATI Physical Therapy (Px. 21). The November 21, 2017 physical therapy notes indicate that Petitioner:

> Patient continues to present with impairments involving strength, pain, these deficits limit patient's ability to perform these tasks: lifting overhead, overhead tasks: sustained/repetitive, using heavy machinery/ power tools (Px. 21).

After examination of the left upper extremity, Dr. Atluri noted that Petitioner had functional improvements of the left elbow, forearm, and wrist/hand with therapy but not of the left shoulder, he discontinued physical therapy and again ordered the left shoulder arthroscopy procedure for the labral tear (Px. 14). On January 2, 2018, Dr. Atluri continued to give Petitioner work restrictions of no use of left arm and noted that the surgery was pending approval (Px. 14).

Petitioner testified that he did not undergo surgery for the left shoulder superior labral tear because the insurance company did not approve it (Tr. pg. 39). Petitioner testified that he continues to experience left forearm and elbow pain (Tr. pgs. 40-41). Petitioner still cannot raise his left arm high, he cannot help with the house chores and cannot help at the supermarket like before which he was able to do before the March 21, 2017 work injury (Tr. pgs. 41-42). Petitioner testified that he did not have any pains in his left shoulder or left elbow before March 21, 2017 (Tr. pg. 59). Petitioner further testified that he would undergo the left shoulder surgical procedure if it was approved by workers' compensation (Tr. pg. 40).

b) JUNE 28, 2017 INJURY:

Petitioner testified that on June 28, 2017, he was working light duty at Arthur Schuman Midwest, LLC while still employed by Metro Staff, Inc. (Tr. pg. 44). Petitioner testified that he did not work as a machine operator after 5/11/17 due to the no use of the left arm restrictions imposed by Dr. Atluri (Tr. pg. 45). Petitioner testified that he performed various functions at work but only with his dominant right arm due to the left arm restrictions (Tr. pgs. 44-45, 51).

Petitioner testified that one of his functions was to lift and pull pallets carrying cheese from the freezer with a pallet jack; and he would place the pallets next to the machines for the machine operators (Tr. pgs. 44-45). Petitioner testified that he would also pull and push pallets carrying boxed cheese crackers that weighed about 720 lbs. with the use of either a manual or electric pallet jack to an area where he would have to seal each individual box (Tr. pgs. 33-34, 75). Petitioner further testified that he had to pass each box through a nylon seal machine manually (Tr. pgs. 44-45).

Petitioner testified that on June 28, 2017, he felt strong pain to his right shoulder when pulling and pushing a manual pallet jack, and that due to all the repetitive movements he had developed a cyst on his right wrist (Tr. pgs. 45-47, 75). Petitioner further testified that the cyst was like a small ball that caused him pain when he would want to move his right wrist (Tr. pgs. 46-47).

Petitioner testified that he notified his supervisor, Nelson, of his work injury on June 28, 2018 (Tr. pg. 47). On June 30, 2017, Petitioner notified Estella from Metro Staff of the work injury to the right arm; and Estella sent Petitioner to Physicians Immediate Care that same day (Tr. pgs. 47-48).

On June 30, 2017, Dr. Wollin examined Petitioner's right shoulder and wrist and noted the following in his records:

> "Patient states he is having right wrist and shoulder pain now since he has to primarily use this arm instead of his left which he injured previously. He has been using his right arm only to work, starting 2 days ago he developed pain to his right posterior shoulder and to the dorsum of his right wrist." (Px. 13).

Dr. Wollin's medical records indicate that Petitioner's right wrist and shoulder pain complaints had a gradual onset, and that the pain was worse when working (Px. 13). On examination, Dr. Wollin noted tenderness to the right supraspinatus tendon and over the right trapezius muscle, a tender rotator cuff and biceps tendon, and tenderness to mid dorsum wrist and extensor tendon with a ganglion cyst over the dorsum wrist (Px. 13). Dr. Wollin ordered physical therapy for the right shoulder and right wrist, gave Petitioner work restrictions of no lifting over shoulder greater than 0 lbs., to limit repetitive motion with right hand, to wear splint, and prescribed Deltasone to reduce the inflammation (Px. 13).

On July 14, 2017, Dr. Wollin recommended that Petitioner continue physical therapy for the right wrist and shoulder and ordered an MRI of the right shoulder (Px. 13). Physicians Immediate Care's activity log regarding the right shoulder MRI notes that the facility received a call on July 20, 2017 from the worker's comp. adjuster stating the claim was disputed and that nothing would be authorized "for now" (Px. 13).

On July 28, 2017, Dr. Wollin noted that Petitioner had right shoulder pain upon abduction and pronation of the right shoulder with sharp pain present at the lateral to anterior aspect of shoulder with radiation to the neck and down to the forearm with a tingling sensation in his fingers (Px. 13). Dr. Wollin also noted that approval for both the right shoulder MRI and physical therapy was pending (Px. 13). Dr. Wollin's notes indicate that Petitioner wanted to continue therapy as it was helping his right forearm and wrist pain (Px. 13).

On August 3, 2017, Petitioner was seen by Dr. Boersma at Physicians Immediate Care (Px. 13). Dr. Boersma's August 3, 2017 records document right shoulder and deltoid pain, severe tenderness over bone and muscle and over dorsal and palmar wrist, severe tenderness over the right palm and muscles, reduced dorsiflexion, volar flexion, radial and ulnar flexion, reduced forearm pronation and supination with pain (Px. 13). He prescribed Petitioner Mobic (Px. 13). Dr. Boersma ordered no exercise of the right arm or wrist/hand, avoid strong gripping, limit repetitive motion with right hand, no lifting over shoulder and no lifting from waist to shoulder greater than 5 lbs. (Px. 13). Based on the physical examination, Dr. Boersma also recommended a right shoulder MRI and pain management evaluation (Px. 13). On August 11, 2017, Petitioner was given work restrictions of no exercise of the right arm or wrist/hand, limit repetitive motion of right hand/arm and shoulder, and was told to consider a right shoulder steroid injection (Px. 13).

Petitioner testified that he told his treating physician, Dr. Atluri, about his right arm injury and complaints, but Dr. Atluri could not treat him without authorization from the insurance company (Tr. pg. 73). The July 6, 2017 medical note indicates that Dr. Atluri requested authorization to treat the right shoulder and wrist injury; however the workers' compensation insurance carrier denied it (Px. 14).

Petitioner further testified that he underwent physical therapy for only a few weeks but was unable to receive any further treatment because the workers' compensation insurance denied further treatment and denied authorization for the right shoulder MRI (Tr. pgs. 51-52). Petitioner testified that Metro Staff, Inc. and Arthur Schuman Midwest, LLC were unable to accommodate the work restrictions imposed by Dr. Wollin (Tr. pgs. 48-49). Petitioner testified that he continues to have right shoulder

pain (Tr. pg. 52). He cannot use his right arm without experiencing pain over the top of the shoulder or wrist pain. Petitioner testified that he has not worked since June 30, 2017 and has not received any temporary total disability benefits since said date (Tr. pgs. 51-52).

FINDINGS/ANALYSIS

WITH RESPECT TO ISSUE C, ISSUE E AND ISSUE F – DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENTS?

WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENTS?

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

THE ARBITRATOR FINDS AS FOLLOWS:

a) **MARCH 21, 2017 INJURY**:

The medical records corroborate Petitioner's testimony that he suffered a work injury on March 21, 2017 while he was working as a machine operator as an employee of Metro Staff, Inc., working at the Arthur Schuman Midwest, LLC plant. Furthermore, Petitioner's description of injury, of operating a machine that required him to constantly and forcefully push a board with his left upper extremity, is consistently reflected in Dr. Atluri and Dr. Wollin's medical records admitted into evidence and in his testimony.

On June 21, 2017, Petitioner was examined by Dr. Neal, Respondents' §12 retained expert. Dr. Neal testified that he asked Petitioner to remove the brace from his left forearm, wrist, and hand and to remove his shirt (Rx. 1, pg. 15). Dr. Neal further testified that Petitioner unbuttoned his shirt using only his right hand and kept his left arm very still and at his side (Rx. 1, pg. 15). Dr. Neal testified that Petitioner's left upper extremity movement was tremendously guarded (Rx. 1, pg. 16). Dr. Neal also testified that there was a greater examination of the left shoulder in comparison to the

left elbow, forearm or wrist, while noting that left wrist range of motion was painful (Rx. 1, pg. 57). Moreover, Dr. Neal agreed that the MRI arthrogram demonstrated evidence of a superior labral tear (Rx. 1, pg. 59).

Dr. Neal testified that an acute labral tear could be the result of a traumatic injury of an outstretched arm (Rx. 1, pg. 63). Moreover, Dr. Neal agrees that a shoulder labrum tear can occur if a person dislocates their shoulder as a result of a work related activity (Rx. 1, pgs. 64-65). Dr. Neal testified that he did not read Petitioner's job description, did not know how much force Petitioner had to apply while operating the cookie machine, or how often Petitioner had to push and pull with his left shoulder (Rx. 1, pgs. 70-71).

Dr. Neal testified that a labral tear would elicit pain located superiorly and anteriorly (Rx. 1, pg. 60). Further, Dr. Neal testified that a person with a labral tear injury could have pain placing their arm in overheard or elevated positions (Rx. 1, pg. 66). Dr. Neal's observations and examination of Petitioner's left upper extremity are consistent with his medical opinions regarding the symptomology of a labral tear. However, Dr. Neal concluded that Petitioner did not suffer a March 21, 2017 work related injury based on his observations and the arthrogram report.

The Arbitrator discounts Dr. Neals opinion because it fails to account for the fact that the Petitioner had no prior left shoulder, elbow, forearm or wrist injuries and no medical treatment to said body parts prior to the March 21, 2017 work injury. The Arbitrator also notes that Petitioner worked as a machine operator, a physically demanding job that required Petitioner to use constant force to push and pull a plastic board with his left arm, while he simultaneously used his right arm to pour cheese into the vat during his 12-hour shift. The Arbitrator notes that Petitioner was required to

work 12-hour shifts, 5-7 days per week for approximately seven months prior to the work injury. The mechanism of the injury corroborated Petitioner's subjective complaints and his treating physicians diagnosis. Therefore, the Arbitrator finds that Petitioner sustained a work related injury on March 21, 2017 when he forcefully pushed the board on the machine which resulted in a left shoulder labral tear and left radial nerve compression. The Arbitrator notes that although Dr. Neal does not find causation, he does not disagree with the objective findings of a labral tear. His notes do not show that Petitioner was exaggerating his symptoms or that there was a disconnect between Petitioner's subjective complaints and the objective medical findings. Therefore, the Arbitrator affords less weight to IME Dr. Neal opinion.

The Arbitrator also finds that Petitioner reported his injury to Nelson, the plant supervisor at Arthur Schuman Midwest, LLC, on the same day, and reported the injury to Claudia from Metro Staff, Inc., the following day. This further strengthen Petitioner's claim that he suffered a work injury. There is no evidence to refute Petitioner's testimony as to notice. Therefore, Respondents' claim that there was no notice given to the employer regarding the March 21, 2017 injury is denied. The Arbitrator specifically notes that medical authorization was given by a Metro Staff employee, Marisol Glaser, on April 10, 2017 which is contained in the Physician Immediate Care medical records admitted into evidence. The Arbitrator finds notice was given since Petitioner's medical treatment for the work injury was authorized by his employer.

The Arbitrator finds that, looking at the totality of the evidence, the opinions of Petitioner's treating physicians, Dr. Prasant Atluri, orthopedic surgeon, and Dr. Wollin, the Physicians Immediate Care physician, are more credible than the opinion of Respondents' retained medical expert, Dr. Neal. Dr. Neal's testimony that a person

suffering from a labral tear injury would have pain placing their arm in overhead or elevated positions coupled with the fact that he agrees that the arthrogram shows that Petitioner has a labral tear is inconsistent and disingenuous with his conclusory opinion that Petitioner did not suffer a work injury on March 21, 2017. Specifically, the Arbitrator notes that Dr. Neal also observed that Petitioner's left shoulder movement was guarded and accepted that Petitioner has subjective medical findings of a labral tear. Dr. Neal's failure to account for Petitioner's mechanism of injury weakens his final opinion.

The Arbitrator finds that Petitioner testified consistently with the medical records. Accordingly, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment with Respondents. Further, the Arbitrator finds the Petitioner's current condition of ill-being (left shoulder, elbow, forearm and wrist) is causally related to his work injury of March 21, 2017, and that timely notice was unequivocally given to Respondents.

As an additional note, the Arbitrator finds the Petitioner to be credible on the issue of the mechanism of the injury. The Petitioner was involved in repetitive type work but also suffered a specific accident. He testified that on March 21, 2017 he was constantly and forcefully pushing a board with his left arm when he was injured. In the Arbitrator's estimation Petitioner's testimony that he was involved in repetitive work but that the traumatic injury occurred on a specific day does not diminish his credibility. The Arbitrator notes that Petitioner's descriptions of his work injury to Dr. Atluri and Dr. Wollin's are consistent with his testimony.

b) JUNE 28, 2017 INJURY:

After the March 21, 2017 injury to his left extremity, Petitioner continued to work using his dominant right arm. On June 28, 2017, Petitioner was operating a pallet jack.

The pallet jack at the employer's business was either manual or electric and the operated the pallet jack to deliver cheese to the operators. Petitioner also operated a nylon seal machine to seal the cheese. Petitioner claims that he injured his right shoulder when operating a manual pallet jack on June 28, 2017. He claims that he develoved a cyst on his right wrist. (Tr. pgs. 45-47, 75). Petitioner testified that he notified his supervisor, Nelson, of his work injury on June 28, 2018 (Tr. pg. 47). On June 30, 2017, Petitioner notified Estella from Metro Staff of the work injury to the right arm; and Estella sent Petitioner to Physicians Immediate Care that same day (Tr. pgs. 47-48).

On June 30, 2017, Dr. Wollin examined Petitioner's right shoulder and wrist and noted the following in his records:

> "Patient states he is having right wrist and shoulder pain now since he has to primarily use this arm instead of his left which he injured previously. He has been using his right arm only to work, starting 2 days ago he developed pain to his right posterior shoulder and to the dorsum of his right wrist." (Px. 13).

Dr. Wollin's medical records indicate that Petitioner's right wrist and shoulder pain complaints had a gradual onset, and that the pain was worse when working (Px. 13). On examination, Dr. Wollin noted tenderness to the right supraspinatus tendon and over the right trapezius muscle, a tender rotator cuff and biceps tendon, and tenderness to mid dorsum wrist and extensor tendon with a ganglion cyst over the dorsum wrist (Px. 13). Dr. Wollin ordered physical therapy for the right shoulder and right wrist, gave Petitioner work restrictions of no lifting over shoulder greater than 0 lbs., to limit repetitive motion with right hand, to wear splint, and prescribed Deltasone to reduce the inflammation (Px. 13).

Approval for both the right shoulder MRI and physical therapy (besides a few sessions) was denied. On August 3, 2017, Petitioner was seen by Dr. Boersma at Physicians Immediate Care (Px. 13). Dr. Boersma's records document right shoulder and deltoid pain, severe tenderness over bone and muscle and over dorsal and palmar wrist, severe tenderness over the right palm and muscles, reduced dorsiflexion, volar flexion, radial and ulnar flexion, reduced forearm pronation and supination with pain (Px. 13). Dr. Boersma also recommended a right shoulder MRI and pain management evaluation (Px. 13). On August 11, 2017, Petitioner was given work restrictions of no exercise of the right arm or wrist/hand, limit repetitive motion of right hand/arm and shoulder, and was told to consider a right shoulder steroid injection (Px. 13).

Petitioner testified that the employer could not accommodate his restrictions so he could not return to work. He has not worked since June 30, 2017 and has not received any temporary total disability benefits since said date (Tr. pgs. 51-52). Petitioner requests the MRI, pain management and physical therapy as recommended by his physicians Dr. Wollin and Dr. Boersma.

The Respondent argues that the Petitioner's did not suffer a work accident and therefore is not entitled to any benefits (TTD or medical) because he has given inconsistent accounts of how his injury occurred. The Respondent points to the lack of specificity of whether the Petitioner suffered repetitive trauma injury or a specific date injury. The Respondent also points out that the Petitioner's testimony about the weight of the box of cheese that Petitioner said he was holding during his accident is inconsistent. (10 lbs. vs. 18 lbs) Although the Arbitrator concedes that there are minor inconsistencies in Petitioner's testimony and that his account of his injury included both,

repetitive trauma as well as specific injury, the Arbitrator does not find the same as detrimental to Petitioner's case.

This is mainly so because the medical records corroborate Petitioner's testimony that he suffered a work injury on June 28, 2017 as a result of having no use of the left upper extremity; and he could only perform his job duties with the use of his right upper extremity. Petitioner's description of injury is consistently reflected in the medical records admitted into evidence and in his testimony.

On October 16, 2017, Petitioner was examined by Dr. Neal, Respondents' §12 retained expert, for the June 28, 2017 right shoulder and wrist work related injury. Petitioner argues that Dr. Neal's testimony regarding the June 28, 2017 work related injury should be given little to no deference. Dr. Neal testified that he did not know how long Petitioner had exclusively used the right upper extremity at work during his 12-hour shifts prior to the June 28, 2017 work injury (Rx. 1, pgs. 81-82). Dr. Neal testified that he did not know that Petitioner operated a pallet jack and also did not know how much weight or force Petitioner had to apply to maneuver it (Rx. 1, pgs. 82-83). Dr. Neal agrees that repetitive injuries can cause ganglion cysts (Rx. 1, pgs. 77-79). Dr. Neal testified that he believed an MRI of the right shoulder would be useful to explain Petitioner's symptomology; and he would not disagree if someone wanted to order it (Rx. 1, pgs.84).

The Arbitrator gives greater deference to the opinions of the two treating physicians than that of Respondents' §12 examiner based on the totality of the evidence. The Arbitrator notes that Petitioner had no prior right shoulder, forearm, or wrist/hand injuries and no medical treatment to said body parts prior to the June 28, 2017 work injury. The Arbitrator notes that Petitioner was working for Metro Staff, Inc.,

at Arthur Schuman Midwest, LLC, with work restrictions of no strong gripping with the left hand, to limit repetitive motion with left hand, no over the shoulder lifting, and no pushing/pulling greater than 10 lbs. since April 2017. The Arbitrator notes that prior to the June 28, 2017 work related injury, Petitioner was working with only his right arm due to the no use of the left arm work restrictions imposed by Dr. Atluri since May 11, 2017.

Petitioner reported his injury to Nelson the plant supervisor at Arthur Schuman Midwest, LLC, immediately following the incident. Petitioner also reported the June 28, 2017 injury to Estela an employee from Metro Staff, Inc. Respondents' assertion that there was no notice given to Respondents regarding the June 28, 2017 injury is without merit. Petitioner's medical records contain a medical authorization given by two Metro Staff, Inc., employees, Monique Edwards and Marisol Glaser, on 6/30/2017. Based on the totality of the above evidence, notice was clearly provided.

The Arbitrator finds that Petitioner testified credibly coupled with the medical records. Therefore, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment with Respondents on June 28, 2017. Further, the Arbitrator finds the Petitioner's current condition of ill-being (right shoulder, forearm and wrist/hand) is causally related to the gradual work injury of June 28, 2017, and that timely notice was unequivocally given to Respondents.

WITH RESPECT TO ISSUE G – WHAT WERE PETITIONER'S EARNINGS?

THE ARBITRATOR FINDS AS FOLLOWS: The Arbitrator finds Petitioner credible and finds that he worked 12-hour shifts on average 5-7 days per week and earned $9.50/hour. The Arbitrator finds that the Petitioner worked an average of 60-84 hours per week, and that there were weeks in which Petitioner worked less than five (5) days. The Arbitrator finds that Petitioner's pay stubs entered into evidence accurately reflect

that overtime was consistent and required, and that Petitioner worked for approximately nine (9) months before the June 28, 2017 work injury.

Where the employment prior to the injury extended over a period of less than 52 weeks the method of dividing the earnings during that period by the number of weeks and parts thereof shall be followed. 820 ILCS 305/10. Petitioner's pay stubs document that he worked 38 out of the 52 weeks in the year prior to his work accident. Therefore, the Arbitrator finds that Petitioner earned $18,676.80, and pursuant to §10 of the Act, Petitioner's average weekly wage is $491.49 ($18,676.80 ÷ 38 = $491.49).

WITH RESPECT TO ISSUE J – WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAVE RESPONDENTS PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

THE ARBITRATOR FINDS AS FOLLOWS: The Arbitrator incorporates her findings of ISSUE C, ISSUE E, and ISSUE F into ISSUE J herein.

Petitioner currently has numerous medical bills, listed below, that have not been paid by Respondents since they dispute that Petitioner suffered work injuries on March 21, 2017 and on June 28, 2017. The Arbitrator has already determined liability in the form of causal connection between Petitioner's March 21, 2017 and June 28, 2017 work injuries and his current condition of ill-being.

Exhibit	Medical Provider	Amt. of Bill
Px# 16	Hand to Shoulder Associates, a/k/a Hand Surgery Associates	$ 708.00
Px# 17	Northwest Radiology Associates	734.00
Px# 18	Physicians Immediate Care	1,676.11
Px# 19	Physicians Immediate Care Physical Therapy	891.00
Px# 20	ATI Physical Therapy	23,470.57
	TOTAL	$ 27,479.68

The Arbitrator has reviewed Petitioner's medical records and bills and finds that these bills were unpaid by the workers' compensation carrier, and that the medical

records document that the only services that Petitioner received were for problems associated with the March 21, 2017 and the June 28, 2017 work injuries.

The Arbitrator finds that the medical expenses are consistent with the medical treatment reflected in the medical records for such services. The Arbitrator specifically notes the medical treatment received by Petitioner was reasonable and necessary to treat his March 21, 2017 and June 28, 2017 work injuries. Based upon the medical records admitted into evidence along with Petitioner's unrebutted testimony, the Arbitrator orders Respondents to pay Petitioner the reasonable and necessary medical expenses (Px. 16, Px. 17, Px. 18, Px. 19, & Px. 20) incurred in the care and treatment which medical bills total $27,479.68. All awarded medical bills are to be paid subject to the fee schedule.

WITH RESPECT TO ISSUE K – IS PETITIONER ENTITLED TO PROSPECTIVE MEDICAL CARE? THE ARBITRATOR FINDS AS FOLLOWS:

PROSPECTIVE MEDICAL RELATING TO MARCH 21, 2017 INJURY:

The Arbitrator notes that Petitioner had no prior left shoulder, elbow, forearm or wrist injuries and no medical treatment to said body parts prior to the March 21, 2017 work injury. The Arbitrator also notes that Petitioner worked as a machine operator, a physically demanding job, working 12-hour shifts, 5-7 days per week for approximately seven (7) months prior to the work injury.

The Arbitrator finds that, when looking at the totality of the evidence, the opinions of Petitioner's treating physicians, Dr. Prasant Atluri, orthopedic surgeon, and Dr. Wollin, the Physicians Immediate Care physician, are more credible than the opinions of Respondents' retained medical expert, Dr. Neal. Further, the Arbitrator finds that Dr.

Neal's opinions and diagnosis regarding the left shoulder, forearm, elbow and wrist to be conflicting to the objective observations, his medical expertise and his testimony in which he admits that Petitioner has a left shoulder labral tear. The Arbitrator finds that Petitioner testified credibly coupled with the medical records.

Accordingly, the Arbitrator found that the Petitioner's current condition of ill-being (left shoulder, elbow, forearm and wrist) is causally related to his work injury of March 21, 2017, and that Petitioner continues to have pain to the left shoulder.

Since the Arbitrator finds liability in favor of Petitioner, she also finds the prospective medical issue, *i.e.* the left shoulder surgery recommended by Dr. Atluri, in favor of Petitioner. Therefore, Respondents are ordered to authorize and pay for the medical expenses related to the surgery recommended by Dr. Atluri.

PROSPECTIVE MEDICAL RELATING TO JUNE 28, 2017 INJURY:

The Arbitrator notes that Petitioner had no prior right shoulder, forearm, or wrist/hand injuries and no medical treatment to said body parts prior to the June 28, 2017 gradual work injury. The Arbitrator finds that the opinions of the two physicians from Physicians Immediate Care, Dr. Boersma, DO and Dr. Wollin, are more credible and disregards Dr. Neal's testimony regarding the right upper extremity work related injury due to a *Ghere* violation in the October 16, 2017 §12 report. In the alternative, the Arbitrator notes that Dr. Neal testified that Petitioner did not suffer a right upper extremity work related injury, but agreed that an MRI of the right shoulder would be useful to explain Petitioner's symptomology and would not disagree if someone wanted to order it.

The Arbitrator finds that Petitioner testified credibly coupled with the medical records. Further, the Arbitrator finds the Petitioner's current condition of ill-being (right

shoulder, forearm and wrist/hand) is causally related to his gradual work injury of June 28, 2017. Since the Arbitrator finds liability in favor of Petitioner, he also finds the prospective medical issue, *i.e.* physical therapy for the right wrist and shoulder and the right shoulder MRI recommended by both Dr. Wollin and Dr. Boersma. Therefore, Respondents are ordered to authorize and pay for the medical expenses related to the right upper extremity, right shoulder MRI and and physical therapy as recommended by Petitoner's treating doctors.

WITH RESPECT TO ISSUE L – WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator has already determined Petitioner's AWW is $491.49. Therefore, Petitioner's TTD rate is $327.66/wk. The Arbitrator further finds that Petitioner has not been released back to work; and no treating physician has stated that Petitioner is at MMI of either the left or the right upper extremity. The medical records demonstrate Petitioner has work restrictions of no use of the left arm, and limited repetitive motion of the right arm, hand and wrist, avoid strong gripping, no lifting over the shoulder and no lifting from waist to shoulder greater than 5 lbs. which Respondents did not accommodate.

The Arbitrator finds that while Respondents rely on the opinion of its §12 examiner as its basis for denying Petitioner's temporary total disability, Respondents no longer have a good faith basis to deny said benefits given that this Arbitrator found that the deposition testimony regarding the October 16, 2017 §12 report to be a *Ghere* violation. As such, Respondents have effectively waived any and all reasonable basis to deny Petitioner temporary total disability benefits. Accordingly, the Arbitrator finds that there is no medical basis for Respondents' refusal to pay Petitioner's temporary total disability benefits which he is entitled to as provided in Section 8(a) of the Act.

Moreover, the Arbitrator finds Petitioner's testimony of continued bilateral upper extremity limitations coupled with the medical records, and his work status restrictions that he is not able to work, credible.

Therefore, the Arbitrator finds that based on the medical records admitted into evidence, Petitioner's unrebutted testimony, along with the Arbitrator's findings of causal connection between Petitioner's March 21, 2017 and June 28, 2017 work injuries, Petitioner is entitled to temporary total disability benefits from: June 30, 2017 through January 29, 2018 (the last date of hearing) which represents **30-3/7 weeks.** The Arbitrator orders Respondents to pay Petitioner a total of **$9,970.23** (30-3/7 weeks x $327.66) in back temporary total disability benefits. The Arbitrator also finds that Petitioner is entitled to temporary total disability benefits from January 30, 2018 through the present and orders Respondents to issue Petitioner's temporary total disability benefits, so long as Respondent is unable to accommodate Petitioner's work restrictions.

WITH RESPECT TO ISSUE M – IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO ISSUE M - SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENTS?

The Arbitrator has already determined liability in the form of causal connection between Petitioner's March 21, 2017 and June 28, 2017 work injuries and his current condition. The Arbitrator finds that the Respondents relied on the opinion of its §12 examiner as its basis for denying Petitioner's medical treatment, recommended surgery and TTD benefits. Although the Arbitrator disagreed with the Dr. Neal's final opinion, the Arbitrator finds that the Respondents had a good faith basis to deny liability. The Arbitrator does not find, based on the totality of the evidence that the Respondents

actions were unreasonable or vexatious. Therefore, the Arbitrator denies penalties under Sections 16, 19 (l) and 19(k).

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

Fernando Izaguirre,

Petitioner,

vs. NO: 15 WC 8955

City of Chicago,

Respondent.

19IWCC0642

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, medical expenses and temporary total disability and being advised of the facts and law, affirms and adopts with changes as stated below the Decision of the Arbitrator, which is attached hereto and made a part hereof. However, the Commission corrects an error located within the Arbitrator's Decision. 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).

Within the Arbitrator's order, it is specified that Respondent "shall pay reasonable and necessary medical services directly to the medical providers, pursuant to the medical fee schedule, of $1,563.00 to Accelerated/Athletico Physical Therapy, $2,774.40 to ATI Physical Therapy, $10,070.00 to Advanced Billing Collection Specialists for Gray Medical, $928.00 to Southwest Physicians Group and $4,500.00 to GhFitLab, as provided in Sections 8(a) and 8.2 of the Act." The Commission strikes this language and orders Respondent to pay reasonable and necessary medical services, pursuant to the medical fee schedule, as provided in sections 8(a) and 8.2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 26, 2019 is hereby affirmed and adopted with changes as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, 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 county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

NOV 22 2019

DATED:
d: 10/17/19
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

IZAGUIRRE JR, FERNANDO
Employee/Petitioner

Case# **15WC008955**

CITY OF CHICAGO
Employer/Respondent

19IWCC0642

On 3/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0010 CITY OF CHICAGO LAW DEPT
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

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

Fernando Izaguirre, Jr.
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **008955**

Consolidated cases:

19IWCC0642

An *Application for Adjustment 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 N. Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **November 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **June 6, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**63,440.50**; the average weekly wage was $**1,220.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**173,357.61** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**173,357.61**.

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

ORDER

Respondent shall pay reasonable and necessary medical services directly to the medical providers, pursuant to the medical fee schedule, of $1,563.00 to Accelerated/Athletico Physical Therapy, $2,774.40 to ATI Physical Therapy, $10,070.00 to Advanced Billing Collection Specialists for Gray Medical, $928.00 to Southwest Physicians Group, and $4,500.00 to GhFitLab, as provided in Sections 8(a) and 8.2 of the Act. (PX8-12) This excludes the bill from Oral & Maxillofacial Surgery Chicago for the date of service September 7, 2017 in the amount of $301.00. (PX13)

Respondent shall pay Petitioner Temporary Total Disability Benefits of $189,971.42 (233 and 4/7 weeks X 2/3 X $1220.00), Subject to any credit.

Respondent shall receive credit for its TTD Payment of $173,357.61, per parties' stipulation. (Arb.X1)

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

3/25/19
Date

ICArbDec19(b)

MAR 2 6 2019

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on November 28, 2018 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator Kay.

SUMMARY OF FACTS AND EVIDENCE

The parties proceeded to hearing on November 28, 2018, with disputed issues as to whether Mr. Fernando Izaguirre (hereinafter "Petitioner") current condition of ill-being is causally connected to his injury while working for the City of Chicago (hereinafter "Respondent") on November 28, 2018. In addition, whether the Respondent is liable for unpaid medical bills in the amount of $20,136.40 and whether the Petitioner is entitled to temporary total disability benefits (hereinafter "TTD") for the period of June 7, 2014 through November 28, 2018 representing 233 4/7th weeks. In contrast, Respondent claims Petitioner is entitled to TTD from the period of June 7, 2014 through September 1, 2017 and October 4, 2017 through August 8, 2018 representing 213 1/7th weeks. Prospective care is also at issue. (Arb. X1)

The parties stipulated that on June 6, 2014 the Petitioner and Respondent were operating under the Illinois Workers' Compensation Act (hereinafter "Act") and had a relationship of employer and employee. (Arb.X1) The parties stipulated that Petitioner did sustain an accidental injury that arose out of and in the course of her employment with Respondent and the Respondent received notice of the accident within the time limits stated in the Act. (Arb.X1) The stipulated average weekly wage pursuant to Section 10 of the Act was $1,220.00, Petitioner was 46 years of age at the time of the accident, single, with 2 dependent children. (Arb.X1)

On the date of the accident, Petitioner testified that he was working for Respondent as a booter. (AX1; PX3, 18; T.13.) Petitioner had been working for Respondent since 1999, initially in fleet management. (T 13-14.) Starting in 2002, Petitioner's job responsibilities involved applying the Denver boot to vehicles whose owners owed a debt to the City of Chicago. (T 13-14.) As a booter, Petitioner would drive around different neighborhoods surveying them for vehicles that needed a boot applied to them. (T 14.) Petitioner's job would then entail getting out of the van, taking the device out of the van, putting it on the vehicle's tire, and using a drill and a lock to affix it to the tire. (T 14.) Petitioner also carried a walkie-talkie with him in case he ran into any obstacles from the public. (T 14.) He testified that his hands always had something in them. (T 14.)

Petitioner testified that putting the boot on the tire required him to bend over and get down on his knees, as he needed to be able to keep his tools with him and balance while seeing both sides of the tire. (T 15.) The job was created for two people, but he performed it alone. (T 16.) Petitioner testified that Respondent provided its booters with one pair of knee pads each, which helped somewhat. (T 16.)

Petitioner testified that his job with Respondent requires him to kneel or squat 10 to 15 times an hour throughout the work day. (T 45, 48-51.) He estimated that the boot he has to carry while working weighs between 35 and 40 pounds, that the lock he carries to place on the boot weighs about 9 or 10 pounds, and that he has to carry a drill and a walkie-talkie as well. (T 51.) He testified that while he does not have to climb ladders for his job with Respondent, he does have to climb up a very big step on the side of the truck. (T 51-52.)

On June 6, 2014, Petitioner was at work. About 20 different booting devices had been loaded up into his van, piled on top of each other in a disorderly fashion. (T 17.) Cables and wires coming out of the devices became entangled. (T 17-18.) When it became time to immobilize a vehicle, he grabbed a device, and it lactched on to many others. (T 17.) Petitioner grabbed a device and pulled, but it latched onto other devices,

many of which came out of the van with it. (T 17-18.) Petitioner tried to maintain his balance; he felt his right knee twist "pretty bad" from the strain. (T 18-19.) Petitioner wanted to put the device on the vehicle as fast as possible to avoid conflict; he could already hear voices and someone screaming. (T 18.)

Petitioner testified that he felt pain in his knee; nonetheless, he separated the device from the others and got down on his knees to immobilize the vehicle. (T 19.) While he was on his knees, he felt a burning sensation in his knee. (T 19.) When he stood up, Petitioner had to use the cart to support himself; he felt a sensation of pulling or tearing in the knee. (T 19, 20.) Petitioner testified that he called his supervisor to report the accident and to tell him that he needed assistance. (T 20.) Petitioner stated that his supervisor informed him that he was at another situation at the time so he had to sit there and wait in the van until his supervisor arrived. (T 20.)

On June 6, 2014, Petitioner sought treatment in the ER at Mercy Works. (T 21.) Petitioner's knee was very swollen. (T 21.) Petitioner was assessed with a right knee strain; he was prescribed an aluminum crutch and referred to Dr. Craig Westin (hereinafter "Dr. Westin"). (PX2, T 21-22.)

On June 12, 2014, Petitioner received right knee x-rays at Mercy Hospital disclosing moderate joint space narrowing, osteophyte formation and spurring, but no fracture. (PX2.)

On June 27, 2014, Petitioner presented to Dr. Westin at Illinois Bone and Joint Institute with complaints of right knee pain. (T 22; PX3A.) Dr. Westin wrote, "Fernando is well known to me from his prior right knee problems. He reinjured the right knee again on June 6, 2014." Petitioner related his history of injury: he was pulling a boot out of his van at work when it got stuck; as he was pulling the boot loose, he hyperextended his right knee. (PX3A.) This produced an increase in his right knee pain. (PX3A.) He reported that he had to stop working after he got the boot on because his knee was so painful. (PX3A.) Petitioner informed Dr. Westin that the Denver boots weighed 35-40 pounds each, and reported that he put on 10 to 15 of them per day. (PX3A.) On examination, Dr. Westin noted tenderness diffusely at the medial and lateral patellofemoral joints as well as the medial and lateral tibiofemoral joints, with tenderness maximal to the medial tibiofemoral joint. (PX3A.) Dr. Westin took weightbearing x-rays, which he compared with x-rays from a year prior; they disclosed significant narrowing in the tibiofemoral joint space, with only 2 mm left in the right knee, half the space of the left knee. (PX3A.) Dr. Westin assessed Petitioner with right knee osteoarthritis with "recent significant aggravation." (PX3A.) Dr. Westin administered a shot of cortisone to the knee, prescribed Norco and physical therapy at Accelerated Rehab, and instructed Petitioner to go on sedentary duty with no bending, squatting or kneeling and 10 pounds maximum lift. (PX3A.)

On July 28, 2014, Petitioner returned to Dr. Westin complaining of continuing significant pain in his right knee. (PX3A.) Petitioner reported that he was using Tylenol PM and hydrocodone three times a week. (PX3A.) Dr. Westin opined that the cortisone shot had not been very effective, and recommended that they try Synvisc. (PX3A.) Dr. Westin continued Petitioner on physical therapy and maintained his restrictions. (PX3A.)

On August 25, 2014, Petitioner returned to Dr. Westin again, once more reporting significant pain in his right knee. (PX3A.) Petitioner remained off work, as he had not been offered modified duty within his restrictions. (PX3A.) Dr. Westin reviewed Petitioner's PT records; he opined that Petitioner's right knee was not progressing well with therapy due to pain. (PX3A.) The effects of Petitioner's cortisone shot had now fully worn off. (PX3A.) Dr. Westin administered a Synvisc-One injection to Petitioner's medial right knee, which he hoped would produce better pain relief. (PX3A.) Dr. Westin stated that he wanted to continue Petitioner on

physical therapy to at least get him weight-bearing; if not, Petitioner would become a candidate for a total knee replacement. (PX3A.) Dr. Westin maintained Petitioner's restrictions. (PX3A.)

On September 9, 2014, Petitioner followed up with Dr. Westin. (PX3A.) The Synvisc shot had not helped him very much, but Dr. Westin opined that it was still too soon to say that the shot had not been effective due to the short amount of time passed since it was administered. (PX3A.) Dr. Westin opined that Petitioner's right knee arthritis appeared to have progressed since his work accident of June 6, 2014, and that it would have to be managed with the long-term in mind. (PX3A.) Dr. Westin opined that "his previous job putting Denver boots on cars is not well suited because of the bending, squatting, kneeling and lifting." (PX3A.) He stated: "Ultimately, he will need long-term restrictions such as no walking or standing longer than tolerated, probably not lifting over 20 pounds, no climbing, no squatting or kneeling." (PX3A.) Dr. Westin further opined that Petitioner was morbidly obese, and that it was imperative that he lose weight; he suggested that Petitioner obtain a referral to a weight loss team from his primary care physician. (PX3A.)

On September 29, 2014, Petitioner presented to Dr. Westin once more for follow-up. (PX3A.) Review of physical therapy records disclosed that Petitioner was still having significant knee pain even with a 4-inch step, and that he was reluctant to give up using the crutch due to the stability it offered him. (PX3A.) Dr. Westin concluded that the Syncvisc-One injection had not worked very well. (PX3A.) He stated: "I am afraid that our next step is total knee replacement. He is working on trying to get weight loss program started through his primary care physician. I think that is imperative because BMI is over 40." (PX3A.) Dr. Westin stated that Petitioner remained unable to return to his regular job; he had Petitioner finish his scheduled physical therapy pending the weight loss program. (PX3A.)

On October 21, 2014, Petitioner reported back to Dr. Westin and told him that he felt he was gaining a strength with his physical therapy. (PX3A.) His knee was sore, and he was using Limbrel and Norco approximately once per day. (PX3A.) Dr. Westin scheduled repeat cortisone injections to help Petitioner complete physical therapy; he reiterated his opinion that Petitioner would likely be a candidate for total knee arthroplasty. (PX3A.)

On December 5, 2014, Petitioner returned for a follow-up visit with Dr. Westin. (PX3A.) Dr. Westin opined that there had not been much progress; Petitioner's quadriceps remained weak despite 46 PT visits, and the injection given on October 31, 2014 had produced nothing more than a transient effect. (PX3A.) Dr. Westin stated:

> "Clinically, this dates back to his injury of June 6, 2014 when he hyperextended his right knee and had sudden increased pain. Prior to that, he has had significant prior problems, even some degenerative narrowing on the weightbearing x-ray but he had been able to function. His last visit prior to the injury on June 21, 2013 included a functional capacity evaluation where he was able to function enough to return to work. In my opinion, the most recent injury accelerated his preexisting arthritis and caused a permanent aggravation."

(PX3A.) Dr. Westin discontinued PT due to the lack of progress. (PX3A.) He opined that Petitioner was a candidate for medial compartment arthroplasty, but that a total knee arthroplasty may be needed depending on the status of the patellofemoral joint. (PX3A.)

On December 23, 2014, Dr. Westin reviewed a peer review by Dr. Steven Pearson (hereinafter "Dr. Pearson"), who opined that he could not authorize a total knee replacement procedure in light of Petitioner's BMI of greater than 40 and biological age of less than 50, each a risk factor increasing the likelihood of

operative failure. (PX3A.) Dr. Westin noted that Petitioner had a BMI of 41.4 as of September 9, 2014. (PX3A.) Dr. Westin recommended that Petitioner begin a weight loss program with a goal of reaching BMI 38.4. (PX3A.)

Petitioner began a weight loss program with Gh FitLab spanning more than two years. (PX12.)

On September 30, 2016, Petitioner returned to Dr. Westin with 20 pounds lost and a BMI of 40.2. (PX3A.) Petitioner reported that his right knee pain had decreased from a 10/10 to a 7/10, but that it continued nonetheless, right worse than left. (PX3A.) Dr. Westin noted that he and Dr. Pearson agreed that if Petitioner reached a BMI of less than 40, reconsideration of surgery would be given. (PX3A.) Standing radiographs disclosed that Petitioner's knees were now essentially bone-on-bone, worse on the right. (PX3A.) Petitioner's left knee problems started following the meniscectomy in 2012 and his right knee pain started from a right knee reconstruction ACL and partial lateral meniscectomy on December 26, 2003. Dr. Westin administered a cortisone injection to the right knee, and instructed him to return in 2 to 3 months when he was close to a BMI of 40. (PX3A.)

On January 9, 2017, Petitioner returned to Dr. Westin weighing 255 pounds from 292 pounds and still taking Norco to manage his knee pain. (PX3A.) Dr. Westin administered a Monovisc injection to the right knee and instructed Petitioner to return again in March, with likely scheduling of total or partial knee replacement to follow. (PX3A.)

On February 16, 2017, Petitioner underwent a right knee MRI.

On March 17, 2017, Petitioner returned to Dr. Westin weighing 246 pounds, with a BMI of 37.4. (PX3A.) Petitioner reported that he was feeling less pain with weight loss, but that he was still suffering diffuse pain, worse medially, and that he still had trouble with climbing even a single flight of stairs. (PX3A.) Petitioner could now walk 5 or 6 blocks before becoming limited by pain. (PX3A.) Dr. Westin opined that additional weight loss would help Petitioner's symptoms but would not solve his arthritis. (PX3A.) Dr. Westin reviewed the MRI and noted, "The x-ray appearance of [Petitioner's] left knee is almost as bad as the right." He instructed Petitioner to continue weight loss and stated that he would schedule a right knee arthroplasty procedure in six weeks. (PX3A.)

On May 1, 2017, Petitioner followed up with Dr. Westin. (PX3.) He weighed 245 pounds at this visit; Dr. Westin opined that Petitioner had plateaued in his weight loss. (PX3.) Dr. Westin recommended that they proceed with the arthroplasty surgery. (PX3.) He stated that Petitioner's patellofemoral joint looked fairly regular in his February 16, 2017 MRI, and so he wanted to perform a diagnostic arthroscopy at the start of the procedure to determine whether it would make sense to perform only a unicompartmental arthroplasty. (PX3.) If the patellofemoral joint appeared satisfactory during the arthroscopy, Dr. Westin stated, they would do only a unicompartmental replacement. (PX3.) He estimated a 50% chance of ultimately performing a unicompartmental arthroplasty rather than a total knee arthroplasty. (PX3.)

On or about September 1, 2017, Petitioner was scheduled to undergo the recommended surgery. However, it was observed that Petitioner had an infected cyst in his mouth. (T 27.) The cyst would have interfered with the implant. (T 27.) On or about September 7, 2017, Dr. Prem Patel removed the cyst. (T 27-28.)

On October 4, 2017, Petitioner underwent right knee replacement surgery with Dr. Westin at Weiss Memorial Hospital. (PX4; T 24, 41.) Pre-operatively and post-operatively, Petitioner was diagnosed with "Right knee post-traumatic arthritis." (PX4.) Dr. Westin began with a diagnostic arthroscopy of the right knee; subluxing the patella, he observed bone-on-bone arthrosis in the medial compartment, some remaining space in the lateral compartment, and fraying of the anterior ACL in the cruciate ligaments. (PX4.) Dr. Westin then proceeded with a right total knee arthroplasty. (PX4.) He cut out existing bone and implanted a Triathlon Stryker knee replacement system, which he cemented and clamped to Petitioner's tibia, femur, and patella. (PX4.)Post-operatively, Petitioner continued to follow up with Dr. Westin regularly. (PX3.)

On October 23, 2017, at Petitioner's initial follow-up Dr. Westin, he put Petitioner on PT at ATI. (PX3.) On November 17, 2017, Dr. Westin changed Petitioner over to Atheltico. (PX3.) Dr. Westin began to wean Petitioner off of Norco, and Petitioner made progress with regaining range of motion. (PX3.) Dr. Westin predicted that Petitioner would eventually be capable of occasional 50-pound lift. (PX3.) By March 2, 2018, Petitioner's right knee was capable of flexion to beyond 105 degrees, albeit with a 10-degree extensor lag. (PX3.) He stated that Petitioner needed to gain more strength, to be followed by an FCE. (PX3.) By May 7, 2018, Petitioner was able to achieve flexion to 120 degrees with good motion and stability, but with 10-degree extensor lag, weakness, and trace effusion. (PX3.) Dr. Westin opined that Petitioner was still not capable of returning to work. (PX3.)

On December 29, 2017, Dr. Westin noted that Petitioner's knee "is improving." Petitioner has had nearly full extension and flexion greater than 110 degrees. Dr. Westin noted, "His left knee is also giving him difficulty, which is not a surprise." Dr. Westin further stated, "With his right total knee and arthritis left knee, it is not realistic or wise that he returns to his previous job of booting automobiles for the rest of his career. I think the right knee will be certainly capable of 50 pounds lifting occasionally, but we will reassess his ability to work in the next two months." (PX3A; PX3).

On March 2, 2018, it was noted that Petitioner's knee condition had improved. Dr. Westin further noted that Petitioner would have to be diligent with his home exercises to build more strength. Dr. Westin noted that Petitioner had not been putting enough effort with his home exercises to increase his strength. The doctor explained that strength could only be built though home exercises not at therapy twice a week. Dr. Westin noted that Petitioner "ultimately will have a maximum lifting of 50 pounds to protect both the right total knee arthroplasty and the arthritic left knee." (PX3A; PX3).

On May 7, 2018, Petitioner reported that he was not doing very well. Petitioner was noted that he had gain 30 pounds since August 24, 2017. Dr. Westin wrote, "Objectively, he has good motion and good stability, but I do not think he is working hard enough with physical therapy." (PX3A; PX3)

On June 25, 2018 Petitioner returned to Dr. Westin, who stated that Petitioner was making good progress with physical therapy. (PX3.) Petitioner reported reduced pain in his knee. (PX3.) On examination, his right knee was free of effusion and capable of full active extension as well as flexion to 110 degrees. (PX3.) Dr. Westin opined that Petitioner "will not be able to return to his previous job of booting cars because of the lifting and squatting involved." (PX3.) He recommended an FCE to determine the extent of Petitioner's abilities. (PX3.)

On July 10, 2018, Petitioner underwent a §12 examination with Dr. Shane Nho (hereinafter "Dr. Nho") at the request of the Respondent. (R X1) Petitioner complained of pain over the lateral and medial aspects of his right knee. On provocative testing of the right knee, Dr. Nho observed tenderness over the patella, patella tendon, lateral joint line, popliteal fossa, and medial joint line. Dr. Nho opined that Petitioner had "sustained an

aggravation of pre-existing knee osteoarthritis," and that his current symptoms were "related to post-operative condition as a result of the total knee replacement." (R X1) Dr. Nho opined that Petitioner could return to work full-duty with respect to his right knee; he further opined that Petitioner's right knee was at MMI. (RX1) Petitioner testified that Dr. Nho never asked him what he did for a living and never elicited information about how often Petitioner would be on his knees during the course of his job. (T 43.)

On July 27, 2018, Petitioner returned to Dr. Westin. (PX3.) Petitioner complained of knee soreness, though he had improved the extensor lag of his right knee significantly. (PX3.) Dr. Westin examined Petitioner. (PX3.) Dr. Westin noted his impression that Petitioner was at MMI regarding the right knee. (PX3.)

On September 4, 2018, Petitioner underwent an FCE at ATI Physical Therapy. (PX9 at 946; T 30.) The FCE was valid, with Petitioner providing full effort. (PX9 at 946, 952.) The FCE determined that Petitioner was capable of 8 hours a day of occasional lift of 47.8 pounds above the shoulder; 8 hours a day of occasional seated lift of 57.8 pounds from desk to chair with regular breaks; 4 hours, 40 minutes a day of occasional standing lift of 36.8 pounds from chair to floor; and 8 hours a day of walking and carrying 37.0 pounds occasionally, with regular breaks. (PX9 at 946.) Petitioner was further deemed capable of only occasional bending/stooping, and minimally occasional crouching, kneeling, and squatting. (PX9 at 949.)

The FCE noted that Petitioner had bilateral reports of knee pain during the assessment, with demonstrated limitations of kneeling, crouching, crawling, and squatting; Petitioner was deemed capable of performing these motions for no more than 0-30 minutes per day. (PX9 at 946.) The FCE report stated: "Per the job description that was received via the employer the client is required to lift 35 lbs. frequently; which was not demonstrated within the FCA." (PX9 at 946.) Based upon the job description provided by Respondent, the FCE concluded that Petitioner's capabilities fell below the level required for him to return to his previous position full-duty. (PX9 at 946.)

Following the FCE, Dr. Westin imposed permanent restrictions on Petitioner: 40 pounds maximum lift, no lifting below knee level, no ground-level lifting, no squatting, and no climbing ladders. (T 45.)

On September 28, 2018, a private investigator hired by Respondent took surveillance footage of Petitioner. Respondent submitted a video clip.

On October 27, 2018, Dr. Nho completed and IME addendum to his original § 12 report at Respondent's request. Dr. Nho opined that Petitioner's treatment had been reasonable and necessary, and that "there is no treatment that I believe was unreasonable or unnecessary." Dr. Nho opined that Petitioner's FCE was valid, limited by bilateral knee pain and low back pain. Dr. Nho again opined that Petitioner could return to work full-duty, and that Petitioner's right knee was at MMI. (R X2)

On November 26, 2018, Dr. Westin filled out medical questionnaire on Petitioner's behalf for a reasonable accommodation request with Respondent. (PX14.) Dr. Westin stated that, to a reasonable degree of medical certainty, Petitioner had a permanent impairment of his right knee impacting his ability to stand, walk, lift, and bend. (PX14.) Dr. Westin wrote that, based on Petitioner's FCE, Petitioner had restrictions of occasional floor lifting of 35 pounds maximum, occasional chair-to-desk lifting of 50 pounds maximum, occasional carrying of 35 pounds maximum in each hand, standing for 4 hours maximum, and walking for 8 hours on level ground only. (PX14.) He stated: "Mr. Fernando Izaguirre cannot return as a Booter on a permanent basis." (PX14.)

Petitioner has not worked since June 6, 2014. (T 12-13.) Petitioner testified that he did not think he could return to working as a booter, as that would require him to be on his knees continually throughout the day and require him to continuously climb back into a big van. (T 35.) He testified that he was concerned he might finish booting a vehicle and then struggle to get back up. (T 35.) Petitioner testified that Respondent does not want its employees who drive on medications, even over-the-counter medications, as they can cause drowsiness. (T 55.) Petitioner testified that he applied for a job transfer with Respondent; as of the date of hearing, the application remained pending. (T 31-33.)

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment/Summary of Testimony:

The Petitioner, Mr. Fernando Izaguirre, was the only witness to testify on behalf of the Petitioner at trial. The Arbitrator finds the overall testimony of Petitioner to be truthful, credible and otherwise unrebutted in regard to his past medical history, mechanisms of injury, course of medical treatment and his current subjective complaints.

With respect to issue (F) whether the Petitioner's current condition of ill-being is causally related to the Injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that the Petitioner proved by a preponderance of the evidence that his current condition of ill-being is causally connected to his work accident that occurred on June 6, 2014.

Respondent concedes that Petitioner's accident arose out of and in the course of his employment, but disputes that his present condition of ill-being is causally related to the work accident. For the following reasons, the Arbitrator finds that Petitioner's condition is causally related to his work accident.

Although it is true that Petitioner had preexisting right knee osteoarthritis, the mere fact that degenerative changes pre-existed the accident does not resolve the issue of causation; when a work accident aggravates a preexisting condition, the law in Illinois is that causation is established. *See Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 215 (2003).

In this case, Petitioner testified that although he had right knee pain before June 6, 2014, he was capable of working full-duty during that period. (T 38, 59-60.) Immediately following the June 6, 2014 accident, however, Petitioner could not even stand back up on his own—to get back up, Petitioner had to use the cart to support himself. (T 19, 20.) He testified that the difference in his right knee pain post-accident was tremendous; he testified that he could not walk anymore because it hurt to step and his knee would become immediately inflamed. (T 63.) Petitioner had to call his supervisor, then sit and wait for assistance getting back into his van. (T 20.)

Consistent with this testimony, the medical evidence demonstrates that Petitioner suffered an aggravation of his right knee condition. Dr. Westin had already been treating Petitioner for his knee issues for quite some time when Petitioner presented to him on June 27, 2014. (T 22; PX3A.) After hearing Petitioner's history of his June 6, 2014 work accident and performing a physical examination with weightbearing x-rays, Dr. Westin assessed Petitioner with right knee osteoarthritis with "recent significant aggravation." (PX3A.) During

his October 4, 2017 total knee replacement surgery, Dr. Westin diagnosed Petitioner both pre-operatively and post-operatively with "Right knee post-traumatic arthritis." (PX4.)

The Arbitrator notes, that Dr. Nho also concluded that Petitioner's work accident produced an aggravation of his right knee condition. In his Section 12 report, Dr. Nho wrote: "He is currently complaining of knee pain over the lateral and medial aspects of the knee s/p right total knee replacement. He is undergoing physical therapy. He sustained an aggravation of pre-existing knee osteoarthritis."

Each medical treater in the medical records submitted into evidence agreed that Petitioner's work accident of June 6, 2014 aggravated his right knee osteoarthritis. Consistent with the evidence, the Arbitrator therefore finds that Petitioner's current condition of ill-being in his right knee is causally related to the work accident of June 6, 2014.

With respect to issue (J), whether the Respondent paid for all appropriate charges for all reasonable and necessary medical services, 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 the medical services provided to the Petitioner were reasonable and necessary to cure his condition of ill-being related to his accident on June 6, 2014. Respondent disputes its liability for Petitioner's outstanding medical bills, claiming that Petitioner's condition of ill-being is not causally related to his workplace accident. However, as discussed above, the Arbitrator has found that Petitioner's condition of ill-being is causally related to his workplace accident. The Arbitrator notes that on October 27, 2018, in Dr. Nho's §12 addendum, he opined that Petitioner's treatment had been reasonable and necessary, and that "there is no treatment that I believe was unreasonable or unnecessary." (RX2) The Petitioner has submitted into evidence outstanding bills totaling $20,136.40. (P X8-12) Specifically, outstanding bills for $1,563.00 to Accelerated/Athletico Physical Therapy, $2,774.40 to ATI Physical Therapy, $10,070.00 to Advanced Billing Collection Specialists for Gray Medical, $928.00 to Southwest Physicians Group, and $4,500.00 to GhFitLab. The Arbitrator notes that the Petitioner also submitted a bill for his oral surgery dated September 7, 2017 in the amount of $301.00. (P.X13) The Arbitrator is not awarding costs for aforementioned bill. However, the Arbitrator finds Respondent responsible for all of the other medical expenses totaling $19,835.40. (P.X8-12)

With respect to issue (K), whether Petitioner is entitled to Temporary Total Disability Benefits, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. Consistent with the Arbitrator's findings as to causation and medical expenses, the Arbitrator finds Petitioner is entitled to temporary total disability benefits regarding his injury on June 6, 2014. Petitioner contends that he is entitled to TTD benefits from June 7, 2014 to the date of hearing, representing 233 and 4/7th weeks. Respondent accepts most of this period, but contends that the TTD period should be from June 7, 2014 to September 1, 2017 and then from October 4, 2017 to August 8, 2018, representing 213 and 1/7th weeks.

Following the work accident on June 6, 2014, Petitioner has not returned to work. (T 12-13)

First, the Arbitrator addresses the period of September 1, 2017 to October 4, 2017. Respondent claims that it is not liable for TTD benefits during this period because Petitioner's surgery was delayed by an unrelated mouth infection. "It is axiomatic that employers take their employees as they find them." *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672 (2003). Petitioner remained unable to work during this

period due to causally related work injuries—there is nothing in the Act which permits Respondent to cease paying TTD benefits for this period merely because Petitioner's treatment was delayed. The Arbitrator finds that Petitioner is due TTD for the period from September 1, 2017 to October 4, 2017.

Next, the Arbitrator must determine whether Petitioner remains unable to return to work so as to qualify for TTD benefits after August 8, 2018. Although Petitioner was found capable of working medium duty during his FCE, Petitioner was found to be incapable of returning his previous position by a valid FCE. Petitioner testified that he had applied for a job transfer with Respondent; as of the date of hearing, however, the application remained pending. (T 31-33.) Petitioner received an email the day of the arbitration hearing informing him of next steps for the reassignment application process. (T 32-33.)

Respondent disputes Petitioner's inability to return to his previous position at full duty, relying upon the opinion of Dr. Nho. Dr. Nho opined that Petitioner could return to his previous job at full-duty; however, the Arbitrator does not find this opinion persuasive. Petitioner testified that Dr. Nho never asked him what he does for a living during the Section 12 examination, and that Dr. Nho never elicited information about how often Petitioner would be on his knees during the course of his job. (T 43.) Consistent with Petitioner's testimony, Dr. Nho's initial Section 12 report makes no mention whatsoever of Petitioner's actual job requirements before concluding that he can return to work full-duty.

In his addendum report, Dr. Nho does cite the requirement that Petitioner must be able to frequently lift 35 pounds for his job; however, Dr. Nho fails to note that the very FCE setting forth this requirement found that Petitioner is capable only of walking and carrying 37.0 pounds *occasionally* with regular breaks, incapable of more than occasional bending/stooping, and incapable of more than minimally occasional crouching, kneeling, and squatting. (PX9 at 946, 949.) The FCE report stated: "Per the job description that was received via the employer the client is required to lift 35 lbs. frequently; which was not demonstrated within the FCA." (PX9 at 946.) Based upon the job description provided by Respondent, Petitioner's valid FCE concluded that his capabilities fell below the level required for him to return to his previous position full-duty. (PX9 at 946.)

The Arbitrator notes that these FCE findings are entirely consistent with Dr. Westin's opinion of June 25, 2018: namely, that Petitioner "will not be able to return to his previous job of booting cars because of the lifting and squatting involved." (PX3.) They are similarly consistent with Dr. Westin's opinions recorded in the medical questionnaire of November 26, 2018, in which he opined, "Mr. Fernando Izaguirre can not return as a Booter on a permanent basis." (PX14.) The Arbitrator finds that the evidence supports Dr. Westin's opinion in this matter.

Respondent also points to its surveillance footage—however, the footage Respondent submitted shows Petitioner doing nothing outside of his restrictions. The clip does not rebut any of the conclusions of Petitioner's FCE, and is wholly consistent with Petitioner's testimony that he can perform activities of daily living like grocery shopping. (T 34.)

Because the Respondent has failed to adduce evidence convincingly demonstrating that Petitioner can return to his previous position at full duty, because Respondent has not offered Petitioner an accommodation within his restrictions, and because Respondent has not yet processed Petitioner's request for a job transfer, the Arbitrator finds that Petitioner remains unable to return to his current employment with Respondent, and therefore remains eligible for TTD benefits after August 8, 2018.

In total, the Arbitrator finds that Petitioner is due TTD from June 7, 2014 to November 28, 2018, representing $189,971.42 (233 and 4/7th weeks X 2/3 X $1220.00).

Signature of Arbitrator

3/25/19
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 Causal Connection and award prospective medical care	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY G. ZIOMEK,

Petitioner,

vs. NO: 15 WC 11225

CITY OF CHICAGO,

Respondent.

19IWCC0643

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection and prospective medical care, and being advised of the facts and law, reverses in part 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 pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

I. FINDINGS OF FACT

A. Background and Accident

Petitioner injured his lower back in an undisputed accident on March 13, 2015, while working as a truck driver for Respondent. Petitioner's job involved delivering materials to crews working at various locations. He typically drove approximately six hours of each work day. Petitioner was occasionally required to lift or carry boxes of bolts and screws. He was required to bend or squat to pick up boxes, and to push or pull boxes if they moved within the truck bed. He occasionally was required to climb the side of a 10-wheeler dump truck to cover the load with a tarp.

On March 13, 2015, Petitioner was working for Respondent at 1501 39th Street, driving a 10-wheeler with a trailer carrying 20 tons of gravel. Petitioner stated he was pulling out of the yard when his truck hit a bump. The truck had an air seat, which had been compensating for Petitioner's weight. When Petitioner came down from the bump, the air seat blew out, causing him to land on the corner of the seat. Petitioner testified that days later, his foot began "flapping" when he walked. He also began to experience back pain and sought medical attention.

Prior to March 15, 2015, Petitioner performed these duties without difficulty. He had undergone a laminectomy in 1998 but was released to return without restrictions. From 2006, when Petitioner started working for Respondent, through March 13, 2015, Petitioner had not received medical treatment for his back or right hip. During the same period, Petitioner had not received any new injuries to his back or right hip.

B. Medical Treatment and Section 12 Examination (Dr. Siemionow)

Between March 16 and July 14, 2015, Petitioner saw several doctors, including Drs. Diadula and Ali at MercyWorks, as well as Drs. Zindrick and Chekka. Petitioner generally complained of 7-8/10 low back pain, radiating to the left leg more than the right.

On March 16, 2015, Petitioner saw Dr. Diadula at MercyWorks. In taking Petitioner's medical history, Dr. Diadula noted Petitioner had undergone a laminectomy in 1998 after a truck rollover accident. In addition, Petitioner had a motorcycle accident in 2011 and underwent a three-level cervical fusion in 2012. The doctor noted complaints of tailbone pain and 7-8/10 low back pain "radiating to the left leg more than the right with numbness and cramping at the back of the legs all the way to the heels." Dr. Diadula diagnosed Petitioner with contusions of the lumbar spine and coccyx and released Petitioner to full duty at Petitioner's request.

On March 23, 2015, Dr. Diadula additionally prescribed a lumbar spine MRI. The lumbar spine MRI, performed on April 3, 2015, revealed significant foraminal stenosis for the L5 nerve roots bilaterally, suspect for L5 nerve root impingement, mild to moderate acquired stenosis greatest at L4-L5, suspected right foraminal disc protrusion at L4-L5, and generalized disc bulging at multiple levels.

On April 9, 2015, Dr. Diadula noted ongoing complaints of 8/10 low back pain "radiating to the left leg more than the right leg" and weakness in both legs when starting to walk. Dr. Diadula recommended Petitioner see his own orthopedic surgeon and discharged Petitioner from care.

On April 15, 2015, Petitioner saw Dr. Zindrick, who indicated Petitioner described his symptoms as primarily in his legs, worse on the left side. Dr. Zindrick observed "[n]o pain with gentle range of motion with [Petitioner's] hips." He diagnosed acute low back pain "with left greater than right radiculopathy" and degenerative disc disease.

Petitioner was examined by Dr. Chekka on June 2, 2015, upon referral by Dr. Zindrick and Petitioner's primary care physician. Petitioner again complained of bilateral leg pain, left greater than right. Dr. Chekka also observed Petitioner had an abdominal wall vertical hernia, which

Petitioner's primary care physician indicated was a stable finding and diagnosis, with no GI distress, symptoms of incarceration, or significant pain. After reviewing the MRI, Dr. Chekka administered bilateral L5-S1 transforaminal epidural steroid injections.

On June 17, 2015, Dr. Zindrick noted Petitioner's ongoing back and bilateral leg complaints, left greater than right. Petitioner indicated the recent injections afforded only temporary relief. When Petitioner last visited Dr. Zindrick on July 14, 2015, he referred Petitioner to Dr. Lorenz for a surgical consultation.

Petitioner saw Dr. Lorenz on August 5, 2015. Following an examination and review of Petitioner's lumbar spine MRI, Dr. Lorenz recommended a revision decompression and a fusion from L4-S1. He also recommended Petitioner remain off work, as he had been directed since March 25, 2015.

At Respondent's request, Petitioner saw Dr. Siemionow, a spine surgeon, for purposes of a Section 12 examination. Dr. Siemionow's report, dated September 16, 2015, recorded complaints of pain in the lower back, buttocks, legs, and calves. Dr. Siemionow agreed with Dr. Lorenz's surgical recommendation. On November 16, 2015, Petitioner informed Dr. Lorenz he wished to proceed with the surgery.

Dr. Lorenz performed the surgery on January 8, 2016, at Adventist Hinsdale Hospital. Petitioner testified that when he came out of anesthesia, in the presence of his family, he was "yelling and more or less crying that [his] hip was hurting like [he] never felt before." Petitioner also testified he remained in the hospital until January 13, 2016.

C. Post-surgical Treatment and Second Section 12 Examination (Dr. Siemionow)

On January 20, 2016, Petitioner saw Dr. Lorenz's assistant, Jennifer Silvia, P.A. She recorded Petitioner was initially doing well after being discharged from the hospital. However, approximately two days after coming home, Petitioner began to complain of right groin pain which left him unable to bear his full weight on his right lower extremity. Petitioner denied any specific trauma or injury. Petitioner stated the groin pain became worse with standing or walking but improved with sitting. Petitioner was using a walker to ambulate secondary to the groin pain. He only placed weight on the ball of his right foot.

After examining Petitioner and obtaining X-rays of his right hip and lumbar spine, Silvia found it likely Petitioner strained his right groin area. She prescribed Celebrex, Flexeril and Norco. She also recommended heat and ice applications, as well as groin stretches. Silvia told Petitioner to continue using the walker, but to place full weight on his right leg to reduce the risk of straining other muscles. She further directed Petitioner to remain off work.

Petitioner again saw Silvia on January 25, 2016. Petitioner was still using a walker but was able to place full weight on his right leg. He stated his right groin pain was worse with the first few steps after standing but improving thereafter. On examination, Silva noted minimal pain on palpation over the right groin and no pain over the right greater trochanter. Silva recommended continuing with the treatment and continued to keep Petitioner off work.

On February 3, 2016, Dr. Lorenz recommended an MRI of Petitioner's right hip. The MR arthrogram, performed on February 8, 2016, showed an abnormal fluid signal and edema interspersed throughout the course of the right psoas muscle adjacent to the visualized lower lumbar spine extending into the iliopsoas in the pelvis. The interpreting radiologist described this finding as non-specific, indicating it could be related to a hematoma or an infection. The radiologist also noted an increased signal of the paraspinal muscles in the lower lumbar spine posteriorly and fluid collection at the laminectomy site, which was probably post-surgical, though he could not rule out infection. In addition, the radiologist noted a small cleft of high signal extending into the undersurface of the superior labrum, "suspicious for non-displaced superior labral tear." He saw no evidence of a right hip contusion, fracture, or avascular necrosis. The radiologist further described the study as limited due to Petitioner's pain in the supine position.

On February 15, 2016, Petitioner saw Dr. Domb, based on a referral from Dr. Lorenz. Dr. Domb's history records Petitioner's right groin pain as beginning immediately after the surgery. The examination indicated positive anterior impingement testing and anterior apprehension. Dr. Domb also reviewed the X-rays and right hip MRI. Dr. Domb described Petitioner as having a complex pain pattern. He attributed Petitioner's right groin pain to a right-sided labral tear indicated on the MR arthrogram, as well as edema/fluid signal in the right psoas muscle.

Dr. Domb also noted a thickening of the femoral shaft. He ordered a right femur MRI to evaluate a lesion for possible malignancy or infection. This MRI was performed on February 24, 2016. The interpreting radiologist found the area of thickening was non-aggressive and benign-appearing. The etiology was uncertain, possibly related to prior trauma.

On Dr. Lorenz's recommendation, Petitioner began physical therapy with Athletico on April 8, 2016. The therapist noted the history of the accident along with Petitioner's report of falling while using a balance board during therapy following the accident. Petitioner complained of low back pain and bilateral leg weakness, worse on the right.

Petitioner saw Silvia on April 27, 2016, complaining of increased lower back pain after exiting his wife's car during the prior week. Silvia again prescribed Celebrex and Flexeril and recommended Petitioner stay off work.

On May 12, 2016, Petitioner returned to Dr. Domb, who recorded some improvement of Petitioner's hip complaints secondary to therapy but with persistent groin pain. Re-examining the MR arthrogram, Dr. Domb noted: "Right hip partial thickness tearing of the gluteus medius, this is more apparent on further review. Labral tearing as previously noted." Dr. Domb recommended a right hip injection, which Petitioner received on May 23, 2016.

Dr. Lorenz saw Petitioner on May 26, 2016, noting complaints of right-sided lower back pain, as well as left hip and leg pain. Dr. Lorenz also noted Petitioner had emergency room care following a pre-syncopal event at therapy. Emergency room personnel attributed Petitioner's symptoms to anxiety and prescribed Cymbalta and Xanax.

On June 23, 2016, Petitioner saw Dr. Domb, stating he continued to experience right hip

pain and had received only temporary relief from two hip injections. Dr. Domb re-examined Petitioner and found him a candidate for surgery to address the labral tear. Dr. Domb also opined that Petitioner's right hip condition "related to [his] previous work-related injury, dating back to 3/13/16 [sic]."

On July 7, 2016, Dr. Lorenz found Petitioner's anxiety and depression was well-controlled with Cymbalta. Petitioner complained of a pinching pain over his left lumbar spine, occasionally radiating into the left thigh. Dr. Lorenz told Petitioner to return after the surgery recommended by Dr. Domb.

At Respondent's request, Petitioner saw Dr. Siemionow for another Section 12 examination on October 5, 2016. Dr. Siemionow's report noted improvement of Petitioner's back following the lumbar spine surgery. However, Petitioner complained of pain in the anterior groin, proximal lateral thigh and right buttock. On physical examination, Dr. Siemionow noted Petitioner had a mildly antalgic gait and localized right hip pain with internal and external rotation of the right leg. He again found a causal relationship between Petitioner's accident and his lumbar spine condition. Dr. Siemionow declined to opine on Petitioner's hip condition because this was not his field of expertise. He believed Petitioner capable of light duty with no lifting over 20 pounds.

On December 8, 2016, Petitioner saw Silvia after visiting his primary care physician due to right-sided testicular and groin pain, as well as a new complaint of left groin pain and increased low back pain. Silvia described Petitioner's gait as antalgic. She recommended follow up with Dr. Domb for these complaints, refilled Petitioner's Norco prescription, and directed Petitioner to remain off work.

Petitioner saw nurse practitioner Stephanie Rabe on December 12, 2016, reporting bilateral hip and groin pain, worse on the right. Rabe recommended Petitioner begin another course of therapy while awaiting authorization of the hip surgery recommended by Dr. Domb.

D. Third and Fourth Section 12 Examinations (Drs. Nho and Siemionow) and Continued Medical Treatment

At Respondent's request, Petitioner saw Dr. Nho for a Section 12 examination on January 23, 2017. In his report of the same date, Dr. Nho indicated he reviewed the medical records and MRI reports. Upon examining Petitioner's right hip, Dr. Nho observed negative impingement, negative psoas impingement, negative lateral rim impingement, negative ischiofemoral impingement, positive trochanteric pain sign, positive sub spine impingement and negative straight leg raising. Petitioner's left hip showed positive impingement and positive psoas impingement, but referred in the lumbar spine.

Dr. Nho interpreted the right hip MRI images as showing "signal on T1 weighted images of the iliopsoas musculature" and abnormal increased signal in the posterior spinal muscles at the level of the laminectomy, which he thought were "likely related to post-surgical changes." Petitioner's chondral labral surfaces appeared to be largely intact.

Dr. Nho diagnosed Petitioner with right iliopsoas hematoma. When asked whether

Petitioner's bilateral hip pain was related to the work accident, Dr. Nho replied, "No." When asked whether current medical treatment is necessary for the right hip, the doctor again answered "No." Although the iliopsoas hematoma caused some discomfort, Dr. Nho believed Petitioner's "symptoms are related to his post-surgical situation." Dr. Nho opined Petitioner could return to work for full duty without restrictions.

On April 17, 2017, Petitioner was again seen by Dr. Lorenz, who described Petitioner's gait as antalgic. Petitioner complained of increased lumbar back pain with radiation extending into his hips and groin bilaterally. Reviewing Petitioner's records, Dr. Lorenz documented complaints of radiating bilateral leg pain after the accident and significantly increased right hip and groin complaints after the lumbar surgery. He opined that Petitioner's back was unable to progress due to the hip complaints, which he described as "related to his work-related injury" of March 13, 2015.

At Respondent's request, Petitioner saw Dr. Siemionow for another Section 12 examination on August 23, 2017. In his report of the same date, Dr. Siemionow noted Petitioner reported having groin pain "essentially ever since the time of the 3/13/15 accident." Petitioner currently complained of 8/10 low back pain, right groin pain, "right proximal left thigh pain," numbness down both legs, plus occasional pain in the tailbone and left leg. Petitioner also reported taking Norco six times daily.

Dr. Siemionow reviewed Petitioner's updated medical records. He observed Petitioner had an antalgic gait favoring the right leg, some mild groin discomfort, pain over the greater trochanter with internal and external rotation of the right hip, limited range of motion in the lumbar spine, absent reflexes in the legs, and negative straight leg raising bilaterally. Petitioner was relying on a walker to ambulate.

Dr. Siemionow again found a causal relationship between Petitioner's accident and his lumbar spine condition. He also found Petitioner at MMI for that condition and believed Petitioner could perform sedentary duty, though a functional capacity evaluation would be beneficial in establishing any restrictions. He further advised Petitioner should not drive or operate heavy machinery based on his Norco intake.

E. Additional Information

Regarding his current condition of ill-being, Petitioner testified he has experienced constant right hip pain since the back surgery. His pain goes from the tailbone and radiates to his hip and groin. Petitioner takes Norco for the pain and uses a walker at Dr. Lorenz's recommendation.

Petitioner acknowledged the report of injury he completed on March 16, 2015 recorded only a back injury. Petitioner also acknowledged he underwent surgery following his motorcycle accident but denied injuring his hip in that accident. According to Petitioner, his prior cervical fusion was unrelated to any accident. He lost four months after the cervical fusion, but then returned to work for Respondent.

Petitioner further testified he experienced hip pain from the date of the March 13, 2015 accident but conceded he did not receive any hip treatment until after the back surgery. He stated he once fell over onto the doctor's desk at MercyWorks because his leg gave out. Petitioner reiterated his foot was "flopping on the floor" as he walked. Petitioner did not recall telling Dr. Zindrick he had no hip pain with gentle range of motion. He did recall falling on his right side during one of the therapy sessions Dr. Zindrick prescribed.

II. CONCLUSIONS OF LAW

A. Petitioner's Credibility

The Commission notes the Arbitrator's conclusions on the issue of Petitioner's credibility but views the evidence differently. Petitioner reported symptoms in his foot days after the work-related injury and consistently reported pain radiating into both legs, albeit more on the left side prior to the back surgery. The concentration of Petitioner's radicular symptoms on the left greater than right prior to his surgery is in line with Petitioner's left-sided lumbar pathology. Indeed, he required a revision decompression and two-level fusion.

Petitioner testified he first noticed a large amount of pain in his right hip when he came out of anesthesia following the back surgery. However, the foregoing does not contradict Petitioner's prior complaints which were bilateral but worse on the left side before the surgery. In April 2015, Dr. Zindrick observed no pain with gentle range of motion with Petitioner's hips, but this also was prior to Petitioner's back surgery. Petitioner also had been diagnosed with a hernia, although Petitioner's primary care physician indicated this was a stable finding and diagnosis, with no GI distress, symptoms of incarceration, or significant pain.

Petitioner testified that he complained of a large amount of hip pain following the back surgery and began to experience significant right groin pain approximately two days after his January 13, 2016 discharge from the hospital. Petitioner also complained of right groin pain to Silvia approximately five days later. The medical records reveal Petitioner's reports of slow improvement in his low back condition and symptoms following surgery and corroborate his testimony about post-operative right hip complaints within days of his release from the hospital.

By February 15, 2016, Dr. Domb attributed Petitioner's right groin pain to a right-sided labral tear indicated on the MR arthrogram, as well as the edema/fluid signal in the right psoas muscle. The findings of the radiologist are consistent with Dr. Domb's findings and objectively corroborate Petitioner's complaints of right hip and groin pain. Petitioner's increasingly bilateral hip complaints since April 8, 2016 are not inconsistent with his initial complaints or those in the weeks following the back surgery. Rather, the Commission views the evolution of Petitioner's complaints before and after his back surgery as consistent with a chain of causation from the accident leading to Petitioner's current condition, as discussed below. Given the totality of the record, the differences between Petitioner's testimony and the medical records do not undermine his credibility overall. Thus, the Commission finds that Petitioner to be credible overall taking his testimony in light of the record as a whole.

B. Causal Connection and Prospective Medical Care

The issues in dispute relate solely to Petitioner's right hip condition. In consideration of the record as a whole, the Commission reverses the Arbitrator's ruling that Petitioner failed to establish a causal connection between the March 13, 2015 work accident and the right hip condition for which Dr. Domb has recommended surgery.

"Accidental injury 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." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). "Every natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent intervening accident that breaks the chain of causation." *National Freight Industries v. Illinois Workers' Compensation Comm'n*, 2013 IL App (5th) 120043WC, ¶ 26. "For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition." *Global Products v. Workers' Compensation Comm'n*, 392 Ill. App. 3d 408, 411 (2009). "So long as a 'but-for' relationship exists between the original event and the subsequent condition, the employer remains liable." *Id.* at 412.

The record demonstrates that Petitioner's treating physicians found his hip condition was the result of the work-related accident. Dr. Domb, a hip specialist, ultimately opined that Petitioner's right hip condition was related to his injury at work. In treating Petitioner, Dr. Domb attributed Petitioner's right groin pain to a right-sided labral tear and the edema/fluid signal in the right psoas muscle indicated in Petitioner's February 2016 right hip MR arthrogram. His further review also revealed right hip partial thickness tearing of the gluteus medius. Dr. Lorenz also opined that Petitioner's back was unable to progress due to the hip complaints.

The Section 12 examinations do not convince the Commission that Dr. Domb is incorrect. Dr. Siemionow declined to opine on Petitioner's hip condition because this was not his field of expertise. Moreover, in his third examination of Petitioner, Dr. Siemionow noted Petitioner reported having groin pain "essentially ever since the time of the 3/13/15 accident." Dr. Nho found no causal connection between the work accident and Petitioner's bilateral hip pain. However, while the Arbitrator discounted Dr. Domb's opinion as conclusory, Dr. Nho answered with a single word: "No." The lack of explanation is notable, given that Dr. Nho later opined Petitioner's "symptoms are related to his post-surgical situation."

The Arbitrator discounted Dr. Lorenz's opinion based on the idea that Petitioner could not show a significant increase in hip pain where the pre-surgical medical records did not mention such pain. The pre-surgical records, however, contain Petitioner's complaints extending beyond his back into his lower extremities generally. Moreover, the Commission focuses on the opinions given by Dr. Domb, the hip specialist in this case.

Dr. Domb's opinions were based in part on his further review of Petitioner's February 2016 right hip MR arthrogram. The findings of the interpreting radiologist are consistent with Dr. Domb's findings and objectively corroborate Petitioner's complaints of right hip and groin pain which came to the fore after surgical intervention for the more problematic lumbar condition with

radicular symptoms. Petitioner was asymptomatic in the right hip prior to the accident but had complaints regarding both lower extremities following the accident. Petitioner's severe left-sided low back condition, which resulted in revision decompression and two-level fusion, does not exclude that Petitioner, a 63-year-old truck driver, sustained a partial labral tear and right hip partial thickness tearing of the gluteus medius at the time of his undisputed accident. Petitioner's right-sided symptoms were less prominent than the low back symptoms until surgery fully revealed or exacerbated them.

The weight of the evidence, taking the combined opinions and supporting medical documentation as set forth above, demonstrates the work-related injury was a causative factor in the resulting right hip condition of ill-being. Petitioner's necessary and reasonable back surgery was part of a but-for chain of causation leading to Petitioner's current condition.

Accordingly, the Commission reverses the Arbitrator's finding as to causal connection to find Petitioner's current condition of ill-being causally related to the accident of March 13, 2015. The Commission, having found an ongoing causal connection to Petitioner's condition of ill-being, also finds Petitioner met his burden of proving entitlement to prospective care in the form of the right hip surgery recommended by Dr. Domb.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner proved he sustained an accident arising out of and in the course of his employment with Respondent on March 13, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for Petitioner's prospective medical care prescribed by Dr. Domb for the right hip as it is causally related to the accident.

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 county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

19IWCC0643

DATED: NOV 22 2019
10/17/19
BNF/kcb
045

Barbara N. Flores

Marc Parker

Dissent

I respectfully dissent from the Decision of the majority. Petitioner's testimony regarding when his right hip symptoms began was inconsistent and not corroborated by the treatment records. As these inconsistencies greatly diminish Petitioner's credibility, I would have found that Petitioner failed to meet his burden of proving that his right hip condition was causally related to his March 13, 2015 work accident.

Petitioner testified both that his right hip pain was present within days of his accident and that it abruptly began after his January 8, 2016 lumbar surgery. This conflicting testimony fails to establish whether his right hip symptoms onset around March 2015 or January 2016. The treatment records also do not corroborate Petitioner's testimony that he had right hip pain since the accident date. Specific complaints of right hip pain were not documented in the treatment records until January 20, 2016, approximately 10 months after Petitioner's accident. Moreover, although Petitioner's pre-surgery records document radiating leg pain, the pain is noted to be predominantly on Petitioner's left side. Later post-surgery treatment records also refer to Petitioner's hip problems as bilateral as opposed to localized only in his right hip. These treatment records fail to corroborate Petitioner's testimony that he experienced constant right hip pain that began on the accident date.

Petitioner failed to provide credible testimony regarding the onset date and nature of his right hip pain. For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator.

DLS/met
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Deborah L. Simpson

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# NOTICE OF ARBITRATOR DECISION
8(A)

ZIOMEK, JEFFREY G
Employee/Petitioner

Case# **15WC011225**

CITY OF CHICAGO
Employer/Respondent

19IWCC0643

On 10/19/2017, 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 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0010 CITY OF CHICAGO DEPT OF LAW
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
8(A)

Jeffrey G. Ziomek
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # 15WC 11225

Consolidated cases: D/N/A

19IWCC0643

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **9/26/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 19IWCC0643

On the date of accident, **3/13/2015**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds Petitioner failed to establish causation as to his claimed right hip condition of ill-being.

In the year preceding the injury, Petitioner earned $**69,801.27**; the average weekly wage was $**1,342.33**

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

The parties deferred the issue of unpaid medical expenses. Arb Exh 1.

The parties agree Petitioner was temporarily totally disabled from March 26, 2015 through September 26, 2017, a period of 130 6/7 weeks. Arb Exh 1.

Respondent shall be given a credit of $**117,491.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**117,491.52**.

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

ORDER

FOR THE REASONS SET FORTH IN THE ATTACHED DECISION, THE ARBITRATOR DECLINES TO AWARD PROSPECTIVE CARE IN THE FORM OF THE RIGHT HIP SURGERY PRESCRIBED BY DR. DOMB.

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

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

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

Molly C Mason

Signature of Arbitrator

10/19/17
Date

ICArbDec19(b)

OCT 19 2017

Jeffrey Ziomek v. City of Chicago
15 WC 11225

Summary of Disputed Issues

19IWCC0643

The parties agree Petitioner injured his lower back on March 13, 2015, while working as a truck driver for Respondent. T. 4-7. Respondent authorized and paid for the lumbar spine surgery Petitioner underwent on January 8, 2016. Respondent disputes causation as to a claimed right hip condition. Petitioner seeks prospective care in the form of right hip surgery recommended by Dr. Domb.

Arbitrator's Findings of Fact

Petitioner testified he initially worked for Respondent between 1998 and 2004. He resigned in 2004 and was re-hired in 2006. T. 12, 41. As of his March 13, 2015, accident, he was working as a truck driver. He operated several kinds of trucks, including four-wheeled dump trucks, "gate" trucks with removable panels and ten-wheeled dump trucks used to haul machinery. T. 13. He is a member of the Teamsters union, Local 700.

Petitioner testified his job involved delivering materials to crews that were working at different locations. He was not required to perform much lifting or carrying. T. 13. The heaviest item he was required to lift was a 50-pound box of screws or bolts. T. 13. He sometimes had to climb up on the side of a 10-wheeler to tarp a load. T. 13. Some of the trucks he drove had attached ladders but most of the time he had to climb up the side of the truck bed. T. 14. The top of the bed was typically 10 feet above ground level, meaning he had to climb about 4 feet. T. 14. He occasionally performed squatting and/or bending while moving or repositioning a box. T. 14. The maximum weight he had to push or pull was 50 pounds. T. 14-15. He was required to walk into the office to swipe in for the day and out in the yard to track down a foreman or access his assigned vehicle. T. 15. He did not perform much standing or twisting. He typically drove about 6 hours out of each workday. T. 15.

Petitioner testified he was able to perform all of his assigned duties prior to March 13, 2015. T. 15-16.

Petitioner acknowledged undergoing lumbar spine surgery in 1998, following an accident. He was released to full duty after he recovered from this surgery. T. 16-17.

Petitioner denied injuring his back or undergoing any back-related care between the time he resumed working for Respondent in 2006 and the March 13, 2015 accident. T. 17.

Petitioner denied injuring his right hip or undergoing any right hip care before the March 13, 2015 accident. T. 17-18.

Petitioner testified his duties on March 13, 2015 involved driving a 10-wheeler while pulling a 20-ton trailer filled with gravel. On two occasions that day, while leaving the yard and driving northbound on Ashland (T. 31), he hit bumps in the road. The 10-wheeler was equipped with a Bostrom-type air seat. On both occasions, the seat went up when he drove over the bump but "blew out" when it came back down, causing him to end up in a corner of the seat. T. 18-19.

On direct examination, Petitioner testified that, about four days after the accident, he began experiencing "flapping" of his foot while walking. Later the same week, his back "started hurting a little bit more," prompting him to seek medical attention. T. 19. He first sought care on March 16, 2015. On that date, he saw Dr. Diadula at MercyWorks. T. 19.

Dr. Diadula's note of March 16, 2015 reflects a date of accident of March 13, 2015. It also reflects that Petitioner reported injuring his tailbone when the seat of the truck he was driving broke. Dr. Diadula noted complaints of tailbone pain and 7-8/10 low back pain "radiating to the left leg more than to the right with numbness and cramping at the back of the legs all the way to the heels."

With respect to Petitioner's past medical history, Dr. Diadula noted that Petitioner underwent a laminectomy in 1998, following a rollover truck accident. He also noted that Petitioner had a motorcycle accident in 2011 and underwent a three-level cervical fusion in 2012.

On examination, Dr. Diadula noted scarring from the prior back surgery, limited flexion and extension, right straight leg raising to 25 degrees with the pain "cross[ing] to the left hip," left straight leg raising to 50 degrees, tenderness in the lower lumbar spine and coccyx and a little swelling in the coccyx.

Dr. Diadula obtained lumbar spine and sacral X-rays. He indicated these X-rays showed no fracture of the coccyx. He diagnosed contusions of the lumbar spine and coccyx. He prescribed Ibuprofen, ice/heat, home exercises and a doughnut seat. He released Petitioner to full duty, indicating he did so at Petitioner's request. PX 1, pp. 1-2.

Petitioner did not testify to resuming full duty after his initial visit to Dr. Diadula. [The parties stipulated Petitioner was temporarily totally disabled from March 16, 2015 through the hearing. Arb Exh 1.]

Petitioner returned to MercyWorks on March 23, 2015 and again saw Dr. Diadula. The doctor noted the same symptoms and examination findings. He diagnosed contusions of the lumbar spine and coccyx and lumbar radiculopathy. He prescribed a lumbar spine MRI, along with heat/ice applications and home exercises. He again released Petitioner to full duty. PX 1, p. 2. T. 20.

Petitioner returned to MercyWorks on March 25, 2015 and saw a different physician, Dr. Ali. Petitioner indicated he returned to the facility "to be put off work," indicating he had taken half a day off the previous day due to lower back pain. Dr. Ali noted a complaint of lower back pain, rated 8/10, "with occasional left radicular pain." He also noted that Petitioner denied any numbness or weakness. He described Petitioner's gait as normal. He described straight leg raising as negative bilaterally. He noted Petitioner was awaiting the recommended MRI. He directed Petitioner to stay off work on April 2nd or three days after the MRI, whichever was earlier.

The lumbar spine MRI, performed without contrast on April 3, 2015, showed significant foraminal stenosis for the L5 nerve roots bilaterally, suspect for L5 nerve root impingement, mild to moderate acquired stenosis, greatest at L4-L5, suspicion for a right foraminal disc protrusion at L4-L5 and generalized disc bulging at multiple levels. PX 2, pp. 1-2.

On April 9, 2015, Dr. Diadula noted ongoing symptoms of 8/10 low back pain, "radiating to the left leg more than to the right leg," with the pain worsening when initiating walking. He also noted that Petitioner complained of "weakness in both legs" when starting to walk. On examination, he noted a complaint of pain "crossing to [the] left hip" when he raised Petitioner's right leg. After reviewing the MRI, he prescribed Norco and indicated Petitioner planned to see "his own orthopedic surgeon spine specialist," Dr. Zindrick. He discharged Petitioner from care. PX 1, pp. 3-4.

Petitioner first saw Dr. Zindrick on April 15, 2015, with the doctor recording the following history:

> "[Petitioner] was injured at work on March 13, 2015. He is a truck driver and on that date the air cushion in his seat gave way and he bottomed out 2 different times in a short period of time. He developed immediate pain in his lower back that shot all the way towards his mid back and neck. He went to MercyWorks and had X-rays performed. He was given Norco for pain. He attempted to return to work but unfortunately his symptoms progressively increased and he began having radiating pain, with numbness and weakness into his left leg."

Dr. Zindrick indicated that Petitioner described his symptoms as primarily in his legs, "worse on the left hand side."

Dr. Zindrick interpreted the MRI as showing disc desiccation and bulging with a right paracentral protrusion at L4-L5 and disc bulging and foraminal stenosis bilaterally at L5-S1.

On examination, Dr. Zindrick noted a limited and painful range of lumbar spine motion, positive straight leg raising on the left at 90 degrees and "no pain with gentle range of motion" of the hips.

Dr. Zindrick diagnosed acute low back pain "with left greater than right radiculopathy" and degenerative disc disease. He prescribed a Medrol Dosepak, Relafen and physical therapy. He directed Petitioner to remain off work. PX 3, pp. 1-4.

Petitioner underwent a physical therapy evaluation at ATI on April 20, 2015. The evaluating therapist noted primary complaints of low back pain, "shooting pains down L leg" and right thigh pain. PX 4.

Petitioner returned to Dr. Zindrick on May 19, 2015. T. 21. The doctor noted ongoing low back and radicular leg symptoms. He described the leg symptoms as "worse left than right." He described Petitioner's gait as antalgic. He obtained lumbar spine X-rays with sacral views. He indicated the films showed degenerative changes but no evidence of acute fracture. He recommended pain management, to include lumbar injections, along with Mobic and continued therapy. He directed Petitioner to remain off work. PX 3, pp. 4-7.

Records in PX 4 reflect that physical therapy at ATI was placed on hold on May 20, 2015 due to lack of insurance authorization. PX 4, p. 7.

Petitioner saw Dr. Chekka on June 2, 2015, at the referral of Dr. Robinson, his primary care physician, and Dr. Zindrick. T. 21.

Dr. Chekka recorded a history of the work accident and subsequent care. He noted that Petitioner complained of bilateral leg pain, left greater than right, radiating into both feet, as well as occasional left leg weakness. He indicated that Petitioner reported discontinuing therapy after twelve sessions due to severe pain.

Dr. Chekka described Petitioner's gait as minimally antalgic. On examination, he noted a restricted range of lumbar spine motion in all planes, a positive slump seat test and a subtle motor deficit on the left. After reviewing the MRI, he recommended bilateral L5-S1 transforaminal epidural steroid injections, to be followed by an additional course of physical therapy. PX 5, pp. 1-3. He administered the injections the same day. PX 5, pp. 5-6.

On June 17, 2015, Dr. Zindrick noted ongoing back and bilateral leg complaints, "left greater than right." He also noted that Petitioner "was recently diagnosed with a hernia" and had intentionally lost forty pounds. He indicated that the recent injection provided only temporary relief. He prescribed a lumbar CT myelogram and continued to keep Petitioner off work. PX 3, pp. 8-10.

Dr. Zindrick last saw Petitioner on July 14, 2015. He noted that Petitioner had recently undergone a CT scan of his abdomen, per his primary care physician, but had not undergone

the recommended lumbar CT myelogram due to lack of authorization. He indicated Petitioner was still experiencing back and bilateral leg pain, worse on the left, as well as "catching his feet when walking." He referred Petitioner to his associate, Dr. Lorenz, for a surgical consultation. PX 3, pp. 11-12.

Petitioner first saw Dr. Lorenz on August 6, 2015. T. 22. The doctor's note of that date sets forth a history of the prior rollover accident and L4-L5 discectomy as well as the March 2015 work accident. He noted complaints relative to the low back and legs as well as recent complaints of pain extending into the upper thoracic area and neck.

Dr. Lorenz described Petitioner as standing "with a flat back pitched forward." On initial examination, he noted very limited forward bending, negative straight leg raising, absent reflexes bilaterally, some minor weakness to ankle dorsiflexion and no atrophy. He interpreted the lumbar spine MRI as showing significant spinal stenosis at L4-L5 compressing the exiting L5 nerve root bilaterally and a recurrent disc herniation at L4-L5. He recommended a revision decompression and a fusion from L4-S1. He directed Petitioner to remain off work. PX 6, pp. 1-4.

At Respondent's request, Petitioner saw Dr. Siemionow, a spine surgeon, on September 16, 2015, for purposes of a Section 12 examination. T. 22. In his report of the same date, Dr. Siemionow recorded a history of the March 16, 2015 work injury, noting that Petitioner described his impact against the truck seat as "significant enough to cause the airbag to become deployed." He also recorded a history of the 1998 lumbar spine surgery and 2012 cervical fusion.

Dr. Siemionow noted complaints of pain in the lower back, buttocks, legs and calves. He also noted that Petitioner described his legs as "giving out" and reported deriving only transient relief following the epidural injection.

Dr. Siemionow described Petitioner's gait as normal. On lumbar spine examination, he noted a 25% reduction in range of motion and negative straight leg raising bilaterally.

Dr. Siemionow indicated he reviewed the report of injury (RX 1), the MRI report and notes from Drs. Zindrick and Lorenz. He indicated he agreed with Dr. Lorenz's recommendation of a decompression and fusion at L4-S1. He described the treatment to date as reasonable and necessary. He found a causal relationship between the work accident and Petitioner's current lumbar spine condition. He opined that Petitioner could perform sedentary duty while awaiting the recommended spinal surgery. He anticipated that Petitioner would reach maximum medical improvement a year after this surgery. RX 2.

Petitioner returned to Dr. Lorenz on November 16, 2015, with the doctor noting severe back pain as well as pain radiating down both legs, "left greater than right." He indicated Petitioner wanted to proceed with surgery. He directed Petitioner to remain off work in the interim. PX 6, pp. 5-7.

Dr. Lorenz performed a revision discectomy at L4-L5 on January 8, 2016. The surgery took place at Adventist Hinsdale Hospital. In his operative report, Dr. Lorenz indicated that, following the surgery, Petitioner was "transferred to the recovery room with stable vital signs, moving all extremities consistent with pre-operative abilities." PX 7, pp. 1-5.

Petitioner testified that, as he came out of anesthesia following his back surgery, in the presence of his family, he was "yelling and more or less crying that [his] hip was hurting like [he] never felt before." T. 23. Petitioner also testified that, after the surgery, he remained in the hospital until January 13, 2016. T. 23. Petitioner did not offer into evidence any hospital records other than the operative report.

On January 20, 2016, Petitioner saw Dr. Lorenz's assistant, Jennifer Silvia, P.A. [hereafter "Silvia"], at Hinsdale Orthopaedics. Silvia recorded the following history:

> "Initially doing well after hospital discharge, states he was going up and down the stairs in his house at least 8x/day as well as walking extended amounts. About 2 days after coming home from the hospital, began to complain of right groin pain. Unable to bear full weight on right lower extremity secondary to pain. Denies specific trauma or injury. Groin pain worse with standing and walking. Improves with sitting. Otherwise denies leg pain, numbness, tingling, fevers, change In bowel or bladder habits. Using walker to ambulate secondary to groin pain."

Silvia noted that Petitioner relied on the walker to ambulate and only placed weight on the ball of his right foot. On examination, she noted no pain on palpation over the right greater trochanter, right groin pain with flexion, adduction and internal rotation of the right hip and decreased right iliopsoas strength secondary to pain.

Silvia obtained X-rays of the right hip as well as the lumbar spine. She described the right hip films as unremarkable. She found it likely that Petitioner had strained his right groin area. She prescribed Celebrex and refilled prior prescriptions for Flexeril and Norco. She also recommended heat/ice applications and groin stretches. She indicated that Petitioner could continue using the walker but recommended that he place full weight on his right leg to decrease the risk of straining other muscles. She directed Petitioner to remain off work. PX 6, pp. 14-17.

Petitioner returned to Hinsdale Orthopaedics on January 25, 2016 and again saw Silvia. Silvia noted that Petitioner was still using a walker but reported being able to bear full weight on his right leg. She also noted that Petitioner described his right groin pain as "worse with first few steps after standing and then beginning to improve." On re-examination, she noted "minimal pain on palpation over right groin" and no pain over the right greater trochanter. She

recommended that Petitioner continue the medication, ice/heat applications and gentle groin stretches. She continued to keep Petitioner off work. PX 6, pp. 19-21.

The right hip MR arthrogram, performed on February 8, 2016, showed an abnormal fluid signal and edema interspersed throughout the course of the right psoas muscle adjacent to the visualized lower lumbar spine extending into the iliopsoas in the pelvis. Dr. Musabji, the interpreting radiologist, described this finding as non-specific. He indicated it could be related to a psoas hematoma or infection. He also noted an increased signal of the paraspinal muscles in the lower lumbar spine posteriorly and fluid collection at the laminectomy site. He indicated these findings could be post-operative but that he could not exclude the possibility of infection. He further noted a small cleft of high signal extending into the undersurface of the superior labrum "suspicious for non-displaced superior labral tear." He saw no evidence of a right hip contusion, fracture or avascular necrosis. He described the study as "limited" due to Petitioner's reported extreme pain in the supine position. PX 8, pp. 1-2.

Dr. Musabji indicated he compared the MR arthrogram images with pelvis and lumbar spine X-rays taken on May 19, 2015. PX 8, pp. 1-2. No pelvic X-ray report of that date is in evidence.

Petitioner first saw Dr. Domb on February 15, 2016. The doctor's history reflects that Petitioner's right groin pain "began immediately after spine surgery."

On right hip examination, Dr. Domb noted positive anterior impingement testing and anterior apprehension. He obtained X-rays and also reviewed the MR right hip arthrogram. He described Petitioner as having a "complex pain pattern." He ascribed Petitioner's right groin pain to both the right-sided labral tear demonstrated on the arthrogram and the edema/fluid signal in the right Psoas muscle. He viewed the area of thickening of the femoral shaft shown on X-ray as "incidental," indicating it "could represent malignancy or infection." He ordered a femoral shaft MRI, to further evaluate this thickening, along with an initial course of conservative care. PX 9, pp. 1-3.

Petitioner underwent the right femur MRI on February 24, 2016. Dr. Musabji interpreted this study as showing a "10 centimeter long area of periosteal thickening at the lateral aspect of the proximal/mid femoral diaphysis without associated edema, reaction or enhancement in the adjacent muscles or marrow changes in the adjacent femur." He did not see any suspicious bone lesions. PX 9, p. 7.

Petitioner began a course of physical therapy at Athletico on April 8, 2016. The evaluating therapist noted a history of the 1998 lumbar surgery and March 2015 work accident. She further indicated that Petitioner reported falling while using a balance board at a therapy facility after the March 2015 accident. She noted complaints of low back pain and bilateral leg weakness, worse on the right. PX 10, pp. 1-4.

On April 27, 2016, Silvia described Petitioner as presenting "with increased lower back pain after getting out of his wife's car a week ago." On examination, she noted negative straight leg raising bilaterally. She prescribed Celebrex, along with Flexeril, as needed, and recommended that Petitioner continue therapy and remain off work. PX 6, pp. 35-37.

Petitioner returned to Dr. Domb on May 12, 2016. The doctor noted some improvement of the prior hip complaints, secondary to therapy, but persistent groin pain, especially with abduction activities. He recommended a right hip injection. Petitioner underwent this injection on May 23, 2016. PX 9, pp. 14-17.

On May 26, 2016, Dr. Lorenz noted complaints of right-sided lower back pain as well as "left hip and leg pain." He also noted that Petitioner had recently undergone Emergency Room care at Christ Hospital following a "pre-syncopal event" at therapy. He indicated that Emergency Room personnel attributed Petitioner's symptoms to anxiety and started him on Cymbalta and Xanax. He noted that Petitioner was awaiting an appointment with a psychiatrist at Christ Hospital. He recommended that Petitioner keep this appointment, stay off work and follow up with Dr. Domb for his right hip. PX 6, pp. 39-42. [No Christ Hospital or psychiatric records are in evidence.]

Petitioner returned to Dr. Domb on June 23, 2016. The doctor noted that Petitioner was still experiencing right hip pain and had derived only temporary relief from two injections. After re-examining Petitioner, he found him to be a candidate for right hip surgery to address the labral tear. He further found Petitioner's right hip pathology to be "related to previous work-related injury dating back to 3/13/16 [sic]." PX 9, pp. 19-22.

On July 7, 2016, Dr. Lorenz described Petitioner's anxiety and depression as well controlled with Cymbalta. He indicated that Petitioner reported improvement of his low back symptoms but continued to complain of "pinching pain over his left lumbar spine with intermittent radiation into left thigh." He obtained lumbar spine X-rays and interpreted the films as showing a stable L4-S1 fusion. He noted Petitioner was awaiting authorization of the right hip surgery recommended by Dr. Domb. He recommended that Petitioner return to him following this surgery. PX 6, pp. 42-44.

At Respondent's request, Dr. Siemionow re-examined Petitioner on October 5, 2016. T. 27. He noted the intervening lumbar spine surgery. He indicated that Petitioner reported improvement of his back pain since this surgery but was now complaining of pain in the anterior groin, proximal lateral thigh and right buttock. He noted that Petitioner had recently seen Dr. Domb and that this doctor was recommending right hip surgery to address labral pathology.

On re-examination, Dr. Siemionow noted a "mildly antalgic gait favoring the right lower extremity" and localized right hip pain with internal and external rotation of the right leg. He also noted negative straight leg raising bilaterally.

Dr. Siemionow interpreted July 2016 lumbar spine films as showing proper instrumentation placement and evidence of "solid arthrodesis L4 to S1."

Dr. Siemionow again found a causal relationship between the work accident and Petitioner's lumbar spine condition. He declined to address causation vis-à-vis the right hip, indicating that this was not within his field of expertise. He did state, however, that the hip condition would "more likely than not interfere with [Petitioner's] lumbar spine rehabilitation." He saw no need for additional lumbar spine imaging and found Petitioner capable of light duty with no lifting over 20 pounds. RX 2.

Petitioner saw Silvia at Hinsdale Orthopaedics on December 8, 2016. Silvia noted that Petitioner had recently seen his primary care physician due to right-sided testicular and groin pain and a "new complaint of left groin pain." She also noted that Petitioner was experiencing increased low back pain. She described Petitioner's gait as antalgic. On examination, she noted a complaint of "stretching pain" in the left groin with extension of the left hip. She recommended that Petitioner continue to follow up with Dr. Domb for his right hip "as well as evaluation for new left groin/hip complaints." She refilled Petitioner's Norco prescription and directed Petitioner to remain off work. PX 9, pp. 23-26.

Petitioner saw Stephanie Rabe, a nurse practitioner, at Hinsdale Orthopaedics on December 12, 2016. Rabe noted a complaint of bilateral hip and groin pain, worse on the right. She also noted that Petitioner viewed all of his symptoms as starting after his March 2016 work accident. She recommended that Petitioner begin another course of therapy for both hips and his back, while awaiting authorization of the right hip surgery recommended by Dr. Domb. PX 9, pp. 27-29.

At Respondent's request, Petitioner saw Dr. Nho on January 23, 2017 for purposes of a hip-related Section 12 examination. T. 27. In his report of the same date, Dr. Nho indicated that Petitioner denied having any hip pain prior to his work accident. Dr. Nho also indicated he reviewed records from MercyWorks, Dr. Zindrick, Dr. Chekka, Dr. Lorenz and Dr. Domb, along with the MRI reports, in connection with his examination.

Dr. Nho noted that Petitioner was "complaining now of bilateral hip pain," right worse than left, worse with walking, getting up from a chair, using stairs and exercising.

On right hip examination, Dr. Nho noted extension of 0 degrees, flexion to 100 degrees, external rotation to 30 degrees, internal rotation to 15 degrees, negative impingement, negative psoas impingement, negative instability, negative posterior impingement, negative lateral rim impingement, negative ischiofemoral impingement, positive trochanteric pain sign, positive sub spine impingement and negative straight leg raising. His findings as to the left hip were similar with the exception of positive impingement and positive psoas impingement, "but referred in the lumbar spine."

Dr. Nho obtained plain hip X-rays. He interpreted these films as showing a right hip lateral center edge angle of 39 degrees and an alpha angle of 51 degrees and a left hip lateral center edge angle of 33 degrees and an alpha angle of 66 degrees.

Dr. Nho interpreted the right hip MRI images as demonstrating "signal on T1 weighted images of the iliopsoas musculature" and an abnormal increased signal in the posterior paraspinal muscles at the level of the laminectomy, "likely related to post-surgical changes." He indicated the chondral labral surfaces appeared to be "largely intact."

Dr. Nho described Petitioner's current diagnosis as "right iliopsoas hematoma." He found no causal relationship between the work accident and Petitioner's bilateral hip pain. He indicated that, while the iliopsas hematoma had "caused some discomfort," this was likely related to Petitioner's "post-surgical situation." He did not recommend any additional treatment for Petitioner's bilateral hip pain. With respect to this condition, he found Petitioner capable of full duty. RX 4.

Petitioner returned to Dr. Lorenz on April 24, 2017, with the doctor recording the following interval history:

> "Mr. Ziomek presents to the office for follow-up. He continues to await approval for right hip surgery. He continues to complain of increased lumbar back pain with radiation extending into his hips and groin bilaterally extending down posterior aspect of lower extremities bilaterally."

He described Petitioner's gait as antalgic, indicating that Petitioner complained of increased back and left hip pain when walking.

Dr. Lorenz went on to address causation. He indicated he reviewed Petitioner's records but did not specify which records he looked at. He indicated the records documented complaints of radiating bilateral leg pain after the accident and "significantly increased" right hip and groin complaints following the lumbar spine surgery. He described Petitioner as unable to progress, back-wise, due to the hip complaints. He described those complaints as "related to his work related injury from 3/13/15." PX 6, pp. 49-52.

At Respondent's request, Dr. Siemionow examined Petitioner a third time on August 23, 2017. In his report of the same date, the doctor indicated that Petitioner reported having groin pain "essentially ever since the time of the 3/13/15 accident."

Dr. Siemionow noted current complaints of 8/10 low back pain, right groin pain, "right proximal left thigh pain," numbness traveling down both legs, occasional tailbone pain and occasional left leg pain. He indicated that Petitioner reported taking Norco 10/325 six times per day.

Dr. Siemionow indicated he reviewed Dr. Nho's report and recent records from Dr. Domb, Dr. Warren [sic], Athletico Physical Therapy and Dr. Lorenz.

On re-examination, Dr. Siemionow noted an antalgic gait favoring the right leg, some mild groin discomfort and pain over the greater trochanter with internal and external rotation of the right hip, a limited range of lumbar spine motion, intact sensation in the legs, absent reflexes in the legs and negative straight leg raising bilaterally. He indicated Petitioner was relying on a walker to ambulate.

Dr. Siemionow again found a causal relationship between the work accident and Petitioner's lumbar spine condition. He further found Petitioner to be at maximum medical improvement with respect to this condition. He felt Petitioner could perform sedentary duty but indicated a functional capacity evaluation "would be beneficial in establishing his restrictions." He indicated Petitioner should not drive or operate machinery, given his Norco intake. RX 5.

Petitioner denied reinjuring his right hip after March 13, 2015. T. 27-28.

Petitioner testified he has experienced constant right hip pain since the back surgery of January 8, 2016. The pain "goes from the tailbone and radiates to the hip to the groin." His right leg is now numb almost to the ankle. He takes six Norcos per day for his symptoms. Dr. Lorenz prescribed this medication. He also uses a walker at Dr. Lorenz's recommendation. T. 28-29.

Under cross-examination, Petitioner identified RX 1 as a report of injury he completed and signed on March 16, 2015. T. 30. The report sets forth the following description of the March 13, 2015 accident:

> "While driving truck #DT236R the seat bottomed out 2 different times after hitting holes and injured driver's back."

In response to a question asking whether he reported only a low back injury to Respondent, Petitioner initially indicated he also complained of his leg when he went to MercyWorks. He then acknowledged reporting only a back injury in the report he completed. T. 31.

Petitioner acknowledged being involved in a motorcycle accident in 2011 or 2012. T. 32. He also acknowledged undergoing a three-level cervical spine fusion. He testified that the motorcycle accident resulted in rib fractures, for which he underwent Emergency Room care. The need for the fusion did not result from any accident. T. 33-34. He also denied injuring his right hip in the motorcycle accident. T. 32-33.

Petitioner testified he did in fact experience right hip pain before the January 8, 2016 back surgery. He had right hip pain from the March 13, 2015 accident forward. At one of his

visits to MercyWorks, he fell over onto the doctor's desk due to his leg giving out. T. 34-35. At MercyWorks, he complained of his back and leg. He also complained that his foot was "flopping on the floor" as he walked. T. 35. He acknowledged he did not undergo any right hip treatment until after the January 8, 2016 back surgery. T. 35. The first time he saw a doctor, he complained of back and hip pain, as well as "flopping" of his foot. T. 36. He is aware that Drs. Siemionow and Nho are not treating physicians. T. 37. His family physician is Dr. Warren Robinson. He has seen Dr. Robinson for about thirty years. T. 38. He does not recall telling Dr. Zindrick he had no hip pain with gentle range of motion. Dr. Zindrick prescribed physical therapy. At some point during the therapy, his leg gave out, causing him to fall onto his right side. T. 39. Before he began working for Respondent, he drove a concrete truck for twenty-four years. T. 39. The job he performed for Respondent primarily consisted of driving. He lifted and maneuvered materials only as needed. He drove alone, without a laborer. T. 41. He has not met with the pension board and has no upcoming appointments with this board. T. 41.

On redirect, Petitioner indicated he experienced a reduced range of neck motion following his cervical spine fusion but was not subject to any formal restrictions. T. 42. He lost four months of work following the fusion and was then able to return to work for Respondent. T. 42-43. He was honest with the doctors he saw for his work accident. He has not reviewed the records these doctors wrote. It seems like his hip symptoms get worse each day. T. 44.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning the timing of the onset of right hip symptoms was internally inconsistent. On direct examination, he initially indicated he began experiencing pain radiating to his right hip a few days after the work accident. T. 19. A few minutes later, he testified to an abrupt onset of right hip pain as he came out of anesthesia in January 2016, following his lower back surgery. T. 23. He indicated he has experienced constant right hip pain since this surgery. T. 28. Under cross-examination, however, he acknowledged he mentioned only a low back injury in his accident report, while claiming he "had hip pain from the day of the accident." T. 34. He went on to state he first experienced right hip pain while coming out of anesthesia after his back surgery. T. 36. He also, for the first time, mentioned falling, both at MercyWorks and during physical therapy.

Petitioner's testimony is also inconsistent with his medical records. The earliest records, from MercyWorks, do set forth complaints of radiating leg pain but they describe this pain as primarily left-sided. On April 9, 2015, Dr. Diadula noted a complaint of pain crossing to the left hip when he lifted Petitioner's right leg. On April 15, 2015, a month after the accident, Dr. Zindrick noted "no pain" with gentle range of motion of the hips. Like Dr. Diadula, he described Petitioner's leg complaints as worse on the left. He never documented groin complaints but, on June 19, 2015, did indicate Petitioner had "recently been diagnosed with a hernia." A month later, he noted Petitioner had recently undergone an abdominal CT scan per his primary care physician. [Petitioner did not testify to hernia- or abdomen-related care and did not offer any

records from his longtime primary care physician, Dr. Robinson.] On June 2, 2015, Dr. Chekka noted bilateral leg complaints but, like Drs. Diadula and Zindrick, he described them as worse on the left. He noted a hernia on examination and no hip complaints. Dr. Lorenz's pre-operative notes document no groin or hip complaints. The doctor's operative report of January 8, 2016 reflects that Petitioner was able to move all of his extremities in the recovery room. Petitioner stayed in the hospital for five days after the surgery but his records concerning that stay are not in evidence. [It is clear to the Arbitrator that many treatment records are missing since the pre-printed numbers at the bottom of the records in PX 5 reference a total of 1661 pages.]

The first note that specifically mentions right hip pain is Silvia's post-operative note of January 20, 2016. That note is not consistent with Petitioner's testimony in that Silvia indicated Petitioner initially did well following the surgery and did not begin experiencing right groin pain until two days after being discharged from the hospital.

A further complication is that, while Petitioner did not testify to any left hip problems, the most recent records describe his hip problems as bilateral. On December 8, 2016, Silvia noted a "new complaint" of left groin pain. She referenced a recent hernia evaluation performed by Dr. (Warren) Robinson but, again, Dr. Robinson's records are not in evidence. On May 26, 2016 and April 24, 2017, Dr. Lorenz noted a complaint of left hip pain. On December 12, 2016 and February 15, 2017, Dr. Domb's assistant noted a complaint of "bilateral hip pain, right worse than left." On January 23, 2017, Dr. Nho, Respondent's hip examiner, also described Petitioner's hip pain as bilateral. He actually noted more abnormalities on left hip examination than on right hip examination. RX 4.

Overall, the Arbitrator found Petitioner inconsistent and less than credible with respect to the onset and nature of his hip complaints. The right hip MR arthrogram showed pathology but the cause of this pathology is murky at best. The fact that Petitioner's left hip is also symptomatic undermines his claim that the work accident and/or accident-related back surgery caused a specific trauma to the right hip.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of March 13, 2015 and his claimed right hip condition of ill-being?

The Arbitrator initially finds that Petitioner failed to establish a causal connection between the March 13, 2015 work accident and the right hip condition for which Dr. Domb has recommended surgery. In so finding, the Arbitrator relies in part on the foregoing credibility assessment. Petitioner provided varying accounts of the etiology of his right hip pain. None of those accounts match with his records. Right hip pain is first documented on January 20, 2016, with Silvia, Dr. Lorenz's assistant, indicating Petitioner began experiencing this pain recently, about two days after being discharged from the hospital. Not long thereafter, the hip complaints evolve again and become bilateral.

The Arbitrator has also considered the varying causation-related opinions offered by Drs. Lorenz, Domb and Nho. In the Arbitrator's view, the opinion voiced by Dr. Lorenz is based on a faulty history since he described Petitioner's right hip complaints as "significantly increasing" following the lumbar spine surgery. The doctor's allusion to an increase in complaints implies that right hip pain was noted before the surgery but no pre-operative records specifically mention such pain. Moreover, Silvia's note of January 20, 2016 does not describe Petitioner's right hip pain as increasing postoperatively. Instead, Silvia documented an abrupt onset of right hip pain two days after Petitioner was discharged from the hospital. Dr. Domb's timeline is more accurate, in that he described the right hip symptoms as starting after the surgery, but his causation opinion is conclusory and not well-explained. Neither Dr. Lorenz nor Dr. Domb gave a deposition.

Is Petitioner entitled to prospective right hip surgery?

Based on the foregoing credibility- and causation-related findings, the Arbitrator denies Petitioner's claim for prospective care in the form of right hip surgery.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Lamoureux,

Petitioner,

vs. NO: 14 WC 17547

Washington Group-Alberici,

Respondent.

19IWCC0644

DECISION AND OPINION ON REMAND

This matter now comes before the Commission on remand from the circuit court. Per the remand order, dated November 1, 2018, the circuit court confirmed the Commission's February 22, 2018 decision relative to accident. The Court reversed the Commission's decision relative to causal connection and remanded the matter for a Commission finding of the same.

Procedurally, this matter was tried before Arbitrator Nancy Lindsay on May 11, 2017. Petitioner alleged an accident on November 14, 2013, involving an injury to his right hand. The Arbitrator found that Petitioner did suffer an accident on the date in question, but that his right hand condition of ill-being was not causally related to said accident.

The Arbitrator's decision is attached hereto and made a part hereof. The decision of the Arbitrator delineates the facts of the case in detail. As relevant to the issues on remand, the Commission notes:

In reaching her decision, the Arbitrator found the history provided by Petitioner at the emergency room on the date in question "highly significant." Petitioner reported that he injured himself that morning while squeezing vice grips at work. This emergency room visit occurred

immediately after the shift Petitioner testified he was injured during. Subsequent medical records noted an identical mechanism of injury, which was also consistent with Petitioner's testimony.

Petitioner testified regarding his reasoning for not wanting to report the accident, as well as why he misrepresented the cause of his injury in his disability application with his union as well as a patient questionnaire with Dr. Lents. Petitioner had not been employed by Respondent long and was in a precarious financial position and was afraid of losing his job due to an injury claim. Buttressed by the fact that timely notice was provided and Petitioner's wife testified that Petitioner did not injure himself at home, the Arbitrator found Petitioner's reasoning to be credible. The Arbitrator also noted that Petitioner repaid all of the funds received on account of his misrepresentation.

Despite a finding of accident, the Arbitrator declined to find causal connection to Petitioner's current right hand condition. In doing so, the Arbitrator relied upon the medical records of Dr. Tobin pre-dating the accident. Petitioner's failure to testify regarding a prior right hand/wrist injury, along with witness testimony that Petitioner had informed his foreman after the accident that he had "re-broke" his hand factored into the Arbitrator's decision. X-rays on the date of accident revealed degenerative changes and Petitioner continued working for Respondent instead of presenting to Dr. Tobin the day after the accident as planned. Petitioner waited 19 days to present to Dr. Tobin (he presented the day after being laid off). On that date (December 3, 2013) Petitioner's symptoms were different than those he complained of on the date of accident. Additional records from Dr. Tobin reveal a history of chronic right wrist pain, a prior right carpal tunnel surgery and a recent injury. An MR Arthrogram revealed a broken thumb. The findings discuss a possible old fracture.

The Arbitrator noted that Dr. Lent's causation opinion on Petitioner's behalf was unpersuasive, as it was based on the emergency room records but did not contemplate Petitioner's prior treatment with Dr. Tobin. Further, Dr. Lent never testified with a reasonable degree of medical certainty that Petitioner's right wrist condition was caused by the work accident. He only testified that it "probably could."

The Arbitrator found that there was too much information lacking to find causation in favor of Petitioner. Accordingly, causal connection was denied.

The Commission affirmed and adopted the Arbitrator's decision in total.

The circuit court confirmed the Commission's decision relative to accident, but reversed the Commissions finding relative to causal connection. Given that accident was found, the circuit court has found no justification for denying causal connection. The two appear to be synonymous in this case. The circuit court noted the emergency room record on the date of accident, in which Petitioner complained of hand swelling, pain and tenderness, and compared it to the December 3, 2013 record of Dr. Tobin, in which dorsal swelling, pain with a clenched fist and tenderness along the MCP joint was noted. With numerous references to a finding of accident in the Arbitrator's Decision, the circuit court could not reconcile the conflicting findings relative to accident and causal connection.

The circuit court noted that one reason given by the Arbitrator for not finding causal connection was that Petitioner did not testify to a prior right wrist injury. However, the January 7, 2014 Arthrogram record indicates Petitioner underwent a prior carpal tunnel surgery. Regardless of whether or not Petitioner testified to it, the medical evidence of the same was presented to, and referenced by, the Arbitrator.

The Arbitrator also found it significant that there was unrebutted evidence of Petitioner informing his foreman that he "re-broke" his right hand. The circuit court agrees that this testimony was unrebutted, but gives greater weight to the fact that there was no medical evidence corroborating such an injury. After the accident in question, right hand x-rays were taken. Had there been a prior break in the hand, calcification would have been present along the line of the fracture and it would have been referenced in the radiologist's report. The circuit court found no such reference, and thus treated said x-rays as dispositive of the issue of a prior right hand fracture. The circuit court also noted that three Respondent supervisors testified to the safety-conscious environment at Respondent's work locations. With this in mind, coupled with the fact that Petitioner was observed by supervisors routinely, it seems unlikely that all supervisors would fail to notice Petitioner on-site with a broken hand. Moreover, even if there was evidence of a previously fractured right hand, the circuit court wonders why the accident in question would not be designated an aggravation of a pre-existing condition? From a compensability standpoint, aggravation is no less sufficient than a new acute injury.

The circuit court also noted that its confusion was apparently shared by the Respondent. In its Response Brief, Respondent discussed the issue of causal connection using phrases such as "it could be that the Commission," "the Commission could have decided," "the Commission could have determined," and "it could be that Arbitrator Lindsay." These statements emphasize the difficulty in attempting to reconcile the Commission's decision.

Based on the above reasoning, the circuit court reversed the portion of the Commission's decision relative to causal connection.

In keeping with the circuit court ruling, the Commission awards Petitioner all reasonable and necessary medical expenses related to the accident in question.

Also in keeping with the circuit court ruling, the Commission finds that Petitioner is entitled to temporary total disability benefits for a period of 4 weeks (April 2, 2014 through May 1, 2014). Respondent did not dispute the dates, only liability.

With regard to permanent disability, Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at arbitration, the Commission addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of § 8.1b(b), the Commission notes no AMA impairment rating was offered by either party. Therefore, the Commission assigns no weight to this factor.

With regard to subsection (ii) of § 8.1b(b), the occupation of the employee, the Commission notes Petitioner was employed as an Iron Worker at the time of his accident, a job which requires much physical exertion; however at the time of hearing Petitioner was retired. Therefore, the Commission assigns little weight to this factor.

With regard to subsection (iii) of § 8.1b(b), the Commission notes Petitioner was 43 years old at the time of the accident. Thus, the Commission assigns significant weight to this factor.

With regard to subsection (iv) of § 8.1b(b), the future earning capacity of the employee, the Commission notes Petitioner is now retired. Petitioner testified that due to his experience, he could have gained employment as a foreman, which would insulate him from a lot of the physical aspects of being an Iron Worker. The Commission assigns significant weight to this factor.

With regard to subsection (v) of § 8.1b(b), evidence of disability corroborated by the treating medical records, the Commission notes that, based on opinion of Dr. Lents, Petitioner sustained a scapholunate dissociation of the right wrist and right thumb gamekeeper fracture, which was surgically repaired with a right proximal row carpectomy and a right percutaneous pinning of the gamekeeper fracture. One week after surgery Petitioner's wound became infected.

An incision was made, the wound was drained, pins were removed and an external fixator was applied. Dr. Lent testified that by July of 2014 Petitioner was doing very well with a little pain but good motion. Petitioner was told to return as needed, but had not returned as of February 13, 2017. The Commission assigns significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Commission finds that Petitioner has established permanent partial disability to the extent of a 7.5% loss of use of his hand and a 40% loss of use of his thumb pursuant to Section 8(d)2 of the Act.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner did sustain accidental injuries arising out of and in the course of his employment with Respondent on November 14, 2013.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner established a causal connection between these accidental work-related injuries and his current condition of ill-being.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay any and all medical expenses related to Petitioner's right hand condition pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,034.72 per week for a period of 4 weeks (April 2, 2014 through May 1, 2010), that being the period of temporary total incapacity for work under section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 (*maximum rate*) per week for a period of 15.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 7.5% loss of use of Petitioner's hand, and the sum of $721.66 per week for a period of 30.4 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 40% loss of use of Petitioner's thumb.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $37,600.00.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 22 2019
d: 10/17/19
BNF/wde
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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 ADAMS)	☒ Reverse	☐ Second Injury Fund (§8(e)18)
	ON REMAND FROM CIRCUIT COURT	☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia S. Willis,

Petitioner,

vs. NO: 14 WC 00548

Niemann Foods, Inc.,
d/b/a Pet Supply Plus,

Respondent.

19IWCC0645

DECISION AND OPINION ON REMAND

This matter now comes before the Commission on remand from the Circuit Court. The Arbitrator found that Petitioner did sustain an accident arising out of and in the course of her employment with Respondent. The Arbitrator also found Petitioner's current condition of ill-being to be causally related to said accident, awarded all reasonable and necessary medical expenses and further ordered Respondent to pay for prospective medical care prescribed by Dr. Glanton. Lastly, the Arbitrator found that Petitioner had not yet reached maximum medical improvement, and thus declined to address the issue of permanency. The Commission affirmed and adopted the arbitration decision. The Circuit Court found the Commission's decision to be against the manifest weight of the evidence, reversing and remanding the matter with instructions to find that Petitioner reached maximum medical improvement as of March 24, 2015, and to determine an award, if any, for permanent disability.

The Commission hereby incorporates by reference the findings of fact delineated in the Arbitrator's decision, which is attached hereto and made a part hereof, to the extent that it is not inconsistent with the Circuit Court's decision.

As relevant to the issues on remand, it is noted that on March 4, 2013 Petitioner was a dog groomer for Respondent, and she injured her low back while lifting a golden retriever weighing between sixty and eighty pounds. Ensuing medical treatment for Petitioner's persistent low back

19IWCC0645

pain included medications, steroid injections, and a home TENS unit. She was diagnosed with low back pain, a chronic lumbar strain with muscle spasm and somatic dysfunction of the lumbar and lower extremities.

Petitioner underwent a Section 12 examination with Dr. Weiss at Respondent's request on November 19, 2013. Following the examination, Dr. Weiss diagnosed pre-existing lumbar degenerative disc disease and a resolved lumbar strain secondary to the accident.

Petitioner treated conservatively for her ongoing pain throughout 2014 and was referred to Dr. Glanton on February 16, 2015. Petitioner complained of severe lumbar stabbing pain. Dr. Glanton diagnosed low back pain secondary to lumbar facet arthropathy and discussed a right L3/4 median branch nerve radiofrequency ablation and right L5 primary dorsal ramus radiofrequency ablation. Respondent's insurance carrier did not approve the same, however.

Dr. Weiss performed a second Section 12 examination at Respondent's request on March 24, 2015. Petitioner's pain complaints remained constant. Dr. Weiss' diagnoses mirrored that of his November 2013 examination, and he attributed Petitioner's ongoing complaints to her pre-existing degenerative condition. Dr. Weiss opined that Petitioner sustained no permanent partial disability as a result of her accident and that she had reached maximum medical improvement.

Petitioner returned to Dr. Glanton on February 23, 2016 and treated with him periodically throughout the remainder of the year and into 2017. On May 31, 2017, with Petitioner's symptoms still present, Dr. Glanton referred Petitioner for consideration for an SI joint fusion. On August 17, 2017, Dr. Glanton was called as a witness by Petitioner and gave testimony at an evidence deposition. He testified that Petitioner had developed an SI joint condition which was causally related to her work accident.

In his decision, which was affirmed and adopted by the Commission, the Arbitrator agreed with Respondent's contention that Dr. Glanton's causation opinion was based on speculation. "The doctor admitted knowing very little about the accident itself and even less about [Petitioner's] various treatments and results over the nearly two years before he was able to see her. [Dr. Glanton] was also not given any hypothetical facts upon which to base his opinions. However, his opinions concerning the mechanism of injury do make sense and are persuasive to the Arbitrator..[*sic*]" ("Arbitration Decision," at 12). The Circuit Court found that Dr. Glanton's opinion was speculative and lacked foundation for admissibility. The court went further and indicated that Dr. Glanton's opinion should have been stricken. See *Kleiss v. Cassida,* 297 Ill.App.3d 165 (4th Dist. 1998).

With Dr. Glanton's opinion stricken, the Circuit Court found that the Commission's decision finding Petitioner's current condition to be causally related to the accident in question was against the manifest weight of the evidence. The Circuit Court questioned how the Arbitrator could determine Petitioner's exact pain source, considering the difficulty medical providers had in doing the same. The Circuit Court also noted how other possible causes identified by physicians were discounted in the decision, included postural deconditioning, morbid obesity and degenerative disc disease.

Accordingly, in compliance with the Circuit Court's order, the Commission finds that Petitioner reached maximum medical improvement as of March 24, 2015, the date of Dr. Weiss' second examination. Dr. Weiss offered the only admissible expert opinion on this issue.

Although not specifically ordered by the Circuit Court, the Commission, in keeping with the Circuit Court's order, also finds that Respondent shall only be liable for medical expenses related to Petitioner's lumbar strain through March 24, 2015.

Having found maximum medical improvement, the Commission now turns its attention to the issue of permanent disability. Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at arbitration, the Commission addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of § 8.1b(b), the Commission notes no AMA impairment rating was offered by either party. Respondent requested such a rating from Dr. Weiss who did not provide such a rating stating, rather, the following: "Based on Ms. Willis's current objectively unremarkable examination and noting the unremarkable examination in November of 2013, I do

not believe Ms. Willis has sustained any permanent impairment secondary to the March 4, 2013 work injury in question." Therefore, the Commission assigns no weight to this factor.

With regard to subsection (ii) of § 8.1b(b), the occupation of the employee, the Commission notes Petitioner was employed as a dog groomer at the time of her accident, medium level work requiring lifting of 25 pounds frequently or 50 pounds occasionally as noted by Dr. Weiss. Petitioner testified that she was attending junior college in pursuit of her Associates Degree, but no evidence was submitted regarding the extent or substance of those studies such that her occupation would change as a result. Thus, the Commission finds this factor weighs in moderate favor of a decreased permanent disability.

With regard to subsection (iii) of § 8.1b(b), the Commission notes Petitioner was 44 years old at the time of the accident. This fact is stipulated by the parties. Given Petitioner's younger age, it will necessitate her to manage the effects of her injury for a longer period of time. Thus, the Commission finds this factor weighs in favor of an increased permanent disability.

With regard to subsection (iv) of § 8.1b(b), the future earning capacity of the employee, the Commission notes there was no evidence offered regarding Petitioner's future earning capacity. Again, Petitioner testified that she was attending junior college in pursuit of her Associates Degree, but no evidence was submitted regarding the extent or substance of those studies such that her occupation and consequential earning capacity would change as a result. Thus, the Commission assigns no weight to this factor.

With regard to subsection (v) of § 8.1b(b), evidence of disability corroborated by the treating medical records, the Commission notes Petitioner sustained a lumbar strain, which was treated conservatively. As the Circuit Court found Dr. Glanton's opinion inadmissible, it cannot be relied upon in weighing the factors; however, Dr. Weiss opined Petitioner's lumbar condition was caused by the work accident but has since resolved. Dr. Weiss also opined that Petitioner's ongoing complaints were due to unrelated conditions. Thus, the Commission finds this factor weighs in favor of a decreased permanent disability.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Commission finds that Petitioner has established permanent partial disability to the extent of a 5% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner has failed to prove a causal connection between her accident and her current condition of ill-being. Further, Petitioner reached maximum medical improvement as of March 24, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $370.80 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 5% loss of use of Petitioner's person as a whole.

not believe Ms. Willis has sustained any permanent impairment secondary to the March 4, 2013 work injury in question." Therefore, the Commission assigns no weight to this factor.

With regard to subsection (ii) of § 8.1b(b), the occupation of the employee, the Commission notes Petitioner was employed as a dog groomer at the time of her accident, medium level work requiring lifting of 25 pounds frequently or 50 pounds occasionally as noted by Dr. Weiss. Petitioner testified that she was attending junior college in pursuit of her Associates Degree, but no evidence was submitted regarding the extent or substance of those studies such that her occupation would change as a result. Thus, the Commission finds this factor weighs in moderate favor of a decreased permanent disability.

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With regard to subsection (iv) of § 8.1b(b), the future earning capacity of the employee, the Commission notes there was no evidence offered regarding Petitioner's future earning capacity. Again, Petitioner testified that she was attending junior college in pursuit of her Associates Degree, but no evidence was submitted regarding the extent or substance of those studies such that her occupation and consequential earning capacity would change as a result. Thus, the Commission assigns no weight to this factor.

With regard to subsection (v) of § 8.1b(b), evidence of disability corroborated by the treating medical records, the Commission notes Petitioner sustained a lumbar strain, which was treated conservatively. As the Circuit Court found Dr. Glanton's opinion inadmissible, it cannot be relied upon in weighing the factors; however, Dr. Weiss opined Petitioner's lumbar condition was caused by the work accident but has since resolved. Dr. Weiss also opined that Petitioner's ongoing complaints were due to unrelated conditions. Thus, the Commission finds this factor weighs in favor of a decreased permanent disability.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Commission finds that Petitioner has established permanent partial disability to the extent of a 5% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner has failed to prove a causal connection between her accident and her current condition of ill-being. Further, Petitioner reached maximum medical improvement as of March 24, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $370.80 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 5% loss of use of Petitioner's person as a whole.

19IWCC0645

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay any and all medical expenses related to her lumbar strain through March 24, 2015 pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 22 2019
D: 10/3/19
BNF/wde
045

Barbara N. Flores

L. Elizabeth Coppoletti

Marc Parker

18WC34563
18WC34564
1

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James T. Mullaney,

Petitioner,

vs.

NO: 18 WC 34563
18 WC 34564

City of Chicago,

Respondent.

19IWCC0646

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2019, is hereby affirmed and adopted.

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

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

19IWCC0646

No county, city, town, township incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 26 2019
o11/21/19
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MULLANEY, JAMES T
Employee/Petitioner

Case# **18WC034563**

17WC016180
18WC034564

CITY OF CHICAGO
Employer/Respondent

19IWCC0646

On 5/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1759 MARTAY LAW OFFICE
WILLIAM H MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0010 CITY OF CHICAGO CORP COUNSEL
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James T. Mullaney
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **18** WC **34563**

Consolidated cases: 17 WC 16180, 18 WC 34564

19IWCC0646

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **04-08-19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0646

FINDINGS

On **3/8/17**, 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 $**82,920.77**; the average weekly wage was $**1,594.63**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**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 Petitioner continued to work full duty following his 03-08-17 accident and, subsequently, re-injured the same body parts on 05-16-17, the Arbitrator will address the nature and extent of Petitioner's injuries in his decision on the latter claim (18 WC 34564).

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

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

Signature of Arbitrator

05-20-19
Date

MAY 2 1 2019

James T. Mullaney v. City of Chicago

18 WC 34563

Statement of Facts

On March 8, 2017, Petitioner was employed by Respondent as a Laborer for the Department of Transportation. On that day, Petitioner was 52 years of age and had been employed by Respondent since approximately 1991.

On that day, Petitioner was on duty and was dismantling a barricade using a saw. As Petitioner was operating the saw, he experienced symptoms in his right hand and wrist. Petitioner reported this incident and sought initial treatment at MercyWorks (Px5). Ten days later, Petitioner underwent a right wrist x-ray, which revealed degenerative changes at the scaphoid and the trapezium/trapezoid. Following initial treatment at MercyWorks, Petitioner was referred to Dr. William Heller of Midland Orthopaedics.

Following referral to Dr. Heller, Petitioner received a corticosteroid injection into the first carpometacarpal joint and continued working full duty (Px4).

Conclusions on Law

In regards to (F), "Is the Petitioner's current condition of ill-being related to the injury?" the Arbitrator finds:

Petitioner current right wrist, hand, and thumb condition is causally related to his accident on March 8, 2017 as well as his subsequent injury on May 16, 2017.

In regards to (L), "What is the nature and extent of Petitioner's injury?," the Arbitrator finds:

As Petitioner continued to work full duty following his March 8, 2017 accident and, subsequently, re-injured the same body parts on May 16, 2017, the Arbitrator will address the nature and extent of Petitioner's injuries in his decision on the latter claim (18 WC 34564).

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MULLANEY, JAMES T
Employee/Petitioner

Case# **18WC034564**

17WC016180
18WC034563

CITY OF CHICAGO
Employer/Respondent

19IWCC0646

On 5/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1759 MARTAY LAW OFFICE
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0010 CITY OF CHICAGO CORP COUNSEL
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30 N LASALLE ST SUITE 800
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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

James T. Mullaney
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 18 WC 34564

Consolidated cases: 17 WC 16180
18 WC 34563

19IWCC0646

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **April 8, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **05-16-17**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**83,353.86**; the average weekly wage was $**1,602.96**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**47,633.04** for TTD, $**0** for TPD, $**0** for maintenance, and $**22,418.71** for other benefits, for a total credit of $**70,051.75**.

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

ORDER

The Arbitrator finds that TTD benefits were not properly paid, and Petitioner's claim for additional benefits to November 18, 2018 is awarded.

As a result of the injuries sustained, Petitioner is entitled to have and received from Respondent 57.35 weeks at a rate of $775.18 because he sustained a 35% loss of use of the right thumb and 15% loss of use of the right hand.

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

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

Signature of Arbitrator

05-20-19
Date

James T. Mullaney v. City of Chicago

18 WC 34564

Statement of Facts

19IWCC0646

On May 16, 2017, Petitioner was employed by Respondent as a Laborer for the Department of Transportation. That day, Petitioner was 52 years of age and had been employed by Respondent since approximately 1991.

On May 16, 2017, Petitioner was on duty and was lifting a cabinet when he experienced additional symptoms in his right hand, wrist and thumb. Petitioner reported this incident and sought initial treatment at MercyWorks before referral to Dr. William Heller of Midland Orthopaedics.

On June 9, 2017, Petitioner presented to Dr. Heller, who reviewed MRIs and diagnosed Petitioner with right thumb CMC arthrosis, a small TFCC injury, and a probable chronic partial-thickness scapholunate injury (Px4). That day, Dr. Heller discussed with Petitioner the possibility of a right thumb CMC arthroplasty with ligament reconstruction utilizing FCR tendon.

On June 29, 2017, Petitioner sought a second opinion from Dr. John Fernandez, who concurred with the recommendation for surgery (Px6). Petitioner continued to follow up with Dr. Fernandez and was recommended for a course of physical therapy.

On December 28, 2017, Petitioner attended an Independent Medical Examination (IME) with Dr. Bryan Neal of Arlington Orthopedic & Hand Surgery Specialists, Ltd (Rx1). Following his examination of Petitioner and an extensive review of Petitioner's medical records, Dr. Neal issued an IME Report. In his report, Dr. Neal disagreed with the CMC joint osteoarthritis diagnosis of Petitioner's treaters and instead assessed Petitioner with STT osteoarthritis. Dr. Neal further stated that while surgery was reasonable, it was "not related to work activities of May 16, 2017 . . . [T]he work activities on this day did not cause aggravate, or accelerate any condition but was a transient expression (exacerbation) of a preexisting condition."

Following issuance of the IME report, Petitioner continued to pursue treatment with Drs. Heller and Fernandez (Px4 & Px6). On March 30, 2018, based upon Petitioner's non-compliance with Dr. Neal's recommendations, Petitioner's Temporary Total Disability (TTD) benefits were suspended by Respondent. Following suspension of TTD, Petitioner applied for and received Ordinary Disability benefits totaling $23,938.86 (Rx2).

Petitioner testified that, on July 9, 2018, he underwent the surgery recommended by Drs. Heller and Fernandez. On November 19, 2018, following a course of post-operative physical therapy,

Petitioner returned to work full duty with no restrictions to his usual and customary position as a Laborer.

Petitioner testified that, upon returning to work, he resumed earning the same or higher wages as he had prior to his May 16, 2017 accident. Petitioner testified that, since returning to work, he has not pursued any additional treatment nor lost any additional treatment because of his right hand, wrist, or thumb.

Conclusions on Law

To be compensable under the Illinois Workers' Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." *Ill.Rev.Stat.1991, ch. 48, par. 138.2.* The employee has the burden of establishing both requirements. *Castaneda v. Industrial Comm'n (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.* An injury "arises out of one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Jewel Cos. v. Industrial Comm'n (1974), 57 Ill.2d 38, 40, 310 N.E.2d 12.*

In regards to (F), "Is the Petitioner's current condition of ill-being related to the injury?" the Arbitrator finds:

Petitioner current right hand, wrist, and thumb condition is causally related to his accident on May 16, 2017 as well as his prior injury on March 8, 2017; in that the weight of the evidence established that Petitioner's work accidents aggravated, accelerated and/or exacerbated his pre-existing degenerative arthritis to his right hand, wrist, and thumb.

In regards 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:

To the extent that charges for reasonable and necessary medical services remain outstanding, the parties agreed on the record that Respondent is authorized to resolve any awarded balances directly with the providers pursuant to the fee schedule.

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

Respondent was not justified in terminating Petitioner's TTD benefits on March 30, 2018 despite the issuance of Dr. Neal's IME report and examination. Accordingly, the Arbitrator finds that TTD benefits are owed until November 18, 2018.

In regards to (L), "What is the nature and extent of Petitioner's injury?" the Arbitrator finds:

In determining the level of petitioner's disability, the Arbitrator considers five factors:

(1) In this case, neither party entered an impairment report into evidence; however, this alone does not preclude an award for permanent partial disability.

(2) Petitioner was employed as a Laborer for the Department of Transportation, and he returned to work full duty to his usual and customary employment following the conclusion of his treatment. Petitioner's full duty release confirms that he can perform the duties of his position. The Arbitrator places great weight on this factor.

(3) Petitioner was 52 years of age on the date of his accidents and, accordingly, has entered the latter half of his work life. The Arbitrator places some weight on this factor.

(4) Petitioner's future earning capacity was unaffected by his March 8, 2017 and May 16, 2017 accidents because, following the conclusion of his treatment, Petitioner returned to work in the same position as he held prior to his accident. Petitioner's testified that, upon returning to work, he resumed earning the same or higher wages as he had prior to his accidents. The Arbitrator places great weight on this factor.

(5) The treating medical records in this case confirm Petitioner returned to work with no restrictions.

As a result of the injuries sustained, Petitioner is entitled to have and received from Respondent 57.35 weeks at a rate of $775.18 because he sustained a 35% loss of use of the right thumb and 15% loss of use of the right hand.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tawny Jaylynn Adams,
Petitioner,

vs.

No. 14 WC 22022

City of Carbondale,
Respondent.

19IWCC0647

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses and vocational rehabilitation expenses, 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 37-year-old solid waste collector in the Street Department of the City of Carbondale, injured her right shoulder on April 14, 2014 from repetitively lifting trash receptacles. She was diagnosed with a rotator cuff tear and underwent two arthroscopic surgeries on her right shoulder, on December 20, 2014 and March 30, 2017.

Following a §19(b) hearing in June 2015, the Arbitrator issued a decision on September 17, 2015, finding Petitioner had proved both a work accident and causal connection between that accident and her right shoulder condition. The Arbitrator awarded Petitioner medical expenses and temporary total disability benefits. On October 14, 2016, the Commission affirmed that decision.

This current Review follows Petitioner's second arbitration hearing of May 8, 2018. In a decision dated August 14, 2018, The Arbitrator awarded Petitioner, "reasonable and necessary medical services outlined in Petitioner's group exhibit." Petitioner's group exhibit included: a $126.00 bill from Shawnee Healthcare for an office visit on May 11, 2015, a $10,918.02 bill from St. Joseph Memorial Hospital for emergency room services provided on May 12, 2015, and a $7,908.05 bill for vocational rehabilitation from England and Company Rehabilitation Services.[1] Respondent's only claim of error in the Arbitrator's August 14, 2018 decision is that the Arbitrator should not have awarded the aforesaid bills to Petitioner.

[1] The Arbitrator also awarded Petitioner 15% body as a whole under §8(d)2; ordered Respondent to hold Petitioner harmless from claims by providers of services for which Respondent received a credit, and gave Respondent a §8(j) credit for payments it made. Those parts of the arbitration decision are not at issue in this Review.

Petitioner's May 11, 2015 and May 12, 2015 Bills

Petitioner testified that while in therapy at Southern Illinois Orthopedic Center, her therapists, "were trying to get my arm to full range of motion," but her shoulder wasn't giving like it was supposed to, and, "apparently, my body compensated, and they pulled everything in my right upper quadrant of my stomach." She testified she couldn't stand up straight and was told to go to the emergency room. Petitioner did not testify to the date on which that alleged therapy took place, or offer any physical therapy records to support her testimony.

On May 11, 2015 Petitioner sought treatment at Shawnee Healthcare. Petitioner did not offer testimony about this particular visit. The medical records which are in evidence do not support Petitioner's claim that her treatment on this date was related to her work accident. Records from Dr. Cameron at Shawnee Healthcare on May 11, 2015, document Petitioner's complaint of abdominal pain for the past day, along with her report of developing right upper quadrant pain after running. Dr. Cameron further documented Petitioner's history of chronic right rib problems and of her chiropractor advising her to get x-rays to rule out broken ribs. Dr. Cameron's records did not include any history that Petitioner's pain began following physical therapy.

Petitioner visited the St. Joseph Memorial Hospital's emergency room on May 12, 2015. Those records indicate Petitioner came to the emergency room complaining of right upper quadrant pain since Sunday night. Petitioner denied her pain was caused by trauma. No history of any physical therapy incident was documented.

The Commission finds Petitioner did not prove the treatment she received from Shawnee Healthcare on May 11, 2015 and the emergency room treatment she received from St. Joseph Memorial Hospital on May 12, 2015, were causally related to her April 14, 2014 accident. There is no credible evidence to support that Petitioner's abdominal or upper quadrants stomach complaints are in any way related to her right shoulder treatment or stem from her injury at work. Accordingly, the Commission vacates the Arbitrator's award of those bills.

Petitioner's Vocational Rehabilitation Bills

Respondent claims the rehabilitation services of England and Company were improperly awarded because: Respondent never terminated Petitioner as an employee, her earning capacity was not reduced as a result of her accident, and England and Company's rehabilitation services continued during periods when Petitioner was not at MMI as well as after she began a new job earning a higher rate of pay.

Petitioner was released at MMI by Dr. John Davis on November 18, 2015 pursuant to the results of an FCE Petitioner was ordered to undergo. The FCE was performed on December 9, 2015 and found Petitioner able to work only at a Medium physical demand level. The results were valid. Her prior job as a solid waste collector required the ability to work at a Heavy physical demand level. After receiving those restrictions, Petitioner asked a supervisor whether Respondent could accommodate her restrictions with a position in the Street Department. Petitioner was told the Street Department could not accommodate her restrictions.

19IWCC0C47

Throughout 2016, Petitioner, whose highest education is a high school GED, searched weekly for jobs within her restrictions on the City of Carbondale's website. Petitioner admitted she had not looked elsewhere for employment because she believed a position within her restrictions at the City would become available, and she liked the work she had been doing.

On December 22, 2016, Petitioner's counsel retained the vocational services of England and Company to evaluate Petitioner and assist in finding her employment. With their assistance, Petitioner broadened her job search and began searching for employment with other employers.

In January 2017, Respondent sent Petitioner to a Section 12 examination with Dr. Rotman. He opined that Petitioner was not at maximum medical improvement, that she required further medical care, and that Petitioner's condition of ill-being at the time remained causally related to the accident at work. Dr. Rotman recommended an arthrogram. That test revealed a partial tear of her right subscapularis, which ultimately led to Petitioner's second arthroscopic shoulder surgery performed on March 30, 2017 by Dr. Nathan Mall. Respondent acknowledges that following that surgery, England and Company's vocational rehabilitation services to Petitioner were temporarily put on hold.

After recovering from her March 2017 shoulder surgery, Petitioner resumed her job search with England and Company. She was unable to locate suitable employment until December 2017, when Petitioner accepted an offer made by Respondent for a Utility Maintenance Worker position in the Water and Sewer Department of the City of Carbondale. This position was temporary. England and Company continued its minimal, routine vocational rehabilitation services with Petitioner for another three months while Petitioner worked in the temporary position. On April 12, 2018, upon learning that Petitioner's Utility Maintenance Worker position had become permanent, England and Company discontinued its services.

The Commission finds no precedent which would preclude an award of vocational rehabilitation services in the instance case. It became clear that, given Petitioner's restrictions, her chances of returning to her prior position with Respondent were small, regardless of the fact that she had not been formally terminated. Respondent suggests that termination from its employment was a prerequisite to her entitlement to vocational rehabilitation. Given the facts in this case, the Commission disagrees. Petitioner diligently sought employment with Respondent but was told no positions were available within her restrictions. Then, after undergoing additional medical treatment prompted by Dr. Rotman's examination, Petitioner resumed the services of a vocational rehabilitation counselor. Respondent was unable to accommodate her restrictions. After Petitioner's condition reached a plateau, a position with Respondent eventually became available. Respondent offered the position to Petitioner, which she accepted. However, the position was temporary in nature. Under those circumstances, it was appropriate for Petitioner to utilize vocational rehabilitation services in making every effort to find permanent employment.

Respondent further argues that vocational rehabilitation was not warranted in this case because, since Petitioner eventually found a job at a higher rate of pay, she suffered no reduction in earning capacity. However, at the time vocational rehabilitation began, it appeared likely that Petitioner's restrictions would cause a reduction in her earning capacity, which vocational rehabilitation could help mitigate. Moreover, at the time vocational services commenced, Petitioner's job security was diminished. Both of those circumstances were ones the Illinois Supreme Court found appropriate for the Commission

to consider in determining the extent to which vocational rehabilitation is necessary. See *National Tea Co. v. Industrial Commission*, 97 Ill. 2d 424 (1983). That Petitioner eventually was successful in finding employment above her prior salary because a temporary position became available with Respondent, and that position became permanent, did not render the vocational rehabilitation services she received, prior to that time, unreasonable or unnecessary.

Respondent further contends vocational rehabilitation to Petitioner was improper because she was not at MMI when those services were provided. However, when Petitioner began working with England and Company, she had been released at MMI by Dr. John Davis since November 18, 2015. The Commission acknowledges that after Dr. Rotman's IME in January 2017, Petitioner was no longer at MMI for a time. However, the Commission does not find that circumstance, given the change in Petitioner's physical condition and fluctuating availability of employment with Respondent or elsewhere, mandated Petitioner's vocational rehabilitation be terminated. In fact, England and Company did suspend its services to Petitioner following her March 2017 surgery and during her recovery. Petitioner resumed working with England and Company after Dr. Nathan Mall allowed her to resume looking for work in June 2017.

Although Petitioner was receiving TTD benefits during some of the time she received vocational rehabilitation from England and Company that did not render the vocational assistance unnecessary. Courts have found appropriate awards of both vocational rehabilitation and TTD benefits during the same periods. See *Freeman United Coal Mining Co. v. Industrial Commission,* 318 Ill. App. 3d 170, 251 Ill. Dec. 966 (5th Dist., 2000); *Archer Daniels Midland Co. v. Industrial Commission,* 138 Ill. 2d 107, 149 Ill. Dec. 253 (1990). Considering that Petitioner had been previously released at MMI in November of 2015, had been given permanent restrictions that the employer was unable to accommodate for over a year and she underwent a second shoulder procedure, it was reasonable for her to resume vocational rehabilitation when Dr. Mall allowed her to do so in June 2017. The Arbitrator's award of vocational rehabilitation given the facts in this case was appropriate.

Finally, the Commission does not find the vocational rehabilitation services which England and Company provided for a short period after December 2017 to be unwarranted. Although Petitioner found a new job, it began as a temporary position. It was appropriate for Petitioner to continue searching for a permanent position. When England and Company learned that Petitioner's temporary position had become permanent in April 2018, its services ended. Under the circumstances of this case, the Commission finds all of the vocational rehabilitation services provided by England and Company to have been reasonable and necessary, and affirms the Arbitrator's award which ordered Respondent to pay its bills.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical bills from Shawnee Healthcare for treatment on May 11, 2015, and the award of medical bills from St. Joseph Memorial Hospital for treatment on May 12, 2015, are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award to Petitioner of the accrued vocational rehabilitation expenses of England and Company is affirmed.

19IWCC0647

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 26 2019

o-10/03/19
mp/mcp
68

Marc Parker

Barbara N. Flores

CONCURRENCE IN PART AND DISSENT IN PART

I concur with the majority's decision as it relates to the denial of the medical bills; however, I respectfully dissent as to the majority's decision to award the vocational rehabilitation expenses.

The record evidences Petitioner met with Mr. Tim Kaver, a vocational counselor of England and Company on January 6, 2017. PX12. Thereafter, Mr. Kaver prepared his initial report on February 5, 2017 and his vocational rehabilitation plan on February 22, 2017. *Id.* Mr. Kaver based his vocational opinions, in part, on an FCE completed on December 12, 2015 as well as Petitioner's subjective understanding of her health history. Mr. Kaver found Petitioner unable to return to work at her prior occupation and identified a radiological technologist as Petitioner's chosen career objective with corresponding educational requirements identified. *Id.*

On January 30, 2017 prior to the issuance of either of Mr. Kaver's reports, Petitioner was evaluated pursuant to Section 12 of the Act by Dr. Mitchell Rotman. Dr. Rotman found Petitioner's condition was not stable i.e. Petitioner was no longer at maximum medical improvement and further treatment was necessary specifically an MRI and surgery. RX1.

On February 27, 2017, Petitioner sought treatment from Dr. Mall who prescribed the previously recommended MRI which evidenced a re-current tear. Dr. Mall recommended additional surgery specifically with the hope "the restrictions would lighten to the point in which she would be able to find more jobs that would meet her restrictions and *potentially even return back to her prior job with some modifications*." (emphasis added) Moreover, Dr. Mall provided more stringent restrictions pending surgery. PX10.

On March 30, 2017, Dr. Mall performed surgery and authorized Petitioner off work. Petitioner continued follow-up care with Dr. Mall, which included extensive physical therapy and work conditioning. On September 9, 2017, Dr. Mall evaluated Petitioner noting "I think that she could return back to work in a full-duty capacity with this position currently without any need for additional work conditioning. However, if she is to return back to a throwing position, I do believe that an additional three weeks of work conditioning will be necessary." PX10

Throughout this period, Respondent continued to pay disability benefits. RX3. Even such, Petitioner continued to employ the services of England and Company specifically in an effort to establish a new career path and obtain additional schooling. PX10.

On Dr. Mall's recommendation, Petitioner underwent additional work conditioning. On September 26, 2017 at the completion of work conditioning, Dr. Mall evaluated Petitioner who was concerned about a full-duty return to work. Dr. Mall "explained to the patient that based on the surgery that I performed, there should not be any reason why she would not be able to return back to her normal job duties, and she agrees with this. She feels she is weaker from her prior surgery and is concerned about her overhead lifting of heavy weight for her normal job duties." PX10. An FCE was prescribed and performed on February 6, 2018 which evidenced Petitioner was able to return to work at the heavy physical job demand level. PX8. On March 6, 2018, Dr. Mall released Petitioner to return to work with restrictions based on the FCE and placed Petitioner at maximum medical improvement. PX10.

In the interim, Petitioner returned to work in December of 2017 for Respondent in a different department. T. 12. As of the date of hearing (May 18, 2018), Petitioner continued to perform the job and was interviewing with Respondent for a job in a different department. T. 15. Petitioner testified her current job required physical work, which for the most part, she was able to perform. T. 14.

Despite Dr. Mall's opinions and Petitioner's return to work in December of 2017, she continued to employ the services of England and Company. To that end, Mr. Kaver continued vocational services throughout December of 2017 and following into April of 2018 again with the goal of retraining and educational arrangements. Services were discontinued on April 12, 2018. PX12.

In the seminal case *National Tea Co. v. Industrial Commission*, the Supreme Court of Illinois established the underlying standard for an award of vocation rehabilitation services holding "a claimant has been deemed entitled to rehabilitation where [*she*] sustained an injury which caused a reduction in earning power and there is evidence rehabilitation will increase [*her*] earning capacity." 97 Ill. 2d 424, 4432, 454 N.E.2d 672 (1991). Thusly, the Commission is tasked with weighing certain factors which either substantiate or mitigate the award of vocational services as "the employer is required to 'underwrite' the expenses attendant to rehabilitation, it is essential that any program selected be reasonable and realistic." *Id.* at 433. One of the factors to consider is "[*her*] prospects for recovering work capacity through medical rehabilitation or other means." *Id.*

Given the evidence, I disagree with the majority and find the vocational rehabilitation services were neither reasonable nor warranted. The majority finds the rehabilitation services to be reasonable given Petitioner's release from medical care, the FCE performed in December of 2015 evidencing restrictions, and Petitioner's inability to obtain employment within the parameters of these restrictions. What this finding ignores is Petitioner's actual medical status upon the initiation of vocational

rehabilitation. Dr. Rotman evaluated Petitioner on January 30, 2017, prior to the formulation of a vocational plan, and found Petitioner was no longer at maximum medical improvement and in need of more treatment. As such, Petitioner embarked on a significant course of medical care which included surgery and physical rehabilitation. Moreover, Dr. Mall, Petitioner's treating physician, believed from the onset that the additional surgery and treatment would likely increase Petitioner's lifting abilities and possibly allow a return to her pre-injury job, stating on February 27, 2017 "the restrictions would lighten to the point in which she would be able to find more jobs that would meet her restrictions and *potentially even return back to her prior job with some modifications*." (emphasis added). Dr. Mall reiterated this opinion following the surgery and physical rehabilitation stating on September 6, 2017 "I think that she could return back to work in a full-duty capacity with this position currently without any need for additional work conditioning. However, if she is to return back to a throwing position, I do believe that an additional three weeks of work conditioning will be necessary." PX10

The majority without addressing Dr. Mall's opinions finds "at the time vocational rehabilitation began, it appeared likely that Petitioner's restrictions would cause a reduction in her earning capacity, which vocational rehabilitation could help mitigate. Moreover, at the time vocational services commenced, Petitioner's job security was diminished." *Supra*, p. 4, ¶ 2. Presumably such finding is based upon the opinions of Mr. Kaver from early February of 2017, but the record indicates Mr. Kaver was unaware of Petitioner's ongoing treatment with Dr. Mall which commenced on February 27, 2017. More importantly, Mr. Kaver formulated his vocational opinion and suggested rehabilitation program, a new vocation which required additional schooling, based on an FCE performed two years prior which was irrelevant given Petitioner's continued medical care and Dr. Mall's opinion. Mr. Kaver never re-evaluated the vocational program as Petitioner's medical condition progressed and her restrictions changed. Additionally, Mr. Kaver's reports and corresponding invoices evidence his services were limited to identifying a new career path for Petitioner and not job placement services within her current skill-set. As Mr. Kaver stated "Our goal is for Tawny to select an appropriate career goal, leading towards the development and implementation of her vocational rehabilitation plans. Tawny's successfully implemented vocational rehabilitation plans will allow her to become reemployed in a physically appropriate career for which she holds a sincere interest." PX12, February 5, 2017-initial vocational report.

Petitioner's desire to pursue further education with a less physically taxing career in mind is laudable, but such costs should not be borne by Respondent when they are not warranted. Section 8(a) requires that "[t]he employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee including all maintenance costs and expenses incidental thereto." *820 ILCS 305/8(a)* (West 2013). The vocational services provided were not necessary. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ADAMS, TAWNY JAYLYNN
Employee/Petitioner

Case# **14WC022022**

CITY OF CARBONDALE
Employer/Respondent

19IWCC0647

On 8/14/2018, 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 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY PC
THOMAS RICH
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FAIRVIEW HTS, IL 62208

0299 KEEFE & DEPAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HEIGHTS, IL 62208

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

TAWNY JAYLYNN ADAMS
Employee/Petitioner

v.

CITY OF CARBONDALE
Employer/Respondent

Case # 14 WC 22022

Consolidated cases: _____

19IWCC0647

An *Application for Adjustment 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 **May 8, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 14, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$8,753.93**; the average weekly wage was **$486.44**.

On the date of accident, Petitioner was **37** 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 **$all paid** for TTD, $- for TPD, $- for maintenance, and **$3,000.00** for other benefits **(permanent partial disability advance)**, for a total credit of **$3,000.00**.

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

ORDER

Respondent shall pay reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in § 8(a) of the Act.

Respondent shall also pay the vocational expenses of England and Company pursuant to § 8(a) of the Act.

Respondent shall be given 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 § 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$291.86**/week for **75** weeks, because the injuries sustained caused the **15%** loss of the **body as a whole**, as provided in § 8(d)2 of the Act.

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

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

Signature of Arbitrator

8/14/18
Date

AUG 14 2018

FINDINGS OF FACT

This matter was previously heard by an Arbitrator appointed by the Commission on June 17, 2015. (PX13) Findings were rendered in favor of Petitioner and affirmed by the Commission on appeal. *Id.* Those findings contained in the Commission's Decision, which was entered into evidence, are incorporated herein by reference. *Id.*

Following her surgery with Dr. Davis, Petitioner was sent for more physical therapy and work hardening. (T.9; PX5, 6/24/15, 7/29/15) When Petitioner continued to have symptoms despite surgery and physical therapy, Dr. Davis recommended a functional capacity evaluation. (PX5, 11/18/15) This was done at Apex Network Physical Therapy on December 9, 2015, and the recommendations/findings were as follows:

RECOMMENDATIONS

- During the FCE the worker was observed to lift 50 lbs from floor to waist, which places the worker in the Medium physical demand level.
- The Performance Criteria Profile is most consistent with acceptable effort.
- Level of effort indicates that the worker most likely participated with full effort.
- Based on the level of effort displayed, the demonstrated physical tolerances may be used to project actual functional ability at this time.

The functional abilities displayed on this date

- Are not consistent with full duty demands per the available job description information. (PX8, 12/9/15)

Because Petitioner worked in a heavy occupation, that of a trash collector, she was not able to return to her former occupation for Respondent. *Id.*

Respondent then obtained an examination with Dr. Rotman, which took place on January 30, 2017. (RX1) Dr. Rotman's impression was status post treatment for a small partial rotator cuff tear. *Id.* He believed that Petitioner's recovery had been significantly prolonged, and he did not believe she should have permanent restrictions. *Id.* Because of her continued complaints of pain and clicking noted in her shoulder on examination, he recommended an MRI gadolinium arthrogram to determine the condition of her rotator cuff tear. *Id.* He believed that if the rotator cuff was re-torn, she would require repeat surgery; however, if it was healed, she may just require an arthroscopic debridement to smooth out the area of her shoulder that was clicking. *Id.* He did not believe Petitioner was at maximum medical improvement; but if the rotator cuff was healed on the MRI, then she could return to work full duty. *Id.*

The MRI was completed on February 27, 2017, and showed supraspinatus repair changes without evidence for a definite recurrent full thickness tear, but thinning of the anterior supraspinatus tendon that results in contrast extension. However, the upper subscapularis demonstrated an insertional tear with partial anteromedial subluxation of the biceps long head

near the top of the bicipital groove, which the radiologist interpreted as a probable intrasubstance tear. (PX9)

Petitioner then saw Dr. Nathan Mall for a second opinion on February 27, 2017. (PX10, 2/27/17) He took the history of the injury, noted the prior surgery, and stated that Petitioner was put on permanent restrictions. *Id.* He noted that Dr. Rotman recommended an MRI of the shoulder. *Id.* Petitioner reported minimal symptoms of pain; however, major issues with weakness with lifting away from her body or over her head. *Id.* Dr. Mall's examination revealed weakness with rotator cuff testing, pain over palpation of the biceps tendon within the bicipital groove, and a positive O'Brien's test. *Id.* He reviewed Petitioner's MRI, which he believed showed incomplete healing of the rotator cuff anteriorly and also some abnormality of the biceps tendon where it appeared to be subluxed into the scapularis. *Id.* He noted that the rotator cuff just behind the supraspinatus appeared to be incompletely healed and thin. *Id.* He believed Petitioner had incomplete healing of the rotator cuff of the anterior margin of the supraspinatus, which was in the same area of the prior rotator cuff repair. *Id.* He recommended repeat surgery. *Id.*

Petitioner's revision surgery was done on March 30, 2017. (PX11, 3/30/17) Objective intraoperative findings included a deformed subscapularis which he debrided to give more distance between the subscapularis and the coracoid. *Id.* He also removed a coracoid spur. *Id.* He noted that the subacromial space had extensive adhesions which were not described by Dr. Davis in his initial surgery. *Id.* The thicker adhesions were debrided, which allowed him to outline the acromion and visualize and remove a slight acromial spur. *Id.* Petitioner was further stabilized with biceps tenodesis, anchoring the biceps tendon to the anterior humeral cortex. *Id.*

Following surgery, Petitioner improved to the point where she was referred for physical therapy. (PX10, 4/13/17) Dr. Mall also released Petitioner to light duty; however, Respondent would not accommodate Petitioner or allow her to work in any capacity. *Id.* Follow-up visits showed that Petitioner was doing well, making good progress, and regaining some of her strength. (PX10) On August 8, 2017, Dr. Mall referred Petitioner for 3 weeks of work conditioning. (PX10, 8/8/17) On September 6th, Dr. Mall recommended 3 more weeks of work conditioning. (PX10, 9/6/17)

Despite the MRI and intraoperative findings reflecting extensive pathology, Dr. Rotman authored an addendum report characterizing Petitioner's right shoulder pathology as "quite minimal." (RX1, 11/27/17) He believed that many of the findings during surgery were chronic rather than related to the injury, with the exception of the adhesions and synovitis. *Id.* He indicated that he would have expected Petitioner to return to work in 3 months following surgery, and gave Petitioner an impairment rating of 3% with respect to her right upper extremity based on his diagnosis of a partial thickness lesion of the rotator cuff with residual discomfort "without consistent objective findings." *Id.* He felt that Petitioner's rating fell under Class I with only slight residual loss of motion. (RX1, 11/27/17)

A repeat functional capacity evaluation was done on February 6, 2018, and the recommendations were as follows:

RECOMMENDATIONS

- During the FCE the worker was observed to lift 65 pounds from floor to waist, which places the worker in the Heavy physical demand level.
- The Performance Criteria Profile is most consistent with acceptable effort.
- Level of effort indicates that the worker most likely participated with full effort.
- Based on the level of effort displaced, the demonstrated physical tolerances may be used to project actual functional ability at this time.

The functional abilities displayed on this date

- Are mostly consistent with full duty demands per the available job description information. (PX8, 2/6/18)

At the last visit with Dr. Mall on March 6, 2018, he reviewed the functional capacity evaluation, noted that Petitioner gave a valid effort on appropriate tests, and noted that the revision shoulder surgery improved her capacity to lift. (PX10, 3/6/18) As a result, Petitioner was able to return to work with restrictions based on the functional capacity evaluation. *Id.* Petitioner continued to describe pain and symptoms on shoulder intensive days and at nighttime. *Id.* Dr. Mall noted that although Petitioner could perform most of her job duties, there would be certain things she would be unable to do with her permanent restrictions, namely no lifting overhead more than 25 pounds, no lifting greater than 65 pounds floor to waist, no lifting greater than 30 pounds from waist to chest, and no pushing and pulling greater than 125 pounds. *Id.*

Prior to the functional capacity evaluation and following surgery, Petitioner looked for work on her own and was also assisted by England and Company to find employment. (T.9; PX12) At the same time, Petitioner testified that it was her stated desire to go back to work for the City of Carbondale. (T.9-10) Despite being released to light duty numerous times by Dr. Mall, Petitioner was never given the opportunity. *Id.* Ultimately, in November or December of 2017, Respondent's Human Resources Department contacted Petitioner and asked if she would be willing to come back to a temporary position. (T.11-12) This new position was in the water and sewer department. (T.12) Her previous was in the street department. (T.12) For the last 6 months she has been working on a sewer crew, and her duties include running sewer lines, replacing sewer lines, driving the jet truck to remove sewer backups, and assisting the water crew with water breaks. (T.11-12) Although the work is physical, she is able to do the majority of her duties. (T.13) She stated:

> The majority of it. I'm actually really lucky. I am on a crew with three people, and the two guys that I work with, anything that I have a hard time with, they're willing to help out. You know, like if something is too heavy, for example, we have to carry a pump that probably weighs over 100 pounds, I can't carry it by myself, so we both will get it out of the truck, you know, stuff like that. But for the most part, I can do the work. Some things

cause me to get very sore, cause me to have problems sleeping and stuff, but I've sort of become accustom to that over the last four years. (T.13-14)

Petitioner has also bid on another job as a utility maintenance worker in the meter services department. (T.14) She believes that this will be less physical, and the most demanding part of her job will be digging. (T.14-15) She testified that even though that is still difficult for her, she will not be digging for 8 hours. *Id.*

Despite the improvement resulting from her second surgery and subsequent physical therapy and work hardening, she still has symptoms of pain and weakness at the end of her shift. (T.10; PX10, 3/6/18) She takes prescription medication on an as-needed basis when there are very heavy weeks. (T.16-17) She testified that while her range of motion has improved, she has what she refers to as "catches." (T.17) She is still working on improving her shoulder strength by performing her work hardening exercises. (T.17-18)

Respondent's also disputed the reasonableness and necessity of emergency room bill from May 11, 2015. (T.19) Petitioner testified that after her first surgery, she was in physical therapy, and while the therapist was trying to get her arm to full range of motion, her body compensated, and the therapist pulled everything in her right upper quadrant of her stomach. (T.19) Since she couldn't stand up straight, she went to the emergency room and got a CT scan. *Id.*

CONCLUSION

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

Upon a claimant's establishment of a causal nexus between injury and illness, employers are responsible for the employees' medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n,* 294 Ill.App.3d 705, 691 N.E.2d 13 (2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001).

The Arbitrator finds that all of Petitioner's medical care has been reasonable and necessary. Petitioner's second surgery was clearly reasonable given the findings on her MRI, her functional impediments highlighted by her first functional capacity evaluation, and her significantly prolonged recovery. With regard to the emergency room visit as a result of her physical therapy injury, the law establishes that injury that occurs as a result of treatment is a treated as a natural consequence of the work-related injury and is compensable. *Fermi National Accelerator Laboratory v. Industrial Comm'n,* 586 N.E.2d 750, (2nd Dist., 1992) The Arbitrator therefore finds nothing unreasonable about Petitioner's medical care. While Dr. Rotman believed that Petitioner's post-operative therapy and work hardening was excessive, the Arbitrator is not

so persuaded by the objective medical evidence, and the fact that Petitioner still requires permanent restrictions per her second functional capacity evaluation, despite the improvement in her function when compared with her first FCE.

Based upon the foregoing findings, Respondent shall pay the medical bills contained in Petitioner's group exhibit pursuant to section 8.2, the medical fee schedule contained in the amendment to the Illinois Workers Compensation Act. Respondent shall receive credit for any and all amounts previously paid, but shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

With regard to Petitioner's vocational rehabilitation, the law holds that when a claimant is unable to return to their former occupation or find suitable employment or have suffered a loss in earning power, they are eligible for vocational rehabilitation. *Nat'l Tea Co. v. Indus. Comm'n*, 97 Ill. 2d 424, 454 N.E.2d 672 (1983). The evidence clearly shows that Petitioner was not able to return to her former position following her surgery, and at the time there was absolutely no indication at all that Respondent was going to offer her employment within her restrictions. Petitioner testified without rebuttal that despite being released to light duty numerous times by Dr. Mall, she was never given the opportunity to return to work with Respondent until after she had retained the services of England and Company even though it was her earnest desire to do so. (T.9-10) Petitioner thus enlisted the services of England and Company to find suitable employment. (T.9) The Arbitrator therefore awards the accrued vocational expenses, as it was more than reasonable for Petitioner to obtain job search and placement services under the circumstances.

Issue (L): What is the nature and extent of the injury?

Pursuant to §8.1(b) of the Act, the nature and extent of Petitioner's injuries is to be reached by evaluating five factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. The Act provides that "no single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1(b)(v).

(i) Impairment Rating: Respondent submitted an impairment rating performed by Dr. Rotman, who concluded that Petitioner sustained only 3% impairment to her right upper extremity. The Arbitrator does not find this rating credible based on the fact Dr. Rotman did not acknowledge the objective evidence in making his determination. He characterized Petitioner's post-operative pathology as "minimal" and disregarded many of the pertinent findings as not being related to Petitioner's work injury. (RX1) He incorrectly believed that Petitioner's condition was "without consistent objective findings" which prompted him to evaluate her under Class 1. *Id.* He further based his rating based on his opinion that Petitioner was at maximum medical improvement with no restrictions, contrary to the FCE performed thereafter which led to

Petitioner's permanent restrictions. As such, the Arbitrator gives no weight to the impairment rating.

(ii) Occupation: Petitioner has been able to return to a temporary position with Respondent on a work crew in the water and sewer department. (T.13-14) Her occupation continues to be demanding physically demanding with respect to her right shoulder. *Id.* She testified that she obtains assistance from crew members when needed. *Id.* The Arbitrator places greater weight on this factor.

(iii) Age: Petitioner was 37 years old at the time of her injury. (AX1). Given the extended number of years Petitioner must live and work with her disability, the Arbitrator gives greater weight to this factor pursuant to *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016).

(iv) Earning Capacity: There is no evidence of reduced earning capacity in the record. Accordingly, the Arbitrator gives no weight to this factor.

(v) Disability: Petitioner sustained injury to her right shoulder that necessitated a right rotator cuff repair, as well as a second surgery to address unnoticed subscapularis tearing, biceps tendon pathology, adhesions, and coracoid and acromial spurring. (PX11; PX13) Petitioner thereafter required extensive therapy and work hardening, and was ultimately placed at maximum medical improvement with permanent restrictions of no lifting overhead more than 25 pounds, no lifting greater than 65 pounds floor to waist, no lifting greater than 30 pounds from waist to chest, and no pushing and pulling greater than 125 pounds. (PX10, 3/6/18) Despite the improvement resulting from her second surgery and subsequent physical therapy and work hardening, she still has symptoms of pain and weakness at the end of her shift. (T.10; PX10, 3/6/18) She takes prescription medication on an as-needed basis when there are very heavy weeks. (T.16-17) She testified that while her range of motion has improved, she has what she refers to as "catches." (T.17) She is still working on improving her shoulder strength by performing her work hardening exercises. (T.17-18)

The Arbitrator notes that Petitioner's complaints are fully corroborated by her treating records. Accordingly, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 15% loss of her body 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAUL REVELES,

Petitioner,

vs.

NO:16 WC 12273

CAPRI SPORT RISTORANTE,

Respondent.

19IWCC0648

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, medical including prospective medical, average weekly wage rate, penalties and fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 11, 2018 is hereby affirmed and adopted.

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the

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

DATED: NOV 26 2019
KAD/bsd
O102219
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

REVELES, RAUL
Employee/Petitioner

Case# **16WC012273**

CAPRI SPORT RISTORANTE
Employer/Respondent

19IWCC0648

On 1/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2234 CHEPOV & SCOTT LLC
NATALIA OLEJARSKA
5440 N CUMBERLAND AVE STE 150
CHICAGO, IL 60656

0863 ANCEL GLINK
BRIT ISALY
140 N DEARBORN ST SUITE 600
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
CORRECTED ARBITRATION DECISION

RAUL REVELES
Employee/Petitioner

v.

CAPRI SPORT RISTORANTE
Employer/Respondent

Case # 16 WC 12273

Consolidated cases: _____

19IWCC0648

An *Application for Adjustment 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 **June 27 and September 29, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status 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 15, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

On the date of accident, Petitioner was **36** years of age, ***single*** with **5** dependent children.

Respondent shall be given a credit of **$1,680.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

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

ORDER

THE ARBITRATOR FINDS PETITIONER FAILED TO PROVE HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT ON MARCH 15, 2016. ACCORDINGLY, ALL CLAIMS FOR BENEFITS ARE DENIED. PETITIONER'S CLAIM FOR PENALTIES AND ATTORNEY FEES IS DENIED. ALL OTHER ISSUES ARE MOOT.

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

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

Signature of Arbitrator

January 10, 2018
Date

4821-2151-9444, v. 1

JAN 11 2018

Raul Reveles v Capri Sport Ristorante
16 WC 12273

Statement of Facts

A. Testimony of Raul Reveles

Raul Reveles ("Petitioner") testified that on March 15, 2016, he was 35 years old on and that that he has five children under age 18. (T 16-17) Petitioner testified that the highest grade level he has completed is the 11th grade and did not graduate. Petitioner testified that his work experience includes working at a bakery, washing pans at a restaurant named Giovanni's B, as a busboy, as a cook at a pizzeria called Spizzico, as a line cook at Al's Pizza and he has done banquets. (T 19-21) After Al's Pizza, Petitioner testified that he went to work at Capri Sport Ristorante ("Respondent"), working as a cook and making pizza. Petitioner testified that he commenced working there around February, 2016 and worked until March 19, 2016. (T 22-23)

The Petitioner testified that his job duties for the Respondent included making all the dishes on the menu and when the pizza guy was busy, he would also help making pizzas. (T. 24-25) The petitioner testified that he was in charge of running the whole kitchen, meaning that if something were to go wrong, a dish coming out wrong, it would be his responsibility. He also ordered the produce, the bread, cans of tomatoes and any other items required to make the food. (T 25) He worked 12 hour shifts and worked on his feet throughout the day. (T 26) He was hired at Capri's by GiGi, the owner of Capri Ristorante. (T 26) Petitioner testified that his uncle, Julio Reveles, came to work for the Respondent as a pizza maker and was hired by GiGi. (T 27) Petitioner testified that he worked five to six days a week, from 10:00 a.m. to 10:00 p.m., approximately 60 to 72 hours a week. (T 28-29) Petitioner testified that he was paid two checks

and then he was paid cash. He was paid for about three months for January, February and March. He remembers that the checks he received were for $700.00 each without a name on it, that he had to put his own name on the check. (T 30) Petitioner was shown Px. 6, a photocopy of the check made payable to Anna Rogio, dated 03/12/16 in the amount of $700.00 drawn from an account from Capri Sport, Inc. (T 31-34) Px. 7 is a stub from one of the checks that he received from the currency exchange. It is in the amount of $650.00. (T 35)

Petitioner testified that Roberto, his supervisor while working for the Respondent, trained him to make dishes. (T 36 - 37) Whether it was chicken limone, chicken marsala, or chicken toscana, he would use a pan and show the Petitioner how to make all the dishes from beginning to end, including the sauces. (T 37) There were about 7 or 8 dishes on the menu, and he could make all of them. (T 38) He would also use cooking alcohol in making many of the dishes, such as chicken marsala. (T 39) Roberto trained him for about three days to make dishes with cooking alcohol. (T 39-40) He would work every day at Capri's as a cook, and the only day he did not work as a cook was when the pizza guy had his day off and he would then make then pizzas. (T 40)

Petitioner testified that prior to March 15, 2016, he never had pain in his leg or in his knee and never had any trouble moving around quickly. (T 42) Petitioner testified that on March 15, 2016, he started work at 10:00 a.m. Petitioner testified that sometime between 6:30 p.m. and 7:30 p.m., he had an accident in the kitchen. (T 43) Petitioner testified that he was getting a lot of orders and was making chicken marsala and he ran out of marsala wine. He could not reach the shelf where the bottle was stored. Petitioner testified that he put his left foot on the steam table and when he reached to grab the bottle, the table moved and he fell, with his left knee cracking as he fell on his butt. (T 44-45) Petitioner testified that chicken marsala is

made of mushrooms, wine, a little bit of butter and the chicken. The wine was located on a big shelf on top of the steam table. The shelf at Capri Sport with the wine on it is about 6 ½ feet or 7 feet tall. (T 45-46) He was facing the shelf and when he put his leg on the table with wheels, the table moved. Petitioner testified that his right leg was on the table, his left leg was on the pizza table and the left leg moved because the pizza table had wheels. He felt a crack in his left leg and in less than 5 minutes, his left knee was swollen. (T 47-48) Petitioner testified that his uncle came to see him, but nobody else could make the order so he continued and finished his shift that day. (T 48) He felt extreme pain, 10 on a scale of 1 out of 10, in his left knee. (T 49-50)

The Petitioner testified that he called Roberto and told him the same day that the accident took place, telling him that he fell and he was in pain. Petitioner testified that on the following day, he showed Roberto (at the restaurant) his left knee, because he had an ice pack on the knee and it was swollen. (T 50-51) Petitioner testified that he continued to work for the Respondent, until Roberto called him and told him that he was off that Monday which petitioner understood to mean that he was fired. (T 53)

Petitioner testified that he went to the emergency room at Presence St. Mary on March 28, 2016. (T 54) He was discharged after getting x-rays and instructed to put ice packs on his left knee so the swelling would go down. (T 56)

Petitioner next saw Dr. Ron Silver, whom he heard about from a T.V. commercial. (T 56) Petitioner testified that he first saw Dr. Ron Silver on March 28 or 29, 2016, and complained of left knee pain with a history of the work accident. He told Dr. Silver that he was grabbing a bottle of wine and he fell when he was on the table with his knee and was trying to grab the bottle. (T 57) Dr. Silver prescribed that he remain off work and provided him with a long brace along with medications including Terocin patches, Ultram for pain, Meloxicam for inflammation

and a prescription for physical therapy for four months, from April through July, 2016. (T 59-60) Petitioner continued to see Dr. Silver approximately every six weeks for refills of medication, and had his last visit on June 20, 2017. His next visit is approximately on August 1, 2017. (T 61) While he has been seeing Dr. Silver, his pain fluctuated between a 7 and a 10 out of 10. (T 61) Petitioner testified that on April 7, 2016, he underwent a left knee MRI and was advised that his meniscus was torn and that he needed surgery. (T 62)

He did not return to work for Capri's because they had already had someone working for them. Petitioner testified that he has tried to look for work but cannot stand up for a period of time. He has a lot of friends with restaurants who need help but he cannot work because of his knee condition. (T 63) Petitioner testified that he is unable to work because the pills make him tired and he cannot stand up for a long period of time with the medication. Without the medication, he can stand for about an hour, two hours at most. (T 63) He feels tired and drowsy all the time as a result of the medication and pain limits him most from finding a job. (T 64) Dr. Silver has prescribed him off work since the first day he saw Dr. Silver. (T 64) After he stands for longer than an hour or two, he feels pain in his left leg and notices swelling.

He wears a brace most of the time and when he goes to sleep, he puts a patch on his knee. At the Arbitratio Hearing, petitioner testified that he was wearing a short brace and is currently taking medication including Ultram and Meloxicam. He has been taking this medication since the first date he went to see Dr. Silver. (T 66-67) Petitioner testified that he could not perform a job as a cook while on these medications. (T 67) Petitioner testified that he would like to go back to work, but he is limited because he has not had surgery on his left knee. (T 67) Since the accident date, he has not had any accidents at home, or any falls. (T 67-68) Currently, he cannot play with his kids or play soccer in a league. (T 68)

On cross-examination, the Petitioner testified that Roberto had come by Al's where he was working to see if he wanted to work as a cook. He asked him whether he could make pizza. (T 71)

The Petitioner testified that the cooking wine for chicken marsala was right near him in the kitchen. The extra bottles of cooking wine were in the back. (T 81) The Petitioner testified that he has not worked since working at Capri Sport Ristorante. (T 88) Petitioner testified that he has not earned any money at all since working at Capri Sport Ristorante. (T 88) Petitioner testified that he does not believe he can work in a restaurant because of the pills that he takes and that they are really strong, making him drowsy. (T 88)

B. Testimony of Julio Reveles Rivas

Julio Reveles Rivas testified that he is the Petitioner's uncle. He and Raul both worked at Capri Sport Ristorante. (T 97) He worked for the Respondent for six months, until June, 2016. (T 98) He started working at Capri about three weeks after Raul started. (T 98) Julio testified that he was paid $600.00 per week and was paid with a personal check without the payee name but just with the amount. (T 99) Julio made pizzas at the restaurant and was also the dishwasher and would assist Raul in the kitchen. (T 100) Raul's position was cook. (T 101)

The day of the accident, March 15, 2016, Julio was washing dishes in the sink and the Petitioner called him to bring him a ladder. Julio testified that when he returned with the ladder, he found the Petitioner on the floor. (T 103-104) Julio testified that he helped him get up because his knee was hurting. (T 104) Raul worked with him for the rest of the day but he looked like he was in pain because his knee was swollen. (T 105) Julio testified that he quit working with the Respondent because Roberto told him that GiGi wanted him to say that it was Raul's fault and Julio said that he was going to tell the truth. (T 107) Julio testified that while

working at Capri Sport Ristorante during the six months he was there, the bottles of cooking wine were stored on the top shelf while some wine was near the bottom, used to prepare the dishes, but when the bottom bottles were finished, that's when people would get the bottles from the top shelf. (T 113-114) The top shelf in the kitchen held over-stock or extra bottles of wine. (T 114)

C. **Testimony of Antonella Rovito**

Antonella Rovito testified that with her husband, she was the co-owner of Capri Sport Ristorante and that the lease started in January, 2016, and they legally opened to the public March 28, with their grand opening March 31. They closed the restaurant in August, 2016. (T 116-117) The address of Capri Sport Ristorante was 8300 South Wolf Road, Willow Springs, Illinois. Respondent's Exhibit 3 showed a flyer for their grand opening on March 31, 2016. (T 118) Ms. Rovito was in charge of the books and payroll at Capri Sport Ristorante. (T 120) However, she did not ever pay Raul Reveles for working at Capri Sport Ristorante. (T 120) When shown Petitioner's Exhibit 6, which is a J.P. Morgan check from Capri Sport Ristorante, Ms. Rovito agreed that that was her handwriting, including her signature and the date but that she did not write the name "Ana S. Rogio" as the payee on the check. She agrees that it was her custom to give out paychecks without a name as the payee. (T 121) Ms. Rovito also testified that in January, 2016, there would be no cook working for the restaurant because there was no food being made and that they probably did not yet have a pizza oven. (T 124) She also testified that Petitioner worked for Respondent for two weeks, and remembers that because she went out of town after he left. (T 124) Ms. Rovito testified that if Petitioner fell, he did not tell anyone about it including her or her husband, the co-owners of the company. She found out about it six weeks later, when she received something in the mail. When she got the paper in the mail, she called

her husband, who did not know about it, and asked Roberto, who said that he did not know anything about it. (T 127-128)

Ms. Rovito also testified that she remembers the kitchen at Capri Sport, which was smaller than this arbitration hearing room and that cooking alcohol would not have been kept on a high shelf because it was a hazard and "against insurance". (129) Ms. Rovito and her husband were both co-owners and were both in charge of books and payroll. (T 133) The Petitioner's Exhibit 6, the check that was signed and dated but did not have a payee, was handed to Julio Reveles, not Raul Reveles. (T., p. 135) Ms. Rovito also testified that she was in Capri Sport Ristorante on a day-to-day basis and that there was no cooking alcohol on the top shelf in the kitchen. (T 136-137) Ms. Rovito testified that Petitioner's Exhibit 7, a statement from a currency exchange that says "Raul Carlos Reveles" does not make sense since it is for a check at G&A Banquets and Catering and that her assumption is that his uncle doesn't have an account and gave it to his nephew to cash while he was working for Capri Sport Ristorante. (T 138) Ms. Rovito testified that she promised that if she got a copy of the check, which says check #2155, that she did not write anyone's name on that check. (T 140)

Ms. Rovito testified that she does not even believe the accident that allegedly occurred on March 15, 2016, happened. She believes that it happened somewhere else. (T 145) Additionally, Ms. Rovito testified that she would never give Petitioner a check because she was not in charge of paying him as her husband, instead, was taking care of seeing if his employment would work out. And even though the currency exchange receipt (Px. 7) shows the receipt of a check from the banquet hall, she also knows that he never worked at the banquet hall. She believes that Julio gave the check to Petitioner to cash at the currency exchange. (T 149-150)

D. **Testimony of Fillippo Rovito, Jr., ("GiGi")**

Fillippo Rovito (also known as "GiGi") is the co-owner of the Respondent, the Capri Sport Ristorante. (T., p. 153) Roberto, his chef, was in charge of hiring the Petitioner. A few days, maybe three or four days, after the accident of March 15, 2016, Chef Roberto told him about the alleged accident. (T., p. 154-155) The Petitioner was hired to make pizza for Capri Sport Ristorante. (T., p. 155) He already had a cook for this restaurant: Chef Roberto. (T 155) Mr. Rovito testified that he thinks he paid the Petitioner a couple hundred dollars in cash, one time. (T 157) He does not recall ever handing a wage check in an envelope to the Petitioner. *Id.* Mr. Rovito knows that he had his grand opening of Capri Sport Ristorante on March 31, 2016. He knows this because there were members of the Blackhawk team who offered to come there that day. (T 158) He disputes that Raul Reveles was working for him at Capri Sport Ristorante as early as January, 2016 as nobody was there in January. (T 159) There were no ovens running and no food was being served in January or February. (T 160)

As for the location of the cooking alcohol at Capri Sport, the wine and vodka and all other alcohols used for cooking is on a rail next to the cook at waist level in the kitchen. (T 161-162) Extra alcohol was kept in a little shack in the back of the restaurant, kept on a shelf where he does not need to use a ladder to reach it. (T 162) But again, Petitioner was hired to make pizzas at Capri Sport and was not hired to make chicken marsala. Either Chef Roberto or his back-up chef, Julio Reveles, would make chicken marsala. (T 163)

The Petitioner was hired by Roberto through his uncle and they did not know if the Petitioner was staying because he worked for another pizza place. Mr. Rovito did not know whether he was working full-time or part-time. There was not too much to do yet because the restaurant was not fully open along with operating ovens. (T 164) But he remembers that

Petitioner gave him a couple hundred dollars cash and Reveles said he cannot get paid by check because he had some child support problems. (T 165)

Mr. Rovito confirmed filling out and signing a Wage Statement confirming that he had given $200.00 total to Mr. Reveles. (*See* Rx. 1, Wage Information Request with certification) (T 166)

Mr. Rovito believes that the Petitioner has been employed as recently as one month ago at another restaurant. (T 168) He believes that the Petitioner is working at an Italian restaurant that starts with a "P". (T 169) Mr. Rovito believes, "100%" that Petitioner is currently working at a restaurant after he said that he got hurt. (T 182) He has seen camera film footage of Raul working at another restaurant. (T 185-186)

Chef Roberto is a supervisor in his restaurant and Roberto is responsible to inform him if somebody falls or gets hurt. (T 192)

E. Testimony of Pablo Gonzalez ("Chef Roberto")

Pablo Gonzalez ("Chef Roberto") is currently employed by GiGi Filippo and he was also employed at the Capri Sport Ristorante. (T 196-197) He was in charge of training employees for Capri Sport Ristorante. Raul Reveles was an employee who was directed to make pizzas at Capri Sport Ristorante. (T 197) Roberto testified that never trained Petitioner to make the dish chicken marsala, because the Petitioner was just a pizza maker. Julio Reveles is also a pizza maker, like his nephew. (T 199-200) Around March, 2016, the cook at Capri Sport Ristorante was known as "Skinny".

Roberto testified that regarding bottles of marsala wine, they were not kept on a shelf at Capri Sport but they were stored, instead, in a storage house, similar to the ones sold at Home Depot. The wine would be inside boxes and stored on shelves at about eye level. (T 201-202)

Additionally, such cooking wine, like marsala wine, would also be next to the stove meant for cooking. (T 202)

Roberto was never aware of a pizza maker doing other stuff that does not correspond to pizzas, such as making dishes. (T 203)

Roberto testified that he learned about the Petitioner claiming a work accident at Capri Sport three days after the accident from his uncle. His uncle said that he had fallen. (T 203)

Roberto testified that he never trained Raul Reveles to make the dish, chicken marsala, according to Capri standards, because he already had a cook at Capri Sport. (T 206)

Three or four days after March 15, 2016, Roberto was informed by Julio that Raul was injured at work. When Julio was informing him of this, Raul was standing in the kitchen by a door and he saw Raul's left knee swollen, but does not remember seeing him with ice packs on his leg. (T 216-217)

Roberto testified that he has not seen bottles of cooking alcohol in any other place besides at the rail at waist level in the kitchen and in the shed at Capri Sport. (T 221)

In response to the Arbitrator's examination, Roberto testified that the shelf where the boxes of pizza are kept is at a height level where people can grab them. There is not a steam table under that shelf but rather the steam table is placed on the other wall on the other side of the restaurant. There is not a pizza table on wheels under that shelf. (T 227-228)

F. **Testimony of Craig Brown**

Craig Brown is an employee of Advantage Surveillance and works as a private investigator. He has worked as a private investigator for about 10 years and his job duties

include doing surveillance, preparing court documents, trailing claimants and making video and photographs. (T 230-231)

Craig Brown received an assignment with regards to Petitioner, Raul Reveles, which included surveillance of his activities over the course of four days, including April 18, 19, 26 and 27, 2017. (T 232) Brown testified that he knew what Mr. Reveles looked like because of "pre-surveillance" where his employer gathered information and gives him a photograph along with an address of Mr. Revelles. (T 232) Brown testified that over these days in April, he saw Mr. Reveles working at Prima La Pizza in Hillside, Illinois. (T 233) Brown testified that he observed Reveles working at Prima La Pizza on April 19 and 26, 2017 and has video evidence of Mr. Reveles working there. (T 234) Brown testified that he used a covert video recording device to videotape Reveles' activities (T., p. 235)

Craig Brown played his DVD disc with a copy of his video surveillance in open court on his computer. (Disc marked and admitted as Rx. 4) Craig Brown testified that on April 19, 2017, he recorded Reveles as wearing black pants, burgundy polo shirt with a black collar. Brown testified that petitioner is dropping his kids off from his car. (T 241-242) (*See* Rx. 4, DVD, Clip: IL-2017-00205-003-Clip 3) There are 18 clips altogether in this DVD. (T., p. 243) The clips of April 19, 2017, at around 11:30 a.m., is when he is seen in a back window of the kitchen at Prima La Pizza. The clip at time mark 6:56 is a man standing in the window whose face you can see. (T., p. 246-247) (*See* Rx 4, DVD, Clip: IL-2017-00205R1-001:18:56:47) Craig Brown testified that he knew that Reveles carpooled to the location and entered in the back and went to work, because he followed him on April 26, from 11:00 a.m. until 9:00 p.m. On April 19, he watched him until 4:00 that day, and for that whole period of time, the Petitioner was in the kitchen, seen through the kitchen window. (T., p. 248-250) (*See* Rx. 4, DVD, Clip:

IL-2017-00205-Clip 5; 2:09:36; 2:10:41) Brown testified that he also had surveillance of petitioner doing activity around his house, dropping his kids off and reporting to work. (T. 251) Brown testified that he knows for sure that the individual depicted in the video is Raul Reveles because at one point he was close enough to touch the Petitioner. Petitioner, in one of the clips on the disc, was trailed to a donut shop and he and Mr. Brown passed one another. (T 257) (*See* Rx 4, DVD, IL-2017-00205-002-Clip 1; 22:59:52)

G. **Testimony of Valentin Vazquez**

Valentin Vazquez is currently employed by Capri Banquets, but was first hired in 2016 as a cook. (T. 9-29-17, p. 7-8) Mr. Vazquez personally met Petitioner at the restaurant, Prima La Pizza. Mr. Vazquez confirms that the person in the video is the Petitioner who is now in the hearing room where he is testifying. (T. 9-29-17, p. 8) Mr. Vazquez last saw Petitioner on March 30, 2017 at Prima La Pizza, located in Hillside, Illinois. (T. 9-29-17, p. 9) He saw the Petitioner in the kitchen of the restaurant because he was working in the kitchen that day. Mr. Vazquez was hired by Edgar, the manager at Prima La Pizza, and he worked just one day. (T. 9-29-17, p. 10) He went there for work for just one day because Chef Roberto asked him as a favor to record Mr. Reveles while he worked that day at Prima La Pizza. (T. 9-29-17, p. 11) He worked during the hours of 10:00 a.m. to 3:00 p.m. on March 30, 2017. Edgar introduced Mr. Vazquez to the Petitioner, Raul Reveles. (T. 9-29-17, p. 11) On March 30, 2017, Petitioner taught Mr. Vazquez how to make sandwiches, pasta, how to prep, and how to cook the pastas. In addition to Mr. Reveles and Mr. Vazquez, Julio Reveles, the Petitioner's uncle, was also working that day. (T. 9-29-17, p. 12)

Mr. Vazquez has video evidence, taken as a video on his Android cell phone of Raul Reveles working at Prima La Pizza. (T. 9-29-17, p. 13) Additionally, a copy of this video

burned to a disc, which was also shown to the Arbitrator. (T. 9-29-17, p. 20) (*See* DVD, Rx 5) Additionally, three still photographs from the video show Mr. Reveles in the kitchen at Prima La Pizza, wearing an apron. (T. 9-29-17, p. 22-23) (*See* photo, Rx. 6)

H. Rebuttal Testimony of Raul Reveles, Petitioner

The Petitioner testified that he has never worked at Prima La Pizza, including not on either March, 2017 or April, 2017. However, he knows all of the employees who work there including Julio Reveles, his uncle, Casimior Reveles, his uncle, Victor Reveles, his brother, and Julio Reveles, his brother. (T. 9-29-17, p. 28) In March, 2017, only one of his brothers, Julio Reveles, worked there. (T. 9-29-17, p. 31) The Petitioner testified that he and his brother Julio look alike, as they are the same height, they look like each other and has a shaved head. (T. 9-29-17, p. 32) Petitioner presented Petitioner's Exhibit 8, four photographs of his family, including a photograph of Victor, Julio, Eric, him and his mother and father. (T. 9-29-17, p. 33) This photograph of Julio is a fair and accurate representation of what he looked like in March and April, 2017. (T. 9-29-17, p. 35) His brother, Julio Reveles, would leave the house around 9:15 in the morning and return around 9:45 at night in March and April, 2017. He knows his brother's, Julio's, work schedule, because he lives with him. (T. 9-29-17, p. 38 - 39) Since the work accident, his family members, including Julio, Teresa, Tereso, Uncle Julio, his brother, and one of his cousins, Alejandro Sanchez, all live with him. (T. 9-29-17, p. 43)

The Petitioner testified that he has been to Prima La Pizza. Sometimes he makes food at Prima La Pizza and tries to help them out to make plates, dishes, and create dishes for them. (T. 9-29-17, p. 43-44) Every Friday, Saturday and Sunday, they have a different night special from the menu, where different plates are taken out of the menu. (T. 9-29-17, p. 44) He helps create plates on the weekend in exchange for food. (T. 9-29-17, p. 45) He goes to Prima La Pizza once

a week, no matter what. (T. 9-29-17, p. 45) He does this to do "La Conda", which is like a lottery to pay bills, rent, etc. (T. 9-29-17, p. 46-47) He has also been in the kitchen of Prima La Pizza because the owner lets him make his own plates of food. However, the Petitioner testified that he has not ever worked in the kitchen of Prima La Pizza. (T. 9-29-17, p. 47)

Regarding the video clip taken by Craig Brown, and in particular that took place in the bakery, he agrees that it was him with his son. (T. 9-29-17, p. 48) He also borrows his brother's or his wife's car to go to the grocery store, the doctor, or pick up his sons from school. (T. 9-29-17, p. 49) Also, the clip of a man putting groceries and two kids in a parked SUV and then driving away was also probably him and his children. (T. 9-29-17, p. 49-50) When he drives the car, he does not take medications. He stopped taking his medications two months ago. (T. 9-29-17, p. 50)

The Petitioner agrees that in the video clips of a man or men with a shaved head in the kitchen of Prima La Pizza seen through the back window, it could have been him or his brother, Julio Reveles. (T. 9-29-17, p. 51)

He agrees that the video shown by Mr. Vazquez showing a man in the kitchen at Prima La Pizza, was him. He was eating a sandwich in the kitchen. He was not working at Prima La Pizza on that day, March 30, 2017, between 10:00 a.m. and 3:00 p.m. (T. 9-29-17, p. 52-53) Petitioner testified that the owner is generous and lets him go into the kitchen and make a meal, and sometimes he even makes pizza to take home. (T. 9-29-17, p. 53-54) Currently, the Petitioner testified that he is working nowhere and has not worked anywhere since his injury on March 15, 2016. He has not been working since his injury because he needs a surgery on his knee. (T. 9-29-17, p. 54) Until he has this surgery, he is unable to squat down, move fast and climb and descend stairs. (T. 9-29-17, p. 55) Currently, he is wearing a brace, as has been

prescribed by his doctor. (T. 9-29-17, p. 55) The Petitioner testified that the owner of Prima La Pizza allows him to be in the kitchen and make himself food. He says the owners allow him to eat for free because he knows the cooks that have been working there. (T. 9-29-17, p. 60-61) He also thinks that the owner allows everyone to take food home who works in the kitchen, not just him. (T. 9-29-17, p. 61) The Petitioner agreed that he was explaining to Mr. Vazquez who took the video how to make a certain dish. (T. 9-29-17, p. 62) He understood that Mr. Vazquez was in the kitchen to become a cook at Prima La Pizza. Although there were other actual workers there that day, including Jesus, Edgar and his Uncle Julio, the Petitioner was there making a sandwich and since he was asked a question by Mr. Vazquez how to make the dish, he told him how to make it. (T. 9-29-17, p. 63)

To this day, the Petitioner testified that he still goes to Prima La Pizza for free meals, and goes once a week to pick up the money for La Conda. (T. 9-29-17, p. 64) Petitioner testified that on Fridays, Saturdays and Sundays, when a special is put out not on the menu, the Petitioner is called to give them pointers. It is the petitioner's testimony that he does not get paid for these visits in the kitchen but instead, the owner gives him food. (T. 9-29-17, p. 64) Petitioner testified that he never received any money from Mr. Nick of Prima La Pizza. (T. 9-29-17, p. 68)

The Petitioner does not think it is unusual for people to just hang out in the kitchen during open hours. Because all of his friends go there, hang out in the back, in the kitchen. ((T. 9-29-17, p. 70) In his 20 year experience as a cook, during lunch time, he has also had people stand in his kitchen, if the owner allows it. (T. 9-29-17, p. 71)

I. <u>Rebuttal Testimony of Craig Brown</u>

Mr. Brown testified that there were two occasions that he followed Raul Reveles to Prima La Pizza, on April 18 and 26, 2017. (T. 9-29-17, p. 73) The Petitioner arrived at the restaurant

around 10:30 a.m., carpooling with two other individuals in the same residence, on April 18 and when Craig Brown left Prima La Pizza at 7:00 p.m., their car was still outside the restaurant. (T. 9-29-17, p. 75-76) During the days, between 10:30 a.m. and 7:00 p.m., Mr. Brown testified that he saw Mr. Reveles in the pick-up window in the kitchen in the restaurant. (T. 9-29-17, p. 76) Mr. Brown testified that in his video clips, in clip 5 and clip 6, he is walking past the kitchen window. In clip 7, he was observed standing in the pick-up window. He is viewing these clips in the evening of April 18, 2017. And the last clip was recorded around 7:30 p.m. that night. (T. 9-29-17, p. 77-78) (See Rx 4, DVD, IL-2017-00205R1-001-clip 6; 18:56:47) He did not see the Petitioner leave the evening of April 18, 2017. (T. 9-29-17, p. 79)

For the next video surveillance of April 26, 2017 at Prima La Pizza, Mr. Brown testified that he arrived with the Petitioner around 10:30 a.m. and the clips on the DVD disc, Rx. 4, and clip 3, departing from the residence and clip 6, standing at the pick-up window at the restaurant. (T. 9-29-17, p. 79)

II. CONCLUSIONS OF LAW

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

The Petitioner is alleging that he sustained an unwitnessed accident at work, that he continued to work and that he did not receive any medical care for 13 days after the incident. The Arbitrator finds that in these circumstances, a petitioner must testify in a credible manner to prove by a preponderance of the evidence that he did in fact sustain an accident arising out of and in the course of his employment. The Arbitrator heard the witnesses testify and observed

their demeanor. The Arbitrator specifically finds that the petitioner's testimony was not credible. The Arbitrator finds the testimony of the petitioner was credibly rebutted by the testimony of Pablo Gonzalez, Valentin Vasquez and Craig Brown and by the video surveillance recordings entered into evidence.

The petitioner testified that he was employed as a cook by the respondent and was trained to make various dishes by Pablo Gonzalez also referred to as Chef Roberto. However, Gonzalez testified that he hired the petitioner as a pizza maker and not as a cook that prepared dishes. Gonzalez also testified he never trained the petitioner to make dishes.

The petitioner claims that he injured his injured his left knee when he climbed a table(s) to reach a bottle of Marsala Wine on a shelf that was 6 ½ to 7 feet off the ground. However, Gonzalez testified that the bottles of Marsala Wine were not stored on a tall shelf in the kitchen but rather in on a shelf at waist level in the kitchen. Gonzalez testified that spare bottles of Marsala Wine are stored at eye level in a shed or storage house that is outside the kitchen.

Petitioner testified that he told Gonzalez about the alleged accident on March 15, 2016. Gonzalez testified that on March 15, 2016 petitioner never told him that he injured himself at work. Gonzalez testified that 3 days after March 15, 2016 the petitioner's uncle who also worked for the respondent told him that petitioner had fallen.

The petitioner testified that that he cannot work because the "strong" pills make him tired and drowsy all the time and that he cannot stand up for a long period of time without medication. Petitioner testified that without medication he can only stand for an hour or two. Craig Brown testified that during the course of his video surveillance of petitioner, he observed the petitioner driving his children. Brown subsequently testified that he saw the petitioner at Prima La Pizza.

Brown testified that he observed the petitioner standing for multiple hours in the kitchen area of this restaurant on April 19, 2017. Brown also observed petitioner at the same facility on April 26, 2017 from 11:00 am through 9:00 pm.

The petitioner testified that he has been to Prima La Pizza where the owner allegedly lets him in the kitchen to make his own plates of food but claims he never worked there or was paid. He also testified that on the weekends he goes to the restaurant to "give pointers" on how to prepare the food.

Valentin Vazquez testified that he was hired on March 30, 2017 to work on Prima La Pizza and observed the petitioner working there on this date. Further, Valentin testified that petitioner taught him how to make sandwiches and cook the pastas. Vazquez testified that he also recorded video on his phone of petitioner working at this restaurant.

Video evidence reviewed by the Arbitrator rebuts the petitioner's testimony that he cannot work and that he cannot stand for more than an hour or two. To the contrary, the video surveillance reviewed shows the Arbitrator that the petitioner is capable of working. Further, the Arbitrator did not find any evidence in the videos of the petitioner walking with an altered gait or of favoring his left leg. The petitioner does not appear to be "drowsy" in any of the videos including those that show him driving his children and the videos appear to establish that petitioner can stand and function for more than 2 hours in a row, contrary to his testimony.

Based upon all of the above, including the fact that petitioner's testimony contradicted itself, was contradicted by the video surveillance and by the credible testimony of Valentin Vazquez, Craig Brown and Pablo Gonzalez (also known as "Chef Roberto"), the Arbitrator finds that petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with the Respondent on March 15, 2016.

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

The Arbitrator that as the petitioner failed to prove he sustained an accident arising out of and in the course of his employment with the Respondent, that the issue of whether his current condition of ill-being in his left leg is causally related to the injury is moot.

G. What were Petitioner's earnings?

The Arbitrator finds that as the petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with the respondent, the issue of Average Weekly Wage is moot.

J. Were 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 that as the Petitioner failed to prove he sustained and an accident arising out of and in the course of his employment with the Respondent, the petitioner's claim for medical bills and prospective medical care is denied.

K. What temporary benefits are in dispute? TTD?

The Arbitrator finds that as the Petitioner failed to that he sustained an accident arising out of and in the course of his employment by the Respondent, the petitioner's claim for temporary total disability benefits is denied.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator concludes that the respondent's denial of benefits by the respondent was not unreasonable and vexatious in this matter based on the testimony and evidence presented at the Arbitration Hearing. Petitioner's Motion for Penalties and Attorney Fees are thereby 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 PEORIA	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Balensiefen,
Petitioner,

19IWCC0649

vs.

NO: 13 WC 16918

Emerald Performance Materials,
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/exposure, causation, medical temporary disability, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

The 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 27 2019
o10/3/19
LEC/rm
043

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0649

BALENSIEFEN, JOHN Case# **13WC016918**

Employee/Petitioner

EMERALD PERFORMANCE MATERIALS

Employer/Respondent

On 11/9/2018, 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 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0000 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN AVE SUITE 108
CHAMPAIGN, IL 61821-7047

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

19IWCC0649

- ☐ 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 Balensiefen
Employee/Petitioner

v.

Emerald Performance Materials
Employer/Respondent

Case # **13** WC **16918**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Peoria**, on **9/20/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident 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

19IWCC0649

On **4/23/13**, 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 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 $**94,096.60**; the average weekly wage was $**1,809.55**.

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

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

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

ORDER

Petitioner failed to meet his burden of proof on the issues of accident and causation. Therefore all benefits are denied.

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

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

Signature of Arbitrator Gerald Granada

11/7/18
Date

FINDINGS OF FACT

This case involves a Petitioner alleging occupational disease sustained while working for the Respondent on April 23, 2013. Petitioner is alleging he was exposed to numerous chemicals in the workplace, and as a result of his exposure, he is suffering from iron deficiency anemia. Respondent disputes Petitioner's claims and the issues in dispute are: 1) accident, 2) causation, 3) medical expenses, 4) TTD and 5) permanency.

Petitioner testified he started working at Respondent's facility in 1988. When he began working at the facility, it was owned by BF Goodrich. Respondent, Emerald Performance Materials, is the current owner of the facility. Respondent is a chemical manufacturer. Petitioner testified that when Emerald took over the plant, they were much more lax with respect to safety. Petitioner testified that when BF Goodrich operated the plant, things were fixed right away.

Petitioner spent his first five years in Building 712, which is a three-story building. Petitioner testified his job duties included mixing chemicals. He testified to having daily skin exposure to morpholine vapors on the skin. He wore Nomex gloves, a hard hat, and a small facial mask when packaging. Petitioner testified the exposure on the skin was on his face, hands, and throat. The exposure felt like a burn from aftershave.

After spending five years in Building 712, Petitioner began working in Building 711 where he spent the majority of his career. Petitioner's job title was that of a First Class Chemical Operator. Petitioner further testified to some exposure in Building 711 where they made a product causing exposure to paraformaldehyde vapors. Petitioner testified described Building 711 is a single-story metal building. It is about 120 feet long and about 30 feet wide. Petitioner testified one person works in the building on any given shift. Petitioner talked about the ventilation used in the building and described the primary ventilation as a cross ventilation system with three fans on each side of the building - two which were not always working properly. Additional ventilation was utilized when the weather was warm in that an overhead door was opened and three regular doors were opened. There was also a louver vent on the ceiling, which was utilized when weather permitted.

When describing the process of the chemical production, Petitioner testified they utilized two reactors which are 500 gallons each and made of heavy steel. There are also charge tanks made of steel. Outside the building there are storage tanks for raw materials that included aniline, sulfur, and carbon disulfide. Petitioner described that by pushing a button, the raw materials would be pumped into the building through pipes and into charge tanks. By pushing another button, the materials were transferred from the charge tank to a reactor.

The next step in the process was to push a button to heat up the reactor. The heating mechanism utilized a liquid called Dowtherm. A coil inside the reactor transferred the higher temperatures to the product. Once the temperature reached a certain point, the Dowtherm would be turned off, and the chemicals would self-react. Petitioner testified the chemical mixture reached 500 degrees and 1,000 psi. The chemicals would react for three to four hours, and during that time, Petitioner went to the other end of the building to keep an eye on the purification system. Once the chemicals were done mixing in the reactor, Petitioner would relieve the pressure on the reactor and push another button to transfer the materials from the reactor through pipes to a second bigger reactor. 1,000 gallons of water were added to the second reactor, which cooled off the material and caused another reaction. The mixture in the second reactor was further mixed with a mechanical agitator that was initiated by the pushing of a button.

After about one hour, another button was pushed to transfer the materials through pipes to another vessel called a raffinate tank, which was located outside the building. The raffinate tank fed to an extractor column where

the material was washed with a chemical called toluene. The toluene rinsed out the product, which was a liquid called sodium MBT crude. Petitioner described the crude in the raffinate tank is like tar. The toluene separates the tar from the crude such that the tar goes into one storage tank, and the washed crude goes to a different storage tank. The crude is a liquid material, and it is then used for various purposes within the plant.

Throughout each step of the process, Petitioner testified that if there were no leaks and the pipes were sealed, he would not have exposure to any of the chemicals. However, Petitioner testified there were often leaks involving various chemicals.

While working in Building 711, Petitioner normally wore glasses, a hard hat, and Nomex clothing which is a fire-retardant uniform. He also wore gloves most of the time. Petitioner testified he was exposed to toluene and hydrogen sulfide. The hydrogen sulfide was a by-product of gas that would come off the reactor. Petitioner testified that when he first got to work, he could smell the hydrogen sulfide, but he later became sensitized to it and could no longer smell it.

Petitioner wore a "rattler" which is a monitor for hydrogen sulfide. The rattler would vibrate when the level of hydrogen sulfide reached five parts per million. Once the exposure got to 10 parts per million, the rattler would vibrate and beep. Petitioner explained that when the rattler went off, you knew there was a leak in the building, and the rattler went off on a weekly basis. The safety department would be notified, and someone would come down to their location and look things over. When the rattler indicated the hydrogen sulfide reached 25 parts per million, Petitioner would wear a respirator that provided fresh air. Alternatively, he would walk out of the building until the exposure cleared. Petitioner further testified the rattlers were not very accurate and would either over-report or under-report the level of exposure. Petitioner indicated the hydrogen sulfide would leak from a seal on the agitators. If more than one person complained about the smell of the hydrogen sulfide, the maintenance department would repair the leak.

With respect to toluene, Petitioner testified it was stored in tanks outside of the building where he worked. He indicated there were several leaks in the vent header systems, and there were sometimes leaks in the overhead pipes that brought toluene into the building. These leaks occurred on a monthly basis. He further explained sometimes the leaks were not cleaned up, sometimes they were hosed down, and sometimes a floor dry agent was put on the spill. Petitioner further testified that one time, they used a kiddie pool to collect the liquid toluene leak. The toluene emits vapors, so they wore breathing equipment. The toluene has a strong smell, and Petitioner testified that he would get lightheaded if he breathed in a lot of it. Petitioner further testified to random exposure to toluene when he helped the maintenance men fix the leaks. However, he always wore personal protective equipment when breaking lines open to repair leaks.

With respect to aniline, Petitioner testified he would randomly be exposed when a charge pump seal failed. Petitioner testified aniline would leak about four times per year as a result of a faulty gasket or pump seal – that would generally be fixed within 24 hours.

Petitioner talked about his exposure to carbon disulfide. He described the substance as a liquid that was similar to gasoline. He testified it leaked from a faulty pump seal or flange on a monthly basis. Petitioner testified it smelled like rotten egg, which is similar to hydrogen sulfide.

With respect to dermal exposure, Petitioner testified he might get a splatter of toluene on his skin or possibly a drip of carbon disulfide and aniline. Petitioner further indicated most of his exposure would have been by

inhalation. Petitioner wore his respirator mask weekly or possibly two times per week because of the potential hydrogen sulfide exposure based upon the rattler alerts.

Petitioner testified that he was exposed to methylene chloride in building 725, when he first started working at the plant. He did not work with it generally, but he cleaned up some vessels containing methylene chloride when he was working as a helper.

Petitioner further testified to being exposed to Cure-Rite powder when he went into Building 725 to use the lunchroom. Petitioner indicated there was a significant amount of dust in the building, and he would generally not be wearing a respirator when going to lunch.

Petitioner testified he always used personal protective equipment when cleaning up leaks. Despite showering at the end of the workday before leaving Respondent's facility, he would sometimes get a chemical smell on his bed sheets.

Medical Treatment

With respect to Petitioner's medical care, he treated primarily with Ruth Smith, a nurse practitioner, and Dr. Bajaj from Illinois Cancer Care.

On March 24, 2011, Petitioner began treating with Nurse Smith. The records from Nurse Practitioner Ruth Smith include a Patient Health Summary. The summary includes a listing of active problems. One of the problems is listed as anemia, iron deficiency-unknown etiology. The records also show that Petitioner was taking medication for gastroesophageal reflux, had a past history of atrial fibrillation and an occasional heart flutter. Petitioner was also on blood thinners for six months due to a blood clot. Nurse Smith noted Petitioner's diagnoses included hypertension and hypothyroidism. (Rx1) The Patient Health Summary also includes a social history that has a section on occupational safety. The summary states that there were no significant occupational safety risk factors. (Px25)

The July 28, 2011 records from Nurse Smith indicate Petitioner was there for lab results. Petitioner provided a history of having a blood clot several years earlier as well as a history of arrhythmia. Petitioner reported feeling good, but he was "locked out" of his work. Under the social history section, Nurse Smith noted Petitioner had no significant infectious disease risk factors, and Petitioner had no significant occupational safety risk factors. (Rx2)

Lab studies from November 2, 2011 revealed a decreased red blood cell count. Dr. Homer Pena from the St. Francis Medical Center for Occupational Health referred Petitioner for a consult due to a concern that Petitioner was suffering from blood loss from the gastrointestinal tract. Dr. Pena was concerned it could be serious. (Px25)

On November 11, 2011, Petitioner saw Dr. Marianna Cuany for a review of his bloodwork that was done at his workplace as part of an annual physical. Dr. Cuany indicated there were no significant occupational safety risk factors. She interpreted the lab studies to reveal a low level of hemoglobin and a low level of iron. She diagnosed Petitioner with anemia, iron deficiency-unknown etiology. (Px25)

Petitioner returned to see Nurse Smith March 23, 2012. Petitioner complained of an increased feeling of being winded for a couple of years. His shortness of breath came about with activity. Petitioner also reported the

shortness of breath was a gradual thing and he noticed it when walking long distances. Petitioner also reported a history of a DVT in his leg and was on coumadin for about six months. That diagnosis and treatment was performed several years earlier. Petitioner also had an atrial fibrillation, and many years earlier, they shocked his heart to cure the atrial fibrillation. Petitioner had been taking medication since then. Nurse Smith again noted there were no significant occupational safety risk factors. Her review of systems section indicates Petitioner was suffering from fatigue and shortness of breath. Nurse Smith ordered a chest x-ray and some lab studies. She also commented Petitioner may need a referral for a stress test. Petitioner was also advised that if his shortness of breath increases, he should report to the emergency room.

On June 5, 2012, lab studies were performed showing Petitioner had severe iron deficiency and would require oral iron supplementation. Dr. Cuany noted they were considering a blood transfusion. (Px25)

Petitioner testified that on the evening of June 13, 2012, he was unable to catch his breath. The morning of June 14, 2012, he became extremely winded when just trying to brush his teeth. He reported to the Methodist Medical Center emergency room where he was admitted for a 10-day period and was diagnosed with bilateral massive pulmonary emboli with saddle embolus. He was also diagnosed with iron deficiency anemia, a large hiatal hernia, hypothyroidism, and hypertension. The history in the hospital records indicates Petitioner had been experiencing intermittent shortness of breath for the previous six months. Petitioner further reported that the day before the hospital visit, his symptoms became worse, and on June 14, 2012, he was unable to catch his breath. He was experiencing intermittent left calf swelling for at least a couple of weeks, and three weeks earlier, Petitioner was advised he had a superficial blood clot in his left calf. Petitioner was given a heparin drip for the pulmonary embolus. At the time of discharge, Petitioner was placed on iron supplements. (Px25) The records from the hospital include a social history of Petitioner working in a chemical plant where they deal with hydrogen sulfide, carbon disulfide, and aniline. (Px25)

While at the hospital, Petitioner was evaluated by Dr. Wasim Ellahi for the iron deficiency anemia diagnosis. Dr. Ellahi noted in the social history that Petitioner works in a chemical plant in Henry, Illinois. His assessment was Petitioner had iron deficiency anemia with a history of gastroesophageal reflux disease. The doctor ordered an EGD and a colonoscopy. If those were negative, the plan was to proceed with a small bowel capsule endoscopy. (Px25) The EGD did not identify a localized source of bleeding. Similarly, the colonoscopy did not reveal a source of bleeding to explain Petitioner's decreased hemoglobin level. The small bowel series also failed to identify any localized bleeding. The study did show a large sliding hiatal hernia.

On July 2, 2012, Nurse Smith completed Family Medical Leave Act documentation indicating Petitioner should be off work from June 14, 2012 through August 1, 2012. The basis for Petitioner's off-work status included bilateral pulmonary emboli, severe anemia, weakness, and shortness of breath. Additionally, Nurse Smith's report of workability dated July 2, 2012 indicates the restrictions were temporary in nature. Nurse Smith also wrote on the FMLA documentation that once the anemia was resolved, Petitioner should not have any flare-ups. (Px29)

Petitioner returned to see Nurse Smith July 30, 2012. He complained of feeling weak and having shortness of breath with exertion. Petitioner also noted his left leg was always swollen, and it was worse by the end of the day. Following an exam, Nurse Smith indicated she would keep Petitioner off work for now because he was still too weak to work all day, and Petitioner did not think his employer would allow him to work half days. Nurse Smith ordered a venous duplex bilateral leg study to assess the blood clots in Petitioner's legs. Petitioner was to follow-up pending the test results. (Px25) Nurse Smith also wrote a note indicating Petitioner should remain off work pending results of further testing. No release date was set. (Px29) The ultrasound duplex

study performed on July 31, 2012 revealed a blood clot extending from the left mid-superficial femoral vein to the midcalf. The clot was occlusive and was believed to be relatively acute. The DVT progressed to a large saddle pulmonary embolus for which Petitioner was hospitalized. (Px25)

Following the ultrasound on the legs, Petitioner began treating with Dr. Madhuri Bajaj at Illinois Cancer Care. The note from Dr. Bajaj dated August 3, 2012 indicates Petitioner's history dates back to five years earlier when Petitioner experienced a left leg DVT in the ankle area that was unprovoked and treated with coumadin for a six month period. There was no etiology for the DVT. After completing the coumadin therapy, Petitioner was monitored for any recurrence. It was not until one month before Dr. Bajaj's evaluation that Petitioner sustained another DVT of the left leg. The finding was based upon an ultrasound duplex of the legs from April 23, 2012, which showed a blood clot in the left calf.

Dr. Bajaj noted that over the past two months, a new issue regarding Petitioner's anemia presented with a drop in hemoglobin. Petitioner was given three units of packed red blood cells for the anemia in early June 2012. Dr. Bajaj wanted updated lab studies to assess Petitioner's condition. Dr. Bajaj noted Petitioner works as a chemical operator at Emerald Materials, but he did not comment on any potential relationship between Petitioner's employment and his medical conditions. Dr. Bajaj recommended indefinite coumadin therapy because of the recurrence of the blood clots. (Px26)

On August 31, 2012, Dr. Bajaj commented the work-up did not reveal any evidence of bleeding. He diagnosed Petitioner with iron deficiency anemia. Petitioner reported he felt well and was not having any specific issues with the coumadin treatment. Petitioner reported he felt a bit more fatigued. (Px26) On October 29, 2012, Petitioner reported to Dr. Bajaj that he was still experiencing shortness of breath with exertion. Dr. Bajaj referred Petitioner for a cardiology evaluation. (Px26) On November 12, 2012, Dr. Bajaj started an IV iron program to help replete iron stores a bit faster. (Px26) The December 7, 2012 iron stores showed good improvement. (Px26)

On January 3, 2013, Petitioner returned to see Nurse Smith. He reported he had no energy, and that he was still not able to work. He also reported swelling and tingling in his left leg as well as episodes of cardiac palpitations or arrhythmias. Nurse Smith again noted there were no significant occupational safety risk factors. Nurse Smith did not comment on the need for restrictions or limitations on Petitioner's activities. She also indicated Petitioner should follow-up as needed and at least monthly for lab studies. (Px25)

On January 18, 2013, Petitioner reported his energy level felt better and Dr. Bajaj noted an ultrasound showed most of the blood clot in the leg was resolved. Dr. Bajaj indicated Petitioner would stop taking iron to determine what the hemoglobin trend would be. Petitioner was also scheduled to undergo an ablation for the blood clot in the leg. (Px26) On February 28, 2013, Petitioner's hemoglobin was improved, but the iron levels were significantly lower. Dr. Bajaj recommended to Petitioner that he start taking over-the-counter iron pills again. (Px26) On May 30, 2013, Dr. Bajaj indicated Petitioner had been diligent with his oral iron program. On July 25, 2013, Petitioner acknowledged that he sometimes forgets to take his iron pills. On October 24, 2013, Petitioner reported he stopped taking the iron supplements to see how his numbers would be. Petitioner's iron levels were decreased, and Dr. Bajaj encouraged Petitioner to resume the oral iron supplementation. (Px26) On January 23, 2014, Dr. Bajaj again noted Petitioner was not compliant with taking the iron supplements. Dr. Bajaj again encouraged Petitioner to be compliant with the program. (Px26) After noting on April 29, 2014 that Petitioner had been diligent with taking his iron supplements two times per day, Dr. Bajaj thought Petitioner should be able to sufficiently replete the iron stores and transition to an iron-rich diet. (Px26)

On August 26, 2014, Dr. Bajaj noted Petitioner was only taking one pill per day, and his hemoglobin and iron levels were good. Dr. Bajaj concluded Petitioner's iron deficiency anemia was resolved. He advised Petitioner to continue taking one oral supplement pill per day.

Petitioner returned to see Dr. Bajaj six months later on February 24, 2015. Petitioner had not been compliant with taking the oral supplements. His hemoglobin was slightly lower than what it was in August 2014. (Px26) On June 23, 2015, Dr. Bajaj noted Petitioner's hemoglobin was within a normal range. He stated Petitioner's iron was at an optimal level with Petitioner taking one iron tablet per day. Dr. Bajaj noted Petitioner was following with his primary care physician on a regular basis, so he planned on seeing Petitioner in six months or a year unless there was a dramatic change in the iron levels. (Px26)

On June 21, 2016, Dr. Bajaj noted Petitioner failed oral iron supplements and he began administering injections. On July 19, 2016, Petitioner reported his fatigue was improved. Petitioner's hemoglobin level was within normal limits. Dr. Bajaj also noted Petitioner's cardiologist switched Petitioner's medications to help with the anemia. (Px26)

When Petitioner returned to see Dr. Bajaj September 20, 2016, Dr. Bajaj noted Petitioner was replete with normal hemoglobin levels. Dr. Bajaj would continue on observation only at that point because Petitioner could have an iron-rich diet as Petitioner had been transitioned to Xarelto from coumadin. (Rx13)

On April 20, 2017, Dr. Bajaj stated Petitioner's iron levels were suboptimal. Dr. Bajaj expressed a concern that Petitioner may have an occult source of GI blood loss contributing to his iron deficiency. Dr. Bajaj gave Petitioner an iron injection and advised Petitioner to return in six months. (Rx14)

Petitioner attended a Medicare Initial Annual Wellness Visit May 22, 2017. The note indicates Petitioner has a generally active lifestyle with no difficulties performing activities of daily living. The functional assessment indicates Petitioner did not need any assistance performing daily activities. The review of systems did not reflect any abnormalities. Similarly, the physical exam did not reveal any abnormalities. (Rx15)

Petitioner returned to see Dr. Bajaj December 26, 2017. The iron levels were again noted to be replete, and Petitioner did not have any anemia after the previous injection therapy. There was no evidence of a GI bleed. Petitioner was advised to eat a variety of iron-rich foods. (Rx17)

As of March 27, 2018, Dr. Bajaj indicated Petitioner's iron level was replete and the hemoglobin level was within normal limits. Petitioner had not had any injections since November 2017. Petitioner denied having any fatigue. (Px26) On June 26, 2018, Dr. Bajaj again indicated there was no evidence of anemia. (Px26)

At trial, Petitioner testified he did not have any restrictions imposed on his activities from any of the various doctors. The medical records include treatment by Dr. James Williams for venous insufficiency. (Rx4, Rx5) Dr. Cuany also treated Petitioner for a cervical problem. (Rx6, Rx7, Rx8) Additionally, Dr. Mina treated Petitioner for his cardiac condition. (Rx11, Rx16)

Petitioner testified that he first learned of a potential relationship between anemia and his work exposure April 22, 2013 - the date he met with Dr. Fletcher. He further testified he is still getting treatment for anemia by way of injections. He sees Dr. Bajaj every six months or a year. His most recent injection prior to the September 20, 2018 trial date was in January 2018. Petitioner indicated he feels better after receiving the iron injection.

He also testified to feeling more run down as the injections become more remote. He still sees Dr. Mina for his blood pressure and cardiac issues. None of his doctors have any restrictions imposed on his activities. He also indicated he has not made any attempt to return to work after being discharged from the hospital in June 2012.

With respect to his current activities, Petitioner testified he is always on his feet and he is busy. He tinkers in his garage and does a lot of mowing. He takes his dog for walks, and he does a lot of fixing up of little things, which he described as piddling. Petitioner performs a minimal amount of exercise on an exercise bike and on the "Chuck Norris exercise thing."

Retained Medical Expert: Dr. David Fletcher

At the request of Petitioner's attorney, Petitioner was evaluated by Dr. David Fletcher. Dr. Fletcher testified by way of evidence deposition August 31, 2016. (Px1) Dr. Fletcher is board-certified in occupational medicine and has reviewed several cases involving this Respondent at the request of Petitioner's attorney, Tim Shay. (Px1, pp.4-5)

Dr. Fletcher testified he saw several employees of Respondent's facility and did an epidemiologic investigation looking at people, place, and time factors that may contribute to human illness. Dr. Fletcher further indicated he has a lot of training in toxicology through his specialty of occupational medicine. He further explained toxicology is a major portion of training when a physician becomes board-certified in occupational medicine. (Px1, p.6)

Dr. Fletcher testified about criticisms of his opinions set forth in the report of Dr. Shirley Conibear who was retained by Respondent as an expert. Dr. Fletcher noted that Dr. Conibear thought Dr. Fletcher had the wrong diagnosis. Dr. Fletcher explained that his diagnosis of microcytic anemia was accurate, but Dr. Conibear's diagnosis of iron deficiency anemia was a more specific description of Petitioner's anemia. (Px1, pp.8-9)

Dr. Fletcher opined that Petitioner's exposures in the workplace interfered with his body's ability to absorb and metabolize iron to produce red blood cells. (Px1, p.9) He indicated the chemicals causative of anemia and other blood disorders include toluene and Cure-Rite. He then stated we do not know exactly, because there was not any testing of the chemicals. (Px1, pp.13-14)

Dr. Fletcher further testified the material safety data sheet for toluene reflects chronic exposure, which could lead to anemia. (Px1, p.14)

With respect to aniline, Dr. Fletcher testified the Material Safety Data Sheet documents suppression of a blood-forming organ system that can result in anemia. (Px1, p.16)

Dr. Fletcher testified he went to the plant, and surveyed the plant from outside the gates. He testified there was an irritating smell outside the plant in July 2013. (Rx1, pp.16-17)

Dr. Fletcher reviewed a Quarterly Non-Compliance Report for the first quarter of 2007. He believed the document cited deficiencies as far as reporting goes. He interpreted the document to confirm Petitioner had exposure in the workplace.

Dr. Fletcher further indicated heavy metal exposure including lead is a known agent that causes anemia. (Px1, pp.18-19)

Dr. Fletcher reviewed several documents from various agencies citing violations on the part of Respondent. He interpreted the documents to show Respondent exhibited poor compliance with the controlling of hazardous chemicals in terms of spills and leaks. (Px1, pp.19-27)

Dr. Fletcher was involved in advising and consulting with the Teamsters Union to have a Health Hazard Evaluation performed. He also interacted with the individuals from NIOSH involved with the study. Dr. Fletcher testified to his significant knowledge of the NIOSH investigation and criticized the investigation because they never tested Cure-Rite, which is a known carcinogen. (Px1, p.31)

Based upon his review of the medical records, Dr. Fletcher noted Petitioner had a diagnosis of a pulmonary embolism with severe anemia. He commented Petitioner worked uneventfully for Respondent until he had a sudden onset of shortness of breath, chest pain discomfort, and was hospitalized. (Px1, p.39)

With respect to Petitioner's exposure, Dr. Fletcher testified Petitioner had the potential for both dermal and inhalation exposure to toluene. He noted NIOSH was critical of Respondent's respiratory program, and he further stated the proper personal protection equipment may not have been properly utilized. (Px1, p.41)

Based upon all of the information available to him, Dr. Fletcher diagnosed Petitioner with microcytic anemia as a result of iron deficiency. He testified to a causal relationship between the medical condition and Petitioner's exposures to a multitude of chemicals including the heavy metal exposure to lead. (Px1, p.44)

Dr. Fletcher further testified Petitioner could not return to work for Respondent because Dr. Fletcher could not certify Petitioner's respirator status. He did believe Petitioner could perform sedentary work. Dr. Fletcher further commented Petitioner has atrial fibrillations, DVTs, and other conditions, so he would be concerned that Petitioner would have a problem if he exerted himself. (Px1, p.45)

When describing Petitioner's condition, Dr. Fletcher testified symptoms of fatigue, a lack of ability to do anything, malaise, shortness of breath, and slowness of movement are all symptoms of anemia. (Px1, pp.47-48)

On cross exam, Dr. Fletcher indicated the chemicals responsible for Petitioner's anemia included lead, aniline, hydrogen sulfide, carbon disulfide, toluene, and methylene chloride. (Px1, pp.51-52)

Dr. Fletcher acknowledged he never mentioned lead in his written report. He then stated lead was never tested. (Px1, p.52)

Dr. Fletcher acknowledged the relationship between aniline and anemia was from a study involving animals. He acknowledged the Material Safety Data Sheet did not mention anything about anemia in humans. Dr. Fletcher could not name any medical studies finding a causal relationship between any of the named substances and anemia developing in humans. (Px1, pp.54-55)

Dr. Fletcher did indicate there were multiple studies concluding lead exposure causes anemia. However, Dr. Fletcher did not know what was Petitioner's exposure to lead – as he could not say the amount or frequency of Petitioner's exposure to lead. (Px1, pp.55-56)

When asked about Petitioner's exposure to aniline, Dr. Fletcher testified we know Petitioner had exposure, but there were no records of air sampling, and he did not have industrial hygiene data specifically for Petitioner. He further explained he did not know the intensity of the exposure to aniline. (Px1, pp.56-57)

Dr. Fletcher also testified he could not say Petitioner experienced exposure to hydrogen sulfide on a daily basis. He noted there was a limited database of information. He further explained it would be rare to have a definite cause and effect. Furthermore, Dr. Fletcher testified that to this day, there has still not been an explanation for Petitioner's anemia. (Px1, pp.59-60)

Despite the lack of information, Dr. Fletcher believes the exposures in an additive fashion are the cause of Petitioner's iron deficiency anemia. Dr. Fletcher did acknowledge that not everyone at Emerald has anemia. He further agreed that someone can have the same exposure as Petitioner and not develop anemia. (Px1, pp.60-61) Dr. Fletcher acknowledged the pulmonary emboli was not an occupational problem. Similarly, Petitioner's blood clots were not related to workplace exposure, and Petitioner's cardiac issues including atrial fibrillation were not related to Petitioner's workplace exposure. (Px.1, pp.61-62)

Dr. Fletcher could not say how much exposure Petitioner had to carbon disulfide, toluene, or methylene chloride. He complained about the employer not having a program in place with urine sampling so that various markers and exposures could be properly identified and managed. However, he then acknowledged that Respondent's medical surveillance program identified Petitioner's anemia. (Px1, pp.62-63)

Dr. Fletcher was critical of Respondent's respirator fitting program, but he acknowledged the workers in Respondent's facility were fit for respirators every year. Dr. Fletcher did not recall Petitioner saying that his respirator did not fit correctly. Dr. Fletcher was also unable to say whether Petitioner's personal protective equipment was not appropriate for him. (Px1, pp.63-64)

Dr. Fletcher acknowledged the NIOSH report did not mention anyone wearing ill-fitting respirators. Dr. Fletcher commented the issue was whether the appropriate cartridge was used in the respirator, but he did not have enough information to comment on that issue. (Px1, pp.64-65)

With respect to Petitioner's condition, Dr. Fletcher indicated iron deficiency anemia is a common problem. He explained anemia is essentially a low blood count from the number of red blood cells carrying oxygen. (Px1, pp.65-66) Dr. Fletcher further acknowledged conditions related to iron levels in the blood are more common with individuals suffering from hypothyroidism. Petitioner was diagnosed with hypothyroidism at least as far back as 2009. (Px1, p.71)

When asked about Petitioner's symptoms, Dr. Fletcher agreed that with iron supplementation, the blood count is raised, so Petitioner would not have shortness of breath or fatigue. (Px1, p.72)

Dr. Fletcher also agreed with Dr. Conibear that Petitioner's medications consisting of Nexium and Omeprazole reduced the amount of stomach acid and can interfere with the absorption of iron. (Px.1, p.73)

When asked about other doctors' opinions, Dr. Fletcher testified none of the treating doctors rendered an opinion that Petitioner's anemia was causally related to his exposure in the workplace. (Px1, pp.77-78)

When asked about the various violations in Respondent's facility, Dr. Fletcher was unable to testify to any specific relationship between the violations and Petitioner's medical condition. (Px1, pp.78-87)

Dr. Fletcher criticized Dr. Conibear's opinions by noting it was ridiculous that Dr. Conibear stated in her report that Dr. Fletcher did not have access to the NIOSH report. Dr. Fletcher then acknowledged that his report was completed May 13, 2013 and the NIOSH report is dated June 2014. He then acknowledged it was accurate that he did not have the final report from the Health Hazard Evaluation when he issued his report in May 2013. (Px1, pp.87-88)

When asked about his involvement with several alleged chemical exposure cases filed against Respondent, Dr. Fletcher testified that he and Petitioner's attorney went to a bar and met with 15 or 16 representatives of the Teamsters Union and their agents in Peoria. They also talked to a couple of representatives in Chicago. Dr. Fletcher indicated the lock-out contributed to the investigation of work-related conditions. (Px1, pp.89-90)

Dr. Fletcher further acknowledged that the Health Hazard Evaluation concluded there was no evidence of any connection between work exposures and the medical conditions alleged in the workers' compensation cases. (Px1, p.92)

Dr. Fletcher expressed an interest in the Cure-Rite assessment, which was never performed. He noted Cure-Rite is a carcinogen, but Petitioner does not have cancer. He further acknowledged that based upon his physical exam of Petitioner, there were no manifestations of a cancerous condition. (Px1, pp.92-93)

Retained Medical Expert: Dr. Shirley Conibear

At the request of Respondent, Petitioner was evaluated by Dr. Shirley Conibear. Dr. Conibear testified by way of evidence deposition October 25, 2016. (Rx1) Dr. Conibear is board-certified in occupational medicine. She also has a Masters of Public Health including classroom work in epidemiology, biostatistics, and toxicology. She has been a medical consultant for 15 years at two different plants. At the time of her deposition, Dr. Conibear was also running a medical surveillance program and performed Fitness for Duty exams. She also performed exams for hazmat, asbestos, and lead. (Rx1, pp.4-6)

Based upon her review of the medical records and exam of Petitioner, Dr. Conibear testified Petitioner had anemia 6-12 months prior to undergoing a blood transfusion in June 2012. The diagnosis was iron deficiency anemia. (Rx1, pp.9-10) Dr. Conibear explained Petitioner's condition by indicating he was not getting enough iron in his food, and he was not absorbing it through his stomach and intestines. Another possibility was that Petitioner was losing blood somewhere. However, no source of bleeding was discovered, and there was nothing about Petitioner's diet that would lead to a conclusion that the diet was responsible for anemia. (Rx1, pp.10-13)

Dr. Conibear concluded Petitioner was not absorbing iron because of the depleted acid in his stomach. She further explained Petitioner's medications, including Nexium and Omeprazole, could interfere with the absorption of iron. Consequently, Dr. Conibear concluded that those medications at least contributed to Petitioner's anemia condition. (Rx1, pp.13-15)

Dr. Conibear explained the significance of the lab studies and the various findings. She noted the lab studies performed June 5, 2012 showed critically low hemoglobin. Petitioner's microcytic anemia was based upon the MCV finding. Additionally, the study showed a recent change in the size of the red blood cells. (Rx1, pp.18-19)

Dr. Conibear reviewed several Material Safety Data Sheets. She indicated there was nothing to indicate exposure to aniline, carbon disulfide, or toluene would be responsible for iron deficient anemia. (Rx1, pp.22-28) In support of her opinion, Dr. Conibear indicated she reviewed textbooks, and she currently teaches residents at the University of Illinois College of Medicine residency program.

Similarly, Dr. Conibear testified there is nothing about methylene chloride that would lead to iron deficiency anemia. She then stated that both aniline and methylene chloride are known to cause hemolytic anemia which is the destruction of red blood cells. However, hemolytic anemia and iron deficient anemia are different conditions. She further explained hemolysis occurs rapidly on contact of a chemical with the red blood cells and low iron is a slow process. (Rx1, pp.30-31)

Dr. Conibear testified there was nothing about sodium hydrosulfide also known as NaSH that would cause or lead to iron deficient anemia. (Rx1, p.32)

Dr. Conibear summarized that none of the chemicals discussed would contribute to Petitioner's condition. (Rx1, p.34)

When asked about the NIOSH report (Px22), Dr. Conibear testified it was performed by a certified industrial hygienist and an occupational medicine physician. She thought the Health Hazard Evaluation was done appropriately, and there was no overexposure to aniline identified. (Rx1, pp.35-38)

At the time of her exam of Petitioner, she noted swelling and discoloration with the loss of pulses in Petitioner's left leg. She identified some neurologic abnormalities of the reflexes in the knees as well as sensation to light touch being decreased in the left foot. She further noted decreased sensation to vibration bilaterally at the ankles. (Rx1, p.39) Dr. Conibear testified the symptoms she noted were not related to iron deficient anemia or anything associated with the workplace. Dr. Conibear further explained there was no causal relationship between Petitioner's exposures in the workplace and his medical condition. The chemicals to which he was exposed have never been shown to cause iron deficiency anemia. (Rx1, p.40)

Dr. Conibear further explained the presentation of Petitioner's anemia was typical and was explained by other factors typical of iron deficiency anemia. His condition was explained by the medication he was taking and the condition being reversed by taking iron supplements. (Rx1, p.41)

Investigative Reports

Petitioner presented several exhibits consisting of Material Safety Data Sheets for various chemicals. Petitioner's Exhibit 4 is the Material Safety Data Sheet for Cure-Rite18 powder. The exhibit indicates the powder is a carcinogen and could cause respiratory irritation. The Material Safety Data Sheet does not identify anemia as a potential consequence of exposure.

Petitioner's Exhibit 5 is a Material Safety Data Sheet for hydrogen sulfide. The potential health effects do not include anything that would impact the blood or cause anemia.

Petitioner's Exhibit 6 is a Material Safety Data Sheet for methylene chloride. The chronic effects could be to the liver as determined by animal studies, but the effect has not been identified in humans. Similarly, the chemical was found to be carcinogenic in experimental animals at a relatively high dose, but it was unlikely to

be a cause of cancer in humans. There is no indication methylene chloride exposure would lead to iron deficiency anemia.

Petitioner's Exhibit 7 is a Material Safety Data Sheet for morpholine. The chronic health effects include potential damage to the kidneys, liver, and bladder. No mention is made of blood disorders or anemia.

Petitioner's Exhibit 8 is a Material Safety Data Sheet for toluene. Chronic exposure could involve damage to numerous organs. The exhibit indicates studies of workers have shown long-term exposure may be related to effects on the liver, kidneys, and blood. However, the effects were limited to serum enzymes and decreased white blood cell counts.

Petitioner's Exhibit 9 is a Material Safety Data Sheet for carbon disulfide. Numerous potential effects on humans are noted, and one of several chronic exposure risks is listed as anemia. The MSDS for carbon disulfide does not specify what kind of anemia is a potential risk. It does indicate the chemical evaporates rapidly at room temperature.

Petitioner's Exhibits 11 through 19 relate to various violations from the Illinois Environmental Protection Agency or the U.S. Environmental Protection Agency. The violations relate to deficient reports, faulty monitoring of valves and open-ended lines, a failure to reasonably identify leaking components of a particular chemical, and a failure to immediately report a discharge of substances.

Petitioner's Exhibit 20 consists of a letter from NIOSH to Respondent dated March 19, 2013. The letter sets forth the results from the first of two visits to Respondent's facility. The letter notes air samples were tested in Building 711 and 725. Additionally, the evaluators reviewed industrial hygiene sampling from 2010. The evaluators determined there were no overexposures to aniline, carbon disulfide, hydrogen sulfide, methylene chloride, morpholine, or toluene.

Petitioner's Exhibit 22 is the final report for the Health Hazard Evaluation dated June 2014. The report documents that during the second visit to Respondent's facility, the production of OTOS was observed. The Arbitrator notes that the chemical name for OTOS is set forth on page iii of Petitioner's Exhibit 22. This is the same chemical compound as Cure-Rite18 powder as identified on page 2 of Petitioner's Exhibit 4. The Health Hazard Evaluation report further indicates the crude manufacturing process was observed. Aniline was not found on surface wipe samples.

The Health Hazard Evaluation documents employee interviews, a records review consisting of OSHA logs of work-related injuries and illnesses and workers' compensation claims, air sampling records, the facility respiratory protection program, hazard communication program, weekly safety check sheets, and accident reporting procedures. The evaluators also reviewed medical records including medical surveillance records. Additionally, they performed an extensive literature search for information relating to the predominant chemicals to which employees would be exposed. The evaluation also included air sampling, surface sampling, and workplace observations.

The evaluators concluded that all airborne exposure levels which they measured were well below the occupational limits except for OTOS. Overexposures to OTOS were noted in employees bagging the material and troubleshooting a clog in the bagging operation. The report expressly indicates the kidney diseases in former employees were unrelated to workplace exposure. No mention was made of their being any issues or concerns with any of the potential exposures being a causative factor for iron deficiency anemia.

Petitioner's Exhibit 23 consists of the testimony of a former worker at Respondent's facility, David Smid. Generally speaking, Mr. Smid testified to significant exposures in the workplace as a result of poor conditions for which Respondent was responsible.

CONCLUSIONS OF LAW

1. With regard to the issues of accident and causation, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the medical evidence. Specifically, the Arbitrator looks to the evidence from the experts utilized in this matter.

Petitioner filed an Occupational Diseases claim alleging he sustained iron deficiency anemia as a result of chemical exposures in the workplace. It is well-settled that a claimant has the burden of proving by a preponderance of the credible evidence all the elements of his claim, including that the injury arose out of and in the course of employment. Parro v. Industrial Comm'n, 260 IL App 3d 551 (1993). This case was filed under the Occupational Diseases Act. Consequently, the claimant must show that he suffers from an occupational disease which arose out of the employment and there is a causal connection between the conditions under which the work is performed and the occupational disease. It is the claimant's burden to prove that he suffers from such a disease, and there is a causal connection between his disease and his employment. Omron Electronics v. Illinois Workers' Compensation Comm'n, 214 IL App (1st) 130766WC. Additionally, 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 v. Industrial Comm'n, 77 Ill.2d 482 (1979).

Here, Petitioner relies upon the opinions of his examining physician, Dr. Fletcher, to support his position that there is a causal relationship between his workplace exposures and his anemia condition. However, Dr. Fletcher testified he did not know the extent of Petitioner's exposure to any of the potential chemical culprits. Rather, Dr. Fletcher appears to rely upon Respondent being cited by the Illinois and U.S. Environmental Protection Agencies for various violations. He interpreted the various violations to support that Petitioner was exposed to numerous chemicals.

In contrast to Dr. Fletcher's opinions, the Material Safety Data Sheets do not identify iron deficiency anemia as a potential risk of exposure. The only Material Safety Data Sheet which even mentioned anemia was for carbon disulfide. However, the Material Safety Data Sheet did not specify what type of anemia could be a result of chronic exposure. It should also be noted that Petitioner testified that if there were no leaks in the production process where he worked, he would not suffer from any exposure. With respect to carbon disulfide, Petitioner testified the material came into the building from a storage tank outside through pipes and into other vessels. Dr. Fletcher acknowledged iron deficiency anemia is a common condition suffered by members of the general public without exposure to the chemicals produced in Respondent's facility.
He reported the substance leaked on a monthly basis when a pump seal or flange failed.

The Arbitrator finds persuasive the opinions and testimony of Dr. Conibear, who testified that exposure to carbon disulfide does not increase the risk of a person developing iron deficiency anemia. She testified that exposure to aniline and methylene chloride has a relationship to hemolytic anemia, but that is a different condition that what Petitioner has. Dr. Conibear attributed Petitioner's low iron to the medications he was taking for reflux. The medications decreased the amount of acid in the stomach, which prevents the stomach and intestines from absorbing iron.

The Arbitrator also finds it significant that Dr. Bajaj never rendered an opinion on causation. He was aware of Petitioner's occupation in a chemical factory, but he declined to render any opinions on the issue of causation. Similarly, Dr. Ellahi knew of Petitioner's exposure to hydrogen sulfide, carbon disulfide, and aniline, but he declined to render an opinion that there was a causal relationship between Petitioner's exposures and his anemia condition. Furthermore, Petitioner treated with Dr. James Williams for veinous insufficiency and with Dr. Adel Mina for cardiac issues. Dr. Williams and Dr. Mina also declined to render any opinions on Petitioner's anemia condition or its cause.

Significantly, Dr. Fletcher initiated a Health Hazard Evaluation performed by NIOSH. The evaluation included the taking of air samples, surface samples, observations of the production process, interviews of workers and medical records, and extensive research of literature. The evaluators included an occupational medicine physician and a certified industrial hygienist. They determined there were no overexposures in the workplace to suggest the existence of a causal relationship between workplace exposures and the workers' medical conditions.

The Arbitrator also notes an expert opinion is only as valid as the basis and reasons for the opinion. Gyllin v. College Craft Enterprises, Ltd., 260 IL App 3d 707 (2nd Dist. 1994). See also Fortney v. Crossman Roofing Company, 98WC54367, 05IWCC0117 (causal connection opinion assigned no weight when the opinion was found to be speculative). Given the lack of information Dr. Fletcher has concerning the level of exposure to each of the chemicals in Respondent's facility, and in light of the lack of any specific information or evidence causally relating the various chemicals to iron deficiency anemia, the Arbitrator finds the opinions of Dr. Fletcher are speculative. Therefore, the Arbitrator assigns lesser weight to Dr. Fletcher's opinions on causation.

Based upon the totality of the evidence, the Arbitrator finds Petitioner failed to prove he suffers from an occupational disease which arose out of the employment and that there is a causal connection between the conditions under which the work is performed and the occupational disease. As such, Petitioner's claim for benefits is denied.

2. Based on the Arbitrator's findings above, all other issues are rendered moot.

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

Vickie L Soelter,

Petitioner,

19IWCC0650

vs.

NO: 16 WC 21229

Marking Specialists,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, 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 27, 2019, is hereby affirmed and adopted.

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

19IWCC0650

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 27 2019
o11/21/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

19IWCC0650

SOELTER, VICKIE L
Employee/Petitioner

Case# **16WC021229**

MARKING SPECIALISTS
Employer/Respondent

On 3/27/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1380 LAW OFFICES OF DANIEL E MURPHY
53 W JACKSON BLVD
SUITE 1342
CHICAGO, IL 60604

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

19IWCC0650

STATE OF ILLINOIS)
) SS
COUNTY OF DU PAGE)

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

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

Vickie L. Soelter
Employee/Petitioner
v.
Marking Specialists
Employer/Respondent

Case # 16 WC 21229

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of Wheaton on **May 22, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. **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 **May 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$131,541.80;** the average weekly wage was **$2,529.65.**

On the date of accident, Petitioner was **61** 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 **$132,232.61** for TTD, **$0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of **$ $132,232.61**

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

ORDER

Medical benefits

Respondent shall pay Respondent shall pay the bills totaling **$81,439.84**, subject to the fee schedule and pursuant to §8 and §8.2 of the Act; credit to be given for any payments made directly by respondent or pursuant to §8 j.

Respondent shall authorize and pay for the cervical and lumbar injections prescribed by Dr. Novoseletsky, and any other reasonable, necessary and related treatment as prescribed by Dr. Novoseletsky in accordance with the provisions of §8 and §8.2 of the Act and the fee schedule.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits at the rate of **$1,398.23** per week for **104-5/7weeks**, commencing **May 20, 2016 through May 22. 2018.**

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

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

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

Christine MOny

Signature of Arbitrator

March 25, 2019

Date

MAR 2 7 2019

19IWCC0650

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vickie L. Soelter	)
Petitioner,	)
vs.	) **No. 16 WC 21229**
Marking Specialists	)
Respondent.	)
	)

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

This matter proceeded to hearing in Wheaton on May 22, 2018, under the provisions of §19b/§8a. The parties agree that on May 19, 2016, petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act, that their relationship was one of employee and employer and that petitioner sustained accidental injuries that arose out of and in the course of her employment with respondent. They agree petitioner earned $131,541.80 in the year pre-dating the accident; and petitioner's average weekly wage, as calculated pursuant to §10, was $2,529.65.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills;
3. Whether petitioner is entitled to payment for prospective medical treatment
4. Whether petitioner is due TTD.

STATEMENT OF FACTS

Petitioner, Vickie Soelter, Testimony

Petitioner was employed by respondent as a marking specialists. Her duties included driving and performing manual labor. She worked full-time, but seasonally. She was also employed by IDOT full-time, but seasonally, as a highway maintenance worker. On May 16, 2016, she was rear-ended by another vehicle while stopped on an exit off Route 20. She was driving respondent's utility truck. She described the impact as heavy.

She had pain in her right shoulder, neck and lower back. She denied prior injuries to her right shoulder, neck and lower back. She described the pain as a 7 or 8 out of 10. She was attended by ambulance personnel at the scene and then went home to tend to her dogs. She later went to Sherman Hospital where X-rays were taken. She followed up with her primary care doctor, Dr. Demke, for three weeks. She last saw Dr. Demke on May 23, 2016 when she was referred to an orthopedic surgeon. She selected Suburban Orthopedics where she received treatment to her right shoulder and hand by Dr. Chhadia beginning in June, 2016. Thereafter she received treatment from Dr. Novoseletsky. She remains under the care of Dr. Novoseletsky.

At respondent's request, she was examined by Dr. Bernstein on October 30, 2017 and Dr. Troy Karlsson on March 13, 2018.

She continues to have pain in her neck all day for which she takes Norco. She said she has problems turning her neck three inches to the left or right. She also has pain in her shoulder. She

is unable to perform the job in her condition as she is required to use blasters and grinders in the performance of her job. As for her job with IDOT, she has to change plow blades and pick up road-kill; which can include deer. Dr. Chhadia has imposed lifting restrictions.

On cross-examination she admitted she completed physical therapy in February, 2017. She claims all she does is watch a lot of movies and takes her dogs, that weigh fifteen pounds each, for walks. She wears a brace. She does grocery shopping every three weeks and drives every other week.

Dr. Dmitry Novoseletsky Curriculum Vitae (PX.1)

Dr. Novoseletsky's curriculum vitae indicates he is board certified in physical medicine and rehabilitation and pain medicine.

Suburban Orthopaedics Records (PX.2)

Petitioner presented at the office of Dr. Ankur Chhadia on June 10, 2016 with complaints of back, neck and [right] shoulder pain relative to the May 19, 2016 auto accident. She reported she had been seen in the ER shortly after the accident, followed up with her primary care physician who eventually recommended she see an orthopedic surgeon. After the examination, Dr. Chhadia concluded petitioner had a sprain, and aggravation of, lumbar and cervical degenerative disc disease, as well as a sprained right shoulder with possible rotator cuff tear. MRIs were ordered; she was kept off work.

The June 27, 2016 cervical MRI showed multilevel spondylosis without significant central stenosis and with several levels of neural foraminal narrowing.

The June 29, 2016 lumbar MRI showed multilevel central canal and foraminal stenosis with a central disc protrusion at L3-L4 contributing to the central stenosis.

She was seen again on July 8, 2016. Her neck was better; she had intense right shoulder pain. She was receiving physical therapy. The right shoulder MRI of June 27, 2016 showed a large full-thickness rotator tear. Surgery was prescribed; she was kept off work.

Petitioner followed up with Dr. Chhadia on August 24, 2016 after undergoing a right shoulder arthroscopic rotator cuff repair, SAD, biceps tenotomy and limited debridement on August 18, 2016. Physical therapy was recommended and ordered. She was kept off work. She followed up on September 21, 2016 and October 19, 2016.

On November 16, 2016, petitioner advised Dr. Chhadia that her right shoulder pain flared up and was the same as it was before surgery. She also had numbness and tingling on the right hand. She was referred to Dr. Novoseletsky for an evaluation.

On December 14, 2016, due to weakness and ongoing pain, Dr. Chhadia order an EMG, repeat MRI and again referred petitioner for pain management to Dr. Novoseletsky. Petitioner continued off work and continued with physical therapy.

Petitioner underwent a repeat right shoulder MRI on January 4, 2017 which showed only a small labral tear.

On January 11, 2017, Dr. Chhadia continued petitioner's physical therapy and released her to limited work.

On February 8, 2017, petitioner advised Dr. Chhadia that she was having pain that radiated into her neck and left shoulder. She was again referred to Dr. Novoseletsky; work restrictions were continued.

She was seen again by Dr. Chhadia on March 8, 2017 with the same ongoing complaints. She was again referred to Dr. Novoseletsky and kept on the same work restrictions.

On April 3, 2017, petitioner was first seen by Dr. Novoseletsky. His diagnosis was lumber facet syndrome/whiplash, IDD and radiculopathy/radiculitis and cervical IDD, facet syndrome and sacriliitis. A lumbar epidural steroid injection (LESI) was recommended. Petitioner was kept off work.

On April 5, 2017, petitioner was released to return to restricted work by Dr. Chhadia of lifting no greater than two pounds or overhead lifting with right arm.

Petitioner underwent an EMG of her upper extremities on April 11, 2017 which showed evidence of bilateral C6 radiculopathy.

Petitioner saw Dr. Novoseletsky on April 20, 2017 with ongoing pain. Dr. Novoseletsky kept petitioner completely off work.

Petitioner was seen by Dr. Chhadia on May 3, 2017. Dr. Chhadia released petitioner to modified work.

On May 18, 2017, Dr. Novoseletsky could not perform a LESI for insurance reasons; petitioner was kept completely off work.

On May 31, 2017 Dr. Chhadia again released petitioner to modified work [as it related to her right shoulder].

On June 15, 2017 Dr. Novoseletsky was unable to perform a LESI due to insurance issues; petitioner kept completely off work.

On June 28, 2017, Dr. Chhadia continued to restrict petitioner to modified work.

Petitioner returned to Dr. Novoseletsky on July 13, 2017. She received a L3, L4, L5 lumbar medial branch block for diagnostic purposes. She was kept off work.

Petitioner was seen by Dr. Chhadia on July 26, 2017, who kept her on restricted duty.

On August 10, 2017, Dr. Novoseletsky performed another set of lumbar medial branch blocks and kept petitioner off work.

On August 25, 2017, Dr. Novoseletsky performed a left sacroiliac joint injection and kept her off work.

Petitioner was seen by Dr. Chhadia on August 30, 2017 and was kept on light duty.

On September 7, 2017, Dr. Novoseletsky performed a left sacroiliac joint injection. Petitioner was kept off work.

Petitioner was seen by Dr. Chhadia on September 27, 2017 and kept on restricted work.

On October 5, 2017, Dr. Novoseletsky advised he postponed the left sacroiliac joint injection until after the cervical epidural steroid injection (CESI) was completed. Petitioner was kept completely off work.

Petitioner saw Dr. Chhadia on October 25, 2017 and kept petitioner on restricted work.

On November 1, 2017, Dr. Novoseletsky was awaiting authorization to proceed with the CESI and kept petitioner completely off work.

Petitioner followed up with Dr. Chhadia on November 22, 2017; petitioner was kept on restricted work.

The records end with the November 27, 2017 visit with Dr. Novoseletsky. Dr. Novoseletsky was awaiting insurance authorization for the CESI. He kept petitioner off work.

Suburban Orthopaedics February, 2018 Records (PX.3)

Petitioner saw Dr. Chhadia on February 14, 2018; petitioner's work restrictions remained as before.

Petitioner saw Dr. Novoseletsky on February 15, 2018, who was awaiting insurance authorization to perform a CESI. He kept petitioner off work.

Dr. Novoseletsky March 12, 2018 Records (PX.4)

Petitioner was seen by Dr. Novoseletsky on March 12, 2018. Dr. Novoseletsky was awaiting insurance authorization to perform a CESI.

Dr. Ankur M. Chhadia Curriculum Vitae (PX.4a)

Dr. Chhadia's curriculum vitae indicates he is board certified in orthopaedic surgery and orthopaedic surgery sports medicine, as well as board certified as an independent examiner.

Suburban Orthopaedics March, 2018 Records (PX.5)

The records consist of Dr. Chhadia's March 13, 2018 disability note keeping petitioner completely off work and Dr. Chhadia's office notes from March 12, 2018.

Dr. Dmitry Novoseletsky March 23, 2018 Deposition (PX.6)

Dr. Novoseletsky, testified in behalf of petitioner via deposition. He first examined petitioner on April 3, 2017 as a referral by Dr. Chhadia. Dr. Novoseletsky testified that his differential diagnosis of the cervical spine was of cervical facet syndrome/whiplash, internal disc disruption, radiculopathy or radiculitis; and the low back differential diagnoses, internal disc disruption, lumbar facet syndrome and sacriliitis. Dr. Novoseletsky believed these findings were aggravated or accelerated as a result of the work accident of May 19, 2016. Dr. Novoseletsky has been seeking for approval to perform cervical epidural steroid injection and potentially for sacroiliac joint injections. Dr. Novoseletsky confirmed petitioner remains off work from her occupation with respondent as a result of the work accident.

On cross-examination, Dr. Novoseletsky disagreed with Dr. Bernstein's opinion as to the findings on the cervical MRI from June 26, 2016. Dr. Novoseletsky believed the cervical MRI showed interior subluxation at C2-3, C3-4 and C4-5, as well as foraminal narrowing at C5-6. He did not believe the findings were solely degenerative changes.

Dr. Novoseletsky disagreed with Dr. Bernstein's findings and opinions as stated in Dr. Bernstein's October 3, 2016 report. Specifically, Dr. Novoseletsky noted Dr. Bernstein overlooked the fact that petitioner was rear-ended by another vehicle that was driving at an estimated speed of 55 MPH. Dr. Novoseletsky noted Dr. Bernstein reported petitioner had received epidural steroid injections (ESI) without improvement. This was incorrect as petitioner never received an ESI. Finally, although Dr. Bernstein acknowledged petitioner's EMG supported bilateral C6 radiculopathy, Dr. Novoseletsky noted Dr. Bernstein failed to include any mention of the positive EMG in his findings. Dr. Novoseletsky also noted Dr. Bernstein gave no diagnosis. (21-22)

Dr. Ankur Chhadia April 9, 2018 Deposition (PX.7)

Dr. Chhadia testified in behalf of petitioner via deposition. He first saw petitioner on June 10, 2016. His diagnosis was lumbar degeneration disc disease aggravation and lumbar sprain; cervical degenerative disc disease aggravation and sprain; and right shoulder sprain with possible rotator cuff tear.

He performed surgical repair to petitioner's right shoulder on August 18, 2016 for rotator cuff tear which was caused by the work accident. He kept petitioner off work from the date he first saw petitioner until January 12, 2017, at which time he released petitioner to no more lifting than two pounds on the right arm, no overhead lifting at all with the right arm.

Dr. Chhadia was not sure if petitioner was at maximum medical improvement as it relates to the shoulder; he was awaiting her response to the cervical treatment to be performed by Dr. Novoseletsky.

As of the last time Dr. Chhadia saw petitioner on March 14, 2018, he kept her completely off work due to her cervical problem.

Workers Compensation RX Solution Bills (PX.8)

Total claimed amount is $7,466.02 for medication.

Prescription Bills (RX.9)

Petitioner claims a total of $60.28 out of pocket expenses for prescriptions.

Advocate Sherman Hospital Records (PX.10)

Petitioner presented in the emergency room on May 19, 2016, three hours after the accident. Her history was that she had been rear-ended by a vehicle traveling at 50 MPH. She was wearing a seat belt, but there were no airbags. Her complaints included neck, lower back and right arm. X-rays were taken.

Ashton Center for Day Surgery August 16, 2016 Operative Report (PX11).

Dr. Chhadia performed arthroscopic surgery on August 16, 2016 to petitioner's right shoulder repairing a rotator cuff tear, supraspinatus and infraspinatus, subacromial bursitis and impingement and biceps tendinitis and labral tearing.

Petitioner's State of Illinois Employment Information (PX.12)

Petitioner's W-2 from the State of Illinois, dated 01-21-2016, shows petitioner earned a total of $16,421.58. The documents also include a statement by petitioner declining the winter seasonal offer in the 2016 to 2017 year due to temporary total disability.

Suburban Orthopaedics Bills (PX.13)

These medical bills total $73,884.38 for services rendered from June 10, 2016 through April 30, 2018; of which remains a claimed balance of $373.62 after payments and adjustments.

Additional Prescription Bills (PX.14)

Petitioner claims out of pocket payments of $28.96 for prescriptions.

May 16, 2018 Suburban Orthopaedics Records (PX.15)

Petitioner was seen by Dr. Chhadia on May 16, 2018. Her symptoms continue the same as her last visit on April 18, 2018. She was kept completely off work by Dr. Chhadia.

Dr. Avi Bernstein October 30, 2017 Report (RX.2)

At respondent's request, petitioner was evaluated by Dr. Avi Bernstein on October 30, 2017. Dr. Bernstein examined petitioner and reviewed medical records. He concluded petitioner was at maximum medical improvement within three to six months of her injury. Dr. Bernstein however, asked to review the actual diagnostic images.

Dr. Avi Bernstein April 26, 2018 Addendum Report (RX.3)

Dr. Bernstein reviewed additional records, including the June 27, 2016 cervical MRI and June 29, 2016 lumbar MRI. Dr. Bernstein did not find any significant stenosis or traumatic injury to petitioner's cervical or lumbar spine. His opinion remained the same as expressed in his October 30, 2017 report.

Dr. Troy Karlsson March 13, 2018 Report (RX.4)

Dr. Karlsson examined petitioner's right shoulder on March 13, 2018 at respondent's request. Dr. Karlsson also reviewed medical records and diagnostic testing. Dr. Karlsson concluded petitioner was capable of returning to full-duty work as it related to petitioner's right arm. Dr. Karlsson also surmised that because petitioner had ongoing complaints of pain in her right arm, the rotator cuff tear was not caused by the work accident.

MedVoc Rehabilitation May 11, 2018 Labor Market Survey Report (RX.5).

A labor market survey was conducted by rehabilitation counselor Jacqueline Bethell and job placement specialist Lauren Egle determined petitioner could earn anywhere from $10.25 to $26.40 per hour in what appears to be the same position petitioner was working for respondent at the time of her injury.

Respondent's TTD Payment List (RX.6)

The list purportedly shows TTD payments made from May 17, 2017 through March 13, 2018.

Respondent's Medical Payment List (RX.7)

The list shows payments made to various medical providers.

CONCLUSIONS OF LAW

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

F. With respect to the issue of whether petitioner's condition of ill-being is causally related to the claimed accidental injuries, the Arbitrator makes the following conclusions of law:

As a result of the work accident of May 19, 2016, petitioner suffered a torn rotator cuff tear of the right shoulder, sprain and aggravation of degenerative disc of the cervical and lumbar spine. Although petitioner's right shoulder injury may have reached maximum medical improvement, her lumbar and cervical injury remained symptomatic.

The April 11, 2017 EMG confirmed evidence of bilateral C6 radiculopathy for which she requires cervical epidural steroid injections. As for the lumbar spine, the June 29, 2016 MRI showed a central disc protrusion at the L3-4 level for which for which petitioner received medial branch blocks and was to receive a sacroiliac joint injection, which was postponed until after the CESI was authorized and administered. To date, petitioner has not received the required treatment to the cervical and lumbar spine and remains symptomatic and unable to work.

Although petitioner had reportedly had pre-existing degenerative condition involving her right arm, neck and lower back, there is no evidence she had prior problems and worked two full-time physically demanding jobs with respondent and IDOT. In addition, Dr. Novoseletsky believed petitioner's condition was not all degenerative.

Based upon the foregoing facts, the Arbitrator finds petitioner's ongoing cervical and lumbar spine condition, that remains symptomatic resulting in petitioner's ongoing disability was cause by the work accident of May 19, 2016.

The Arbitrator makes this finding despite Dr. Bernstein's opinion as Dr. Bernstein failed to take into consideration petitioner's positive cervical EMG, the fact that petitioner has not yet received any of the epidural steroid injections (although he stated she had) and failed to provide a diagnosis. Therefore, the Arbitrator did not find Dr. Bernstein's opinion to be persuasive.

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

The Arbitrator, finding petitioner's ongoing cervical and lumbar spine condition was caused by the work accident of May 18, 2016, and acknowledges the majority of Suburban Orthopaedics bill has been paid leaving a balance of only $373.62, awards the medical bills totaling $81,439.84 subject to the fee schedule, §8 and §8.2 of the Act, with credit to be given for all payments made by respondent directly or pursuant to §8j.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator finds petitioner's ongoing cervical and lumbar spine condition, which requires cervical epidural steroid and sacroiliac injections, and awards treatment of same, along with any other reasonable and necessary treatment to cure petitioner of her ongoing symptomology of the cervical and lumbar spine, pursuant to the fee schedule and in accordance with §8 and §8.2 of the Act.

L. In support of the Arbitrator's decision with regard to TTD, the Arbitrator makes the following conclusions of law:

The labor market survey introduced by respondent at Respondent's Exhibit 5, is not relevant to the issue of temporary total disability or maintenance as petitioner's condition has not yet reached a permanent state and the labor market survey provided physically similar jobs to that of petitioner's job with respondent. Although Dr. Chhadia released petitioner to return very restricted work as of January 11, 2017, relative to her right shoulder, Dr. Chhadia determined petitioner was totally disabled as of March 13, 2018. Furthermore, Dr. Novoseletsky stated petitioner has not yet reached maximum medical improvement, relative to her cervical and lumbar spine, and remains totally disabled as of April 3, 2017.

Based upon the foregoing, the Arbitrator finds petitioner is, and remains, temporary total disability as of May 20, 2016; and awards temporary total disability from May 20, 2016 to May 22, 2018, or 104-5/7 weeks, at the rate of $1,398.23 per week.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Kesner,

Petitioner,

19IWCC0651

vs.

NO: 16 WC 27950

Jerry Castle & Son,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of fees, penalties, temporary disability, maintenance, vocational services and rehabilitation, credit for overpayment 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 21, 2019, is hereby affirmed and adopted.

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

19IWCC0651

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 $25,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 7 2019
o11/21/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

19IWCC0651

KESNER, ROBERT
Employee/Petitioner

Case# **16WC027950**

JERRY CASTLE & SON
Employer/Respondent

On 3/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0391 HEALY SCANLON LAW FIRM
MATTHEW M GANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

19IWCC0651

ROBERT KESNER
Employee/Petitioner

Case # 16 WC 27950

v.

Consolidated cases:

JERRY CASTLE & SON
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **ARBITRATOR BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on 11/20/18 and 1/10/19. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

H. ☐ What 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, **4-10-15**, Respondent was operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,160.00**; the average weekly wage was **$920.00** .

On the date of accident, Petitioner was **55** years of age, **_single_**, with **0** children under 18.

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

By stipulation, Respondent shall be given a credit of **$53,097.14** for TTD, $ **0** for TPD, **$42,516.77** for maintenance, and $ 0 for other benefits, for a total credit of **$95,613.91**. 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 **$613.33** per week for **86-5/7th** weeks commencing **April 11, 2015** through **December 7, 2016** as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner maintenance benefits **$613.33** per week for **109-1/7th** weeks commencing **December 8, 2016** through **January 10, 2019** as provided in Section 8(a) of the Act. Against this award and by stipulation, Respondent shall be entitled to a credit of **$42,516.77** for maintenance benefits paid under Section 8(a) of the Act. Respondent's request that this credit operate as an overpayment is denied.

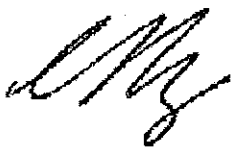
Respondent shall pay for and authorize the recommended job placement and vocational rehabilitation plan as outlined by Ed Steffan, including any and all incidental vocational assistance thereto.

Petitioner's request for penalties and attorney's fees is ***denied***.

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

RULES REGARDING APPEALS Unless a *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

3-21-19
Date

ICArbDec19(b) p. 2

MAR 21 2019

FINDINGS OF FACT

On April 10, 2015, Petitioner, Robert Kesner, was a 54-year-old truck driver for Respondent, Jerry Castle & Son. Petitioner had been working for Respondent for approximately a year and a half. *Id.* at 16. At the time of the injury, Petitioner was earning $920 per week. *Id.* at 15. Petitioner's entire employment history consists of manual labor. *Id.* at 39. Prior to working for Respondent, Petitioner had worked as a bricklayer from 1976 to 2007. *Id.* at 39. Following that job, Petitioner drove roll-off and dumpster trucks. *Id.* at 39. Petitioner's last job prior to working for Respondent was as a driver, driving semi-trucks hauling material for a concrete company. *Id.* at 39.

Petitioner's job duties with Respondent varied from driving trucks and hauling tractors and equipment, to pulling motors, and power washing. *Id.* at 14, 16. On April 10, 2015, Petitioner picked up a load of scaffold and brought it back to the shop to unload. *Id.* at 16. After unloading the scaffold, Petitioner was transporting a high-lift tractor to a job site. *Id.* at 16. While driving, Petitioner's truck broke down. *Id.* at 17. Another driver and mechanic came to assist Petitioner. *Id.* at 17. Petitioner had to put his tractor on top of a flat-bed trailer to bring it back to the shop for repair. *Id.* at 17. As they were about to leave, one of them noticed the hazard lights were still activated on Petitioner's truck which was loaded on top of the flatbed trailer. *Id.* at 17-18. Petitioner climbed up to his truck to turn the hazard lights off. *Id.* at 18. When he was about ten feet above ground on the flat-bed, he fell backwards onto the road and lost consciousness. *Id.* at 18. Petitioner was in the middle of the road after his fall and had to crawl back to the side of the road. *Id.* at 18. Petitioner testified he was performing his normal job duties at the time of his accident, because he regularly loaded equipment on trucks that required climbing. *Id.* at 18-19.

After Petitioner's fall, employees of Respondent came to his aide and called for an ambulance. *Id.* at 19. Petitioner was taken directly to the hospital. *Id.* at 19. Petitioner testified he was experiencing pain from his head, elbow, neck, back, but his pain was predominantly coming from his left arm which he could not move at the time. *Id.* at 19-20.

Petitioner testified that prior to April 10, 2015, he did not experience any issues with his left arm. *Id.* at 16-17. He had no prior treatment to his left shoulder. *Id.* at 17. At no point in his life had Petitioner previously injured his left shoulder or arm prior to April 10, 2015. *Id.* at 17.

That same day he was taken to Thorek Memorial Hospital. Px8. Petitioner provided a history of an injury occurring that day at work after falling off a truck. Petitioner complained of pain in his left shoulder and problem with his elbow movement. Petitioner denied any prior injuries. On April 13, 2015, Petitioner first presented to Dr. Michael Birman of Hand to Shoulder Associates on April 13, 2015 with complaints of left shoulder pain following a fall at work three days prior. Px9.

On April 29, 2015, Petitioner first presented to Dr. Matthew Bernstein of Barrington Orthopedic Specialists with complaints of left shoulder pain, with symptoms occurring constantly. Px5. Petitioner reported that he fell off a truck on April 10, 2015 at work. Dr. Bernstein opined Petitioner most likely suffered a large rotator cuff tear. The plan was for MRI and PT.

On May 13, 2015, petitioner returned to Dr. Bernstein with aching pain in his left shoulder radiating in the entire shoulder and upper arm, aggravated by daily activities. Px5. Dr. Bernstein diagnosed Petitioner with a rotator cuff tear and recommended left shoulder arthroscopy. On May 28, 2015, Petitioner underwent and Dr. Bernstein performed a left shoulder arthroscopy, subacromial decompression, distal clavicle excision, coracoplsasty, labral repair, biceps tenodesis and massive RCT repair. Px1.

On June 4, 2015, petitioner began physical therapy with AthletiCo that lasted 6 weeks. Px4. On June 8, 2015, Petitioner followed up with Dr. Bernstein. Petitioner was in therapy and he was instructed not to use the left arm. On July 6, 2015, petitioner returned to Dr. Bernstein with his physical therapist because his shoulder was stiffer than anticipated. Px5. On August 17, 2015, Dr. Bernstein noted Petitioner continued wearing his arm sling but was still having difficulty with range of motion. Px5. Additional therapy was recommended. On September 28, 2015, Petitioner returned to Dr. Bernstein with continued complaints and arm stiffness despite participating in therapy. The plan was for a new MRI. On October 2, 2015, MRI of the left shoulder revealed post-surgical rotator cuff repair changes. On October 6, 2015, petitioner returned to Dr. Bernstein with similar complaints of pain and restricted range of motion. Px5. Dr. Bernstein advised Petitioner that the MRI may not reveal all of the possible findings and that a rotator cuff revision may be necessary. Petitioner was then discharged from physical therapy with AthletiCo. Px4:181.

On November 2, 2015, Petitioner underwent a second surgery consisting of a rotator cuff repair revision performed by Dr. Bernstein. Px5:60. On the same date, Petitioner presented to AthletiCo to develop the therapy program he will be undergoing, consisting of 16 weeks of therapy. Px4:185. On November 4, 2015, Petitioner saw Dr. Bernstein for a follow-up visit. Px5. The stiffness in Petitioner's shoulder persisted despite using a continuous passive motion machine. On November 13, 2015, Petitioner returned to Dr. Bernstein, noting he was using the CPM machine six hours a day and performing therapy daily as well. Px5. Dr. Bernstein noted potential for permanent stiffness and possible re-current tearing. Petitioner continued to see Dr. Bernstein in follow up, unchanged and with ongoing pain and stiffness. Px5. A new MRI was ordered, which showed a full-thickness complete retracted supraspinatus tear. Px2:4.

Petitioner switched care and on April 11, 2016, Petitioner first presented to Midwest Orthopedics at Rush and treated with Dr. Brian Cole. Px3. Dr. Cole took a history of Petitioner's injury and subsequent treatment, and recommended a rotator cuff reconstruction revision. Petitioner was discharged from AthletiCo pending a second revision surgery. On May 10, 2016, Petitioner underwent and Dr. Cole performed a third surgery, which was the second revision surgery consisting of a rotator cuff repair revision, subacromial decompression, hardware removal, synovitis excision, and extensive intraarticular debridement. Px6:10. Petitioner followed up with Dr. Cole through September 2016. Following this third surgery, Petitioner attended 49 physical therapy visits at AthletiCo from June 1, 2016 through September 30, 2016. Px4:312-400.

On December 8, 2016, Petitioner last treated with Dr. Cole at which time he was given permanent restrictions consisting of a ten-pound lifting maximum, avoidance of overhead activities, no lifting overhead more than five pounds, and no ladder or stair climbing. Px3:3. Dr. Cole placed Petitioner at MMI noting that the restrictions were permanent.

Petitioner testified that after Dr. Cole placed Petitioner on permanent restrictions on December 8, 2016, Petitioner called his employer to notify them and followed-up by faxing them the report. *Id.* at 52. Petitioner testified he did not hear anything from Respondent. *Id.* at 32. At no point has Respondent attempted to accommodate Petitioner's restrictions or provide any light-duty role. *Id.* at 34.

Petitioner testified he does not have a high school diploma, and did not regularly attend school following the fifth grade as that is when he started working instead of attending class. *Id.* at 40. Petitioner testified that he believed he was enrolled in school until freshman year of high school. *Id.* at 40. Petitioner does not own a computer or any type of tablet. *Id.* at 40-41. Petitioner testified that he does not have a computer or possess any "technology skills." *Id.* at 41. In the rare event Petitioner needs to use a computer, he goes to his local library where someone assists him with whatever he may need. *Id.* at 41.

On March 7, 2017, Petitioner testified he with vocational counselor, Mickey Mudhar, of Encore Unlimited per Respondent. *Id.* at 35. Mudhar compiled three separate reports relating to Petitioner. Rx4-5,

Px14. Mudhar did not perform reading or writing tests during his meeting with Petitioner. *Id.* at 41. Petitioner described his reading and writing capabilities as not very good. *Id.* at 41. Petitioner testified that, he is dyslexic and never learned to write, and as a result his spelling is very poor. *Id.* at 42. Petitioner testified he provided Mudhar answers to the questions asked of him. *Id.* at 35. Petitioner has not heard or seen from Mudhar since his meeting with him on March 7, 2017. *Id.* at 35. Petitioner testified he was not provided information from Mudhar or Respondent about potential job leads, nor information about receiving additional job training, from Mudhar or his company. *Id.* at 36. Petitioner was under the impression that Mudhar was going to assist him in obtaining new employment. *Id.* at 37. They did not discuss Petitioner's own self-directed job search. *Id.* at 60-61.

After no response from Mudhar, Petitioner said he attempted to find employment on his own. *Id.* at 42. Petitioner began reaching out to bus companies in attempt to find a job. *Id.* at 42, 44. He testified he went personally to where buses parked and talked to individuals about getting a job. *Id.* at 63. Petitioner began with trying to get a job with Fox Lake, because he would see people by their bus terminal. *Id.* at 44. When he learned they were looking for drivers, he went to the Lotus School by his house to get assistance with filling out an application on the computer. *Id.* at 44, 62-63. Petitioner applied in person to Morton Bus and Durham Bus companies and received assistance in filling out applications on the computer. *Id.* at 45, 64. He applied to Antioch School District Bus company and another bus company from a banner he saw. *Id.* at 64. Petitioner testified he did not hear back from any of the bus companies he applied to. *Id.* at 45.

Thereafter, Petitioner applied for jobs with two dog kennels in the area that had "help wanted" signs displayed. *Id.* at 45. Additionally, there was an advertisement in the newspaper that Petitioner pursued for a job walking dogs and house sitting. *Id.* at 45. Petitioner testified he did not own a computer and would look for advertisements in the newspaper and banners displaying jobs. *Id.* at 45. He would then physically go to the locations in an attempt to obtain a job. *Id.* at 46. Petitioner testified he never had to fill out an application, rather people would fill them out for him on a computer. *Id.* at 46.

Petitioner testified his attempt to find work began approximately a month or two after he reached MMI. *Id.* at 58. Petitioner testified he discussed job prospects with his friend Tom Krenzil, an electrician. *Id.* at 61. As Petitioner grew up in and has always worked in trades, he reached out to his contacts regarding employment in a labor related position. *Id.* at 62. In addition to these attempts, Petitioner searched for jobs posted in a local newspaper. *Id.* at 62. Upon questioning from the Arbitrator in an attempt to clarify confusion with recalling dates by Petitioner, Petitioner testified that he began searching for jobs at the kennels and additional positions shortly after he sent his permanent restrictions to Respondent but did not hear back from them. *Id.* at 84-85. However, after Respondent interjected with saying 2018. *Id.* at 83-84.

On January 18, 2018, Petitioner presented to Dr. Troy Karlsson pursuant to Respondent's request under Section 12 of the Act. Rx6. Petitioner reported complaints of constant pain in his left shoulder, which he described as being deep in the shoulder and feels like bone-on-bone at times. Dr. Karlsson agreed with Dr. Cole that Petitioner has limited motion and weakness to external rotation. Dr. Karlsson opined Petitioner was at MMI and that there should be no overhead use with Petitioner's left arm whatsoever. Dr. Karlsson opined Petitioner would only be able to return to work if he could avoid the use of the left arm above shoulder level. Dr. Karlsson agreed with the restrictions given by Dr. Cole of no work at or above shoulder level on the left, and no lifting with the left arm beyond ten pounds.

Dr. Karlsson reviewed Respondent's video surveillance footage of Petitioner and found it consistent with the limitations he noted. Rx6. In the addendum report, Dr. Karlsson noted that "there are no activities noted here which are inconsistent with the limitations of motion that he demonstrated on exam to me or to earlier examiners including therapy and treaters," and that his activities "would be consistent with the

limitations that I listed in the Independent Medical Evaluation of being able to work with the left arm below shoulder level and lifting up to 10 pounds with the arm."

On June 11, 2018, Dr. Karlsson testified on behalf of Respondent. Rx6. Dr. Karlsson agreed that medical treatment provided to Petitioner was reasonable and necessary for the injury he sustained. Dr. Karlsson testified that Petitioner complained that it felt like his shoulder was just hanging at times, it felt like bone-on-bone pain at times, and that he felt his entire arm would go dead or numb at times lasting for two to fifteen minutes. Dr. Karlsson testified consistent with his report that Petitioner's external rotation was only 10 degrees with his left arm, compared to 70 on the right side. Additionally, on rotating to touch his back, Petitioner could only reach the hip pocket on the left, and he could touch his midthoracic spine on the right. Rx6:12.

Dr. Karlsson agreed with Dr. Cole that Petitioner was at MMI on December 8, 2016. *Id.* at 13. He noted Dr. Cole's permanent restrictions. *Id.* at 13:7-11. The doctor believed the surveillance video confirmed his medical opinion that Petitoiner could return to work using the left arm but nothing over shoulder level. *Id.* at 16:5-9. Dr. Karlsson performed an AMA impairment rating, yielding a 19% upper extremity impairment or an 11% whole person impairment.

On cross examination, Dr. Karlsson testified that while he agreed with Dr. Cole's opinion that Petitioner had permanent restrictions to the left shoulder, Dr. Karlsson disagreed Petitioner needed restrictions relative to no lifting, pushing or pulling greater than 10 pounds. *Id.* at 24:19-23. The doctor clarified: "[I]n other words, I felt that he could be lifting and manipulating objects greater than that as he had a healthy right arm, and the left arm would be able to assist somewhat." *Id.* 24:23-25:1-3. The doctor was unsure whether this portion of the restriction specified what arm. The doctor then testified he was unsure if he would concur that 10 pounds was an appropriate limitation as people can still move greater than 10 pounds. The doctor then estimated 20 pounds. He was also unsure whether the 10 pounds restriction was as the left or if it was overall but testified 10 pounds would be too light. *Id.* at 27.

When asked about climbing restrictions, Dr. Karlsson did not see any restriction for that but nevertheless testified he did not believe Petitioner needed that as someone with a cuff problem could perform overhead climbing or climbing ladders. *Id.* The doctor explained that climbing did not necessarily require strength or force by, in this case, the left upper extremity as primary propulsion is from the legs. *Id.* at 28. Dr. Karlsson agreed his report stated Petitioner should do no overhead use of the left arm whatsoever for securing a load. *Id.* at 29. He agreed that Petitioner's job did not require loading or unloading but only use of a binder weighing 10 pounds and chains weighing 35 pounds. The doctor could picture using the chains both below and above the shoulders. Dr. Karlsson testified he thought there was a good chance Petitioner still had a tear in the arm based on the high riding humeral head that he visualized on plain x-ray. *Id.* t 32. Dr. Karlsson testified he did not have anything in his record that he obtained Petitioner's consent to perform the AMA rating. *Id.* at 49-50.

On August 24, 2018, after Petitioner was unsuccessful in finding his own employment, he sought help from a vocational counselor of his own, Mr. Ed Steffen. *Id.* at 46-47. Petitioner met with Mr. Steffen on August 24, 2018. *Id.* at 47. Had Mr. Steffen's services been approved by Respondent, Petitioner testified that he believes he would undergo skilled training, learn computer skills, and do whatever he was told to do to help find employment. *Id.* at 47. Despite Mr. Steffen's services having not been approved, Petitioner has continued to actively seek employment on his own. *Id.* at 47. Additionally, Petitioner testified that if Respondent's insurance company provided Petitioner with vocational services, Petitioner would listen to those counselors and do everything within his capabilities to find employment. *Id.* at 47-48. Petitioner testified that he wants to work and he would take a job if he was offered one. *Id.* at 48.

Petitioner testified that in order to obtain money Petitioner sold two of his cars. *Id.* at 49. In additional to selling his classic cars, Petitioner cashed a savings bond he held and had to borrow money from people. *Id.* at 49-50.

Testimony of vocational counselor, Edward Steffan

Edward Steffan testified on behalf of Petitioner. *Id.* at 87. Steffan works for EPS Rehabilitation, Inc. and provides vocational placement services. *Id.* at 88. Steffan received his bachelor's degree in psychology, a master's degree in rehabilitation counseling, and as a certified rehabilitation counselor has to have a hundred hours every five years of related continuing education. *Id.* at 89. Additionally, Steffan is a licensed professional counselor by the State of Illinois, Department of Professional Regulation, and a certified rehabilitation counselor by the Commission on Rehab Counselor Certification. *Id.* at 89.

Steffan issued a report pertaining to his evaluation of Petitioner on September 4, 2018. *Id.* at 90-91. Steffan generated an Illinois Workers' Rehabilitation Plan that was filed with the Illinois Workers' Compensation Commission on November 14, 2018. *Id.* at 92, 95. Steffan testified that Petitioner requires vocational placement assistance for him to secure employment. *Id.* at 95. He testified that this is necessary due to Petitioner's limited education, limited skills, and diminished physical capabilities which result in him losing access to the jobs available in the area he resides. *Id.* at 95-96. Steffan's opinion is that Petitioner requires an organized approach with a professional counselor to produce a resume, teach him job seeking skills, interview techniques, how to identify potential employers that have positions within his capacities, which are all necessary for him to secure and maximize his earning potential. *Id.* at 96.

Steffan evaluated Petitioner's permanent restrictions, recorded Petitioner's educational background, that Petitioner left school to start working around ten years of age and Petitioner did not receive a high school degree, nor does he have a GED. *Id.* at 96-99.

Steffan noted that prior to Petitioner's work injury, Petitioner held positions classified as unskilled to low, semi-skilled occupations that would vary between medium and heavy exertional levels. *Id.* at 100. With his permanent restrictions, Petitioner is unable to work in his prior capacity. *Id.* at 100-101. From a vocational standpoint, as it related to trucking jobs, Steffan did not believe Petitioner would be able to pass a Department of Transportation physical or a post job offer physical. *Id.* at 104. He stated that it would be counterproductive to have Petitioner apply to truck driving positions, when these positions will not accommodate the restrictions of Petitioner. *Id.* at 102-103. Steffan has placed clients in truck driving roles in the past, and is familiar with the role of a truck driver and the person who would fit that position. *Id.* at 103. Based on this experience, Steffan does not believe Petitioner would qualify for the position. *Id.* at 104. Steffan testified that the Department of Transportation lifting requirement is 50 pounds. *Id.* at 106. With Petitioner's permanent restrictions, it is unrealistic for him to gain employment as a truck driver again. *Id.* at 106-107.

Steffan testified that Petitioner used to be a very active individual who would ride dirt bikes, hot rods, and would water ski and snow ski. *Id.* at 107. Petitioner's attitude was pleasant and cooperative as noted by Steffan. *Id.* at 108.

Petitioner advised Steffan that he was previously evaluated by a vocational counselor and thought that individual was going to assist him in obtaining employment, but that had not transpired. *Id.* at 109.

Steffan concluded Petitioner had no skills related to the process of securing employment. *Id.* at 109. With the appropriate training and assistance from a certified rehabilitation counselor, Steffan opines that due to Petitioner's impairments and work history, Petitioner would be able to earn between $11 and $14 an hour. *Id.* at 109-110. Due to Petitioner's incompetency with computers and lack of a high school degree or GED, he would not be a viable candidate for employment without the assistance of a vocational counselor. *Id.* at 110-111.

Steffan testified that if Petitioner continued with his own self-directed job searches as he has, it is more probable than not that he will continue to be unsuccessful without assistance. *Id.* at 111.

Steffan testified that although Petitioner had no GED, his physical capabilities allowed him to work. *Id.* at 126. Steffan testified he did not know how long it would take to obtain a GED as a pre-test is required to determine training.

Testimony of Respondent's vocational counselor, Mickey Mudhar

Mickey Mudhar testified on behalf of Respondent. *Id.* at 134. Mudhar is a vocational case manager or certified rehabilitation counselor with Encore Unlimited. *Id.* at 134-135. Upon Respondent's request, Mudhar evaluated Petitioner on March 7, 2017, and complied a report based upon that interview on March 16, 2017. *Id.* at 136. Mudhar testified Petitioner indicated he had not done any job search at the time of the evaluation. *Id.* Mudhar relied on Dr. Cole's December 2016 permanent restriction of "limited ability to reach overhead, no lifting, pushing, pulling or anything greater than ten pounds, no lifting overhead and no extended forward flexion above 90 degrees." *Id.* at 137. Mudhar testified that an additional restriction of no ladder or stair climbing would not affect his assessment of job availability. *Id.* at 138. Petitioner related to Mudhar he had a commercial driver's license to operate heavy trucks. *Id.* Mudhar was assisted with a computer software program using Petitioner's transferrable skills to come up with potential employment positions. *Id.* at 138-139. Mudhar had no input in coming up with the positions for Petitioner, he testified that it was all generated by the computer. *Id.* at 139. The software indicated suitable positions included industrial order clerk, assignment clerk, dispatcher, repair order clerk, scheduler for maintenance, gate guard salesperson for general hardware, estimator and general inspector. *Id.*

Using this report and Dr. Cole's December 2016 restrictions, Mudhar performed a labor market survey on March 21, 2017. *Id.* at 140, Rx4. Based on the computer-generated survey, Petitioner's education, training, experience and restrictions, Mudhar testified there was a reasonable, stable labor market for Petitoiner. *Id.* at 141.

These jobs included high school hall monitor, inventory clerk, meter reader, machine operator, warehouse worker, wire cutter, assembler, cashier, customer service, and security officer. *Id.* The pay range was $11 to $14.50 per hour. *Id.* Mudhar stated that he did not use CDL trucking positions because he was following the computer program. *Id.* at 140-141. Mudhar testified that if Dr. Karlsson's restrictions were followed, it would increase the number of positions available and possibly increase his wages. *Id.* at 141-143. Mudhar testified that DOT physical does not require any physical lifting requirement but an employer seeking to fill a trucking position may. *Id.* at 143-144.

Mudhar generated a second labor market survey dated February 16, 2018. *Id.* at 144, Rx5. The 50-mile radius survey generated positions that increased Petitioner's range of pay from $22.00-$40.87 per hour. *Id.* at 145-146. Mudhar testified there were trucking companies with jobs that require no touch and no loading. *Id.* at 145. The new survey included various trucking positions, all of which Mudhar testified would be within Dr. Cole's restrictions. *Id.* at 145-146. Mudhar concluded petitioner had sufficient skills given his CDL license to obtain employment without further training. *Id.* at 146-147.

Mudhar did not believe obtaining GED and job placement would be beneficial as it would result in a lower rate of pay. *Id.* at 147. Mudhar stated CDL, no touch, no loading jobs would give Petitioner the highest and greatest earning capacity. *Id.* Mudhar testified that at no time did he tell Petitioner he was going to assist him in finding work. *Id.* at 148.

Upon cross examination, Mudhar admitted that he actually generated three reports. *Id.* at 150, Px14. Mudhar' s first survey of March 21, 2017 resulted in potential wage range of $11.00-$14.50 an hour. *Id.* at 151-

152, Rx4. Mudhar's second survey, not discussed on direct, was dated October 31, 2017, and resulted in an increased potential wage range of $15.66-$28.85 an hour. *Id.* at 153-154, Px14. Mudhar testified that nothing regarding vocational assessment had changed in between these two reports. *Id.* at 154.

Mudhar testified he then conducted a third labor market survey dated February 16, 2018. *Id.* at 155-156, Rx5. Mudhar agreed that the wage nearly doubled in the four months between the second and third reports. *Id.* at 155-156, 159. The wage range was now $22.00-$40.87 per hour. *Id.* Mudhar agreed Petitioner was getting more and more employable as Mudhar wrote his reports. *Id.* Mudhar stated that the third survey followed the restrictions set forth by Dr. Karlsson. *Id.* at 157.

In his initial assessment and first report pertaining to Petitioner, Mudhar compiled a three-phase plan for rehabilitation. *Id.* at 163. Mudhar testified that Petitioner's required job seeking skills training, computer training skills, training with how to assemble a resume and cover letter, mock interview assistance, and online job application assistance. *Id.* at 164-166. Mudhar was not aware whether Respondent provided any of these services to Petitioner. *Id.* at 166. Mudhar stated that while he not detail lifting requirements for the truck jobs in the third survey but that he indirectly asked whether those employers had physical exam requirements. *Id.* at 175-176. Mudhar further testified that he did not believe Petitioner needed to complete the phases outlined in his initial assessment because Petitioner had shown he had found employment in the past. *Id.* at 181-182, Rx3. Mudhar stated the phase detail was boilerplate and that he could not explain how Petitioner had found employment in the past. *Id.* Mudhar testified there is no reason to believe Petitioner would not give a good faith effort in searching for a job. *Id.* at 180-181.

Surveillance Footage

Respondent presented two individuals who conducted surveillance of Petitioner. The first individual called to testify was Robert Wicks. *Id.* at 194. Wicks oversees the surveillance unit at Condata. His first surveillance of Petitioner was performed on September 16, 2017 where Wicks followed Petitioner from his house to a farmer's market and two garage sales. *Id.* at 195-196.

Wicks conducted surveillance of Petitioner again on November 3, 2017. Petitioner was visualized at his home, walking with a dog in his right arm. *Id.* at 200. Wicks agreed he has no medical training, was not aware of Petitioner's restrictions, never saw Petitioner carry more than 2 pounds in the left arm and did not see Petitioner use the left arm in November. *Id.* at 202-205.

Petitioner's use of his left arm was opening and closing a car door, and carrying car keys. *Id.* at 206. Wicks testified that he never saw Petitioner perform any activities that would be inconsistent with an individual who should not be lifting more than 10 pounds with the left arm. *Id.* at 208-209.

The next surveillance personnel Respondent called was Stacy Schwartz. Schwartz conducted surveillance of Petitioner on August 14, 2018 at his residence. *Id.* at 211. Schwartz recorded Petitioner outside with his dog, wiping dew off his car with both arms, shaking a car mat with the left arm and lifting the dog. *Id.* at 212-217.

Schwartz continued her surveillance on August 18, 2018 where petitioner was seen taking his motorcycle out, carrying out buoys, sweeping the sidewalk. *Id.* at 225-229. Schwartz is not a licensed private investigator in the State of Illinois. (TR2. pg. 8. Schwartz has her Permanent Employee Registration Card, which is not a private detective license.

ISSUE (C) Is Petitioner's present 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. Petitioner credibly denied any prior condition of ill-being relative to the left arm and sustained the accident of April 10, 2015 wherein he fell on his left arm and underwent three surgeries. Based upon the opinions of Dr. Cole and Dr. Karlsson the Arbitrator finds a causal relationship between the incident of April 10, 2015 and Petitioner's current condition of ill-being relative to the left arm.

ISSUE (L) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner was proclaimed to be at maximum medical improvement on December 8, 2016 by Dr. Cole. Prior to this date, Petitioner was restricted from returning to work by his treating physicians. Following this date, Petitioner has not seen a physician for care since that date, is not taking any type of medication nor utilizing any assistive device. Wherefore, the Arbitrator finds that as a result of the incident of April 10, 2015 Petitioner was temporarily disabled through April 11, 2015 through December 7, 2016, a period of 86-5/7 weeks. See, Ax1. Respondent shall pay Petitioner temporary totally disability benefits of $613.33 per week for 86-5/7th weeks commencing April 11, 2015 through December 7, 2016 as provided in Section 8(b) of the Act.

Petitioner also seeks maintenance benefits from December 8, 2016 through the present. Ax1. Petitioner credibly testified that after he was placed at maximum medical improvement by Dr. Cole on December 8, 2016, he attempted to return to work and Respondent did not reply. This testimony was credible and unrebutted. Further, Dr. Cole's permanent restrictions were endorsed as appropriate by Dr. Karlsson, who indicated there should be no overhead use with Petitioner's left arm whatsoever, that Petitioner would only be able to return to work if he could avoid the use of the left arm above shoulder level and that he agreed with the restrictions given by Dr. Cole of no work at or above shoulder level on the left, and no lifting with the left arm beyond ten pounds. The Arbitrator places little weight, however, on Dr. Karlsson's testimony stating that he felt 10 pounds was too light, that Petitioner's 10-pound restriction as to lifting, pushing or pulling was not needed and that Petitioner could lift greater than 10 pounds as he had a healthy right arm. These opinions were new as of the date of his testimony, in contravention of his previous medical opinion and otherwise not further supported by persuasive explanation. Even assuming these restrictions were applicable, there is no evidence that Respondent offered Petitioner employment within any restriction.

Petitioner credibly testified that he attempted to look for work after meeting with Mudhar in March 2017. Although there was confusion as to when petitioner began looking for work, the Arbitrator resolves this confusion and finds that petitioner's testimony credibly established that he began looking for work shortly after sending his permanent restrictions to Respondent and after meeting with Mudhar, all of which would have been in 2017 rather than 2018. Petitioner cooperated with efforts to look for work by meeting with Mudhar and then seeking his own vocational assistance. Therefore, the Arbitrator finds Petitioner had undisputed permanent work restrictions that prevented him from returning to his former job or to any accommodated position with Respondent, that petitioner timely began looking for work and has been unsuccessful and is therefore entitled to maintenance benefits. Respondent shall pay Petitioner maintenance benefits $613.33 per week for 109-1/7th weeks commencing December 8, 2016 through January 10, 2019 as provided in Section 8(a) of the Act. Against this award and by stipulation, Respondent shall be entitled to a credit of $42,516.77 for maintenance benefits paid under Section 8(a) of the Act. Respondent's request that this credit operate as an overpayment is denied.

ISSUE (K), (O) Is Petitioner entitled to any prospective medical care/Vocational Rehabilitation?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. In this case, Petitioner does not have a high school diploma and did not regularly attend school following the fifth grade. T. at 40. Petitioner testified that, he is dyslexic and never learned to write, and as a result his spelling is very poor. *Id.* at 42. Petitioner does not own a computer or any type of tablet. *Id.* at 40-41. Petitioner does not have any computer or technology skills. *Id.* at 41. When using a computer, he goes to his local library where someone assists him with whatever he may need. *Id.* at 41.

Petitioner testified credibly regarding as to his unsuccessful self-directed job search, which included contacting Respondent, inquiring with friends, applying with bus companies, schools and kennels. his failed attempts to obtain employment on his own. Petitioner timely began looking for work shortly after being placed at MMI. Petitioner reasonably waited after meeting with Mudhar in March 2017, expecting that help would be offered to look for and/or obtain employment. When that did not occur, Petitioner timely sought out his own vocational expert in August 2017 with Ed Steffan. Petitioner credibly testified he did not have a computer and did not know how to use one.

The initial assessments of both vocational counselors indicate Petitioner would benefit from vocational assistance in order to secure gainful employment. Steffan's assessment clearly relied on the permanent restrictions issued by Dr. Cole. Mudhar's assessment initially relied on those as well but during his testimony, Mudhar indicated that his last survey of October 2017 utilized Dr. Karlsson's proffered restrictions. In order to determine which vocational counselor's opinion is entitled to greater weight, the Arbitrator must first assess the medical opinion on which each relies.

Dr. Cole's permanent restriction was no lifting greater than 10 pounds, avoidance of overhead activities, no ladders, no climbing. Although these restrictions as contained in the medical record do not mention commercial trucking specific work, these restrictions did factor in Petitioner's subjective complaints, physical exam findings, objective findings and functional limitations.

Dr. Karlsson's initial opinion was that he agreed with those permanent restrictions. He viewed surveillance and found that it was in line with Petitioner's restrictions. In a subsequent addendum, Dr. Karlsson stated that Petitioner could work as a truck driver where he did not load or unload and where there was no overhead use with the left for securing loads. Further, the doctor indicated Petitioner could use the right to move chains up to 35 pounds, with the left arm operating as some assistance. He also indicated Petitioner should have "no work at or above shoulder level on the left." During his deposition, Dr. Karlsson further opined that Petitioner did not need ladder or climbing restriction as it did not require force or use of the left arm. The Arbitrator places little weight on the opinion that Petitioner could use the right arm to move a 35-pound chain and could somehow only use the left arm as an assist but within the 10-pound lifting restriction. The Arbitrator also places little weight on the opinion that Petitioner did not need ladder or climbing restrictions because such activity necessarily requires work at or above shoulder level on the left, in direct contravention of Dr. Karlsson's other opinion that "no work at or above shoulder level on the left" should be performed. Further, the Arbitrator is not persuaded that ladder and climbing only require power from the lower extremity. Even if true, this does escape the fact that such an activity necessarily requires overhead use of the left arm. The opinions that Petitioner should not do overhead work but could climb did not factor how Petitioner would be able to climb up and into any commercial truck. The Arbitrator notes that Petitioner climbed up to the truck when the accident occurred. Dr. Karlsson also testified that he was unsure to what the 10-pound restriction applied to but also stated that he believed it was too light. This too is entitled to little weight as it is not supported by any further persuasive explanation. Having considered both opinions, the Arbitrator assigns greater weight to and adopts the opinions offered by Dr. Cole rather than Dr. Karlsson.

Relying on Dr. Cole's permanent medical restriction, Steffan's vocational opinion is that if Petitioner continued with his own self-directed job searches as he has, it is more probable than not that he will continue to be unsuccessful without assistance. T. at 111. Steffan's opinion is that Petitioner requires an organized approach with a professional counselor to produce a resume, teach him job seeking skills, interview techniques, how to identify potential employers that have positions within his capacities, which are all necessary for him to secure and maximize his earning potential. *Id.* at 96. Steffan further testified that Petitioner was able to work his entire life with the lack of education and no GED, because his physical abilities allowed him to, which he no longer possessed due to his work injury. *Id.* at 126. Regardless if Petitioner would be qualified for employment, Petitioner lacks the competence to search for employment due to his lack of basic skills, and therefore requires assistance from a rehabilitation counselor. *Id.* at 128-129.

Respondent's witness, Mudhar, proposed a three-phased approach in his plan yet Mudhar attempted to explained during his testimony that this was simply "boilerplate" language and that Petitioner does not need vocational services because he had found work before. Mudhar could not state how exactly Petitioner had found that work before. If in fact this was boilerplate language and Mudhar simply pasted words into a report, then Respondent has not dispensed with its duty of providing proper vocational services and Mudhar's conclusions should be entitled to little weight. Further, Mudhar testified that he did not "directly" inquire with the employers listed in the third survey regarding Petitioner's restrictions. The Arbitrator finds that Mudhar's original assessment is more credible than his trial testimony, which contradicted his own findings. Mudhar admitted that nothing had changed in terms of Petitioner's assessment other than the third labor survey considered Dr. Karlsson's permanent restrictions which yielded trucking jobs. See, Rx5. The Arbitrator assigns less weight to Mudhar's testimony when compared to Steffan's.

As it related to truck driving positions, the Arbitrator agrees with the testimony of vocational expert, Steffan, in that Petitioner would not be a qualified candidate for that type of position. There was a factual dispute over whether the DOT had lifting requirements; Steffan testified that the lifting requirement was 50 pounds while Mudhar testified there was none. Steffan testified Petitioner would not pass this lifting requirement. Regardless of any Federal or Illinois DOT lifting requirement, this does not address or reconcile Petitioner's restriction of no overhead work, which Respondent failed to establish Petitioner could do in any trucking job. For the February 2018 survey, Mudhar relied on Dr. Karlsson's opinion, which the Arbitrator has already declined to adopt. Therefore, the Arbitrator assigns little weight to Mudhar's vocational opinion that Petitioner could work in trucking and that he did not need vocational assistance in that regard since he had secured employment in the past. The Arbitrator makes no findings or conclusions as to the wages Petitioner could be earning as that is more appropriate for a nature and extent hearing. The Arbitrator reserves these facts for a later hearing as necessary.

Regarding the CDL license, the Arbitrator notes that Petitioner only self-reported his medical examination and no further evidence was introduced to establish what lifting requirements are imposed by either Federal or Illinois law. Nevertheless, whether Petitioner possessed an updated CDL licensing is not relevant to whether Petitioner requires vocational rehabilitation and/or whether Petitioner is able to obtain employment. See, Rx9, Rx11.

The evidence establishes that Petitioner has been unable to look for work on his own under Dr. Cole's restriction and has not had the benefit of assistance. Petitioner previously cooperated with both Mudhar and Steffan and indicates he wishes to undergo rehabilitation. Petitioner's counselor, Steffan, submitted a rehabilitation plan as required under the Rules, further evincing an intent to cooperate and a willingness to undergo vocational rehabilitation. Therefore, Respondent shall pay for and authorize the recommended job placement and vocational rehabilitation plan as outlined by Ed Steffan.

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

Petitioner's request for penalties and fees are denied in as much as Respondent presented a reasonable dispute and defense to the issue of Petitioner's permanent restriction and whether he should be eligible for vocational rehabilitation services.