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

Winston Robinette,
Petitioner,

v.

NO: 11 WC 19907

The American Coal Company,
Respondent.

17IWCC0615

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 whether Petitioner sustained accidental injuries as a result of exposure to an occupational disease, causal connection, statute of limitations, and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2016 is hereby affirmed and adopted.

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

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

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: OCT 2 - 2017

LEC/mck

O: 8/1/17

43

Charles J. DeVriendt

Joshua D. Luskin

DISSENT

I respectfully dissent. I view the medical evidence in a different light than the majority as I would afford greater weight to the opinions of Dr. Selby and Dr. Meyer both of whom are certified B Readers whereas Dr. Paul is not. Further, the diagnostic x-rays performed while Petitioner was in Respondent's employ (11/02/07; 03/05/08; 12/09/08; 04/05/11) fail to evidence pneumoconiosis, and the x-rays performed previously (01/16/75; 03/28/01; 01/31/02) similarly fail to evidence the disease. I would find Petitioner failed to prove he suffered an occupational exposure leading to his development of pneumoconiosis, emphysema, and asthma and deny the matter in its entirety.

Accordingly, I dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINETTE, WINSTON
Employee/Petitioner

Case# **11WC019907**

THE AMERICAN COAL COMPANY
Employer/Respondent

17IWCC0615

On 8/11/2016, 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 0.44% 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:

0755 CULLEY & WISSORE
300 SMALL STREET
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

17IWCC0615

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WINSTON ROBINETTE
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 11WC 19907

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **July 16, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0615

FINDINGS

On **April 28, 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 occupational disease that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$48,535.24**; the average weekly wage was **$933.37**.

On the date of accident, Petitioner was **65** 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

Respondent shall pay Petitioner permanent partial disability benefits, commencing 4/28/08, of $248.91/week for the duration of the 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.

Michael K. Nowak, Arbitrator

7/28/16
Date

ICArbDec p. 2

AUG 11 2016

FINDINGS OF FACT

Petitioner was 72 years old at the time of arbitration. He lives in Litchfield, Illinois. Petitioner graduated from high school and had some schooling here and there following high school. Petitioner worked 30 years in the coal mining industry, all underground. Petitioner testified that in addition to coal dust, he was exposed to silica dust, roof bolting glue fumes, diesel fumes, and trowel, which is a two-part epoxy. He was also exposed to smoke from coal fires.

Petitioner last worked a shift in the coal mine on April 28, 2008, with Respondent. Petitioner was 65 years old on that date and his job classification was frontline foreman. He testified that he was exposed to dust on that day. Petitioner testified that was the last day he worked at the mine because he got into an argument with his supervisor. He testified that the supervisor called him and two other foreman liars, and he just decided to quit.

Right after he left the coal mine, Petitioner worked for three to four months delivering false teeth from the Dental Arts Laboratory to different dentists in Springfield. In that job he worked part-time and made $7.00 per hour. He also worked delivering air conditioners and furnaces for Rogers Supply in Springfield, Illinois for five or six months. At that job he earned $14.00 per hour.

Petitioner started his mining career with Crown Coal Company in 1966. His first job was as a shooter which is the person who shoots the coal down so that it can be loaded out. He testified that was a really dusty job. He also ran a shuttle car at that mine. That job also required him to work at the face of the mine. Petitioner then worked at a motorcycle shop from 1969 to 1973 and managed a motorcycle dealership from 1973 to 1977. Petitioner went to work for Peabody in January 1975 and worked there until August 1994. He worked as a loading machine operator for three years and then went into management. He was a section foreman. He testified that he was exposed to even more dust than the miners because he had to take air readings every so often. These readings were taken at the face where the guys were working. He left Peabody when that mine shutdown in 1994. He then went to work for Amax in 1996 to 1997 as a foreman. That mine had a lot of diesel equipment, and they were running two units so Petitioner was exposed to a lot of diesel fumes in that mine. Petitioner went to work for Black Beauty Mine in 2001. He worked there through 2006 as a ram car operator. He worked at Monterey Coal from 2006 to 2007, as a frontline foreman. Petitioner then worked at Respondent from November 2007 to April 2008, as a foreman. Petitioner's job as a foreman at Respondent included taking air readings and being up at the face of the mine to make sure that everything was right before everything got rolling

Petitioner testified that he first noticed breathing problems in 1994. He noticed that he was getting shorter and shorter of breath and that when he would go outside in the high humidity and heat, he could hardly breathe. He first noticed the problems when he was a shift manager. He testified that from the time that he first noticed his breathing problems until he left the mine, the breathing problems got a lot worse. He testified that since leaving the mine his breathing problems have gotten worse. He testified that he was having a lot of problems as of the time of arbitration. He testified that he could walk half a block at most on level ground before becoming short of breath. He could climb six or seven stairs before having to rest. Petitioner testified that he does not take breathing medication. He testified that his breathing difficulties affect his daily life quite a bit because he cannot do too much. He testified that if he picks something up and tries to carry it, by the time he

gets to where he is going he has to sit down because he cannot get any air. Petitioner testified that he likes to dance and sing karaoke. He testified that he can do one dance at a time and then has to sit down for three.

Petitioner testified that his primary care physician is Dr. Roger Wujek with Litchfield Family Practice. He testified that he talked to Dr. Wujek about his breathing problems. He testified that he was honest with Dr. Wujek whenever he questioned him about any complaints or symptoms that he had. Petitioner testified that he smoked for about 10 years from 1984 to 1994. He smoked about half a pack a day. Petitioner takes medication for blood pressure and arthritis.

Petitioner signed up for Social Security when he left the mine. He also received a "small" pension from UWMA and from some of the coal mines where he worked. In his job with Rogers Supply, he worked in the warehouse. Anything that came in he would stack up with a forklift. He also made deliveries two days a week to different places in Illinois. When he made the deliveries, he would pull a little ramp out and slide the HVAC units down the ramp and tell the people here it is. He testified that these things weighed 100 to 110 pounds. He might also pick a few parts for a customer.

Petitioner testified that from time to time while he was a coal miner, he underwent chest x-ray screening for black lung by NIOSH. The last time that was done was just five months before he left Respondent. NIOSH would send him reports and tell him what the films revealed. Petitioner did not bring any of those letters to arbitration.

Petitioner testified that he saw Dr. Paul at the request of his counsel. Dr. Paul caused spirometry to be performed on him. He testified that he saw Dr. Cohen at the Coal Miners Clinic in Springfield where he also had spirometry performed. He went to see Dr. Cohen in Springfield because of an ad in the newspaper. He testified that the report from Dr. Cohen's testing was in his car at the time of arbitration. Dr. Cohen also arranged for him to undergo an analog chest x-ray in Lincoln, Illinois. Petitioner did not get a report from that chest x-ray, but he got the film back. He testified that he gave that film to his attorney.

Medical records of Litchfield Family Practice were admitted into evidence. They begin with an office visit of August 25, 1998. At that time Petitioner complained of sinus drainage. His lungs revealed some minimal expiratory wheezing. The diagnosis was upper respiratory infection, rule out pneumonia. (Respondent's Exhibit No. 5, p. 187). Petitioner was seen for upper respiratory infections and sinusitis multiple times throughout 1998 and 1999. (*Id.*, at 185-188). Petitioner was seen on May 25, 2006, to reestablish care. On that date his review of systems respiratory revealed no cough or difficulty breathing. His chest exam was normal. (*Id.*, at 181-183). Petitioner was seen on March 5, 2008, at which time he complained of cough which had been present for three days. It was characterized as both dry and productive of mucoid sputum. Review of systems revealed cough but not dyspnea. The assessment was cough. (*Id.*, at 177-178). Petitioner returned on September 11, 2008, for physical exam. Review of systems respiratory revealed no cough and no difficulty breathing. (*Id.*, at 170-172). Petitioner presented for his annual physical on December 16, 2009. He had no complaints and had a good energy level. (*Id.*, at 162-164). When seen on May 5, 2010, for blood pressure check, Petitioner denied dyspnea. (*Id.*, at 161). Petitioner was seen on September 8, 2010, with complaint of cold symptoms including sneezing, nasal congestion, scratchy throat, sore throat, productive cough, and facial pressure and pain with headache. The onset was two days prior. Petitioner did not suffer wheeze or shortness of breath. Review of systems respiratory revealed the presence of a mild cough, but no dyspnea. Physical

examination of the chest revealed breath sounds to be normal with no adventitious sounds. The assessment was pharyngitis and acute sinusitis. (*Id.*, at 159-160). Petitioner was seen on December 8, 2010, for annual physical exam. He had no current medical problems. Review of systems respiratory revealed no cough and no difficulty breathing. Physical examination of the chest revealed normal breath sounds with no adventitious sounds. (*Id.*, at 153-156). Petitioner presented for colonoscopy on September 26, 2011. Review of systems respiratory revealed no cough and no difficulty breathing. (*Id.*, at 142-144).

Dr. Paul examined Petitioner on April 24, 2012, at the request of his attorney. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2). Dr. Paul is the Medical Director of St. John's Respiratory Therapy and a Clinical Assistant Professor of Medicine at SIU Medical School. He specializes in allergy and pulmonary diseases. Dr. Paul reads 15 to 20 chest x-rays per day and interprets about the same number of pulmonary function tests per day. (Petitioner's Exhibit No. 1, p. 8). Dr. Paul is board certified in internal medicine and allergy and immunology. (*Id.*, at 51). Dr. Paul is neither an A-reader nor a B-reader. Dr. Paul's diagnoses were pneumoconiosis, emphysema and asthma. He testified that the physical examination of the chest revealed wheeze that was consistent with both emphysema and asthma. (*Id.*, at 9-10). Dr. Paul testified that the fact that Petitioner had wheezing on the date that he examined him suggested that he was asthmatic. (*Id.*, at 10). Dr. Paul testified that the spirometry that he performed suggested emphysema because Petitioner had a low FEV1 and a decreased carbon monoxide diffusing capacity. He testified that it also suggested pneumoconiosis because Petitioner had a decreased total lung capacity which went along with restrictive lung disease. The testing suggested asthma because he had a 33% improvement after bronchodilators in his FEV1. (*Id.*, at 10-11).

Dr. Paul testified that in his opinion Petitioner had coal workers' pneumoconiosis (CWP) caused by coal dust and a coal mine environment. (*Id.*, at 13). Dr. Paul testified that in light of his diagnosis of coal workers' pneumoconiosis, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. (*Id.*, at 15-16). Dr. Paul testified that in his opinion Petitioner had clinically significant pulmonary impairment in terms of physical examination of the chest and his complaints. He testified that Petitioner had radiographically apparent pulmonary impairment caused by coal dust. He also testified that Petitioner had physiologically significant pulmonary impairment as shown on the pulmonary function testing. Dr. Paul testified that all of these impairments were caused by the coal mine environment. (*Id.*, at 18-19). Dr. Paul testified that when Petitioner had a presentation as he did at the time of Dr. Paul's examination he would be limited to sedentary work. (*Id.*, at 20).

Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in the lungs, a tissue reaction to it. The scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. By definition, if one has coal workers' pneumoconiosis, he would necessarily have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (*Id.*, at 22-23). Dr. Paul testified that a person could have radiographically significant coal workers' pneumoconiosis and have normal pulmonary function tests, normal blood gases and normal physical examination of the chest. Dr. Paul testified that the scarring of pneumoconiosis can be both obstructive and restrictive. (*Id.*, at 26-27). Dr. Paul testified that simple coal workers' pneumoconiosis is typically asymptomatic. He testified that, more likely than not, simple pneumoconiosis will not progress once the exposure ceases. (*Id.*, at 43-44). Dr. Paul testified that the scarring of pneumoconiosis is permanent. He testified that the impairment from pneumoconiosis is permanent as well. (*Id.*, at 51).

Dr. Henry K. Smith, B-reader and board certified radiologist, interpreted chest x-ray for Petitioner dated January 31, 2002, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in the bilateral middle and lower lung zones. He made an identical interpretation of chest x-rays dated November 2, 2007, December 9, 2008, March 5, 2008, and July 5, 2012. He interpreted a chest x-ray of April 5, 2011, as positive for pneumoconiosis, profusion 1/0 with P/S opacities in the bilateral middle and lower lung zones. (Petitioner's Exhibit No. 2).

Dr. Michael Alexander, B-reader and board certified radiologist, interpreted chest x-ray of January 31, 2002, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. He made an identical interpretation of chest x-rays dated November 2, 2007, March 5, 2008, December 9, 2008, and July 5, 2012. (Petitioner's Exhibit No. 3).

Records of chest x-rays taken of Petitioner as part of the Coal Workers' Health Surveillance Program were admitted into evidence. Petitioner's chest x-ray of January 16, 1975, was interpreted by an A-reader and a B-reader as negative for pneumoconiosis. The chest x-ray of March 28, 2001, was interpreted by two B-readers as negative for pneumoconiosis. A chest x-ray of January 31, 2002, was interpreted by two B-readers as negative for pneumoconiosis. A chest x-ray of November 2, 2007, was interpreted by an A-reader and a B-reader as negative for pneumoconiosis. (Respondent's Exhibit No. 4).

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed chest x-rays for Petitioner. Dr. Meyer is board certified in radiology and is a B-reader. Dr. Meyer reviewed films dated January 13, 2002, November 2, 2007, March 5, 2008, December 9, 2008, April 5, 2011, and July 5, 2012. (Respondent's Exhibit No. 2, pp. 3-4, 40). Dr. Meyer testified that the 2002 film showed the lungs to be well expanded with no radiographic findings of coal workers' pneumoconiosis. The lungs were again clear with no radiographic findings of coal workers' pneumoconiosis on the 2007 examination. (*Id.*, at 4). Dr. Meyer testified that on the chest x-rays from 2008 and 2011, the lungs were clear. He testified that there was a linear band at the left lung base. He testified that there was no evidence of emphysema. He opined that the linear parenchymal band was just an area of scarring from a previous inflammatory process and would not be related to an exposure to a coal mine. Dr. Meyer testified that often times it is an area of prior infection such as pneumonia. (Respondent's Exhibit No. 1, pp. 40-41). With regard to the 2012 examination, Dr. Meyer described the lungs as being clear with no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 4).

Dr. Jeff Selby examined Petitioner at the request of Respondent's counsel on July 5, 2012. (Respondent's Exhibit No. 3, p. 8). Dr. Selby is board certified in internal medicine and pulmonology, and is also a B-reader. (*Id.*, at 4-5). Dr. Selby's examination included an occupational and medical history, physical exam and various laboratory testing. (*Id.*, at 8). Petitioner's chief complaint was breathing; he stated that he had noticed breathing problems for 10 years or more. He reported that he did not cough or wheeze. His wife, however, stated that he wheezed at night or after an upper respiratory infection. Petitioner walked one quarter mile four times per week and also worked out four times per week. Petitioner started smoking in 1966 at a rate of less than one pack per day and stopped in 1994. (*Id.*, at 9-10). The chest exam showed clear breath sounds with good airflow. Dr. Selby found the chest x-ray of July 5, 2012 showed no parenchymal or pleural abnormalities consistent with pneumoconiosis and was negative for coal workers' pneumoconiosis. Dr. Selby also caused pulmonary function testing to be performed. That testing revealed normal spirometry, lung volumes and diffusion capacity with a significant improvement post bronchodilator. (*Id.*, at 12-13). Exercise testing was

performed. Dr. Selby testified that based upon a reasonable degree of medical certainty, Petitioner was capable of heavy manual labor. (*Id.*, at 14-15). Dr. Selby's final assessment regarding Petitioner was that he did not suffer any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment. Dr. Selby concluded that Petitioner does not have coal workers' pneumoconiosis. He also concluded that Petitioner had the respiratory or pulmonary capacity to perform any and all of his previous coal mine duties including his last job working as a mine foreman. Dr. Selby testified that Petitioner had a history and pulmonary function testing consistent with asthma which was not caused by nor contributed to by coal mine dust inhalation or work in or around the coal mine. Dr. Selby testified that Petitioner's history of cigarette smoking and exposure to secondary cigarette smoke could be contributing to or entirely causative of any dyspnea he experiences. Dr. Selby also testified that Petitioner was quite obese and his large abdomen and general obesity were major contributors to any dyspnea that he experienced. (*Id.*, at 15-17).

Dr. Selby reviewed treatment records regarding Petitioner. He also reviewed chest x-rays dated January 16, 1975, March 28, 2001, January 31, 2002, November 2, 2007, March 5, 2008, December 9, 2008, and April 5, 2011. (*Id.*, at 30). Dr. Selby found the chest x-rays of January 16, 1975, and March 28, 2001, to be unreadable due to underexposure, poor contrast and poor processing. Dr. Selby found no evidence of pneumoconiosis on the chest x-rays of January 31, 2002, November 2, 2007, March 5, 2008, December 9, 2008, and April 5, 2011. (*Id.*, at Deposition Exhibit No. 3). Dr. Selby testified that for a person to have coal workers' pneumoconiosis, in addition to having coal mine dust in the lungs, a tissue reaction is required. That tissue reaction is called scarring or fibrosis. (*Id.*, at 91). Dr. Selby testified that by definition if a person has pneumoconiosis, he would necessarily have an impairment in the function of his lung at the very site of the scarring, whether that impairment could be measured by spirometry or not. (*Id.*, at 91).

The Arbitrator notes that Petitioner had an audible wheeze at the time of hearing.

CONCLUSIONS

Issue (C): Did an occupational disease 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 disease?

Petitioner's testimony that he was exposed to diesel fumes, fumes from roof bolting glue, coal dust, and silica dust, was unrebutted. The Arbitrator found Petitioner to be a forthright and credible witness.

The Arbitrator finds the testimony and/or opinions of Dr. Paul, Dr. Smith, and Dr. Alexander more persuasive than those of Dr. Meyer and Dr. Selby in this case. Dr. Paul diagnosed Petitioner with coal worker's pneumoconiosis (CWP), emphysema, and asthma. Dr. Paul found Petitioner to have clinically significant pulmonary impairment, radiographically apparent pulmonary impairment, and physiologically significant pulmonary impairment. He further testified that Petitioner's impairment and diagnoses resulted from his exposures as a coal miner and rendered him permanently precluded from working as a coal miner.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he developed occupational diseases including, CWP, emphysema, and asthma, which arose out of and in the course of his employment as a coal miner and that his current condition of ill being is causally related to said diseases.

Issue (O): Was disablement timely under the Occupational Diseases Act?

For purposes of Section 1(e) of the Occupational Diseases Act, an employee is considered disabled from earning full wages at the work in which he was engaged when last exposed to the hazards of the occupational disease or equal wages in other suitable employment where he can no longer work without endangering his life or health. *Freeman United Coal Mining Co. v. Ill. Workers' Comp. Comm'n*, 999 N.E.2d 382 (5th Dist. 2013), citing *Owens-Coming Fiberglas Corp. v. Industrial Comm'n*, 362 N.E.2d 335 (1977).

Dr. Paul found Petitioner to have clinically significant pulmonary impairment, radiographically apparent pulmonary impairment, and physiologically significant pulmonary impairment. He further testified that Petitioner's impairment and diagnoses resulted from his exposures as a coal miner and rendered him permanently precluded from working as a coal miner.

Both Dr. Paul and Dr. Selby testified that asthma can result in a waxing and waning of pulmonary function that could render Petitioner capable of heavy manual labor on some days, but only sedentary labor on others. They also both testified that an asthma attack can be fatal. Dr. Selby testified that if Petitioner's asthma were caused in part or aggravated in part by his coal mine exposures, then his coal mine exposures would have been a causative factor in his dyspnea.

The Arbitrator finds that Petitioner's CWP, asthma, and emphysema cause disablement by both impairment in function and by an inability to return to the environment of a coal mine without endangering Petitioner's health.

Although Dr. Selby disputes that Petitioner suffers from CWP, both he and Dr. Paul agree that if a miner is found to have CWP at any time in his life, he would have had the disease, at least to some degree, when he left mining.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner's disablement was timely under the Occupational Diseases Act.

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

Petitioner requests a wage differential award under Section 8(d)1 of the Act. That Section provides, in pertinent part:

> If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. *820 ILCS 305/8(d) 1*

In discussing awards under Section 8(d)1 the Court in *Levato v. Ill. Workers' Comp. Comm'n*, 14 N.E.3d 1195 (1st Dist. 2014) succinctly stated:

> Our supreme court has expressed a preference for wage-differential awards over scheduled awards. See *Gallianetti v. Industrial Comm'n, 315 Ill. App. 3d 721, 727, 734 N.E.2d 482, 487, 248 Ill. Dec. 554 (2000)* (citing *General Electric Co. v. Industrial Comm'n, 89 Ill.2d 432, 438, 433 N.E.2d 671, 60 Ill. Dec. 629 (1982))*. "As a general matter, *section 8(d)(2)* applies to those cases in which a claimant suffers injuries that partially incapacitate him from pursuing the usual and customary duties of his line of employment, but do not cause him to suffer an impairment of earning capacity." *Gallianetti, 315 Ill. App. 3d at 728-29. Section 8(d)(2)* may also apply in circumstances where a claimant suffers an impairment of earning capacity but waives his right to recover under *section 8(d)(1). Id.*
>
> To qualify for a wage differential award, the claimant must prove a partial incapacity that prevents him from pursuing his usual and customary line of employment and an impairment of earnings.

Id., at 1200-01.

Based on the above findings, Petitioner has proven that he has impairment in the function of his lungs. Petitioner has proven an inability to work further as a coal miner without endangering his life or health.

The Petitioner has also proven what he was able to earn following the end of his coal mine employment. By his unrebutted testimony, Petitioner established that after leaving coal mining he had two positions, with his highest wage in such employment being $14 per hour. The parties stipulated that Petitioner's average weekly wage as a coal miner was $933.37. After coal mining, he was able to earn $14 an hour, or $560.00 per week. The difference between his mining wage and what he is able to earn is $373.37 per week. Sixty-six and two-thirds percent of this amount is $248.91.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 4/28/08, of $248.91/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

STATE OF ILLINOIS)
)SS
COUNTY OF SANGAMON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joshua Moore,
Petitioner,

vs. NO. 01 WC 46145

17IWCC0616

B & B Electric,
Respondent.

DECISION AND OPINION ON §8(a) PETITION

Timely Petition pursuant to §8(a) of the Act having been filed by Petitioner and due notice provided to all parties, the Commission, after considering the issue of causal relationship, medical expenses and prospective medical care and being advised of the facts and the law, grants Petitioner's §8(a) Petition to the extent of awarding payment for prescribed medications, medical expenses and replacement of the spinal cord stimulator battery, but denies Petitioner's request for an IT pain pump.

Procedural History

This matter was initially settled by the parties with lump sum settlement contract approved by the Commission on October 6, 2006. The contract noted temporary total disability benefits paid prior to settlement equaling 287 weeks at $733.33 per week. The settlement amount equals $200,000.00. Respondent agreed to pay the following medical providers directly: Lifestar Ambulance: $668.15; Clinical Pathologists: $671.00; Vine Street Clinic: $355.00; Springfield Clinic: $5,004.00; Memorial Medical Center: $79.31, $660.60 and $106.30; Clinical Radiologists: $344.00, $588.50 and $337.00; University Anesthesiologists, Dr. Lubenow: $3,081.00 and $237.00. The settlement contract evidences Petitioner's rights under §8(a) would remain open.

On October 27, 2009, Petitioner filed a §8(a) Petition. In its Decision and Opinion on §8(a) Petition dated February 17, 2011, the Commission granted the §8(a) Petition and ordered Respondent to pay the medical expenses contained in PX15 and the cost of one stellate ganglion block to be followed by radio frequency thermocoagulation subject to §8.2 Medical Fee Schedule.

17IWCC0616

On October 31, 2013, Petitioner filed a §8(a) Petition. On June 26, 2014, the matter proceeded to hearing before Commissioner Basurto. In its March 30, 2015 Decision and Opinion on §8(a) Petition, the Commission granted Petitioner's §8(a) Petition to the extent of the costs of the prescribed medications listed and circled in PX8, found Petitioner entitled to prospective medical care of Ketamine infusions prescribed by Dr. Lubenow but denied Petitioner's request for mileage reimbursement for his visits to Dr. Lubenow. Petitioner requested the Commission award medical benefits as set forth in his exhibits, including payment of prescribed medications listed in PX8. However, Petitioner did not submit any medical bills, and he did not testify to any medical bills remaining outstanding. The Commission noted no causation opinion existed regarding Petitioner's lumbar condition, and the parties stipulated Respondent is not liable for lumbar epidural steroid injections.

Petitioner's attorney filed this current §8(a) Petition on March 16, 2016. On April 7, 2017, the matter proceeded to hearing before Commissioner Coppoletti. The parties timely filed briefs, and oral arguments were heard on August 2, 2017.

FINDINGS OF FACT

A. Petitioner's Testimony

Petitioner testified on May 8, 2000, he was an electrician working for Respondent when he fell off a ladder landing on a steel stud lacerating his right elbow, his dominant arm. T. 8. Thereafter, Petitioner was diagnosed with CRPS. *Id.* Petitioner commenced treatment with Dr. Lubenow in 2002 and continues to treat with Dr. Lubenow traveling from Springfield, Illinois to Chicago, Illinois for his appointments. T. 9-10.

Petitioner testified since the hearing of June 26, 2014, he underwent a series of three Ketamine injections which provided some pain relief, temporary in nature. T. 10. Petitioner testified Dr. Lubenow implanted a spinal cord stimulator which currently is not functional due to the battery's failure. T. 11. Prior to the battery's failure, Petitioner testified he obtained relief especially when the spinal cord stimulator was reprogrammed by Metronic representatives. T. 12. The Petitioner testified regarding a notation made by Dr. Candido of Petitioner disabling his spinal cord stimulator. T. 15. Petitioner advised he disable the spinal cord stimulator as he felt it was bothering his neck, and once it was reprogrammed, he felt better and used the spinal cord stimulator on a regular basis. T. 15-16. Petitioner testified without the spinal cord stimulator being functional, his pain has increased, and he feels a burning and aching in his right arm. T. 18.

Since the spinal cord stimulator ceased functioning, Petitioner testified his ability to perform his daily activities has been affected such as shaving and showering as it is painful. T. 19. Household activities such as performing the laundry are more difficult to complete, and he is no longer able to vacuum due to the pain. T. 19-20. Petitioner testified on a typical day he awakes at approximately 4 a.m.; makes breakfast; watches television; and does some light cleaning. T. 23.

Petitioner testified Dr. Lubenow recommended an IT pain pump but only once Petitioner ceased smoking. T. 12-13. Petitioner testified his goal was to stop smoking, but he continued to smoke. T. 13-14. Petitioner stated the IT pain pump has not been implanted. T. 12.

Petitioner testified as to his current medications: 1) morphine which is also MS Contin, 2) Lyrica, 3) Topamax, 4) Baclofen, 5) Klonadine, and 6) Magoxide. T. 20-21. Respondent is no longer authorizing payment for these medications, therefore, Medicaid is paying for the same. T. 21. Petitioner testified he desired to have a new battery for his spinal cord stimulator as well as payment for his medication. T. 24. Petitioner testified due to his reliance on Public Aid for payment of his medication and their rules, he would go months without refills of certain medications. *Id.* Petitioner testified he was unable to recall when the Respondent's carrier last paid for his medications as such payments were so long ago. T. 25. Petitioner testified he last saw Dr. Lubenow on February 1, 2017. T. 22.

On cross-examination, Petitioner testified he is solely treating with Dr. Lubenow for his condition but has seen other physicians in the office on occasion. T. 25-26. Petitioner confirmed his honesty when discussing his condition with Dr. Lubenow. T. 26-27. Petitioner confirmed he reviewed Dr. Lubenow's records and had no reason to dispute the contents of the same. T. 27. When the spinal cord stimulator worked properly, Petitioner utilized a remote control to disable/enable as well as modify the settings. *Id.* Petitioner testified he utilized the spinal cord stimulation approximately 24 hours a day and periodically disables the same as he has utilized the device for approximately 20 years. T. 28-29.

Petitioner testified Dr. Lubenow spends approximately five minutes with him at any one visit. T. 29. On January 16, 2016 Dr. Candido evaluated Petitioner at Respondent's request pursuant to Section 12 of the Act. *Id.* Petitioner testified he was honest with Dr. Candido during the evaluation regarding his symptoms. T. 29-30. Petitioner testified Dr. Candido examined him but not in the same manner as Dr. Lubenow as Dr. Lubenow performed different testing. T. 30. Petitioner advised his difficulty sleeping is attributable to his overall condition, not solely his back pain. T. 30-31.

On re-direct examination, Petitioner testified the pain from chronic regional pain syndrome plays a factor in his trouble sleeping. T. 31. Petitioner testified Dr. Lubenow evaluated him once a month for approximately a year, but in 2016 Dr. Lubenow evaluated him every three months. *Id.* Dr. Lubenow begin the three-month intervals following the Ketamine injections, and during the evaluations, Dr. Lubenow examines him which includes extension of his hands with measurements as well as extension of his arms with measurements. T. 32-33. During the evaluations, Dr. Lubenow is assisted by a resident who performs the same tests as Dr. Lubenow. T. 34.

Commissioner Coppoletti described Petitioner's appearance as he was seated with his shoulders slumped downward with his head coming forward, and it did not appear as though his head raised up completely. T. 35. Petitioner stated his neck "is always like that" due to the pain. *Id.*

17IWCC0616

B. Petitioner's Medical Treatment

The medical records evidence Petitioner continued to treat with Dr. Lubenow at Rush Pain Center. On April 15, 2015, Dr. Lubenow evaluated Petitioner who reported a 30% relief of pain with the stimulator but increased sensitivity in his hands. A Medtronic representative re-programed his stimulator. Dr. Lubenow noted that for the last two years he had been complaining of pain in his left hand, but the stimulator was helping it. Petitioner reported charging the stimulator every nine days to two weeks, and Dr. Lubenow noted the battery of the stimulator would cease functioning in the next year. Dr. Lubenow diagnosed chronic regional pain syndrome (CRPS) of both upper extremities and refilled Petitioner's medications. Petitioner was to follow-up for Ketamine infusions. PX2.

On April 28, 2015, Dr. Amin evaluated Petitioner and provided the initial Ketamine infusion. On April 29, 2015, Dr. Lubenow evaluated Petitioner who reported excellent relief upon awakening but overnight noticed his hands developed increased swelling and pain with a pain level at 6/10. Dr. Lubenow provided the second Ketamine infusion. On April 30, 2015, Dr. Lubenow noted Petitioner reported he was 60% better the previous night and was 30% better this morning with complaints of bilateral hand edema. Dr. Lubenow provided Petitioner the third Ketamine infusion. PX2.

On July 23, 2015, Dr. Lubenow evaluated Petitioner who complained of pain which was distributed on the medial aspects of both forearms extending from the elbow to the entire hand bilaterally with significant allodynia. Petitioner also reported worsening pain in his bilateral feet with burning and allodynia and minimal walking ability. A Medtronic representative reprogrammed the stimulator. Dr. Lubenow assessed CRPS of both upper extremities and recommended continued medications. Petitioner was interested in IT pump trial which was scheduled. PX2.

On September 23, 2015, Dr. Lubenow evaluated Petitioner who reported worsening of his upper extremity symptoms with hand swelling and allodynia. Dr. Lubenow noted Petitioner continued to smoke one pack per day and suffered burns on both hands from dropping cigarettes, which had further exacerbated his pain. Petitioner also reported non-radiating, burning pain in his right foot with allodynia that limited his ability to walk for distances. Dr. Lubenow noted Petitioner had recent exacerbation of schizophrenia after not taking antipsychotics for several days after the prescription ran out leading him to experience excessive paranoia that impeded him from taking his other medications which caused a worsening of his pain symptoms. The episode required hospitalization, and Petitioner was living with his parents temporarily for assistance with medication management and administration. Dr. Lubenow noted his pain had been well controlled on Oxycontin after switching from MS Contin at the last visit. He ran out of Oxycontin prescription two days prior and was prescribed clonidine patch with minimal relief. Dr. Lubenow noted Petitioner was scheduled for IT pump trial October 13, 2015 which would be postponed until further evaluation given Petitioner's continued tobacco use. The examination and assessment were the same. Dr. Lubenow continued medications and added Medrol Dosepak for his worsening hand symptoms. Dr. Lubenow noted, "Encouraged smoking cessation, patient informed that he will not be candidate for IT pump trial until symptoms better

17IWCC0616

controlled and he stops smoking. If symptoms persist or worsen and patient can stop smoking he will be a candidate for IT pump trial." PX2.

On October 21, 2015, Dr. Lubenow evaluated Petitioner who reported the spinal cord stimulator was not holding a charge very well and requested a new battery. Dr. Lubenow noted Petitioner's use of Oxycontin and his request to return to MS Contin. Petitioner reported less tobacco use, currently smoking two packs over the last month. A Medtronic representative reprogrammed the stimulator to better capture his arms. Dr. Lubenow noted Petitioner was reaching the end of life for the battery and currently he had symptoms in both arms and both legs. Dr. Lubenow opined, "In an effort to give him optimal pain relief I recommend he proceed with an SCS revision and replace his current leads with two new 1X8 electrodes connected to a MRI compatible IPG." Dr. Lubenow noted when Petitioner stopped smoking, he would discuss the IT pump trial. He placed Petitioner back on MS Contin. PX2.

On November 25, 2015, Dr. Lubenow evaluated Petitioner and noted "He states that he turned off his SCS this month because it was making his CRPS symptoms worse." Petitioner complained of horrible pain in the left arm. Petitioner reported he ceased smoking and using a nicotine patch. The examination and assessment were the same, and medications were prescribed. Dr. Lubenow scheduled the replacement of the IPG battery and leads with placement of cervical and lumbar leads for coverage of the feet for December 14, 2015. The IT pain pump was discussed and was placed on hold until Petitioner stopped smoking. PX2.

On January 14, 2016, Dr. Lubenow evaluated Petitioner who complained of bilateral hand and feet pain, bilateral leg pain worse on right and body pain. Petitioner reported his pain levels remained static with it waxing and waning. The examination and assessment were the same. The stimulator was reprogrammed to capture the arms better. Dr. Lubenow noted he was awaiting approval for ITP implant. PX2.

On March 2, 2016, Dr. Lubnow evaluated Petitioner who complained of neck pain, bilateral upper extremity pain, low back pain, bilateral lower extremity pain and pain in his right hand and foot. He reported the pain medications helped but felt his pain was worse. Dr. Lubenow noted the spinal cord stimulator was placed in 2007 and the expected battery life extended to September 2016. Dr. Lubnow noted Petitioner's severe arm symptoms of burning, aching, tingling, numbness and pain as well as aggravating factors of cold weather and showering. Dr. Lubenow recommended a narcotic weaning program to transition to Sub Oxone from Morphine. Dr. Lubenow recommended the spinal cord stimulator battery be replaced. PX2.

On June 8, 2016, Dr. Lubenow evaluated Petitioner who complained of bilateral hand and forearm pain, left greater than right, lateral right forearm hyperalgesia and left forearm hyperalgesia which wrapped around. Petitioner reported he turned off his spinal cord stimulator on June 4th because he felt sick to his stomach and turned it back on June 6, 2016. His examination was the same. Dr. Lubenow noted that Petitioner met "Budapest Criteria" for CRPS of both upper extremities. He also noted Petitioner needed a SCS battery exchange as soon as possible. PX2.

17IWCC0616

On September 15, 2016, Dr. Lubenow evaluated Petitioner and noted "Pt states his SCS device "shut off" two days-ago and since then he has had exacerbation of his pain in his upper extremities." Petitioner reported cold type sensation in his body with burning type pain in his forearms as well as shooting pain from his fingers to his elbows, right greater than left. Petitioner reported that with the spinal cord stimulator his pain level was 6/10, but since the device ceased working, his pain escalated to 8/10. A Medtronic representative confirmed the battery failed, and the workers' compensation insurer had denied replacement. Dr. Lubenow opined a new battery replacement was necessary immediately and continued medications. Dr. Lubenow noted the same as above on October 19, 2016 and refilled Petitioner's medications. PX2.

On December 15, 2016, Dr. Lubenow noted Petitioner met the Budapest Criteria for CRPS of both upper extremities and continued medications. On February 1, 2017, Dr. Young of the Rush Pain Center evaluated Petitioner who reported continued pain in both arms, but his symptoms were better on his current regimen. Dr. Young continued medications.
On March 22, 2017 DR. Lubenow evaluated Petitioner for complaints of neck pain and back pain. Petitioner reported his medication regimen reduced those pains by 70%. Dr. Lubenow noted Petitioner underwent a lumbar spine MRI on January13, 2017. He continued medications. PX2.

In his evidence deposition given on March 8, 2017, Dr. Lubenow testified he is an anesthesiologist with board certification in pain medicine. Dr. Lubenow testified regarding his participation in a task force convened by the International Association for the Study of Pain in Budapest with a mandate to devise new diagnostic criteria for the disease of CRPS. PX3, p. 6-7. Dr. Lubenow testified Dr. Candido was not a participant in the task force with no involvement in the creation of these Budapest criteria. PX3, p. 8. Following the conference and its recommendations, a randomized control study was conducted at centers throughout the world, one or which was Dr. Lubenow's center. The results of that study bore out the recommendations from the conference that utilizing the Budapest criteria is the most accurate way to diagnosis CRPS. PX3, p. 9. Dr. Lubenow testified he knows Dr. Candido, and in his opinion, Dr. Candido does not possess the same expertise in diagnosing CRPS. PX3, p. 11.

Dr. Lubenow testified regard his treatment of Petitioner which began as an independent medical evaluation physician requested by Cincinnati Insurance. PX3, p. 12. Dr. Lubenow testified the spinal cord stimulator provided significant partial improvement of Petitioner's symptoms. PX3, p. 12. Dr. Lubenow opined it is medically necessary to replace the battery for the spinal cord stimulator and explained the device mutes out or dampens down or diminishes the flow of pain impulses before they reach the brain. PX3, p. 13. Dr. Lubenow testified throughout the course of his treatment of Petitioner, the spinal cord stimulator has been an effective means of treating his CRPS. PX3, p. 14.

Dr. Lubenow testified Dr. Candido did not have a full and complete understanding of Petitioner's history as he omitted some of his medications. PX3, p. 19. In his January 12, 2016 report, Dr. Candido opined all symptoms of a CRPS for Petitioner had resolved; Dr. Lubenow disagreed with that opinion. *Id.* Dr. Lubenow believed Petitioner meets the Budapest criteria. PX3, p. 20. Dr. Lubenow believed Petitioner has significant physical examination findings to

17IWCC0616

warrant a diagnosis of CRPS. *Id.* Dr. Lubenow opined Dr. Candido has a history of misunderstanding and misapplying the Budapest criteria. *Id.* During Dr. Candido's evaluation photographs were taken which Dr. Lubenow reviewed which he felt supported the diagnosis of CRPS. PX3, p. 22. Additionally, Dr. Lubenow took issue in the manner Dr. Candido performed the evaluation as well the positioning of Petitioner's hands when taking the photographs. PX3, p. 23-24.

Dr. Lubenow testified he personally examined Petitioner on March 22, 2017 and performed range of motion testing. PX3, p. 25. Abduction of the right shoulder was limited to 140 degrees and forward elevation was limited to 150 degrees, which was not normal. *Id.* Dr. Candido either did not measure that or did not measure it accurately if his numbers are substantially different. *Id.* Petitioner lacked 15 degrees of full extension of the elbow and normal flexion; wrist flexion was 35 degrees and wrist extension 40 degrees; the left upper extremity was similar, other than the degree of wrist extension was somewhat greater, 55 degrees in the right and 40 degrees in the left. PX3, p. 26. Petitioner was unable to extend his fingers past negative 25 degrees at the interphalangeal joints which Dr. Candido did not measure during his evaluation of Petitioner. *Id.* Petitioner also presented with allodynia and swelling of the left upper extremity. *Id.*

Dr. Lubenow testified when the spinal cord stimulator ceased working due to the battery's failure, he increased some of Petitioner's opioid medications. PX3, p. 27. Dr. Lubenow opined Petitioner continues to suffer from CRPS. PX3, p. 29-30. Dr. Lubenow opined replacement of the spinal cord stimulator's battery is reasonable and necessary. PX3, p. 30. The battery has failed and Petitioner needs a replacement. *Id.* Dr. Lubenow opined the medications he prescribed are reasonable and necessary. PX3, p. 30-31. Dr. Lubenow opined Petitioner is dependent on opioids. PX3, p. 31. Dr. Lubenow opined if Petitioner were to cease smoking he would be a candidate for an IT pain pump. PX3, p. 32. Dr. Lubenow disagreed with Dr. Candido that the spinal cord stimulator could be removed without changing Petitioner's condition as Petitioner has received improvement from the stimulator. PX3, p. 33. Dr. Lubenow disagreed with Dr. Candido's opinion that Petitioner's current condition is either related to a central pain syndrome or a psychiatric condition. *Id.* Dr. Lubenow opined central pain syndrome is a wastebasket diagnosis. PX3, p. 34. He acknowledged Petitioner does have depression and anxiety. *Id.* Petitioner's pain symptoms wax and wane and that could also be in part an explanation for Dr. Candido's observations. PX3, p. 35. Dr. Lubenow believed Dr. Candido conducted Petitioner's examination inaccurately. *Id.*

On cross-examination, Dr. Lubenow testified Dr. Candido was not asked to participate in the Budapest meeting. PX3, p. 36-37. Dr. Young, Dr. Lubenow's colleague, authored the February 1, 2017 office note, so Dr. Lubenow was not sure what Dr. Young meant by saying Petitioner's symptoms are better on his current regimen. PX3, p. 37-38. Dr. Lubenow evaluated Petitioner on December 15, 2016, and his office notes are the most accurate to understand Petitioner's condition. PX3, p. 39. Dr. Lubenow's December 15, 2016 findings are essentially the same as his October 19, 2016 findings, which are the same as the June 8, 2016 findings. PX3, p. 42. The findings of April 28, 2015 seem to be essentially the same as the findings in December 2016. Px3, p. 46. Dr. Lubenow testified it is possible due to the characteristic CRPS

17IWCC0616

symptoms of waxing and waning could explain the lack of symptoms at the time of Dr. Candido's independent medical evaluation. PX3, p. 46-47.

On re-direct examination, Dr. Lubenow testified the October 2016 visit was just a couple days after the spinal cord stimulator's battery failed, so an abrupt worsening of symptoms might not appear and the worsening of physical examination findings may take a much longer time frame. PX3, p. 48. Dr. Lubenow opined the continued use of medication can help offset for a shortened period the failure of the spinal cord stimulator. Px3, p. 49.

Petitioner submitted medical bills from his entire treatment with Dr. Lubenow from February 27, 2002 through February 1, 2017 and these were admitted into evidence as PX4. The Commission notes for purposes of this §8(a) Petition, the relevant period for these medical bills is from April 15, 2015 through February 1, 2017. There is a date of service listed as March 22, 2017, but there are no charges listed for this date. From April 15, 2015 through February 1, 2017, total charges equal $6,329.00 with insurance payments of $1,948.72 and insurance write-off adjustments of $3,143.28. Therefore, the balance due is $1,237.00.

Petitioner submitted a printout from the Illinois Department of Healthcare & Family Services which evidences payment for prescription medications from the department to Bond Drug Company of Illinois. This was admitted into evidence as PX5. The Commission notes for purposes of this §8(a) Petition, the relevant period for these prescription medications is from April 15, 2015 through March 22, 2017, the period Petitioner treated with Dr. Lubenow. The last payment was made on February 25, 2017. The total amount of payments equals $1,793.36.

Petitioner submitted printouts from Walgreens Pharmacy, and these were admitted into evidence as PX6. The Commission notes for purposes of this §8(a) Petition, the relevant period for these prescription medications is from April 15, 2015 through March 22, 2017, the period Petitioner treated with Dr. Lubenow. The exhibit evidences the charges for prescription medications were submitted to either Cincinnati Insurance, Health Alliance, ILMED or Medicaid. The entries only indicate the quantity of the medication dispensed and the amount insurance saved Petitioner. For the relevant period, the following were the only charges to Petitioner, which indicate he paid cash: April 16, 2015 for $6.94; February 26, 2016 for $11.89; July 21, 2016 for $12.99; August 22, 2016 for $6.94 and January 21, 2017 for $29.99. The total paid by Petitioner is $68.75.

C. Kenneth Candido, M.D.

On January 12, 2016 at Respondent's request, Dr. Candido evaluated Petitioner pursuant §12 of the Act. In his report of that date (RX1), Dr. Candido reviewed and noted the medical records from February 27, 2002 to date. Dr. Candido obtained a history from Petitioner who rated his pain generally at rest 2-4/10 in the right arm/elbow and up to 8-9/10 with increased activity and his current pain at 7/10. Petitioner reported pain in both hands and feet, the right generally worse. Dr. Candido found Petitioner's neck was stiff and constantly flexed/drooped which Petitioner attributed to the leads which his doctor wanted to replace. On examination of the upper extremities, Dr. Candido found a well healed surgical scar on right elbow; no color changes between right and left sides; no sweating abnormality; no atrophy; no temperature

17IWCC0616

disparities between left and right sides; no tactile allodynia and no hyperalgesia to deep digital pressure in either arm; symmetrical range of motion; no tremor and no trophic signs. Dr. Candido opined from an objective perspective, there existed no signs of RSD or CRPS present. On motor examination, there was no observed reduction in range of motion of bilateral shoulders, including elevation to 180 degrees, extension to 45 degrees, abduction to 180 degrees, external rotation 45 degrees; no bilateral weakness of the biceps, triceps and deltoid, all 5/5; no weakness of the bracioradialis or for wrist flexion bilaterally. On sensory examination, there was diffuse hypoesthesia within the right extremity, most prominent in C5-C6; glove hypoesthesia's; on the left, sensation was intact in dermatomes C4-T1. Nerves were tested bilaterally for radial, ulnar and median nerves and there was no hypoesthesia, no hyperalgesia and no allodynia. Dr. Candido noted temperature measurements of both arms. Lower extremities nerves were tested and had the same nerve results as above.

Dr. Candido noted Petitioner apparently had a diagnosis of CRPS and opined, "That condition has resolved. He has zero objective criteria to support CRPS." Dr. Candido diagnosed: a) Chronic pain syndrome, unspecified; b) Opioid dependence; c) Nicotine dependence; d) CRPS, resolved; e) left hip pain. Dr. Candido opined Petitioner's treatment appeared to have been reasonable and necessary. Dr. Candido opined an intrathecal (IT) pain pump would be considered reasonable and necessary if there was a pain condition being treated which could be causally linked to the May 8, 2000 work accident. Dr. Candido opined the use of an IT pump in the present case would not be consistent with treatment of such a condition; rather it would be used because Petitioner is opioid dependent, using 270 mg Morphine per day. An IT pump would be an attempt to reduce his daily oral consumption of Morphine. "However, since the CRPS is of historical interest only, and since it presently has no objective basis as an ongoing medical condition in the Claimant, then an IT pump would not be a reasonable treatment based upon the work related accident." Dr. Candido opined it is just as reasonable, if not more so, to wean Petitioner off the opioids, replace opioids using a multi-modal analgesic regimen and insist he undergo a smoking cessation program. RX1.

Dr. Candido opined the spinal cord stimulator could be removed/explanted without changing the clinical condition of Petitioner as there were no objective findings of CRPS. Dr. Candido noted Petitioner was using Morphine and Lyrica for pain and Baclofen for spasticity although he did not identify any spasticity, therefore, he found no rationale for ongoing use of the medication. Dr. Candido opined 270 mg/day of Morphine is excessive for Petitioner's present condition and recommended he be weaned from the medication accordingly. Dr. Candido found no causal relationship between depression or anxiety and the work injury. Dr. Candido opined Petitioner can work a light duty job. RX1.

On May 15, 2016, Dr. Candido authored an addendum report in response to a letter received from Respondent's attorney dated April 4, 2016. Dr. Candido reviewed Dr. Lubenow's office notes from March 2, 2016 and disagreed with Dr. Lubenow's findings of hand allodynia, molting, swelling and edema of the left upper extremity. Dr. Candido noted Petitioner presented with no evidence of any such findings Dr. Lubenow had noted. Dr. Candido opined Dr. Lubenow's examination of March 2, 2016 was unrecognizable to him as being related to Petitioner and suspected one of Dr. Lubenow's residents preformed the examination. Dr. Candido noted his independent medical evaluation photographs and opined it is not logical or

17IWCC0616

medically possible to examine those images, and then to claim that Petitioner has any color changes, edema or pain to light touch in the upper extremities. Dr. Candido would not change his opinions.

In his evidence deposition given on November 1, 2016 deposition, Dr. Candido testified he is board certified in anesthesiology with a subspecialty in pain medicine. Dr. Candido recited from the above-referenced reports. Dr. Candido testified as to allodynia which does not occur without the subjective component of a report of pain to light touch. RX3, p. 12. Dr. Candido testified every pain report is always a subjective reporting. RX3, p. 13. Dr. Candido testified during his evaluation of Petitioner on January 12, 2016, Petitioner reported the spinal cord stimulator was functioning. RX3, p.16. Dr. Candido testified he performed a through physical examination of Petitioner after which he diagnosed chronic pain syndrome. RX3, p. 20-25. Dr. Candido opinioned Petitioner was in no need of opioids/narcotics and should be weaned from the same. RX3, p. 26. Dr. Candido felt Petitioner's CRPS was resolved and his symptoms did not qualify under the Budapest criterial. RX3, p. 27-29.

Dr. Candido testified Petitioner suffered from continuing pain which was disproportionate to the original injury, but of the subjective criteria, Petitioner exhibit only one of four- temperature, asymmetry with skin color changes and felt the other seven of eight categories were totally absent. RX3, p. 29. Dr. Candido opined Petitioner needed no further treatment for CRPS including the IT pain pump. *Id.* Dr. Candido opined as far as Petitioner's work-related injury, he was fully recovered. RX3, p. 39-40.

On cross-examination, Dr. Candido testified the dynamometer used during the independent medical evaluation appeared to be legitimate. RX3, p. 40. Dr. Candido believed Petitioner provided an effort during testing. RX3, p. 42. Petitioner's right hand was 35% to 40% less grip strength than his left hand. RX3, p. 43. Dr. Candido opined Petitioner was at maximum medical improvement. *Id.* Dr. Candido testified the photographs he took during the evaluation are not refutable. Dr. Candido had no explanation as to why there existed a discrepancy between his findings and those of Dr. Lubenow. RX3, p. 50.

CONCLUSIONS OF LAW

§8(a) Petition

"Under the provisions of section 8(a) of the Act, an employer is required to pay for all necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of an accidental injury sustained by an employee and arising out of and in the course of her employment. *820 ILCS 305/8(a)* (West 1998)." *Second Judicial District Elmhurst Memorial Hospital v. The Industrial Commission*, 323 Ill. App. 3d 758, 764 (2001). "[A]n employee is entitled to recover only those medical expenses which are reasonable and causally related to an industrial accident." *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 389 (1981).

Following the decision rendered on March 30, 2015, Petitioner continued to treat with Dr. Lubenow. Dr. Lubenow's records evidence continuous treatment for right upper extremity

17IWCC0616

Complex Regional Pain Syndrome (CRPS) as well as subjective and objective signs of the condition. The Commission finds Dr. Lubenow's opinions are more persuasive than those of Dr. Candido as Dr. Lubenow was part of the group that developed the Budapest Criteria, and further Dr. Lubenow has been Petitioner's treating physician for many years. Both physicians relied on the same Budapest Criteria in diagnosing Petitioner's condition but arrived at different conclusions. The Commission notes when Dr. Candido evaluated Petitioner on January 12, 2016, Petitioner's spinal cord stimulator was functioning which would explain Petitioner's apparent lack of symptoms on that date. Further Dr. Lubenow explained symptoms of CRPS could wax and wane. Additionally, Dr. Lubenow took issue with the manner Dr. Lubenow performed the physical evaluation of Petitioner as well as the photographs. Lastly Dr. Lubenow opinioned since the failure of the spinal cord stimulator, Petitioner presented with symptoms consistent with CRPS which were increasing due to the stimulator's failure. Accordingly, the Commission affords greater weight to the opinions of Dr. Lubenow and finds based on Dr. Lubenow's records and his testimony, Petitioner's treatment was causally related, reasonable and necessary.

The Commission awards Petitioner $1,237.00 for medical expenses for his treatment with Dr. Lubenow from April 15, 2015 through February 1, 2017. PX4. The Commission awards Petitioner $68.75 as reimbursement for his payment for prescription medications to Walgreens Pharmacy from April 15, 2015 through March 22, 2017. PX6. The Commission orders Respondent to reimburse the Illinois Department of Healthcare & Family Services in the amount of $1,826.83 for payment for prescription medications from April 15, 2015 through March 22, 2017. PX5. The Commission finds Petitioner is entitled to prospective medical care consisting of the spinal cord stimulator battery replacement and necessary medications and orders Respondent to pay for same as well as ongoing medical expenses attendant to the same. The Commission denies Petitioner's request for the IT pain pump given his inability to quit smoking.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition pursuant to §8(a) of the Act is hereby granted to the extent of awarding payment for prescribed medications, medical expenses and replacement of the spinal cord stimulator battery, but Petitioner's request for an IT pain pump is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $1,305.75 for reasonable, necessary and related medical expenses under §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 the sum of $1,826.83 to the Illinois Department of Healthcare & Family Services for prescription medication expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care and Respondent shall pay for spinal cord stimulator battery replacement prescribed by Dr. Lubenow and associated medical expenses prospectively.

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.

17IWCC0616

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 2 - 2017
LEC/maw
o08/02/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rodney West,
Petitioner,

vs. NO: 14WC 5913

NAPA Auto Parts D/b/a L & L of Ster,
Respondent.

17IWCC0617

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b), having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses 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.

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

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

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

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: OCT 2 - 2017
MJB/bm
o-9/18/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

WEST, RODNEY
Employee/Petitioner

Case# **14WC005913**

NAPA AUTO PARTS D/B/A L & L OF STERLING
Employer/Respondent

17IWCC0617

On 5/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4342 REHN & SKINNER LLC
JOHN REHN
5 E SIMMONS ST
GALESBURG, IL 61401

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG S YOUNG
300 HAMILTON BLVD PO BOX 6199
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RODNEY WEST,
Employee/Petitioner

v.

NAPA AUTO PARTS D/B/A L & L OF STERLING
Employer/Respondent

Case # **14** WC **005913**

Consolidated cases: **n/a**

17IWCC0617

An *Application for Adjustment 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 **Rock Island, Illinois**, on **March 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0617

FINDINGS

On the date of accident 12/28/2013, 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.

In the year preceding the injury, Petitioner earned **$42,374.81** the average weekly wage was **$814.90**.

On the date of accident, Petitioner was 36 years of age, married with 2 dependent children.

Respondent shall be given a credit of $0 or TTD. Having found Petitioner failed to prove his accident arose out of his employment with Respondent, all other remaining issues are hereby considered ***moot***.

ORDER

Petitioner failed to prove his accident arose out of his employment with Respondent. All other claim for compensation is hereby ***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

5-2-2016
Date

ICArbDec19(b)

MAY 2 - 2016

BACKGROUND

Rodney West filed an application for adjustment of claim alleging injuries arising out of and in the course of his employment against Napa Auto Parts d/b/l as LNL of Sterling Inc. occurring on 12/28/13. Rx1. The claim was assigned case number 14 WC 5913. The parties presented for arbitration in Rock Island Illinois on 3/2/16. Ax1. At that time, the parties agreed to proceed to arbitration before Arbitrator Maria Bocanegra who was then covering for Arbitrator Pulia. The following is a recitation of the facts adduced at trial.

FINDINGS OF FACT

Rodney West ("Petitioner") testified that he began employment as a store manager at the NAPA store in Galesburg in February 2012. The Galesburg NAPA store does business under the name L & L of Sterling ("Respondent"). Respondent is in the business of providing automobile parts. Respondent sells automotive parts including windshield wiper blades. Petitioner's duties included managing the day to day operations, taking care of customers and helping to install wiper blades.

Petitioner testified that he began work for Respondent around 7 am on the morning of 12/28/13. He said he felt fine that morning when he went to work. Later that morning, he sold wiper blades to a customer at Respondent's place of business. A record dated 12/28/13 shows that a 9:24 am, two wiper blades were sold by Petitioner to a customer for a 2003 Honda Accord. Px3, Rx6. Petitioner testified that after selling the blades, he went to the customer's car and installed the wiper blades. While installing the wiper blade he twisted and lifted his body and he felt a pop in his low back and a shooting pain down the left leg. He finished installing the last wiper, went back to into the store and finished work. He said he had difficulty moving around, that it was very hard to walk and could not put a lot of pressure on the left leg.

Petitioner admitted he had previously purchased his own personal wiper blades at Respondent's place of business for his wife's truck. A business record confirms that on 12/16/13, Petitioner sold himself two wiper blades. Px20, Rx6. He said he installed them the same day he purchased them on Respondent's site. Petitioner testified he told Tim Donahue via phone that he had injured his back installing a wiper blade on a car. Petitioner admitted he did not tell Donahue he hurt his back at work putting on blades.

Petitioner worked until 4:00 pm that day and then drove home. Petitioner later completed his own Illinois form 45 and he dated it 12/28/13. Px4, Rx2. Petitioner wrote that he injured his back while installing wiper blades on a customer car. Specifically, he wrote that I "laid the empty package down and turned to install the wiper blades." He continued writing that he injured his back when he turned his back popped and shot pain down his left leg.

Petitioner said he called Dr. Phillips and saw him on an emergency basis. Px6:1, line 92. He was driven by his wife. Records show that on 12/28/13, Dr. Phillips saw Petitioner. Px16. The doctor wrote the following regarding Petitioner's subjective complaints: "Rod was leaning over the hood of a car leaning forward putting wiper blades on a customers [sic] car and turned wrong and felt a pop or twinge in the lower back and pain shot into the left leg." The doctor noted Petitioner injured himself at work but did not want to seek worker's compensation. The doctor felt testing was indicative of disc protrusion or prolapse. Petitioner testified that prior to the incident in question, he had some prior back treatment in the form of adjustments and maintenance. He said he did not previously have shooting pain down the leg into the foot.

On 12/29/13, Petitioner presented to Galesburg Cottage Hospital emergency room. Px11, Rx8. Chief complaint listed hip pain without known injury. Initial assessment noted Petitioner reported putting wipers on the day before and that he turned the wrong way and began having pain to his hip. Petitioner admitted to a prior history of back problems but denied having any back pain at that time. He denied numbness or tingling in the

legs. *Id.* at 318. Petitioner was prescribed Norco and Neurontin. Petitioner was taken off of work for 3 days. Diagnosis was acute sciatica. *Id.* at 315. Petitioner testified he was instructed to follow up with his primary doctor, Dr. Sloan.

Treatment – 2014

On 1/2/14, Petitioner saw Dr. Sloan and related he was changing wiper blades and twisted a certain way which had worsened his chronic back pain. Px14. Dr. Sloan described it as an acute exacerbation of what he though was chronic back pain. The doctor wrote that Petitioner related that "since October on he is having pain on the left side going down to about the level of the knee." With this episode, it went passively down to the foot. Petitioner rated pain a 10 out of 10 in intensity and indicated the pain went down into his foot with the episode on 12/28 and that he had pain into his foot ever since the date of injury. An MRI was ordered. Px14, Rx4B. On 1/6/14, Petitioner saw Dr. Carrier for a chief complaint of lower back pain radiating down the left leg present for "10 days." Px9:111, 173, 185. The doctor diagnosed lumbar radiculopathy. The plan was for an MRI and physical therapy.

On 1/7/14, Petitioner presented to Cottage Rehabilitation & Sports Medicine for physical therapy. Px9:155. The history listed was that Petitioner "was turning to lean down to put on wiper blades when he felt a pain in his leg and back." Px9, Px10.

Petitioner testified that because of the insurance approval issues, he contacted Mike Eberley ("Eberley") who was the health insurance salesman for Respondent. On 1/8/14, Petitioner e-mailed Eberley stating he injured his back on 12/28/13 while "putting on a set of wiper blades."

On 1/10/14, lumbar spine MRI showed a large extruded disc fragment on the left-side of L4-5 causing mass effect on the thecal sac as well as on the left side L5 nerve root. Px8:76, Px11:311-12. Petitioner was referred to Midwest Orthopaedic Center by Dr. Carrier.

On 1/22/14, Petitioner was evaluated by Dr. Mulconrey's physician assistant at Midwest Orthopaedic. Petitioner noted on the intake form that the problem started when he "twisted while applying windshield wipers." Px13:925. The new patient form noted Petitioner had leg pain and numbness present since 12/28/13. He arrived seated in a wheelchair and said that he had sustained an injury when changing a windshield wiper blade "on his car" resulting in an acute onset of leg and back pain. The pain was mostly in the left leg in the buttocks, front of the thigh, leg, calf and foot. The MRI was reviewed and the plan was for surgery. On 1/24/14, Petitioner underwent and Dr. Mulconrey performed a left hemi laminectomy and partial facetectomy and foraminotomy at L4-5. Px7, Px13:901, Px17.

On 2/10/14, Petitioner followed up and related that his left leg pain had resolved almost immediately after surgery. He remained off work. On 3/12/14, Petitioner advised Dr. Mulconrey that he was doing well and ready to return to light duty work. Px13:876. The plan was for physical therapy, light duty work of no more than 10 pounds and follow up.

On 3/21/14, Petitioner presented to Cottage Rehabilitation and Sports Medicine for initial physical therapy evaluation following his first lumbar surgery. Px10. The history listed was that Petitioner was installing wiper blades when he "turned" and heard a pop in the back and pain in the low back and down the left lower extremity. Petitioner underwent additional physical therapy on 3/27/14. He reported increased pain and declined to continue therapy until seen by his doctor.

Petitioner did not return to any doctor until 6/2/14, at which time he saw Dr. Mulconrey. Px13. At that time, he related he was doing well and that his lower extremity radiculopathy had resolved. Objectively, he was

symmetric in regards to strength. Petitioner was released to return to work with the 50-pound maximum lifting restriction. Follow-up was scheduled at which time the doctor thought Petitioner would reach maximum medical improvement. On 7/21/14, Dr. Mulconrey placed Petitioner at maximum medical improvement.

On 8/13/14, Petitioner contacted his doctor's office noting an onset two weeks prior of low back pain and left leg falling asleep. He related no particular injury. On 8/18/14, Petitioner followed up with Dr. Mulconrey. Px13:859. Petitioner related that he was doing well but began having more low back pain and symptoms into the left leg. He felt the symptoms were almost identical to the pain he was experiencing previous to this surgery. He has been having numbness into the left leg. He had no weakness in the legs. He was having difficulty with changing positions. On exam, Petitioner was positive for straight leg raise on the left.

On 9/18/14, repeat MRI showed recurrent disc herniation. Px8:80. Findings at L3-4 and L5-S1 were unchanged from prior study. On 10/1/14, Petitioner followed up with Dr. Mulconrey. Px13. The doctor reviewed the recent MRI and noted the recurrent disc herniation at L4-5. The plan was for epidural steroid injections versus revision discectomy versus instrumented spinal fusion at L4-5. Petitioner elected to proceed with spinal fusion.

Treatment - 2015

On 1/8/15, Petitioner underwent and Dr. Mulconrey performed a lumbar fusion at L4-5. Px12:389-391, Px13:812-812. Petitioner began occupational therapy. Px12. On 1/26/15, Petitioner followed up with Dr. Mulconrey. His preoperative pain was resolved. He was having some mild pain in the hips. He was using Oxycodone and Valium as prescribed. On exam, muscle groups were symmetric in regards to strength and Homan's testing was negative bilaterally. The plan was to continue medications, begin home therapy program, follow-up and Petitioner was ordered off of work.

On 2/23/15, Petitioner followed up with Dr. Mulconrey. Px13. His preoperative pain was resolved. He had some increased pain in the groin region although not severe. He was taking no medications. Petitioner remained off work for the next 8 weeks. On 4/3/15, Petitioner returned to Dr. Mulconrey. Px13. He was off all current medications and was taking Tylenol for pain relief. Petitioner noticed an increase in lateral thigh pain and increasing lumbar based pain. Petitioner was concerned regarding his L5-S1 disc. On exam, he was symmetric in regards to strength. X-rays confirmed instrumentation and fusion. The plan was for new MRI. Petitioner was off work for the next 8 weeks. On 4/13/15, MRI the lumbar spine showed broad-based protrusion along with facet arthropathy and posterior epidural lipomatosis resulting in mild central canal and minimal foraminal narrowing in abutment of the dissenting left L4 nerve root at L3-4. Caudal to the fusion, at L5-S1 there was a shallow broad-based central protrusion without central canal stenosis, foraminal stenosis or nerve root compression.

On 4/20/15, Dr. Mulconrey reviewed the MRI the lumbar spine dated 4/13/15 and noted degenerative disc disease at L3-4, mild disc protrusion at L3-4, mild narrowing of the spinal canal, left greater than right. Also noted was significant degeneration of the disc at L5-S1 and questionable annular fissure. Continued conservative treatment was recommended.

On 6/1/15, Petitioner followed up with the doctor. He reported significant left lower extremity radiculopathy. He had positive straight leg raise on the left lower extremity. Petitioner was noted to have significant degenerative disc disease at L5-S1 along with mild annular bulge. The doctor noted that a recent MRI of April 2015 showed significant annular fissure L5-S1 along with increased loss of disk height thereby increasing fissuring of the L5-S1 segment as well as mild central canal stenosis at L3-4. Assessment was status post fusion, degenerative disc disease, annular fissure at L5-S1 and spinal stenosis at L3-4. They discussed the

possibility of extending the fusion to include L5-S1 and a possible decompression of L3-4. Petitioner was ordered off work for the next 8 weeks.

In June 2015, Dr. Mulconrey reviewed the recent lumbar CT scan. Px13:778-779. The doctor noted instrumentation in appropriate position and there was evidence of fusion present. Petitioner had mild spinal stenosis at L3-4, mild facet arthropathy on the left greater than the right and mild disc protrusions which were partially calcified at L5-S1. The doctor noted the presence of kidney stones, which he recommended Petitioner see his primary doctor for before proceeding with surgery. On 7/14/15, Dr. Mulconrey's nurse requested pre-operative work up from Dr. Carrier for a proposed IPSF L5-S1, TLIF L5-S1 and decompression of L3-4 and L5-S1. Px13:773.

On 7/27/15, Petitioner returned to Dr. Mulconrey. Px13:760. Petitioner was ready to proceed with the proposed surgery. Petitioner continued to deal with bilateral lower extremity symptoms, left greater than right. Petitioner continued to have significant degenerative disc disease at L5-S1 with spinal stenosis at L3-4. The doctor discussed the possibility of decompression at L3-4. The doctor noted that "due to his history of decompression and the necessity to spinal fusion at L4-5, he would like to proceed with a fusion at the L3-4 segment as well."

On 8/6/15, Health Alliance Connect sent a letter of denial for the proposed lumbar surgery. Px13. The reviewing doctor found that after review of medical records, x-rays and films, it was noted that Petitioner had solid instrumented fusion of L4-5 with no motion on bending forward and backward. The MRI indicated minimal disc bulges at L3-4 and L5-S1 and there was no spinal canal narrowing or compression or narrowing of the openings of the spinal nerve roots. Further, leg symptoms did not include numbness, tingling, muscle pain or weakness and there were no symptoms of narrowing of the spinal nerve passageways. The doctor concluded there was no relationship or correlation between imaging results and clinical symptoms, no evidence of infection, tumor or fracture. With evidence of solid fusion and no clinical signs or symptoms to suggest disease above or below the L4-5 fusion, the medical need for a decompression fusion had not been established. Approval was denied.

On 8/27/15, Dr. Mulconrey wrote a letter on behalf of Petitioner. Px13:751-752. The doctor explained that Petitioner was status post lumbar compression at L4-5. He noted Petitioner had a recurrence of symptoms and was progressed to instrumented spinal fusion at L4-5 in January 2015. Following surgery, Petitioner initially did well but had an increase in symptoms in his lumbar based pain as well as the lower extremity. By April 2015, Petitioner began experiencing pain in the lateral portion of the thigh. The pain progressed such that by August 2015 Petitioner was experiencing bilateral lower extremity radiculopathy, left greater than right. The doctor described radiculopathy as including numbness in the anterior portion of the thigh, the posterior portion of the calf and bilateral feet. The doctor noted there was significant positive straight leg raise and neural tension signs. His current recommendation was for decompression of L3-4 and L5-S1. Radiographic studies confirm degenerative disc disease and loss of foraminal height at both L3-4 and L5-S1. The doctor noted significant facet arthropathy at L5-S1. Imaging in April 2015 again indicated central canal stenosis at L3-4 as well as annular fissure at L5-S1. The doctor noted that the annular fissure at L5-S1 was present in the September 2014 MRI but had enlarged as of April 2015. Petitioner related to the doctor that he felt his symptoms were refractory to conservative treatment in the past and was no longer interested further interventional pain management.

On 9/21/15, Petitioner was evaluated by Benjamin Holman, PA-C, at Midwest Orthopaedic Center for unrelated left knee pain. Px13:734-742. Petitioner gave a history of camping and injuring himself while using a hatchet when splitting wood. Holman noted that "the weakness that he is having after this injury is worse than he had for many radicular back issues."

On 10/16/15, Health Alliance Connect issued its appeal decision, noting it was upholding it previous denial of approval for the proposed decompression of L3-4 and L5-S1 and extension of fusion to L5-S1. Px13:729. The rationale given was medical appropriateness based on the documentation submitted, noting the following:

> *"You have lower back and left leg pain, not otherwise described, after two lumbar operations at L4-5. Radiographic studies show "abutment "of the left L4 nerve root at L3 for an otherwise minimal disc protrusions and degenerative changes at L3-4 and L5-S1. Based on the supplied clinical documentation, you have not had an adequate trial of conservative management. Additionally, there is no evidence of lumbar instability, and there is no good correlation of your radiographic studies with your history and physical examination. In fact, you have had no meaningful examination, and the only finding described in the documentation submitted is a positive straight leg raise on the left side. As such, there is no medical necessity for the fusion, based on the supplied documentation, as there is no reasonable rationale for the recommended surgery."*

On 12/7/15, Petitioner contacted his doctor's office informing them that he had fallen twice once at Walmart and once at home. Both times, his left leg buckled. Petitioner contacted wanting to know if he should continue aquatic therapy. Petitioner felt relief in the water but pain when he got out.

Petitioner's Prior Medical Treatment

Petitioner admitted to prior back treatment. Respondent admitted the prior medical records of Dr. Alan Phillips. Rx7. Medical records dating back to 2007 confirm Petitioner treated occasionally and somewhat sporadically for lower back pain. The following dates are noted: 1/30/07, 5/12/07, 9/28/08, 11/3/08, 12/6/08, 1/3/09, 1/26/09, 2/16/09, 3/2/09, 3/30/09, 6/1/09, 6/6/09, 9/14/09, 10/5/09, 10/19/09, 11/2/09. During and for these dates of service, it appears Petitioner received treatment for low back pain thoracic pain and cervical pain. These complaints were treated conservatively by way of manipulation, electrical muscle stimulation, moist heat, ultrasound and soft tissue massage.

Records also show that, consistent with Dr. Phillips's testimony, on 6/4/10 Petitioner related involvement in a semi accident occurring previously on 1/4/10. Petitioner related he was struck on the left side of the pick-up truck by a semi. He complained of localized right sacroiliac and lower back tenderness with stiffness and soreness. Objectively, palpation spasm and tenderness were noted from L4-S2. In addition, palpation, mild to moderate tenderness were observed on L3 through L6 facets. Diagnosis in relevant part was lumbosacral neuritis or radiculitis and secondary diagnosis was lumbago with muscle spasm. Treatment was the same as prior visits.

Petitioner returned several months later on 8/20/12 for aching back pain and moderate neck pain. Lumbosacral neuritis or radiculitis is listed as one of the diagnoses. Petitioner again treated for the low back on 9/4/12 where again mild to moderate tenderness on palpation was observed at the L4 facet. Diagnosis was sacral region with associated sacroiliac joint neuritis. Treatment remained conservative to in relevant part L4 and L5. Petitioner would again treat in a similar fashion for similar complaints on 9/18/12, 11/13/12 and 1/8/13. Pain about the right sacroiliac joint was noted. In February 2013, Petitioner again treated for the lower back noting that symptoms were improved with standing and rest. Objectively, mild to moderate tenderness was found in the sacroiliac joints bilaterally, the L5 facet bilaterally. Diagnosis and treatment were unchanged. Petitioner return on 4/5/13 for localized lower back pain and right sacroiliac pain. Objectively, ranges of motion were moderately restricted due to pain, palpation produced mild to moderate tenderness observed at the L4 and L6 facets. On 5/3/13, Petitioner returned for hip, lower back and thoracic pain. Objectively, palpation showed moderate tenderness was found at the L3 facet bilaterally. Diagnosis and treatment was unchanged. On 7/3/13, Petitioner returned with complaints of low back pain, thoracic pain and cervical pain. Objectively,

active range of motion testing was moderately restricted on right rotation and mildly restricted a left rotation. On 8/26/13, Petitioner returned for lumbar and sacral discomfort. Symptoms were aggravated by walking and standing and reduced by sitting. Subluxations with spasm, hypo mobility and point tenderness were found and adjusted in relevant part at L4 and L5 and sacrum. On 104/13, Petitioner complained of lumbar pain. Multiple subluxations with spasm, hypo mobility in and point tenderness were found in relevant part at L3. On 10/28/13, Petitioner returned to Dr. Phillips complaining of neck pain only. On 12/20/13, Petitioner returned to Dr. Phillips complaining of tightness in the lower back with mild tenderness in the lower back. He related that most of the pain is in the upper back and neck. Objectively, multiple subluxations with spasm, hypo mobility and point tenderness were found and adjusted at the relevant level of L3. Petitioner reported feeling better after treatment. It was determined that his prognosis was good.

Petitioner testified that he feels the same as before the fusion. He still has pain down the leg, his foot falls asleep and his lower back hurts. Regarding his back, Petitioner testified he has pain down the left leg, lower back pain and left hip pain. He described his back pain as constant and that most days he rates it 4-5 out of 10. To ease his back pain, he lays flat on his back. He testified to difficulty with sleep at night. He testified he had no such prior symptoms and has had these symptoms since the date of accident. Petitioner confirmed he has never received temporary total disability and that he is currently on work restrictions. He testified he attempted to contact Donahue regarding work restrictions but did not get a call back. He said he found out in May 2014 he was fired and received a COBRA letter. Petitioner testified he requested a Form 45 and waited to do so because he was certain it was a supervisor's responsibility to fill one out. Petitioner wishes to proceed with surgery.

Testimony of John Brooks

John Brooks ("Brooks") testified on behalf of Petitioner. Brooks was a delivery man and recalled 12/28 as a date he remembers well as it is the date of his daughter's birthday. Brooks testified that on 12/28/13, Petitioner began the work day and appeared to be his normal self and did not appear to be in pain or have trouble walking and/or standing or sitting. Brooks remembered that on the morning of 12/28, Petitioner went outside to help a customer and when Petitioner returned inside, Petitioner told him he hurt his back outside. He said Petitioner was having difficulty walking. Brooks said that prior to Petitioner helping that customer, he appeared fine. He further testified Petitioner said he thought he did something but did not specify.

Testimony of Kim West

Kim West ("West) testified on behalf of Petitioner. She is Petitioner's wife. West testified that while she did not remember the specific dates she did remember a day that her husband came home from working and he had significant back pain. She recalled they called his chiropractor and drove there. She recalled petitioner had to lie on his belly in the back seat. She recalled the next day she took him to the emergency room. West further testified that her husband did not have the back problems and/or pain or symptoms which he exhibited on 12/28/13 before his injury.

Testimony of Tim Donahue

Tim Donahue ("Donahue") testified on behalf of Respondent. He is Petitioner's supervisor. Donahue agreed manager duties included installing wiper blades. Donahue agreed that on 12/28/13 he called the store and spoke to Petitioner. Donahue said Petitioner reported having back pain and that Petitioner had hurt his back installing a wiper blade. Donahue did not ask if Petitioner hurt his back and work and Petitioner did not say. where it occurred. Donahue further stated that on 12/29/13 petitioner called him to tell him he was in the emergency room getting treated and would not be coming to work. According to Donahue, Petitioner did not say how he injured his back and they did not discuss completing any administrative forms. Donahue said

Petitioner was trained on how to complete those. Donahue testified he prepared an overnight bag so that he could cover Petitioner's work.

Donahue said Rx8 was a documented encounter occurring on 12/31/13 where he contacted Petitioner on and asked how he was feeling. He asked Petitioner to come to work for couple of hours to help out. He knew Petitioner was not supposed to drive and he would send a driver to come pick him up and then take him home. West then called Donahue and notified him that Petitioner would not be into work due too much pain. It appears that the document continues but there is only one page submitted into evidence. Donahue testified he wrote down the encounter because he wanted to remember it.

On 2/17/14 Donahue completed Illinois Form 45. Rx3, Px5. Donahue wrote that Petitioner twisted his back installing wiper blades. The address of the accident was listed as 883 West, Dayton in Galesburg Illinois at approximately 7 AM. The date of the accident was written along with several question marks. Donahue testified Jacobs directed him to complete the Form 45.

Testimony of Elizabeth Jane Jacobs

Jane Jacobs ("Jacobs") testified on behalf of Respondent. She is the office manager. She said managers were supposed to fill out the Form 45 when accidents occurred. To her knowledge, such a policy was conveyed to Petitioner. She stated that Petitioner was supposed to fill out the form 45 but directed Donahue to fill out the form after receiving an email from Petitioner regarding workers' compensation claims and benefits. Jacobs testified that after she receives a Form 45, she makes sure it is filled out completely and forwards in onto their workers' compensation insurance carrier.

Jacobs testified that she and Petitioner spoke in January 2014 about group insurance issues involving getting MRI approval. He called seeking assistance. Jacobs said he did not mention anything about a work injury. Jacobs directed Petitioner to the agent for their group insurance, Mike Eberley. Jacobs also testified that she received an email from Petitioner on 2/10/14 informing Jacobs that he had been hurt at work. Jacobs said exhibit Rx4C was a copy of an email from Petitioner to Jacobs requesting papers related to worker's compensation. He stated he injured himself on 12/28 installing a wiper blade on a customer's vehicle. She said this was the first time she learned he was claiming a work injury. Jacobs said later received Petitioner's completed Form 45 after 2/17. Rx2. Jacobs identified Rx13 as FMLA paperwork she would have received. In it, Petitioner's doctor describes the Petitioners condition commenced on 12/28/13. It is faxed on 1/30/14 from Midwest Orthopaedic. Jacobs also identified Petitioner's wages and time card. She stated he was salaried. Rx5, Rx12. The wages were faxed on 2/25/14 and the time card was generated on 12/29/13.

Testimony of Rod Tulin

Respondent also called Rod Tulin ("Tulin") to testify. Tulin testified that when he first came to work on 12/28/13, Petitioner was in pain and that Petitioner told Tulin that he had injured his back changing wiper blades at home. He said he observed this around 8 am. Tulin did not recall when it was in regards to the first time he spoke to anyone about Petitioner appearing to be injured at the start of the work day. Tulin did admit that his job involved making deliveries and that he would have gone out on a delivery and come back to the NAPA store later in the day on the 28th. Petiioner testified that he was not at the counter and would have been in the back of the store when Tulin came to work that morning. On cross, Tulin said that Petitioner appeared normal the day before 12/28.

Testimony of Richard Michael Eberley

Mike Eberley ("Eberley") testified for Respondent. He is a friend of Breck Loos, Respondent's owner and is also an insurance agent who sells insurance policies to Respondent. Eberley testified that in January 2014 he received a phone call from Petitioner and that Petiioner told Eberley that Petitioner hurt himself changing a wiper blade while at home. Eberley did not have any notes from that conversation and did not make any notes of the conversation. Eberley received a follow-up email from Petitioner. The follow-up email from Petitioner related Petitioner injured himself changing wiper blades. Eberley admitted that he occasionally plays golf with Breck Loos and would have dinner on occasion with Breck Loos. Respondent exhibit 4B is a copy of an email sent from Eberley to Don Lester. In the email Eberley has forwarded on to Lester a copy of Petitioners summary of what had occurred. Eberley wrote Lester "Don it's your problem broker again! Can you please call me regarding this after you had a chance to read it? I would appreciate it. Thanks, Mike." Petitioner's email to Eberley is dated 1/8/14. Eberley's email to Lester is dated 1/8/14.

Evidence Deposition Testimony of Dr. Phillips

On 8/28/14, the parties took the evidence deposition of Dr. Alan Phillips, DC. Px1. The doctor testified that Petitioner related to him that he had been working that day and was leaning over the hood of a car on a rainy day and was putting on new windshield wipers on a customer's car. Petitioner turned wrong or while being bent over or maybe twisted a little bit and actually felt a pop or a twinge in his lower back and he began having radiating pain into the left leg. The doctor testified that Petitioner related the incident had occurred at work in a parking lot. The doctor summarized treatment. The doctor testified that it was his opinion that Petitioners injuries were related to an incident that occurred at work.

Under cross-examination, the doctor stated he has treated Petitioner on and off for about 7 years. The doctor confirmed that in June 2010 Petitioner saw Dr. Phillips in reference to a semi accident. The doctor confirmed the Petitioner received treatment for his back. The doctor agreed that Petitioner had a long-standing history of back pain. The doctor further admitted that he treated Petitioner for pain complaints in the lower back, upper back and neck on 12/20/13. The doctor admitted that following the 12/28/13 incident, he did not review any MRIs of the lumbar spine or any x-rays of the lumbar spine. The doctor stated that his causation opinion was based solely on what Petitioner reported to him. On redirect, the doctor clarified that the 12/20/13 visit did not have any indication of any complaints of pain shooting into the leg. The doctor said they were more generic complaints about the back. Further sciatica was not a diagnosis on that date or in the two visits prior to 12/20/13.

Evidence Deposition Testimony of Dr. Mulconrey

On 2/16/15, the parties took the evidence deposition of Dr. Daniel Mulconrey. Px2. The doctor confirmed the Petitioner related that he was changing windshield wipers on a car and had an acute onset of back pain shooting down the left leg. The doctor summarized pre and postoperative care for Petitioner's first surgery. On 7/21/14, the doctor placed Petitioner at maximum medical improvement.

The doctor confirmed that Petitioner returned in August 2014 reporting increasing pain. New MRI showed recurrent disc herniation. Petitioner did not relate any specific incident as the origin of his recurrent pain. Treatment options were discussed and petitioner elected to proceed with fusion surgery. Surgery was completed January 2015. The doctor testified that up until that time, the last work restriction note that was issued was back on 6/3/14. The doctor opined that the relationships between Petitioner's two surgeries were related to Petitioner's history occurring 12/28/13.

The doctor believed that the mechanism of twisting while applying wiper blades or windshield wipers to a car could cause a herniation identified during surgery of January 2014. Under cross examination, the doctor admitted he did not have an opportunity to review any prior to the records from Petitioners other doctors. It was his understanding the Petitioner had no prior back problems. Regarding Petitioner's prior treatment with Dr. Phillips before the alleged work accident, the doctor testified that if that low back pain also included left leg pain then his causation opinion would potentially be impacted as those symptoms would be consistent with the same symptoms that Petitioner reported to him on the date he was first evaluated. Regarding MRI findings, the doctor testified that findings were unlikely to be degenerative in nature. The doctor felt it was more of an acute finding rather than a chronic finding.

On 12/7/15, the parties to the supplemental evidence deposition of Dr. Daniel Mulconrey. Px2A. The doctor testified that following fusion surgery, Petitioner began having increasing pain into the groin region. A repeat MRI was done and treatment remained unchanged. Petitioner returned in June 2015 reporting low back pain as well as pain into both legs now. Petitioner elected to proceed with revision fusion surgery by way of fusion at L3-4 and L5 S1 with laminectomy of L3-4 and L5-S1. The doctor testified that it was his opinion that Petitioner had underlying degenerative conditions of L3-4 and L5-S1 and they became more symptomatic following the fusion procedure.

Under cross-examination, the doctor conceded that his interpretation that the annular fissures were worse when comparing the MRIs of 2014 to 2015 could be also be caused by the natural progression of degenerative disc disease regardless of prior surgeries. The doctor explained that it was his opinion through Petitioner's history and his pain complaints that the symptoms occurred after the last fusion surgery and therefore were related to the segments cranial and caudal or above and below his last fusion surgery and appear to have been aggravated after the last fusion surgery. The doctor also conceded that it could also be related to the natural progression of his degenerative disc disease. When asked whether the need for the third surgery would then also be related to the natural progression of degenerative disc disease the doctor answered that such an opinion was also valid.

Evidence Deposition Testimony of Dr. Degrange

On 3/17/15, the parties to the evidence deposition of Dr. Donald Degrange. Rx11. The doctor testified he performed a section 12 exam at the request of Respondent on 5/15/14. Petitioner told him that on 12/28 he was installing a set of wiper blades on a customer's car. He bent and turned simultaneously and had an onset of low back pain radiating to the left leg including the foot. The doctor testified he reviewed multiple medical records and stated that Petitioner had a long-standing history of low back pain going back to 2000. The doctor recounted the Petitioner treated for his low back as recent as 12/20/13 in the days before the work incident. The doctor noted the prior medical records diagnosed radiculitis but did not specify whether it was in the left lower extremity.

The doctor testified he reviewed MRI findings and would characterize those findings to be degenerative in nature. It was a doctor's opinion that there were no changes to suggest an acute injury on that MRI. The doctor testified he completed an exam of Petitioner and that Petitioner reported occasional stiffness in the low back. He was not taking any medications and he reported he was doing fine. The doctor testified that to a reasonable degree of medical and surgical certainty Petitioner's diagnosis was that of L4-5 herniated nucleus pulposis and degenerative disc disease. The doctor opined that the reported mechanism of injury did not fit with that diagnosis. He explained that simply bending and twisting was not a sufficient force to cause, aggravate or exacerbate disc degeneration. He found it to be an activity of daily living such as putting on one socks or once trousers. In his opinion, Petitioner's condition of ill-being was neither caused nor aggravated by the mechanism of injury as reported by Petitioner to the doctor. The doctor further opined that the surgery for the disc herniation at L4-5 was not the direct result of the mechanism of injury as reported by Petitioner. The

doctor believed that at the time of his exam, Petitioner was able to return to work without medical restrictions and was otherwise at maximum medical improvement. The doctor testified that recurrent disc herniation occurs in 2-5% of individuals following a discectomy. He testified that the typical surgery consists of a revision discectomy. The doctor testified that following a revision discectomy the chances of a recurrence does go up but somewhere in the range of 7-10% having a second recurrence.

The doctor agreed that Petitioner had to have had significant pre-existing to disc degeneration. He agreed he could not exclude that if Petitioner did in fact have significant pre-existing degeneration then the simple act of bending and twisting could result in a disc herniation. The doctor testified that the onset of radicular pain would take several weeks. The doctor testified that he has never previously testified that he would expect or anticipate there to be immediate pain going into a person's leg after a herniation of the disc. He admitted that the 12/20/13 Dr. Phillips note did not indicate radiculitis or sciatica. The doctor testified there were issues related to the left leg as of 2010 and back in 2000. The doctor changed his testimony, admitting that there was nothing specifically in the prior medical records noting radicular complaints going down into the left leg until the 12/28/13 visit.

CONCLUSIONS OF LAW

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

The Arbitrator has considered all evidence and concludes that Petitioner has failed to prove the issue of accident.

In addressing credibility as it relates to the issue of accident, the Arbitrator finds that Petitioner's testimony was more credible than Tulin's testimony that he injured himself while installing a customer's windshield wiper blades rather than his own personal wiper blades. Tulin could not recall when he first shared this information with Respondent. Tulin was certain he recalled his encounter with Petitioner occurred at 8 am, which is not only the exact moment Tulin clocked into work (Rx5) but also nearly one hour and a half before Petitioner sold the wiper blades to the customer that day. Px3, Rx6. Petitioner's testimony was credibly supported by Brooks, who testified that Petitioner appeared fine at the beginning of work but did not after returning from installing the blades. Brooks was certain of that day as it was his daughter's birthday. Further, even if Petitioner had injured himself changing his wife's truck blades, as Tulin and Eberley claimed, because it also occurred while Petitioner was working, it too would be subject to the same analysis that follows. The Arbitrator notes that Petitioner's wife's vehicle was a truck while the customer's vehicle was a Honda. The type of vehicle is notable, as one of Petitioner's treatment records note he was bent over the car in order to install the blade, something the Arbitrator thinks would have been unlikely had it been a large truck. Further, Petitioner's history of changing or installing wiper blades on 12/28/13 appears consistently through-out his treatment records. The only record to connect the incident to Petitioner's car was Dr. Mulconrey's record but given the preponderance of the evidence and the doctor's subsequent testimony, the Arbitrator believes this to be in error. Having resolved the credibility issue in favor of Petitioner, the Arbitrator turns to the required accident analysis.

In order to recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that his injury "ar[ose] out of" and "in the course of" his employment. 820 ILCS 305/2. The "in the course of employment" element refers to the time, place, and circumstances surrounding the injury. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203 (2003). "That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment." *Id.* The requirement that the injury arise out of the employment concerns the origin or cause of the claimant's injury. *Id.* The occurrence of an accident at the claimant's workplace does not automatically establish that the injury "arose out of" the claimant's

employment. *Parro v. Indus. Comm'n*, 167 Ill. 2d 385, 393 (1995). "The 'arising out of' component is primarily concerned with causal connection" and is satisfied when the claimant has "shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro, Inc.*, 207 Ill. 2d at 203. There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics.

With respect to the third category, "[i]njuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." The increased risk may be either qualitative (*i.e.*, when some aspect of the employment contributes to the risk) or quantitative (such as when the employee is exposed to the risk more frequently than members of the general public by virtue of his employment).

Here, there is no doubt Petitioner's injuries occurred in the course of his employment. The issue is whether his injury arose out of his employment. In this case, Petitioner claims he was injured while turning or twisting to install a wiper blade on a customer's car. Turning or twisting is an activity of everyday life. There is no evidence the injury was caused by a risk personal to the Petitioner or by a risk distinctly associated with his employment. Thus, Petitioner's injury is compensable only if he was exposed to this risk to a greater degree than the general public.

Petitioner has failed to make that showing here. Petitioner said his work duties required him, in part, to sell wiper blades and help customers install wiper blades onto their vehicles. Petitioner testified that on the date in question, he sold and installed wiper blades for a customer. Petitioner failed to testify as to how often he installed wiper blades. (e.g. once per shift, several times per week, seasonally, etc.). Thus, Petitioner failed to show that quantitatively, he was exposed to any risk to a greater degree than the general public. Further, Petitioner failed to testify that qualitatively, he was exposed to the neural risk of twisting in changing wiper blades more frequently than members of the general public. Petitioner merely testified he twisted and felt a pain. He did not state whether the type of vehicle was large or awkward and he did not state whether he is required to install wiper blades in any particular or unusual manner. His medical records fail to shed any further light on this; Dr. Phillips wrote Petitioner was leaning over the hood of a car leaning forward putting wiper blades and turned; emergency records wrote that Petitioner turned wrong; Dr. Sloan wrote Petitioner simply twisted a certain way. Petitioner wrote on his Form 45 that he laid down the packaging and turned to install the blades. None of these descriptions provide anything beyond twisting or turning that would suggest an increased exposure to a risk.

The Arbitrator notes the special concurrence made in *Adcock v. Indus. Comm'n*, which maintained that if an employee is injured while "performing a common bodily movement that is required by his job duties," then the injury "arose out of" his employment, even if the physical action that caused the injury is something that virtually everyone does on a daily basis. 38 N.E.3d 587, 598-602, 395 Ill. Dec. 401 (2d Dist. 2015). The majority in *Adcock* pointed out that: " '[i]n order for an injury to arise out of one's employment, the risk must be: (1) a risk to which the public is generally not exposed but that is peculiar to the employee's work, or (2) a risk to which the general public is exposed but the employee is exposed to a greater degree.' If neither of these factors apply, *i.e.*, if the injury is caused by an activity of daily life to which all members of the public are equally exposed (or by a risk personal to the employee), then there can be no recovery under the Act, even if the employee was required to perform that activity by virtue of his employment." See, *e.g.*, *Hopkins v. Indus. Comm'n*, 196 Ill. App. 3d 347, 348-52. See also *Karastamatis v. Indus. Comm'n*, 306 Ill. App. 3d 206, 209 (1999). For the foregoing reasons, the Arbitrator has no choice but to conclude that Petitioner failed to prove his accident arose out of his employment with Respondent. All other claim for compensation is hereby ***denied.***

ISSUE (E) ***Was timely notice of the accident given to Respondent?***
ISSUE (F) ***Is Petitioner's current condition of ill-being causally related to the injury?***
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 temporary benefits are in dispute?***
ISSUE (K) (O)Is Petitioner entitled to any prospective medical care?

Having found Petitioner failed to prove his accident arose out of his employment with Respondent, all other remaining issues are hereby considered moot. All other claim for compensation is hereby denied.

Signature of Arbitrator

5-2-2016
Date

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

Maricela Perez,

Petitioner,

vs. NO: 15 WC 16125

D & S Communications, Inc,

Respondent.

17IWCC0618

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: OCT 2 - 2017
o092117
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

PEREZ, MARICELA
Employee/Petitioner

Case# **15WC016125**

D & S COMMUNICATIONS INC
Employer/Respondent

17IWCC0618

On 2/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLENS HASKINS NICHOLSON
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

3227 HOLECEK & ASSOCIATES
CASEY J HUNTER
215 SHUMAN BLVD
NAPERVILLE, IL 60563

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) & 8(a)

Maricela Perez
Employee/Petitioner

v.

D&S Communications, Inc.
Employer/Respondent

Case # 15 WC 16125

Consolidated cases: N/A

17IWCC0618

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Wheaton**, on **January 6, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, March 31, 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 as explained *infra*.

Timely notice of this accident *was* given to Respondent as explained *infra*.

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

In the year preceding these injuries, Petitioner earned an average weekly wage of $420.00.

On this date of accident, Petitioner was 47 years of age, *married* with 2 dependent children.

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

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

As agreed, Respondent is entitled to a credit for all bills paid through its group medical provider under Section 8(j) of the Act. AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that she sustained a repetitive trauma injury on March 31, 2015, that proper notice of the accident was given, and a continued causal connection between the injury at work and her ongoing condition of ill-being.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care in the form of bilateral carpal tunnel release surgery as prescribed by Dr. Chhadia pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

February 2, 2017
Date

FEB 6 - 2017

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

Maricela Perez
Employee/Petitioner

v.

D&S Communications, Inc.
Employer/Respondent

Case # **15** WC **16125**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include whether Petitioner sustained a compensable accident on March 31, 2015, whether Petitioner provided proper notice, whether there is a causal connection between Petitioner's current condition of ill being and his alleged accident, and whether Petitioner is entitled to prospective medical treatment in the form of bilateral carpal tunnel release surgeries as recommended by Dr. Chhadia. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background & Prior Medical Treatment

Maricela Perez (Petitioner) testified that she was employed by D&S Communications, Inc. (Respondent) and had been so employed for approximately three years as a Telephone Assembler. Petitioner testified that the phones on which she worked were for business use in offices or hospitals. She testified that she produced, on average, 20 to 25 phones per day, which was the quota.

Petitioner explained the physical requirements of her job disassembling, cleaning, and re-assembling old phones. She testified that she would open up each phone, which required strength. She used both hands to pry open the casing of the phone using one hand to grip the phone and the other hand to remove all of the internal components, including a little screen. She then had to pass all of the usable internal components into a new plastic casing and close the re-assembled phone.

To perform these tasks, Petitioner explained that she used a battery-powered screwdriver as well as a conventional screwdriver. Petitioner testified that she used strength in the disassembly process removing all of the internal components of the old phone. She also testified that she used strength in the reassembly process placing everything into a new casing and ensuring that the screws were tight. Petitioner also explained that she pushed downward on the automatic screwdriver to tighten the screws. On cross examination, Petitioner testified that is right-hand dominant, but explained that she did not use one hand more than the other because she would use the left hand to hold the phone and the right hand to use the screwdriver.

About six months after working for Respondent, Petitioner testified that she started noticing symptoms in her hands. Specifically, she noticed that when she started opening the old phones her fingers would go numb and she experienced numbness in the nerves of her arms from her elbows to her wrists.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)."

On cross examination, Petitioner testified that she was allowed three breaks per day, but she worked 10 hours per day. She explained that over her three years of employment she would produce about 20 phones per day, but she did not recall whether there were days when she only produced six phones. Petitioner testified that she did not have numbness and tingling in her hands until she started working for Respondent. Previously, Petitioner did not work. Petitioner testified that she continued to work for Respondent for 2½ years after she started having symptoms in her hands.

Medical Treatment

The medical records of Dr. Pepa reflect that Petitioner presented on March 31, 2015 for various issues including right flank pain and "tingling and numbness of both hands and arms. This began 2 years ago. She is unsure if it is work related." RX4 at 6-7. Dr. Pepa diagnosed Petitioner with bilateral carpal tunnel syndrome and provided her with carpal tunnel splints for both hands. *Id.*

Petitioner testified that on March 31, 2015, she saw her primary care physician, Leo Pepa, M.D. (Dr. Pepa). She testified that she went to see Dr. Pepa because she could not stand the numbness in her hands anymore and she wanted to "see what it was." On cross examination, Petitioner maintained that she told Dr. Pepa what she felt in her hands and he said he would send her to the hospital. Petitioner testified that she told Dr. Pepa that her hands hurt and were numb and that she wanted to know what caused those symptoms.

Notice

Petitioner testified that Dr. Pepa gave her a note stating that she was treating with him and she took that note to someone at the company. Petitioner testified that she did inform Respondent that she had symptoms because she would bandage her hands. She also testified that she would tell her co-workers and told her boss, Raul Flores (Mr. Flores). Petitioner testified that she used her group insurance for medical treatment.

On cross examination, Petitioner reiterated that she told Respondent that she had pain in her hands from working and explained that she told them about it when her hands started hurting more and more. Petitioner testified that she did not recall when exactly, but she told Mr. Flores.

Petitioner was presented with Petitioner's Exhibit 6, which is a doctor's note from Dr. Pepa dated March 31, 2015. PX6. Dr. Pepa writes that Petitioner was seen in his office and that any questions can be directed to his office. *Id.* Petitioner testified that she took this note to work around the time that Dr. Pepa wrote it and gave it to the boss at work. On cross examination, Petitioner testified that she took this note to Mr. Flores and she was terminated three days later.

Continued Medical Treatment

On April 7, 2015, Petitioner underwent a bilateral upper extremity EMG/NCV for paresthesias in both hands as ordered by Dr. Pepa. PX3; RX4 at 12. The results showed evidence of bilateral median entrapment neuropathy at the wrists consistent with bilateral moderately advanced carpal tunnel syndrome, worse on the left. *Id.* On cross examination, Petitioner testified that the person that reviewed her told her that her left hand was worse than the right hand, but she testified that both hands hurt.

Petitioner followed up with Dr. Pepa on April 11, 2015. RX4 at 12. He noted that she had moderately advanced bilateral carpal tunnel syndrome, worse on the left based on the EMG report, and that Petitioner

experienced numbness of the entire digits of both hands. *Id.* Dr. Pepa referred Petitioner to an orthopedic specialist. *Id.*

On April 24, 2015, Petitioner saw Ankur Chhadia, M.D. (Dr. Chhadia) at Suburban Orthopaedics. PX1; RX5 at 5-7. Dr. Chhadia noted the following history in pertinent part:

> **Onset date:** approximately on 2 years ago
> **Cause / mechanism:** overuse work She states she used to work repa[i]ring telephones. She states she workfor five days for ten hours daily. She states she opened and closed phone[s] using a tool on her right hand. The tool did vibrate. She states she never reported her pain to her supervisors. She states she would wear bandages around her hands while working. She went to her PCP who recommend[d]ed to get an EMG at Sherman hospital, which she brought the report with her today. She states she was tool [sic] that she had nerve damage.
>
> Patient states her left hand is worse on the right. The patient complaints of numbness and tingling constantly on bilateral hands and fingers. She states she feels pain on bilateral forearms. She has trouble when lifting something heavy and when gripping. She states her arms and hands are very weak.
>
> She states she is taking Advil prn for pain.
>
> She denies of any treatment. She denies any physical therapy.
>
> She stopped working 3 to 4 weeks ago. She was fired.

Id. On physical examination, Dr. Chhadia noted positive findings bilaterally with Tinel's, Phalen's, carpal tunnel compression, and cubital tunnel testing. *Id.* Dr. Chhadia also reviewed Petitioner's April 7, 2015 EMG results noting evidence of bilateral median entrapment neuropathy at the wrist consistent with bilateral moderately advanced carpal tunnel syndrome, worse on the left. *Id.* He diagnosed Petitioner with bilateral carpal tunnel syndrome with mild bilateral cubital tunnel syndrome stemming from overuse repetitive work injury. *Id.* Dr. Chhadia recommended surgery. *Id.*

On cross examination, Petitioner testified that she told Dr. Chhadia about her job duties. Petitioner denied telling Dr. Chhadia that she did not report the injury to her boss at work.

Petitioner returned to Dr. Chhadia on May 27, 2015. PX1; RX5 at 1-4. Petitioner reported constant numbness and tingling bilaterally in the hands, worsening symptoms, continued difficulty pushing, pulling, and twisting as well as worsened pain in the morning, loss of strength, and that her hands were very weak. *Id.* Dr. Chhadia reiterated his recommendation for surgery to address Petitioner's bilateral carpal tunnel syndrome and mild bilateral cubital tunnel syndrome stemming from overuse, repetitive work injury with moderate-to-severe symptoms that persisted despite prolonged non-operative treatment. *Id.*

Section 12 Examination – Dr. Sagerman

On January 6, 2016, Petitioner submitted to a medical evaluation at Respondent's request with Scott Sagerman, M.D. (Dr. Sagerman). RX2. Dr. Sagerman examined Petitioner and reviewed her treating medical records after which he issued a report rendering opinions regarding the relatedness, if any, of Petitioner's physical condition with the alleged incident at work. *Id.* Dr. Sagerman noted Petitioner's report that "she developed symptoms of numbness and tingling involving both hands two years ago. The onset was gradual. There is no history of

trauma. She felt her symptoms while she was working repairing phones. She has been treated with a wrist splint." *Id.*

Dr. Sagerman noted his review of an EMG performed on January 6, 2016 with evidence of mild to moderate bilateral median neuropathy's at the wrist, worse on the left, with minimal active denervation, no evidence of ulnar neuropathy or cervical radiculopathy. RX2. He also reviewed the job video. *Id.* Dr. Sagerman noted the following:

> Video demonstration of the patient's work activities was viewed. Small parts are placed into a phone backing on tabletop at waist height while the worker is standing. Small tools and an air hose are used intermittently momentarily. The phone components are assembled manually. Several screws are inserted with the use of a pneumatic screw driver. Overall, the manual activities of the job are low-force and varied.

Id. Dr. Sagerman opined that Petitioner's subjectively reported symptoms of paresthesias in both hands were consistent with carpal tunnel syndrome as confirmed by her EMG with worse findings in the left hand. RX2. He opined that Petitioner's bilateral carpal tunnel syndrome, and any recommended medical treatment including surgery, was not causally related to Petitioner's job duties and that the cause was idiopathic. *Id.* Dr. Sagerman also noted that Petitioner had an increased body mass index which was a contributor factor for the development of carpal tunnel syndrome in Petitioner's case. *Id.*

Deposition Testimony – Dr. Sagerman

On March 8, 2016, Respondent called Dr. Sagerman as a witness and he gave testimony at an evidence deposition. RX3. Dr. Sagerman testified that he is an orthopedic surgeon that performs hand surgeries specializing in orthopedic sports medicine. RX3 at 5-9; RX3 (Dep. Ex. 1).

Dr. Sagerman maintained that Petitioner's bilateral carpal tunnel syndrome was not causally related to her job duties. RX3 at 13-14. He based his opinion on his review of the job video, which did not demonstrate work activities that would cause or aggravate the condition of carpal tunnel syndrome. *Id.*, at 14. Dr. Sagerman testified that the job video reflected low-force and varied activities. *Id.*, at 14, 36. He also testified that Petitioner's body mass index was significant as it was an associated contributing factor for developing carpal tunnel syndrome. *Id.*, at 15. Dr. Sagerman maintained that Petitioner's carpal tunnel syndrome was idiopathic in nature, with no identifiable cause. *Id.*, at 15, 34.

Dr. Sagerman testified that it was not significant to his analysis that Petitioner reported to Dr. Pepa that she was unsure whether the injury was work-related. RX3 at 18. He also testified that he did not diagnose Petitioner with cubital tunnel syndrome. *Id.*, at 23, 34.

On cross-examination, Dr. Sagerman testified that he did not perform Tinel's testing on Petitioner because it is subjective and unreliable. RX3 at 21. He acknowledged that Petitioner had no prior carpal tunnel syndrome diagnosis. *Id.*, at 22-23.

Dr. Sagerman also acknowledged that his opinions relating to Petitioner's job were based entirely on the job video. RX3 at 28. He did not receive a written job description of Petitioner's duties at work. *Id.* Dr. Sagerman admitted that the worker in the job video was shown placing small parts in a phone, using small tools to perform that job, using an air hose, assembling phone parts manually, inserting several screws, and utilizing a pneumatic

screwdriver. *Id.*, at 28-30. Dr. Sagerman did not independently recall whether the worker in the job video was gripping components, pushing components into a board with flexed or extended hands, grasping components from time to time, or squeezing a bottle. *Id.*, at 30-32. He also testified that manual work involving the use of handheld tools can cause carpal tunnel syndrome depending on the overall type of work and frequency of usage. *Id.*, at 33.

Deposition Testimony – Dr. Chhadia

On November 14, 2016, Petitioner called Dr. Chhadia as a witness and he gave testimony at an evidence deposition. PX2. Dr. Chhadia testified that he is an orthopedic surgeon that performs hand surgeries specializing in orthopedic sports medicine. PX2 at 4-5; PX2 (Dep. Ex. 1).

Dr. Chhadia opined that the occupational functions that Petitioner described to him were more likely than not causally connected to her bilateral carpal tunnel syndrome. PX2 at 6-7. He testified that he reviewed a job video from Respondent including certain of Petitioner's duties at work. *Id.*, at 7. Dr. Chhadia testified that the repetitive fine manipulation, gripping, and twisting-type motions reflected in the video that Petitioner had to perform, as well as the pace, frequency, and duration per day during which she had to perform these duties, in his opinion, contributed to her condition. *Id.*, at 7, 17. Dr. Chhadia testified that he understood that Petitioner did not have a prior history or prior treatment for bilateral carpal tunnel syndrome when she saw him in April of 2015. *Id.*, at 7-8.

On cross examination, Dr. Chhadia testified that Petitioner's bilateral carpal tunnel syndrome was caused by overuse at work, repetitive trauma, but acknowledged that carpal tunnel syndrome could be caused by a degenerative condition. PX2 at 9-10. He testified that he reviewed Petitioner's EMG which showed advanced carpal tunnel syndrome. *Id.*, at 10. Dr. Chhadia testified that Petitioner reported that her condition had been ongoing for years. *Id.*, at 10-11, 17-18. He was not aware how many years Petitioner had been working for Respondent. *Id.*, at 11. Dr. Chhadia also acknowledged that there were other factors that could contribute, or make patients more susceptible, to developing carpal tunnel syndrome (i.e., obesity, age, gender). *Id.*, at 12-13.

Dr. Chhadia testified that he viewed the use of an electric screwdriver in the job video. PX2 at 14-15. In his opinion, use of such a screwdriver could contribute to carpal tunnel syndrome. *Id.* Dr. Chhadia also testified that while Petitioner's EMG showed advanced stages of carpal tunnel syndrome in the left hand, and Petitioner used an electric screwdriver in her right hand, it did not necessarily mean that Petitioner's left hand carpal tunnel syndrome was a pre-existing condition. *Id.*, at 15, 16.

Dr. Chhadia maintained that Petitioner's work activities either caused or aggravated her underlying carpal tunnel condition "to the point where it's become symptomatic with the occupation that she's done, to my knowledge, to lead her to necessitate surgery." PX2 at 15-16. He acknowledged that he did not know how many phones Petitioner assembled per day and that taking breaks between assembly could be a factor in whether her carpal tunnel syndrome was work-related, but testified that he understood that Petitioner was assembling phones on a "kind of repetitive, fast basis[… and] it's ongoing motion." *Id.*, at 17.

Job Video

Respondent offered into evidence the job video reviewed by Petitioner, Dr. Chhadia, Dr. Sagerman and Mr. Flores. RX6. The 7½ minute video reflects an employee placing small parts into a phone casing (i.e., number buttons). *Id.* The employee then places other small plastic pieces into the phone and cleans several components with a cleaning solvent in a spray bottle and drying the components with an air hose. *Id.* The employee cleans

and inserts other, larger electrical components into place within the phone casing. *Id.* The employee then uses an electrical screwdriver to tighten several screws downward to secure the electrical component into the casing. *Id.* The employee uses hot glue and tape to secure two pieces of a smaller, caller *ID* casing before securing it to the inside of the larger telephone casing. *Id.* The employee uses both hands in performing these functions. *Id.* Finally, the employee uses the electric screwdriver to secure the top and bottom portions of the phone casing together as well as additional screws to affix a piece that angles the phone upward. *Id.*

Petitioner testified that the job video is an accurate depiction of the work that she performed, but testified that it does not show when the telephones are being opened. Petitioner explained that this omission is significant because one uses more strength disassembling the old phones.

Raul Flores

Raul Flores (Mr. Flores) testified that he is employed by Respondent, and has been since 1996. He explained that he is a Telephone Repair Manager supervising the tech center. Mr. Flores testified that Respondent's business is to repair, refurbish, and install telephone equipment.

Mr. Flores testified that techs repair telephones and place them into new housings. Techs pull telephones to see if they work, replace the housings, clean the phones, and put them back together. To perform these functions, the employee uses a regular screwdriver as well as an electric screwdriver with a thumb-operated button that can be adjusted to several positions and whatever speed the user needs. The typical work schedule is 40 hours per week with three breaks per day.

Petitioner started working for Respondent in about December of 2012 and that she worked for Respondent for about 2½ years. Mr. Flores was her direct supervisor. He explained that he interviewed Petitioner and she listed prior experience repairing circuit boards at Otto Engineering on her application. Mr. Flores also testified that Petitioner's job involved testing phones to see if they worked, cleaning the inside pads, drying the inside, and placing internal components into new casings.

Mr. Flores testified that he told Petitioner that she was to immediately notify him if she was hurt at work. He testified that Petitioner never reported any accident or injury to her hands. He also testified that Petitioner did not show him any medical documents, including the note from Dr. Pepa reflected in Petitioner's Exhibit 6. Mr. Flores observed Petitioner working, but never noticed that she was in any kind of pain, holding her hands, or compensating with one hand or the other due to pain. Mr. Flores maintained that Petitioner never told him of any pain or symptoms in her hands, or that she was claiming any injury at work. However, on cross examination, Mr. Flores acknowledged that he saw Petitioner wearing bandages on her hands.

On cross examination, Mr. Flores testified about the job video and explained that a film crew came twice to take videos of Petitioner's work duties. He let the filming crew into the building and directed them to Maricela, another employee, and to the location where the work was being done. Mr. Flores testified that he was not otherwise involved in the job video production. With respect to the job duties reflected in the video, Mr. Flores acknowledged that it does not reflect the process of disassembling old phones, opening the old phones or using a putty knife to unfasten interior parts secured with hot glue.

Mr. Flores testified that Petitioner's production was low, averaging 12 phones per day, and decreased when the company changed the type of phones it produced. He testified that Petitioner could not see the parts in the newer, smaller phones and she told him so. Mr. Flores testified that Petitioner's production was in the 20's very

few times and that her production decreased approximately one year after she started. He explained that his knowledge of Petitioner's production rates was based on his independent recollection as well as his review of production records before the hearing.

Regarding Petitioner's work performance, Mr. Flores testified that Petitioner started out well, but then she started to make the same mistakes over and over again. He testified that there were complaints from customers because the inside pads of the phones were not cleaned. Mr. Flores testified that Petitioner received verbal disciplinary warnings and three different warnings. The first warning was oral and given to Petitioner within her 90-day probation period for gossiping. The second warning was also for gossiping, but was a written warning. Mr. Flores testified that Petitioner was also given two other warnings for putting in the wrong number buttons on the phones (i.e., two of the same number instead of 0-9).

Mr. Flores also testified that Petitioner produced only between 6-12 phones per day. He explained that an experienced tech would produce about 20 phones per day, although some produced more and others less. However, Mr. Flores also acknowledged that if Petitioner did not write down the work that she performed, the work would not count toward her production rates. He further acknowledged that Petitioner had to reassemble or "re-work" phones that had previously been assembled, but rejected by quality control. In these instances, re-assembly or "re-work" of the phone did not count toward Petitioner's production totals.

Ultimately, Petitioner testified that the general manager, Grace, terminated Petitioner from Respondent's employment. Mr. Flores testified that Grace is his sister.

Additional Information

Petitioner testified that she no longer works for Respondent. She stopped working for Respondent around April 4, 2015. Petitioner testified that she was terminated from her position and she has not returned to work for Respondent, but she has returned to work for another company, an agency called Pronto Help, in April of 2016. Petitioner testified that she worked for them for one month. She worked doing assembly work squeezing and using strength, but her hands hurt and she could not squeeze a lot. On cross examination, Petitioner testified that she was terminated from Respondent's employment because she was not putting the phones back together in the correct way.

Regarding her current condition of ill-being, Petitioner testified that she feels pain and tingling in her hands. Petitioner testified that the symptoms are daily and when she squeezes things, her hands hurt. For example, when she is mopping, wringing mops, or opening tight jars. She also experiences numbness throughout the night. Petitioner testified that she does massage her hands, but the pain does not go away. She testified that the pain started when she was working.

Petitioner testified that she would like to undergo the surgery recommended by Dr. Chhadia.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2011). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). Additionally, Petitioner must establish the "'arising out of' component [which] refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of her employment) to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

In repetitive-injury cases, the facts must be closely examined to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006) (*citing Three "D" Discount Store*, 198 Ill. App. 3d 43, 49 (4th Dist. 1989)). 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 (*citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529 (1987)). 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).

Given the totality of this record, the Arbitrator finds that Petitioner has established that she sustained a repetitive trauma injury on March 31, 2015 as claimed. In so concluding, the Arbitrator finds Petitioner's testimony to be credible and the opinions of Petitioner's treating physician, Dr. Chhadia, to be persuasive.

Many of the facts in this case are undisputed, or uncontroverted. Petitioner worked for Respondent for approximately 2½ years as a telephone assembler before her alleged repetitive trauma injury to the bilateral hands. She worked full time, 10 hours per day with several breaks throughout the day. Petitioner's job duties required her to disassemble old phones, clean and test the inside components, and place the working interior of the old phones combined with any necessary new components into new phone casings. To perform her work, Petitioner used an electric screwdriver, a conventional screwdriver, and a putty knife, as needed, to disassemble and reassemble the phones. In addition, Dr. Pepa and Dr. Chhadia, as well as Respondent's Section 12 examiner, Dr. Sagerman, noted Petitioner's consistent report that she had ongoing symptoms of numbness and tingling in the hands for two years or so prior to first seeking treatment with Dr. Pepa. Petitioner worked for Respondent throughout the aforementioned period of time without the need for medical treatment. She had no history of medical treatment to the hands before March 31, 2015.

The parties' dispute centers on the nature of Petitioner's job duties. Petitioner explained her job duties in detail. Mr. Flores corroborated Petitioner's testimony, but took exception to the quality of her work and her penchant for gossip. He testified that Petitioner's production rates were much lower than she estimated and, in doing so, explained that Petitioner made errors in the re-assembly of phones such that any "re-work" was not counted toward her production totals. Mr. Flores also testified that if Petitioner did not write down the work that she did, it was not counted toward her production totals. Indeed, Petitioner had been subject to discipline for the type of production errors that required "re-work," would not count toward her totals, and ultimately resulted in her termination.

A job video was also offered into evidence. Each of the witnesses in this case had an opportunity to review the video. Petitioner agrees that it accurately reflects her job duties, but the video omits the process of opening old telephones. Mr. Flores admitted on cross examination that the job video omits this initial part of the process. Thus, the only evidence relating to the disassembly process necessary for Petitioner to correctly, or incorrectly, produce any phones per day comes from her own testimony, which is otherwise corroborated by the job video and, admittedly, by Mr. Flores. Petitioner explained that this initial disassembly process requires more strength in the use of the hands than the other portions of production. Moreover, given the testimony of Mr. Flores that Petitioner was having repeated problems in the correct production of phones, it is plausible that she engaged in the disassembly process more often than others without the benefit of production rates equal to the work performed to achieve those rates. This is consistent with Petitioner's testimony that she "produced" more phones per day than indicated by Mr. Flores.

Petitioner testified that she performed work with both of her hands using an electric and conventional screwdriver, which required forceful gripping and "strength" over most of 10 hours per day for 2 ½ years. Her testimony is corroborated overall by the testimony of Mr. Flores and the job video. Based on the foregoing, the Arbitrator finds the testimony of Petitioner to be credible.

Petitioner and Respondent also rely on the opinions of Dr. Chhadia and Dr. Sagerman, respectively, to support their assertions that Petitioner's bilateral hand condition was, or was not, caused by her job duties. Given the testimony of Petitioner and Mr. Flores, it is clear that neither Dr. Chhadia nor Dr. Sagerman had the opportunity to observe the manner in which old phones are disassembled because that portion of the production process is omitted from the video. Dr. Chhadia noted Petitioner's initial history that she repaired telephones five days per week, ten hours per day during which she "*opened and* closed phone[s]" using a tool that vibrated in her right hand. PX1; RX5 at 5-7 (*emphasis* added). At his deposition, Dr. Chhadia maintained that the use of the tools and work described in the video was sufficient to cause or aggravate her condition. By contrast, Dr. Sagerman admitted that he based his opinion regarding causal connection solely on his review of the job video showing, in his opinion, low-force and varied activities. He also admitted that manual work involving the use of handheld tools can cause carpal tunnel syndrome depending on the overall type of work and frequency of usage.

Neither physician had the opportunity to observe the force, hand posturing, tool usage, or length of time involved in opening old phones, but Dr. Sagerman excluded Petitioner's description of the job duties in favor of the job video. Dr. Chhadia considered Petitioner's description of the job duties as well as the job video, which omits an important portion of the production process as noted by Petitioner and acknowledged by Mr. Flores. Based on the foregoing, the Arbitrator finds the opinions of Dr. Chhadia to be more persuasive than those of Dr. Sagerman in this case.

Additionally, an employee claiming that she suffered a repetitive-trauma injury must still point to a date within the statutory limitations period on which both the injury and its causal link to her work became plainly apparent

to a reasonable employee. *Durand*, 224 Ill. 2d at 65 (*citing Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 209 (1st Dist. 1993)); *see also Peoria County*, 115 Ill. 2d at 531. "[B]ecause repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work." *Id.*, (*citing Oscar Mayer v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (4th Dist. 1988)).

Petitioner testified that she first sought medical treatment because she could no longer tolerate the symptoms in her hands and to determine their cause. Dr. Pepa's records corroborate Petitioner's testimony. Dr. Pepa diagnosed Petitioner with bilateral carpal tunnel syndrome based on her clinical presentation and ordered an EMG, which confirmed his diagnosis. He also referred Petitioner to a specialist for further care. Petitioner testified that she provided a copy of the March 31, 2015 note from Dr. Pepa to Mr. Flores. Mr. Flores testified that Petitioner never provided such a note to him and that he never observed Petitioner in pain or gripping her hands, but he later admitted that he observed Petitioner wearing bandages on her wrists at some point. Dr. Chhadia's initial treatment note of April 24, 2015[2] reflects Petitioner's report that she wore bandages at work; something to which she testified at the hearing. Petitioner had symptoms beginning sometime after six months of employment with Respondent. Petitioner continued to work, without any medical treatment, through March 31, 2015. Mr. Flores testified that Petitioner repeatedly made mistakes ultimately leading to her termination. To that end, he explained that Petitioner's production rate was lower than that of other employees, acknowledging that "re-work" did not count toward her production totals.

Based on the totality of the record, the Arbitrator finds that Petitioner has established that she sustained a repetitive trauma injury at work that manifested on March 31, 2015 as claimed.

In support of the Arbitrator's decision relating to Issue (E), whether timely notice of the accident given to Respondent, the Arbitrator finds the following:

Notice of an accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing, but not later than 45 days after the accident with some very limited exceptions. 820 ILCS 305/6(c). The purpose of the notice requirement is to enable an employer to investigate an alleged accident. *Seiber v. Industrial Comm'n*, 82 Ill. 2d 87, 95 (1980). A claimant's compliance with the notice requirement is established by placing the employer in possession of the known facts related to the accident within the statutory period. *Seiber*, 82 Ill. 2d at 95.

As noted in the accident analysis above, Petitioner claimed that she sustained a repetitive trauma injury at work. When the numbness and tingling in her hands became intolerable, Petitioner sought medical treatment for the first time with Dr. Pepa on March 31, 2015. She explained that she provided Dr. Pepa's note to Respondent. Mr. Flores denied that he ever had notice of any injury at work, or that he ever received any note from Petitioner. However, he admitted on cross examination that he did observe Petitioner with bandages on her hands, which contradicted his testimony on direct examination. The Arbitrator finds that Petitioner's testimony

[2] Dr. Chhadia's initial treatment note of April 24, 2014 also reflects Petitioner's report that "she never reported her pain to her supervisors." PX1; RX5 at 5-7. At the hearing, Petitioner testified on cross examination that she did not recall telling Dr. Chhadia that she had *not* reported pain to her supervisor and, to the contrary, she testified that she gave the prior note of March 31, 2015 from Dr. Pepa to Mr. Flores. The Arbitrator finds this discrepancy to be *de minimus* when viewing the evidence as a whole. Dr. Chhadia's notes contain several scrivener's errors, and Petitioner's testimony is consistent overall with the remainder of the record.

with regard to notice is credible and that Petitioner gave proper and timely notice[3] of her accident to Respondent.

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The medical records reflect that Petitioner received her first medical treatment for the symptoms in her hands beginning March 31, 2015. Petitioner thereafter sought treatment from Dr. Chhadia, who diagnosed Petitioner with bilateral carpal tunnel syndrome and cubital tunnel syndrome that he opined were causally related to her duties at work. As explained above, the Arbitrator finds that Petitioner sustained a compensable accident at work on March 31, 2015 and further finds the opinions of Dr. Chhadia to be persuasive. No evidence was introduced regarding an intervening accident and the Arbitrator does not find the opinion of Dr. Sagerman that Petitioner's carpal tunnel syndrome is solely a degenerative condition to be persuasive. Based on all of the foregoing, the Arbitrator finds that Petitioner has established a continued causal connection between her bilateral carpal tunnel syndrome and cubital tunnel syndrome and accident at work on March 31, 2015.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner established that she sustained a repetitive trauma injury at work that manifested on March 31, 2015 and that her current condition of ill-being is causally related to her accident at work. Petitioner's condition has not improved thereafter such that her treating physician, Dr. Chhadia, recommends bilateral carpal tunnel release surgery.

In consideration of the record as a whole, the Arbitrator awards the recommended prospective medical care in the form of bilateral carpal tunnel release surgeries as prescribed by Dr. Chhadia pursuant to Section 8(a) of the Act as the treatment is reasonable and necessary to alleviate Petitioner from the effects of her injury at work.

---

[3] Additionally, Petitioner's Application for Adjustment of Claim was filed on May 14, 2015 within the statutory 45-day period. Section 8(j) of the Act which states, in relevant part, "[i]n the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act ... the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments." 820 ILCS 305/8(j)(1). The parties agreed that Respondent would be entitled to a credit for any payments made by the group insurance carrier and the amount of any such credit was not placed at issue. AX1.

16WC24329
Page1

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

Daryl Grison,

Petitioner,

vs. NO: 16 WC 24329

Central Groceries Inc,

Respondent.

17IWCC0619

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 16, 2017, is hereby affirmed and adopted.

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

17IWCC0619

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.

OCT 2 - 2017

DATED:
o092817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

GRISON, DARYL
Employee/Petitioner

Case# **16WC024329**

CENTRAL GROCERIES INC
Employer/Respondent

17IWCC0619

On 2/16/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

3998 ROSARIO CIBELLA LTD
MARK MATRANGA
116 N CHICAGO ST SUITE 600
JOLIET, IL 60432

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)

DARYL GRISON,
Employee/Petitioner

v.

CENTRAL GROCERS, INC.,
Employer/Respondent

Case # 16 WC 24329

Consolidated cases: n/a

17IWCC0619

An *Application for Adjustment 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, Illinois**, on **12/16/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0619

FINDINGS

On the date of accident, **7/21/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$83,304.00**; the average weekly wage was **$1,602.00**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$13,731.43** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$13,731.43**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$169.76** to Dr. Mark Chang, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of **$169.76** for medical benefits that have been paid and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$1,068.00/week** for **19-1/7th** weeks, commencing **7/22/16- 9/14/16** and **9/29/16- 12/16/16**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$13,731.43** for TTD.

The Arbitrator awards the L4-5, L5-S1 laminectomy and discectomy and Coflex® surgery prescribed by Dr. Mark Chang, as well as any pre and post-operative medical care incidental 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

2-14-17
Date

ICArbDec19(b)

FEB 16 2017

17IWCC0619

BACKGROUND

Daryl C. Grison ("Petitioner") filed an application for adjustment of claim pursuant to the Illinois Workers' Compensation Act (Act) seeking benefits from his employer, Central Grocers, Inc. ("Respondent") for injury to his low back occurring on July 21, 2016. On November 6, 2016, Petitioner filed a petition for immediate hearing under 19(b) and on December 16, 2016, the parties proceeded to arbitration on the disputed issues of causation, liability for unpaid medical bills, temporary total disability, and prospective medical care under Section 8(a).

FINDINGS OF FACT

At trial it was undisputed that on July 21, 2016, Petitioner suffered accidental injuries to his low back while working for Respondent as a delivery driver. Specifically and on that date, petitioner said he injured his low back while unloading groceries off the work truck by hand. He recalled unloading 600-700 pieces manually over 1.5 hours and in a repetitive fashion. Petitioner felt an onset of back pain but kept working and upon finishing, noticed increased pain. He reported this immediately to Tom Pirro and was unable to finish his route.

That same date, Petitioner was sent to Physician's Immediate Care and complained of low back, right-sided leg pain and associated numbness and tingling. He was given ice, a back brace, medications and sent to work full duty.

On July 22, 2016, petitioner saw Dr. Abraham Mathew. Dr. Mathew diagnosed a back injury and prescribed medications to treat the Petitioner's work injury. Petitioner started in an off work medical status on July 22, 2016. Petitioner followed up with Dr. Mathew on July 29, 2016 and August 15, 2016. At the July 29, 2016 visit Dr. Mathew prescribed a course of physical therapy. Petitioner testified to undergoing a course of physical therapy with only minimal relief from his pain symptoms. At the August 15, 2016 office visit Dr. Mathew referred Petitioner to a back specialist, Dr. Mark Chang. Px1.

On September 6, 2016, petitioner began treating with Dr. Mark Chang at the referral of Dr. Mathew. Dr. Chang noted the Petitioner's low back pain and noted the Petitioner's pain radiating into his left leg causing numbness and weakness. Neurological exam showed mild weakness in the left ankle, decreased sensation to pinprick in the left foot area and positive SLR. The doctor's impression was acute lower back pain, acute left L5 radiculopathy possibly due to a nerve impingement at the L5-S1 level where there was severe disc degeneration. He noted x-rays showed severe degeneration at L5-S1 that had been "asymptomatic" until this recent injury. An MRI was ordered, which showed in part degeneration, narrowing and facet arthropathy at L4-5 and significant neural foraminal stenosis at L5-S1. Px2.

On September 29, 2016, Petitioner saw Dr. Chang, still complaining of significant pain in his back. Dr. Chang reviewed his MRI that day and referred the Petitioner for injections with a pain management doctor. At the Petitioner's November 1, 2016 office appointment Dr. Chang began reviewing the possibility of spine surgery as an option to treat the Petitioner's back injury. px2.

Petitioner testified to undergoing a course of two pain injections in his back with only minimal symptomatic relief. On December 1, 2016, Dr. Chang recommended surgery at L4-5 and L5-S1 via laminectomy, discectomy and Coflex® due to Petitioner's continued pain in his back, radiculopathy and the lack of significant relief he experienced from other treatment measures including physical therapy and pain injections. He was continued off of work. Px2.

Petitioner testified to continuing significant pain in his back at the time of trial that he experiences on a daily basis. Petitioner takes pain medications daily to treat his pain but the pain medications provide very little relief from his pain. Petitioner testified to wanting to proceed with the surgery recommended by Dr. Chang to try and fix his injury so he's not in so much pain. Petitioner acknowledges he goes to the gym and swims and goes in the hot tub and sauna. Petitioner testified that his physicians have encouraged him to try and remain active despite his injury.

Respondent sent the Petitioner for an IME with Dr. Kern Singh on September 14, 2016. Rx1. Dr. Singh felt the Petitioner sustained a lumbar strain injury as a result of his July 21, 2016 work accident. Dr. Singh wrote an addendum on November 16, 2016 after a review of the Petitioner's MRI films but his opinions regarding the Petitioner's injury were unchanged.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator found his testimony to be candid, forthright and credible as to his history of injury, treatment and current condition.

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 Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being as it relates to his lower back/lumbar spine condition(s) is causally related to his undisputed work accident.

In so finding, the Arbitrator notes Petitioner was in a state of good health prior to the work accident and prior to the onset of his lumbar condition, with no known injuries or symptoms to his back. Since the accident, Petitioner has had significant onset of pain, numbness and tingling, which have not resolved with reasonable conservative measures.

Dr. Chang's impressions persuasively and credibly describe "acute" lower back pain and he noted that Petitioner's L5-S1 pathology was asymptomatic prior to his work accident. Neurological exam suggested deficits and both x-ray and MRI confirmed severe degeneration and stenosis at L5-S1. Read together, Dr. Chang's impressions are supported by objective medical evidence. Petitioner continues to have significant pain in his back which radiates into his left leg. In weighing the medical opinions offered by Dr. Singh, the Arbitrator does not find those opinions persuasive, as Dr. Singh saw Petitioner one time and was the only record to suggest Waddell findings and a simple muscle strain. The preponderance of the evidence documents an immediate and consistent onset of low back pain, right-sided symptoms and numbness and tingling along with failed medical care. Petitioner's complaints have remained consistent and suggest more than a muscle strain. In addition, Dr. Singh did not address Petitioner's identified L5-S1 pathology in any further detail other than to suggest degeneration at L4-5.

Based on the foregoing and on the record as a whole, the Arbitrator finds that, under a chain of events theory, Petitioner's current condition of ill-being as it relates to his low back was rendered symptomatic by and is causally related to the July 21, 2016 work injury.

ISSUE (J),(O) WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY AND HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The medical services provided to the Petitioner have been both reasonable and necessary. The Petitioner has had standard conservative treatment measures for his back injury including: doctor's visits, diagnostic testing, physical therapy, injections, and prescription medications. The Arbitrator finds the Petitioner's treatment to date to be reasonable and necessary and awards the Petitioner **$169.76** for Dr. Mark Chang's outstanding medical bill.

ISSUE (K), (O) PROSPECTIVE MEDICAL CARE

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner is awarded prospective medical care as recommended by Dr. Mark Chang including the L4-5, L5-S1 laminectomy and discectomy and Coflex® surgery, including all associated usual pre and post-operative care incidental thereto. This award is based upon Petitioner's related condition having failed conservative measures as noted by Dr. Chang and based on Petitioner condition of ill-being not yet reaching maximum medical improvement.

ISSUE (L), (O) 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 is awarded temporary total disability (TTD) benefits from July 22, 2016 to September 14, 2016 and September 29, 2016 to December 16, 2016, a period of 19-1/7th weeks. These dates reflect when Petitioner was prescribed off work for these dates by Dr. Mathew and Dr. Chang. Px1-2. Petitioner returned to work for a period of about two weeks in September 2016 but Dr. Chang took him back off work on September 29, 2016 after the Petitioner attempted a good faith period of returning to work.

Signature of Arbitrator

2-14-17
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Donovan,
Petitioner,

vs.

NO: 14 WC 08970

Illinois Bell Telephone Co. D/B/A AT & T,
Respondent.

17IWCC0620

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, penalties, fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2016, is hereby affirmed and adopted.

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

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

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

DATED: OCT 4 - 2017
o092117
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

DONOVAN, MICHAEL
Employee/Petitioner

Case# **14WC008970**

ILLINOIS BELL TELEPHONE CO D/B/A AT&T
Employer/Respondent

17IWCC0620

On 11/28/2016, 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 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5614 LAW OFFICES OF CAMERON B CLARK
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
THOMAS C FLAHERTY
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Michael Donovan
Employee/Petitioner

v.

Illinois Bell Telephone Co., d/b/a AT&T
Employer/Respondent

Case # 14 WC 8970

Consolidated cases: N/A

17IWCC0620

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **September 22, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, January 30, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding these injuries, Petitioner earned $47,840.00; the average weekly wage was $920.00.

On this date of accident, Petitioner was 59 years of age, *married* with no dependent children.

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

Respondent shall be given a credit for $0 for TTD, $0 for TPD, $0 for maintenance, and as agreed for other benefits (i.e., non-occupational indemnity disability benefits), for a total credit as agreed[1].

As agreed, Respondent is entitled to a credit for all bills paid through its group medical provider ($89,414.41 BCBS;$83,440.72 BCBS; $22,833.27 Arcadia Health) under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable injury on January 30, 2014 or any causal connection between the alleged injury at work and any ongoing condition. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

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

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

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

Signature of Arbitrator

November 16, 2016
Date

NOV 2 8 2016

[1] The parties stipulated on the Request for Hearing form as follows: **"The parties stipulate that Petitioner has been paid non-occupational indemnity benefits to which Respondent is entitled to a Credit under Section 8(j) of the Act, in the event of an adverse decision."** AX1.

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

Michael Donovan
Employee/Petitioner

v.

Illinois Bell Telephone Co., d/b/a AT&T
Employer/Respondent

Case # **14** WC **8970**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include whether Petitioner sustained a compensable accident on January 30, 2014, whether Petitioner provided proper notice, whether there is a causal connection between Petitioner's current condition of ill being and his alleged accident, whether Respondent is liable for payment of certain medical bills, whether Petitioner is entitled to temporary total disability benefits commencing on February 21, 2014 through September 22, 2016, whether Petitioner is entitled to prospective medical treatment in the form of ongoing pain management, and whether Respondent is liable for penalties and fees pursuant to Sections 19(k), 19(l) and 16 of the Illinois Workers' Compensation Act ("Act"). Arbitrator's Exhibit[2] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background & Prior Medical Treatment

Michael Donovan (Petitioner) testified that he was employed by AT&T (Respondent) on January 30, 2014 as a Premises Technician and had been so employed for approximately three years in that capacity. He was originally hired on June 15, 2001. Petitioner explained his job duties to include installing and repairing the "U-verse" television and internet system. In so doing, he could be working on telephone poles or in backyards and crawl spaces, etc.

Petitioner testified that he had no prior incidents or accidents involving his cervical spine, but did have some prior medical treatment including cervical spine injections in 2012 – 2013. Petitioner testified that he was able to return to his regular job duties and perform his work thereafter. Also, Petitioner testified that no doctor had recommended a cervical spine fusion prior to his alleged date of accident. He explained that, prior to January 30, 2014, any symptoms including soreness and stiffness related to his cervical spine were remedied by a couple of Tylenol pills.

The medical records reflect that Petitioner saw John Prunskis, M.D. (Dr. Prunskis) between February 14, 2012 and July 9, 2013. RX2. At his initial visit on February 14, 2012, Petitioner reported "a chief complaint of pain principally between his shoulder blades and neck area, left greater than right. He also has pain in his lower back as well. His lower back pain is more in the middle. He describes the pain as burning and spasm. He also feels some lightheadedness when he moves his head. Pulling his shoulders back makes the pain better. Bending forward makes the pain worse. The pain is about an 8 out of 10. He can only walk about five minutes before he must stop due to the pain. It is difficult for him to do and be engaged in work." *Id.* Dr. Prunskis noted that Petitioner had cervical disc disease and osteophytes in the cervical spine as well as cervical facet arthropathy. *Id.* Dr. Prunskis also noted myofascial pain of the rhomboid muscles medial to both scapulae and the left

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

trapezius muscle. *Id.* Dr. Prunskis ordered a cervical spine injection. *Id.*

Dr. Prunskis then ordered and administered epidural steroid injections, facet joint injections, nerve branch blocks, and radiofrequency ablations in the cervical spine. RX2. At Petitioner's last visit with Dr. Prunskis on July 9, 2013, Petitioner reported that he was feeling greater pain on the right side of his neck after his last left cervical radiofrequency ablation. *Id.* Petitioner was instructed to return after a lumbar MRI for a low back condition. *Id.*

January 30, 2014

Petitioner testified that he was working as a Premises Tech for Respondent in Pingree Grove, Illinois on January 30, 2014. He testified that he was driving westbound on Route 20 traveling 45-50 mph slowing down for a curve in the road. Then, Petitioner testified the wind came up and all he could see in front of him was two headlights coming toward him. So, Petitioner testified that he moved over to the right to avoid the accident and the next thing he knew he was being bounced all over the inside of the cab as he went off the road and came to a sudden stop in a ditch. Petitioner described the bouncing around to be "almost like sitting on a bronco buck where you were going one direction and the next and trying to hold yourself in place. I had my foot buried on the brake pedal. I was trying to hang on and keep the brakes applied and just, you know, being tossed around."

Petitioner testified that he experienced something like an adrenaline rush and was not too sure about what happened until it was over. He was a little shaken up and stiff, but thought he would be okay. Petitioner described the weather conditions on January 30, 2014 to be extremely windy and snowy.

Following the incident, Petitioner testified that he called Eric White (Mr. White) and told him that he went off in a ditch to avoid a head-on accident and that he needed a tow truck. He testified that Mr. White told him to call "fleet services" to have his truck towed and put back on the road. On cross-examination, Petitioner testified that it was the tow truck driver who told him not to stay on route 20 and to pull into the lot because there was so much traffic.

Petitioner testified that he call fleet services and, quite some time later, a tow truck arrived. Then, Petitioner testified that after his vehicle was towed out of the ditch, he drove straight down the road to get it off of the curve in the road and pulled into the lot at the police station. Petitioner described that he could barely get the truck turned into the lot.

Petitioner explained that he inspected the vehicle and was going to make a police report, but then Mr. White showed up in the parking lot. He testified that did not submit a police report because Mr. White looked at the truck and said there was no damage and suggested that he go on with his day. Then, Mr. White left and Petitioner tried to drive the truck, but he could not steer it. So, Petitioner testified that he called Mr. White back to which Mr. White told him to call the tow truck back and have the truck towed to the garage. Petitioner testified that the tow truck came back.

The following day, on January 31, 2014, Petitioner testified that he reported for work and requested that an accident report be completed. Petitioner testified that he went to give Mr. White the red book that he (Petitioner) had filled out and he asked Mr. White to fill out an accident report. According to Petitioner, Mr. White said that there was no damage to the truck and if it was under $500, there was no accident so he did not need a right book and further stated that as far as he was concerned Petitioner could shred or throw out the red book. See RX3 (blank red book). Petitioner testified that there is a garbage can with a slit in it that is locked for personal information to be shredded.

Petitioner testified that he was not allowed to fill out any type of accident or incident report on that date. Petitioner also testified that his truck was in the garage on January 31, 2014. There was a note inside the truck for him from the mechanic indicating that the truck was ready to go. He explained that "[i]t had to thaw out overnight because the engine compartment was packed with snow."

On cross-examination, Petitioner testified that he is familiar with Respondent's policies and procedures requiring him to notify his manager of a work injury. He also acknowledged that if his own manager was not available, should notify another manager. Petitioner testified that he had a prior workers' compensation claim against Respondent, which was settled.

February 14, 2014

On cross-examination, Petitioner testified that he was working on February 14, 2014. He had previously requested an accommodation from Respondent with respect to blood pressure or stress issues so that he did not have to work extra overtime.

Petitioner acknowledged that he was involved in a verbal altercation with Louis Sacco (Mr. Sacco), his on-duty manager, on February 14, 2014 regarding leaving work early that day. Petitioner did not remember whether he used profanity, although he said it was possible, and did not remember if he was upset with Mr. Sacco because he was not being given an accommodation with regard to the number of hours that he was supposed to work, but said that was also possible.

Later, however, Petitioner testified that he did not recall the verbal altercation with Mr. Sacco. He also did not recall contacting Mr. White after the discussion with Mr. Sacco, or whether there was any reason to feel that his job might be in jeopardy.

February 15, 2014

Petitioner testified that he continued to work for Respondent through February 15, 2014. During that time, he testified that he noticed that his cervical spine was getting "sorer and sorer every day." He explained that the soreness was on the left side of his neck and he could barely turn his neck to the left. Petitioner testified that he used the same work truck between January 31, 2014 and February 15, 2014.

Petitioner testified that he was at work on February 15, 2014 and he experienced stroke-like symptoms. He testified that he understood that he had a stroke, but does not remember experiencing it and did not recall much of this day.

On cross examination, Petitioner acknowledged that the first time he went for medical care and treatment after the accident on January 30, 2014 was February 15, 2014. Petitioner explained that he did not recall much from this day, but testified that his wife says that he called her that day.

The medical records reflect that Petitioner was admitted in the emergency room at St. Alexius Medical Center on February 15, 2014. PX1 at 3-4. Petitioner was referred for a neurologic consultation from the emergency room because of a stroke alert called for acute stroke, which was performed by Daniele Anderson, M.D. (Dr. Anderson). *Id.* Dr. Anderson noted that Petitioner the following history:

> The patient is a 59-year-old gentleman with a history of a previous stroke in February 2012, at which

> time he was seen at Alexian Brothers Medical Center. He reports similar stroke symptoms at that time with left-sided weakness in speech difficulty. The patient also has a history of diabetes mellitus, hypertension, hyperlipidemia, hyperthyroidism, and depression. The patient was home with his wife this morning. She left the house at 7:15, and he was in a normal state of health. The patient's wife attempted to call him on the telephone as the patient was driving to work sometime before 9:30 this morning, and the patient's wife noted that the patient had difficulty attempting to speak with some slurred speech. She told him to pull his car over and was able to communicate with him enough to find out where he was. She called 911 and paramedics arrived. They brought this patient to St. Alexius Medical Center as a stroke alert.
>
> When the patient arrived at St. Alexius, he had dysarthria, as well as mild left-sided weakness of the arm. He reported tingling and numbness of the left face, arm, and leg. His NIH Stroke Scale Score was 5. The patient was considered for intravenous tPA. A CT scan of the brain showed no acute abnormality. The patient met all criteria for administration of intravenous tPA, and this was administered at 10:10 a.m. So far, the patient has shown some improvement, as he can now speak more clearly. He does still have some mild left arm weakness, and here ports numbness and tingling in the left face, arm, and leg.
>
> Testing at this point includes a CT of the head showing no acute abnormality. His CBC is normal, coagulation profile is normal, CMP shows glucose 142, otherwise normal.

Id. After a physical examination, Dr. Anderson diagnosed Petitioner with stroke or transient ischemic attack causing initially dysarthria and left-sided weakness and numbness of the face and arm, possibly leg. *Id.* She ordered following stroke protocol, MRIs of the brain and cervical spine, MRAs of the head and neck, a 2-D echocardiogram, and therapies and labs per stroke protocol. *Id.*

Petitioner underwent the recommended diagnostic tests. Petitioner's cervical MRA was unremarkable. *Id.*, at 16. The intracranial MRA, which was compared with one from February 5, 2012, was also unremarkable. *Id.*, at 17. Petitioner's brain MRI showed non-specific white matter disease which may represent chronic small vessel ischemic change and no acute intracranial abnormality or evidence of acute infarction. *Id.*, at 17-18. The plain head CT was negative. *Id.*, at 23.

Petitioner's cervical spine MRI showed: (1) severe spinal stenosis with narrowing of the bilateral neuroforamina at C5-C6 and C6-C7 with no significant change from prior study on March 13, 2012 and no evidence for cord compression; (2) posterior disc bulge resulting in moderate spinal stenosis at C3-C4; and (3) a posterior disc bulge resulting in moderate spinal stenosis at C3-C4 and C4-C5 which are new findings since his prior exam on March 13, 2012 with no evidence for cord compression. *Id.*, at 19-20.

On February 18, 2014, Reinhold Llerena, M.D. (Dr. Llerena) noted Petitioner's follow up after his hospitalization for possible stroke on February 15, 2014. PX1 at 12-15. Dr. Llerena noted his review of Petitioner's diagnostic test results from the emergency room at St. Alexius Medical Center and diagnosed Petitioner with spinal stenosis in the cervical spine with severe restriction of extension, no evidence for CVA, and he noted this could be the cause of his symptoms. *Id.* He referred Petitioner for a neurosurgical consultation. *Id.* Petitioner testified that Dr. Llerena indicated that he did not sustain a cerebral accident or TIA, and referred him to neurosurgery for treatment.

Petitioner's Return to Work

On cross examination Petitioner testified that he returned to work on February 20, 2014 and reported to his supervisor, Mr. White. The following day, February 21, 2014, Petitioner testified that he attended a disciplinary

meeting with Mr. White, Mr. Sacco, and a representative from his union. The purpose of the meeting was to discuss the altercation between Petitioner and Mr. Sacco on February 14, 2014 and Petitioner testified that he was told that he threatened Mr. Sacco, which he did not recall. Petitioner understood that allegations were being raised against him, but he testified that he was in so much pain that he finally told them that he was going to see a doctor because his neck hurt.

On re-direct examination, Petitioner testified that no discipline resulted from the meeting. On re-cross examination, Petitioner testified that he has not been back to work since this meeting.

Continued Medical Treatment

Petitioner saw Bryan Bertoglio, M.D. (Dr. Bertoglio) on February 21, 2014. PX1 at 43-53, 66-69. He completed a form entitled "Spine Patient Health Assessment Form[.]" PX1 at 47-53. In response to a question whether the problem was associated with an injury, Petitioner described the injury as follows: "PUT WORK TRUCK IN DITCH TO AVOID HEAD ON ACCIDENT[.]" *Id.*, (EMPHASIS in original). Dr. Bertoglio noted the following history:

> Michael is a 59yo RHD mail who presents today for evaluation of severe neck pain. He has a h/o bilateral UN transposition, bilateral carpal tunnel release, and bilateral radial nerve decompression between 2004-2005 with supposed electrophysiologic resolution on post-procedure EMG per pt. He noted partially subjective improvement postoperatively as well. His residual UE symptomatology as well as his neck pain has been severely exacerbated by a MVA 2-3 weeks ago when he drove into a ditch to avoid a head-on collision with an errant vehicle. He will be filing work comp.
>
> He describes a constant aching and sharp neck pain into the upper thoracic spine. It radiates into the bilateral scapula and shoulders, as well as down the left posterolateral upper arm. He also note paresthesias of the left UE below the elbow. L>>>>R UE. His pain is provoked by any cervical ROM as well as general activity. He denies alleviative factors.
>
> He denies imbalance. No bowel or bladder difficulty.
>
> He has undergone conservative measures over the years, including PT and the procedures as noted above. He is under the care of Dr Prinskis who performs injections on a regular basis. He last underwent a radiofrequency ablation in 08/2013. He has had no new injections since the MVA.

PX1 at 43-46. In pertinent part, Dr. Bertoglio diagnosed Petitioner with an acute cervical strain, chronic cervical pain, and severe cervical stenosis at C5-C6 and C6-C7. *Id.* Dr. Bertoglio noted his review of Petitioner's films and that "[Petitioner] had a preexisting condition of cervical stenosis which has been secondarily exacerbated by the recent MVA. It is therefore felt beyond a reasonable degree of medical certainty to be a work related injury via indirect mechanism. Due to the severity of stenosis is recommended that the pt undergo cervical decompression with an ACDF C5-6/C6-7. His symptoms are multifactorial, which makes complete relief uncertain, but the severity of stenosis alone warrants surgical decompression." *Id.* Petitioner was placed off of work. PX1 at 70.

On February 24, 2014, Petitioner saw Dr. Llerena for pre-operative clearance for the scheduled cervical spine surgery with Dr. Bertoglio. PX1 at 9-11. Dr. Llerena diagnosed spinal stenosis in the cervical spine with severe restriction of extension, no evidence for CVA, and he noted this could be the cause of his symptoms. *Id.*

On February 27, 2014, Petitioner underwent the recommended surgery with Dr. Bertoglio. PX1 at 64-65. Pre-

and post-operatively, Dr. Bertoglio diagnosed Petitioner with C4-C5, C5-C6, and C6-C7 cervical spondylosis and stenosis with myelopathy and radiculopathy. *Id.* He performed the following procedures: (1) C4-C5, C5-C6, and C6-C7 intercervical discectomy and fusion with microdissection with the operating microscope, structural allograft, and instrumentation; and (2) intraoperative fluoroscopy, electromyogram, and somatosensory evoked potentials monitoring. *Id.*

Petitioner was discharged from the hospital on March 1, 2014 with a diagnosis of cervical spinal stenosis and spondylosis with myelopathy and radiculopathy post C4-C7 surgery with discectomy and fusion. PX1 at 62-63. The attending physician, Taeksoo Shin, M.D. (Dr. Shin) noted Petitioner had a "questionable history for CVA. He had similar symptoms 2 years ago, but MRI was negative according to the patient. He has hypertension, depression, and thyroid disease , and history of diabetes." *Id.*

Petitioner saw Dr. Llerena on March 18, 2014 reporting that he felt a little better. PX1 at 9, 26-28. Dr. Llerena noted that Petitioner's headaches were much improved after the surgery and instructed him to follow up with Dr. Bertoglio as well. *Id.* Petitioner was kept off of work. PX1 at 73. Dr. Bertoglio also kept Petitioner off of work at his follow up visits on April 15, 2014 and May 27, 2014. PX1 at 74-75.

On June 2, 2014, Petitioner returned to Dr. Llerena reporting severe pain, unusual symptoms including sensation of shortness of breath when he bends forward in a certain way, and mild dizziness. PX1 at 28-30. Dr. Llerena diagnosed cervical spine stenosis noting that Petitioner would undergo an MRI under anesthesia that week. *Id.* He also diagnosed Petitioner with headaches noting Petitioner's complaint of constant pain mainly in the back of the head, which had improved somewhat after using the cervical collar, but subsequently returned. *Id.*

On September 11, 2014, Petitioner saw Lukasz Chebes, M.D. (Dr. Chebes) at Alexian Brothers Medical Center for pain management. PX11 at 1-4. Petitioner reported persistent neck and radicular pain after his surgery with no significant relief from a cervical epidural steroid injection on August 20, 2014. *Id.* Dr. Chebes diagnosed Petitioner with cervicalgia, for which he prescribed narcotic pain medications, and cervical radiculitis. *Id.* On September 19, 2014, Petitioner underwent an interlaminar cervical epidural steroid injection with Dr. Chebes. PX11 at 6-7. On October 2, 2014, Petitioner returned to Dr. Chebes reporting 30% relief after his recent injection. PX11 at 9-12. Petitioner received another interlaminar cervical epidural steroid injection performed by Dr. Chebes on October 17, 2014. PX11 at 12. On October 30, 2014, Petitioner reported to Dr. Chebes approximately two weeks of relief after his recent injection. PX11 at 13-16. He also reported "new upper thoracic pain just below the fusion without radiation." *Id.* Dr. Chebes added a diagnosis of thoracic spine pain and ordered a thoracic MRI. *Id.*

Petitioner underwent the recommended thoracic MRI on November 7, 2014. PX11 at 16-17, 25-26. The interpreting radiologist noted mild degenerative anterior marginal osteophyte formation in the mid-and lower thoracic spine with no central canal or neuroforaminal stenosis at any thoracic level. *Id.*

On November 13, 2014, Dr. Chebes noted that there was no significant upper thoracic finding in Petitioner's recent MRI and he recommended cervical nerve blocks. PX11 at 18-20. On December 5, 2014, Dr. Chebes performed bilateral diagnostic medial branch nerve blocks at C4, C5, C6, and C7. PX11 at 21-22.

Records Review – Dr. Mirkovic

On January 6, 2015, Srdjan Mirkovic, M.D. (Dr. Mirkovic) issued a report at Respondent's request rendering opinions regarding the relatedness, if any, of Petitioner's medical conditions to his alleged accident at work. RX1. He reviewed Petitioner's treating medical records from St. Alexius Medical Center, Dr. Bertoglio, Illinois

Pain Institute (Dr. Prunskis), Dr. Llerena, Dr. Chebes, Dr. Anderson (neurology), Petitioner's cervical MRIs of February 4, 2012, October 9, 2012 and February 15, 2014, Petitioner's November 7, 2014 thoracic MRI, Petitioner's February 27, 2014 surgical report, and a post-surgical report dated February 31, 2014. *Id.*

Dr. Mirkovic opined that the events on January 30, 2014 did not cause, aggravate, accelerate or exacerbate Petitioner's pre-existing degenerative condition in the cervical spine or his long-lasting pre-existing chronic neck pain. *Id.* He also opined that the events of January 30, 2014 did not cause Petitioner's need for surgical intervention. *Id.*

In so concluding, Dr. Mirkovic indicated that Petitioner had a clearly documented history of chronic neck pain going back as far as 2007, which continued to be symptomatic in 2008. *Id.* He noted that in 2012, Petitioner underwent aggressive, non-operative pain management treatment with Dr. Prunskis that extending into 2013 during which Petitioner underwent 25 cervical spine injections without improvement. *Id.* Dr. Mirkovic also noted Petitioner's complaints of pain at levels of 8/10 or 9/10 at visits with Dr. Prunskis on February 4, 2012 and June 18, 2013. *Id.* Petitioner's records also showed that Petitioner underwent epidural steroid injections, cervical facet injections, cervical median nerve branch blocks, and cervical rhizotomies. *Id.* Dr. Mirkovic noted that "[t]he extent and aggressive nature of the nonoperative care that [Petitioner] underwent during that period of time, without significant improvement, also emphasizes the inability to identify a clear pain generator, to explain the patient's symptoms." *Id.*, (emphasis in original).

Dr. Mirkovic further noted that, based on his understanding that Petitioner's "vehicle was traveling at approximately 5 to 10 miles per hour, due to traffic, secondary to the snow… the patient's vehicle got stuck in the snow and that subsequently, there was no evidence of damage to the vehicle. The mechanism of the events described would not have been of sufficient magnitude to permanently cause, aggravate, accelerate or exacerbate [Petitioner's] pre-existing chronic cervical condition." *Id.* Dr. Mirkovic indicated that Dr. Llerena's February 18, 2014 noted post-hospitalization for a stroke work-up reflects that Petitioner did not present with complaints of increased neck pain or any new clinical or neurological findings in relation to the cervical spine. *Id.* He also noted, among other significant findings in Petitioner's medical records, that Petitioner's February 15, 2014 cervical MRI was compared to the prior March 13, 2012 cervical MRI and the comparison did not show any structural change at C5-C6 or C6-C7, cord compression, which is consistent with a lack of clinically objective findings to suggest an ongoing cervical myelopathy to explain Petitioner's symptoms or a clear pain generator, and only showed moderate changes from C3-C4 and C4-C5, which was more likely than not progressive degeneration. *Id.*

Continued Medical Treatment

On January 12, 2015, Petitioner reported 75% improvement after his December 19, 2014 left atlantoaxial joint injection with remaining upper neck pain radiating to the cervical, but no radiation down the arm. PX11 at 27-30. He also reported that his lower neck pain remained resolved after his nerve blocks. *Id.*

Petitioner did not return to Dr. Chebes until March 11, 2016 for injections and Dr. Chebes noted Petitioner's report of 70% improvement thereafter at a follow up visit on March 24, 2016. PX11 at 31-36. He returned on April 12, 2016 at which point Dr. Chebes noted that Petitioner's cervicalgia was stable and decreased Norco was indicated. PX11 at 36-40.

On May 13, 2016, Petitioner saw Dr. Bertoglio reporting continuing pain in the upper-mid cervical region to the base of her neck on the left, and he began complaining of dizziness, dimming vision, and presyncope when turning his head in certain positions. PX11. Dr. Bertoglio noted that this was concerning for dynamic posterior

circulation compromise as assessed by Dr. Aranas. *Id.* Dr. Bertoglio diagnosed Petitioner with possible dynamic vertebral artery compression, C3-C4 spondylosis, and adjacent segment degeneration status post C4-C7 ACDF symptomatic with pain. *Id.* He recommended a dynamic angiogram and reviewed the case with another physician, Dr. Malisch. *Id.* Dr. Bertoglio indicated that if dynamic compromise was demonstrated at C3-C4, or no dynamic compromise was identified, then he would consider a C3-C4 ACDF for radicular pain and degeneration or at a different level if dynamic compression was identified. *Id.*

Petitioner returned to Dr. Bertoglio on June 10, 2016. PX11. Dr. Bertoglio noted that Petitioner's dynamic angiogram ruled out VA compression with head position, but Petitioner continued to report pain in the neck to the proximal shoulders/base of the neck posteriorly without significant change. *Id.* He diagnosed Petitioner with C3-C4 spondylosis/stenosis from adjacent segment degeneration. *Id.* Dr. Bertoglio discussed the option of another surgery vs. further pain management and noted that Petitioner would be considering his options including treatment with another pain management specialist since Dr. Chebes was leaving the practice. *Id.*

On July 13, 2016, Petitioner saw Arpan Patel, M.D. (Dr. Patel) for neck pain, upper back pain, and bilateral shoulder pain. PX11. Dr. Patel recommended a C4-C5 epidural steroid injection followed by dual diagnostic medial branch blocks at the two, C3, and C4 to determine if facet arthropathy is resulting in Petitioner's occipital headaches. *Id.* He also recommended considering radiofrequency ablation and trigger point injections to address the myofascial component of Petitioner's neck pain. *Id.*

Eric Steven White

Eric White (Mr. White) testified that he is employed by Respondent as a Senior Technical Professional Process and Quality Manager (Manager). He has been employed by Respondent for 16 years. On cross examination, Mr. White testified that he began working in this position at the end of March of 2014, which was a lateral move. Previously, Mr. White was a Manager of Network Services.

Mr. White testified that he is familiar with Petitioner, who was employed by Respondent from January of 2013 through March of 2014. Mr. White explained that he was Petitioner's supervisor.

Mr. White testified that there were severe snow storms and white-out conditions on January 30, 2014. He sent Petitioner out to work on this date and did not have any conversation with Petitioner until later in the day at approximately 11:30 a.m. or 12:00 p.m. Mr. White explained that he received a call from Petitioner while he (Mr. White) was at another location with another technician. Mr. White testified that he answered the call and the person calling identified himself as Petitioner. Mr. White testified that Petitioner told him that he had an incident regarding his vehicle. According to Mr. White, Petitioner told him that he had a car coming into his Lane as he was approaching a turn on route 20 and, to avoid a collision, Petitioner decided to go toward the right hand shoulder that had snow in it and he was stuck in the snow. Mr. White responded by asking Petitioner whether he was ok, to which Petitioner responded that he was. Mr. White testified that he asked whether everyone else was ok, to which Petitioner replied that there were no other vehicles involved, but he was unable to get out of the ditch. Mr. White told Petitioner to call "fleet," Respondent's automobile repair maintenance department.

Mr. White testified that he told Petitioner to have fleet pull him out of the ditch then, if it was possible to drive the vehicle, to go down the block to find a side-street parking lot or something and to stay out of traffic. Mr. White testified that he told Petitioner that he would then be there.

When Mr. White arrived, he testified that he found Petitioner in the parking lot of the Pingree Grove fire

house/police station. Mr. White testified that he saw the truck and Petitioner. He asked Petitioner again if he was ok, to which Petitioner responded, yes, that he had a little bit of a rush.

Mr. White testified that they looked at the vehicle and he asked Petitioner if anything was wrong with the vehicle. According to Mr. White, Petitioner responded that when the tow truck pulled him out of the ditch, he drove the truck in a straight line and there was something funky with the steering of the vehicle. Mr. White testified that he did not observe any damage to the vehicle. Next, he and Petitioner popped the hood of the vehicle and looked in the engine compartment, tire wells, and the whole front end of the vehicle where there was snow. Mr. White testified that he told Petitioner that since the vehicle could not be driven that he should call fleet and have it towed to the Elgin garage, where both he and Petitioner worked.

Next, Mr. White testified that an hour or so went by and he received a phone call from Petitioner. According to Mr. White, Petitioner stated that the mechanic looked at the vehicle and the issue was that the snow built up in the suspension area causing it to drive funny. Mr. White testified that he sent Petitioner back out to work in the same vehicle.

Mr. White was presented with Respondent's Exhibit 3, which is a blank booklet entitled "Motor Vehicle Accident Report." RX3. Mr. White testified that this form is used when a motor vehicle accident occurs with damage to Respondent's vehicle, a non-company vehicle, or any non-company property. He testified that they are known as "red books." Mr. White testified that these red books are filled out by the vehicle driver. Mr. White testified that Petitioner asked if he could fill out a red book on January 31, 2014 and they discussed that there was no property damage, motor vehicle damage, or non-company vehicle damage so it would be unnecessary to fill one out because there was no accident. Mr. White testified that Petitioner did not give him a filled out red book on January 31, 2014.

On cross examination, Mr. White testified that no pictures were taken of the vehicle on January 30, 2014. He maintained that there was no property damage, company vehicle damage, or no non-company property damage that would require completion of a red book. Mr. White testified that there was no accident. He also maintained that Petitioner did not give him a completed red book and that he did not instruct Petitioner to shred any red book. Mr. White testified that he contacted his supervisor, the area manager, and "because there was no injur[y], no property damage, no company vehicle damage, no non-company vehicle damage, that they considered it an incident and to record it as a non-medical incident."

Mr. White also testified about a "morning tailgate," which is a weekly meeting during which achievements are awarded and important company issues and topics are discussed. All U-verse technicians and managers attend these meetings. Mr. White testified that safety and work-place injuries are also discussed at these meetings. Mr. White explained that there was a morning tailgate on January 31, 2014 at which time he asked Petitioner to speak. Mr. White testified that he asked Petitioner to speak at that morning tailgate because they try to use "near miss incidents" as examples where an accident could occur, such as in severe snowstorm/white-out conditions, and he wanted Petitioner to share his story with the other technicians about how he avoided the accident. According to Mr. White, Petitioner went into detail of exactly what happened with the incident describing that he was driving on route 20 basically in a flat plain area that was very windy going 10 miles per hour because, he believed Petitioner said that, he could not see in front of him more than three feet and as he was coming up to a turn her, he saw headlights and a vehicle approaching his lane at which time he had to decide whether to continue on that path or toward the roadside median. Mr. White testified that Petitioner "ended the meeting saying that he went to the road side. The vehicle did not go back into its lane and with his quick thinking, that he walked away injury free."

Mr. White testified that Petitioner did not report any injury or physical complaints from January 31, 2014 through February 14, 2014 and he continued to work his regular duties operating the same vehicle that went into the ditch on January 30, 2014.

Mr. White explained that Respondent's policy is that once an injury occurs, the employee is supposed to notify the supervisor immediately or, if unavailable, another supervisor. Mr. White testified that if Petitioner had reported a workplace injury, Mr. White would have reported it in the Safety Injury Reporting (SIR) system. Mr. White testified that in his capacity as a manager, he has reported four workplace accidents in 18 months and he has never deviated from this process. On cross examination, Mr. White testified that the 18 month period was while he was a Manager of Network Services. He also testified that none of the metrics on which manager bonuses are based are attributable to safety. Rather, Mr. White testified that managers receive bonuses based only on efficiency, productivity, and dispatch efficiency metrics as well as attendance and whether his employed complete their training courses, etc.

Mr. White also testified that regarding the incident between Petitioner and Mr. Sacco on February 14, 2014. Mr. White testified that Mr. Sacco is a member of Respondent's management as of September of 2013. On February 14, 2014, Mr. Sacco was the Duty Manager after 4:00 p.m., which is the person that all technicians can contact after 4:00 p.m. with any work-related issues or questions. Technicians call also contact the duty manager to see if all work is completed that day.

On February 14, 2014, Mr. White testified that he left work at approximately 3:45 p.m. After leaving work, Mr. White testified that he did not have any contact with Petitioner other than a voicemail received on his company cell phone. Mr. White testified that Petitioner stated that he had an argument with Mr. Sacco and that he was probably going to lose his job and he also heard laughter as Petitioner hung up the phone. Mr. White testified that he tried to contact Petitioner, but the call went directly to voicemail so he then called Mr. Sacco. The following day, on February 15, 2014, Mr. White testified that Petitioner was working and subsequently stopped working because he understood that Petitioner possibly had a stroke. Petitioner did not return to work until February 20, 2014. On cross examination, Mr. White testified that he did not receive any paperwork regarding a stroke, but Petitioner provided a medical note stating that he was cleared for work.

On February 21, 2014, Mr. White testified that he had a meeting with Petitioner, Mr. Sacco and the union steward, Ed Bash (Mr. Bash) at approximately 8:15 a.m. The meeting took place in the sub-office at the Elgin garage and was in reference to Petitioner's actions on February 14, 2014 with Mr. Sacco. Mr. White testified that the meeting was an investigation into insubordination and violence in the work place. Mr. White testified that Petitioner seemed upset, stared at Mr. White during the whole meeting, and he did not want to answer questions. There was also argument among the meeting attendees. Mr. White testified that the meeting ended with Petitioner and the union steward, Mr. Bash, stating that they needed a couple of minutes after which they left the room. Mr. White testified that five minutes later Petitioner told him that he was leaving work, that they were causing him stress, and that he'd had it. According to Mr. White, Petitioner did not give any other reason.

On cross examination, Mr. White testified that no formal action has been taken because Petitioner has not returned to work. On re-direct examination, Mr. White explained that the collective bargaining agreement requires involvement by several departments and completion of investigation. As of February 21, 2014, Mr. White testified that Petitioner's work status was pending an investigation of a suspension pending termination. The investigation has not been concluded because Petitioner has not returned to work.

Mr. White maintained that Petitioner made no reports of work injuries whatsoever. Mr. White also testified that if an employee came to him with a completed red book, and it was refused, then that employee would likely

report it to the union steward. Mr. White denied that he ever told any employee to throw out a completed red book.

Then on March 3, 2014, Mr. White testified that he received a call from an unknown number and a woman identified herself as Terry, Petitioner's wife. Mr. White testified that Mrs. Donovan told him that she was having trouble submitting a workers' compensation claim to the claim department. Mr. White asked Mrs. Donovan why Petitioner was not making the claim himself. He also asked Mrs. Donovan when Petitioner was hurt, to which she responded that Petitioner "can't call and that [Petitioner] really hurt himself on January 30th but he didn't want to let you know." Mr. White testified that he told Mrs. Donovan that he would contact the claim department after he contacted his supervisor, and did so.

Louis Sacco

Louis Sacco (Mr. Sacco) testified that he is employed by Respondent as an Internet Entertainment and Field Services (IEFS) employee. Mr. Sacco was Petitioner's manager in this role, and had been so employed for three years since September of 2013. On cross examination, Mr. Sacco testified that while he was previously a technician working with Petitioner he was also a garage union steward and elected chairman.

On February 14, 2014, Mr. Sacco was a manager in Petitioner's garage. He testified that on February 14, 2014 he was the Evening Duty Manager, which is the manager that takes responsibility at 4:00 p.m. to ensure that the work is covered and all technicians are out of the field safely at the end of the evening. On this evening, Mr. Sacco testified that he received a voicemail from Petitioner on his company cell phone between 5:00 p.m. and 6:00 p.m. Mr. Sacco testified that he did not listen to the voicemail, but returned Petitioner call. On cross examination, Mr. Sacco testified that he was at home at that point because he had been at work since 7:00 a.m. that day and there is a rotation between the 11 managers to be the evening duty manager on any given day.

Mr. Sacco described the phone conversation. He testified that he asked Petitioner what was going on and apologized for missing his phone call. Mr. Sacco responded, "[n]othing. I'm going home." Mr. Sacco asked Petitioner what the process was going home at the end of the evening to which Petitioner responded "[t]o contact the duty manager and I did that, and you did not answer your [expletive] phone." He testified that he then asked Petitioner what he was supposed to do if he could not get a hold of the duty manager, to which Petitioner responded "that he had called [Mr. Sacco and Mr. Sacco] did not do [his] job as the duty manager and he was [expletive] going home." Mr. Sacco testified that he apologized to Petitioner explaining that he was on the phone with another technician at the time returning his call as quickly as he could. Mr. Sacco added that he asked Petitioner "[j]ust to make sure we're clear, what is the expectation for going home at the end of the evening[?]" According to Mr. Sacco, Petitioner "told [him that] he was not going to answer any more of [his expletive] duty questions."

Mr. Sacco testified that he asked Petitioner to please stop swearing at him at which point Petitioner said "when [Mr. Sacco] first got promoted into the garage, [Petitioner] tried to have everybody get along with [Mr. Sacco]. Now, he's going to have everybody turn [their backs] on [Mr. Sacco]." Mr. Sacco testified that he told Petitioner that he understood his feelings to which Petitioner responded "[t]his is why I want to leave the [expletive] garage because you're an [expletive] manager on a power trip." Mr. Sacco testified that he reiterated that he understood Petitioner's feelings but wanted to make sure that they were clear on the expectation. According to Mr. Sacco, Petitioner proceeded to talk and swear at him at which point he told Petitioner that if they could not continue the conversation without swearing or raising their voices, he would have to end the conversation. Petitioner then said "[y]ou're the reason for my high blood pressure. I'm going to file EEOCs and lawsuits against you to put your [expletive] on the hot seat." Other than the reference to his high blood

pressure, Mr. Sacco testified that Petitioner did not report any injury.

Mr. Sacco testified that he later received a text from Petitioner's work phone to Mr. Sacco's work phone asking who the duty manager was in Elgin the following day, to which he responded that he (Mr. Sacco) was the duty manager.

Mr. Sacco also testified about a text message exchange with Petitioner on February 15, 2014. Mr. Sacco testified that Petitioner sent him a text message, which stated that he had no "WAP," a wire access point for the wireless set top boxes. Mr. Sacco testified that he asked Petitioner whether anyone had one on their truck, to which Petitioner responded "[n]o[, n]obody has more than one." Mr. Sacco testified that he responded, ok, "[w]hen you need one, we'll cross that bridge when we get there."

Subsequent to this exchange, Mr. Sacco testified that he received a phone call from a woman who identified herself as Petitioner's wife. Mr. Sacco testified that Mrs. Donovan sounded frantic and she asked him whether he had spoken with Petitioner recently, to which Mr. Sacco testified that he spoke with Petitioner about 45 minutes to one hour ago. Mrs. Donovan stated that Petitioner was at the Moretti's parking lot on Route 20 slurring his words and mildly unresponsive. Mr. Sacco asked Mrs. Donovan if she had called 911, which she stated she had. Mr. Sacco testified that he then called Petitioner on another phone and he answered. Mr. Sacco explained that Petitioner was not very responsive and he was slurring his words. Then, Mr. Sacco heard sirens and then some people knocking on Petitioner's vehicle. A couple of seconds later the call ended. Afterward, Mr. Sacco drove to the company vehicle to ensure it was locked and secured and drove to the hospital where Petitioner was received.

At the hospital, Mr. Sacco testified that Mrs. Donovan introduced herself and he asked her how Petitioner was doing after which they went outside to smoke and Mrs. Donovan asked Mr. Sacco if he could drive her back to her car located at the Moretti's parking lot. Mr. Sacco did so.

Mr. Sacco also testified that about a meeting held on February 21, 2014 to discuss what happened on the phone between him and Petitioner. On cross examination, Mr. Sacco testified that he is not aware of any EEOC filing from Petitioner filed prior to February 14, 2014. He denied every telling Petitioner that he could work Petitioner as many hours as he wanted to and that he could work him like a dog.

Theresa Donovan

Theresa Donovan (Mrs. Donovan) testified that she understands that there was an incident where Petitioner's work vehicle went off the road.

Mrs. Donovan testified that she contacted Mr. White on one occasion via telephone on the day that the workers' compensation claim was filed, on or about March 3, 2014. Mrs. Donovan testified that she told Mr. White that they needed to get the workers' compensation claim filed for Petitioner's accident to which Mr. White responded that Petitioner had back problems prior and the accident did not have anything to do with Petitioner's current back problems. Mrs. Donovan responded that if he (Mr. White) would not file the claim, then they would have to do that on their own. She also testified that Petitioner had tried to file the claim 2-3 times and Mr. White completely ignored that part of the conversation. Mrs. Donovan testified that the conversation ended with Mr. White telling her that he would call her back and he did so 20 minutes later with the workers' compensation claim number.

On cross examination, Mrs. Donovan testified that she has been married to Petitioner for 35 years and she was

aware that he was involved in disciplinary action at work involving Mr. Sacco stemming from an incident or altercation. Mrs. Donovan denied that Mr. White asked her why Petitioner did not report the workers' compensation claim himself.

Additional Information

Petitioner testified that from March 1, 2014 to the date of the hearing he has continued to undergo pain management, currently with Dr. Patel. Petitioner has also undergone various injections and pain management modalities. In addition, Petitioner testified that he has had three in-patient stays at medical facilities. He explained that none of his physicians have released him to full duty work or back to work in any capacity. Petitioner has applied for social security disability benefits and he received benefits as of February of 2014. PX7. Petitioner testified that he has not sustained any additional injuries after January 30, 2014.

Petitioner testified that he had not received any temporary total disability payments from Respondent. However, he did receive either short or long term disability benefit payments from Respondent. In addition, Petitioner's medical bills have been paid by Respondent's group health insurance carrier.

Regarding his current condition of ill-being, Petitioner testified that he has limited motion in his neck to the left as well as up and down. He described that some days are good and a couple of hydrocodone tablets are sufficient whereas other days he cannot get out of bed or his recliner because of the discomfort. Petitioner takes up to four hydrocodone tablets per day. He testified that he uses heat packs and tries to do some exercise and as much as he can, but he stops when he feels pain.

On cross examination, Petitioner testified that he has not operated a motorcycle since his accident.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

Given the totality of this record, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable injury on January 30, 2014 as claimed. In so concluding, the Arbitrator does not find Petitioner's testimony to be credible, as it is controverted by the testimony of Mr. White and Mr. Sacco as well as unsupported by his reports to his own medical providers. The Arbitrator also finds the opinions of Respondent's records reviewer, Dr. Mirkovic, to be persuasive regarding the cause of Petitioner's cervical condition compared to Dr. Bertoglio. First, the Arbitrator addresses Petitioner's testimony.

Petitioner did not receive any medical treatment for his cervical spine condition until after receiving treatment for stroke-like symptoms on February 15, 2014. The medical records prior to January 30, 2014 reflect that Petitioner's cervical spine condition was severely degenerated. The medical records also reflect that Petitioner did not report that he was in an accident at work on January 30, 2014 while being treated in the emergency room. Mrs. Donovan, who also provided information when Petitioner's history was being taken by the attending physician, did not report any accident at work on January 30, 2014. It was not until February 18, 2014, after Dr. Llerena told Petitioner that he did not suffer from any cerebral event on February 15, 2014 and that his cervical condition likely stemmed from degeneration that Petitioner first reported any traumatic event causing the symptoms in his neck. It is in this context that Petitioner's testimony is considered.

Petitioner also described a more rigorous event when his truck skidded into a ditch on January 30, 2014 than what was described by Mr. Sacco or reflected in the condition of the truck thereafter. Petitioner testified that on January 30, 2014 he was driving his work truck at about 45-50 mph, but slowing down for a curve in the road, when he saw oncoming headlights coming into his lane. He explained that he swerved to avoid an accident ending up in a ditch on the side of the road. Despite the decreasing speed coming up to the curve in the road, Petitioner described that he was bouncing around in the cab of the truck "almost like sitting on a bronco buck[, and...] being tossed around."

However, several facts are undisputed when considering Petitioner's and Mr. White's testimony. Petitioner's work truck had to be retrieved by a tow truck from the ditch and placed back onto the side of the road. Petitioner drove the truck to the parking lot of a police station from where it was towed back to Respondent's garage and repaired. The following morning, on January 31, 2014, Petitioner resumed use of the same truck. There is simply no evidence of any mechanical problems as a result of the January 30, 2014 incident requiring repairs beyond thawing out snow. Petitioner's contention that he was involved in a vehicular incident sufficient to bounce him around the cab of the truck like a bucking bronco at a rate of speed higher than 10 miles per hour is unlikely, but there are other indications in the record that Petitioner's testimony is less than reliable.

According to Petitioner, he was going to file a police report, but did not after speaking with his supervisor, Mr. White, who went to the police parking lot to inspect the truck with Petitioner. Petitioner testified that he completed a red book with details about the accident on January 30, 2014, which he presented to Mr. White the

following day when he asked Mr. White to complete an accident report. At a minimum, Petitioner and Mr. White agree that Mr. White told Petitioner that there was no need to fill out a red book. However, Mr. White repeatedly denied that Petitioner presented him with any red book or that there was any need to fill one out. Petitioner and Mr. White's testimonies, taken together, along with the functionality of Petitioner's truck the morning after the incident on Route 20, support Mr. White's testimony that according to Respondent's policies there was no need to complete a red book because there was no evidence of damage to the truck, Petitioner, or any non-company property or other individual.

Petitioner had also previously filed a workers' compensation claim and was familiar with Respondent's policies regarding such claims. Petitioner asserts that for two weeks after his accident he continued to work despite increasing soreness in the neck through February 15, 2014 to the extent that he could barely turn his neck to the left. This relatively short period of time between the accident, as described by Petitioner, and his first medical treatment of any kind thereafter is not dispositive on the issue of whether Petitioner's alleged trauma in his work truck on January 30, 2014 would be sufficient to cause a compensable aggravation of his already severe cervical spine condition. However, Petitioner's hospitalization for stroke-like symptoms on February 15, 2014 was preceded by an unpleasant conversation with his supervisor, Mr. Sacco, the day before. The history that Petitioner or his wife provided in the emergency room does not refer to any incident in his truck at work on January 30, 2014 or any increased soreness in the neck over several weeks thereafter.

Petitioner followed up with Dr. Llerena on February 18, 2014. He did not report any accident at work at this time. Dr. Llerena diagnosed Petitioner with cervical spinal stenosis with severe restriction of extension and no evidence for CVA, which Dr. Llerena indicated could be the cause of Petitioner's symptoms. Petitioner admitted that he understood from Dr. Llerena that he did not sustain a cerebral accident or TIA. The medical records of Dr. Llerena are devoid of any reference by Petitioner of his reportedly severe neck pain at that time to the events of January 30, 2014. It was only after Dr. Llerena informed Petitioner that the degeneration could be a cause of his symptoms—and after Petitioner's conversation with Mr. Sacco—that Petitioner first reported that the events of January 30, 2014 could have caused his condition and when Petitioner did so on February 21, 2014 it was on the same day that he was told about impending disciplinary action at work.

On February 21, 2014, Petitioner completed a form for Dr. Bertoglio in which he described his injury after he "PUT WORK TRUCK IN DITCH TO AVOID HEAD ON ACCIDENT[.]" PX1 (EMPHASIS in original). While it might be wholly plausible given another global set of facts that Petitioner was simply a patient awaiting diagnoses from his physicians to understand the cause of his physical condition to that point, Petitioner had previously filed an workers' compensation claim and was, therefore, not wholly unfamiliar with the process. Petitioner was aware of the pending disciplinary action against him at work when he went to the emergency room on February 15, 2014 for stroke-like symptoms. Mrs. Donovan was also aware of the discipline when she called Petitioner's supervisor, Mr. White, on March 3, 2014 to report that he did not want to tell him about the accident at work and was having difficulty filing a workers' compensation claim.

Petitioner was able to work after dozens of cervical injections, nerve branch blocks and ablations that ended approximately six and a half months before his alleged trauma on January 30, 2014. Petitioner was also able to work for two weeks despite purportedly increasing soreness, but did not report any trauma attributable to the January 30, 2014 events until after he was subjected to discipline at work that might include termination—and, consequently, a termination of his workers' compensation and group insurance benefits—and after his own physician told him that it was not likely a stroke that caused his symptoms, but rather his cervical degenerative disease. Petitioner's wife, not Petitioner, also testified that he was having trouble filing a workers' compensation claim, but he had filed and settled such a claim previously without a problem. The involvement of Mrs. Donovan between her husband and his supervisor might be explained by the fact that he had a stroke on

February 15, 2014, but that was not her testimony. Moreover, Petitioner's memory was suspiciously clear on direct examination, when it served to support his theory of recovery, compared to cross examination. Petitioner was notably unable to remember the discussion during the disciplinary meeting on February 21, 2014 or specifics about the conversation that generated the discipline with Mr. Sacco on February 14, 2014, the day before he was taken to the emergency room. Petitioner's testimony under these circumstances is questionable.

Mr. Sacco also provided testimony in contravention of Petitioner's version of events about the discussion they had on February 14, 2014. While Mr. Sacco explained his statements to Petitioner with more finesse than he described Petitioner's statements during the conversation, Mr. Sacco had a clear memory of events on both direct and cross examination. Notwithstanding, it is not solely Mr. Sacco's testimony, or Mr. Sacco and Mr. White's testimonies taken together, that diminish the reliability of Petitioner's testimony; it is the totality of the record including the sequence of events, comparison of Petitioner's testimony to his reports as reflected in the medical records, and comparison of Petitioner's testimony to that of both Mr. White and Mr. Sacco that brings Petitioner's testimony into question. In light of the record as a whole, the Arbitrator does not find Petitioner's testimony to be credible.

Next, the Arbitrator addresses the medical records and physicians' opinions. Respondent did not require Petitioner to submit to a Section 12 examination. Instead, it engaged Dr. Mirkovic to perform a review of Petitioner's treatment records. Mr. Mirkovic rendered various opinions regarding the relatedness, if any, of Petitioner's cervical spine condition to the events of January 30, 2014. Dr. Mirkovic plausibly determined that it was Petitioner's severe cervical degenerative disc disease that caused Petitioner's need for medical treatment and not a vehicular incident at work on January 30, 2014.

Dr. Mirkovic noted the extensive and aggressive nature of Petitioner's pre-2014 nonoperative care for the cervical spine ending in mid-2013 noting that Petitioner's own physician at that time was unable to identify a clear pain generator to explain his symptoms. Dr. Mirkovic also noted that, based on his understanding that there was no evidence of damage to Petitioner's vehicle as a result of the January 30, 2014 incident, the mechanism as described was of insufficient magnitude to permanently cause or aggravate Petitioner's pre-existing cervical condition. Dr. Mirkovic further highlighted that Petitioner's February 15, 2014 cervical MRI was compared to the prior March 13, 2012 cervical MRI. This comparison failed to show any structural change at C5-C6 or C6-C7 or cord compression, which he believed was consistent with a lack of clinically objective findings suggesting ongoing cervical myelopathy explaining Petitioner's symptoms and failing to suggest a clear pain generator. Dr. Mirkovic also stated that the MRI comparison only showed moderate changes from C3-C4 and C4-C5, which was more likely than not progressive degeneration rather than an acute process.

By contrast, Petitioner's treating physician, Dr. Bertoglio, opined that Petitioner's pre-existing cervical stenosis was exacerbated by the recent motor vehicle accident at work and the cervical spine condition was, therefore, work-related. Dr. Bertoglio noted Petitioner's report on February 21, 2014 of "neck pain has been severely exacerbated by a MVA 2-3 weeks ago when he drove into a ditch to avoid a head-on collision with an errant vehicle[.]" However, this history of the onset of Petitioner's symptoms is undermined by the lack of Petitioner's neck complaints for weeks after a purportedly traumatic, acute exacerbation of severely degenerative cervical disease on January 30, 2014 until after a breakdown in his employment relationship. Petitioner also had attended a disciplinary meeting the very same day that he first reported neck symptoms purportedly stemming from his truck incident at work. Petitioner barely remembered the conversation, but testified that he was accused of threatening Mr. Sacco, which he also failed to recall. Petitioner admitted that there were allegations being raised by Respondent against him at that time, but explained that it was the amount of pain that caused him to state that he was going to see a doctor. Petitioner did exactly that in seeing Dr. Bertoglio, but the motivation to do so is not likely a traumatic bucking bronco-type vehicular incident at work

on January 30, 2014 that would have likely caused severe symptomatology and a more timely search for medical attention, but rather a work-related disciplinary dispute that could lead to his termination of employment. The Arbitrator does not find Dr. Bertoglio's opinion based on Petitioner's reports to be persuasive when considering the record as a whole.

In sum, given the sequence of events including Petitioner's lack of cervical complaints after an accident he described as bouncing him around like a bucking bronco, the lack of damage to the truck, the lack of medical treatment until the day after a verbal altercation with his supervisor that lead to discipline possibly including termination, and the lack of cervical complaints during emergency room treatment or until after his own physician (Dr. Llerena) told him that his symptoms were likely degenerative in nature, the Arbitrator finds that Dr. Mirkovic had a fair understanding of the mechanism of Petitioner's alleged injury and the most likely, medically plausible source of his cervical spine condition thereafter. The Arbitrator finds the opinions of Dr. Mirkovic to be persuasive in this case.

Based on all of the foregoing, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable injury at work on January 30, 2014 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

In support of the Arbitrator's decision relating to Issue (M), whether penalties and fees should be imposed on Respondent, the Arbitrator finds the following:

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's alleged injury on January 30, 2014 was compensable and arose out of his employment as alleged. The testimony of Respondent's witnesses, Mr. White and Mr. Sacco, refute Petitioner's version of events. Moreover, the opinions of Respondent's records reviewer, Dr. Mirkovic, plausibly establish that Petitioner's cervical condition was due to his severe, documented cervical degenerative condition rather than his incident in a truck at work. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kimberly Meeks,
Petitioner,

vs.

Cook County Public Defender,
Respondent.

17IWCC0621

NO: 13 WC 7609

DECISION AND OPINION ON REVIEW

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

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

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

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

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

DATED: OCT 5 - 2017
o9/28/17
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain her burden of proving that her current conditions of bilateral carpal tunnel syndrome and tensynovitis/trigger finger in the right ring finger and left middle finger were caused by work activities, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner testified she worked for Respondent since 1999. In the three years prior to February of 2013 she was designated as stenographer IV, though she did not specifically engage in stenography, and also worked as a clerk. Her job entailed typing information on a computer keyboard for public defenders. She estimated that she was typing for 80% of the time from 2010 to 2013. When defendants are in custody [she had] to input information on each defendant, which is a lot." Her typing was continuous and rapid. She typed 80 words a minute. She normally took about three, 15-minute breaks during a workweek. Petitioner's alleged repetitive keyboarding is the only basis for arguing her conditions are related to her work activities.

Petitioner presented to Dr. Kronen reporting she developed significant pain in her hand with numbness/tingling over the past two to three years, but it was worsening. She had been a "stenographer" for Cook County Jail "for a very long period of time with constant typing." An EMG was "minimally positive" for carpal tunnel syndrome. Dr. Kronen diagnosed bilateral carpal tunnel syndrome, flexor tenosynovitis, and basal joint arthritis. On March 25, 2013, Dr. Kronen performed radical flexor tensynovectomy of the right wrist, right carpal tunnel release, and injection in the right thumb basal joint. On May 14, 2013, Dr. Kronen performed release of the tendon sheath of the right 4th finger. In a letter to Petitioner's lawyer, Dr. Kronen opined that her carpal tunnel syndrome and right 4th trigger finger were causally related to her repetitive activity.

On March 14, 2014, Petitioner presented to Dr. Ellis for a medical examination under Section 12 of the Act. After his review of her medical records and examination, Dr. Ellis opined that Petitioner's bilateral carpal tunnel syndrome and trigger finger were not related to her work activities. He explained that "routine clerical work has never been demonstrated to be causative or contributory to the development of carpal tunnel syndrome." Her carpal tunnel syndrome and arthritis are idiopathic and her diabetes was contributory to both carpal tunnel syndrome and trigger finger.

In finding Petitioner proved accident and causation, the Arbitrator found the opinion testimony of Dr. Kronen more persuasive than Dr. Ellis. By affirming and adopting the Decision of the Arbitrator, the majority is confirming that assessment, an assessment with which I disagree. In my opinion Dr. Ellis' conclusions were more persuasive than Dr. Kronen. I agree with his opinion that repetitive keyboarding alone does not cause, or contribute to, carpal tunnel syndrome. I also agree with his assessment of the importance of vibration and/or repetitive forceful gripping as a principle cause of that condition as opposed to simply repetitive activity.

In addition, Dr. Kronen assumed that Petitioner was performing her current functions for "a very long time," 13&½ years. However, at arbitration Petitioner was specifically asked only about her job activities for the three years immediately prior to her alleged date of manifestation. Directing Petitioner to testify specifically about her activities during that time period suggests that her job activities changed and she did not necessarily have the same job activities throughout

her employment with Respondent. In addition, Dr. Kronen believed incorrectly that Petitioner was actually engaged in stenography. Petitioner complained about the use of a different keyboard and its position, Petitioner did not provide information as to how long she used it. Finally, Dr. Ellis noted Petitioner's long-standing insulin-dependent diabetes, which is a condition known to be contributory to the development of both carpal tunnel syndrome and trigger finger. Dr. Kronen did not address the issue of Petitioner's diabetes in his causation opinion.

Based on the persuasive opinions of Dr. Ellis, I would have found that Petitioner did not sustain her burden of proving an accident or a causal connection between her work activities and her conditions of ill-being, reversed the Decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0621

MEEKS, KIMBERLY
Employee/Petitioner

Case# **13WC007609**

COOK COUNTY PUBLIC DEFENDER
Employer/Respondent

On 11/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0132 STATES ATTORNEY OF COOK COUNTY
CYNTHIA ASHFORD-HOLLIS
500 RICHARD J DAALEY CENTER
CHICAGO, IL 60602

17IWCC0621

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

Kimberly Meeks
Employee/Petitioner

v.

Cook County Public Defender
Employer/Respondent

Case # **13** WC **7609**

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **9/22/16 and 10/21/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/21/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** sustain repetitive trauma injuries arising 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 that Petitioner established causation as to bilateral carpal tunnel syndrome, finger triggering and tenosynovitis but not as to bilateral basal joint arthritis.

In the year preceding the injury, Petitioner earned **$43,411.68** ; the average weekly wage was **$834.84**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **1** dependent child.

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

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

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

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

ORDER

Medical benefits

Respondent shall pay Petitioner reasonable and necessary medical services of $34,574.00, as provided in Sections 8(a) and 8.2 of the Act. For the reasons set forth in the attached decision, the Arbitrator declines to award certain claimed charges that relate to care of the right hip and basal joint arthritis. PX 4.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $556.56/week for 29 1/7 weeks, commencing 4/1/13 through 8/11/13 and 11/25/13 through 2/3/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 2/21/13 through 10/21/16, and shall pay the remainder of the award, if any, in weekly payments.

Permanent Partial Disability

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of each hand (51.25 weeks), 30% loss of use of the right ring finger (8.1 weeks) and 15% loss of use of the left middle finger (5.7 weeks) pursuant to Section 8(e) of the Act.

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

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

Molly C Mason

Signature of Arbitrator

11/2/16
Date

NOV 2 - 2016

Kimberly Meeks v. Cook County Public Defender
13 WC 7609

Summary of Disputed Issues

Petitioner, a longtime stenographer and clerk, alleges bilateral carpal tunnel syndrome, trigger finger conditions and tenosynovitis secondary to repetitive trauma. Petitioner alleges a manifestation date of February 21, 2013.

The disputed issues include accident, causal connection, medical expenses, temporary total disability during two post-operative intervals and nature and extent. Arb Exh 1.

Procedural Note

This case was bifurcated, with no objection from Petitioner, so as to allow Respondent to check its documents concerning Petitioner's claimed lost time. The Arbitrator closed proofs on October 21, 2016. Neither party presented any evidence on that date.

Arbitrator's Findings of Fact

Petitioner testified she originally began working for Respondent in February 1999. She left for a period thereafter but returned on November 8, 1999.

Petitioner testified she performed two distinct jobs, stenographer and clerk, for Respondent during the three years before February 21, 2013. She was originally a stenographer but had to take on the clerk job due to layoffs.

Petitioner testified that both of her jobs required extensive typing and data entry. As a stenographer, she typed various documents, including motions, letters and memos, for public defenders. As a clerk, she had to input data for various defendants as they were taken into custody. She typed on a computer keyboard, using both hands. She estimated she typed at a speed of 80 words per minute between 2010 and 2013.

Petitioner testified she worked from 8 AM to 4 PM, Monday through Friday. She regularly took a lunch break from noon to 1 PM. She was allowed to take two additional 15-minute breaks each workday but did not always do so, due to the press of work. She estimated she took about three 15-minute breaks per week.

Petitioner testified that, about a year before February 21, 2013, she began noticing pain in her hands, wrists, palms and all of her fingers when typing. Her symptoms progressed over time. She denied having symptoms at night during this period. She informed her supervisor, Maureen Gluffee. [Notice is not in dispute.]

Petitioner initially testified she first sought treatment for her condition on February 21, 2013, when she saw Dr. Kronen, a hand surgeon. She then added that she also saw her personal care physician, Dr. Hagan, and underwent an EMG.

Many of Dr. Hagan's records (RX 2) are handwritten and difficult to read. A note dated September 28, 2012 reflects that Petitioner complained of left hand pain secondary to a dispenser falling onto her hand at McDonald's that day. The note appears to state: "the whole dispenser fell on the left hand – it just happened today at McDonald's." On examination, Dr. Hagan noted some left hand swelling. RX 2, C47. She ordered left hand X-rays, which were performed at Advocate Christ Medical Center the same day. The radiologist noted no fractures, dislocations or other bony abnormalities. He indicated he compared the results with an earlier X-ray of July 16, 2011. RX 2, C77. No report concerning the earlier X-ray is in evidence.

Dr. Hagan's next note is dated January 14, 2013. The history appears to read as follows: "her hands hurt every day – it doesn't move up her arms – it's every day at ____ [illegible] – it's been terrible." The doctor prescribed an EMG and bilateral hand X-rays. RX 2, C46.

The bilateral hand X-rays, performed on January 21, 2013, were unremarkable, with the radiologist noting no atrophy or calcifications. RX 2, C67.

On February 14, 2013, Dr. Hagan noted that Petitioner was still experiencing hand pain and was awaiting an EMG. RX 2, C44.

According to Respondent's Section 12 examiner, Dr. Ellis, Petitioner underwent EMG and nerve conduction testing by Dr. Adair on February 19, 2013. This testing showed "very mild bilateral median neuropathies at the level of the wrist consistent with carpal tunnel syndrome." RX 1. The EMG/NCV report is not in evidence.

On February 21, 2013, Petitioner saw Dr. Kronen, a hand surgeon affiliated with MidAmerica Orthopaedics. The doctor identified Dr. Hagan as the referring physician. He noted complaints of pain, numbness and tingling in both hands and pain in "multiple digits." He also noted that Petitioner reported working as a stenographer at the Cook County Jail "for a very long time with constant typing on the stenograph machine during the day." He indicated that Petitioner "has had a rheumatoid work-up which was negative." He also indicated he reviewed X-rays and the EMG.

On examination, Dr. Kronen noted a limited range of motion in both hands secondary to pain and swelling. He also noted "significant swelling in the palmar aspects of the hands bilaterally at the level of the A1 pulley with some triggering of the right ring finger flexor tendon and evidence of tenosynovitis in all of the digits." He further documented "pain at the CMC joint of the thumb" and positive grind, median nerve compression and Tinel's testing.

Dr. Kronen described Petitioner as having severe carpal tunnel syndrome from a symptomatic perspective, while acknowledging that the EMG was only "minimally positive." He

discussed treatment options for both this condition and the flexor tenosynovitis. He indicated that Petitioner expressed a desire to undergo surgery rather than injections.

Dr. Kronen addressed causation as follows:

> "She informs me that she does feel that this may have developed due to her work as a stenographer, which she has been doing for 13 years specifically due to the fact that there is a specific definitive repetitive activity requiring her to type on the machine for 8 hours continuously."

PX 4.

Petitioner identified PX 1 as an accident report she completed on February 26, 2013. In this report, Petitioner described her two jobs. She indicated she typed consistently throughout each day and also performed other clerical tasks, including coding, faxing and moving files. She stated she had begun experiencing symptoms in her hands and fingers several months earlier but initially did not know the cause of these symptoms. She also described her work equipment:

> "I also was given a temporary keyboard by my supervisor (while my keyboard was being repaired) for a length of time, which seemed to have made my hands have more pain than usual. I told my boss the keyboard was too low and very uncomfortable to type with. She said my keyboard was still being repaired. I asked for another one, none available. I also had severe pain with my regular keyboard as well but temporary keyboard was more painful."

Respondent raised no objection to PX 1.

On March 22, 2013, Dr. Kronen performed the following surgical procedures: a right carpal tunnel release, a radical flexor tenosynovectomy of the right wrist and a right thumb basal joint arthritis injection. PX 4.

A nursing note dated March 23, 2013 reflects that Petitioner called Dr. Kronen's office that day, spoke with Dr. Brisbin and reported various symptoms which she attributed to Vicodin, a pain medication prescribed by Dr. Kronen. Dr. Brisbin noted a history of well-controlled diabetes and hypertension. She started Petitioner on Tramadol and Naprosyn. PX 4.

Petitioner returned to Dr. Kronen on April 1, 2013, with the doctor noting slight improvement of the numbness and tingling, along with a "much better range of motion of [the] fingers." He identified "triggering now of the right 4th digit." He injected this finger with Kenalog. PX 4.

On April 15, 2013, Petitioner saw Dr. Kronen again and complained of persistent triggering of the right fourth finger. On re-examination, the doctor noted persistent triggering and tenderness at the base of the fourth right digit overlying the A1 pulley. He recommended a pulley release, noting that Petitioner did not respond to the injection. PX 4.

In April and May of 2013, Petitioner saw Dr. Brisbin for bilateral hip pain. PX 4. At the hearing, Petitioner described her hip condition as non-work-related.

On May 14, 2013, Dr. Kronen performed a trigger release of the right ring finger. In his operative report, he documented "severe thickening of the A1 pulley." At the doctor's direction, Petitioner continued attending occupational therapy following this procedure. PX 4.

On June 13, 2013, Dr. Kronen noted that Petitioner reported improvement and was no longer experiencing numbness, tingling or triggering. He recommended two more weeks of therapy and indicated he would schedule the left hand surgery if all was well at that point. He released Petitioner to left-handed work. PX 4.

On June 27, 2013, Dr. Kronen described Petitioner as "doing well" with respect to her right hand. He indicated he planned to schedule the left carpal tunnel release. PX 4.

On July 9, 2013, Dr. Kronen operated on Petitioner again, performing a left carpal tunnel release. PX 4.

On July 16, 2013, Dr. Kronen sent a lengthy narrative report to Petitioner's counsel, outlining his examination findings and causation-related opinions. He indicated he viewed Petitioner as having severe carpal tunnel syndrome from a clinical standpoint, despite the minimally positive EMG results, based on the duration and intensity of Petitioner's symptoms. He indicated he first took Petitioner off work on April 1, 2013 and that she remained off work despite his having cleared her for light duty because her employer could not accommodate her. He addressed causation as follows:

> "Given the patient's description of her job activities which clearly require substantial amounts of repetitive activity as a stenographer, to a reasonable degree of medical and surgical certainty the development of her flexor tenosynovitis bilaterally, carpal tunnel syndrome bilaterally and trigger digit of the right 4th [finger] are work-related conditions. With respect to her basal joint arthritis, despite the fact that she does repetitive activity, it is my opinion that this is not a work-related condition and should be handled under her private medical insurance."

PX 4.

On July 22, 2013, Petitioner returned to Dr. Kronen and reported resolution of her left hand numbness and tingling. The doctor removed the sutures and prescribed occupational therapy. PX 4.

At the next visit, on August 8, 2013, Dr. Kronen described Petitioner as "doing well." He cleared Petitioner for full duty as of August 12, 2013 but prescribed two more weeks of occupational therapy. PX 4.

Petitioner returned to Dr. Brisbin on August 27, 2013 and complained of acute right hip pain secondary to wearing high heels while attending a funeral. The doctor recommended against an injection, noting Petitioner's history of diabetes. She prescribed Naprosyn and home exercises. PX 4.

On September 19, 2013, Dr. Kronen noted satisfactory wound healing. He also noted that Petitioner had resumed full duty. He placed Petitioner at maximum medical improvement and released her from care on a PRN basis. PX 4.

Petitioner returned to Dr. Kronen on October 7, 2013 and complained of swelling in her right ring finger. On examination, the doctor noted tenderness and swelling at the base of that finger, overlying the released annular pulley, but no triggering. He injected the finger and allowed Petitioner to continue full duty. PX 4.

On October 28, 2013, Petitioner returned to Dr. Kronen and reported ongoing swelling and pain in her right ring finger. The doctor's examination findings were unchanged. He prescribed occupational therapy and ordered autoimmune panel testing "to determine whether there is any underlying autoimmune disease which could be causing this problem as well." PX 4.

Petitioner returned to Dr. Kronen on November 25, 2013 and complained of persistent problems with her left middle finger and right ring finger. After re-examining Petitioner, the doctor recommended right ring finger surgery and a left middle finger injection. He noted that Petitioner expressed a desire to take care of her right hand before proceeding with any left-sided intervention. PX 4.

On December 3, 2013, Dr. Kronen operated on Petitioner's right hand again, performing a flap closure and a flexor tenosynovectomy of the right ring finger. In his operative report, he noted "significant scar tissue as well as severe flexor tenosynovitis of the flexor digitorum superficialis and flexor digitorum profundus tendons proximal to the area where [Petitioner] had the previous surgery for her trigger digit release." PX 4.

On December 16, 2013, Dr. Kronen directed Petitioner to continue therapy for the right ring finger. He released Petitioner to primarily left-handed work. PX 4.

At the next visit, on December 30, 2013, Dr. Kronon recommended additional therapy for the right ring finger and indicated he planned to proceed with left middle finger surgery in 2014. PX 4.

On January 7, 2014, Dr. Kronen operated on Petitioner's left middle finger, performing a trigger release and flexor tenosynovectomy. PX 4.

At the first post-operative visit, on January 20, 2014, Dr. Kronen described Petitioner as "doing well." He recommended additional therapy. PX 4.

On February 3, 2014, Dr. Kronen prescribed additional therapy, noting "some grip strength weakness" in the left hand, and released Petitioner to full duty as of February 4, 2014. PX 4.

On February 24, 2014, Dr. Kronen noted that Petitioner was having difficulty fully extending her left middle finger. He prescribed various home exercises "to break down the scar tissue" and allowed Petitioner to continue full duty. PX 4.

Petitioner returned to Dr. Kronen on March 20, 2014 and complained of right ring finger pain and swelling. On examination, the doctor noted triggering of this finger at the level of the A2 pulley rather than the A1 pulley. He informed Petitioner that the A2 pulley is typically not released during a trigger digit operation. He administered an injection and allowed Petitioner to continue full duty. PX 4.

On April 10, 2014, Petitioner informed Dr. Kronen that her right ring finger triggering had resolved. The doctor released her from care on a PRN basis. PX 4.

Petitioner next saw Dr. Kronen on August 18, 2014. She complained of pain and triggering in both her right middle and ring fingers. The doctor noted some nodule formation and swelling but no triggering on examination. He injected both fingers. He indicated he discussed a "rheumatoid arthritis work-up" with Petitioner and learned from her that "this was just recently done and was negative." PX 4.

On August 27, 2014, Petitioner saw Dr. Kronen's partner, Dr. Moravek, and complained of right shoulder pain of five or six months' duration. According to the doctor, Petitioner did not recall injuring the shoulder but reported performing repetitive overhead activities and lifting at work. On examination, the doctor noted tenderness in the right biceps. He administered an injection and prescribed medication. PX 4.

On November 19, 2014, Petitioner returned to Dr. Moravek and reported doing well, shoulder-wise. The doctor prescribed home exercises and released Petitioner from care on a PRN basis. PX 4.

Petitioner saw Dr. Kronen the following day, November 20, 2014, and complained of persistent triggering in her right ring finger. On examination of that finger, the doctor noted triggering "with obvious swelling and tenderness." He recommended surgery. PX 4.

On January 12, 2015, Dr. Kronen noted that his request for right ring finger trigger surgery had been denied by workers' compensation. He noted triggering on examination and again recommended surgery. PX 4.

On September 24, 2015, Petitioner returned to Dr. Kronen and complained of left ring finger triggering of about two weeks' duration. The doctor indicated that Petitioner denied any history of trauma. He injected the left ring finger. PX 4.

On October 29, 2015, Petitioner saw Dr. Kronen again. She reported improvement of her left ring finger triggering and complained of minimal right hand pain. The doctor re-examined Petitioner and indicated he saw no need for treatment. PX 4.

On December 3, 2015, Petitioner returned to Dr. Kronen and complained of right middle finger triggering of several weeks' duration. The doctor injected the finger. PX 4.

Petitioner returned to Dr. Kronen on January 7, 2016 and reported incomplete resolution of her right middle finger triggering following the injection. The doctor recommended against performing another injection at that point "due to the increased risk of tendon rupture." He directed Petitioner to return in five weeks. PX 4.

At the next visit, on February 11, 2016, Petitioner again complained of right middle finger triggering. The doctor discussed various treatment options, including surgery, and administered another injection. PX 4.

On April 11, 2016, Petitioner returned to Dr. Kronen and complained of pain and swelling in her left ring finger. On examination, the doctor noted a reduced range of motion of that finger "with nodule formation, significant swelling and tenderness." He administered an injection. PX 4.

Petitioner testified she has undergone no additional care for her hands or fingers since her last visit to Dr. Kronen on April 11, 2016. She is not scheduled to return to Dr. Kronen in the future. At Dr. Kronen's direction, she remained off work between April 1 and August 12, 2013. She resumed full duty thereafter and was then off again from November 25, 2013 through February 4, 2014. She returned to full duty thereafter and still performs the same jobs for Respondent.

Petitioner acknowledged having been an insulin-dependent diabetic for eighteen years. She testified she tested negative for rheumatoid arthritis.

Petitioner testified she still experiences pain in both hands. Her right hand is worse than her left. She described the pain as "extensive." Her palms and the bases of her fingers swell when she types at work. Her right ring finger is beginning to bother her. Her work schedule has not changed. She experiences numbness in the middle and ring fingers of both hands. She experiences numbness at night at times but it is worse at work. The surgeries helped overall but her symptoms returned after she went back to work. She takes Tylenol along with medication prescribed by Dr. Kronen. She takes this medication at and after work. The medication helps "for a while."

Under cross-examination, Petitioner testified that Dr. Hagan has been her family physician since about 2011. She did not recall undergoing treatment for her hand and finger problems before February 21, 2013. When Respondent asked her about Dr. Hagan's note of September 28, 2012, which states that a dispenser at a McDonald's restaurant fell onto Petitioner's hand, Petitioner responded by saying "that is incorrect." Petitioner then acknowledged that the dispenser "came out" of the wall and that she underwent X-rays following this incident. She was unable to recall whether she complained of continued hand and new hip pain to Dr. Hagan on March 19, 2013. She indicated she cannot remember exact dates and would need to consult a calendar to be sure. She testified the EMG was prescribed due to her job-related pain rather than the dispenser incident. She has taken insulin for thirteen years. She also takes medication for high blood pressure. She is not sure how long she has taken this medication. She has been back to full duty since April 2015. She still has two job titles and continues to work on a computer. She denied being diagnosed with joint arthritis. When confronted with Dr. Kronen's note of July 16, 2013, which mentions joint arthritis, she replied, "that is incorrect."

On redirect, Petitioner acknowledged that a McDonald's cup dispenser did fall onto her hand, maybe in 2012. She underwent an EMG before February 21, 2013. Dr. Kronen released her to light duty at times but she never performed light duty. When she returned to work, she returned to full duty.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner's description of her job duties was credible and unrebutted. In PX 1, a lengthy accident report, Petitioner offered even more detail concerning the increased symptoms she developed while using a temporary keyboard. Respondent did not object to PX 1 or call any witness to rebut the contents of that document. Respondent's Section 12 examiner, Dr. Ellis, referenced a job description which indicated Petitioner was required to "constantly" use her hands for fingering, twisting and grasping. Respondent did not offer this job description into evidence.

Petitioner was somewhat evasive about the September 2012 McDonald's dispenser incident. Ultimately, she conceded a dispenser did fall onto her hand at McDonald's but she

distinguished this event from her ongoing hand-related job demands. The Arbitrator does not view the dispenser incident as having caused the conditions Petitioner claims in this case. Dr. Hagan's records show that Petitioner mentioned the incident at one visit, on September 28, 2012, and related that the dispenser struck only her left hand. Petitioner underwent left hand X-rays the same day. The results were negative. There is no evidence indicating Petitioner returned to Dr. Hagan thereafter until January 2013, when she complained of persistent bilateral hand pain. The Arbitrator finds credible Petitioner's testimony that the treatment she sought at this point was due to her work-related bilateral hand problems and not the dispenser incident. That incident involved only the left hand.

Did Petitioner establish repetitive trauma injuries manifesting on February 21, 2013? Did Petitioner establish a causal connection between those injuries and her claimed current bilateral hand/wrist and finger conditions of ill-being?

The Arbitrator finds that Petitioner established repetitive trauma injuries manifesting on February 21, 2013. The Arbitrator finds those injuries to include bilateral carpal tunnel syndrome, finger triggering and tenosynovitis of multiple fingers. In so finding, the Arbitrator relies on the following: 1) the duration of Petitioner's employment; 2) Petitioner's credible description of the keyboarding and data entry she performed while working for Respondent; 3) Petitioner's credible testimony that, during the three years before February 21, 2013, she actually performed two separate jobs, both of which involved keyboarding and data entry; 4) Petitioner's accident report (PX 1), which describes, in detail, problems she encountered with both her regular keyboard and a substitute keyboard that was "too low"; 5) the job description referenced by Respondent's examiner, Dr. Ellis; and 6) Dr. Kronen's medical records and July 16, 2013 report.

The Arbitrator acknowledges that Petitioner has taken insulin for diabetes for many years and that Dr. Ellis viewed diabetes as contributing to both the carpal tunnel and the finger triggering. The Arbitrator notes that Dr. Kronen expressed awareness of Petitioner's medical history and that his partner, Dr. Brisbin, documented Petitioner's diabetes in her April and May 2013 notes. PX 4. It is not as if Dr. Kronen was unaware of this condition when he commented on causation on July 16, 2013. Under Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (2003), an employer takes an injured worker as it finds him. The injured worker need only establish that the work activity was a cause of his condition. He need not exclude all other possible contributing causes.

The Arbitrator views February 21, 2013 as an appropriate manifestation date despite the fact Petitioner underwent an EMG, which showed carpal tunnel syndrome, two days earlier. It was on February 21, 2013 that Petitioner first learned, from Dr. Kronen, of a connection between her repetitive work duties and her conditions. Durand v. Industrial Commission, 224 Ill.2d 53 (2006).

The Arbitrator finds that Petitioner established causation as to her bilateral carpal tunnel syndrome and as to her trigger finger and tenosynovitis conditions of ill-being. In so

finding, the Arbitrator relies on the factors outlined above. Overall, the Arbitrator finds Dr. Kronen's causation-related opinions more persuasive than those of Dr. Ellis. Dr. Kronen saw Petitioner over an extended period of time while Dr. Ellis examined Petitioner once. Dr. Ellis's credibility was undermined by his failure to address the contents of Petitioner's accident report. He indicated he reviewed this report but his own report contains no mention of the keyboard positioning problems Petitioner described. The Arbitrator disagrees with his statement that Petitioner performed only "routine clerical duties." That statement is inconsistent with Petitioner's testimony that she actually performed two different jobs and typed for hours each day.

The Arbitrator finds that Petitioner did not establish causation as to bilateral basal joint arthritis or as to the right-sided basal joint arthritis injection Dr. Kronen performed in conjunction with the right carpal tunnel release on March 22, 2013. In his lengthy report of July 16, 2013, the doctor indicated he did not view Petitioner's bilateral basal joint arthritis as work-related. PX 4.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled during two post-operative periods: from April 1, 2013 through August 12, 2013 and from November 25, 2013 through February 4, 2014. Arb Exh 1.

The Arbitrator has already found in Petitioner's favor on the issues of accident/repetitive trauma and causation. While Respondent's examiner did not find causation, he did not dispute the need for treatment.

The Arbitrator finds that Petitioner was temporarily totally disabled from April 1, 2013 through August 11, 2013 (133 days) and from November 25, 2013 through February 3, 2014 (71 days), a total of 204 days, or 29 1/7 weeks. The Arbitrator notes that Dr. Kronen released Petitioner to resume full duty as of August 12, 2013 and February 4, 2014.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims outstanding medical expenses in the amount of $35,115.00 from Mid America Orthopaedics/Hand and Shoulder Clinic (the partnership where Dr. Kronen practices). The Arbitrator notes that these claimed charges include charges for treatment of the right hip and basal joint arthritis. Petitioner does not claim any right hip injury and the Arbitrator has found that Petitioner failed to establish causation as to her bilateral basal joint arthritis condition. Of the claimed $35,115.00, the Arbitrator declines to award the following: 1) 3/22/13, $120.00, Dr. Kronen, basal joint arthritis injection; 2) 4/1/13, $275.00, Dr. Brisbin, office visit and right hip X-rays; and 3) 4/25/13, $146.00, Dr. Brisbin, office visit and right hip injection.

The Arbitrator awards Petitioner medical expenses in the amount of $34,574.00 ($35,115.00 minus the denied expenses outlined above, which total $541.00), subject to the fee schedule.

What is the nature and extent of the injury?

Because Petitioner's repetitive trauma injuries manifested after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. That section sets forth several factors to be considered in assessing permanency, with no single factor to be given more weight than another. The first factor, any AMA impairment rating, is not relevant since neither party offered such a rating into evidence. As for the second and third factors, occupation and age at the time of the injury, the Arbitrator notes Petitioner was 48 as of February 21, 2013 and had two occupations: stenographer and clerk. The Arbitrator does not view the fourth factor, impairment of future earnings, as relevant, since Petitioner resumed full duty and claims no wage loss. As for the fifth factor, evidence of disability corroborated by the treating medical records, the Arbitrator notes that Dr. Kronen's records document some reduced grip strength and recurrent triggering despite surgical intervention.

In assessing permanency, the Arbitrator notes that, while Petitioner has been back to full duty for some time, she credibly testified to bilateral hand pain, pain and swelling in her fingers and palms, especially when keyboarding at work, and numbness in several fingers.

The Arbitrator awards permanency equivalent to 12.5% loss of use of each hand, 30% loss of use of the right ring finger and 15% loss of use of the left middle finger.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Gonzalez,
Petitioner,

17IWCC0622

vs.

NO: 11 WC 39176

Elite Staffing, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. 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: OCT 5 - 2017
o9/21/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0622

GONZALEZ, MARIA
Employee/Petitioner

Case# **11WC039176**

ELITE STAFFING INC
Employer/Respondent

On 1/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.59% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID Z FEUER
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

1980 LAW OFFICES OF STEVEN TENZER
20 S CLARK ST
SUITE 700
CHICSGO, IL 60603

17IWCC0622

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Maria Gonzalez
Employee/Petitioner

v.

Elite Staffing
Employer/Respondent

Case # **11** WC **39176**

Consolidated cases: **N/A**

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 2, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the five weeks preceding the injury, Petitioner earned **$567.20**; the average weekly wage was **$113.44**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

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

Respondent is entitled to a credit of **$0** 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 reflected in the medical bills submitted into evidence by Petitioner that remain unpaid from CAPS and EqMD, as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of any other medical bills is denied.

Permanent Partial Disability: Person as a Whole

As explained in the Arbitration Decision Addendum, based on the factors delineated in Section 8.1b of the Act, and the record taken as a whole, Respondent shall pay Petitioner permanent partial disability benefits of $113.44/week for 12.5 weeks, because the injuries sustained caused the 2.5% loss of use of the person as a whole (low back), as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

January 10, 2017
Date

JAN 17 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Maria Gonzalez
Employee/Petitioner

v.

Elite Staffing
Employer/Respondent

Case # **11** WC **39176**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include whether there is a causal connection between Petitioner's low back condition and accident on September 2, 2011, Respondent's liability for payment of Petitioner's medical bills, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Maria de la Luz Gonzalez (Petitioner) testified that she was employed by Elite Staffing, Inc. (Respondent). She sustained an undisputed accident at work on September 2, 2011.

On the date of accident, Petitioner testified that she finished working at around 2:00 p.m., took off her gown and hung it in its place. She explained that she lifted her left arm to move the plastic curtain aside, she stepped forward, and tripped on a pallet jack as she was exiting the door. Petitioner also explained that when she fell her whole body went down landing on pieces of steel causing her to hurt her whole body. Petitioner testified that she felt back pain as well as numbness in her hands and legs. Two co-workers helped Petitioner get up and she then sought medical care at a hospital.

Medical Treatment

The medical records reflect that Petitioner presented at the Provena Mercy Medical Center emergency room on September 2, 2011. PX2. She reported lumbar pain after her fall at work. *Id.* Petitioner underwent x-rays of the spine. *Id.* The interpreting radiologist noted a likely acute 33% wedge compression deformity of the L1 vertebral body. *Id.* The emergency room physician diagnosed Petitioner with an acute compression fracture of L1, prescribed Vicodin as needed, and instructed her to follow up within three days. *Id.*

On September 6, 2011, Petitioner saw Charles Woodward, M.D. (Dr. Woodward) at Provena Mercy Medical Center. PX1. She reported that she was working when she tripped over a hand jack between the forks on a hand jack and fell directly on her gluteal area. *Id.* Petitioner complained of mid to lower back pain and radiating pain into her legs. *Id.* Dr. Woodward noted his review of Petitioner's x-rays which showed an L1 wedge compression fracture in Petitioner's prior medical history including polio which affected her right foot and ankle. *Id.* On physical examination, straight leg raise testing was negative and Petitioner had tenderness to palpation at T12, L1, and L2. *Id.* Dr. Woodward diagnosed Petitioner with an L1 compression fracture and

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)."

recommended an orthopedic consultation for further evaluation and treatment. *Id.*

On September 13, 2011, Petitioner presented at Castle Orthopaedics and Sports Medicine to see Suresh Velagapudi, M.D. (Dr. Velagapudi). PX1. He noted the following history in pertinent part:

> Ms. Delaluz Gonzalez is 54. She presents to the office for evaluation related to her back as well as complained about having paresthesias in both of her hands and pain at the base of her thumbs. She reports she had tiredness into her arms. She reports all of these dates back to 09/02/11 when she was working for her employer through a temporary staffing company and stepped on a pallet jack and slipped and fell, ended up landing on her seat with her hands behind her such that dorsiflexed wrist. She complains about having pain as noted above. She has been on Norco as well as taking Voltaren, which she was on previously for left-sided sciatica. She has paresthesias in both of her hands. She reports also having some paresthesias in her feet. She is a diabetic for about 12 years. She takes oral hypoglycemic. There is a comprehensive history and review of systems that I have had a chance to look at.

Id. On physical examination, Dr. Velagapudi noted tenderness on percussion of her back around L1 vertebra, a negative straight leg raise bilaterally, and excellent motion of her elbows and wrists with tenderness corresponding bilaterally at the CMC joints with a positive Tinel's sign to the right and positive bilateral Phalen's maneuver more severe on the right. *Id.* Dr. Velagapudi diagnosed Petitioner with a lumbar L1 compression fracture with about 30% compression anteriorly with no evidence for retropulsion and bilateral CMC arthritis. *Id.* He recommended treatment of the spine with analgesics. *Id.*

On October 14, 2011, Petitioner returned to Dr. Velagapudi reporting continued back pain and some numbness in her hands. PX1. He noted Petitioner's request whether she would benefit from an MRI of the back and noted "I have indicated to her based on the fact that she has absence of radicular symptoms and clinically having an L1 compression fracture, MRI is clinically not indicated and I explained that to her and her son and I think she understands it better." *Id.* Dr. Velagapudi recommended physical therapy for range of motion and strengthening three times a week for 4-6 weeks. *Id.* In the interim, he kept Petitioner on work restrictions. *Id.*

Petitioner testified that she then sought treatment at Nuestra Clinica with Dr. Gabriel Rivera (Dr. Rivera) where she received chiropractic treatment and physical therapy. Petitioner testified that the treatments helped her. The medical records reflect that Petitioner underwent chiropractic and physical therapy treatment there from October 17, 2011 through June 1, 2012 without significant improvement. PX3.

In the interim, on October 31, 2011, Petitioner saw Matthew Ross, M.D. (Dr. Ross) at Midwest Neurosurgery & Spine Specialists as referred by Dr. Rivera. PX3. Dr. Ross noted the following in history in pertinent part:

> ... back pain following a work injury 2 months ago. The patient states that she works in a factory as a packer. On September 2, 2011, she tripped and fell over what sounds like banding straps on a pallet. The patient reported the injury immediately. She was taken to Mercy Hospital were x-rays were taken of her hands and spine. She was then given pain medication and sent home. She states that initially she had tingling in her hands and legs. Essentially, everything was hurting. The patient was referred to an orthopedic surgeon. He told her that she had a spinal fracture. He did not recommend any specific treatment for the fracture other than a workup for osteoporosis. The patient states that she then [saw Dr. Rivera]. Since working with [him and his team], she has undergone therapy. She is noticing gradual improvement in her back pain. There is no radiation of pain into her extremities. She has not observed any weakness or persisting sensory loss.

PX3. Dr. Ross noted that he reviewed Petitioner's cervical, thoracic, and lumbar spine x-rays which showed a

wedge compression deformity of the L1 vertebral body, but "[i]t is not possible to ascertain whether this is a new or old fracture. She has some spondylosis in her thoracic spine, otherwise her back looks quite youthful." *Id.* Dr. Ross opined that Petitioner's back pain may be due to her compression fracture as a result of the fall at work which appeared to be healing and improving with therapy. *Id.* He recommended continued chiropractic and physical therapy with an emphasis on work preparation activities. *Id.*

As ordered by Dr. Rivera, Petitioner underwent an MRI of the lumbar spine on December 12, 2011 at Fox Valley Imaging. PX3. The interpreting radiologist noted a 25% compression deformity of the L1 vertebra and moderate central spinal stenosis at L4-L5 which was multifactorial. *Id.*

Section 12 Examination – Dr. Espinosa

On April 3, 2012, Petitioner submitted to a medical examination with Francisco Espinosa, M.D. (Dr. Espinosa) at Respondent's request. RX5 (Dep. Ex. 2). Dr. Espinosa examined Petitioner, reviewed various treating medical records and rendered opinions about Petitioner's condition and its relatedness, if any, to her accident at work. *Id.* In his report, Dr. Espinosa noted the following history in pertinent part:

> Mrs. Gonzalez is a 54-year-old woman who works for Elite Staffing and was performing work on September 2, 2011 when she stepped on a pallet jack accidentally, slipped and fell, landing on her buttocks and her hands. She sustained a low back injury as well as injured her wrist.

RX5 (Dep. Ex. 2). Dr. Espinosa the following reports of ongoing symptoms by Petitioner in pertinent part:

> ...persistent neck pain and low back pain. She denied any bladder or bowel dysfunction related to the accident of September 2, 2011. She does say that she had intermittent pain with change in position, particularly in the hand but no significant symptoms in the lower extremities except for the weakness that she has from her polio in the right leg and foot. She had numbness and tingling as well as weakness. Her symptoms are exacerbated by positions or activities and are alleviated by changing position and medication. She is not able to drive a car. She is able to put on her shoes and socks. Valsalva maneuvers do exacerbate her symptoms.
>
> ...
>
> She has not worked since September 2, 2011 because of her back pain. She describes her sitting tolerance as less than one hour, or standing tolerance as less than one hour, and her walking tolerance as more than two blocks. On a scale of one to ten, with ten being the most severe, the patient describes the pain as a 5 with exacerbations to 8.
>
> ... She does experience difficulty sleeping because of her pain. ...

RX5 (Dep. Ex. 2). After a physical examination, Dr. Espinosa noted that Petitioner was having mainly pain in the L4 area and in the neck around C5, but in the paraspinal muscles she had no midline bony pain and she mainly referred to muscle pain. *Id.* He determined that Petitioner was suffering primarily for myofascial pain with an L1 fracture that had healed. *Id.* Dr. Espinosa noted his review of Petitioner's MRI scan of December 12, 2011 at which point Petitioner L1 fracture had already healed. *Id.* He indicated that the report clearly stated that there was a chronic appearing compression deformity of about 25% involving the body of L1 and wedging of the vertebra anteriorly with no significant edema meaning that it had healed. *Id.*

Dr. Espinosa noted that his examination of Petitioner took place approximately seven months after her fall at

work and that "there is no need for kyphoplasty and the pain that she is experiencing is not referred to L1 but mainly myofascial pain in the lower lumbar region around L4 and in the cervical region around C5." *Id.* He also opined that there was a definite causal relationship between Petitioner's L1 fracture and her fall at work, but the L1 fracture was healed and Petitioner's December 12, 2011 MRI no longer showed any edema and only a 25% loss anteriorly with no retro repulsion or compromise of the spinal canal. *Id.* For her myofascial pain, Dr. Espinosa indicated that Petitioner needed to learn physical therapy exercises in a registered and acceptable program followed by home exercises afterwards. *Id.*

Utilization Review

Respondent requested a utilization review related to Dr. Rivera's request for authorization of 77 chiropractic therapy visits from October 17, 2011 through June 1, 2012. RX2. The request was non-certified by Edwin Rabin, D.C. (Dr. Rabin) beyond nine visits. *Id.* Dr. Rabin noted that ODG-TWC guidelines allowed for nine visits over eight weeks and a total of up to 18 visits over a 6-8 week period with evidence of objective and functional improvement. *Id.* Dr. Rabin noted, "[i]n this case, considering the claimant was initially seen for chiropractic therapy on 10/17/11, 9 initial visit starting 10/17/11 is reasonable to see if any objective and functional gains are attainable with such conservative treatment. However, on 11/04/11 after approximately 9 chiropractic visits, there is very limited documentation of objective and functional improvements from the initial visits. There is also no mention of any aggravation of symptoms after the initial 9 visits to warrant additional chiropractic care. Absent such information, the need for additional chiropractic therapy beyond the initial 9 visits is not seen as medically necessary." *Id.*

Deposition Testimony – Dr. Espinosa

Respondent called Dr. Espinosa as a witness and he provided testimony at an evidence deposition on October 19, 2016. RX5. Dr. Espinosa testified that he is a board certified neurosurgeon with specialty in the spine. RX5 at 5-7; RX5 (Dep. Ex. 1).

Dr. Espinosa testified that Petitioner did not require any kyphoplasty to treat the healed, chronic compression fracture reflected in Petitioner's December 2, 2011 MRI. RX5 at 12-14. He explained that at the time he evaluated Petitioner, she was having pain in her neck and lower back more typical of muscle pain which, in his opinion, was myofascial pain involving the muscle which was the source of her diffuse back pain. *Id.*, at 14. Dr. Espinosa maintained that Petitioner's L1 fracture was healed and Petitioner required no further treatment for her soft tissue injury other than some physical therapy after which Petitioner would reach maximum medical improvement. *Id.*, 18-19.

On cross examination, Dr. Espinosa acknowledged that Petitioner had been receiving chiropractic treatment and physical therapy, but his recommendation for physical therapy was specifically to address myofascial release. RX5 at 21-22. He indicated that 12-15 sessions of electrical stimulation would be appropriate. *Id.*, at 22, 24. He also indicated that chiropractic manipulation could be harmful and he did not recommend manipulation for patients with fractures. *Id.*

Additional Information

Petitioner testified that after she was released to light duty work on June 3, 2012 she did not try to go to back to work because she was not feeling well so she went to Mexico. Petitioner explained that she did not attempt to work anymore because she had no strength.

Regarding her current condition of ill-being, Petitioner testified that her hands go to sleep and hurt. She also experiences weakness in her legs. Petitioner testified that she cannot do simple things at home because her back hurts. For example, Petitioner explained that everything that requires strength and that she has to do with her hands causes her back pain. Petitioner testified that she was feeling happy working before her accident, but has felt this way after her accident at work. She explained that she feels sad because she cannot work. Petitioner also explained that she started working with Respondent because she had a son studying, but then she could not work after her accident.

Petitioner testified that she has not had any other accidents after September 2, 2011. She also has not had any further medical attention after seeing Dr. Rivera because she understood that she would have to pay for it. However, in Mexico, Petitioner testified that she had medical treatment all the time for her low back. There are no outstanding medical bills from any treatment in Mexico in dispute.

On cross examination, Petitioner testified that she did not have any other accident before her accident at work and no problems with her legs or back. Petitioner acknowledged that she had polio as a child, but that never stopped her from working. Petitioner testified that she had not sustained any other foot or ankle injuries.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The medical records reflect that Petitioner received emergency care immediately after her fall and she was released from the hospital with a diagnosis of an L1 compression fracture. Petitioner followed up with Dr. Velagapudi who recommended a course of physical therapy and analgesics to treat her symptoms. He did not recommend a lumbar MRI. Petitioner then sought chiropractic care with Dr. Rivera. He referred Petitioner to Dr. Ross, a neurosurgeon, who indicated that continuing chiropractic care and physical therapy was appropriate. Petitioner testified that her chiropractic treatment was helpful. However, the medical records of Dr. Rivera reflect no significant improvement as noted by Dr. Rabin, Respondent's utilization reviewer. Moreover, Respondent's Section 12 examiner, Dr. Espinosa, noted that while some physical therapy was appropriate to address Petitioner's myofascial pain for her soft tissue injuries as a result of the fall at work, chiropractic manipulation was not appropriate for Petitioner's compression fracture.

Based on the foregoing, the Arbitrator finds that Petitioner has established a causal connection between her low back condition and accident at work to the extent opined by Dr. Espinosa.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that that Petitioner has established a causal connection between her low back condition and accident at work to the extent opined by Dr. Espinosa. The medical bills submitted into evidence are for medical services including, and beyond, those found to be reasonable or necessary by Dr. Espinosa or by Respondent's utilization review. The Arbitrator finds that the medical bills from CAPS and EqMD that remain unpaid are within the treatment recommended by Dr. Espinosa and should be paid pursuant to Sections 8(a) and 8.2 of the Act. However, the medical bills from Nuestra Clinica for chiropractic care were not recommended by Dr. Espinosa as reasonable or necessary—indeed, he opined that it could be harmful—and these bills were further submitted to a utilization review, which found that they were neither reasonable nor necessary.

Petitioner underwent extensive chiropractic treatment at Nuestra Clinica. A review of the records and the

utilization review report reflects that some of the services were for body parts not at issue in Petitioner's above-captioned claim, including the cervical spine. Moreover, Dr. Rivera's request for authorization of 77 chiropractic therapy visits from October 17, 2011 through June 1, 2012 was non-certified by Respondent's utilization reviewer, Dr. Rabin, beyond nine visits. Dr. Rabin noted that there was no evidence of objective and functional improvement after those visits and no mention of any aggravation of symptoms thereafter to warrant additional chiropractic care. As opined by Dr. Espinosa and Dr. Rabin, in the absence of such information or other evidence to support the reasonableness of the extensive chiropractic care to related—and wholly unrelated—body parts, the Arbitrator finds that Petitioner has failed to establish that the chiropractic treatment with Dr. Rivera beyond that authorized by Respondent's utilization review is either reasonable or necessary and Petitioner's claim for payment of those bills is denied.

Accordingly, the Arbitrator finds that the medical bills submitted into evidence by Petitioner that remain unpaid from CAPS and EqMD shall be paid by Respondent pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of any other medical bills is denied.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of the injury, the Arbitrator finds the following:

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

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

Considering these factors in light of the evidence submitted at the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a packer in a factory at the time of her accident. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the accident. This fact is stipulated by the parties. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that there was no evidence of any diminishment in Petitioner's future earnings capacity as a result of her accident. Thus, the Arbitrator 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 Arbitrator notes that Petitioner sustained an L1 compression fracture as a result of her fall at work. The MRI, which her own treating physician did not recommend, showed a fully healed compression fracture. Dr. Espinosa opined that Petitioner required a course of physical therapy to address Petitioner's myofascial pain and that chiropractic manipulation was not appropriate. Thus, the Arbitrator 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 Arbitrator finds that Petitioner has established permanent partial disability to the extent of 2.5% loss of use of the person as a whole (low back) pursuant to §8(d)2 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

Curtis Sidwell,
Petitioner,

vs.

Archer Daniels Midland Company,
Respondent.

17IWCC0623

NO: 11 WC 21470

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 29, 2016, is hereby affirmed and adopted.

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

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

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

DATED: OCT 5 - 2017
o9/7/16
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0623

SIDWELL, CURTIS
Employee/Petitioner

Case# **11WC021470**

ARCHER DANIELS MIDLAND COMPANY
Employer/Respondent

On 2/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN & ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0771 FEATHERSTUN GAUMER ET AL
DANIEL L GAUMER
225 N WATER ST SUITE 200
DECATUR, IL 62523

17IWCC0623

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

Curtis Sidwell
Employee/Petitioner

v.

Archer Daniels Midland Company
Employer/Respondent

Case # **11** WC **21470**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **January 6, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 10, 2011,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$28,912.00**; the average weekly wage was **$556.00.**

On the date of accident, Petitioner was **41** years of age, *married* with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,713.05** in non-occupational indemnity disability benefits, for a total credit of **$2,713.05.**

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent, and that his current condition of ill-being is casually related to his alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent shall be given a credit in the amount of **$2,713.05** for non-occupational indemnity disability benefits paid.

Respondent shall be given a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

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

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

Melinda M. Pinkerton Gillman

Signature of Arbitrator

2/24/16

Date

FEB 29 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Curtis Sidwell
Employee/Petitioner

Case # 11 WC 21470

v.

Consolidated cases: N/A

Archer Daniels Midland Company
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he lives in Watson, Illinois and was first employed with Respondent on February 5, 2007 as a forklift operator. He testified that he remained in that position up through May 10, 2011. He testified that prior to this case, he had never filed any worker's compensation claims nor had he received treatment for his left knee prior to May 10, 2011. He testified that in the six months leading up to May 10, 2011, he did not run or cycle as a hobby. He testified that he is currently 5' 11" inches tall and weighs 185 pounds, that he had the same height and weight in 2011 and that he had the same body habitus since his graduation from high school.

Petitioner testified that as a forklift operator in May of 2011 and for the six months or so prior, his job duties included receiving loads of product on semis, LTL carrier drop-offs, gathering orders, filling orders on pallets and throwing bags all day. He testified that in mid-2010, there was a change in his job duties. He testified that in mid-2010 they started working two men short of a crew and that up to mid-2011 they were still two men short. He testified that with the schedule that they had, it was a pretty hectic 8-hour shift. He testified that they were working overtime a lot and sometimes worked on Saturdays as well because they were two men short.

Petitioner testified that from March 2011 up to May 2011, they would load and unload on average 7-10 loads per day, which did not include customer pick-ups or LTL drop-offs. When asked how many skids of product would be on a typical truck or load, he testified that on a normal outbound load, 95% of the time there would be 2,000 pound super sacks, and that they fit 22 skids on a semi to fill the truck. When asked if he was simply driving the forklift all day while loading the trucks, Petitioner responded that the job description on loading the trucks with the 2,000 pound super sacks was that they had to blow the excess product off of the totes before they loaded the totes onto the semi. He testified that he would have to go pick up one skid at a time, drag it with his fork truck to the air compressor, set it down, get off his fork truck, blow the tote off, get back on his fork truck, load the tote and repeat the process some 20 times.

Petitioner testified that in addition to this operation, he would have to get up and down off his forklift truck 46-47 times per load, sometimes more. He agreed that there were 7-10 loads per day, sometimes more. With respect to his lifting requirements during the course of a day, Petitioner testified that the bags weighed anywhere from 40-60 pounds, and that occasionally they had 75-100 pound barrels for an LTL drop-off and would have to "double team" on the 100-pound barrels. He testified that normally he was lifting 40-50 pound bags when gathering orders for customers, and that he would do this

every day. He testified that for getting up and down off the forklift, he would use his left foot to push off and to get up into the forklift. When asked how much his left knee bended when getting in and out of the forklift, Petitioner responded that his left knee would bend 90 degrees to get to his step, which was 18-24 inches high. He testified that he would generally be landing on a concrete floor.

Petitioner testified that he operated the forklift by stepping up, and that it had brake and gas pedals as well as a clutch brake assembly. He testified that the one that he used and worked with every day all day had a clutch brake assembly, and that he used the right foot for the gas pedal and the left foot for the clutch brake assembly. He testified that he did constant braking and clutching all day long.

Petitioner testified he noticed in the months leading up to May 2011 that as he performed his job duties, a couple of hours into his shift he would have pain and achiness that got worse as the day went on. He testified that at the end of the day he was in quite a bit of pain, and that he would have to lift his leg in order to get into his car and could not bend it. He testified that in the last 2-3 weeks prior to May 10th, it progressed and got worse.

Petitioner testified that on May 10th between 9:00 and 9:30, he went out to load an outbound load of 2,000-pound super sacks and noticed that his knee was starting to hurt pretty badly, and by the time he had finished loading the truck and was getting ready to get off his fork truck to seal the driver up, when he stepped down onto the concrete his left knee popped and buckled and he dropped to his knee. He testified that he then sealed the driver up, took his paperwork and got onto the fork truck and drove to other end of the warehouse to report the accident to his supervisor, Paul Gouchenouer. He testified that as he got off the fork truck at the office a co-worker needed him to double-check his loads, so he provided assistance. He testified that as he was turning around to return to the office, there was a metal frame on the floor that was flipped up at the lip. He testified that as he was dragging his left boot, the lip caught the end of his boot and caused him to almost trip and fall. He testified that he then went into the office and reported what happened at north end of warehouse to Paul Gouchenouer and asked to fill out an accident report. He testified that he then contacted his safety manager, Roger Friese, after which Mr. Friese and the plant manager came over, agreed that an accident report needed to be filled out, and sent him to Bonutti Clinic for an evaluation. Petitioner denied having been seen at the Bonutti Clinic prior to this time.

Petitioner testified that at Bonutti Clinic he was initially seen by a nurse and then Dr. Rudert. He agreed that Dr. Rudert asked him how he thought he hurt himself and he explained what happened. He agreed that Dr. Rudert asked him about his job duties, and that he wanted to know how many times a day he got up and down off his fork truck. Petitioner testified that he told him what he testified to at the time of arbitration. He agreed that Dr. Rudert ordered an MRI which was performed the same day, that he recommended medications and that he referred him to Dr. Lee at Bonutti Clinic.

Petitioner testified that his first visit with Dr. Lee took place on June 9, 2011, and that just a day prior to that he was informed that his worker's compensation claim was denied. He testified that he instructed them use his group health insurance as indicated in the letter he received. Petitioner agreed that he was given a cortisone injection on that date, and that he went off work that day. He testified that he was placed on light duty by Dr. Lee, but Respondent was not able to accommodate his light duty at that time. He testified that he was paid short-term disability benefits for June 9, 2011 through September 1, 2011, and that he continued to see Dr. Lee for treatment. He testified that Dr. Lee did another injection and ultimately recommended surgery.

Petitioner testified that he had surgery on his knee on August 10, 2011, and that he had physical therapy at Biomax. He testified that he had follow-up visits in August 2011 and was ultimately returned to work regular duty on September 2, 2011. He agreed that he returned to the same job, but by then they had hired 1 or 2 additional people to help alleviate the hectic scheduling issues. He testified that there

was a "blow off" change as well, and that they were given a reel hose to blow off all 22 loads at once in order to not have to go up and down off the fork truck so many times. He agreed that he continued to use the clutch forklift truck after he returned.

Petitioner testified that after he returned to work in September 2011 and for the next 3-4 months, the pain would reoccur and by the end of his shift he would be in significant pain. He testified that he continued to work without any lost time, and that he went for a six-month follow-up with Dr. Lee in 2012. He testified that Dr. Lee asked him to be evaluated by his partner, Dr. Wente. He testified that Dr. Wente saw him on a couple of occasions and gave him an injection into the left knee joint, which was different than the injections he had been given by Dr. Lee. He testified that he had more therapy at Biomax, and that he then did the exercises at home that they had taught him. He testified that he continued to work on the forklift, and that he did not lose any additional time from work.

Petitioner testified that he saw Dr. Kohlmann one time on April 3, 2014, and that he evaluated him and told him there was no surgical explanation for his knee. He testified that when he returned to work in September and in the couple of months thereafter, he noticed pain in the knee joint on the exterior or outside of his left knee, which was the same as the pain he experienced currently. He testified that he has a 2-inch surgical scar on the exterior side of his left knee, and that he has two scope incisions under his kneecap. He agreed that his not currently under the care of a physician for his knee. He testified that he treats himself for his problems with stretches and Meloxicam. He testified that he has a sheet of exercises from Biomax, so he continues to try to stretch 1-2 times per day. He denied reinjuring the left knee.

Petitioner agreed that he reviewed Petitioner's Exhibit 6, the Medical Bills Exhibit, prior to arbitration. He agreed that his group health paid a large portion of the bills, and that a balance of $3,717.00 remains unpaid.

On cross-examination, Petitioner testified that in May of 2011 there were two additional forklift operators besides him. He testified that normally the three people working included himself, Jeremy Boone and Paul Gouchenouer. He testified that Mr. Gouchenouer took care of the stock side of the warehouse, so whatever stock orders that production needed from across town Mr. Gouchenouer was in charge of gathering the stock and loading it onto a semi to go across town so he did not assist Petitioner and Mr. Boone. He testified that he and Mr. Boone did most of the incoming trucks and outgoing trucks, as well as customer orders and the LTL drop-offs. He testified that there were three loading docks where trucks would come in or would leave with product, and that there would be somewhere in the range of 22 skids of material that would go outbound on a typical truckload and that there would be 22 skids coming in on a full inbound truck.

On cross-examination, Petitioner testified that if he was responsible for unloading a new truck, he would drive over to the semi-trailer and start pulling skids of material off one at a time with his forklift. He testified that he would bring each skid into the warehouse and drop it typically a couple of hundred feet away from the truck. He agreed that he would then turn the fork truck around, drive back to the semi, stick the forks under the next skid, bring it back into the warehouse and set it down next to the other skids he had already dropped off. He agreed that he repeated the process until all of the skids were off the semi-trailer and brought into the building.

On cross-examination, Petitioner testified that the process for super sacks might take 20-30 minutes, but for bagged materials there might be skids leaning which would require him to get off the fork truck and restack the skid before he could lift it up to get it out of the semi. He testified that just about every day with an LTL carrier they would have to restack skids. He agreed that if a truck came in with 22 skids on it, every single one of the skids would not be leaning to the point where he would have

to get off his truck and restack it, and that sometimes he would just stay on the truck, put the forks of the truck under the next skid, pick it up, turn around, drive it back into the warehouse and drop it off, and that he would go back and repeat the process 20-22 times before the truck was empty. He testified at that point, he then got off the truck and tested the product he had just loaded. He testified that the testing depended on the product involved, and that they had sampling books and may need to sample product by using a safety knife or a probe tube. He agreed that he would be walking around the various skids of product, that he would have a clipboard or paperwork with him and that he tested the various products. He agreed that in some cases, it might take him 30-60 minutes to test a particular load, draw the samples and do all the paperwork. He testified that at that time, there would typically be 3-4 semis waiting so he would repeat the process with another truck depending on whether it was inbound or outbound. He testified that for outbound loads, he had to double-check each load to make sure it was the right lot number and product. He testified that he would do the paperwork before the initial loading of the semi, and that there was a staging area where the skids would be staged and ready to go. He testified that this paperwork process typically took 5 minutes or so to complete.

On cross-examination, Petitioner confirmed that the first time he ever received any medical treatment at Bonutti Clinic was on May 10, 2011, and that this was just as truthful as everything else he had testified to. He agreed that a typical work shift was 8 hours, and that there were 10-minute breaks in the morning and the afternoon along with a 30-minute lunch. He testified that his personal doctor was Dr. Frost in Altamont, and that he could not remember when he last saw him but believed it was about his back. Petitioner did not recall seeing him about his knee. He agreed that his wife worked at Bonutti Clinic in 2010-2011, and that she was working at the clinic at the time of his injury. He testified that he has two other pending worker's compensation claims against Respondent for his left elbow, but denied any other injuries.

On cross-examination, Petitioner agreed that he was claiming that at approximately 9:30 in the morning on May 10th, 2011, he stepped off forklift and injured his knee when it buckled and he felt a sudden pain in his knee. Petitioner testified it that had been aching and sore prior to this incident, but agreed that stepping off the forklift made it more painful. He testified that approximately five minutes later, he tripped over the metal edge on the dock plate. When asked if he told Paul Gouchenouer about both injuries, Petitioner responded that he might have but did not recall. Petitioner testified that he was seen at Bonutti Clinic within an hour after his accident because the safety coordinator and the plant manager came over to see him and approved his going to the clinic.

On cross-examination, Petitioner agreed that he told Dr. Rudert and the nurse "the same story" about how he had injured his knee earlier that morning. Petitioner agreed that he told them about what happened to him that morning at work and how he had been hurt at work on the job that day. Petitioner also agreed that he told the individuals who did the MRI about how he had been hurt at work that day. Petitioner agreed that when he said that he told Dr. Rudert and the folks at Bonutti Clinic about how he had injured himself at work on the morning of May 10, 2011, his testimony was just as truthful as everything else he testified to at the time of arbitration.

On cross-examination, Petitioner denied ever telling any doctors or medical providers that his knee problems began when doing something away from work. When asked at the time of the second visit with Dr. Rudert on May 18th whether he again told him the story about how he had been injured at work in the two episodes on May 10th, Petitioner agreed that he explained to Dr. Rudert what happened. Petitioner denied ever being a runner or a jogger, and testified that he played sports in grade school and junior high school but not since.

On cross-examination when asked if he had injured his knee or had increasing pain or swelling in his knee while doing yard work back in 2011, Petitioner responded that there were a couple of times that he noticed swelling when picking up the yard after work. Petitioner denied riding or owning a bicycle.

On cross-examination when asked if he had a hobby of going to auctions, Petitioner responded that periodically he and his wife went to auctions and that he purchased an oil lamp but did not purchase items very frequently. Petitioner denied that when he looked at items he sometimes picked the items up to examine them before he decided whether he was going to bid. Petitioner denied ever telling anyone he worked at auctions. Petitioner agreed that if a medical provider stated that he told them he worked at an auction, he disputed that and stated that he has never worked at an auction.

On cross-examination, Petitioner agreed that he told a provider that after standing all day at an auction, he noticed an increase in pain. He denied ever assisting an auctioneer by picking up items and showing them to the other bidders. He denied ever telling anyone that his left knee symptoms began or started following his activities of going to an auction. Petitioner testified that he believed that he told someone that his left knee problems were not work-related, and that he thought he told either Dr. Lee or Dr. Rudert that he could not attest to why his leg was hurting before the May 10th incident. Petitioner denied ever telling any doctor or medical provider that he had not sustained any injury to his knee.

On cross-examination, when asked whether his knee had been popping for years before May of 2011, Petitioner responded that prior to the May 10th incident he had noticed popping in his knee whenever he would walk or if he got off the fork truck a certain way. He denied having increasing left knee pain or increasing left knee symptoms while mowing the grass or using a mower. He denied ever injuring his knee again after the August 2011 surgery performed by Dr. Lee, and also denied ever injuring his knee off the job. He testified that Respondent's doctor sent him to Dr. Stephens.

On cross-examination, Petitioner agreed that he spent about four months in jail in Effingham in the fall of 2011 on work release. He agreed that after he was released, he went back to see Dr. Lee and that was when Dr. Lee referred him to Dr. Wente. Petitioner testified that his knee was bothering him the same after he got out of jail. When asked if he did anything while he was in jail to aggravate his knee at all, Petitioner responded that he worked and slept. Petitioner agreed that he was allowed to work his regular job at Respondent while incarcerated.

On cross-examination, Petitioner disagreed with Dr. Lee's assertion that he expected Petitioner was going to recover full use and function of his knee. He agreed that when he last saw Dr. Lee, he told Petitioner to come back to see him if he had any persistent problems. Petitioner testified that he had not seen Dr. Lee since 2012. When asked if he had any future appointments scheduled for his knee, Petitioner responded that he would not patronize Bonutti Clinic and that he would go to a specialist or a knee doctor.

On cross-examination when asked when he went to see Dr. Rudert on May 10th whether it was true that his wife had already called there the day before to make an appointment, Petitioner responded that he "vaguely" recalled coming home from work on the 9th, calling his wife at Bonutti Clinic and asking her if she could get him in for his knee.

On cross-examination, Petitioner denied that when he saw Dr. Wente in 2012 that he was able to do all the activities that he wanted to do. When asked what activities he was unable to do at that point that he had done before, Petitioner responded that he was unable to squat, bend or extend his leg, and that it was starting to ache more as he progressed at work to the point where he was limping again. He agreed that he told Dr. Wente about the activities that he was no longer able to do.

On cross-examination, when asked which chores he was able to do away from work from the time of his May 10th injury until he went off work on June 9th, Petitioner responded that he was able to take out the trash. When asked if he did any carpentry work or painting, Petitioner responded that he could not recall. When asked if he stained his deck, Petitioner responded that he might have taken a paint roller with an extension and rolled water sealant on his deck but he did not know. When asked if it would make his knee hurt more, Petitioner responded that he had an 8 by 10 deck, so he stood in one spot. He denied that it aggravated or made his knee worse. He denied having injured himself off the job anywhere since April of 2015, the date of his second elbow claim.

On redirect examination, Petitioner agreed that from May 10 to June 9, 2011, he worked regular duty. He agreed that he was still lifting the 50-60 pound bags when he needed to lift them, and he was still ascending and descending from the forklift. He agreed that he was still unloading the trucks and doing all of the things he did over an 8-hour day as he testified previously to.

On redirect examination, Petitioner agreed that his wife, Tracy, worked in the accounting department at Bonutti Clinic. When asked whether Respondent's doctor sent him to see Dr. Stephens for his knee, Petitioner responded that it was not specifically Dr. Stephens that he was sent to but that Respondent's physician told him that he needed to go see a knee specialist. He further testified that this occurred just a few months ago, and that Respondent's physician was Dr. Braco in Decatur. Petitioner agreed that when Dr. Lee saw him in 2012, he referred him to Dr. Wente and that it was his understanding that Dr. Lee had discharged him from his care over to Dr. Wente's care.

On redirect examination, Petitioner agreed that when he was on work release he was "let out" every day to go to work at Respondent, and that he had to return directly to the facility where he was being held. He agreed that there was no way to make an appointment to do anything other than work.

On redirect examination, Petitioner testified that the Bonutti Clinic records were incorrect when they stated that he had had hernia surgery. Petitioner testified approximately six months to a year before May 10, 2011, he noticed popping in his left knee. He testified that approximately 2-3 months before May 10, 2011, he was limping. He testified that he had no idea what was causing the problem at that time. He agreed that he told Dr. Rudert he was not sure what the cause of the injury was. Petitioner testified that it was Dr. Rudert's statement in the office note of May 10, 2011 that it may be due to getting in and out of the forklift all day long and standing on the knee.

On redirect examination, Petitioner testified that he has never worked at an auction, but agreed that it was his hobby. He agreed that his wife accompanied him. He agreed that it was his testimony that on May 10, 2011 he left the plant with the approval of the safety manager to see the Bonutti Clinic, and that Roger Friese, the safety coordinator, also went that day. He denied that Roger Friese ever attended any of his personal doctor appointments.

On further cross-examination, Petitioner agreed that Roger Friese no longer worked for Respondent. Petitioner agreed that he saw Dr. Stephens in Mattoon only once, that he prescribed Meloxicam and that he told Petitioner to ice his knee and elevate it. Petitioner denied returning for any additional appointments.

Paul Gouchenouer was called as a witness by Respondent at the time of arbitration. Mr. Gouchenouer testified that he works for Respondent as an hourly employee, and that this was also his status in May of 2011. He testified that his job title is warehouse lead person, and that he knew Petitioner through work.

Mr. Gouchenouer testified that he worked with Petitioner on a regular basis back in 2011, and that they both drove forklifts. When asked whether his duties as a forklift driver were any different than Petitioner's, Mr. Gouchenouer responded that his was more of gathering stock and unloading stock trailers while Petitioner's was unloading inbound loads and receiving them. When asked to explain the difference in more detail, he responded that with stock gathering he was on and off the forklift more often, and that with receiving once you had the trailer unloaded you were on the forklift. He agreed that Petitioner did more of the receiving of incoming loads than he did, and that when he would receive a truckload he would generally remain on his forklift to unload the pallets.

Mr. Gouchenouer testified that Petitioner would be on his forklift anywhere from 20-30 minutes to unload the trailer, and after the trailer was unloaded, he would sign the driver's paperwork, get the driver out, get the receiver and go down to each pallet, check lot numbers and receive the product. He agreed that Petitioner would also cut into some of the product bags or containers to pull out material to be tested.

Mr. Gouchenouer testified that after the 22 skids had been unloaded, it took normally anywhere from 60-90 minutes to take the samples and do the paperwork before going to the next load. When asked whether Petitioner needed to be on and off the forklift again, he responded that he needed to do so only to put the product in the row and put it away. He agreed that Petitioner might spend an hour doing the paperwork before that would happen.

Mr. Gouchenouer agreed that he had unloaded trailers that came in with new product on skids, but he did not do it as frequently as Petitioner. He agreed that from time to time the skids would be off kilter and would need to be adjusted before they could be picked up with the forklift. He estimated that would happen approximately once or twice a month, depending on the driver that brought it in. He agreed that most of the time when a forklift driver was unloading skids off an incoming truck, the individual simply drove in one at a time and took the skids full of product off the trailer, hauled them back into the warehouse and dropped them off, and that he circled around, went back into the truck while driving the forklift and then took off the next skid. He testified that most of the time the driver would not get off the forklift until the truck was unloaded. He testified that a person typically stayed on the forklift 30 minutes to unload an entire truck before all the 20-22 skids had been taken off and put in the warehouse. When asked where the skids would be dropped in the warehouse, he responded that there were aisleways that ran down from the dock and that they would dump them down the aisleway until the truck was unloaded so the driver would probably be driving anywhere from 100-500 feet.

When asked if back in 2010 and 2011 whether Petitioner ever talked about any of his non-occupational activities or hobbies, Mr. Gouchenouer responded that Petitioner told him that he was building a deck on the back of his house and that he frequently went to auctions. He testified that Petitioner just brought it up on break times that he had gone to an auction.

When asked if Petitioner did any automotive repairs in this time frame, Mr. Gouchenouer responded that he knew that Petitioner talked about fixing an alternator on his car as well as a water pump. He further testified that approximately two years after his surgery, Petitioner remodeled his basement and that this was work that Petitioner did himself. He denied that Petitioner had any duties as part of his job that involved mowing. When asked to assume that Petitioner told somebody he may have re-injured himself mowing and whether that would be away from work, he responded that it was because all of their mowing was hired out.

Mr. Gouchenouer agreed that at some point Petitioner told him that he thought he had hurt his knee stepping on and off a forklift. He denied that Petitioner said anything to him at that point about injuring his knee or hurting his knee tripping over a metal strip on a dock plate. He agreed that he sent

Petitioner over to Roger Friese to fill out an incident report. When asked if he saw the two of them talking about the alleged injury, he responded that they were in the office but he did not know what they were talking about. He agreed that this was this was the same day that he was told of the injury for the first time.

When shown Respondent's Exhibit 5 and asked what it was, Mr. Gouchenouer responded that it was an ADM Incident Report dated May 16, 2011. He testified that the second page was signed by Mr. Friese, and that he was the safety manager. He agreed that Mr. Friese no longer worked for Respondent.

Mr. Gouchenouer agreed that at some point after this claim was made, he actually wrote down approximately how many times he got on and off a forklift in a given day. He testified that his boss gave him a form to fill out to see how many times he would get on and off the forklift, and he agreed that he did his job rather than what Petitioner typically did and that his job involved more times on and off than Petitioner. He testified that on the day when he kept track, he got on and off the forklift about 75 or 76 times. When asked whether he had an opinion in May of 2011 as to how many times Petitioner would have typically been on or off his forklift in a given work shift based on his knowledge and observations, he responded 30-45 times a day on average. He agreed that if Dr. Lee was led to believe that Petitioner was on or off 300-500 times a day, it would not be accurate.

On cross-examination, Mr. Gouchenouer testified that he was not Petitioner's supervisor. He testified that he had a supervisor of his own that he reported to, and that Petitioner had a supervisor that he reported to. He testified that he was just a lead person. He testified that Petitioner was a warehouse operator, and that his title was warehouse lead person. He testified that Petitioner did not have to report injuries to him, and that the safety coordinator's job was to handle safety issues.

On cross-examination, when asked whether he agreed that Petitioner's job as a warehouse operator involved lifting over 50 pounds 12-62 repetitions an hour, Mr. Gouchenouer responded that he disagreed "with the hour part." When ask to assume that the job description stated that Petitioner was required to frequently, 34-66% of the workday, or 12-62 repetitions per hour, lift more than 50 pounds from floor to waist and whether it would be incorrect, he responded that 30-40% of the workday for an 8-hour shift would be correct. When asked how frequently Petitioner would lift 26-50 pounds, he responded 30-40% percent in an 8-hour shift. When asked how frequently he would lift 11-25 pounds, he responded that it depended on what the customer ordered and that it was seldom that they had orders like that so he thought around 25%. He agreed that these were all percentages of the day that Petitioner was driving and getting down and then lifting product. He testified that if Petitioner was not gathering orders, then he was not getting up and down off the forklift.

On cross-examination, Mr. Gouchenouer testified that Petitioner's Exhibit 8 was ADM's Standard Operating Procedures, that it was a job description for a warehouse operator, and that it was prepared by Archer Daniels Midland. He agreed that the job description stated that the warehouse operators were responsible for loading and unloading finished products and ingredients as directed by the warehouse supervisor, and that this was not him. He agreed that he worked in a different area. He agreed that the job description stated that he was to operate forklifts and floor scrubbers in a safe manner, to stage loads and double-check product, to complete ingredient sampling, to dump warehouse dumpsters, to load and unload trucks as required, to ensure paperwork was filled out properly, to record product codes, lot numbers, and bag quantities and to follow all guidelines in SOP W103.

On cross-examination, with respect to the air hose used to blow off product, Mr. Gouchenouer denied using such an air hose but admitted that he was aware that Petitioner did. He testified that it was just an air hose with a wand on it. He testified that prior to May of 2011, the system was different. He testified that the system was a reel hose where you could pull the hose out and blow the totes off, and he

agreed that you would be required to get up and down to operate it. He testified that the reel hose came into operation in approximately 2013, and agreed that he was not operating a reel hose in 2011. He agreed that his forklift had a clutch operation, and that he operated the clutch with his left foot. When asked if it was a braking type of clutch operation, he responded that it was and that it would slow the forklift down if you wanted to lift the forks up at a higher speed. He testified that whenever you wanted to put it up on the rack or when you lifted any pallet above a 4-5 foot level, then you would be using your left foot pushing on the clutch. He testified that he did not use it as a brake, but admitted that some operators did.

On cross-examination, when asked whether inbound loads and outbound loads were handled differently in terms of getting up and down off the forklift, Mr. Gouchenouer responded that tote loads were a little bit different from the inbounds and the outbounds, and that because of the totes you would have to blow them off. He testified that with the new reel system, you could blow them all off at once instead of putting five up by the hose, blowing the five off and then getting back on the forklift.

When asked about the Conway LTL carriers, Mr. Gouchenouer responded that they had Conway coming in every day. When asked if they were "loose" deliveries, he responded that some of them arrived with broken bags, but they were still on the pallets and agreed that they had to be straightened up.

On cross-examination when asked if he was aware that Roger Friese went with Petitioner to the Bonutti Clinic on May 10, 2011, Mr. Gouchenouer responded that he was not aware. He testified that he could not remember whether Petitioner left work at about 10:00 a.m. that day. When asked if he would have been responsible for assigning someone to fill Petitioner's spot, he responded that he was not because they all chipped in whenever someone was gone in. He testified that he knew that Petitioner went to Bonutti Clinic, but he did not know whether he was with Roger Friese. He testified that he was aware that Petitioner went to Bonutti Clinic because Petitioner came by after he had returned to work and told him that he had gone to Bonutti Clinic. He testified that Petitioner did not tell him what the doctor told him, but believed it was the same day that the incident report was filled out. He denied having seen the incident report (*i.e.,* RX5) before his testimony on the day of arbitration.

On cross-examination, Mr. Gouchenouer testified that he was aware Petitioner was claiming he had pain in his left knee and that Petitioner's doctor told him it was from getting on and off the lift because that was what Petitioner told him. When asked how long after Petitioner reported the claim did Respondent ask him to record the number of times he got up and off his forklift, he responded about two years later. He agreed that they had the same number of employees on that day as they had on May 10, 2011, so there had been no change in the number of employees.

On cross-examination when asked how many people worked in the forklift area, he responded five and agreed that there were five in 2011 as well. When asked who the five people were in May of 2011, he responded it was Jeremy Boone, Johnnie Ritero, Tony McElroy, Petitioner and himself. He testified that Jeremy Boone and Johnnie Ritero worked with Petitioner. When asked if they were still there, he responded that Jeremy Boone was terminated in either 2013 or 2014, and that Johnnie Ritero was transferred to another facility before he was terminated in maybe 2012 or 2013.

On redirect examination, Mr. Gouchenouer agreed that he did not have any personal stake in the outcome of the case and that he received a subpoena requiring him to testify at the arbitration hearing.

On rebuttal, Petitioner agreed that he testified that he was only working with one other person besides Mr. Gouchenouer. He testified that he, Jeremy Boone and Paul Gouchenouer worked the same shift, and that it was he and Jeremy Boone doing the inbounds, outbounds and receiving and customer

pick-ups. He testified that Johnnie Ritero was sent across town to the production side, and that Tony McElroy was on third shift.

On cross-examination, Petitioner agreed that it was a regular part of his job in some cases to lift 50-pound bags of product. He agreed that he would stack them from one place to another and move them around within the facility. When asked how many hours a day on average he spent walking around picking up and moving bags that were containers of product, Petitioner responded that it depended on how many customer orders the office printed out for them to go gather and how many LTLs needed to be gathered for the day for the LTL carriers to pick up that evening. When asked if he may have spent several hours a day loading or carrying sacks, Petitioner responded that it could have been the case if the schedule was light on the outbound or inbound loads and they had "a ton" of LTLs to go pick up or "a ton" of customer pick-ups. He testified that the forklift would lift full skids out of the rack spaces or the aisle spaces, and they would drag them out and put them onto the pallets they were gathering. He agreed that he spent quite a bit of time picking up the bags physically one by one and moving them from point A to point B. He agreed that when he was doing that, he was not on the forklift.

The Application for Adjustment of Claim reflects that Petitioner alleged that he was injured at work on May 10, 2011 and that his left knee and body were affected. Petitioner signed the Application for Adjustment of Claim on June 16, 2011. (Arb. Ex.2).

The medical records of Bonutti Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner's wife Tracey called on May 9, 2011, indicating that Petitioner had been having severe left knee pain mostly at night and when trying to walk on it. It was noted that Petitioner had been taking Aleve and it was not working, and that Petitioner had stiffness and pain for 2-3 weeks. Petitioner was scheduled to be seen on May 10, 2011 at 9:15 a.m. (PX1).

The records reflect that Petitioner completed an intake form on May 10, 2015, on which Petitioner indicated that it was unknown whether he was being seen as a result of an accident or injury. When asked to describe how the accident or injury occurred, Petitioner indicated "[d]on't really know have had trouble in past with it poping [*sic*]". Petitioner indicated that the issue was not work-related. Petitioner rated his pain as 9-10/10, and indicated that it was a stabbing pain in his left knee. (PX1).

The records reflect that Petitioner was seen by an RN on May 10, 2011 with a chief complaint of left knee pain. It was noted that for the last 2-3 weeks Petitioner had noticed pain anterior and lateral, with no specific injury. Petitioner noticed after he had been at an auction all day standing that the symptoms seemed to start. Petitioner had pain with flexion/extension, and his knee popped. Petitioner had been taking Aleve/Tylenol to get by but that was no longer helping, and the longer he was up on the leg the worse the symptoms got. The impression was left knee pain, and it was noted that the x-rays showed evidence of joint space narrowing. Petitioner was recommended to undergo an MRI and a possible injection if he did not improve. (PX1).

The records reflect that Petitioner underwent an MRI of the left knee on May 10, 2011, which was interpreted as revealing an old injury to the ACL and to correlate clinically with tear involving the anteromedial fibers; no evidence of meniscal tears; fluid intrapatellar fat. (PX1).

The Addendum to the May 10, 2011 office visit as prepared by Dr. Rudert noted that Petitioner did not really know the exact injury to his left knee, but it was noted that it had been bothering him off and on for several months. It was noted that there was no known injury, but he caught his toe on a dock plate yesterday and was really sore when he twisted the knee a little bit which was noted to be temporary. It was noted that if Petitioner was on his knee or standing on it, it was markedly painful by the end of the day, and that it caught, locked and became markedly painful. Petitioner did not know of any injury he could attribute it to, other than it was very tender after he tripped and caught the dock plate. It was also

noted that Petitioner had injuries before that also. The impression was that of internal derangement of the left knee, etiology undetermined. Petitioner was recommended to undergo an MRI, and the Post-MRI Evaluation noted that the MRI showed a meniscal cyst in the posterior aspect of the lateral meniscus, that Petitioner had a little bit of degeneration of the meniscus and some fluid in the joint but that he really did not have any significant tears that could be seen. It was noted that Petitioner was painful in full extension, and that sitting in the MRI scanner was quite uncomfortable. It was noted that Petitioner appeared to have a semimembranosus bursitis in the knee, and that he was painful in the posterior aspect. It was further noted that it may be due to getting in and out of the forklift on and off all day long and standing on the knee. (PX1).

The phone note dated May 17, 2011 noted that Petitioner's wife called in and noted that the cream that was given worked well the first day but now was not working at all. A follow-up appointment was scheduled. (PX1).

The records reflect that Petitioner was seen on May 18, 2011, at which time it was noted that he still had significant discomfort in his left knee. He had lateral pain over the iliotibial band and medial pain over the posteromedial aspect of the knee and occasionally in the patellofemoral joint. He did not know of any specific injury other than he worked at an auction and was standing all day and that started to bother him. It was noted that Petitioner had an old ACL tear in the knee. It was also noted that he felt pretty good in the morning when he got up, but after he was on his feet for a few hours it started to bother him again. The impression was that of left knee patellofemoral syndrome, and he was recommended to undergo an orthopedic consult and physical therapy. It was further noted that Dr. Rudert could not say this was a work-related injury and may just be a progression of patellofemoral joint disease and an old ACL tear. (PX1).

The records reflect that Petitioner completed a History of Injury/Complaint on June 9, 2011, on which he identified a date of injury of May 10, 2011 and described an injury of twisting and tweaking his left knee when getting off a forklift. He indicated that his pain had been present for 4 weeks. He indicated that his injury occurred at work. He was also seen on that date, at which time he reported that he was injured on May 10, 2011 and that he twisted his left knee stepping off a forklift. The records reflect that Petitioner had been sent to physical therapy by Dr. Rudert, which Petitioner stated helped or felt good while he was there but the pain returned after he left. It was noted that Petitioner was currently wearing a knee brace, that he noticed swelling to the knee by the end of the day and that he had a knot to the lateral knee. It was noted that he initially injured his knee by twisting it when stepping off a forklift, and then he tripped on some metal while at work. He stated that his knee popped all the time, and that he felt an initial pop at the time of injury but no bruising. It was noted that Petitioner ambulated with a limp, that he was unable to fully extend or flex the knee, and that for the last week or so he had been noticing pain starting to shoot down his calf and up his lateral thigh as well as the pain to the lateral and posterior knee. The impression of Dr. Lee was that of iliotibial friction band syndrome, and Petitioner was scheduled for an injection and instructed to continue his stretches at home that he was taught in physical therapy. Petitioner was issued work restrictions on that date, indicating that he may not return to work until June 10, 2011 with restrictions on the left lower extremity of no squatting, no climbing with the left leg, brace optional and no carrying over 20 pounds. (PX1).

The records reflect that Petitioner called on June 13, 2011, at which time he wanted to verify how long the injection would take effect. Petitioner stated that if he was on the knee for over an hour the pain returned and he could not tell he received an injection. He also stated that when he returned to work on June 10, 2011 his employer placed him on short-term disability until the left knee was fixed, and that he wanted to get it fixed as soon as possible. The note suggested that Petitioner was recommended to return in 3 weeks for another injection to be sure it could not be resolved with conservative means. Petitioner was given a follow up appointment for July 6, 2011. (PX1).

The records reflect that Petitioner was seen on July 6, 2011, at which time it was noted that he was currently off work due to his work not letting him work with restrictions. He was wearing a brace, and it was noted that his injection helped a little and that the best improvement was right after the injection. The impression was noted to be that of IT band friction syndrome, left, exacerbated by varus alignment. Petitioner was given a Kenalog injection under the ITB. He was instructed to continue home stretching/strengthening for the next two weeks, and if he was having improvement with the injection he could call to be released to go back to work and the brace was optional. Petitioner was issued a Work Status/Instructions on that date, indicating that he was released to work with restrictions of no left lower extremity squatting, no climbing with left leg, brace optional and no carrying over 20 pounds. (PX1).

The records reflect that Petitioner stopped by the office on July 20, 2011 stating that he had an injection in his knee on June 9, 2011 and was doing much better, and that he would like to return to work regular duty on July 28, 2011. He was instructed to return on July 21, 2011 to pick up his updated work slip. A Work Status/Instructions slip was issued on July 20, 2011, allowing Petitioner to return to work without restrictions on July 28, 2011. (PX1).

The records reflect that Petitioner called in on July 27, 2011, requesting that he be taken off work until his next follow up appointment scheduled for August 3, 2011. He stated that he had been up on the leg for the last three days trying to work his leg and get ready for the work week, and that he had been on it for at least 8 hours daily cleaning the garage, doing yard work and performing other physical work. He stated that by the 4th hour he had significant pain on the left side of the knee and that his knee was swollen. It was noted that it was okay to take Petitioner off work until his next appointment or he could go on light duty if it was available. He apparently stated that he would like an off work slip. A Work Status/Instructions slip was issued on July 27, 2011, taking him off work until his follow-up appointment on August 3, 2011. (PX1).

The records reflect that Petitioner was seen on August 3, 2011, at which time he presented for a recheck. Petitioner stated there was more popping, that he wore his brace on occasion and that he had an increase in pain the more he was up walking around. It was noted that Petitioner was doing his home exercise program and that he was currently off work due to his employer not allowing him to return to work with restrictions. The impression was that of left knee pain, IT band friction syndrome. The records reflect that surgery was recommended, which was that of a left knee diagnostic scope and open IT band debridement. Petitioner indicated that he wished to proceed with surgery. He was given a Work Status/Instructions slip indicating that he could return to work on August 3, 2011 with restrictions for the left lower extremity of no squatting, no climbing with left leg, brace optional and no carrying over 20 pounds. (PX1).

The records reflect that Petitioner called in on August 8, 2011, stating that he was having surgery and that his lawyer wanted to know if Dr. Lee would agree that it was a repetitive stress injury and if so, would he put it in his notes. Dr. Lee's response suggested that they first had to confirm the diagnosis with proper treatment and good results, and that if things worked out they could consider the possibility but at this time it was difficult to testify either way. It was noted that if Petitioner's attorney wanted to do so, he could get a second opinion to determine this before surgery was performed. (PX1).

The Operative Report dated August 10, 2011 was included within the Bonutti Clinic records. The report indicated that Petitioner underwent a diagnostic arthroscopy, left knee, and iliotibial band debridement, left knee, and that the pre- and post-operative diagnoses were that of left knee iliotibial band friction syndrome and chronic ACL tear. (PX1).

The records reflect that Petitioner was seen for a dressing change on August 12, 2011, at which time it was noted that his pain was not improved. Intraoperative images were reviewed. He was also

given a Work Status/Instructions slip, indicating that he could not return to work until his follow-up. (PX1).

The records reflect that Petitioner was seen on August 22, 2011, at which time he denied pain and stated that he had pain only if he bent it too far but had almost full flexion already. It was noted that there was minimal bruising on the lateral thigh and knee, and that Petitioner was currently off work. He was walking without difficulty and was walking stairs normally. It was further noted that he was doing better than expected, and was given an option to undergo physical therapy to hasten his ability to return to work. He was also given a Work Status/Instructions slip, indicating that he could not return to work at that time. (PX1).

The records reflect that Petitioner was seen on September 2, 2011, at which time it was noted that he had a moderate amount of swelling in the whole knee followed by localized swelling on the lateral side of the knee. He stated that the swelling had decreased some, and that it became worse after standing all day. It was noted that Petitioner had been elevating and using his anti-inflammatories, and that he had also been doing cycling and stairs to build strength. It was noted that prior to this episode, he had no serious problems with his knee and felt that he could have returned to work next week as planned. He was noted to have post-operative effusion, and was instructed to use a knee sleeve. He was instructed to rest for the next few days, and if he wanted formal physical therapy he could call to start. He was advised to perform leg lifts to tone his quad muscles since he had visible atrophy. He was also given a Work Status/Instructions slip, indicating that he could return to work without restrictions as of September 12, 2011. (PX1).

The records reflect that Petitioner was seen on October 14, 2011, at which time he stated that the bump on the side of his knee had improved. He stated that a couple of weeks ago he was busy at work and was very active and that it became painful with bending his knee, but that over the past two days the pain had improved. It was noted that he was no longer taking Mobic, and that he was no longer wearing the knee sleeve since it bunched up in the back of his knee. It was noted that he was improving, and that he was to continue his stretching and exercises at home. Petitioner was to wear a knee sleeve if needed, and he could obtain a different brace if needed to prevent bunching in the back of the knee while seated on the fork truck. (PX1).

A letter dated November 28, 2011 directed to Jay Johnson of Woodruff, Johnson & Palermo was included within the Bonutti Clinic records. The letter from Dr. Lee indicated that he had been asked his opinion whether or not Petitioner's work activities could have caused, aggravated or accelerated the condition of his left knee for which surgery was performed. Dr. Lee indicated that it was very difficult to determine whether or not his work activities caused the condition. He noted that when Petitioner first saw Dr. Rudert for his condition, he disclosed he noticed pain arising after prolonged standing at an auction. He noted that when Dr. Rudert examined him, Petitioner had pain in both the medial and lateral aspects of the knee as well as over the anterior knee. He indicated that one medical factor that could predispose Petitioner to lateral friction syndrome was the fact that he had varus alignment of his knee which meant he was slightly bowlegged. He noted that by combining his activities of stepping on and off his forklift with varus alignment, it could increase the friction or stresses across the lateral knee. He indicated that tripping on a piece of metal may or may not be a factor since this was difficult to assess by hearsay. He further indicated that tripping on a piece of metal could imply bending the knee, twisting the knee or a combination thereof. Dr. Lee further indicated that he believed Petitioner's anatomic alignment predisposed him to an iliotibial band friction syndrome, and that the height at which he would have to step up into his fork truck could certainly aggravate the condition once it was established. (PX1).

The records reflect that Petitioner called on December 22, 2011, indicating that he had been having increased pain in his knee and would like to know if it was okay to take 6-200 mg Ibuprofen. A return call was made, indicating that 6-200 mg Ibuprofen at one time was too much. It was noted that

Petitioner was serving 120 days of work release and did not want to make an appointment in a uniform, and that he would wait until March to make an appointment. (PX1).

The records reflect that Petitioner was seen on April 12, 2012, at which time he stated that his concern was pain under the patella. It was noted that the lateral knee pain for which he had surgery was improved. It was noted that the pain had been present since surgery and had been increasing in the past couple of months. He complained of the feeling of tightness with hyperflexion, and he was noted to have limited range of motion because of pain. He stated that he had the feeling that the knee would give away. The impression was that of left knee anterior pain, status/post ITB debridement. It was noted that Petitioner may have back problems that needed additional testing. It was also noted that due to the persistence and chronicity of his anterior knee pain, a second opinion with Dr. Wente was recommended. (PX1).

The records reflect that Petitioner was seen by Dr. Wente at Bonutti Clinic on April 17, 2012, at which time it was noted that he had never done that well after surgery. He continued to complain of pain primarily around his patella and a tightness that he felt primarily as he came into flexion. It was noted that the pain was much worse at the end of the day when he was up working on it all day. The impression was noted to be that of left knee pain and fat pad synovitis. The records reflect that Dr. Wente discussed that he thought a lot of Petitioner's limitations came from rather severe fat pad synovitis, which was preventing him from reaching full extension which affected him when he walked. It was noted that Petitioner had come to develop some significant quad weakness which now contributed to patellofemoral pain, but that the first step was to control the synovitis. It was noted that the Celebrex was helping and he also recommended an intraarticular injection of corticosteroid, which was performed. (PX1).

The records reflect that Petitioner called on April 19, 2012, indicating that he had no pain, felt great and wanted to know if he needed to continue taking Celebrex. Petitioner was instructed to continue taking Celebrex until his next office visit as long as he was tolerating the medication. An additional phone was included in the records dated April 20, 2012, at which time Petitioner left a voice mail stating that he bragged too early about his knee feeling great and that he was at work on that date and had pain in his knee again. He was instructed to continue Celebrex, ice and rest, and if he did not see improvement he should call the office. (PX1).

The records reflect that Petitioner was seen on May 18, 2012, at which time it was noted that he had made improvement and that the pain he had with extension was gone. He complained of some pain anterior around his kneecap and some mild achiness, but it was noted that he was doing everything he wanted to be doing. He continued to wear his knee sleeve. The impression was that of left knee pad synovitis, resolved, and left knee patellofemoral pain. As it was noted that he had some issues with bending, squatting and being in certain positions for long periods of time, he was recommended to undergo physical therapy. (PX1).

The records reflect that Petitioner was seen on July 18, 2012 at which time he stated that he still had some occasional stiffness and achiness in his knees, and that he felt that he was improving but that he was not quite back to normal. It was noted that when he worked he felt okay, but when he got home he noticed that he would put on flip flops, sandals, flat shoes or go barefoot and walk his dog, and that this seemed to bother him. It was noted that a discussion was had regarding maintaining appropriate shoe wear with good arch support to see if that helped him maintain better alignment for his patellofemoral tracking, and that he should continue with the strengthening exercises. He was instructed to return as needed. (PX1).

The medical records of Biomax Rehabilitation were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner underwent an Initial Evaluation on May 24, 2011, at which time it was noted that for the past month he had been having left knee pain which had

progressively gotten worse. He stated that on May 10, 2011 he was at work and tripped over a lip on a dock plate, after which he felt instant pain on his knee which was worse than what he was feeling prior to the injury and hurt so bad he was unable to make it to the car. He stated that his pain increased the longer he used his knee, and that when he first got out of bed in the morning he had minimal pain but as the day continued on the pain increased. He stated that there were times when the left knee felt like it was giving out, especially around 5:00 p.m. once he had worked all day. He stated that when bending the knee felt like something was loose, and that he heard popping and clicking when going into flexion. He stated that when going up and down stairs, he kept a straight leg and had to go up sideways. (PX2).

The records reflect that on May 26, 2011, Petitioner noted that after his therapy session on May 24, 2011 he went home and helped his neighbor pick up limbs in his yard for a couple of hours and had intense pain that night. He was unable to sleep that night due to pain and the next morning he was still in pain. He stated that on that date he had rested his knee a lot due to not having to work, and that he was on vacation until June 1, 2011 which would allow him to rest his knee more. The note of May 27, 2011 noted that Petitioner had rested more than usual but still was in pain. He stated that he picked up sticks that day and when he was on his leg for long periods of time, he noted an increase in pain. The note of May 31, 2011 noted that he was staining his deck and going grocery shopping afterwards, which caused his knee to hurt more. The note of June 1, 2011 noted that he reported back to work on that date after being on vacation, and that at about 8:00 a.m. his knee starting hurting badly and had been hurting ever since. It was noted that he did not think physical therapy was helping. The June 3, 2011 note indicated that he was unable to extend or bend his left knee and had to lift it into the car. He reported that rest helped the pain to dissipate, but that after being on his feet or sitting on the forklift with his knee bent his pain significantly increased. He was discharged due to no progress per the therapist and patient report, and it was noted that his goals were partially met. (PX2).

The records reflect that Petitioner underwent an additional physical therapy evaluation on April 17, 2012 with complaints of left knee pain following left knee scope with iliotibial band debridement on August 10, 2011. It was noted that Petitioner stated that he did not know why he was coming to therapy, and that he had therapy in the past that did not work. It was noted that while taking Celebrex he had pain relief until about 2:30 p.m. and then he became less functional and started having increased pain. The records reflect that the therapist was asked to look at how he stated his injury occurred at the previous physical therapy session, and the therapist told him it said he tripped over a lip on a dock. Petitioner stated that actually the first incident occurred when he was getting off the fork he stepped down, twisted his knee and felt a pop in his knee, and then the second injury was tripping over the dock. The records reflect that throughout the entire treatment session, Petitioner would not listen to what the therapist was explaining and was very persistent that what the therapist was finding would not help his problems. It was noted that the therapist felt compliance would be poor. Petitioner did not return to schedule more appointments after his appointment with Dr. Wente, so Petitioner was discharged. (PX2).

The records reflect that Petitioner again underwent an initial evaluation on May 21, 2012, at which time Petitioner stated that he had had the best month he had had in a year, that he started taking Celebrex and then Dr. Wente injected his knee which drastically decreased his pain. He requested a single visit with home exercise program issuance due to transportation difficulties. (PX2).

The transcript of the evidence deposition of Dr. Frank Lee was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Dr. Lee testified that he is board-certified in orthopedic surgery, and that he treats musculoskeletal ailments including tendinitis, bursitis, arthritis, fractures and other maladies involving the upper and lower extremities. (PX3).

Dr. Lee testified that he first saw Petitioner on June 9, 2011 as a referral from Dr. Rudert, who was the clinic's urgent care physician who often saw patients on the first visit to triage and manage conservative care. He testified that Petitioner gave a history of injuring his left knee by twisting it

stepping off a forklift and subsequently tripping on a piece of metal at work, and that since that time he had popping, pain and limping. He testified that the pertinent finding of the physical examination was reproduction of pain in the lateral aspect of his knee, and that the focus of Petitioner's pain was in an area consistent with the iliotibial band which was noted to be a common source of pain with a knee injury. He testified that on that date he diagnosed Petitioner with iliotibial friction band syndrome of the left knee. Petitioner agreed to try an injection, and he was advised to continue stretches that he was taught in physical therapy. (PX3).

Dr. Lee testified that Petitioner's condition improved temporarily which helped to verify that they were on the right track in terms of establishing the diagnosis and treatment, but Petitioner indicated in subsequent visits that the pain returned and remained focused at the iliotibial band of the left knee. A second injection was tried, and it was after that that surgery was recommended. He testified that surgery took place on August 10, 2011, which was a diagnostic arthroscopy. He testified that as they examined Petitioner's knee they did not find any pathology within the knee to account for his pain, so that ruled out an intraarticular source for his knee pain. An open resection of a portion of the iliotibial band was performed to take away the friction next to the femur. The surgery helped Petitioner to get rid of his lateral knee pain and he was able to go back to work and be active. Dr. Lee testified that he last saw Petitioner for an evaluation on April 12, 2012 on which date Petitioner had pain that seemed to emanate from under his kneecap, that the lateral knee pain was still improved by the surgery and stayed consistent post-operatively and that Petitioner was unable to fully straighten the knee because of his anterior knee pain. Dr. Lee testified that this was a different condition than was first diagnosed, and when asked if it was related to the first condition, Dr. Lee testified that it was possibly indirectly related only that it could potentially be in the post-operative period following the arthroscopic portion of the surgery. (PX3).

Dr. Lee testified that the condition appeared to be transient only in that reviewing his partner's progress notes Petitioner responded very well to an injection of steroid into his knee joint as well as with Celebrex. He testified that he made the referral to Dr. Wente, his partner. He testified that he had documentation from June 9, 2011 that recommended limitation to activity with respect to Petitioner's knee that extended through July, that Petitioner was allowed to go back to work without restrictions on July 28, 2011, that he was not allowed to go back to work July 27, 2011 through August 2, 2011, that on August 3, 2011 Petitioner was allowed to go back to work on restrictions and that on August 12, 2011 he was taken off work related to the August 10, 2011 surgery. Dr. Lee testified that Petitioner was released back to work on September 2, 2011 without restrictions. (PX3).

Dr. Lee testified that iliotibial band syndrome was a rare condition, that historically the most common population that developed it were cyclists and long distance runners and that it was thought to be due to repetition of the knee, flexion and extension, and the movement of that tissue on the lateral side of the knee. (PX3).

When posed a hypothetical question that included the assumption that in the six months prior to an onset of knee pain the individual was working in an area that was short-handed and that the individual was required to get on and off the forklift 300-500 times a day and that he would be getting up and down to a concrete surface, that on May 10, 2011 approximately two hours into his shift while getting off the forklift he felt the knee pop and buckle and felt pain and at that point started walking but tripped and got his foot caught on a piece of metal on the floor for which he stumbled but did not fall and noticed additional knee pain, and whether the repetitive ascending and descending from the forklift might or could have been a causative factor in the development of the iliotibial band syndrome, Dr. Lee testified that the hypothetical had to be answered with a hypothetical and that it could potentially contribute to the development of the iliotibial band friction syndrome but it would not be in the realm of the population that typically would developed iliotibial friction syndrome. (PX3).

Dr. Lee testified that obesity was not a contributing factor. He agreed that if the knee was a foot and a half off the ground, it would tend to make it more likely than not that there was a relationship between the activity and the development of the condition. He testified that Petitioner's condition was not common, and he thought the increased demand and stepping where he may not have been used to that increase in repetition could be a contributing factor. (PX3).

On cross-examination, Dr. Lee agreed that he did not personally know how, where or by what means Petitioner came to develop his symptoms other than his relying on the history that Petitioner gave to him. He agreed that his knowledge and opinions were based on what he had been told by others, including Petitioner and his attorney through his questioning. He further agreed that as a doctor there was no way for him to see a patient a month or two after the fact in order to independently determine how they came to develop symptoms. He agreed that if the history was wrong or incomplete, then any opinions he might have about the possible legal cause of the patient's symptoms could be wrong. (PX3).

On cross-examination, Dr. Lee agreed that he first saw Petitioner on June 9, 2011 after he had already been seen several times by Dr. Rudert. He agreed that when he got his history from a patient that in some cases he was relying on information from a person who may have a financial bias or financial interest in a claim they were presenting, and that in some cases that financial factor or financial bias may affect the reliability of the history that he received from the patient. He agreed that he could not personally tell whether Petitioner hurt himself at work or off the job, or if his symptoms came about unrelated to any injury, either at work or away from work. (PX3).

On cross-examination, Dr. Lee agreed that his records showed that on May 9, 2011, Petitioner's wife called in seeking an appointment for him because he was having knee pain, and that it was noted that he had stiffness and pain for 2-3 weeks. He agreed that there was nothing in the note about any injury or the specifics of any injury. He agreed that in the note of May 10th when Petitioner was seen by Sarah Aleshire, the history that he provided was that of in the last two or three weeks he noticed pain anterior and lateral with no specific injury, and that he noticed it after he had been at an auction all day standing the symptoms seemed to start. He agreed that there was nothing in that history indicating that Petitioner had injured himself at work that day or on any previous day, and yet Petitioner's attorney had relayed to him in a hypothetical question some facts that Petitioner was two hours into his shift on May 10th was doing something with his forklift and felt a popping sensation in his knee. He agreed that there was none of that specific history reported to Ms. Aleshire according to his office records. He agreed that Ms. Aleshire would have seen Petitioner first and then he would have been seen by Dr. Rudert shortly thereafter. (PX3).

On cross-examination, Dr. Lee agreed that Dr. Rudert ordered the MRI on May 10th and that it was performed on May 10th as well. He testified that Dr. Norfray, the radiologist, worked in Chicago but he reviewed the film and his impression was that of old injury to the ACL, no evidence of meniscal tears and fluid in the intrapatellar fat pad. He testified that he did not remember if he looked at the film himself when he started treating Petitioner. He agreed that Petitioner would have filled out the History of Injury/Complaint form on May 10, 2011, and that when asked whether he was being seen as a result of an accident or injury and if so what was the date of the injury, Petitioner wrote "unknown." He further agreed that when asked to describe how any accident or injury occurred, Petitioner wrote "Don't really know; have had trouble in past with it popping." (PX3).

On cross-examination, Dr. Lee testified that when asked if it was related to sports or whether it was related to work, Petitioner indicated that it was not related to work. He agreed that based on that history it was his understanding that Petitioner himself initially denied that his problem was work-related based on the form. He agreed that when Petitioner returned on May 18th and saw Dr. Rudert a second time, he told Dr. Rudert that his left knee was still hurting and that he had had those symptoms for about five weeks, which meant his symptoms would have been going on since sometime during the middle of

April. He agreed that Dr. Rudert reported a history that Petitioner did not know of any specific injury other than he worked at an auction and was standing all day and that it started to bother him, and that based on the history given to Dr. Rudert, Petitioner was associating his symptoms with something that occurred standing at an auction all day long. He testified that Petitioner never told him anything about his knee problems beginning after standing at an auction. (PX3).

On cross-examination, Dr. Lee agreed that on the form that Petitioner completed on June 9th he listed a specific injury allegedly occurring on May 10, 2011 where he said he twisted or tweaked his left knee getting off a forklift, and that he checked the box at that point saying it was work-related. He agreed that it was a fair statement that initially Petitioner said it was not work-related and a month later stated that it was work-related. He agreed that Petitioner never told him anything about the symptoms beginning after standing all day at an auction. He agreed that it was his understanding that when he saw Petitioner it was his understanding that his symptoms had begun for the first time on May 10th with a specific episode of stepping off a forklift sometime that day at work, and that this was the history he relied on. He agreed that if he accepted the history that Petitioner gave to Ms. Aleshire on May 10th that he had had symptoms for 2-3 weeks before that, that there was no specific injury, that he noticed his symptoms after he had been at an auction standing all day, and that Petitioner then filled out a history form where he indicated that the condition was not work-related, he agreed that the problems that he treated later in the left knee were probably due to something other than an injury stepping off a forklift on May 10, 2011. (PX3).

On cross-examination, Dr. Lee agreed that if Petitioner had been having symptoms for 2-3 weeks prior to May 10th that would be different than the history that he gave to him on June 9th when he told him that his symptoms began on May 10th. He testified that the type of symptoms complained of and the syndrome that he described could arise without the incidence of trauma and was usually associated with some repetitive phenomenon. He testified that the condition was rare enough but that the cases that they saw could usually be attributed to some sports endeavor, but that was not always the case. He testified that he did not recall whether he inquired about Petitioner's non-occupational activities and what, if anything, he did when he was not at work. He agreed that it might be important to know whether Petitioner had any kind of off-job activity that might be repetitious, and that riding a bicycle might be an activity that could be significant as well as running. (PX3).

On cross-examination, Dr. Lee agreed that when he did the surgery on August 10th, he noted that the medial and lateral meniscus were intact, and that he noted no chondromalacia changes which meant that under the kneecap there were no changes or alterations of the cartilage. He testified that his reference to the ACL having some looseness of the fibers referenced a chronic condition, and that by "chronic" he meant at least three to six months but could not be more specific than that. He testified that he debrided some of those fibers and removed a portion of that tissue, and agreed that the ACL tendon itself was still largely intact but there were fibers that were loose. He agreed that it was mostly a diagnostic procedure to see if there was something to attribute his symptoms to, and that while he was in there he shaved off loose fibers. He agreed that the surgery was successful for what they had set out to do, and that Petitioner reported good relief of symptoms in the follow-up visits after the initial surgery. He agreed that he expected Petitioner would be likely to regain essentially full use and function of his knee, and that when he last saw Petitioner he told him to return if he his problems persisted. (PX3).

On cross-examination, Dr. Lee agreed that Petitioner had not returned to see him in more than one year. When asked if that would further reinforce his opinion that Petitioner was probably doing well with a full recovery, he testified that it was hard to say but that he sent Petitioner to Dr. Wente for a second opinion for the separate problem under the kneecap. He agreed that in all likelihood it was a temporary situation that would resolve mainly because Petitioner had not been seen in the office since 2012, and that he expected the kneecap situation to be temporary and was a separate problem than what was addressed at surgery. He testified that it was unrelated to the causation, but could be related by virtue

of being a sequelae of the arthroscopic part of the procedure but there was no way to know that for sure since it did not arise until a year later. (PX3).

On cross-examination, Dr. Lee agreed that if Petitioner talked to other doctors about the fact that he had developed worsening symptoms when he was working in his garden or in his garage, the symptoms that he had since the surgery might be related to those activities. He agreed that Petitioner did not report to him anything about aggravating his knee working in his garden or his garage. When asked if Petitioner's history of developing left knee symptoms after standing all day at an auction was true and whether the knee problems he treated had been caused or aggravated by that activity, he testified that it was unlikely and that standing was not a known etiology for iliotibial band friction syndrome. He testified that if he was lifting and carrying things throughout the day in addition to standing, it could be contributory. He agreed that this was the history that Petitioner thought was significant when he first came in to see Ms. Aleshire, and that in his mind that was when the symptoms seemed to have begun based on what Petitioner told her. (PX3).

On cross-examination, Dr. Lee testified that the Attending Physician Statement (which was attached to the deposition transcript as Respondent's Deposition Exhibit 1) was a routine form that was completed by his office given Petitioner's apparent application for short-term disability benefits. He agreed that the diagnosis indicated on the form was that of IT Band Syndrome, and he agreed that his office indicated on the form that the condition was not work-related. He agreed that Petitioner's health insurance was through Blue Cross. He agreed that when Petitioner was asked the history on the initial form on May 10th whether he was injured at work or not and Petitioner checked "no," Petitioner was not under any duress from anyone in the office. He agreed that at least one of his bills was submitted to Blue Cross, and on the form his office checked the box indicating that it was not related to employment. (PX3).

On cross-examination, Dr. Lee confirmed that there was no way to confirm when the Appointment Referral Form that referenced that the patient having been incarcerated for three months and wanted to come back and have his knee checked out was prepared. He confirmed that he had no information about Petitioner's incarceration. He confirmed that as of the date of the deposition he did not have Petitioner under any work restrictions, nor did he have any future appointments with Petitioner. He confirmed that there was a gap in time between October 14, 2011 and April 12, 2012, and that this was when he called in with the new problem with the kneecap after his incarceration. He agreed that he did not have any idea if Petitioner did anything while he was incarcerated to somehow injure or aggravate the knee. (PX3).

On redirect examination, Dr. Lee testified that there was no evidence in his file that Petitioner was a cyclist or a runner. He agreed that he would not expect a lay person to make a causal connection opinion as to the origin of his pain, and that this was usually a repetitive phenomenon. He agreed that Petitioner was having symptoms beginning in April culminating in May of 2011. He testified that Dr. Rudert was the occupational medicine physician in the clinic, and that it was his job to evaluate patients and make opinions regarding whether or not a condition may be work-related. He testified that his reliance on that opinion would depend on the situation. (PX3).

On redirect examination, Dr. Lee agreed that in the May 10th office note Petitioner explained that he did not really know what the exact injury was, but that he did go on to explain an injury about the toe on the dock plate the day before and that he also twisted the knee a little bit and that at the end of the day it was markedly painful. He agreed that the MRI was recommended and performed on the same day, and that Dr. Rudert saw Petitioner later that day apparently after the MRI and indicated that he did not think that Petitioner's symptoms were related to his meniscal tear or meniscal pathology. He agreed that Dr. Rudert thought it may be due to getting in and out of the forklift on and off all day and standing on the knee, and that it appeared that it would seem with the description that Dr. Rudert was looking for reasons

or causes of Petitioner's pain. He agreed that the phrasing had a repetitive phenomenon to it, and that it could be consistent with iliotibial band syndrome depending on how high the step was. He agreed that when worker's compensation denied a claim, it was the practice of the office to bill group health insurance. He also agreed that with respect to lifting being a cause of the iliotibial band syndrome, he assumed that Petitioner lifted with his legs. He agreed that if Petitioner had to bend over and lift with his legs that could be a causative factor. (PX3).

On further cross-examination, Dr. Lee agreed that Respondent's Deposition Exhibit 3 appeared to be health insurance claim forms submitted to Blue Cross by his office pertaining to treatment rendered to Petitioner. He agreed that on every one of the bills there was a question asking whether the condition was work-related, and that on each of the bills in the group exhibit the form indicated that it was not work-related. (PX3).

On further redirect, Dr. Lee agreed that it was entirely consistent with the office policy to bill Blue Cross when worker's compensation denied a claim. (PX3).

On further cross-examination, Dr. Lee agreed that he did not know whether his office contacted worker's compensation before they submitted the bills to Blue Cross. He agreed that whatever the cause of the problem was, it was his expectation that he treated it successfully and that Petitioner should recover. (PX3).

On further redirect, Dr. Lee agreed that there was a letter dated June 7, 2011 from ADM sent to him regarding the claim that this was a worker's compensation problem. He also agreed that he had an authorization permitting him to provide ADM with medical records dated May 16, 2011 that was signed by Petitioner. (PX3).

On further cross-examination, Dr. Lee agreed that the letter of June 7, 2011 told his office that ADM was investigating a claim and that they wanted his records to evaluate the claim. He agreed that the billing for the MRI on May 10, 2011 was prepared on May 19, 2011. (PX3).

The medical records of the Effingham Ambulatory Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner underwent surgery by Dr. Lee on August 10, 2011 at this facility, and the procedures performed were that of a diagnostic arthroscopy, left knee, and iliotibial band debridement, left knee. (PX4).

A letter dated June 8, 2011 from Greg Farr at ADM directed to Petitioner was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The letter indicated that after conclusion of their investigation into the request for workers' compensation benefits, it was their position that the knee claim did not arise out of or in the course of his job at ADM and was therefore not work-related. (PX5).

The Medical Bills summary was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The medical records of Orthopedic Partners/Dr. James Kohlmann were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner was seen on April 3, 2014 at which time it was noted that his chief complaint was that of "[l]eft knee pain – twisted knee." Petitioner stated that he had arthroscopic left knee surgery by Dr. Lee in August of 2011, and that a small section of the lateral knee iliotibial band was removed for treatment of what was believed to be iliotibial band syndrome. It was noted that Petitioner had been having prior to that and was still having at that time lateral knee pain and posterior lateral knee pain and pain down in the knee, and that he pointed over the lateral fat pad. He stated that the surgery really did not help, that he was given numerous injections in the mostly anterolateral knee by the iliotibial band and that he had what sounded like an intraarticular left knee steroid injection by another physician at the same clinic. Petitioner reported that he worked as a fork

truck operator and was constantly getting on and off the truck which aggravated his knee, and he reported that squatting was painful. He reported that he did not notice clicking, popping or catching, and that is knee did not give away. He stated that if he had a week or two off work that his left knee felt much better. Dr. Kohlmann noted that he reviewed an MRI scan of the left knee that was done prior to the surgery in 2011, which showed a trace effusion but was otherwise normal. He noted that the anterior cruciate ligament did look slightly wide like it had been partially injured at some time, but that was the only other abnormality. The assessment was that of left knee pain that could be tendonitis of some sort, possible posterior lateral meniscus tear, synovitis left knee. It was noted that Petitioner felt better when he took non-steroidal anti-inflammatory medication, but that he did not want to be on that type of medication for the rest of his lift. He noted that he would not hesitate to order an MRI scan to see if he could find another cause for his pain, but that if the MRI scan looked like the one that he reviewed then he did not know if there was a surgical solution to the problem. It was noted that Petitioner had a large deductible and wanted to think about whether or not to do further work-up. (PX7).

A written job description for Respondent's Warehouse Operator position was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The written job description noted that the Warehouse Operator was responsible for loading and unloading finished products and ingredients as directed by the Warehouse Supervisor. (PX8).

The medical records of DMH Corporate Health were entered into evidence at the time of arbitration as Respondent's Exhibit 1. Petitioner was seen on August 1, 2013 with a complaint of lower middle area back pain. Petitioner stated that he was lifting on a lever and felt pain in his back. He stated that a vendor driver was at the location yesterday and asked him to pull on the tandem lever on the trailer as it was not working properly. The records reflect that the driver was in the cab working the brake and attempting to rock the trailer to free up the tandem lever, and that Petitioner was pulling and yanking on the lever and noted that he strained his back. The diagnosis was noted to be pain, lumbar spine. Petitioner was given work restrictions of no lifting/pushing/pulling greater than 10 pounds and given prescription medications. (RX1).

The DMH Corporate Health records reflect that Petitioner was also seen on August 9, 2013 with complaints of lower middle area back pain. His primary problem was noted to be pain located in the low back, and that the pain was on the left in the lumbar region and was improved. Petitioner was continued on modified work with no lifting over 25 pounds and was instructed to return on August 16, 2013 at which time discharge was anticipated. Petitioner was next seen on August 16, 2013, with complaints of lower middle area back pain. He reported that his back pain had resolved, and he only noted some brief pain if he twisted it a certain way. Petitioner was discharged and returned to regular work. It was noted that Petitioner also mentioned some knee pain that he had from a previous work injury that was better for some time but continued to bother him at times. Petitioner noted when he was mowing about three weeks ago he was mowing down an embankment and his right foot slipped, and that he squatted quickly and deeply with his left knee which was the one that hurt from time to time. He noted acute severe pain which faded after he stood for a while. It was noted that he continued to have some limited range of motion in the knee. (RX1).

The medical records of Bonutti Orthopedic Services, Ltd./Dr. Rudert were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The medical records were nearly identical to those entered into evidence in Petitioner's Exhibit 1.

A 19(b) Petition signed by Jay Johnson on June 16, 2011 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Petition referenced an alleged date of accident of May 10, 2011 in Effingham, and the description of accident was that of "[t]ripped over metal on loading dock." (RX3).

The medical records of Dr. James Kohlmann were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The medical records were nearly identical to those entered into evidence in Petitioner's Exhibit 7.

The Employee Report of Incident was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Employee Report of Incident was prepared on May 16, 2011 and was signed by Petitioner. The Employee Report of Incident identified a date of incident of May 10, 2011 and a time of incident as 9:30 a.m. The nature of the injury/incident was identified as cyst on the meniscus and fluid on knee, and the body part affected was noted to be that of the left knee. When asked to describe how the incident occurred, Petitioner indicated his forklift, getting on and off the forklift all day long repeatedly, and that this had formed a meniscus cyst on the left side of his knee and fluid around the knee joint. The Illinois Form 45 was also entered into evidence as part of Respondent's Exhibit 5, and the document noted that the date of report was that of May 16, 2011 and was prepared by Roger Friese. The date and time of accident was noted to be May 10, 2011 at 10:15 a.m., and it was noted that the employee was claiming that he had pain in his left knee and stated that the doctor said it was from getting on and off the lift. (RX5).

Pre-accident medical records from Dr. Bonutti were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records reflect that Petitioner was seen in November 2008 for right eye irritation; in October 2006 pertaining to low back pain; in March and April of 2006 regarding a lumbar strain; and in April 2010 related to a back claim. (RX6).

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator notes that Petitioner appears to be attempting to allege both a specific trauma on May 10, 2011 (*i.e.*, the tripping over metal on the loading dock as referenced on the Petition For An Immediate Hearing Under Section 19(b) of the Act entered into evidence at the time of arbitration as Respondent's Exhibit 3 and as testified to by Petitioner at the time of arbitration), as well as a repetitive trauma claim with a purported manifestation date of May 10, 2011. The Arbitrator finds that regardless of the duplicative approach to the presentation of evidence in the case, Petitioner has failed to provide that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on that date and that his current condition of ill-being is causally related to his work activities.

The Arbitrator notes that the vast majority of Petitioner's testimony was contradicted by the record as a whole in this case. The Arbitrator notes that Petitioner at the time of arbitration testified as to two separate specific incidents involving his left knee on May 10, 2011, yet the initial treatment records at Bonutti Clinic – including the history form completed by Petitioner himself - made no reference whatsoever to either of the alleged accidents, which the Arbitrator finds to be highly illogical in this case. The Arbitrator would be remiss in failing to note that Petitioner's wife had, in fact, already scheduled an appointment for Petitioner at Bonutti Clinic for the very same day of the alleged accident.

Furthermore, the Arbitrator notes that the histories of accident as contained in the initial medical records as compared to those given to the nurse and Dr. Rudert, the MRI personnel, the Biomax Rehabilitation therapy personnel and Dr. Lee were all inconsistent and varied. Additionally, there were a multitude of inconsistencies between the testimony of Petitioner and that of Paul Gouchenouer at the time of arbitration as to the specifics of Petitioner's job duties, causing the Arbitrator to consider the motivation (or lack thereof) of each individual's testimony. When coupled with Petitioner's denial of

prior treatment at Bonutti Clinic which was clearly proven to be false in light of the multitude of pre-accident treatment records as contained in Respondent's Exhibit 6, the Arbitrator finds that Petitioner's testimony at the time of arbitration lacked credibility and therefore places no evidentiary weight on his testimony.

Furthermore, the Arbitrator notes that Dr. Lee when rendering his causation opinion relied upon a hypothetical, the facts of which were not ultimately proven at the time of trial given the lack of Petitioner's credibility in the testimony about his job duties. The Arbitrator finds to be significant in this case that, on cross-examination, Dr. Lee agreed that his records showed that on May 9, 2011, Petitioner's wife called in seeking an appointment for him because he was having knee pain, and that it was noted that he had stiffness and pain for 2-3 weeks; that there was nothing in the note about any injury or the specifics of any injury; that in the note of May 10th when Petitioner was seen by Sarah Aleshire, the history that he provided was that of in the last two or three weeks he noticed pain anterior and lateral with no specific injury, and that he noticed it after he had been at an auction all day standing the symptoms seemed to start; and that there was nothing in that history indicating that Petitioner had injured himself at work that day or on any previous day, and yet Petitioner's attorney had relayed to him in a hypothetical question some facts that Petitioner was two hours into his shift on May 10th, was doing something with his forklift and felt a popping sensation in his knee. (PX3).

The Arbitrator further finds to be significant that, on cross-examination, Dr. Lee agreed that that it was his understanding that when he saw Petitioner it was his understanding that his symptoms had begun for the first time on May 10th with a specific episode of stepping off a forklift sometime that day at work, and that this was the history he relied on, that if he accepted the history that Petitioner gave to Ms. Aleshire on May 10th that he had had symptoms for 2-3 weeks before that, that there was no specific injury, that he noticed his symptoms after he had been at an auction standing all day, and that Petitioner then filled out a history form where he indicated that the condition was not work-related, he agreed that the problems that he treated later in the left knee were probably due to something other than an injury stepping off a forklift on May 10, 2011. (PX3). As a result of the foregoing, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being in the left knee is causally related to his work activities for Respondent.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on May 10, 2011, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of medical bills, temporary total disability benefits, and nature and extent are moot, and the Arbitrator makes no conclusions as to those issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN WEYH,

Petitioner,

17IWCC0624

vs.

NO: 13 WC 24719

PRAIRIE MATERIALS,

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 causal connection, temporary total disability, medical expenses, and the nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner testified he worked as a bulk cement-trailer-truck driver and injured his right elbow and shoulder on March 19, 2013 while operating a valve on the truck. On April 19, 2013, Dr. Li performed right elbow debridement of a torn tendon and repair of common extensor tendon. Petitioner continued to treat with Dr. Li, who ordered an MRI of his right shoulder. It was taken on June 17, 2013 and showed mild-to-moderate tendonosis/tendonitis without tear, mild biceps tendonitis without tear or dislocation, and mild-to-moderate edema of a glenohumeral ligament that may be the result of the sprain. The findings raised the possibility of "an ill-defined superior labral tear." On September 11, 2013, Dr. Li declared the elbow surgery successful.

On September 20, 2013, Dr. Li performed right shoulder arthroscopy with extensive debridement of tenosynovitis and SLAP tear repair. He noted a Type 1 tear at the anterior aspect of the labrum and a Type 2 tear centered around the 11 and 12 o'clock position, which needed repair. On December 19, 2013, Petitioner was released to full duty work.

17IWCC0624

Currently, Petitioner testified that with movement he starts "feeling little pins and needles tingling in" his elbow running down his forearm. It's the same thing when he is driving. He has also lost his grip strength. He still gets the burning sensation in his shoulder. He can't reach as far behind his back as he used to and has difficulty working overhead. He also lost his strength reaching out and pulling. It is "an annoyance and a pain" but does not stop him from doing his job. He can no longer bowl, play golf, or pull back a bow for bow hunting. He has to get off his motorcycle after 45 minutes because he cannot hold his arm up longer. He takes over-the-counter pain medication twice a day. He wonders if there is still an issue and has considered returning to Dr. Li.

On cross examination, Petitioner testified that since he returned to work at full duty in December 2013 he has not missed any work because of his shoulder or elbow. He has the same title of truck driver that he had prior to the accident. He does not have a set schedule, it depends on the load. He has not turned down work. He has received union scale raises since the accident.

The Arbitrator found Petitioner proved a work-related accident on March 29, 2013 which caused a condition of ill-being of both his right arm and shoulder. He awarded the medical expenses submitted into evidence, four weeks of temporary total disability, and 125.6 weeks of permanent partial disability representing 20% loss of the right arm and 15% loss of the person-as-a-whole. The Commission agrees with the determination of the Arbitrator regarding accident, causation, medical expenses, temporary total disability benefits, and the nature and extent of Petitioner's shoulder injury resulting in the award of loss of 15% of the person-as-a-whole. In this regard, the Commission notes that the shoulder surgery required the implantation of permanent hardware to anchor the labrum to the bone.

However, the Commission concludes that the award of loss of 20% of the right arm is excessive. The Commission notes that Petitioner's testimony about his ongoing impairment revolves mostly around his shoulder rather than his arm. He was able to return to his previous occupation which involves substantial use of his right arm, he did not suffer any loss of earning potential, and there is no evidence in the medical record corroborating substantial ongoing disability regarding Petitioner's arm. The Commission concludes that a loss of 10% of the right arm, in addition to the 15% loss of the person-as-a-whole, is appropriate in this claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $554.79 per week for a period of 4 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $499.30 per week for a period of 100.3 weeks, as provided in §8(d)2 and §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 10% of the right arm and loss of 15% of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses submitted in Petitioner's exhibits 9, 10, 11,12, 13, & 14 under §8(a) of the Act, pursuant to the applicable medical fee schedule.

17IWCC0624

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 proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: OCT 6 - 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-9/7/17
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0624

WEYH, BRIAN
Employee/Petitioner

Case# **13WC024719**

PRAIRIE MATERIALS
Employer/Respondent

On 3/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2615 REISMAN LAW OFFICE
CARL REISMAN
212 W GREEN ST
URBANA, IL 61801

1109 GAROFALO SCHREIBER HART ETAL
ANDREW L RANE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0624

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

Brian Weyh
Employee/Petitioner

v.

Prairie Materials
Employer/Respondent

Case # **13** WC **024719**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Urbana**, on **January 27, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 29, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,273.54**; the average weekly wage was **$832.18**.

On the date of accident, Petitioner was **49** years of age, *married* with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$17,328.67** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 9,10, 11,12,13, and 14, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $554.79 per week for 4 weeks commencing September 20, 2013, through October 20, 2013.

Respondent shall pay Petitioner permanent partial disability benefits of $499.30 per week for 125.6 weeks because the injury sustained caused 20% loss of use of the right arm and 15% loss of use of the body as a whole as provided in Section 8(d)(1) and 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

3/28/16
Date

MAR 31 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim, which alleged that he sustained an accidental injury arising out of and in the course of his employment for Respondent on March 29, 2013. According to the Application, Petitioner was opening a valve on cement bulk trailer and sustained injuries to his right shoulder and arm (Arbitrator's Exhibit 2.) The parties stipulated that Petitioner sustained a work-related accident to Petitioner's right elbow; however, Respondent disputed liability on the basis of causal relationship for all treatment related to the right shoulder injury Petitioner alleges he sustained on that date.

Petitioner claimed entitlement to temporary total disability benefits from September 20, 2013-October 20, 2013. Respondent disputed the same. This was the period of time and Petitioner was off work recovering from right shoulder surgery.

Petitioner began working for Respondent in 2007. Petitioner testified that he was right handed, and that he had treated for right shoulder pain at Carle in 2009. This treatment was not for a work injury. Dr. Bane performed a subacromial decompression and distal clavicle resection on Petitioner's right shoulder on February 5, 2009, and released him on April 3, 2009 (Petitioner Exhibit 1). At the time of his release in 2009 Petitioner testified that his strength in his right shoulder were excellent and range of motion was full. Petitioner testified that he had no problems with range of motion or strength in his right shoulder from April 3, 2009 until March 29, 2013, was under no work restrictions, and had no medical treatment.

Petitioner's job duties consisted of driving a cement truck over the road to pick up concrete mix. Petitioner testified that part of his job responsibility was to open valves on the underside of the cement trucks and that he would do so by gripping the valve, identified in PX 16, and pulling the lever in a downward motion, back towards the body, and then across counterclockwise. The Petitioner testified that on the afternoon of March 29, 2013, he tried to open the valve identified in PX 16 but it was stuck shut. He had previously had problems with this particular valve. Petitioner testified that he used all his force in his right upper extremity, including his right shoulder, to try to force down the lever, heard a pop, and felt immediate pain shooting through his right arm. Petitioner testified that he reported the injury to his supervisor, and was told to go to Safeworks.

Petitioner received his initial medical treatment at Safeworks Illinois the same day. At that time, Petitioner gave a history that he had an acute arm injury that day when he reached under a bulk/semitrailer to turn a valve 90 degrees. He had an

immediate pop in his distal right upper arm and couldn't move his right shoulder. Dr. Fletcher diagnosed a right upper arm/shoulder sprain/strain and ordered imaging to rule out a distal right biceps tear. Dr. Fletcher referred him to Dr. Li for a consultation. Dr. Fletcher took Petitioner off work and ordered him to wear a right arm sling (Petitioner Exhibit 2.)

Lawrence Li, MD at the Orthopedic and Shoulder Center on April 1, 2013, saw petitioner. Dr. Li diagnosed a moderate grade partial tear at the origin of the right common extensor tendon and a biceps tendon strain. Dr. Li recommended surgery to repair the right extensor tendon (Petitioner Exhibit 3.)

Petitioner testified that he worked light duty in Prairie's office while wearing a right arm sling following the injury. Dr. Li performed surgery to repair the right elbow tear of the common extensor tendon on April 19, 2013 (Petitioner Exhibit 3). Dr. Li referred petitioner to physical therapy on April 25, 2013, and other than at therapy, the right arm remained in a sling until May 13, 2013. Petitioner saw Dr. Fletcher that day following therapy and drew a pain diagram, indicating a "knot" on the rear of his right upper arm, which he testified was the same location where he ultimately had right shoulder surgery on September 20, 2013(Petitioner Exhibit 2.) Petitioner testified that he had consistently worn the right arm sling since his injury, even to sleep, and only had taken it off to bathe up until this time. At this visit, Dr. Fletcher's restrictions were limited use of the right arm, no lifting over five pounds, continue medication and physical therapy (Petitioner Exhibit 2).

Petitioner saw Dr. Fletcher on June 13, 2013 and gave a history that his right shoulder symptoms were getting worse. The specific location of the pain was the right posterior arm. At Dr. Fletcher's order, Petitioner had an x-ray at Christie Clinic of the right shoulder that day and these showed downsloping of the acromion. (Petitioner Exhibits 2 and 4) Dr. Fletcher ordered an MRI to rule out lateral impingement.

Petitioner had an MRI done at Open MRI Center in Normal on June 17, 2013. Dr. Li discussed this with Petitioner on June 20, 2013, and based on a review of the MRI, Dr. Li suspected an ill-defined superior labral tear (Petitioner Exhibit 3). Dr. Li ordered an MR Arthrogram of the right shoulder and this was done at the Fort Jesse Imaging Center on July 5, 2013. (Petitioner Exhibit 7). Petitioner saw Dr. Li on July 11, 2013, and reported that his right shoulder symptoms were worse, and that anytime he lifted his right arm pain shot down his right upper arm, that his right

shoulder was painful and that he couldn't sleep. Dr. Li diagnosed a right shoulder SLAP tear and recommended a right arthroscopic shoulder surgery and SLAP repair (Petitioner Exhibit 3).

At the direction of Respondent, Dr. Joseph Newcomer, an orthopedic surgeon, examined Petitioner on August 23, 2013. In connection with his examination Dr. Newcomer reviewed medical records provided him by Respondent. He did not have the MR arthogram report at that examination but reviewed the report prior to his August 8, 2014 evidence deposition. Dr. Newcomer testified that the purpose of his evaluation was to determine if the right shoulder injury was caused by the March 29, 2013 work injury (Respondent Exhibit 1).

Dr. Newcomer reviewed the July 5, 2013 and testified that he saw a type 1 slap tear and was unable to visualize a type 2 slap tear. Dr. Newcomer testified that the Petitioner's 2009 shoulder surgery was unrelated to the 2013 surgery with Dr. Li and that condition did not make it more likely that Petitioner would develop a SLAP tear (Respondent Exhibit 1, p 15-16). Dr. Newcomer explained that a type 1 SLAP tear is typically degenerative, due to abnormal biomechanics of the shoulder secondary to cup arthropathy and a type 2 is much more forceful, due to pulling the anchor off the bone (Respondent Exhibit 1, page 24). Dr. Newcomer testified that he would defer to Dr. Li's word that he saw a type 2 SLAP tear during his surgery (Respondent Exhibit 1, page 25). Dr. Newcomer testified that he didn't believe Petitioner had suffered a SLAP tear on March 29, 2013 because he didn't complain about it for three months (Respondent Exhibit 1, page 26.) Dr. Newcomer testified that symptoms of a SLAP tear would be a tearing sensation, an audible pop, and pain (Respondent Exhibit 1, page 27.) Dr. Newcomer testified that the surgery was reasonable given failed conservative management and symptamatology (Respondent Exhibit 1, page 37). Dr. Newcomer testified that he had no explanation for what caused the tear visualized by Dr. Li in the surgery (Respondent Exhibit 1, page 43.) Dr. Newcomer admitted it would cause a lot of force on the valve to cause the elbow injury (Respondent Exhibit 1, page 45.)

Based on Dr. Newcomer's opinions, Respondent terminated payment of medical benefits and Petitioner used his group insurance to pay for further treatment.

Dr. Li performed a right shoulder arthroscope and SLAP repair on September 20, 2013. Dr. Li testified in his evidence deposition that he found it significant to his opinion regarding the right shoulder that in Dr. Fletcher's April 29, 2013 office note that Petitioner was reaching under a bulk semi trailer to turn a valve 90 degrees and felt a tear or pop in his right arm bicep area; that he complained of pain that radiated into his right arm, and that the pain started as a sharp pain, then turned into a burning, hot sensation (Petitioner Exhibit 16, Pages 7-8). Dr. Li found it

significant that Dr. Fletcher noted at that visit limited abduction of the right shoulder and that he couldn't feel the distal biceps insertion because it meant that Petitioner had injured his shoulder and also that he had enough swelling that he couldn't feel some of the structures he would usually feel. (Petitioner Exhibit 16, Page 8). Dr. Li testified that his initial treatment was limited to the torn right common extensor tendon (Petitioner Exhibit 16, page 10). Dr. Li testified that in the June 13, 2013 therapy note, it was significant to him that as his right elbow got better, his shoulder pain got worse (Petitioner Exhibit 16, page 15). Dr. Li testified that the June 17, 2013 showed a labral tear, and that this tear would cause pain with traction activities, that he wouldn't be able to use it with any type of strength and that inflammation and pain would limit range of motion (Petitioner Exhibit 16, pages 16-17).

Dr. Li testified that in the course of the surgery he visualized the torn labrum that was torn off the socket and he placed anchors to repair the labrum down to the bone (Petitioner Exhibit 16, page 21.)

Dr. Li testified that the SLAP tear was related to the work accident. The basis of his opinion was that he obviously had a difficult time turning this valve and put himself in an awkward position and strained his entire upper extremity and caused injury to his right elbow and right upper shoulder (Petitioner Exhibit 16, page 24.)

Following the surgery Petitioner had therapy at 217 Rehab for his right shoulder and continued to follow treatment with Dr. Li and at Safeworks. Petitioner was off work from September 20, 2013 through 10/20/13 and received no TTD for this period. Petitioner returned to light duty work with Respondent on October 21, 2013. He continued with physical therapy at 217 Rehab until December 2, 2013 (Petitioner Exhibit 6) and was released to full duty work by Dr. Fletcher on December 19, 2013 (Petitioner Exhibit 2).

Dr. Li released Petitioner on January 23, 2014 (Petitioner Exhibit 3). At the time he was released Dr. Li noted loss of internal and external rotation of the right shoulder and mild residual pain in the right elbow.

At trial, Petitioner testified that he continues to have numbness and tingling in the right elbow and that certain motions cause sharp pain. He also has pain in the back side of his right shoulder that goes down his arm, and that lifting more than a case of pop causes pain. He testified that he takes Tylenol and Naproxen on a daily basis for the right shoulder and right elbow pain.

Petitioner is working full duty for Respondent in the same job that he had at the time of the injury. He has not sought further treatment for his right arm or right elbow since being released by Dr. Li, but testified that the pain bothers him enough that he is considering returning for reevaluation.

Conclusions of Law

In Regard to Disputed Issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of March 29, 2013.

In support of this conclusion the Arbitrator notes the following:

The accident was not disputed and Petitioner's testimony regarding the circumstances of its occurrence was not rebutted.

There was no evidence that Petitioner ever had any prior injuries to his right elbow or right labrum.

In regard to the Disputed Issue (J) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner for his right shoulder was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

In support of this conclusion the Arbitrator notes the following:

Respondent's dispute in regard to the reasonableness and necessity of medical treatment Petitioner received is limited to the treatment Petitioner received to his right shoulder starting on June 13, 2013 through his release by Dr. Li on January 23, 2014.

While Dr. Newcomer opined that Petitioner's right shoulder injury was unrelated to the work injury of March 29, 2013 because Petitioner had not complained of right shoulder pain for three months, Petitioner's medical records document that he complained of right shoulder pain, including a pop and immediate pain shooting

through his right arm the day of the injury. Petitioner's arm was in a right sling until May 13, 2013, and he noted pain on a pain diagram that day. Petitioner complained again of right arm pain on June 13, 2013 and consistently thereafter.

The arbitrator finds the opinions of Dr. Li more persuasive than that of Dr. Newcomer.

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

The Arbitrator concludes that Petitioner is entitled to payment of temporary total disability benefits of 4 weeks commencing September 20, 2013, through October 20, 2013.

In support of this conclusion, the Arbitrator notes the following:

Petitioner was under active medical treatment from Dr. Li and Dr. Fletcher during the disputed period (September 20, 2013, through October 20, 2013) and was authorized to be off work.

As noted in disputed issue (J) the Arbitrator concluded that the treatment provided by Dr. Li and Dr. Fletcher was reasonable and necessary.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability benefits to the extent of 20% of the arm and 15% of the man as a whole.

In support of this conclusion the Arbitrator notes the following:

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

At the time of the accident, Petitioner was a truck driver. Petitioner was released to return to work without restrictions and returned to the same job. The Arbitrator gives this factor moderate weight.

Petitioner was 49 years of at the time of the accident. His current complaints include loss of range of motion in his right arm and shoulder, pain in the right shoulder, numbness and tingling in the right arm and elbow which is aggravated by

truck driving, the Petitioner's job. Petitioner can no longer play golf, draw a bow for hunting, or bowl, hobbies he enjoyed prior to the injury. The Arbitrator gives this factor moderate weight.

The medical records confirm that Petitioner suffered a torn right common extensor tendon and right SLAP tear, which were successfully treated by surgery. The SLAP tear required retained hardware to anchor the labrum to the bone. The medical records also confirm that there was no prior treatment for right elbow or a right labral injury. The Arbitrator gives this factor significant weight.

Edward Lee

Edward Lee, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

☐ 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

Victor Levandoski,
Petitioner,

17IWCC0625

vs.

NOS: 12 WC 19342
14 WC 12973

Illinois State University,
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 accident, temporary disability, permanent disability, causal connection, notice, medical, intervening accident and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator issued a permanency award in 12WC19342. The Arbitrator also found that Petitioner failed to meet his burden of proving a compensable accident in the companion case 14WC12973. The Commission affirms both of those findings. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." There is no indication that the matter was arbitrated, or that the decision issued, under Section 19(b). Because one claim has a permanency award and the other claim was denied in its entirety, there are no outstanding issues to be arbitrated. Accordingly, this decision is final. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator and the matter is not remanded for further proceedings.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 2016, is hereby affirmed and adopted with the changes noted above.

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

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

DATED: OCT 6 - 2017
o9/7/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0625

LEVANDOSKI, VICTOR
Employee/Petitioner

Case# **12WC019342**

14WC012973

ILLINOIS STATE UNIVERSITY
Employer/Respondent

On 6/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
ROBERT E WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4138 ASSISTANT ATTORNEY GENERAL
WARREN A WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

JUN 7 - 2016

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

17IWCC0625

STATE OF ILLINOIS)
)SS.
COUNTY OF MCCLEAN)

☐ 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

VICTOR LEVANDOSKI,
Employee/Petitioner

v.

ILLINOIS STATE UNIVERSITY,
Employer/Respondent

Case # **12** WC **19342**

Consolidated cases: **14 WC 12973**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **4/21/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/27/12 and 5/13/13**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

On 4/27/12 Petitioner *did* sustain an accident that arose out of and in the course of employment.

On 5/13/13 Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of the accident on 4/27/12 *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident on 4/27/12.

In the year preceding the injuries, Petitioner earned **$23,782.69**; the average weekly wage was **$619.01**.

On the date of accident, Petitioner was **45** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $412.67/week for 26-4/7 weeks, commencing 5/25/12 through 10/3/12, and 6/13/13 through 8/5/13, as provided in Section 8(a) of the Act. Respondent shall be given credit for all temporary total disability benefits already paid.

Respondent shall pay reasonable and necessary medical services related to petitioner's right knee from 4/27/12 through 12/17/15, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid for reasonable and necessary medical services for petitioner's right knee from 4/27/12 through 12/17/15.

Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $371.41/week for 34.40 weeks, because the injuries sustained caused the 16% loss of the right leg, as provided in Section 8(e) of the Act. The award is inclusive of a credit of 4% loss of use of the right leg which petitioner received in a Settlement approved by Arbitrator Falcioni on 9/8/08 for cases 07 WC 57614, 08 WC 7547 and 08 WC 15570.

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

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

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

Signature of Arbitrator

6/1/16
Date

ICArbDec19(b)

JUN 7 - 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 45 year old cook, sustained an accidental injury to his right knee that arose out of and in the course of his employment by respondent on 4/27/12, and alleges that he sustained an accidental injury to his right knee that arose out of and in the course of his employment by respondent on 5/13/13. The issues in dispute in case 12 WC 19342, with an accident date of 4/27/12 are causal connection, and medical expenses and temporary total disability after 4/15/13. The issues in dispute with respect to the alleged injury on 5/13/13 are accident, causal connection, notice, medical expenses, and temporary total disability.

On 4/27/12 petitioner had been working as a cook for respondent for 16 years. Before 4/27/12 petitioner had been working full duty for respondent without any restrictions or surgery for his right knee. However, before 4/27/12 petitioner did see Dr. Li for problems with his right knee. In 2007 petitioner injured his right knee when he slipped on some water on the floor while working for respondent, and slammed his right knee into the counter. Petitioner underwent 4-6 weeks of physical therapy before being released to full duty work. Thereafter, petitioner worked full duty without restrictions with respect to his right knee until the injury he sustained on 4/27/12. Petitioner did admit that he was just back to work following a work related wrist injury when he sustained his right knee injury on 4/27/12.

On 4/27/12 petitioner was making french toast. When he turned from the counter to the skillet, his foot slipped into a drain, he twisted his right knee, and felt a pop followed by pain in his right knee. Petitioner testified that the drain cover was not properly placed, allowing his foot to slip into the drain. Petitioner's knee began to swell. Petitioner completed an accident report on 4/27/12. (PX4)

Petitioner sought medical treatment on 4/27/12 at St. Joseph's Occupational Health. Petitioner was examined, his knee was wrapped and he was restricted to sedentary work.

On 5/10/12 petitioner presented to Dr. Li. Petitioner reported intermittent, moderate, dull and sharp pain in his right knee. He also reported stiffness, swelling and popping of the right knee. He reported that the pain was worse when petitioner was standing for long periods of time, and better with light use, elevation and warm bath. Dr. Li noted a swelling and tenderness to palpation over the medial joint line, positive McMurray's medial, mild crepitus, and range of motion limited to 110 flexion. Petitioner was diagnosed with a right knee medial meniscus tear/sprain.

On 5/11/12 petitioner underwent an MRI of his right knee. The results revealed horizontal and oblique tear involving the posterior body and horn of the medial meniscus measuring approximately 3 cm trizonal, and Grade 3 chondromalacia in the medial compartment.

On 5/25/12 petitioner underwent a right knee arthroscopy with partial medial meniscectomy, and abrasion chondroplasty of the medial femoral condyle and femoral trochlea. This procedure was performed by Dr. Li. Petitioner followed-up post-operatively with Dr. Li.

On 6/4/12 petitioner's Application for Adjustment of Claim with respect to the injury on 4/27/12 was filed on behalf of petitioner. Petitioner signed the Application on 5/9/12.

Following his surgery petitioner followed up with Dr. Li on 6/4/12 and was prescribed physical therapy.

On 6/4/12 petitioner presented to physical therapy. Petitioner's primary complaint was with respect to swelling, popping and walking on the right knee. Petitioner gave a consistent history of the accident on 4/27/12.

On 7/2/12 petitioner reported that he was doing well post-surgery, but still weak. On 7/16/12 Dr. Li drafted a letter to Robert Williams, attorney. He wrote that he was petitioner's treating physician. He wrote that petitioner gave him a history of tripping over a drain that was not properly covered in the front of his work area where he was cooking on 4/27/12. Dr. Li noted that petitioner reported that his foot got caught in the drain and he twisted his right knee. Dr. Li noted that petitioner was still treating and an MRI of 5/10/12 confirmed a medial meniscus tear, as well as a chondral injury to the medial femoral condyle. Dr. Li then discussed the surgery performed on 5/25/12 and noted that petitioner was still in rehabilitation and unable to work. Dr. Li was of the opinion that petitioner had been off work since 4/27/12 and remains authorized off work. Dr. Li opined that the injury on 4/27/12 was the cause of the development of his right knee medial meniscus tear and chondral fractures, and all subsequent treatment to his right knee is directly related to the injury on 4/27/12. (PX2)

On 7/30/12 Petitioner followed-up with Dr. Li. He reported that his knee was still bothering him. He reported that he lacked strength or endurance. He stated that the pain was better.

On 8/2/12 petitioner presented to the emergency room at St. Joseph Medical Center with an altered mental status after taking Soma the night before and in the morning. Following multiple diagnostic tests it was determined that his altered mental status was caused by the Soma. He was instructed to discontinue the Soma. given a prescription for Amox and told to follow-up with Dr. Li.

On 8/20/12 petitioner reported to Dr. Li that he still had some weakness and some pain. On 9/5/12 petitioner reported that his pain was better but increased after being on his knee for 4 hours. Petitioner's work tolerance was increased to 6 hours a day. On 10/3/12 petitioner reported that his pain was better than before surgery and his strength was improving. He was released to full duty work. Petitioner did not follow-up with Dr. Li again until 3/1/13.

On 10/2/12 petitioner was discharged from physical therapy. It was noted that petitioner had reached all therapy goals. He reported that his right knee was sore by the end of the work day. With regard to stairs petitioner reported mild limitations. He stated that he uses handrails and has some pain, but does it regularly at work.

On 10/4/12 petitioner returned to his full duty job without restrictions. He testified that he did not have issues with his full duty job after he was released to full duty work by Dr. Li until 3/1/13.

On 2/6/13 petitioner underwent a Section 12 examination performed by Dr. Paul Nord, at the request of his attorney. Dr. Nord noted that petitioner continued to have some pain in his right knee, especially with weather changes. He reported that he gets some pain in his right knee going up and down stairs. He also reported some occasional sharp pain in the posterior medial aspect of the right knee area. Petitioner told Dr. Nord that he recently lost 50 pounds. He reported more pain with running, biking and jogging. An examination revealed full motion of his right knee with crepitations with all movements. Petitioner had good sensation and good vascular flow within the area. He walked and moved normally. The circumference of both knees were the same. Dr. Nord also performed a record review. Following his examination and record review Dr. Nord 's impression was that petitioner sustained an acute right knee internal derangement syndrome with medial meniscal tear following a work injury. He noted that petitioner continues to have some pain within his right knee area while bearing weight. He noted that petitioner did not have any pain in his right knee prior to the injury, and has continued to have pain in the right knee at least intermittently since the time of the injury. He was of the opinion that petitioner had reached MMI. Dr. Nord was of the opinion that depending upon how much weightbearing petitioner does and the amount of pain he continues to have in his right knee, he may well need further surgical therapy in the future or at least medicinal therapy for pain and inflammation control.

On 3/1/13 petitioner returned to Dr. Li for follow-up of his right knee. Petitioner reported that over the past two months the pain in his right knee had increased without any new injury. He reported that the pain was worse with prolonged standing. He had pain in the medial area and some patellofemoral pain. Dr. Li examined petitioner and assessed right arthroscopic knee surgery with residual symptoms from

chondral injuries to femoral trochlea and medial femoral condyle. Dr. Li recommended a corticosteroid injection. He also prescribed NSAIDs.

On 4/15/13 petitioner returned to Dr. Li for his right knee. Petitioner reported that his symptoms were better following the corticosteroid injection. He stated that he was able to do activities without pain. Dr. Li's diagnosis was right arthroscopic knee surgery symptoms resolved. Petitioner was instructed to advance activities as tolerated.

On 5/13/13 petitioner was attending a health, safety and sanitation recertification class at the directive of his employer. As he was coming back from the bathroom he felt a sharp pain in his right knee, lost strength in his right leg, and had to lean of the wall. Petitioner denied he twisted his right knee. Petitioner admitted that he did not provide respondent or Dr. Li with any notice of this alleged accident. He also admitted that whenever he had an accident in the past he never failed to report it to respondent. Following this incident petitioner finished the class and returned to class the next day. Petitioner continued to work full duty until he was laid off for the summer. Petitioner only worked for respondent when the students are there.

Petitioner testified that prior to the incident on 5/13/13, his right knee had given out on him at least 4-5 other times and he had talked to Dr. Li about it. Petitioner testified that he had repeatedly seen Dr. Li for pain on the inside of his right knee.

On 5/21/13 petitioner returned to Dr. Li. Petitioner reported that she was doing fine until 5/13/13 when he was attending a Health and Safety class at work and twisted his right knee while walking. He reported that since then the pain has gotten much worse. He stated that his pain was medial and worse with pivoting. He rated his pain at a 6/10. He stated that his pain was occasional, aching, sharp, and moderate in intensity. Dr. Li's diagnosis was a possible new right knee medial meniscus tear from the new injury. Dr. Li ordered an MRI of the right knee.

On 5/24/13 petitioner underwent a repeat MRI of the right knee. The impression was small suprapatellar effusion, chondromalacia of the patella and tricompartment osteoarthritis, thickening and abnormal intrasubstance signal along the lateral aspect of the patellar tendon which may represent a prominent patellar tendinopathy/tendinitis, large free edge tear of the posterior horn of the medial meniscus, and 3 cm Baker's cyst.

On 5/29/13 petitioner followed-up with Dr. Li. Dr. Li assessed a new medial meniscus tear from a twisting injury at work. Dr. Li recommended a right arthroscopic knee surgery.

On 6/13/13 Dr. Li drafted an off work authorization taking petitioner off work until further notice. He noted that petitioner was having surgery on 6/28/13.

On 6/28/13 petitioner underwent another surgery performed by Dr. Li. Dr. Li performed a right knee arthroscopy with partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle, patella and femoral trochlea.

On 7/2/13 petitioner began a course of physical therapy. Petitioner's chief complaint was pain in the right knee, stiffness in the right knee, swelling in the right knee, and an inability to walk normally or do his normal activities was noted. No accident history was noted.

On 7/8/13 petitioner followed-up with Dr. Li. Petitioner reported improvement in his pain from before surgery. Dr. Li prescribed Game Ready Vasopneumatic Cryotherapy to reduce swelling and narcotic use significantly.

On 7/17/13 petitioner underwent a Section 12 examination performed by Dr. Nikhil Verma, at the request of the respondent. Petitioner provided a consistent history of the accident on 4/27/12. With respect to the accident in May of 2013 petitioner stated that he was walking down the hall to a food sanitation class and had an onset of pain. He stated that he did not sustain an injury. He denied a twisting injury or any other mechanism of injury. Petitioner reported that his knee was improving, but he had pain with prolonged walking or stair climbing, or after sitting for long periods of time. Following a record review and examination, Dr. Verma diagnosed status post right knee arthroscopy and partial meniscectomy and revision partial meniscectomy. He opined that petitioner sustained an acute right knee meniscal tear as a result of his injury on 4/27/12 and was placed at MMI. Subsequently the petitioner had a recurrent injury of a non-work related nature and required a secondary surgery, which was not work related. Dr. Verma opined that there is no current causal connection between the petitioner's current right knee status and his work injury of April 2012 because he sustained a recurrent injury to his knee during normal ambulation. He opined that petitioner did not have a significant preexisting condition with regard to his right knee. He opined that petitioner had reached MMI and treatment between 4/27/12 and 2/6/13 was reasonable and appropriate with regard to his right knee condition. Dr. Verma did not believe the petitioner was in need of any further treatment with regard to his work injury, and could work full duty without restrictions after August of 2012. He opined that any off work after that was not related to the work injury of 4/27/12.

Petitioner's last visit to physical therapy was on 7/30/13. Petitioner's chief complaint at that time was that he was overweight. He rated the pain in his right knee as a 3.5/10 at its worst. It was noted that petitioner made excellent progress in therapy, his goals were met, and petitioner planned on returning to work in 2 weeks and felt good about returning to work. His potential to reach his goals was excellent.

On 8/5/13 petitioner followed-up with Dr. Li. Dr. Li noted no swelling, bruising or redness. Petitioner's range of motion was normal. Dr. Li instructed petitioner to continue home exercise program, advance activities as tolerated and return to work full duty. He drafted a work authorization note to this effect.

On 8/6/13 Dr. Li drafted a letter to Steve Williams, petitioner's attorney. Dr. Li wrote that petitioner was rehabilitated with physical therapy after his injury on 4/27/12 and did well postoperatively until 5/13/13 when he was attending a health and safety class at SIU while at work and twisted his right knee again. He noted that a repeat MRI on 5/24/13 determined that petitioner had further tearing of the posterior horn on his medial meniscus. He wrote that petitioner underwent another surgery on 7/2/13 and was currently recovering from that surgery. He opined that the injury of 4/27/12 caused petitioner to develop a medical meniscus tear and also resulted in the need for his surgery on 5/25/12. He further opined that the weakened state of the meniscus was then further aggravated in May of 2013 when he reinjured the same knee at work. He opined that because of the previous meniscus tear caused by the April 2012 work incident, the meniscus was weak and subject to tearing much easier. (PX3)

On 4/16/14 petitioner filed his Application for Adjustment of Claim with respect to the alleged accident on 5/13/13. Petitioner claimed that while walking to a safety class he twisted his knee. Petitioner signed this Application on 3/31/14.

On 6/30/14 the evidence deposition of Dr. Li was taken on behalf of the petitioner. Dr. Li opined that the injury on 4/27/12 may not have caused petitioner's condition entirely, but it would have definitely aggravated the femoral trochlear lesion. Dr. Li opined that the removal of 50% of the posterior horn of the medial meniscus would put more stress on the medial joint line, and increase the likelihood of getting arthritis, and increase the risk of a retearing. He opined that the injury on 4/27/12 caused this condition. Dr. Li opined that the removal of the loose pieces of the cartilage of the medial femoral condyle during his surgery on 5/25/12 was related to the accident on 4/27/12. Dr. Li testified that on 10/3/12 he continued prescribing medications for petitioner because he was still having some pain when he stood on it for a long time. He was also of the opinion that petitioner had some slight decrease in strength at that time.

Dr. Li testified that petitioner's pain in his right knee started to increase in January 2013 without any injury. He noted pain with prolonged standing that was medial and some patellofemoral. He opined that petitioner was having some residual symptoms after having that meniscus removed. He also noted some reduced range of motion. At that time he believed the pain was most likely coming from the chondral loss in the medial joint line. Dr. Li opined that on 5/21/13 petitioner had a positive McMurray's.

Following the alleged injury on 5/13/13 and surgery Dr. Li opined that the injury of 4/27/12 caused the medial meniscus tear, a chondral injury on the medial femoral condyle, and aggravated the femoral trochlear lesion he found during surgery. Dr. Li opined that the April 2012 injury and the subsequent surgical treatment weakened his meniscus and predisposed petitioner to easier tearing of that meniscus in the future.

On cross examination, Dr. Li testified that he treated petitioner in 2007 for his right knee. An MRI dated 2/14/07 revealed no evidence of meniscus tear, and grade 3 chondromalacia in the patellofemoral compartment involving the central trochlea. He opined that the injury on 4/27/12 caused the medial meniscus tear, and aggravated the previous femoral trochlea lesion. Dr. Li opined that petitioner had a dislocation of his right kneecap prior to 2007. Dr. Li was under the impression that petitioner sustained a twisting injury to his right knee on 5/13/13. He testified that petitioner did not tell him how it happened. Dr. Li was of the opinion that walking 500 feet would not cause a medial meniscus tear. He testified that absent a twisting motion one would have to run or walk for years in order for it to cause a medial meniscus tear. Dr. Li testified that if petitioner had a sudden onset of pain while walking , he would have to have had a condition (a tear) that existed at that point that became symptomatic by the walking. He was of the opinion that he would think that it just manifested itself through walking, but did not cause the condition. Dr. Li opined that petitioner's condition as it had existed in 2013, could have been a continuation of the prior injury in 2012. Dr. Li opined that petitioner's condition as it existed in 2012 could not have been a continuation of his 2007 injury, because the injuries were different.

Dr. Li opined that in 2007 petitioner did not have a medial meniscus tear or a chondral injury to the medial femoral condyle, but these conditions were present in 2012. The only thing that was present in 2007, but was worse in 2012 was the femoral trochlear lesion. Dr. Li opined that the fact petitioner had such a large portion of his meniscus removed as part of the surgery in 2012, predisposed petitioner to further injuries to the medial side of his right knee. He opined that these injuries could be acute or on a chronic basis. Dr. Li opined that just straight walking would not cause a new medial meniscus tear, unless one was running many miles over many years.

On 4/29/15 the evidence deposition of Dr. Verma was taken on behalf of respondent. Dr. Verma testified that with respect to the alleged injury on 5/13/13 petitioner told him that he was just walking when he felt pain in his right knee. He denied there was any specific accident. Dr. Verma was of the opinion that petitioner had recovered from the injury on 4/27/12. He believed there was nothing on 5/13/13 that would have contributed or caused any further injury. He opined that normal ambulation would not cause a recurrence. However, he did state that day-to-day activities, including ambulation could cause a recurrence. He was of the opinion that at the time of his first surgery petitioner had degenerative disease involving two compartments of his knee which would be a typical cause of recurrence of pain with walking, and in that situation day to day activities could cause symptoms. He opined that petitioner's recurrence in May of 2013 was related to his degenerative disease and an age related onset.

On cross examination Dr. Verma noted that he had not reviewed the operative report following the alleged accident on 5/13/13. Dr. Verma opined that the degenerative changes in the knee after the surgery in May of 2012, could contribute to the findings in the June 2013 surgery because the petitioner had preexisting chondromalacia there and that is not corrected by an arthroscopic intervention. He opined that the lateral meniscus tear would not be consistent with these findings, but would be a new acute finding. He agreed that the surgery in June of 2013 could have been the result of the degenerative changes in the knee. Other than the findings related to the lateral meniscus, the other findings during the surgery could be related to the degenerative process in the knee. Dr. Verma was of the opinion that the fact that part of the meniscus was removed would not necessitate another arthroscopic surgery but may contribute to some progression of the medial sided chondromalacia. He was of the opinion that it would not affect the trochlea or patellofemoral chondromalacia, or the lateral side of the knee. Dr. Verma opined that a partial meniscectomy may contribute to the deterioration of the cartilage (chondromalacia) around that specific area. Dr. Verma was of the opinion that petitioner's lateral tear following the 5/13/13 alleged injury was not degenerative, but rather acute.

On 5/11/15 petitioner presented to Dr. Li with complaints of continuing right knee pain. Petitioner complained of some pain over the medial aspect of the right knee. Petitioner reported that it was better than before surgery but prolonged standing and walking still caused him pain. Dr. Li examined petitioner and assessed petitioner with a status post right knee arthroscopy with meniscectomy and chondroplasty with residual pain. Dr. Li noted that he would continue to observe petitioner's condition. He was instructed to return or call the office if his problems did not resolve.

On 10/28/15 petitioner followed-up with Dr. Li. Petitioner reported that his right knee had been more bothersome in the last three weeks. He reported that he developed swelling several days ago but now his pain was currently better. His condition was worse than in May. Dr. Li examined petitioner and recommended an MRI to determine treatment plan.

Petitioner underwent a repeat MRI of the right knee that was compared to the MRI of 5/24/13. The impression was status post partial medial meniscectomy, possibility of a recurrent small vertical tear in the posterior horn near the junction with the body is not excluded; tricompartmental degenerative joint disease, moderate to advanced in the medial compartment; and mild subchondral bone marrow edema in the medial aspect of the medial femoral condyle.

On 11/25/15 Dr. Verma performed an AMA Impairment Rating of petitioner. Dr. Verma stated that he could not provide an opinion regarding an AMA Impairment Rating for the injury on 4/27/12 because he did not examine petitioner at that time, and petitioner had subsequent surgery. Dr. Verma was of the opinion that petitioner's status was post right knee arthroscopy, partial medial and lateral meniscectomies, which was a class 1 diagnosis, using the 6th Edition Guides Table 16-3 knee regional grid on page 509. He noted that petitioner completed an AAOS lower extremity score of 18. He noted that the petitioner's functional history adjustment was grade 2 modifier in that he has moderate deficit with mild antalgic gait; his physical exam adjustment was grade modifier 1 in that petitioner had minimal palpatory findings and no effusion; symmetric quad circumference; and his clinical studies adjustment was grade modifier 2 in that clinical studies demonstrate joint space narrowing with associated meniscal pathology and prior MRI scans. Using these adjustments, Dr. Verma found the petitioner's final diagnosis was class 1 Grade E. Using Table 16-3, page 509 again, a 13% lower extremity impairment was found. He was unable to portion the impairment in regards to the first or second injury or surgery.

On 12/17/15 petitioner returned to Dr. Li for follow-up of his right knee. Petitioner reported that his symptoms were the same, but now he was able to tolerate them. He still reported medial knee pain that is aggravated with any type of strenuous use. Dr. Li performed a physical examination that revealed petitioner was in no apparent distress, and all tests were normal. Dr. Li's diagnosis was status post right arthroscopic knee surgery with advanced chondral loss of medial compartment and subchondral bone edema causing pain. Petitioner was released on an as needed basis.

Currently, petitioner complained of weather related pain. He stated that when the barometric pressure changes he has increased pain. Petitioner also complained of increased pain when lifting heavy items. He also reported a limp. Petitioner testified that when driving long distances he has to stop and

get out and walk. Petitioner does not run because it causes increased pain in his right knee. Petitioner reported difficulty going up and down ladders and stairs. When petitioner kneels for more than 2 minutes on his right knee he feels sharp stabbing pains in his right knee. Petitioner uses a cane when the weather is bad. Petitioner reported that his pain persists and he takes Advil to help relieve his symptoms 3-4 times a week.

Petitioner reported that he had treatment for both his knees when in was in the service and treated conservatively for both. Petitioner sustained a twisting injury to the right knee and a contusion to the left knee. Petitioner also reported a history of gout in the past. He testified that he has not had a flare-up since fall of 2014. That flare-up was to his right big toe. Petitioner's gout never affected his knees.

Currently, petitioner continues to complain of pain in the inside of his right knee. Petitioner is a hot rod activist. He also still fishes with his girls. He no longer hunts or takes part in any sports.

Petitioner has reported 18 injuries while working for respondent. However, only 7 of those injury reports resulted in an accident report being drafted. The other injuries were reported so respondent could use the information for tracking.

On 11/1/00 petitioner sustained a contusion to his knee(s); on 2/12/03 he sustained a laceration of his finger(s); on 9/12/03 petitioner sustained a strain of his shoulder(s); on 1/26/04 petitioner sustained a burn of his head; on 1/27/15 petitioner sustained contusion to his skull; on 12/1/05 petitioner sustained a sprain of his back; on 2/13/07 petitioner sustained a sprain of his knee(s); on 10/10/07 and 1/14/08 petitioner sustained a sprain of his hand(s); petitioner sustained a foot/feet contusion; on 3/30/09 petitioner sustained a burn to his hand(s); on 9/26/09 petitioner sustained a contusion to his knee(s); on 2/20/11 petitioner sustained a sprain of his hand(s); on 3/31/12 petitioner sustained a sprain of the hand(s); on 4/27/12 petitioner sustained a sprain to the knee(s); on 4/14/15 petitioner sustained an infection to his lower right leg; on 10/9/15 petitioner sustained a strain to his left elbow; and on 1/8/16 petitioner sustained a strain to his left lower arm. Form 45 Workers Compensation Notice of Injury were drafted for the injuries on 9/26/09, 2/20/11, 3/31/12, 4/14/15; and 1/8/16.

On 9/8/08 petitioner received a Lump Sum Settlement regarding cases 07 WC 57614, 08 WC 7547, and 08 WC 15570. These accidents involved injuries on 1/14/08, 10/10/07, and 2/13/07. The body parts involved were both hands, both arms and right leg. Petitioner received a 4% loss of use of his right leg as part of this settlement. This settlement was approved by Arbitrator Falcioni on 9/8/08.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?
F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The parties stipulate that petitioner sustained an accidental injury to his right knee that arose out of and in the course of his employment by respondent on 4/27/12. The respondent disputes that petitioner sustained an injury to his right knee that arose out of and in the course of his employment by respondent on 5/13/13.

Prior to 4/27/12 petitioner had received treatment for his right knee in 2007 when he slammed it into a counter. He underwent 4-6 weeks of physical therapy, and then was released to full duty. Petitioner sought no further treatment for his right knee until after the accident on 4/27/12.

Following the injury on 4/27/12 petitioner sought treatment at St. Joseph's Occupational Health. Thereafter, he presented to Dr. Li on 5/10/12 with intermittent moderate, dull and sharp pain in his right knee. He also reported stiffness, swelling and popping of the right knee. He reported worsening symptoms when standing for long periods of time. Dr. Li noted swelling and tenderness over the medial joint line, positive Mc Murray's medial, mild crepitus, and limited range of motion. Dr. Li diagnosed a right knee medial tear/sprain. An MRI confirmed a tear involving the posterior body and horn of the medial meniscus measuring approximately 3 cm trizonal, and Grade 3 chondromalacia in the medial compartment.

Petitioner underwent a right knee arthroscopy with partial medial meniscectomy, and abrasion chondroplasty of the medial femoral condyle and femoral trochlea on 5/25/12. Petitioner followed-up post-operatively with Dr. Li. This treatment included a course of physical therapy. On 10/3/12 petitioner reported that his pain was better than before surgery and his strength was improving. Dr. Li released him to full duty work.

When petitioner was examined by Dr. Nord on 2/6/13 he reported that he continued to have pain in his right knee, that included pain going up and down stairs. He also reported occasional sharp pain in the posterior medial aspect of the right knee area, and more pain with running, biking and jogging. Dr. Nord noted that petitioner had full motion of his right knee and crepitations with all movements. Dr. Nord was of the opinion that petitioner had sustained an acute right knee internal derangement syndrome with medial meniscal tear. He was further of the opinion that petitioner continued to have some pain within his right knee area while bearing weight. He also was of the opinion that depending on how much weightbearing petitioner does and the amount of pain he continues to have in his right knee, petitioner

may need further surgical therapy in the future, or at least medicinal therapy for pain and inflammation control.

On 3/1/13 petitioner returned to Dr. Li and reported increased pain in his right knee over the past two months without any new injury. He also reported that the pain was worse with prolonged standing. The pain was in the medial area and some patellofemoral pain. Dr. Li assessed residual symptoms after surgery from chondral injuries to the femoral trochlea and medial femoral condyle. Dr. Li performed an injection and prescribed NSAIDs. Following this, on 4/15/13, petitioner's symptoms were improved and Dr. Li noted that petitioner's symptoms were resolved. He told petitioner to advance activities as tolerated.

Petitioner had no further treatment until after his alleged accident on 5/13/13. However, he testified that his right knee had given out on him at least 4-5 times before 5/13/13 and he had talked to Dr. Li about this. Petitioner testified that on 5/13/13 he was at respondent's health, safety and sanitation recertification class, and as he was coming back from the bathroom he felt a sharp pain in his right knee, lost strength in his right knee and had to lean on the wall. Petitioner testified that he did not twist his right knee. Petitioner continued to work full duty until he was laid off for summer, which was petitioner's normal course of employment for respondent. Petitioner only worked for respondent when the students were present.

Petitioner's first treatment after the alleged injury on 5/13/13 was with Dr. Li on 5/21/13. Contrary to his testimony at trial, the records of Dr. Li indicate that petitioner told Dr. Li that he twisted his right knee while walking while he was attending a Health and Safety class to work. Petitioner reported that since then his right knee had gotten much worse, and was medial and worse with pivoting, Dr. Li diagnosed a possible new right medial meniscus tear. This was confirmed by a repeat MRI on 5/24/13. On 5/29/13 Dr. Li recommended a right arthroscopic surgery. On 6/28/13 Dr. Li performed a right knee arthroscopy with partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle, patella and femoral trochlea. Petitioner continued treating with Dr. Li and this treatment included additional physical therapy.

Although petitioner admitted that he did not report the incident as an injury to respondent. Although there is no written evidence to respondent of an alleged injury on 5/13/13, when respondent had petitioner examined by Dr. Verma on 7/17/13 petitioner provided a consistent history of the accident on 4/27/12. With respect to the alleged accident on 5/13/13 petitioner reported that he was walking down the hall to a food sanitation class and had an onset of pain. He stated that he did not sustain any injury.

He denied a twisting injury or any other mechanism of injury. Petitioner reported that his knee was improving , but he has pain with prolonged walking or stair climbing, or after sitting for long periods of time. Dr. Verma was of the opinion that petitioner had a recurrent injury of a non-work related nature in May of 2013.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained an accidental injury that arose out of and in the course of his employment by respondent on 4/27/12, but failed to prove by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 5/13/13. The arbitrator bases this opinion on the fact that petitioner testified and reported to Dr. Nord that he did not sustain a new injury to his right knee on 5/13/13. He testified at trial, and reported to Dr. Nord that he had an increased onset of pain on 5/13/13 while walking down the hall at the sanitation class he was attending at the request of the respondent. He denied a twisting injury or any other mechanism of injury to Dr. Nord. At trial he also denied he that he twisted his right knee. He testified that he felt a sharp pain in his right knee while walking back from the bathroom while at respondent's sanitation class. He testified that following this sharp pain in his right knee, he lost strength in his right leg and had to lean on the wall.

With respect to the petitioner's current condition of ill-being as it relates to his right knee, the arbitrator relies on the credible medical record and the opinions of Dr. Li and Dr. Nord. The respondent claims petitioner's current condition of ill-being as it relates to his right knee is not causally related to the accident on 4/27/12 after 5/13/13 due to an intervening non-work related injury to his right knee on 5/13/13.

Following the surgery on 5/25/12 petitioner continued to have right knee complaints. On 7/16/12 he reported weakness. On 7/30/12 petitioner reported that his knee was still bothering him and he lacked strength or endurance. He noted that his pain was better. On 8/20/12 he was still reporting weakness and some pain. On 9/5/12 he reported increased pain after being on his knee for 4 hours. Petitioner was still not working 8 hours a day. On that day his work day was increased to 6 hours. On 10/3/12 petitioner's pain was improved and his strength was improving.

He returned to full duty work on 10/4/12. However, when he was examined by Dr. Nord on 2/6/13 he reported some pain in his right knee with weather changes, and going up and down stairs. He also reported occasional sharp pain in the posterior medial aspect of the right knee area. Dr. Nord noted crepitation with all movement. He also noted that petitioner continued to have some pain within his right knee area while weight bearing. He noted that since the injury on 4/27/12 petitioner has had right knee

pain, at least intermittently, since the time of the injury. The arbitrator specifically notes that on this date Dr. Nord was of the opinion that depending on how much weightbearing petitioner does and the amount of pain he continues to have in his right knee, he may well need further surgical therapy in the future, or at least medicinal therapy for pain and inflammation control.

Thereafter, petitioner returned to Dr. Li on 3/1/13 and reported increased right knee pain over the past two months without any new injury. He also noted worse pain with prolonged standing. His pain was in the medial area, and some patellofemoral pain. Dr. Li assessed residual symptoms from chondral injuries to femoral trochlea and medial femoral condyle. Dr. Li performed a corticosteroid injection and prescribed NSAIDs. On 4/15/13 petitioner reported improved symptoms after the injection. Dr. Li told petitioner to increase activities as tolerated.

On 5/13/13 petitioner felt a sharp pain in his right knee, and loss of strength in his right leg, while walking at respondent's sanitation class. He testified that he had to lean on the wall. He denied a twisting injury. He also testified that prior to 5/13/13 his right knee had given out on him at least 4-5 other times.

Dr. Li noted that petitioner told him he twisted his knee on 5/13/13, and had worsening pain. Based on this history Dr. Li diagnosed a possible new right knee medial meniscus tear. A repeat MRI revealed a large free edge tear of the posterior horn of the medial meniscus. On 6/28/13 petitioner underwent a second surgery on his right knee that consisted of a partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle, patella and femoral trochlea. Petitioner followed up post-operatively with Dr. Li through 8/5/13, when Dr. Li released petitioner to full duty work. Petitioner had no real complaints at that time.

On 7/17/13 Dr. Verma opined that petitioner sustained a recurrent injury of a non-work related nature on 5/13/13 and required a secondary surgery that was not work related. As a result he opined that petitioner's current condition of ill-being as it relates to his right knee is not causally related to the accident he sustained on 4/27/12. During his deposition Dr. Verma opined that following the surgery on 5/25/12 normal ambulation could cause a recurrence. Dr. Verma related petitioner's recurrence in May of 2013 to his degenerative disease and an age related onset. He also opined that petitioner's tear after 5/13/13 was not degenerative, but rather acute. However, Dr. Verma admitted that he never reviewed the surgical report in June of 2013. He admitted that given the fact that part of petitioner's meniscus was removed in the first surgery, that could contribute to some progression of the medial sided chondromalacia.

Dr. Li opined that the injury of 4/27/12 caused petitioner to develop a medial meniscus tear and resulted in the need for surgery on 5/25/12. He further opined that the weakened state of the meniscus was then further aggravated in May of 2013. Dr. Li opined that although the injury on 4/27/12 may not have caused petitioner's condition entirely, it would have definitely aggravated the femoral trochlear lesion. He further opined that the removal of 50% of the posterior horn of the medial meniscus would put more stress on the medial joint, and increased the likelihood of a retearing. Dr. Li opined that following the surgery on 5/25/12 petitioner continued to have right knee pain that increased in January 2013 without any injury. He attributed these problems were residual symptoms from having the meniscus removed. At that time he believed the pain was coming from the chondral loss in the medial joint. Dr. Li opined that the 4/27/12 injury and subsequent surgery weakened petitioner's meniscus and predisposed him to easier tearing of that meniscus in the future. Dr. Li was of the opinion that if petitioner had a sudden onset of pain while walking he would have had a condition that existed at that point that became symptomatic by the walking. He opined that petitioner's condition in 2013 could have been a continuation of the prior injury in 2012.

Based on the above, as well as the credible record, that arbitrator finds petitioner's current condition of ill-being as it relates to petitioner's right knee is causally related to the injury petitioner sustained on 4/27/12. The arbitrator bases this finding on the opinions of Dr. Nord, who opined on 2/3/13 (before 5/13/13) that depending on how much weightbearing petitioner does and the amount of pain he continues to have, he may well need further surgery. The arbitrator notes that petitioner continued weightbearing on his right knee and complained of right knee pain after this date. The arbitrator also relies on the opinions of Dr. Li, specifically as it relates to his opinions that although the injury on 4/27/12 may not have caused petitioner's condition entirely, it would have definitely aggravated the femoral trochlear lesion; that the removal of 50% of the posterior horn of the medial meniscus would put more stress on the medial joint, and increased the likelihood of a retearing; that following the surgery on 5/25/12 petitioner continued to have right knee pain that increased in January 2013 without any injury; that the 4/27/12 injury and subsequent surgery weakened petitioner's meniscus and predisposed him to easier tearing of that meniscus in the future; and that petitioner's condition in 2013 could have been a continuation of the prior injury in 2012. The arbitrator finds the opinions of Dr. Nord and Dr. Li more consistent with the credible record than Dr. Verma's.

The arbitrator finds the petitioner has proven by a preponderance of the credible evidence that petitioner sustained an accidental injury to his right knee that arose out of and in the course of his

employment by respondent on 4/27/12; that petitioner has failed to prove by a preponderance of the credible evidence that petitioner sustained an accidental injury to his right knee that arose out of and in the course of his employment by respondent on 5/13/13; that petitioner's current condition of ill-being as it relates to his right knee is causally related to the injury he sustained on 4/27/12; and that petitioner's current condition of ill-being as it relates to his right knee is not causally related to an injury on 5/13/13.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

Respondent does not dispute that petitioner provided timely notice of the accident on 4/27/12. Respondent disputes petitioner gave timely notice of the accident on 5/13/13. Having found petitioner did not sustain an accident on 5/13/13, the arbitrator finds the issue of notice as it relates to an alleged accident on 5/13/13 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?

Respondent's sole dispute as to medical services provided petitioner after 5/13/13 is that petitioner sustained a non-work related injury on 5/13/13 and therefore, all treatment for his right knee after that date was not reasonable and necessary as it relates to the accident he sustained to his right knee on 4/27/13. Having found petitioner did not sustain a new injury on 5/13/13 and that his current condition of ill-being as it relates to right knee is causally related to the accident on 4/27/12, the arbitrator finds all medical services petitioner received for his right knee from 4/27/12 through 12/17/15 were reasonable and necessary to cure or relieve petitioner from the effects of his injury on 4/27/12.

Respondent shall receive credit for all reasonable and necessary medical services for petitioner's right knee from 4/27/12 through 12/17/15 that it has already paid pursuant to Section 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is claiming temporary total disability benefits for the period 5/25/12 through 10/3/12 and 6/13/13 through 8/5/13. Respondent claims petitioner is not entitled to any temporary total disability benefits after 5/13/13 because he did not sustain a work related injury on 5/13/13, and his condition of ill-being after that date is not causally related to the injury on 4/27/12. Having found the petitioner did not sustain a work related injury on 5/13/13 and that petitioner's current condition of ill-being as it relates to his right knee is causally related to his work related injury on 4/27/12, the arbitrator finds petitioner was temporarily totally disabled from 5/25/12 through 10/3/12 and 6/13/13/ through 8/5/13, a period of 26-4/7 weeks, based on the opinions of Dr. Li.

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

As a result of the accident on 4/27/12 petitioner sustained an injury to his right knee. For this injury petitioner underwent two surgeries. He was ultimately released to full duty on 8/5/13.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 13% of the lower extremity as determined by Dr. Verma, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The arbitrator notes Dr. Verma was of the opinion that petitioner's status was post right knee arthroscopy, partial medial and lateral meniscectomies. Dr. Verma also included petitioner's moderate deficit with mild antalgic gait, no effusion, symmetric quad circumference, joint space narrowing, and meniscal pathology. The Arbitrator gives greater weight to this factor given the fact that this AMA Impairment report was completed less than one month before petitioner was last seen by Dr. Li, and two years after petitioner last actively treated with Dr. Li.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a cook. After petitioner was given a full duty release without restrictions petitioner returned to his job as a cook. Since petitioner is still able to perform his regular duty job without restrictions by Dr. Li, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Because of the fact that petitioner still has many working years ahead of him. Petitioner did not offer any evidence that he is not able to perform his full duty job as a result of his injury on 4/27/12. Petitioner's current complaints did not include any complaints resulting from his work duties. 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 no evidence regarding petitioner's future earnings was offered into evidence. 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 notes that when petitioner last followed-up with Dr. Li on 8/5/13 he reported no swelling, bruising or redness. His range of motion was normal. Petitioner was told to continue his home exercise program, and advance activities as tolerated and return to full duty work. Petitioner did not follow-up with Dr. Li again until 5/11/15. At that time he complained of continuing right knee pain. He reported that it was better

than before surgery but prolonged standing and walking still caused him pain. Dr. Li did not give petitioner any restrictions. After that, petitioner followed-up with Dr. Li on 10/28/15 and 12/7/15. On 12/17/15 petitioner reported that his symptoms were the same, but he was able to tolerate them. He reported medial right knee pain that is aggravated by any strenuous use. Dr. Li's examination and tests were all normal. Petitioner was released on an as needed basis, but never returned to Dr. Li.

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 16% loss of use of the his right leg pursuant to §8(e) of the Act. The award is inclusive of a credit of 4% loss of use of the right leg which petitioner received in a Settlement approved by Arbitrator Falcioni on 9/8/08 for cases 07 WC 57614, 08 WC 7547 and 08 WC 15570.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES SAVINO,

Petitioner,

17IWCC0626

vs. NO: 16 WC 10464

EXPEDITERS INTERNATIONAL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner testified he was 62 years old and works as a small pack manager. On September 9, 2015, he was picking up a box weighing about 50 pounds and felt pain in his knee. On October 31, 2015, Dr. Jareb performed right knee arthroscopy, partial medial meniscectomy, and partial lateral meniscectomy, chondroplasty of the medial femoral condyle for medial meniscal tear. Subsequent to his surgery, Petitioner continued to complain of swelling and pain.

Petitioner had physical therapy and work conditioning. By December 18, 2015 he, was at 95.6% of full work demands. On that date, Petitioner also presented to Dr. Jareb. He reported the problem was improving, but "the symptoms occur constantly." Petitioner declined an injection in lieu of a home exercise program. Dr. Jareb released him to full duty and from treatment on a per needed basis. On April 14, 2016, Petitioner returned with complaints that he had constant moderate-to-severe knee pain, with intermittent worsening. The symptoms were aggravated by prolonged walking and work. He reported locking, catching, and occasional giving out. He was working without restrictions. Dr. Jareb diagnosed exacerbation of arthritis, gave Petitioner home exercises, and kept him on full-duty. After he last saw Dr. Jareb, Petitioner had two injections for pain/swelling in the knee. At the time of arbitration, he had no additional appointments scheduled for treatment of his knee.

17IWCC0626

Petitioner testified he had not suffered any knee injury prior to or since this accident. Prior to the injury, he was able to perform his job without pain. Currently, his knee feels "still the same. The same behind the knee and in the one spot." He usually has his son do the yard work now. He can bend down, but "it's just hard to get up. Getting up is the problem." When he wakes up in the morning his knee is sore. He has sharp pain when lifting objects at work. He does not take pain medication because he does not like it. He works 40 to 42 hours a week.

On cross examination, Petitioner testified he worked the same hours as he did prior to the injury. Respondent has been "a little more lenient" on what he can and can't do. He has not been asked to lift as much. They were trying to move him into a more supervisory role, which he appreciated, but he still unloads trucks. He had supervisory responsibilities in previous jobs.

On November 29, 2016, Dr. Coe examined Petitioner and reviewed medical records. Currently, Petitioner complained of pain aggravated by prolonged standing, kneeling, or squatting. He also had stiffness, popping or snapping, and occasional swelling. He was working full duty but had missed about two months due to the injury and associated treatment. On examination, Dr. Coe found no lateral or medial instability, negative drawer signs, full muscle strength with no abnormal coloring or sweating. He had mild residual knee tenderness and swelling, which was consistent with Dr. Jareb's arthritis diagnosis. Petitioner's questionnaire indicated mild-to-moderate functional limitation. Dr. Coe opined that Petitioner was at maximum medical improvement from his work injury and did not need "specific treatment." Any prospective treatment would be related to Petitioner's arthritis. Dr. Coe rated Petitioner's AMA impairment at 10% of the right leg.

In looking at the statutory factors in determining permanent partial disability awards, Petitioner was 61 years of age at the time of the injury and had a limited remainng work life in which he has to deal with the disability. He was able to return to his previous profession and proved no loss of earning potential, though he testified he is not being asked to lift as much as he did previously. While he continued to complain of residual pain and swelling at the time of arbitration he was able to perform his work and was not taking prescription pain medication. Regarding post-operative treatment, both Dr. Jareb and Dr. Coe seemed to attribute his current complaints and any prospective need for treatment on Petitioner's underlying arthritis and not the work injury. In looking at the record in its entirety and the statutory factors in determining permanent partial disability, the Commission concludes that an award of loss of 25% of the right leg is appropriate in this claim and modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $420.35 per week for a period of 53.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 25% of the right leg.

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

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

17IWCC0626

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,500.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: OCT 6 - 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-9/28/17
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0626

SAVINO, JAMES
Employee/Petitioner

Case# **16WC010464**

EXPEDITORS, INTERNATIONAL
Employer/Respondent

On 2/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1752 ASHER, RAYMOND L LTD
LISA T AZOORY
200 W JACKSON BLVD SUITE 1050
CHICAGO, IL 60606

2837 LAW OFFICES JOSEPH MARCINIAK
BRENT HALBLEIB
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

17IWCC0626

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

- [ ] 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

James Savino
Employee/Petitioner

v.

Expediter International
Employer/Respondent

Case # **16** WC **10464**

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Wheaton**, on **2/6/17**. By stipulation, the parties agree:

On the date of accident, **9/9/15**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$36,430.16**, and the average weekly wage was **$700.58**.

At the time of injury, Petitioner was **61** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$420.35**/week for a further period of **64.5** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **30% loss of use of the right leg**.

Respondent shall pay Petitioner compensation that has accrued from **9/9/15** through **2/6/17**, 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.

Carolyn M. Doherty

Signature of Arbitrator

2/22/17
Date

ICArbDecN&E p 2

FEB 23 2017

FINDINGS OF FACT

The only disputed issue at trial was the nature and extent of Petitioner's undisputed work related injury. ARB EX 1. At trial, Petitioner testified that he is 62 years old. On 9/9/15, the date of undisputed accident, Petitioner worked for Respondent as a small pack manager. Petitioner testified that he continues to currently work in that same capacity for Respondent. Petitioner's duties included unloading freight trucks and processing freight. He specifically testified that the freight included small motors weighing up to 150 pounds and that he processed 300 motors per day on a repetitive basis. Petitioner testified that he had no right knee pain and worked pain free prior to 9/9/15.

On 9/9/15 Petitioner was at work on the conveyor belt. He testified that the lifted a 50 pound box while turning slightly when he felt a pop in his right knee. Petitioner noticed immediate swelling of his right knee. Petitioner testified that he went to Physicians Immediate Care the same day on 9/9/15. PX 1. Petitioner's accident history and complaints of sudden onset of right knee pain are consistent in the records. Following exam and x-ray of the right knee, Petitioner was released with a diagnosis of right knee sprain and prescribed pain medication and a knee brace to wear at all times. He was given work restrictions of seated work only and told to follow up in 5 days. PX 1.

The following day on 9/10/15, Petitioner was seen by Dr. Beusse, his primary care physician. PX 2. Petitioner again reported a lifting and twisting injury at work on 9/9/15. He referred Petitioner for a follow up orthopedic physician Dr. Jereb for diagnosed internal knee derangement.

Petitioner saw Dr. Jereb on 9/14/15. Petitioner again reported a consistent history of right knee injury at work upon twisting of his leg while carrying a 45 pound item. Dr. Jereb ordered a right knee MRI which showed a medial meniscal tear. Surgery was prescribed and on 10/13/15, Dr. Jereb performed a right knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, chondroplasty of the medial femoral condyle. PX 4.

Following the surgery, Petitioner attended physical therapy 2 to 3 times per week with follow up visits to Dr. Jereb. In October 2015, Petitioner was continued off work by Dr. Jereb. During physical therapy, Petitioner continued to complain of medial knee pain along with continued improvement in range of motion. Petitioner also demonstrated "impairments to activity tolerance" during PT including "flexibility, pain, proprioception, ROM and strength." On 11/6/15 it was noted that "the above deficits functionally limit the patient's ability to go up and down ladder, ascend and descend stairs, walk on uneven surfaces, sit for longer than 30 minutes." PX 4.

On 11/18/15, Dr. Jereb noted that Petitioner was limited at work to seated duty. At that visit, Petitioner reported that his symptoms were "mild" and "improving" but that he had continued aching pain. Dr. Jereb prescribed additional PT and a follow up in 6 weeks. PX 4. During PT on 11/23/15, Petitioner reported continued pain "on the inside of the right knee." It was noted that Petitioner had "good tolerance and effort to PT interventions." PX 4. During the remaining PT sessions in November 2015, Petitioner continued to report a wobbly feeling in his right knee and pain on the inside of the right knee. PX 4.

On 12/3/15, the PT notes reflect that Petitioner reported having returned to work "yesterday" and that he felt swelling and pain in his knee and calf which he attributed to wearing the knee bandage too tight or for too long or to standing too long at work. On 12/4/15, Petitioner was discharged from PT and sent to work conditioning and an FCE. Upon discharge it was noted that Petitioner reported constant throbbing pain on the inside of this knee with a sensation that his knee will give out. Petitioner also reported difficulty squatting, bending down,

ascending and descending stairs, kneeling on the right knee or walking for a full 8 hour work day. Petitioner began work conditioning on 12/7/15. Petitioner's job duties were subjectively reported by Petitioner at the heavy level and Petitioner was initially assessed as able to work at the medium level on 12/7/15. Petitioner progressed through work conditioning with continued complaints of knee pain, soreness and "give out".

On 12/18/15, Dr. Jereb examined Petitioner and noted continued complaints of pain. Dr. Jereb noted mild swelling and offered Petitioner a cortisone injection which Petitioner refused in favor of home exercise. Petitioner was released from care PRN and returned to work regular duty. Petitioner's final work conditioning evaluation was on 12/18/15. On that date, Petitioner subjectively reported that his work for Respondent was at a medium physical demand level and it was noted that the job demands were modified per Petitioner's report of difficulty with kneeling and pain with squatting. Petitioner was evaluated as able to perform 95.60% of his full work job demands. He was discharged from work conditioning. It was recommended that he return to work with limitations in kneeling. PX 4.

Petitioner testified that he returned to work full duty. He testified that his right knee remained swollen while working and that when he lifted over 20 pounds he could feel pain in his right knee. Petitioner testified that he was able to climb stairs but when going down stairs he experienced pain behind the knee and in the surgical spot. He wore a knee brace during the day while at work.

Petitioner's last visit to Dr. Jereb was on 4/13/16. At that visit, Petitioner reported chronic symptoms since his knee injury at work and that the symptoms occur constantly with intermittent worsening. He reported the pain on the medial aspect on the right side with additional pain in the posterior aspect on the right side. He reported that the symptoms were aggravated by sit to stand transfer, ascending stairs, prolonged ambulation and work activities. Petitioner reported having returned to work without limitations. Petitioner further reported locking, catching and occasional giving out of the knee. He reported constantly going up and down stairs while working full duty and that he takes a break mid day when he performs computer work due to pain in the knee. A right knee exam revealed mild bruising and swelling, medial joint line tenderness, patellar crepitation and painful passive range of motion. Dr. Jereb assessed right knee osteoarthritis and recommended a cortisone injection which as to be given at the next visit scheduled in 4 weeks. Dr. Jereb also prescribed Medrol dose pack for pain and a home exercise program. He again returned Petitioner to work without restrictions. PX 4, PX 2.

Petitioner testified that he wanted a second opinion on his right knee. On July 21, 2016 Petitioner sought treatment from Dr. Domb. Petitioner reported his accident and prior knee surgery and that since the surgery he continued to experience swelling, pain in the medial and posterior knee, locking, catching and give way. PX 3. Exam revealed tenderness at the medial joint line and positive medial McMurray as well as ITB sensitivity. X-rays revealed mild medial cartilage damage. Dr. Domb assessed ITB syndrome and mild cartilage damage. He prescribed a right knee steroid injection and a consult with Dr. Alden for partial knee arthroplasty. Petitioner was returned to modified duty with standing, sitting, bending and squatting as comfort allows. PX 3. Petitioner received a right knee cortisone injection to the right knee on 8/1/16. His last visit to Dr. Domb was on 10/20/16. Petitioner reported that the prior injection helped for 2 months but that the pain and swelling returned. He indicated that he wanted to discuss long term treatment options. PX 5. Petitioner received another cortisone injection. Dr. Domb also discussed possible synvisc and biologic injections to the knee. Petitioner was returned again to modified duty. Petitioner testified that he had not sought treatment with Dr. Alden as of the time of trial nor did he have any scheduled appointments with Drs. Domb or Alden. Again, Petitioner did not request relief under Section 8(a) at trial with the sole trial issue being the nature and extent of his injury.

Petitioner testified that he currently experiences pain behind the right knee and at the surgical spot. He testified that he has difficulty getting up from the ground or from a seated position and that he must use his arms to push

up. He testified that he has stiffness in his knee in the morning but uses yoga stretches to work out the stiffness. Petitioner no longer performs yard work, snow shoveling or heavy lifting. He testified that he feels a sharp pain in his knee when he lifts heavy items at work. He is no longer taking prescribed pain medication. Petitioner continues to wear a knee brace although the brace is not currently prescribed. Petitioner continues to work 40 to 42 hours per week with the aforementioned modifications. He testified that his job duties are the same but that Respondent is "lenient" on what he is required to lift and that he works more in a supervisory capacity.

RX 1 is the report of Dr. Coe dated November 29, 2016. Dr. Coe examined Petitioner and provided an AMA impairment rating of 10% of the right lower extremity under a diagnosis of right knee medial and lateral meniscal tears, status post surgery with residual symptoms. He noted that Petitioner's condition was related to the accident. He noted that Petitioner was not in need of further "specific" treatment for his condition of right knee meniscal tearing and that he was able to return to work at full duty. With regard to Petitioner's continued reported current right knee symptoms, Dr. Coe noted they are consistent with Dr. Jereb's diagnosis of right knee osteoarthritis, a degenerative breakdown of the right knee. He noted that "additional treatments for osteoarthritis would include the injections discussed by Dr. Domb or if symptoms persist partial or total right knee arthroplasty."

CONCLUSIONS OF LAW

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

What is the nature and extent of Petitioner's injury?

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.
(b) Also, the Commission shall base its determination on the following factors:
    (i) The reported level of impairment pursuant to subsection (a);
    (ii) The occupation of the injured employee;
    (iii) The age of the employee at the time of injury;
    (iv) The employee's future earning capacity; and
    (v) Evidence of disability corroborated by medical records.

With regard to paragraph (i) of Section 8.1b (b) of the Act Dr. Coe's AMA report was admitted into evidence as RX 1. Dr. Coe noted that palpation found tenderness at the right knee medial joint margin but no right knee lateral joint margin tenderness, posterior tenderness or anterior tenderness. Patellar grind tests were negative bilaterally. Drawer signs were negative bilaterally and there was no medial or lateral instability. Range of motion of the right knee was 180 degrees extension, 180 degrees being normal, and 140 degrees flexion with 145 degrees as normal. Muscle strength was normal at 5/5. Measurement of the knees was 16.5 on the right and 16 inches on the left. Dr. Coe concluded that Petitioner's impairment is 10% of the right lower extremity under a diagnosis of right knee medial and lateral meniscal tears, status post surgery with residual symptoms. He noted that Petitioner's condition was related to the accident. He noted that Petitioner was not in need of further "specific" treatment for his condition of right knee meniscal tearing and that he was able to return to

work at full duty. With regard to Petitioner's continued reported current right knee symptoms, Dr. Coe noted they are consistent with Dr. Jereb's diagnosis of right knee osteoarthritis, a degenerative breakdown of the right knee. He noted that "additional treatments for osteoarthritis would include the injections discussed by Dr. Domb or if symptoms persist partial or total right knee arthroplasty."

With regard to paragraphs (ii) (iii) and (iv) of Section 8.1b (b) the Arbitrator notes that the 61 year old Petitioner returned to his regular occupation and duties for Respondent with accommodated modifications to his lifting requirements. Petitioner testified that Respondent has been lenient on his lifting requirements and that he has moved to more of a supervisory capacity although still required to lift lighter boxes. The Arbitrator finds that while Petitioner has not sustained any loss of current earnings the Arbitrator considers the Petitioner to be an older individual and concludes that Petitioner may have a greater likelihood of sustaining loss to his future earning capacity than a younger individual with the same injuries.

With regard to paragraph (v) of Section 8.1b (b) the Arbitrator notes that Petitioner sustained meniscal tears to his right knee requiring Dr. Jereb to perform a right knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, chondroplasty of the medial femoral condyle. PX 4. Following surgery Petitioner attended extensive physical therapy and work conditioning as well as two cortisone injections to his right knee. Petitioner consistently complained of continued pain and mobility problems following surgery through trial. Although no current treatment is prescribed, additional treatment to the right knee including varying injections and possible total right knee arthroplasty were discussed with Petitioner. Petitioner currently complains of continued right knee pain for which he wears an unprescribed brace. He has difficulty with daily chores, stair use and standing from a seated position. He does not take prescription medicine for the pain and has not returned for medical care since October 2016.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, and assigning equal relevance and weight of all these factors, including Dr. Coe's AMA impairment rating, the Arbitrator concludes that Petitioner has sustained a 30% permanent loss of the right knee under the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Mota,
Petitioner,
Vs.

17IWCC0627

NO: 13 WC 11310

Greco & Sons, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitioner permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 6, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,024.00. 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: OCT 10 2017
KWL/vf
O-10/3/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0627

MOTTA, JUAN
Employee/Petitioner

Case# **13WC011310**

14WC038080

GRECO & SONS INC
Employer/Respondent

On 2/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0560 WIEDNER & McAULIFFE LTD
JASON T STELLMACH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

17IWCC0627

Case # 13 WC 11310

Consolidated cases: 14 WC 38080

JUAN MOTA
Employee/Petitioner

v.

GRECO & SONS, INC.
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Wheaton**, on **1/20/17**. By stipulation, the parties agree:

On the date of accident, **2/8/13**, 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 **$45,240.00**, and the average weekly wage was **$870.00**.

At the time of injury, Petitioner was **52** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

Respondent shall pay Petitioner the sum of $**534.00**/week for a further period of **86** weeks, as provided in Section **8(e)12** of the Act, because the injuries sustained caused **40% loss of use of the right leg** .

Respondent shall pay Petitioner compensation that has accrued from **2/8/13** through **present**, 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

2/2/17
Date

FEB 6 - 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner sustained and injury to his right leg, which resulted in a displaced fracture of the right tibia and fibula which he underwent a displaced fracture of the tibia for which he underwent surgery on February 9, 2013 consisting of a locked intramedullary rodding of the tibia. (PX. 1, pg. 19, 40). Subsequently, he underwent physical therapy and work hardening he was released full duty on October 8, 2013. (PX. 2, pg. 7). Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator makes the following findings listed below.

(i) Impairment. Respondent offered the AMA rating by Dr. Palacci who treated Petitioner with a zero percent PPI rating. Dr. Palacci classified Petitioner with a proximal tibia shaft fracture, nondisplaced, with no sufficient objective abnormal findings at MMI. However, Dr. Palacci's diagnosis of nondisplaced fracture is not accurate and inconsistent with Dr. Goldberg's diagnosis of a displaced tibia fracture hence requiring the rodding. The PPI range for a displaced tibial shaft fracture is from 14% to 100% impairment of the lower extremity per the AMA Guides. Accordingly, the Arbitrator gives little weight to the impairment rating.

(ii) Occupation. Petitioner continues to work for the Respondent at full duty capacity as a driver which requires that he walk up and down ramps and stairs unloading items. Petitioner's job is physical and the Arbitrator finds that the injury to Petitioner's leg is relatively more incapacitating than if Petitioner's job required no physical work. The Arbitrator gives great weight this factor.

(iii) Age. Petitioner is 56 years old. The Arbitrator finds that Petitioner is an older individual and therefore gives this factor some weight.

(iv) Future Earning Capacity. The injury has not affected Petitioner's earning capacity. He testified he is earning the same if not more than he was prior to the injury. The Arbitrator gives this factor no weight.

(v) Evidence of Disability. Petitioner testified that he continues to notice pain in his knee when walking on uneven surfaces including ramps and stairs. He primarily notices this pain in the knee where the hardware was inserted in his right leg. Following his discharge in October of 2012, Petitioner returned to Dr. Goldberg with continued complaints on February 25, 2014, again on March 11, 2014. (PX. 2, pgs. 2-6). The Arbitrator gives great weight to this factor.

Considering all of the factors required under Section 8.1(b), as well as the Petitioner's trial testimony and the medical evidence, the Arbitrator finds that the Petitioner has suffered the permanent and partial loss of use of the right leg to the extent of 40% thereof due to his injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Connie Willes,

Petitioner,

17IWCC0628

vs.

NO: 15 WC 26480

Dollar General Corporation,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2017 is hereby affirmed and adopted.

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

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 $51,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 10 2017
KWL/vf
O-10/3/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0628

WILLES, CONNIE
Employee/Petitioner

Case# **15WC026480**

DOLLAR GENERAL CORP
Employer/Respondent

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1974 LAWLER & LAWLER
RAYMOND LAWLER
1129 N CARBON
MARION, IL 62959

0000 WIEDNER & McAULIFFE LTD
JAMES A TELHORST
8000 MARYLAND AVE SUITE 550
ST LOUIS, MO 63105

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

17IWCC0628

CONNIE WILLES
Employee/Petitioner

v.

DOLLAR GENERAL CORP.
Employer/Respondent

Case # 15 WC 26480

Consolidated cases: _____

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 30, 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 **$38,799.50**; the average weekly wage was **$746.14**.

On the date of accident, Petitioner was **51** 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 **$0** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of her employment with Respondent on June 30, 2015. The Arbitrator further finds that the Petitioner's low back/left hip condition is and remains causally related to the June 30, 2015 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$497.43 per week** for **17-5/7 weeks**, commencing **August 21, 2015 through December 25, 2015**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for any awarded temporary total disability benefits that were paid by Respondent prior to the hearing.

Respondent shall pay reasonable and necessary medical services as contained in Petitioner's Exhibit 2, totaling $43,058.52, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any awarded medical benefits that were paid by Respondent prior to the hearing, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, if applicable.

The Respondent shall authorize the minimally invasive left-sided SI joint fusion as recommended by Dr. Kube.

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

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

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

Signature of Arbitrator

April 5, 2017
Date

ICArbDec19(b)

APR 17 2017

STATEMENT OF FACTS

On 6/30/15, Petitioner, a 13 year employee, was working for Respondent as a store manager at Dollar General's location in Marion, IL. She testified that her job involved: "everything from A to Z, payroll, scheduling, budgeting, maintenance, taking out the trash." That day, at approximately 6:30 a.m., Petitioner took out a box of trash, which she testified weighed approximately 20 pounds. During the course of lifting the box of trash up and into a trash container, Petitioner felt a "strong strain" in her lower left hip area. She returned to the store, but testified that she felt her lower left hip area beginning to swell. She took Tylenol to try to reduce the pain. Petitioner was able to complete her work shift, as her job duties on Tuesdays were light, and she was able to sit as needed. Petitioner went home when her shift ended at 2 p.m. and continued to feel pain in her lower back and hip area that evening. On cross examination, Petitioner testified that she initially thought that her pain would likely go away, and thus did not immediately report a work accident or obtain medical treatment.

When she awoke the following morning, she testified it felt like there was bulging out of her lower hip, with throbbing and burning pain. She went to work at 6 a.m., but left early due to the pain. She testified that she reported the accident to Respondent that day, which was not rebutted by Respondent.

Petitioner initially treated at WorkCare occupational health on 7/1/15. (Px1/4). A note on WorkCare letterhead indicates an initial workers' compensation visit referral to Family Nurse Practitioner (FNP) Dena Kommer. (Px1/1). Petitioner reported she "was hurting a little bit at work yesterday and she states she could hardly move". A visit summary states: "She denies any known injury". She reported severe burning low back and left hip pain. Left hip x-ray was normal, and lumbar x-ray showed mild arthropathy of the SI joints. Steroids and physical therapy were prescribed, and she was held to light duty (20 pounds with no push/pulling, squatting or climbing). (Px1/4). Petitioner testified that, despite the report, she reported her work injury to WorkCare.

Petitioner testified that she next sought treatment at Logan Primary Care the following Friday (7/3/15) when WorkCare was not answering their phone. She was advised that they couldn't do anything for her and was sent to Herrin Hospital for x-rays and further treatment.

The 7/3/15 records from the Herrin Hospital ER note left lower quadrant back pain radiating to the groin and thigh. She reported going to work normally on Tuesday, and "She thinks she may have lift [sic] a heavy box, that caused the pain". Under "Mechanism of Injury", the note states: "No trauma by history, Spontaneous/no mechanism, Bending". A triage note states: "I seem to have injured my hip at work, the Rx I have isn't working". She worked the rest of that day but on Wednesday was unable to walk. She denied prior back problems. Symptoms were exacerbated by bending, walking and movement. Neurologic examination was normal. At discharge, she was advised to use Tylenol along with steroids and a muscle relaxer, and was to follow up with therapy as scheduled by WorkCare. (Px1/1).

Petitioner began physical therapy at SIH (Rehab Unlimited) on 7/6/15. She reported developing left hip/low back pain while lifting a box at work. It appears that a TENS unit was prescribed by FNP Kommer. The records consistently note burning left thigh pain that got worse through the day and workday. (Px1/1). Petitioner returned to FNP Kommer on 7/8/15 and light duty was continued, adding that Petitioner should be allowed to sit at the register, and that she could stand for up to 45 minutes per hour. On 7/22/15 a lumbar MRI was prescribed, and medication and light duty were again continued. (Px1/4). Petitioner testified that she remained on light duty restrictions and continued to work for Respondent.

The 7/23/15 lumbar MRI report indicated findings of mild degenerative disc disease from L2 to L4, with normal findings from L4 to S1. A slight L2/3 bulge might slightly impinge on the neuroforamen, left greater than right, and a diffuse L3/4 bulge narrowed the neuroforamen somewhat bilaterally. Right kidney pelvocaliectasis was noted, and ultrasound or CT stone protocol were to be considered if clinically warranted. (Px1/10). A physical therapy note (7/29/15) indicated the Petitioner had obtained a kidney evaluation appointment (Px1/1), and the 8/11/15 renal ultrasound prescribed by CNP Gunther showed no stones, but mild prominence of the renal pelvis and two apparent cysts. CT scan was to be considered if clinically warranted. (Px1/10).

An 8/12/15 therapy discharge note indicated Petitioner reported no improvement after 14 visits, so she was discharged to a home exercise program. Her Oswetry score had increased from 23% to 56%. She remained guarded, but not as much as in her initial evaluation. Her long term goals had not been met. A functional note indicated the Petitioner was only capable of 86.8% of her job duties, with limitations on squat lifting and repetitive kneeling. (Px1/1).

On 8/6/15, Petitioner sought treatment with her primary care provider, Certified Nurse Practitioner (CNP) Gina Gunther, at Christopher Rural Health Center. Petitioner noted left low back and hip pain, and that a low back MRI showed right kidney stones, but she had no current right-sided symptoms. Gunther's 8/13/15 report notes Petitioner noted a pull in her left low back, buttocks and hip area, and awoke the next day with severe pain that had persisted. She reported that medication had not helped at all, other than Norco, and therapy was making her worse. Gunther prescribed Neurontin and referred Petitioner to orthopedic surgeon Dr. Kube. (Px1/7).

On 8/14 and 8/19/15, it appears that Petitioner saw Dr. Smith at WorkCare. She reported low back pain into the left hip. While he noted the therapist recommended discharged due to a lack of improvement, additional therapy, medication and light duty were continued. On 8/19/15, Dr. Smith noted Petitioner was also seeing her family doctor and had been referred to an orthopedic surgeon the day before, though it was his recommendation that she see a physiatrist instead and/or Dr. Newell in pain management. He also agreed to increase her Norco dosage despite concern that she was developing a tolerance given her lack of improvement. His concern was possible piriformis syndrome or other deep hip muscle injury as opposed to an SI joint problem. (Px1/4).

On 8/21/15, Petitioner told CNP Gunther that her left low back pain into the buttocks that had improved, but numbness and tingling had increased. She was working light duty but felt she couldn't continue to do so due to pain. Gunther noted that workers' compensation had not yet approved a neurosurgical referral. A left hip x-ray was normal. Petitioner was held off work for a week and was to follow up if she hadn't seen a neurosurgeon by then. (Px1/3 and Px1/7).

On 8/28/15, CNP Gunther noted occupational health (WorkCare) discharged her because she sought treatment with Gunther. She had run out of Norco, which she reported resulted in increasing pain. She had been referred by workers' comp to Dr. Koth, and Petitioner felt like she was unable to return to work because she could only stand for a few minutes and had to sit or even lay down for relief. She reported her pain had not improved since it began. Neurontin did reportedly help her burning thigh pain. Gunther prescribed short term Norco and held Petitioner off work pending Koth's evaluation. (Px1/7).

Petitioner saw Dr. Koth on 9/1/15, reporting a work injury involving lifting a box overhead to throw it in the trash. She complained of constant left sided pain with a three week history of a pins and needles feeling in the top of her thigh. She reported no real improvement with therapy and medication. Lumbar examination was noted as normal, including SI joint findings. Dr. Koth noted MRI showed mild arthritis, with a little mild lateral recess stenosis at L3/4 but "not much seen". The diagnosis was low back pain and radiculopathy, but he found no obvious surgical indication and prescribed therapy and medication. She was restricted to seated work duty. (Px1/2). Petitioner testified that the Respondent could not accommodate this restriction.

On 9/11/15, CNP Gunther refilled a decreased Norco prescription and increased her Neurontin dose, and otherwise Petitioner was to continue Dr. Koth's prescriptions, noting she had a second opinion appointment scheduled with Dr. Kube. (Px1/7).

Petitioner initially saw Dr. Kube on 9/30/15. She was prescribed medications and an SI joint injection was prescribed for a potential diagnosis of an SI joint disorder. He later testified that this was based on some initial examination findings. He also prescribed a lumbar x-ray, which on 10/1/15 showed mild spondylosis. (Px1/3 and Px1/5).

Petitioner saw Dr. Prasad on 10/29/16 on referral from Dr. Kube for left SI injections for lumbar and hip pain radiating into the left leg with numbness and tingling. Petitioner reported 10 out of 10 pain because of discomfort with prolonged sitting. She noted no significant relief since her work accident. The injection was performed and she was to follow up with Dr. Kube. (Px1/9). Petitioner testified that she told Dr. Prasad she didn't have the bulging, swelling feeling in her lower left hip after the injection, but that she was then released and they didn't have much further conversation.

At a 10/19/15 follow-up, Dr. Koth noted Petitioner's condition was unchanged, though Petitioner said therapy helped the tingling in her thigh. It was noted that pain management had scheduled her for an SI joint injection. He recommended waiting to see if the injection helped, noting if it did and other conservative measures failed, a possible SI joint fusion could be considered. Work restrictions were continued. (Px1/2).

On 11/20/15, Dr. Kube's physician assistant Derek Morrow noted Petitioner reported that the SI joint injection relieved 80% of her pain for a couple of hours and really for the rest of the day, but she awoke the next day and the pain was essentially coming back. (Px1/8).

Petitioner attended physical therapy at Novacare from September to November, 2015, as prescribed by Dr. Koth, but Petitioner testified that she had very little relief. In the Arbitrator's review of these records, no significant or lasting improvement is noted over 37 visits through November 30th. At an 11/23/15 reevaluation, Petitioner reported that the SI joint injection she had on 10/29/15 provided no relief, that she was scheduled to return to Dr. Koth on 11/21 and Dr. Kube on 12/16, and that she was requesting a lumbar epidural. (Px1/8).

On 12/18/15, Petitioner called CNP Gunther's office requesting a Neurontin refill. (Px1/7). Petitioner last saw Dr. Koth on 12/21/15. Petitioner reported she was not improved despite the SI joint injection, with ongoing burning hip pain. She had been scheduled for an epidural in January with Dr. Newell. Dr. Koth again noted "a pretty pristine" MRI and surgery wasn't indicated. He modified her work restrictions to no lifting, carrying, pushing or pulling over 50 pounds, and she was to follow up in 2 months. (Px1/2). A 12/22/15 follow up with Gunther noted Petitioner had failed therapy and SI joint injections. She requested a Norco refill pending epidural injection. (Px1/7).

Petitioner testified that she returned to work with Respondent on 12/26/15.

Petitioner saw Dr. Newell on 1/4/16 on referral from Dr. Koth. Petitioner reported moderate to severe (8 out of 10) low back pain that radiated to the left buttock and thigh to the knee since the work accident. His review of the lumbar MRI indicated a circumferential L3/4 disc bulge with protrusion causing some bilateral neuroforaminal narrowing, while the remaining levels "looked good." Petitioner reported a flare up of pins and needles radiating in the left thigh, which had improved some with physical therapy. Medication had provided limited benefit. Dr. Newell believed Petitioner's symptoms were more consistent with an L3/4 disc causing some left radicular pain than with SI joint pain, noting SI joint examination maneuvers were negative. He opined that, based on the stated history, Petitioner's injury was related to the accident. Epidural injections, ongoing therapy and work restrictions were prescribed. Despite these statements, the diagnosis was listed as SI joint pain. (Px1/6).

Dr. Newell performed an epidural injection at left L4/5 on 1/12/16. The report noted: "Typical symptoms were definitely provoked with discomfort into the left thigh. She did get some immediate pain benefit". (Px1/6). On 1/25/16, Petitioner reported to CNP Gunther that the epidural did not really help, but physical therapy helped with her burning pain into the thigh. She was back to work but in pain, and she requested a Norco refill, though she reported taking this only occasionally. (Px1/7). On 2/1/16, Petitioner reported to Dr. Newell that she had no real relief from the injection, but feel Gabapentin was helping. It was hard to tell where Petitioner's pain was coming from. Though he suspected discogenic pain over the SI joint, he was still going to attempt a diagnostic and therapeutic SI joint injection. If that didn't work, he recommended a CT Scan/myelogram and return to surgeon. Light duty and Norco were continued. The SI joint injection was performed on the left on 2/4/16, and Petitioner was noted to have reported at least 50% immediate relief, but not complete. She was to resume therapy and follow up in 3 to 4 weeks. (Px1/6).

On 3/3/16, Dr. Newel's follow up note indicates Petitioner reported no relief with the injection, and that she had been released from therapy without great benefit. He could not reproduce symptoms with provocative maneuvers and noted no SI joint tenderness. He excluded the SI joint as the source of her pain, instead suspecting disc pain ("Very unusual pain symptom, but does appear to be diskogenic at this point."). He recommended she follow up with a surgeon to see if there was any possible treatment, indicating she otherwise would need to learn to live with it and continue to improve with time. He renewed her Norco prescription one additional time. (Rx2).

She testified that she had immediate relief with the SI injection, but that her pain returned. Asked on cross exam if she told Dr. Newell on 3/3/16 that the injection didn't help at all, she testified: "Briefly, it helped". She denied that Newell told her that he didn't think her SI joints were the problem, rather that he indicated he wasn't sure.

On 5/25/16, Petitioner was examined at the Respondent's request by orthopedic surgeon Dr. Mirkin pursuant to Section 12 of the Act. He testified via deposition on 11/28/16. (Rx1). Dr. Mirkin reviewed all prior records regarding treatment of the Petitioner, also reviewed the various diagnostic images and performed a physical examination. Dr. Mirkin testified that the Petitioner had a normal lumbar spine. She had subjective complaints of pain in her left hip, but Dr. Mirkin did not detect swelling during the examination, and he noted no signs of radiculopathy. Dr. Mirkin testified that the Petitioner was at maximum medical improvement and could return to work without restrictions if she desired to do so. He opined thatt she was not a candidate for left SI joint fusion, noting he did not see a basis for fusing a normal joint. Dr. Mirkin believed that the Petitioner may have sustained a left hip strain as a result of the work accident, but did not see any indication of the Petitioner having problems with her left lumbar spine. He did not think she needed any additional medical care, and there was no surgical indication. (Rx1).

After this examination, Dr. Kube issued a report that appears to be dated 6/29/16. He disagreed with Dr. Mirkin's finding, noting that Mr. Mirkin must not have believed that Petitioner had relief from the SI joint injections, or that he must not understand the difference between the diagnostic and therapeutic effects of the injections. He reported that Petitioner had at least three examination signs which supported the SI joint as the source of her pain. Dr. Kube also opined that Petitioner should be limited at work "to some degree", noting she had been able to self-modify, and that this should continue so she can remain employed. A work note states that Petitioner is released to full duty. (Px1/5).

Petitioner testified that she reported immediate but temporary relief to Dr. Kube's office regarding the SI joint injections, but could not recall what she reported to them in terms of the percentage of improvement.

Petitioner continues to see Dr. Kube monthly for evaluation and medication monitoring. The last report in evidence appears to be dated 9/22/16, at which time Dr. Kube was still seeking surgical approval, and she was continued on Tramadol, Flexeril and Mobic, while Norco was added. (Px1/5).

Petitioner testified that she remains on work restrictions from Dr. Koth, and has continued to work for Respondent since December 2015. However, a 7/22/16 work note of Dr. Kube again states that Petitioner can perform full activity. Petitioner testified she has continued to work as a store manager, but indicated she avoids the heavier aspects of the job.

Petitioner agreed on cross exam that she last saw Dr. Koth on 10/19/15, as he relocated, and thus last received restrictions from him at that time, but testified that Dr. Kube kept her on the same restrictions. She testified that Dr. Koth told her verbally that he would consider SI joint fusion if the injections did not work.

Dr. Kube provided his evidence deposition on 10/6/16. (Px3). He testified that Petitioner first appeared on 9/30/15 with complaints of back pain starting with a work injury at the end of June. She reported picking up a box to throw it in a dumpster overhead and while doing so felt a pull in her back, and the next day it increased. About a month and a half after rehab began, she started to notice pain in the left thigh with occasional numbness and tingling. He testified that because SI joint pain can produce back pain, groin pain or sciatic type pain, it's

important to use diagnostic injections. Following Dr. Prasad's SI joint injection of 10/29/15, Petitioner reported approximately 80% improvement to Dr. Kube on 11/11/15, but that it was temporary. A second injection was performed to confirm SI joint dysfunction, this time by Dr. Newell on 2/4/16, and Petitioner again indicated greater than 75% initial improvement to Dr. Kube's office. As such, pelvic studies were planned to prepare for possible minimally invasive SI joint fusion, as Petitioner had failed physical therapy and two injections which included a therapeutic component. (Px3).

Dr. Kube testified that the two injections were the gold standard for diagnosing SI joint dysfunction, and that the second injection's purpose was to confirm the diagnosis if there was initially a false positive. Relief from the local diagnostic injection should occur within 60 minutes, and often much sooner. He testified that diagnostic imaging has been shown to be "relatively worthless" in diagnosing SI joint dysfunction, and that physical exam findings are not completely reliable for this diagnosis either. He opined that the Petitioner's SI joint dysfunction was causally related to the work accident, and necessitated surgery, based on the mechanism of accident and the lack of prior symptoms. Dr. Kube testified that he has continued to hold the Petitioner on light duty restrictions since her initial 9/30/15 visit, and he has continued to see her for medication management, including tramadol and hydrocodone, pending surgical approval. (Px3).

On cross examination, Dr. Kube agreed that diagnostic SI joint injection requires the subjective report of improvement from a patient. He was confident that he had ruled out the Petitioner's left hip and low back is the source of her pain, and did not anticipate any need for surgical treatment of either body part. He agreed that lumbar MRI did not reflect any significant abnormalities. (Px3).

Dr. Kube testified that prior to the advent of minimally invasive SI joint surgery, which was FDA approved in May 2011, treatment for SI joint dysfunction generally consisted of radiofrequency ablation or a spinal stimulator. He noted these latter techniques do not work in 30% of patients, and for those it does work for, there is no real long-term relief. (Px3).

Dr. Kube testified that he would expect radicular symptoms with a back injury very soon after the injury, but with SI joint dysfunction, because it is based on inflammation and not nerve compression, a patient can develop leg symptoms later on. The inflammation can cause the pain to radiate to different nearby areas. He testified that while it is possible a CT scan could potentially see degeneration at the SI joint, it was difficult to view on film because of other structures masking that area. However, he also indicated there was not much clinical relevance to whether there was degeneration or not. (Px3).

On further cross exam, Dr. Kube acknowledged that while he did not believe physical exam findings were reliably diagnostic for SI joint dysfunction, the process of starting the diagnostic injections occurs when he gets at least a couple of physical exam findings that lead to such a conclusion. With regard to Dr. Newell indicating Petitioner did not get relief with the SI joint injection and his opinion that the SI joint had been ruled out as the source of Petitioner's pain, Dr. Kube noted that this was in contradiction to Newell's SI injection report, which indicated at least 50% improvement. He reiterated that long term relief is not important to the diagnosis, initial relief with local injection was.

Dr. Kube cited a paper indicating that 89.5% of SI dysfunction patients have elimination of SI joint regional pain with the prescribed minimally invasive surgery. Only 1 in 4 SI joint patients need surgery. For some, a combination of diagnostic (Lidocaine) and therapeutic (steroid) initial injection can completely relieve the

condition. He testified that prior to minimally invasive surgeries, he would refer SI joint patients to pain management. He sees 100 to 150 such patients per year. (Px3).

Petitioner has continued to typically work 40 hours per week. (Rx3).

Petitioner submitted her claimed medical expenses as Px2.

CONCLUSIONS OF LAW

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

The Arbitrator finds that, based on a preponderance of evidence, the Petitioner has sustained her burden of proof with regard to a June 30, 2015 accident which arose out of and in the course of her employment with the Respondent. The Petitioner has remained consistent in reporting the circumstances of this accident to all of her medical providers, with the exception of the Work Care Clinic.

The Arbitrator notes that while the initial visit summary note of FNP Kommer on 7/1/15 indicates Petitioner denied a known injury, and the progress note itself just indicates only that Petitioner was hurting at work the day before, there is a workers compensation note which indicates that Petitioner was referred to Kommer on a workers' compensation basis in the first place, which supports that Petitioner had already reported her work incident.. The Arbitrator also notes that the reports of FNP Kommer appear to be very template driven, with the language in the reports being very similar each time, which seems to the Arbitrator to reflect a lack of any real detail visit to visit.

At Herrin Hospital, the report noted no "trauma", while also noting that Petitioner reported lifting at work.

Given the consistency of the vast majority of the other medical records indicating an incident of lifting trash, the Arbitrator finds that the greater weight of the evidence supports that the Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent. It appears that the likely scenario in this case is that the Petitioner did not necessarily see her injury as "trauma", per se. The task of taking out the trash was part of the Petitioner's normal job duties, which the Respondent did not dispute. She was subjected to an increased risk of injury since she was discarding trash overhead into a dumpster. The circumstances of the injury do arise out of and the course of her employment.

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

The Arbitrator finds that the Petitioner's condition of ill-being, that being symptoms of left sided pain in the left hip/low back area, is causally related to the 6/30/15 work accident.

The Arbitrator notes that a chain of events analysis appears to apply in this case. Dr. Kube's causation opinion relies upon this analysis. Dr. Newell opined that Petitioner's left hip/low back symptoms were related to the accident based on Petitioner's stated history. While Dr. Mirkin opined that the Petitioner reached maximum

medical improvement based on sustaining a left hip strain on the accident date, he nevertheless agreed that the evidence in this case supported a causal connection between the accident and the Petitioner's initial post-accident complaints.

Dr. Kube testified that Petitioner had no known prior history of an SI joint disorder or any significant treatment for back pain. He noted the symptoms contemporaneously began after lifting and moving a box overhead to put it in the dumpster, and the Petitioner is noted to be of short stature. She reported the inset of symptoms at that time which worsened shortly thereafter. There was no evidence which supported any unrelated cause. As noted, Dr. Mirkin essentially agreed that there was a causal connection of the symptoms, at least initially. His issue was with the Petitioner's ongoing symptoms and the involvement of the SI joint in the symptoms.

The records reflect the fact that Petitioner's symptoms have been generally consistent since the accident occurred. At the time of Dr. Mirkin's appointment with Petitioner in May of 2016, she continued to have the same symptoms she had at the time of the work accident. The fact that Petitioner has had a pattern of consistent pain in the left back and hip area supports the likelihood that the onset of the current condition was at the time of the accident. The Arbitrator gives a degree of weight to the fact that the Petitioner has continued to work despite ongoing symptoms. While it has been on a light duty basis, her unrebutted testimony was that she was generally performing her regular job outside of the heavier aspects of it.

The greater weight of the evidence supports that the Petitioner's current condition is related to the 6/30/15 accident.

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

The Arbitrator finds that the Petitioner is entitled to the medical expenses ($43,058.52) submitted into evidence as Petitioner's Exhibit 2. These bills all appear to involve reasonable and necessary treatment with regard to the Petitioner's onset and continuation of left sided low back/hip pain. Said bills are awarded pursuant to both Section 8(a) and Section 8.2, the medical fee schedule. The parties stipulated that the Respondent is entitled to credit for any medical expenses that were paid prior to the hearing date.

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

The Arbitrator accepts the opinion of Dr. Kube over that of Section 12 examiner Dr. Mirkin with regard to the recommendation of minimally invasive left-sided SI joint fusion. The Petitioner has complained of left sided hip area pain since the accident. The medical records consistently record the Petitioner's symptoms, including the feeling of swelling in the buttocks area.

Dr. Koth indicated that if SI joint injections were diagnostic for SI joint dysfunction, fusion surgery would be considered. While Dr. Newell ruled out SI joint dysfunction as the source of Petitioner's pain, it is interesting to note that his initial report from the injection date noted at least 50% improvement, and his subsequent report indicated that Petitioner reported no improvement. Dr. Kube's testimony in this regard made sense in terms of a patient reporting injection success or failure with expectations of long term improvement, while he was

interested in the diagnostic aspect of relatively immediate but short-lived relief. With that view, it appears that Dr. Newel's records are inconsistent. Thus, while Dr. Mirkin opines that the surgery is not reasonable and necessary, the Arbitrator believes that the preponderance of the evidence supports the surgery. Dr. Mirkin's opinion is well-taken, but it should also be noted that, Dr. Kube has testified to significantly greater experience with SI joint problems and treatments.

Admittedly, Petitioner has indicated that she has had radiating symptoms, including some radicular-type symptoms of numbness and tingling. However, that has resolved, and Dr. Kube did testify that irritation in the area of the SI joint could have created such symptoms.

The Arbitrator specifically notes that this decision places weight on the testimony of Dr. Kube indicating an 89.5% success rate with this surgery. While it is unclear with 100% certainty to the Arbitrator that the Petitioner's problem is related to the SI joint, the preponderance of the evidence supports that being the case. The Arbitrator also wishes to note that a great deal of weight in this conclusion is based on the lack of any significant objective findings in the lumbar spine which would support the Petitioner's ongoing complaints. While this appears to be a relatively new procedure, given the minimally invasive nature of it based on Dr. Kube's testimony, the Arbitrator believes this is the most prudent course of action at this time based on the evidence presented.

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

The main issue with TTD appears to be based on Petitioner's testimony that she had to use about two weeks of vacation time the last week of August 2015 and the first week of September 2015. She otherwise testified that she has received her full pay during the periods of time she has been working light duty.

The Arbitrator finds that Petitioner is owed TTD benefits for the period of 8/21/15 through 12/25/15, which constitutes 17-5/7 weeks. The evidence demonstrates that Petitioner was taken off work by her primary care facility, Christopher Rural Health, on 8/21/15 until she was able to see Dr. Koth on 9/1/15. Dr. Koth then gave Petitioner a set of restrictions that Respondent was unable to accommodate. The Petitioner testified that she returned to her employment with Respondent on 12/26/15, which per Arbx1, the parties agreed to..

Since the Arbitrator finds that Petitioner's condition from 8/21/15 through 12/25/ 15 was causally related to the 6/30/15 work accident, the Petitioner is entitled to TTD for that time period.

Respondent argues that it is only required to pay 16 weeks of TTD because Petitioner received pay for a disputed initial approximate two week period. The Petitioner testified that she took paid vacation time for this time period. The fact that vacation time may have been used does not change the fact that the Petitioner is entitled to TTD during that period of time.

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

Carson Winters,
Petitioner,
vs.
State of Illinois
Menard Correctional Center,
Respondent,

NO: 11 WC 33412

17IWCC0629

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, notice, medical, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 2016 is hereby affirmed and adopted.

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

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

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: OCT 10 2017

o10617
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

WINTERS, CARSON
Employee/Petitioner

Case# **11WC033412**

17IWCC0629

STATE OF ILLINOIS MENARD CORR CTR
Employer/Respondent

On 5/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% 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:

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAY 13 2016

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

17IWCC0629

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Carson Winters
Employee/Petitioner

v.

State of Illinois, Menard Corr. Ctr.
Employer/Respondent

Case # 11 WC 33412

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **July 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ 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 8, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,728.00**; the average weekly wage was **$1,129.38**.

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

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

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

Respondent is entitled to a credit of **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $4,040.22, as set forth in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for the treatment recommended by Dr. Mall.

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

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

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

Michael K. Nowak, Arbitrator

5/9/16
Date

ICArbDec19(b)

17IWCC0629

FINDINGS OF FACT

Petitioner began his career with the State of Illinois on May 30, 1995, as a Correctional Officer at Western Illinois Correctional Center in Sterling, Illinois. (T.15). He transferred to Menard as a Correctional Officer in 1998, and he continued to serve as a Correctional Officer at the time of hearing. (T.15). He testified that he has held no other job title during his 17 years of employment with Respondent. (T.15, 16). He testified that 6 years were spent on the midnight shift, and the remaining 11 years were spent on the day shift. (T.17, 18). Petitioner testified, however, that he worked "quite a bit" on the day shift before his manifestation date in August of 2011, due to the significant amount of overtime worked. (T.18, 50). Petitioner testified that he worked overtime shifts lasting 16 hours approximately 2 to 3 days per week during the 3 to 4 years prior to his manifestation date. (T.18, 19). He testified that many of these shifts were mandated by Respondent due to lack of staffing. (T.18, 19).

Petitioner testified that that prior to the manifestation of his injuries on August 8, 2011, nearly all of his tenure with Respondent was spent working as a wing or gallery officer. (T.16, 17, 47, 48). Since his manifestation date, Petitioner estimated that 85% of his time is spent as a wing/gallery officer, and the remaining 15% is spent as a barber shop officer. (T.16, 17). Petitioner testified that he reviewed the CorVel Job Site Analysis, the "Demands of the Job" form, and the Position Description, all of which were generated by or at the request of Respondent, and agreed with the statements contained therein. (T.17).

Petitioner and Respondent offered Respondent's Job Site Analysis of a Correctional Officer at Menard into evidence. (PX11; RX2). This document provides a narrative description of the job duties and classifies the strength demands of the job as frequent lifting and/or carrying up to 25 pounds, or up to 5 ½ hours per day. *Id.* Correctional Officers are required to frequently pull open doors from 2 ½ to 5 ½ hours per day, up to 66 % of the time or over 200 times per day. *Id.* This includes pulling open heavy steel doors, opening chuckhole doors as needed for dining during lockdown, and cuffing and uncuffing inmates. *Id.* Wrist turning is required 34% to 66% of the time, 2 ½ to 5 hours per day, or up to 300 times per day. *Id.* This amount of work increased when the institution was on deadlock. *Id.*

Respondent's Demands of the Job form included in Petitioner's Workers' Compensation Documentation Log reflects that Petitioner used his hands for gross manipulation (grasping, twisting, handling) for 2 to 4 hours per day, and used his hands for fine manipulation (typing, good finger dexterity) for 0 to 2 hours per day. (PX8).

Petitioner introduced a Position Description for Cellhouse Officers that was prepared by Respondent. (PX15). It describes duties including pulling cell doors twice to ensure that cells are securely locked, random checking of all locks on the gallery, checking cell locks prior to moving inmates into respective cells, performing actual body (skin) counts by looking in or opening the cells, removing inmates from cells for escort, monitoring all movement, searching cells prior to placement of inmates, checking all locks, doors and restraints to ensure they are in proper operational order and secured, shaking down workers and inmates, keying in and out inmates from cells for all movement that is not a mass line movement, searching inmates entering and leaving the gallery, and securing grill and front doors. *Id.* The listed job duties required by Respondent are consistent with the repetitive upper extremity duties Petitioner described during the hearing.

Petitioner testified that the cell doors at Menard Correctional Center are made of steel and opened with Folger Adams keys. (T.19, 20). Petitioner testified that, while many times the keys work as they should, the keys

are "prone to jamming up" and at times require two hands to turn. (T.20). Irrespective of "jamming up," Petitioner testified that each turn of a Folger Adams key moves a tumbler connected to a steel rod that moves and allows the sliding steel doors to pulled open. (T.20). Petitioner testified that some of the doors are difficult and seem "almost off track." (T.20, 21). He stated that he has seen some doors take more than one person open. (T.20, 21).

Petitioner testified that he engaged in bar rapping, which produced tingling in his arms and hands. (T.22). He testified that depending on the assigned gallery or cell house, he rapped anywhere from 48 to 55 cells. (T.22). Petitioner also engaged in "crank rolling" at times to access all of the cells on the gallery. (T.22). To perform this task, Petitioner had to use a Folger Adams key to open the crank box located on the wall, swing the door open, disengage the release and flip the handle out, and turn the crank in the proper direction for either releasing the doors or placing them on deadlock. (T.22, 23). Petitioner candidly testified that the releases and cranks do not malfunction on each occasion; but he testified that at times the releases did not work properly, and other times the crank would suddenly "lock up in the middle and jerk you real hard." (T.22, 23). "That's just the nature of the beast," he stated. (T.23). Since one crank box controlled half of a gallery and Petitioner is assigned 2 galleries, Petitioner would have to roll 4 cranks. (T.52).

Consistent with the Position Description, Petitioner testified that he cuffs and uncuffs inmates, opens and closes chuckholes with Folger Adams keys, and performs property box searches and shakedowns. (T.24-26). Petitioner testified that the chuckholes did not always work properly due to "a maintenance issue" and stated that on such occasions he had to slam the chuckholes shut. (T.25). During shakedowns and property box searches, Petitioner had to pick up and/or move property boxes and search their contents. (T.26). He stated that these boxes, 3' x 2' and 18" x 12" respectively, "get very heavy." (T.26).

Petitioner also testified that the facility goes on "lockdown" under varying levels from 1 to 4. (T.26, 27). He testified that his duties become "much more burdensome" during lockdown. (T.27, 28). When asked to explain how and why, he stated:

> Much more labor intensive. The inmates are not allowed to be out, and the staff does the work of feeding inmates, carrying the trays up and down the stairs, which I guess recently, we've had an MSU group come down that carries the trays up the stairs, but that's just been in the last few years. Before that, it was always the staff that carried them up and down the stairs. (T.28).

Petitioner estimated that in the two to three years before his manifestation date in 2011, the facility was on lockdown 10% to 25% of the year, depending upon the year. (T.27).

Petitioner also introduced a DVD depicting the duties of a Menard Correctional Officer, produced at the request of Respondent, which fully corroborated his description of his job duties. (PX12). The DVD depicts various job tasks, assignments, areas, equipment and mechanisms and features some demonstrations by a variety of Correctional Officers. *Id.* Depictions included the armory, shakedown officer, bar rapping, double gate door, double gate walkway, opening cell doors, turning gallery cranks, receiving control house, control room, receiving door, shower door segregation, shower door, segregation unit, segregation door, chuckholes, double gate, and tower. *Id.* Each area required opening and closing multiple doors and using multiple keys, mostly large Folgers Adams keys. *Id.*

17IWCC0629

Bar rapping was simulated in the DVD and the officer explained that, depending upon the shift, all open bars will be rapped for security purposes. *Id.* Officers are to listen to the sound to ensure that the bar is solid and that inmates have not tampered with the cell doors. *Id.* The officer held the bar with his right hand and struck the bars approximately sixty times to demonstrate bar rapping on one cell (five to six bars vertically in twelve separate sections, each bar struck one time). *Id.*

The Correctional Officers demonstrating these areas and job duties on the DVD used both hands to complete these tasks. *Id.* In fact, when the videographer asked a Correctional Officer if he always turned keys with his left hand, the officer switched hands and stated, "You learn to use both hands in here because you need about four of them." *Id.* On another occasion, when the videographer requested a Correctional Officer to demonstrate the unlocking maneuver in slow motion, the officer tried to do so and the lock stuck. *Id.* He had to turn it multiple times to get it to work and explained that the locks were difficult to turn in slow motion. *Id.* The DVD was stopped when a Correctional Officer struggled to open a cell door and yanked on it repeatedly with both hands. *Id.*

Petitioner called Jay Ziegler, a shift supervisor who was present on behalf of Respondent, as an adverse witness. (T.69, 70). Mr. Ziegler testified that he has not had the opportunity to directly work with Petitioner, but he sees Petitioner several days a week. (T.70, 71). He testified that he was unable to rebut Petitioner's testimony as to his job activities. (T.71).

Petitioner testified that during the course of performing these job duties, he began experiencing symptoms of significant, continuous arm pain and tingling in his hands. (T.29, 30). He stated:

> At home, it became – it would bother me to do simple things, like reading a book or magazine or using a remote control, and that would go on for a period of days, and then I would get to a different spot where I wasn't turning a key as often, and the symptoms would alleviate. And if I got back in a specific spot for several days, it would sneak up on me and bother me again. I noticed at night when I would pick up a glass of water, I couldn't pick it up, and then I actually spilled a few glasses at night. (T.30).

Petitioner testified that he once performed a count of how many keys he was turning during his shift during a time when his symptoms became particularly bothersome while working double gate, and he counted turning keys some 952 times. (T.28, 29). Petitioner testified that he does not suffer from diabetes, gout, hypothyroidism or rheumatoid arthritis. (T.32).

Petitioner testified that he previously sought evaluation with Simple Spinal Health out of Carbondale and Parkcrest Orthopedics for elbow complaints prior to August 8, 2011; however, Petitioner's nerve conduction study was negative, and he was diagnosed with tennis elbow rather than cubital tunnel syndrome. (T.35-37, 42, 43, 54). He further testified that there was no connection made between his complaints and his employment at that time. (T.37, 42). He testified that his job duties were not even discussed with the physician at Parkcrest Orthopedics during the one and only visit in 2009. (T.42, 47). Petitioner also testified that the anti-inflammatory medication prescribed by the Parkcrest physician made his tennis elbow symptoms "go away." (T.57). He stated that he did not have any significant elbow concerns until about the time that he saw Dr. Paletta

and complained of recurrent symptoms. (T.57). Petitioner testified that August 8, 2011, was the first date that he was certain that he suffered from a work-related condition. (T.37).

On August 8, 2011, Petitioner saw Dr. George Paletta of The Orthopedic Center of St. Louis. (PX3, 8/8/11). Dr. Paletta took the history of Petitioner's complaints, including his prior treatment and nerve conduction studies which were normal, and physically examined Petitioner. *Id.* Dr. Paletta's physical examination demonstrated a positive Tinel's sign at the carpal tunnel over the left wrist. *Id.* Dr. Paletta referred Petitioner for electrodiagnostic studies with Dr. Daniel Phillips which were normal. *Id.* Petitioner testified that Dr. Paletta advised him that his studies were "borderline" and that he should closely monitor his situation "so it does not become an issue." (T.56). Consistent with Petitioner's testimony, Dr. Paletta's impression was bilateral carpal tunnel symptoms without electrophysiologic evidence of median nerve compromise. (PX3, 8/8/11). Dr. Paletta stated:

> His clinical symptoms are certainly consistent with carpal tunnel syndrome. Fortunately, the electrophysiologic studies do not demonstrate any evidence of significant compromise of the median nerve. I would recommend that we try a course of night splinting and some anti-inflammatories. *Id.*

On this visit August 8, 2011, Petitioner also provided Dr. Paletta with a thorough description of his job duties of turning keys, bar rapping, rolling cranks, carrying weapon ammunition, cuffing inmates, carrying heavy racks during lockdown, and dealing with difficult cell locks. *Id.* Petitioner reported particular difficulty with turning difficult locks and cranks. *Id.* Dr. Paletta believed, based on the correlation between Petitioner's complaints and his job activities, that Petitioner's upper extremity complaints were related to his work activities. *Id.* However, given the lack of electrodiagnostic confirmation, Dr. Paletta recommended only conservative care at that time. *Id.*

On September 29, 2011, Respondent issued a denial letter to Petitioner advising him that his claim was denied. (RX10). Petitioner testified that the matter was subsequently set for hearing; however, due to the amount of time that elapsed between the hearing and Petitioner's diagnostic studies, Petitioner was asked to be re-evaluated. (T.58, 59).

Petitioner was evaluated by Dr. Nathan Mall on September 13, 2013. (PX5, 9/13/13). Dr. Mall's physical examination demonstrated positive flexion compression tests at the elbow and positive Tinel's at the elbow. *Id.* Dr. Mall's diagnosis was bilateral cubital tunnel syndrome, left greater than right. *Id.* Dr. Mall recommended new nerve conduction studies and continued conservative care. *Id.* Petitioner's new studies were also negative; however, Dr. Mall's physical examination on October 18, 2013, as well as Petitioner's symptoms and complaints, continued to be consistent with bilateral cubital tunnel syndrome. (PX5, 10/18/13). With regard to the negative studies, Dr. Mall explained:

> I again discussed with Mr. Winters the fact that peripheral neuropathies about the hand, wrist, and elbow are considered clinical diagnoses based on the history, symptoms involved, as well as the physical examination. EMG and nerve conduction studies are confirmatory, however, they are also sometimes negative even though the syndrome is present and the patients do respond well to surgical management. Therefore, the negative EMG/nerve conduction study that was

17IWCC0629

> performed today does not rule out the fact that he has cubital tunnel syndrome, however. *Id.*

Given the fact that Petitioner failed a considerable lengthy period of conservative treatment lasting several years, Dr. Mall recommended bilateral cubital tunnel releases. *Id.* Dr. Mall again stated that he believed that Petitioner's ulnar symptoms were related to his prison job duties. *Id.* He stated:

> This requires repetitive use of locks and keys that require turning and gripping objects and having to put significant force through this. These are large locks and keys that require a significant amount of force to turn. The locks and keys are old and are not ergonomic at all. Several studies have evaluated the development of carpal and cubital tunnel syndrome in patients and have noted that there is a much greater degree of this in patients that do repetitive manual activities than in other patients that do sit down type of jobs or even in patients that do repetitive typing type maneuvers. Therefore, I do believe that his current symptoms related to his cubital tunnel syndrome are causally related to his job and should he not have this current job it would be less likely that he would have developed cubital tunnel symptoms that he is current complaining of and the physical exam findings that he is current experiencing. *Id.*

Respondent had Petitioner examined by Dr. Anthony Sudekum on May 12, 2014, after which Dr. Sudekum prepared a report indicating that he did not believe that Petitioner's symptoms or treatment were related to his work activities. (RX4). Dr. Sudekum's physical examination showed positive physical examination findings during Tinel's and Phalen's testing over Petitioner's elbows bilaterally and borderline findings over the wrists bilaterally. (RX4, p.12). Despite this, Dr. Sudekum stated that even Petitioner's "subjective symptoms" were "not indicative of a pathologic peripheral neuropathy, carpal tunnel syndrome or cubital tunnel syndrome." (RX4, p.57, 58). He further indicated "Mr. Winters' relatively benign and normal subjective symptomatology, his lack of any objective evidence of pathology on physical examination and his lack of any objective evidence on multiple nerve conduction studies are all inconsistent with a diagnosis of cubital tunnel syndrome, carpal tunnel syndrome and/or upper extremity peripheral neuropathy." (RX4, p.58 of 63). The Arbitrator notes that this appears to be inconsistent with Dr. Sudekum's own examination findings. He believed that Petitioner had reached maximum medical improvement from any "possible previous work-related injury and/or condition, that may have existed in the past." *Id.* at p.61.

During his deposition testimony on direct-examination, Dr. Sudekum acknowledged that surgery can help patients who suffer from cubital tunnel syndrome that has failed conservative management. (RX5, p.25). He also admitted previously testifying that the job duties performed at the Menard maximum security correction center could potentially serve to aggravate carpal and/or cubital tunnel syndrome. *Id.* at 52, 53. Despite admitting that activities such as bar rapping and opening heavy steel sliding doors were provocative factors *and* admitting that Petitioner was already predisposed to the development of such a condition, he did not believe Petitioner suffered from any type of peripheral neuropathy and did not believe that Petitioner's job duties had any impact on his development of symptoms. *Id.* at 10, 11, 52, 53, 74, 75. He admitted, however, that the records established a connection between his symptoms and complaints and his job duties and stated, "Well, Mr. Winters indicated that his symptoms did improve when he switched jobs. So it would be logical to make an assumption that he was having more symptoms when he was doing this other job. . . So it would be logical to

say that it's possible that he could have had some symptoms during the other assignment that he had prior to the current one, at least current at the time when I saw him. . ." *Id.* at 73, 74.

Although he was aware that Petitioner at times worked as a gallery officer, he was under the impression that Petitioner's duties varied. *Id.* at 56-58. There is no indication that Dr. Sudekum was aware that Petitioner served as a gallery officer for nearly his entire assignment history prior to his manifestation date. He was predominantly aware of Petitioner's history at the time of his independent medical examination occurred in May of 2014.

Dr. Mall also testified by way of deposition. (PX10). Dr. Mall testified that he practices what is commonly referred to as "evidence-based medicine." *Id.* at 6. Dr. Mall testified that carpal tunnel syndrome and cubital tunnel syndrome share many occupational risk factors such as repetitive gripping and grasping of objects with the affected nerves and joints in a flexed position, increased pressure over the affected areas vibrational activities and poor ergonomics. *Id.* at 7-9. While acknowledging Petitioner's non-occupational risk factors, Dr. Mall also acknowledged Petitioner's occupational risk factors. *Id.* at 9, 18, 19, 21. Dr. Mall also testified NeuroMetrix testing is an inferior testing method that does not measure all of the appropriate parameters. *Id.* at 32, 33.

Dr. Mall testified that Petitioner suffered from cubital tunnel syndrome despite his negative electrodiagnostic studies. *Id.* at 13, 14. When asked what led him to that conclusion, he stated:

> The basis was his clinical examination his history, which is – typically if you look at any textbook about carpal or cubital tunnel syndrome, they will all start with, "These are clinical diagnoses," meaning that the EMG/nerve conduction studies are simply a confirmatory test and don't necessarily rule in or out those problems.
>
> It's really based mostly on the clinical history and examination, and by definition, if they have a history that's – that is associated with that disease process and a physical examination that's also consistent with that, then they technically have carpal or cubital tunnel syndrome in this case. *Id.* at 13, 14.

Dr. Mall testified that he also took into consideration the duration of Petitioner's symptoms. *Id.* at 14. Dr. Mall stated that there was no "dramatic rush" that surgery be performed. *Id.* at 20.

Dr. Mall testified that turning heavy prison keys and opening doors required force and gripping that applied force over the elbow in addition to the wrist. *Id.* at 18. He also testified that par rapping caused vibration to the wrist and elbow, which can cause carpal and cubital tunnel syndrome and/or aggravate the symptoms of same. *Id.* at 18, 19. Since Petitioner failed a considerably lengthy period of conservative treatment, Dr. Mall stated that it was reasonable to consider cubital tunnel decompression and possible transposition, depending on how unstable the nerve is after decompression. *Id.* at 19, 20.

At Arbitration, Petitioner testified that he continues to have symptoms of numbness in the two smaller fingers of each of his hands as well as tingling in his elbows and arms. (T.34, 35).

17IWCC0629

CONCLUSIONS

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

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

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961 (1999). 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, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n*, 825 N.E.2d 773 (2nd Dist. 2005) the Appellate Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell*, citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive," in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

In this case, the evidence shows that Petitioner used his hands and arms extensively during the performance of his job duties for Respondent. Further, the Arbitrator finds the opinions and testimony of Dr. Mall much more persuasive than those of Dr. Sudekum in this case. The Arbitrator agrees with Dr. Mall's opinion that EMG findings alone are not dispositive of whether or not a claimant suffers from carpal tunnel syndrome. In reaching this conclusion the Arbitrator finds guidance in prior Commission decisions. *See Joseph Phoenix v. State of Illinois/Menard Correctional Center*, 13 I.W.C.C. 0460 (2013) (Despite negative studies, the evidence supported the claimant's assertion that he sustained repetitive trauma to his upper extremities as a result of his job duties); *Colleen Gilger v. LCN Closures, Inc.*, 12 I.W.C.C. 0267 (2012) (Claimant met her burden of proof regarding accident and causation where both of the claimant's treating physicians and one of

employer's two examining physicians opined that the claimant suffered from carpal tunnel syndrome despite a negative EMG study where there were positive clinical findings.)

Here, the clinical evidence obtained by Petitioner's treating physicians and by Respondent's examiner, Dr. Sudekum, showed positive findings on clinical examination demonstrating bilateral cubital tunnel syndrome.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent and that his current condition(s) of ill-being are causally related to the employment.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?

As the law demonstrates, the method for determining the manifestation date for repetitive injuries is flexible and liberally construed depending upon the facts of the case.

Although Petitioner suffered from elbow complaints prior to August 8, 2011, he was diagnosed with tennis elbow rather than cubital tunnel syndrome. (T.35-37, 42, 43, 54). He further testified that there was no connection made between his complaints and his employment at that time. (T.37, 42). He testified that his job duties were not even discussed with the physician at Parkcrest Orthopedics during the one and only visit in 2009. (T.42, 47). Petitioner also testified that the anti-inflammatory medication prescribed by the Parkcrest physician made his tennis elbow symptoms "go away." (T.57). He stated that he did not have any significant elbow concerns until about the time that he saw Dr. Paletta and complained of recurrent symptoms. (T.57). Petitioner testified that August 8, 2011, was the first date that he was certain that he suffered from a work-related condition. (T.37). The Arbitrator therefore finds that August 8, 2011, is the appropriate manifestation date for Petitioner's condition and proper notice was given as required by the Act,.

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

The Arbitrator finds that all of the medical care rendered to Petitioner has been reasonable, necessary, and sought in the quest to relieve and/or cure the effects of Petitioner's work injuries. Respondent is therefore ordered to pay the medical expenses contained in Petitioner's group exhibit and shall have credit for any amounts paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims from these medical providers arising out of the expenses for which it claims credit.

The Arbitrator finds that Petitioner has not reached maximum medical improvement. Petitioner continues to have complaints and he has not received all the care recommended by his physician, Dr. Mall. Respondent is therefore ordered to authorize and pay for any further care which may be necessary to alleviate Petitioner of his work-related condition under the recommendation of Dr. Mall.

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

Matthew Mason,
Petitioner,
vs.
State of Illinois /
Pinckneyville Correctional Center,
Respondent,

NO: 10 WC 31403

17IWCC0630

DECISION AND OPINION ON REVIEW

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

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

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

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

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.

OCT 10 2017

DATED:

o10317
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MASON, MATTHEW
Employee/Petitioner

Case# **10WC031403**

SOI/PINCKNEYVILLE CORR CTR
Employer/Respondent

17IWCC0630

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

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

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 15 2016

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

17IWCC0630

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

Matthew Mason
Employee/Petitioner

v.

State of Illinois/Pinckneyville Corr. Ctr.
Employer/Respondent

Case # **10** WC **31403**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **April 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0630

FINDINGS

On **August 11, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$55,729.00**; the average weekly wage was **$1,071.71**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **0** dependent child(ren).

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

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

Respondent shall be given a credit of $5,409.69 for TTD, **$0** for TPD, **$0** for maintenance, and one week of service connected disability, for a total credit of **$all paid**.

Respondent is entitled to a credit of **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $28,073.66, as set forth in Petitioner's exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $714.47/week for 8 5/7 weeks, commencing 10/28/10 through 12/26/10, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $5,409.69 for temporary total disability benefits that have been paid and for one week of service connected disability which has been paid.

Respondent shall be given credit for medical benefits previously paid or paid through its group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $643.03/week for 51.25 weeks, because the injuries sustained caused the 12.5% loss of the right hand (25.625 weeks) and the 12.5% loss of the left hand (25.625 weeks), as provided in § 8(e) of the Act.

SEE ATTACHED MEMORANDUM REGARDING TTD CREDIT

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

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

Michael K. Nowak, Arbitrator

1/13/16
Date

JAN 15 2016

FINDINGS OF FACT

At the time his injuries manifested, Petitioner was a 44-year-old right-hand dominant Correctional Officer (CO) for Respondent at Pinckneyville Correctional Center. Petitioner began working for Respondent on July 20, 1998, as a Correctional Officer, and testified that his job title has not changed since 1998. (T.20). Petitioner testified that he does not suffer from gout, hypothyroidism or rheumatoid arthritis. Petitioner stipulated that his claim is for his bilateral hands only. (T.83, 84).

Petitioner testified that of his 17 years as a Pinckneyville Correctional Officer, he has spent approximately 50% of his time as an R5 segregation officer and about 50% of his time as a wing officer. Petitioner testified that he was occasionally assigned to other posts, but the time spent at those posts was miniscule. Petitioner testified that Respondent's job roster was inaccurate, as he did not always work where he was assigned.

Petitioner explained that segregation is where trouble making inmates are placed in isolation. (T.23). The inmates in segregation have to be restrained any time they come out of their cell, and all deliveries such as food, mail and laundry have to be made through a chuckhole. In order to restrain an inmate, Petitioner has to cuff the inmate through the chuckhole and deadlock the cuffs. He testified that inmates at times resist being cuffed and have to be restrained using force. Petitioner described a chuckhole as a drop down slot in front of the cell door, which is opened by a Folger Adams key, and stated that the locks on these mechanisms stick due to rust and grime. He also testified that inmates throw feces and spoiled milk out on the chuckholes. He indicated that with some of the chuckholes "you got to yank on" them to get them open. (T.24) In order to close them he would have to slam them on occasion. (T.25) Petitioner testified that force and heavy grip were required to operate the chuckholes, and that on the majority of occasions he has to use both of his hands to open them. (T.26). He estimated that he has opened thousands of chuckholes over the course of his career with Respondent. (T.28-29).

Petitioner testified that the doors in R5 segregation are made of steel and have a rubber strip on the bottom of the door to stop the inmates from "fishing" or passing things underneath the doors from cell to cell. (T.28). Petitioner testified that this makes the doors more difficult to open, and that he has to use force to pull them open. Petitioner testified that he performs bar rapping on the bars of the segregation showers, which causes vibration.

Petitioner performs shakedowns, which requires him to search through everything in the cell to search for contraband. He testified that he picks up property boxes, lifts mattresses, and searches TV's and radios to look for weapons, cell made alcohol, and anything else that the inmates should not have. Petitioner also performs wing checks every 30-minutes. He testified that he walks down the wing, grabs the handle, and rattles the door to make sure that inmates have not jammed a lock and that the door is closed. Petitioner testified that he uses force in doing so. (T.33). He testified that there are 53 to 56 cells on a wing, and estimated that he was responsible for two wings for approximately 20% of his time as a Correctional Officer. Petitioner testified that he has pulled on thousands of cell doors and turned thousands of keys over the course of his career with Respondent.

Petitioner also testified that his job duties increase when the facility is on lockdown. (T.35). He testified that during a lockdown, all of the inmates are kept in their cells, and Correctional Officers have to do

everything. This includes cleaning, taking out trash, feeding meals, and passing ice. General population inmates have to be serviced through chuckholes during lockdown as though they were in segregation. Petitioner estimated that Respondent's facility was on lockdown for approximately 20% to 25% of its operational time in the years of 2009 to 2010. Petitioner testified that he worked approximately 2 to 3 overtime shifts a month during this period.

The record contains an extensive amount of evidence regarding Petitioner's job duties. Respondent offered into evidence a CorVel Job Site Analysis procured at its request. (PX 5) Respondent also offered DVDs produced at Respondent's direction which depict the job duties of a CO. (PX 7, 8) In addition, Respondent offered a demands of the job statement pertaining to a Pinckneyville Correctional Officer. (PX15) Petitioner's Work History Timeline/Job Description was also admitted into evidence. (PX9)

Petitioner testified that he reviewed Respondent's DVDs, and stated that they did not accurately depict the duties of a Pinckneyville Correctional Officer because they were vague as to what was required of Correctional Officers at Pinckneyville Correctional Center. He testified that there was nothing in the videos about segregation or lockdown, and stated that they did not depict the pace at which he worked.

Respondent's "Demands of the Job" form indicates that Petitioner lifts between 1 to 10 pounds up to 2 hours per day, lifts between 11 to 20 pounds up to 2 hours per day, lifts between 21 to 30 pounds up to 2 hours per day, lifts between 31 to 40 pounds up to 2 hours per day, and lifts between 41 to 50 pounds up to 2 hours per day. (RX1). It also indicated that Petitioner uses his hands for gross manipulation such as grasping, twisting and handling, for up to 2 hours per day, and that Petitioner never used his hands for fine manipulation such as typing and good finger dexterity. *Id.* Petitioner also reviewed Respondent's "Demands of the Job" form and testified that its estimate for both gross and fine manipulation were incorrect. (T.89). Respondent's "Demands of the Job" form conflicts with the independent CorVel analyses performed at Respondent's request.

Both of the CorVel Job Site Analyses categorize the strength demands of Petitioner's job as "Medium" which is defined as "lifting 50 pounds maximum with frequent lifting and/or carrying up to 25 pounds. (RX5). "Frequent" is defined as 2.5 to 5.5 hours per day, 34% to 66% of a day, or 33 to 200 repetitions per day. *Id.* Correctional Officers also engage in "frequent" wrist turning and "frequent" finger manipulation. *Id.* The wrist turning was associated with the opening of doors and chuckholes up to 150 times per shift in the housing unit. *Id.* More keys would be turned during lockdown. *Id.* The CorVel Job Site Analyses indicate that 70% of the key turning is done by wing officers. *Id.* The hand-and-arm usage evaluations in the Analyses quantify a substantially greater amount of activity than what is indicated in Respondent's "Demands of the Job" form.

The Arbitrator notes that the Job Site Analysis and videos do not accurately depict keying and un-keying doors for moving of inmates through the housing units, in passes runs, handling transfer boxes, writs, medical furloughs, medical or furlough bags. Likewise, they do not depict keying out passes for clothing, barber shop, and commissary, or weapons and tactical training.

During the hearing Respondent called Major Jason Thompson, who served at Pinckneyville Correctional Center from July of 1998 until March of 2013. He testified that he believed Petitioner's estimate of turning keys 400 times on a shift was high, but possible on a very busy day. He testified that the keys themselves were what gave Correctional Officers the most trouble at Respondent's facility, but he testified that he believed the

majority of the keys and locks at Pinckneyville were in good working order. He also testified that minimal force was required to open a general population cell door.

Petitioner testified that during the course of performing his job duties, he began developing symptoms of numbness, tingling and paresthesia in his arms and hands. Petitioner saw Dr. Brown on August 11, 2010. (PX3, 8/11/10). Dr. Brown took the history of Petitioner's complaints and his job duties and physically examined Petitioner, which revealed findings consistent with bilateral carpal tunnel syndrome. *Id.* EMG studies performed the same day revealed evidence of severe right carpal tunnel syndrome, moderate left carpal tunnel syndrome, and mild ulnar neuropathy which was not demonstrable during physical examination. (PX3, 8/11/10; PX4). Dr. Brown recommended conservative care through splinting and non-steroidal anti-inflammatory medication. (PX3, 8/11/10). Petitioner testified that this was the first day he underwent any sort of diagnostic testing, required any treatment, or received a diagnosis for his condition. (T.43, 45-47). After he received a diagnosis, Petitioner notified Respondent of his condition on August 16, 2010. (T.45, 46; PX8).

When Petitioner returned to Dr. Brown on September 15, 2010, Petitioner continued to demonstrate clinical evidence of bilateral carpal tunnel syndrome, but no evidence of ulnar neuropathy. (PX3, 9/15/10). Since Petitioner's electro-diagnostic studies were positive for significant bilateral carpal tunnel syndrome, right greater than left, Dr. Brown recommended bilateral carpal tunnel releases. *Id.* He made no treatment recommendations for the left ulnar nerve. *Id.*

On October 28, 2010, Dr. Brown performed a right carpal tunnel release and noted in his intraoperative findings that Petitioner's median nerve had flattened appearance within the carpal tunnel. (PX5, 10/28/10). The same procedure was performed on Petitioner's left side on November 12, 2010, with similar intraoperative findings. (PX5, 11/12/10). Petitioner improved following surgery and therapy and was released to full duty work on December 27, 2010. (PX3, 12/1/10; PX6).

Petitioner testified that his condition improved following surgery. Despite the improvement from surgery, Petitioner continues to have some numbness and tingling in his hands and has experienced a loss in grip strength. Petitioner notices his strength deficit while turning keys, pulling on door handles and shooting his bow. Petitioner takes over-the-counter Tylenol for his symptoms.

Respondent obtained a records review performed by Dr. James Williams. (RX14) Dr. Williams agreed that Petitioner suffered from bilateral carpal tunnel syndrome and left cubital tunnel syndrome and agreed that Petitioner's course of treatment was reasonable for his condition. *Id.* at 13, 14, 29. He did not, however, believe that Petitioner's job duties as a Correctional Officer at Pinckneyville Correctional were a factor in the development or aggravation of his bilateral carpal tunnel syndrome or left cubital tunnel syndrome. *Id.* at 16, 17. He testified that his opinion was based on his understanding that Petitioner's job duties did not require significant force, repetition or vibration, according to Respondent's job analysis reports, DVDs and job descriptions. *Id.* at 14-16, 18. He testified that he believed that Petitioner's hypertension, increased body mass index, hunting hobby and yard mowing were risk factors for his conditions. *Id.* at 15. He did not believe that key turning once every 60 seconds was a factor because he believed there was sufficient rest between turns. *Id.* at 18, 19. He did not know if Petitioner ever worked in Pinckneyville's segregation unit. *Id.* at 31. He acknowledged that working in the segregation unit involves more intensive use of the upper extremities and more turning of Folger Adams keys. *Id.* at 31, 32.

Dr. Brown also testified by way of deposition. (PX7). Dr. Brown testified that he is a board certified hand specialist whose practice is dedicated to care of the upper extremity. *Id.* at 4-6. Dr. Brown testified that he reviewed Dr. Williams' records review and testimony, Respondent's CorVel job site analyses (JSAs) and DVD, Respondent's key usage study, and multiple post descriptions for job assignments at Pinckneyville Correctional Center. *Id.* at 16, 17. In addition, Petitioner provided a hand-written work history timeline and job description. *Id.* at 17. Based on the information that he received, Petitioner's job description, and his history of performing the described duties for over a decade, he believed that Petitioner's job duties were an aggravating factor in Petitioner's condition and need for treatment. *Id.* at 21, 44.

Dr. Brown acknowledged that Petitioner has a history of hypertension or high blood pressure. *Id.* at 21, 22. He testified, however, that recent studies have shown that there is not a strong association between hypertension and carpal tunnel syndrome; and in one prospective controlled study published in the Journal of Hand Surgery, high blood pressure was not even on the list as an important risk factor. *Id.* at 21, 22. He further testified that Petitioner was not obese, but was a muscular individual for whom a BMI calculation would not be an accurate assessment. *Id.* at 22, 23. Dr. Brown did not consider Petitioner's hobbies of hunting or yard mowing to be risk factors given that they were done on a seasonal and/or occasional basis. *Id.* at 23. He specifically disagreed with Dr. Williams' opinion on this subject. *Id.* at 42, 43. He stated:

> . . . My understanding is those activities are done on a seasonal basis, only occasional. And I think if you're going to make an argument that occasional mowing, occasional hunting and yard work could be a factor in the cause of carpal tunnel syndrome, I don't see how you could then exclude 12 years of exposure to forcefully keying these doors several hundred times a day and pushing and pulling on these cell doors hundreds of times a day as not being a factor. *Id.* at 42, 43.

Although Petitioner's EMG studies were positive for left cubital tunnel syndrome, Dr. Brown testified that since Petitioner's clinical presentation for cubital tunnel syndrome was not significant, he did not recommend any additional treatment for same. *Id.* at 25. Dr. Brown testified that concept of latency, or a period of time between the accumulation of pathology and the manifestation of symptomatology, applied to conditions such as carpal and cubital tunnel syndrome. *Id.* at 37-39. He also testified that the threshold, or point at which symptoms manifest, is different for each individual. *Id.* at 39, 40. Despite disagreeing on causal connection, Dr. Brown testified that he and Dr. Williams agreed on certain points, such as Petitioner's diagnosis, Petitioner's course of care, and the superiority of electrodiagnostic studies done by a neurologist versus a NeuroMetrix test; they disagreed on what activities were contributory factors in the development of Petitioner's condition. *Id.* at 41, 42.

Dr. Brown testified that Respondent's JSAs note that 70 percent of hand keying is performed by wing officers, that officers are often responsible for two wings, that the strength demands involved frequent lifting, defined as up to 66% of the day, with carrying, that officers engage in frequent wrist turning related to opening doors and chuckholes (estimated as up to 150 keys turned per day shift), and that more keys are turned during lockdown, which occurred during approximately 25% of the facilities operational time in 2010. *Id.* at 31-33.

Dr. Brown also noted that the key estimation study, which indicated that the average amount of keying done by each correctional officers is about 220 times per day, established that officers perform frequent key turning. *Id.* at 34, 35. Dr. Brown pointed out that in Respondent's DVDs, the amount of rest shown between

key turns was approximately 3 seconds, or the amount of time it took to walk from one cell to the next. *Id.* at 36. He noted that this was a significantly shorter interval period than what Dr. Williams believed it to be, and that this 3 second period was not a sufficient rest interval. *Id.* at 36, 37. He therefore believed that the keying done by Petitioner was an aggravating factor in the development of his condition. *Id.* at 37. Dr. Brown testified that outside of that particular detail, the DVDs were not helpful, as more talking was done than demonstrating. *Id.* at 36. Dr. Brown was aware that a control pod officer was on hand to open gallery doors for mass movements. *Id.* at 69. Dr. Brown testified that all of this information, although not quantitatively identical, corroborated the information provided to him by Petitioner and reinforced his opinion on causal connection. *Id.* at 35, 65.

CONCLUSIONS

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961 (1999). 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, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n,* 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

Petitioner testified that opening Respondent's heavy steel cell doors and chuckholes, performing wing checks, performing shakedowns, and restraining resistant inmates all required the forceful use of his hands and arms. Dr. Brown testified that these are occupational activities that would cause and/or contribute to the

development of carpal tunnel syndrome. The Arbitrator finds that the causation opinion of Dr. Brown is more persuasive than the opinion of Dr. Williams. Dr. Brown had a more thorough understanding of Petitioner's working conditions. Dr. Brown also logically reasoned that if Petitioner's occasional hobbies were a contributing factor, then his employment which involved full-time exposure to the same stressors would also be a contributing factor. The Arbitrator is persuaded by Dr. Brown's credible opinion. In this case, the evidence shows that Petitioner used his hands and arms extensively during the performance of his job duties for Respondent.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent and that his current condition(s) of ill-being are causally related to the employment.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?

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.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: **(a)** the date the employee actually became aware of the physical condition and its relation to work through medical consultation; **(b)** the date the employee requires medical treatment; **(c)** the date on which the employee can no longer perform work activities; or **(d)** when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (Ill. 1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand,* N.E.2d at 927. Claimants are not charged with filing a claim as soon as they believe they may have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. The Supreme Court stated that to rely solely on a claimant's testimony concerning symptoms, without accurate knowledge of the cause of those symptoms, would essentially be asking them to "rely on 'expert' medical testimony from a layperson." *Id.* at 929. The Court also recognized that claimants would have had difficulty proving injury with a sketchy and equivocal understanding of same. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930. In *Durand*, the claimant was not sure her pain was from carpal tunnel syndrome, but "she believed it was work-related" in 1997, some 3 years before her injuries manifested in 2000. *Durand v. Indus. Comm'n*, 862 N.E.2d at 929-30.

In *Three "D" Discount*, the Court held the manifestation date of claimant's injury was the date "petitioner first learned that his condition of ill-being was work related." (*Id.*, 556 N.E.2d at 265) The Court went on to caution "[a]lthough our finding that the injury in this case 'manifested itself' on July 10, rather than August 10, does not affect the Commission's ruling in petitioner's favor, we emphasize that the peculiar facts of each case must be closely analyzed in repetitive-trauma cases to be fair to the faithful employee and his employer as well as to the employer's compensation insurance carrier." (*Id.*)

In *Linda Peters v. Village of Caseyville*, the Commission gave significant weight to the date on which the claimant possessed a "confirmed diagnosis" of her condition in setting the manifestation date. *Linda Peters v. Village of Caseyville*, 14 I.W.C.C. 0796 (2014). The Commission stated:

> The Commission finds that the manifestation date of Petitioner's right carpal tunnel syndrome was March 1, 2012. Although the parties had stipulated to an accident date of September 1, 2010, we find that it is within our discretion to change the accident date to conform-to the evidence. *See Beal v. Town of Normal*, 10 IWCC 380 (2010). The medical records are clear that the first mention of any correlation between Petitioner's right carpal tunnel syndrome and her work duties is the March 1, 2012, office note of Dr. Mirly. Although Petitioner's report of injury on March 2, 2012, indicates a date of accident of "Sept 2011," we find that this is not an appropriate manifestation date in this case because Petitioner did not have a confirmed diagnosis at that time. Based on our determination of the date of accident, we find that Petitioner provided timely notice of her accidental injuries. *Id.*

In the case at bar, Petitioner testified that August 11, 2010, was the first day he underwent any sort of diagnostic testing, required any treatment, or received a diagnosis for his condition. After he received a diagnosis and knew his condition was related to his employment, Petitioner notified Respondent of his condition on August 16, 2010. (PX8)., well within the 45-day period allotted by the Act.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that August 11, 2010, is an appropriate manifestation date under the Act. Petitioner has met his burden of establishing his date of accident and further has provided proper notice as required by the Act.

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

Respondent's records reviewer, Dr. Williams, agreed with Petitioner's diagnosis and also agreed that Petitioner's course of care was reasonable. Respondent shall pay reasonable and necessary medical services of $28,073.66, as set forth in Petitioner's exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given credit for medical benefits previously paid or paid through its group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

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

Petitioner was taken off work by Dr. Brown on the date of his surgery, October 28, 2010, and was returned to full-duty work on December 27, 2010. (PX3, 12/1/10; PX5). Therefore, Petitioner was temporarily

17IWCC0630

and totally disabled for a period of 8 5/7 weeks. Petitioner's TTD rate is $714.47. The parties stipulated Respondent paid $5,409.69 in temporary total disability compensation, and further that Respondent is entitled to credit for payment of one week of service connected disability.

Respondent shall pay Petitioner temporary total disability benefits of $714.47/week for 8 5/7 weeks, commencing 10/28/10 through 12/26/10, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $5,409.69 for temporary total disability benefits that have been paid and for one week of service connected disability which has been paid.

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

As a result of his job duties, Petitioner developed severe right carpal tunnel syndrome and moderate left carpal tunnel syndrome, which required bilateral median nerve/carpal tunnel releases. Petitioner credibly testified that despite the improvement from surgery, he continues to have some numbness and tingling in his hands and has experienced a loss in grip strength. Petitioner notices his strength deficit while turning keys, pulling on door handles and shooting his bow. Petitioner takes over-the-counter Tylenol for his symptoms.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner sustained serious and permanent injuries that resulted in the 12.5% loss of his right hand, and the 12.5% loss of his left hand. Respondent's request for credit is inapplicable as there has been no prior award for either of Petitioner's hands.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Cruz,
Petitioner,
vs.

NO: 11WC 13240

Monterey Mushroom,
Respondent.

17IWCC0631

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 1, 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.

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: OCT 10 2017
o100317
LEC/jrc

043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRUZ, MARIA
Employee/Petitioner

Case# **11WC013240**

11WC015403

MONTEREY MUSHROOM
Employer/Respondent

17IWCC0631

On 2/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 SCHWEICKERT & GANASSIN
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

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

17 I W C C 0 6 3 1

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Maria Cruz
Employee/Petitioner

v.

Monterey Mushroom
Employer/Respondent

Case # **11** WC **13240**

Consolidated cases: **11 WC 15403**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **Ottawa** on **June 24, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. [X] Other **Loss of Trade**

FINDINGS

On **November 8, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,829.52**; the average weekly wage was **$458.26**.

On the date of accident, Petitioner was **43** years of age ***married*** with **4** dependent children.

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

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

To date, Respondent has paid **$9,711.43** 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 **$9,711.43** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,711.43**.

Respondent is entitled to any credit of payment made by the group insurance under Section 8(j) of the Act.

ORDER

Medical Benefits

Respondent shall pay the bills totaling $94,771.42, 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 February 8, 2011 through April 14, 2014, which is 166 weeks at $330.00 per week.

Permanent Partial disability

Petitioner is entitled to 106 weeks @ $330.00 per week as petitioner's permanent disability has resulted in 20% loss of use of person as a whole plus six weeks for specific loss due to the vertebrae fracture.

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 MOy
Signature of Arbitrator

2/1/2017
Date

FEB 1 - 2017

17IWCC0631

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Cruz,	)	
Petitioner,	)	
vs.	)	**No. 11 WC 13240**
Monterey Mushrooms	)	**(Companion 11 WC 15403)**
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Ottawa on June 24, 2016. The parties stipulated petitioner sustained accidental injuries from an accident that arose out of and in the course of her employment with respondent on November 8, 2010, that petitioner's earnings in the year pre-dating the accident was $22,829.52 and her average weekly wage was $458.28.

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 additional temporary total disability.
4. Whether petitioner is entitled to penalties and attorneys' fees.
5. What is the nature and extent of petitioner's injury/loss of tradc?

FINDING OF FACTS

The Petitioner does not speak English; her native language is Spanish. She testified with the assistance of Miguel Arteaga, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Mr. Arteaga served as an interpreter for the Petitioner.

Petitioner testified she graduated from high school in Mexico. This is her highest level of education. Petitioner began working in 2002 for Harper Wyman, a manufacturer of small parts for burners for stoves. She worked for Harper Wyman for two years. Thereafter, she began working for respondent.

From 2004 to her date of accidents, petitioner was a picker and packer for respondent. As a picker she used a lug that contained four baskets. Each basket stood approximately ten inches high and weighed four to five pounds each. As a picker, petitioner climbed the beds of mushrooms using a ladder to climb. In order to reach the highest bed, petitioner had to stand six feet off the ground. Petitioner cut the mushrooms with one hand, while holding the mushrooms in another, all while balancing on the edge of the beds. After the baskets were filled, the picker carries the lugs down the side of the beds to the carrier. Petitioner testified the lugs weighed 20 to 25 pounds and the bags weighed up to 30 pounds. Petitioner was paid by the number of mushrooms picked.

On July 30, 2009, petitioner was working on the lower bed; as she was crouching and turning to pick up the lug she hurt her back. The lug was full; which meant it weighed 20 to 30 pounds. Prior to July 30, 2009, petitioner had minor injuries to her back and other parts of her body, but she recovered from them. She immediately reported the injury to her supervisor. Co-worker Humberto was called to translate as he was bilingual.

Four days after the occurrence she went to Illinois Valley Community Hospital (hereinafter "IVCH") as she had days off after the occurrence. Humberto took her to the hospital. Petitioner followed up with IVCH for treatment, but continued to work in pain. She was released to full duty as of October 30, 2009. She continued to have small aches.

She worked until November 8, 2010 when she sustained another injury. Petitioner was five to six feet off the ground, when her foot slipped off the ledge and she fell to the ground landing on her buttocks and right shoulder. Petitioner remembers passing out and falling backwards several times. She had to be helped up by her coworkers and went to the office. She was taken to the hospital. Petitioner again reported the accident to Humberto.

After her fall petitioner felt like something was broke in her back. She had a lot of pain in her right shoulder. She was again taken to IVCH for treatment. She was only given some medication and was sent to rest for a few days. She returned to IVCH on December 6, 2010 and was placed on work restrictions. On December 29, 2010 a scan revealed petitioner had a fractured coccyx. She had additional X-rays and tests on January 7, 2011. On January 28, 2011 she was seen at IVCH and was placed on work restrictions.

She remained on light duty until February 8, 2011, when she saw her own doctor, Dr. Perales, who kept her completely off work. She followed up with Dr. Perales for several visits. On March 9, 2011 she had an MRI at IVCH.

Dr. Perales referred petitioner to Dr. Kloc for pain management. Dr. Perales also referred petitioner to Dr. DePhillips; whom she saw on May 2, 2011. On May 23, 2011, Dr. DePhillips recommended petitioner undergo a discogram which was performed on July 7, 2011 along with a CT scan.

Petitioner saw Dr. Bernstein on a couple of occasions at the request of respondent. She was also seen by Dr. Bergandi at the request of Dr. DePhillips. Dr. Bergandi recommended the injections performed by Dr. Kloc at IVCH. Petitioner had another MRI in February, 2012. Petitioner discussed surgery with Dr. DePhillips on March 27, 2012. Dr. DePhillips prescribed pain medication, and also medication for depression. She was not depressed before the accident. During this period of time, she was kept off work by Dr. DePhillips. She did not come out of her house or even her room.

At the request of her own attorney, petitioner saw Dr. Delheimer on August 29, 2012. She continued to follow up with Dr. DePhillips a few times in 2012 and 2013, until he left the area. Dr. DePhillips then referred petitioner to Dr. Kube, whom she saw on July 23, 2013. She gave the same history of the accident to Dr. Kube. Dr. Kube recommended additional injections before surgery. Petitioner received two injections which only brought a week of relief. Dr. Kube requested an EMG that was done on September 11, 2013.

Thereafter Dr. Kube recommended and performed surgery on December 9, 2013. She received physical therapy from December 24, 2013 through April, 2014 at City Center Physical Therapy Center. In April, 2014 petitioner underwent a functional capacity evaluation (hereinafter "FCE".) After the FCE petitioner had a lot of pain in her legs and couldn't stand or sit for a long time. She had pain in her low back and down her legs; more on the right. She estimated her pain at four when she was not doing anything and seven when she did activity.

Petitioner performed light duty work until February 8, 2011. Thereafter, except for one and a half days, petitioner has not worked for respondent. Petitioner was notified her employment with respondent was terminated after she exceeded her leave under FMLA. After undergoing a FCE, Dr. Kube released her to return to work with permanent restrictions. Once released by Dr. Kube, at the direction of her attorney, she conducted her own job search; searching for a minimum

17IWCC0631

of ten jobs per week. She prepared a list of jobs she looked for, but it was not complete. She became sad because no one would hire her with her restrictions. She was able to get a temporary job by leaving blank her restrictions.

On February 17, 2015 petitioner began working for Midwest American Growers. Petitioner had looked for work within her restrictions, which she understood to be frequent lifting up to ten pounds and thirty-five pounds occasionally with limited lifting, twisting and bending. The job at Midwest American Growers is a full-time position; she often misses days due to her condition. She worked only for American Growers only until August, as she couldn't stand it anymore. Midwest American Growers grows plants for transplanting.

She continues to have pain in her lower back that goes down her right leg to her knee.

Petitioner testified the most she had to lift at Midwest American Growers was 15 pounds. Petitioner never reapplied to respondent after her FMLA ran out. Petitioner's job at Midwest American Growers required her to plant small plants into a pot by digging a hole into the pot with her finger. She would stand up and sit down at the job. She worked seven to eight hours a day.

Medical Bills (PX.1)

Petitioner submitted the following bills as part of her claim.

$2,220.00 – Dr. George DePhillips
$1,973.60 – EqMD
$860.00 - Dr. Constatino Perales
$4,750.00 – Apex Medical/Dr. Kloc
$1,459.11 – NR Anesthesia & Pain Management
$15,897.50 – Fullerton Surgery Center
$746.00 – Illinois Valley Spine Institute/Dr. Jason Bergandi
$1,098.00 – Hospital Radiology Service
$20,082.71 – Prairie Surgicare
$16,098.50 – Prairie Spine and Pain Institute
$8,185.00 – St. John's Hospital
$3,822.00 – Edward Trudeau MD
$2,400.00 – Airway Anesthesia PC
$15,579.00 – City Center Rehabilitation

Illinois Valley Community Hospital (PX.2)

Petitioner was first seen, after her July 30, 2009 accident, at IVCH Occ-Health on August 3, 2009. The history was consistent with her lifting a bucket of mushrooms when she injured her back. The diagnosis was lumbar strain. She was placed on work restrictions.

She followed up at Occupational Health on August 17, 2009. X-rays showed petitioner had mild degenerative disc disease at the L4-L5 level, along with left-sided hemisacralization of L5 on S1. She was kept on work restrictions.

Petitioner returned to IVCH Occ-Health on August 24, 2009 and September 1, 2009; she was kept on work restrictions. She had received physical therapy from September 25, 2009 through October 16, 2009. On October 3, 2009 petitioner's symptoms resolved and she was released to return to work without restrictions.

Petitioner returned to Occ-Health on November 8, 2010 after falling on her backside at work. X-rays were negative for fractures; only showing mild facet arthropathy at L5-S1. Although

a CT scan of petitioner's pelvis from January 28, 2011 showed transverse S4 segment fracture with changes of healing and no displacement along with left-sided L5 sacralization.

She followed up with Occ-Health on November 12, 2010, November 22, 2010, December 6, 2010. December 28, 2010, January 28, 2011 and March 1, 2011. She was kept on work restrictions from November 8, 2010 through March 1, 2011. At the March 1, 2011 visit, petitioner requested to follow up with her personal physician. A MRI was recommended.

The March 9, 2011 lumbar MRI showed mild diffuse disc bulging at L4-5 with more focal broad-based left far lateral protrusion or bulging contributing to the mild to moderate left-sided neural foraminal stenosis as well as moderate facet hypertrophy and ligamentum flavum enlargement at L4-5.

Petitioner returned to IVCH on April 1, 2011 for pain management by Dr. Ronald Kloc as a referral by Dr. Constantino Perales. She obtained an epidural steroid injection by Dr. Kloc on April 7, 2011.

Petitioner received physical therapy from June 1, 2011 through June 17, 2011.

Petitioner returned to Dr. Kloc on December 14, 2011; bilateral facet injections from L4-S1were performed. A second set of facet injections were performed on December 28, 2011.

A February 7, 2012 lumbar MRI showed L4-5 desiccation and bulging symmetrically, more prominent on the left but similar to the prior exam. Also, there was an associated L4-5 discogenic endplate change.

Dr. George DePhillips Records (PX.3)

These records reflect petitioner was first seen by Dr. DePhillips on May 2, 2011 as a referral from Dr. Constantino Perales. Her history to Dr. DePhillips was consistent with her work accident(s). Dr. DePhillips diagnosed discogenic low back pain at L4-L5 and bilateral lower extremity radiculitis. Dr. DePhillips kept petitioner off work and asked her to return with the MRI film.

Petitioner returned on May 23, 2011 with the MRI film. After reviewing the films, Dr. DePhillips determined petitioner had a disc protrusion and degeneration at the L4-L5 level, with bilateral foraminal stenosis at the L4-5 level, left greater than right and facet arthropathy. Dr. DePhillips recommended therapeutic injections by Dr. Kloc, chiropractic or physical therapy, and possibly a discogram if additional conservative care fails. She was to remain off work.

Petitioner returned to Dr. DePhillips on June 20, 2011. Dr. DePhillips did not find a disc herniation or nerve root impingement. Petitioner expressed a desire to proceed with a discogram to determine if the pain was discogenic at the L4-L5 level.

Petitioner returned to Dr. DePhillips on July18, 2011 after undergoing a discogram by Dr. Malek, which was valid and showed petitioner had concordant pain at L4-L5 level. Petitioner had been seen by Dr. Avi Bernstein on July 11, 2011. Dr. DePhillips wanted to review the report of Dr. Bernstein before making further recommendations.

Petitioner was seen again on August 8, 2011. Dr. DePhillips agreed with Dr. Bernstein's recommendation for additional physical therapy. Petitioner tried and was unable to work within the restrictions outlined by Dr. Bernstein. Therefore, Dr. DePhillips kept petitioner off work.

These records next contain a report dated November 29, 2011. Dr. DePhillips reviewed Dr. Bergandi's recommendation. Petitioner was to undergo two diagnostic facet injections at L4-S1 and possibly a fusion if the injections are negative for facet mediated pain.

Petitioner again saw Dr. DePhillips on January 9, 2012 and January 23, 2012. On February 13, 2012, Dr. DePhillips recommended a fusion at the L4-L5 level. Dr. DePhillips also saw

petitioner on March 27, 2012, at which time he recommended a minimal invasive fusion at the L4-L5 level.

Petitioner returned to Dr. DePhillips on October 1, 2012. She had seen Dr. Delheimer, who agreed petitioner should have the fusion. Petitioner was still awaiting approval for surgery.

Dr. Michael Malek Records/MRI Lincoln Imaging (PX.4 & PX.6)

Petitioner underwent a discogram by Dr. Malek and a post-discogram CT scan on July 7, 2011. The discogram showed pain generators at L4-L5 levels. The CT scan showed annual tears at all levels from L1 through S1.

St. Margaret's Hospital Records (PX.5)

Petitioner received physical therapy in August and September, 2011.

Fullerton Surgery Center (PX.7)

The valid discogram of July 7, 2011 indicated petitioner had concordant pain at the L4-5 level.

Illinois Valley Spine Institute/Dr. Jason Bergandi (PX.8)

Petitioner was seen by Dr. Bergandi on November 11, 2011, at the request of Dr. DePhillips. Dr. Bergandi's diagnosis was degenerative disc disease with exacerbation of a concurrent problem status post fall at work and possible right lower extremity radiculopathy and possible bilateral trochanteric bursitis; right greater than left. Dr. Bergandi noted petitioner had some motor strength weakness on the left.

Dr. Bergandi provided an injection and recommended petitioner undergo facet injections at the L4-L5 level. Dr. Bergandi believed if the injections failed, then petitioner would likely need a L4-L5 discectomy and fusion.

Dr. Constantino Perales (PX.10)

The portion of Dr. Perales' records that were not duplicative of other records indicate petitioner was seen by Dr. Perales in February, March and April, 2011 due to her low back pain and anxiety. Dr. Perales authorized petitioner off work during that period of time.

Dr. Robert Eilers November 13, 2012 Report (PX.11)

Dr. Eilers examined petitioner on November 13, 2012. Based upon the history petitioner provided, medical records reviewed and his examination, Dr. Eilers determined petitioner's injuries, which included a L4-L5 disk herniation/degeneration that was caused or aggravated by her fall at work on November 8, 2010. Petitioner also suffered a sacral fracture and myofascial pain as well as depression secondary to petitioner's chronic pain.

Dr. Eilers opined petitioner probably suffered a mild concussion, but had no residual effects from it. Dr. Eilers also believed petitioner's July 30, 2009 injury resolved without any permanent injury.

Dr. Eilers agreed with the previous recommendation's for a laminectomy and fusion at L4-L5. However, Dr. Eilers was also not optimistic that the surgery would allow petitioner to return to work at her previous job with respondent.

Dr. Robert Eilers April 26, 2013 Deposition (PX. 12)

Dr. Eilers testified to the information contained in his November 13, 2012 (PX.11).

Dr. Robert Eilers June 9, 2014 Deposition (PX.13)

Dr. Eilers testified inaccurately that the EMG by Dr. Trudeau done on September 11, 2013 showed a radiculopathy or pinched nerve on the right (sic) at the L4-L5 level (P.6). Dr. Eilers reviewed the operative report of the surgery performed and testified that the surgery done by Dr. Kube on December 9, 2013 was appropriate (PP. 9-11). Dr. Eilers reviewed the FCE of April 18, 2014, (sic) which had been ordered by Dr. Kube and determined petitioner could only return to work in a sedentary position despite the findings on the FCE (PP. 10-11; 15).

Prairie Spine and Pain (PX.14)

(Petitioner submitted more than five hundred pages identified as Petitioner's Exhibit 14. Approximately 10 of these pages were germane to the treatment at Prairie Spine and Pain by Dr. Richard Kube or Dr. Cummings. All other documents were either irrelevant or duplicates of records introduced. Only those portions of the germane, and not duplicates of records previously introduced, are included in the following analysis of Petitioner's Exhibit 14.)

The report of the February 7, 2012 MRI from IVCH reportedly showed a L4-L5 disc desiccation and bulging; asymmetrical, but more prominent on the left.

On July 23, 2013 petitioner was seen by Dr. Kube as a self-referral for her back pain. Dr. Kube recommended sacroiliac injections to see if that improved her pain.

On July 31, 2013, Dr. Cummings performed bilateral sacroiliac joint injections.

Petitioner returned to Dr. Cummings on August 28, 2013 to discuss the results of the sacroiliac injections. Petitioner reported minimal relief immediately after the injections, but the pain had returned.

Petitioner was seen by Dr. Alexander Cummings on October 7, 2013 to discuss the EMG and discuss epidural injections. Petitioner did not want to proceed with the injections at that time.

Dr. Kube performed a L4-5 hemilaminotomy with decompression for a left L4-5 disk herniation with stenosis and left L5 radiculopathy on December 9, 2013.

Petitioner followed up with Dr. Kube on March 4, 2014. Petitioner was making good progress. Dr. Kube moved her into a conditioning program.

On April 14, 2014, Dr. Kube reviewed the April 9, 2014 functional capacity evaluation, and released petitioner with permanent restrictions of lifting up to 40 pounds. Dr. Kube released her from his care indicating petitioner was at maximum medical improvement.

Dr. Edward Trudeau September 11, 2013 EMG Report (PX.15)

The EMG showed petitioner had left-sided L5 mild to moderate radiculopathy.

City Center Physical Therapy (PX.16)

Physical therapy records from December, 2013 to April, 2014, including a FCE on April 8, 2014.

Job Searches (PX.17).

Job searches from August, 2014 to November, 2014.

Dr. A. Bernstein July 11, 2011 Report (RX.1); Dr. A. Bernstein July 28, 2011 Report (RX.2); Dr. A. Bernstein August 11, 2011 (RX.3); Dr. A. Bernstein Deposition of May 21, 2013 (RX.4)

Dr. Avi Bernstein examined petitioner at the request of respondent on July 11, 2011 and authored three reports and provided testimony via deposition on May 21, 2013.

Based upon Dr. Bernstein's examination of the petitioner on July 11, 2011 and his review of the March 9, 2011 MRI, Dr. Bernstein believed petitioner sustained an aggravation of degenerative disc disease at L4-L5. Dr. Bernstein indicated there was signal changes at L4-L5 and some modic changes at the end plates, but no disc bulging or herniation.

Dr. Bernstein did not believe petitioner had sufficient aggressive physical therapy. He placed a twenty-pound weight lifting restriction on petitioner. He also believed petitioner could return to work after completing six weeks of physical therapy/conditioning rehabilitation.

Dr. A. Bernstein August 28, 2014 Addendum Report (RX.5) and Dr. A. Bernstein February 16, 2016 Deposition (RX.6)

After reviewing Dr. Eilers' deposition, Dr. Kube's December 9, 2013 operative report, the September 11, 2013 EMG and a FCE from April 8, 2014, Dr. Bernstein authored his August 28, 2014 report and testified via deposition on February 16, 2016.

Dr. Bernstein did not have the opportunity to review any MRI scans performed subsequent to his exam of July 11, 2011. Therefore, he was not in a position to render an opinion as to the need for the surgery performed by Dr. Kube on December 9, 2013. However, Dr. Bernstein testified that the surgery performed by Dr. Kube on December 9, 2013 to petitioner's left-sided disc did not correlate with the September 11, 2013 EMG showing acute right-sided radiculopathy (RX.6, pp.8-9).

Dr. Bernstein agreed with the restrictions outlined in the functional capacity evaluation (P.6)

Job Description (RX.7)

This is a job description of petitioner's job as a picker with respondent. The job required the picker to lift or carry frequently up to 20 pounds.

CONCLUSIONS OF LAW

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

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

Petitioner's sacral fracture and left-sided L4-L5 disc herniation with stenosis and accompanying left L5 radiculopathy, necessitating the surgery performed by Dr. Richard Kube on December 9, 2013 consisting of a L4-L5 hemilaminotomy with decompression, was caused by the work accident of November 8, 2010.

The only evidence respondent offered to refute the issue as to causal connection of petitioner's disc herniation and the need for surgery, was the opinion of Dr. Bernstein. Dr. Bernstein agreed he was not in a position to render an opinion as to the need for the December 9, 2013 surgery as he did not have the opportunity to review the subsequent MRIs. However, Dr. Bernstein further testified he questioned the need for the left-sided surgery when the EMG of September 11, 2013 showed right-sided radiculopathy. (It appears Dr. Bernstein picked up on the testimony of Dr. Eilers, who had testified the radiculopathy or pinched nerve was on the right even

though Dr. Trudeau's findings from the EMG were that of left-sided radiculopathy.) Furthermore, the MRIs from March 9, 2011 and February 7, 2012 showed the disc herniation at L4-5 to be on the left. Accordingly, the Arbitrator finds Dr. Bernstein's opinion has no merit.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

Based upon the evidence, the Arbitrator finds the following medical bills were reasonable and necessary to treat petitioner of her 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:

$2,220.00 to Dr. George DePhillips
$1,973.60 to EqMD
$600.00 to Dr. Constatino Perales (2/8/2011-4/21/2011)
$4,750.00 to Apex/Dr. Kloc
$1,459.11 to NR Anesthesia
$15,897.50 to Fullerton Surgery Center
$746.00 to Illinois Valley Spine Institute/Dr. Jason Bergandi
$1,098.00 to Hospital Radiology Service
$20,082.71 to Prairie Surgicare
$15,958.50 to Prairie Spine and Pain Institute (Excludes $140.00 for medical records costs)
$8,185.00 to St. John's Hospital
$3,822.00 to Dr. Edward Trudeau
$2,400.00 to Airway Anesthesia PC
$15,579.00 to City Center Rehabilitation

L. In support of the Arbitrator's decision with regard to TTD, the Arbitrator finds the following:

The medical evidence, including the reports of Illinois Valley Community Hospital, Dr. George DePhillips, Dr. Michael Malek, Dr. Jason Bergandi, Dr. Constatino Perales, Dr. Robert Eilers and Dr. Richard Kube supports petitioner's claim for disability from February 8, 2011 to April 14, 2014. Accordingly, the Arbitrator awards temporary total disability from February 8, 2011 through April 14, 2014, which is 166 weeks at the minimum rate of $330.00 per week.

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

Petitioner sustained a coccyx fracture and a herniated disc at L4-L5 requiring a laminectomy. Despite the injury, petitioner was capable of returning to work at her previous occupation with respondent as a picker according to the functional capacity evaluation and petitioner's surgeon, Dr. Kube, who released petitioner with the forty-pound restriction. This fell within the parameters of the physical demand of the job as stated in the job description (RX.7) and to which petitioner had testified.

Therefore, petitioner does not have a claim for loss of trade. Her injuries did result in a permanent disability of 20% person as a whole pursuant to plus six weeks for the vertebrae fracture pursuant to §8 (d) 2

M. In support of the Arbitrator's decision with regard to penalties and fees, the Arbitrator finds the following:

Dr. Bernstein opined petitioner could return to work with a twenty-pound weight lifting restriction as of July 11, 2011, which is within the job requirements of petitioner's job as a picker with respondent. Although Dr. Bernstein's opinion is insufficient to defeat petitioner's claim for temporary total, it is sufficient to defeat her claim for penalties and attorneys' fees.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Hardwick,

Petitioner,

vs. NO: 16WC 11646

Bahler Trucking,

Respondent.

17IWCC0632

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, temporary total disability, medical expenses, 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 4, 2017, is hereby affirmed and adopted.

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

17IWCC0632

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 10 2017

o100417
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

HARDWICK, LARRY
Employee/Petitioner

Case# **16WC011646**

BAHLER TRUCKING
Employer/Respondent

17IWCC0632

On 4/4/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
GARY J STOKES
200 N GILBERT
DANVILLE, IL 61832

3150 JAMES KELLY LAW FIRM
JASON W JORDING
7817 N KNOXVILLE AVE
PEORIA, IL 61614

17IWCC0632

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)

LARRY HARDWICK
Employee/Petitioner

v.

BAHLER TRUCKING
Employer/Respondent

Case # 16 WC 011646

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Urbana**, on **01/26/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0632

FINDINGS

On the date of accident, **12/02/15**, 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 **$103,957.52**; the average weekly wage was **$1,999.18**.

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

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

Respondent shall be given a credit of **$22,276.64** for TTD, **$0** for TPD, **$0** for maintenance, and **$8,768.96** for other benefits, for a total credit of **$31,045.60**.

Respondent is entitled to a credit for paid medical bills under Section 8(j) of the Act.

ORDER

Respondent is liable for reasonable and related medical bills up through April 13, 2016 as outlined in the attached decision, pursuant to the fee schedule and reduced by Respondent's credit. All additional medical bills are denied.

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

Respondent is liable for temporary total disability benefits of $1,332.79 per week for 16 2/7 weeks, commencing December 22,, 2015 through April 13, 2016, as provided in Section 8(b) of the Act and reduced by Respondent's credit. Respondent shall be given a credit of $562.20 for an over payment of temporary total disability benefits that have been paid.

Petitioner's current condition of ill being is not causally related to the work accident. Petitioner's claim for prospective medical 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.

Edward Lee
Signature of Arbitrator

3/27/17
Date

ICArbDec19(b)

APR 4 - 2017

STATE OF ILLINOIS)
) ss.
COUNTY OF CHAMPAIGN)

17IWCC0632

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATOR'S DECISION

LARRY HARDWICK, Petitioner, vs. BAHLER TRUCKING Respondent.	)	Case No.: 16-WC-011646

STATEMENT OF FACTS

Petitioner is a 54 year-old truck driver. Petitioner had worked for Respondent for five years prior to the December 2, 2015 accident date. Petitioner was a full-time truck driver who hauled livestock. Petitioner mainly hauled hogs, which Petitioner had been doing primarily for 30 years.

On December 2, 2015, Petitioner was involved in an accident at mile marker 200 on Interstate 74, near Danville, Illinois. Petitioner was transporting approximately 90 head of sows from Virginia to Peoria, Illinois. Petitioner left Virginia at approximately 9:00 a.m. Eastern Time on December 1, 2015. The accident occurred at approximately 2:00 a.m. Central Time on December 2, 2015.

Before the accident, Petitioner stopped for fuel and bought three or four bags of almonds to eat as a meal while he was on the road. When Petitioner reached the Indiana/Illinois state line, he started to feel short of breath. Petitioner thought he was having a heart attack, but was having a reaction to the almonds. Petitioner pulled over near the 200 mile marker so he could stop and relax for a few minutes. Petitioner was stopped for seven or eight minutes before he began driving again. When Petitioner was shifting between first and second gear, Petitioner felt like his oxygen was cut off. Petitioner was traveling at approximately 15 miles per hour when the accident occurred. Petitioner pulled off onto a ramp that was on a hill and curved. While Petitioner was gasping for air, he did not follow the curve and drove the truck straight off the edge of the curve. The next thing Petitioner knew, the truck was lying on its right side with Petitioner strapped into his seat.

After the accident, Petitioner used his right leg to brace up against the dashboard of the truck so he could unfasten his seatbelt. After Petitioner got out of his seatbelt, he was standing vertically inside the truck. Petitioner used a hammer to break the front windshield. After breaking the windshield, Petitioner determined he was too large to climb out the hole. Petitioner then pressed overhead to open the driver side door and climbed out through the opening. Petitioner climbed down the truck to get back to ground level.

After he got out of the truck, Petitioner called his employer, Randy Bahler, to inform him of the accident. Petitioner also called the Illinois State Police. Petitioner testified he woke Randy up when he reported the accident. Petitioner denied telling Randy that the accident occurred because Petitioner did not set his brakes. Petitioner believed it was approximately 15 minutes before the authorities showed up on the scene. The hogs in Petitioner's trailer were "hysterical," but the hogs did not get loose. Later, the

hogs were cut out of the trailer. Petitioner denied ever telling anyone that the hogs got loose and that Petitioner had helped the hogs get back into the trailer.

At the accident scene, Petitioner noticed he was "hurting." Petitioner testified he was hurting through his right hip and down his right leg. Petitioner also testified that his back and groin were hurting. An ambulance arrived. Petitioner thought if he could walk around, he would be okay. After calming down, Petitioner testified that he thought he was going to pass out from the pain and the stress.

Petitioner was placed on a stretcher and taken by ambulance to Carle Hospital. It was noted that Petitioner had been ambulatory for some time prior to requesting transport for back pain, which had not gone away and was getting worse. Petitioner's chief complaint was mid-back pain radiating down the right leg. It was noted that Petitioner's vehicle was "almost at a complete stop" when the accident occurred. No swelling or bruising was noted by the emergency personnel.

Petitioner testified that upon arriving at Carle Hospital, he was seen in the emergency room. Petitioner testified he only saw the emergency room doctor for just a minute. Petitioner testified the doctor looked at Petitioner's bruised right buttocks. Petitioner estimated he was in the emergency room for half an hour. Petitioner described his pain as 10/10, which Petitioner believed was "the worst pain he had ever felt." The nurse's notes from Carle Hospital on December 2, 2015 indicate Petitioner complained of back pain from being in his seatbelt. The nurse also recorded that "patient was able to help load all the hogs that got out of the trailer." Petitioner was admitted at 8:12 a.m., and was seen by Dr. Welch at 8:50 a.m. Dr. Welch also recorded a history of Petitioner being a restrained semi driver who was almost at a complete stop when his semi rolled onto its passenger side. Dr. Welch also took a history of Petitioner complaining of back pain from being in his seatbelt. Dr. Welch also recorded that Petitioner was able to help load all the hogs that got out of the trailer.

Dr. Welch recorded Petitioner's complaints of aching, mild pain in the right buttocks due to a seatbelt injury. Dr. Welch noted there were no bruises and no indication of actual back pain other than the localized buttocks pain. Dr. Welch specifically noted Petitioner was "negative for back pain, gait problem, and neck pain." Petitioner's physical examination recorded a normal range of motion, with no evidence of edema or tenderness. Dr. Welch did note a supra umbilical hernia, which he questioned as new. Dr. Welch diagnosed a vehicle accident injury, buttocks contusion, and a ventral incisional hernia. Petitioner was given Toradol and Motrin. Petitioner continued to make 10/10 pain complaints at discharge. Petitioner was given an injury report which indicated that Petitioner could not work for the rest of the day and could perform activity as "comfort allows."

Petitioner testified that his sister took him back to Salem, Indiana, as Petitioner could not drive the truck that he rolled. Petitioner testified that he did not get any "real treatment" while he was in the emergency room. Petitioner denied receiving any medication from his emergency room treatment. When Petitioner got home, Petitioner testified he was having pain down his right hip and leg. Petitioner also testified that he was having pain in his stomach, which felt like someone was sticking him with a knife. Petitioner had a prior hernia repaired with a mesh implant. Petitioner testified he felt like his hernia was bulging out. Petitioner admitted that he had seen a doctor a year previously because his hernia was bulging out, but Petitioner testified that he was not having the pain in his stomach.

Petitioner testified he was seen at Harrison County Hospital four days later. Petitioner presented with a history of a truck crash in Illinois, which he "did not remember until Wednesday." Petitioner complained of pain in the abdomen from a hernia, and pain in the right hip area. Petitioner's abdomen pain was moderate and achy. Petitioner told the admitting doctor that "since the accident he has had umbilical pain and a bulge at the area of his prior surgery for an umbilical hernia ten years ago." On examination, Petitioner's abdomen was tender and Petitioner had diffuse, moderate tenderness in his

back, with no swelling. Petitioner's neurological exam was normal. Petitioner underwent a CT scan of his abdomen which revealed no acute disease, a tiny fat-containing ventral hernia, a small fatty inguinal hernia, and a chronic L5 pars defect. Petitioner was diagnosed with a ventral hernia and a contusion. Petitioner's condition was discussed by Dr. Cobel with Dr. Harris, who was also present for the exam. Petitioner's labs were reviewed, along with abdominal x-rays and the CT. Petitioner was "reassured" and encouraged to follow-up regarding the ventral fat-containing hernia and his contusions. Petitioner was discharged in stable, ambulatory condition. At discharge, Petitioner's upper and lower extremity movement was noted as equal. Petitioner was not taken off work.

Petitioner followed-up with his primary care physician, Dr. Clunie, on December 9, 2015. Petitioner testified that Dr. Clunie examined him for his ventral bulge. Petitioner testified he was still having back and leg pain. The history recorded by Dr. Clunie provides that Petitioner complained of abdominal pain. Petitioner told Dr. Clunie that the hernia was "not protruding or hurting prior to the MVA." Dr. Clunie recorded that Petitioner had a prior CT scan. On examination, Petitioner's back had a normal range of motion and Petitioner moved with a normal gait. Petitioner's diagnosis was injury due to motor vehicle traffic accident and umbilical hernia. Petitioner was given instructions to follow-up with a surgeon for his hernia. Petitioner was not taken off work.

Petitioner followed-up with Dr. Gonzaba on December 15 for his hernia complaints. Petitioner testified that Dr. Gonzaba performed a stomach x-ray; however, the medical records demonstrate that no diagnostic images were taken on that day. Dr. Gonzaba reviewed the CT from Petitioner's December 6, 2015 emergency room visit, which Petitioner testified did not occur. No recurrent hernia was demonstrated by the diagnostics. On physical examination, Dr. Gonzaba recorded a periumbilical small fat-containing nodule, but no hernia. Dr. Gonzaba also noted that Petitioner's range of motion was normal. There was no recorded back or right leg pain, or any other symptoms. The record demonstrates that Petitioner had no actual or suspected pain on December 15, 2015. No treatment other than observation and a follow-up, if needed, was prescribed. Petitioner was not taken off work. Petitioner testified that he has had no further treatment for his hernia.

Petitioner returned to Dr. Clunie's practice on December 21, 2015. Petitioner was seen by Nurse Practitioner Jennifer Murphy. Petitioner testified that the back and right hip/right leg pain had never gone away. Petitioner testified that an x-ray and MRI was ordered, and Petitioner was prescribed Tramadol. Nurse Murphy's note indicates that Petitioner complained of swelling in the right lower leg and sciatic nerve pain. Petitioner described localized pain in the lumbar region which was aching, burning, sharp, shooting, and stabbing. Petitioner described the back pain as moderate. Petitioner stated the pain was worsening. The pain was recorded as radiating to the upper extremities. Petitioner told Nurse Murphy that the ER in Urbana did nothing for him, but that he had an abdominal series and CT at the ER in Harrison County. Petitioner told Nurse Murphy that he had never received an off-work note at that point. Petitioner's pain was exacerbated by "lying flat, movement, prolonged sitting, squatting, standing, and walking." Associated symptoms were gait disturbance. Although Petitioner complained of a decreased range of motion in his back, on exam he was noted to have a normal range of motion. Petitioner was diagnosed with acute low back pain and an abdominal hernia. Petitioner was prescribed a lumbar x-ray and was given a post-dated work note stating he had been off since December 2, 2015 and would be off work until December 28, 2015. Despite the note recording that Petitioner's complaints radiated to the upper extremities, Petitioner testified that he never complained of upper extremity pain to anyone.

Petitioner followed-up with Dr. Clunie on December 30, 2015. Petitioner presented with back pain localized in the lumbar region. The pain was moderate and, again, worsening. Again, the pain was noted to radiate to the upper extremities. Petitioner's exacerbating factors were the same. Again, although Petitioner complained of a decreased range of motion, on examination, Petitioner's range of motion was noted as normal. Petitioner was noted to ambulate with a slow, but steady gait. The

December 21, 2015 x-ray from Harrison County Hospital was reviewed. The x-ray revealed mild Grade 1 spondylolisthesis of L5 on S1 with congenital spondylotic defects. The December 30, 2015 MRI was also reviewed. The impression was multi-level degenerative disc disease and facet joint disease. Petitioner had Grade 1 anterior spondylolisthesis of L5 on S1 due to pars defects. Petitioner also had a small left paracentral disc protrusion at L4-5. Petitioner was referred to a neurosurgeon. Petitioner was taken off work until January 28, 2016. Petitioner denied any changes in his low back pain or the radiation of his pain.

Petitioner saw Dr. Finizio in Corydon, Indiana, on January 18, 2016. Petitioner told Dr. Finizio that he had low back pain that radiated into both of his legs. Petitioner complained of 7/10 pain. Petitioner's neurological examination was normal and Dr. Finizio noted a stable and normal gait. Dr. Finizio diagnosed lumbar stenosis and spondylolisthesis and ordered physical therapy. Dr. Finizio took Petitioner off work until February 15, 2016.

Petitioner was evaluated at the St. Vincent Salem Hospital Rehabilitation services on January 19, 2016. Petitioner noted pain across the low back into the right thigh and occasionally down both legs. Petitioner stated his symptoms had been the same since their onset. Petitioner's exacerbating factors were sitting, walking, and sitting to standing transfers. Petitioner stated his current pain was 7, and 10+ at worst. Petitioner stated he had "electrical fence" sensation down both legs. The pain diagram completed on January 19, 2016 indicated that Petitioner had pain in the low back and right buttocks area with bilaterally equal sensations down both legs. In the comments, Petitioner's therapist noted that Petitioner refused supine and tolerated transitional positions very poorly. The examination was limited, but it was noted that distraction caused Petitioner's straight leg pain to change and centralize. The physical therapist's notes recorded that Petitioner's pain complaints remained stable throughout his therapy. On January 26, 2016, Petitioner described 8/10 pain, but also noted new complaints to his bilateral shoulders. Petitioner's February 5, 2016 discharge summary recorded Petitioner's pain as 6/10. Petitioner noted improving positional and functional tolerance and overall stated he felt 50% better. Petitioner met his first three goals in physical therapy and was making progress towards his remaining two goals. The therapist requested Dr. Finizio advise whether Petitioner should continue with TENS unit, or discharge to home exercise program, or continued PT.

Despite his improvement recorded by the physical therapist, and the recommendation by the physical therapist that Petitioner should continue progressing with therapy towards his remaining goals, Petitioner reported to Dr. Finizio on February 20, 2016 that physical therapy had not helped him with his pain. Dr. Finizio's neurological examination was, again, normal in all respects. However, because Petitioner reported no improvement with physical therapy and continued to make subjective complaints, Dr. Finizio recommended a course of lumbar epidural blocks. Dr. Finizio's office faxed the order to the workers' compensation carrier on March 7, 2016, and one injection was approved on March 14, 2016. Petitioner was scheduled with Dr. Glasgow at Harrison County Hospital for March 24, 2016.

Petitioner presented at Harrison County Hospital on March 31, 2016. Petitioner received a lumbar epidural steroid injection for chronic low back pain, L5-S1 spondylolisthesis, and lumbar facet hypertrophy arthropathy. Prior to the injection, Dr. Glasgow performed a physical examination. Dr. Glasgow specifically noted that Petitioner's SI joint examination was negative and within normal limits. Dr. Glasgow assessed Petitioner's diagnosis as L5-S1 subluxation 5mm anteriorly, mild neuroforaminal involvement, and facet arthritis on the right side at L4-5. Petitioner completed a history form in which Petitioner indicated he was having back pain "with radiation to both legs." A second injection was not scheduled until after Petitioner had another appointment with Dr. Finizio to report on the results from the injection. The follow-up with Dr. Finizio was also recorded in Dr. Finizio's notes. No follow-up appointments with Dr. Finizio were recorded until June 6, 2016. Dr. Finizio's record included a

telephone note from April 21, 2016 and April 29, 2016 in which Petitioner was recommended for a lumbar surgery.

Petitioner was seen by Dr. Soriano, a Section 12 examiner, on April 13, 2016. Petitioner was taken by medical cab to Dr. Soriano's appointment. Petitioner reported to Dr. Soriano that he rolled his semi on its side on December 2, 2015. Petitioner denied not setting the brakes. Petitioner told Dr. Soriano that, after he rolled over, he was able to unbuckle his seatbelt and get out of the cab. Petitioner also told Dr. Soriano that no hogs escaped from the trailer, but a dozen hogs were killed as a result of the rollover. Petitioner reported complaining of midline back pain radiating to the right buttock, thigh, and calf, and into the big toe on the right. Petitioner told Dr. Soriano that he had been unable to return to work because he was in too much pain. Petitioner told Dr. Soriano that his abdominal complaints resolved. Petitioner reported that his physical therapy had not helped, and he was currently using a TENS unit, which Petitioner found beneficial. Petitioner also told Dr. Soriano that he had one epidural with Dr. Glasgow, which was not beneficial. Dr. Soriano reviewed the radiological studies and records. Dr. Soriano also performed a physical examination. Petitioner had a normal neurological examination, with full strength, and normal reflexes. Petitioner's gait was normal. Petitioner was able to support his weight on his heels and toes. Petitioner self-limited his range of motion to 20° in flexion and 10° in extension because of complaints of pain. Lateral bending was performed to 20°. Petitioner's Faber's maneuver bilaterally produced low back pain, as well as hip pain on the left and the right. There was no point tenderness or spasm in Petitioner's back, buttocks, or hips. Dr. Soriano also performed Waddell's testing and Petitioner had three out of five positive Waddell's responses. Dr. Soriano diagnosed Petitioner with a soft tissue injury to the right buttocks and lumbosacral spine. Dr. Soriano opined that Petitioner's pre-existing spondylolisthesis was not aggravated. Dr. Soriano found that Petitioner's onset of bilateral lower extremity pains was somewhat delayed. Dr. Soriano found that there was no neurological deficit and that Petitioner's alternating complaints of right and left lower extremity symptoms did not correspond with the accident. Dr. Soriano believed that Petitioner's physical therapy, medications, and work restrictions to that point were reasonable. Dr. Soriano also felt the epidural was a reasonable attempt to relieve Petitioner's subjective complaints. When Dr. Soriano saw Petitioner, Dr. Soriano opined that Petitioner did not require any further work restrictions and that Petitioner could return to full duty work. Dr. Soriano stated that Petitioner did not suffer any permanent disability and also opined that Petitioner's PPI rating was a 0% whole person impairment.

Dr. Soriano, Respondent's Section 12 examiner, testified by evidence deposition on July 26, 2016. Dr. Soriano is a board certified, licensed neurosurgeon. Dr. Soriano is licensed to practice in both Illinois and Wisconsin. Dr. Soriano also serves as an assistant clinical professor at the University of Illinois School of Medicine. Dr. Soriano testified that he performed an independent medical examination of Petitioner on April 13, 2016. Petitioner told Dr. Soriano that Petitioner was transporting a load of hogs from Virginia to Peoria, Illinois. Petitioner had pulled off the highway because he was queasy and coughing. Petitioner told Dr. Soriano that as Petitioner drove back onto the highway, the semi-truck rolled over. Petitioner denied to Dr. Soriano that he failed to set the brakes. Petitioner also told Dr. Soriano that the hogs did not escape at the time of the accident. Petitioner specifically told Dr. Soriano that his physical therapy had not helped. Dr. Soriano reviewed the medical records and diagnostic images from Petitioner's accident date through the IME. Dr. Soriano noted that there were discrepancies between the medical records and Petitioner's history which he provided to Dr. Soriano. Dr. Soriano performed an examination. Petitioner's neurologic examination was normal, with Petitioner limiting his range of motion due to pain complaints. Dr. Soriano also performed Waddell's testing. Dr. Soriano testified that he performs the same testing on his own patients. Dr. Soriano testified that three out of five positive Waddell signs has been found to be consistent with symptom exaggeration and attempts to portray a condition of ill-being that does not exist on an organic basis. Dr. Soriano testified Petitioner was statistically positive for symptom exaggeration. Dr. Soriano diagnosed Petitioner with a soft tissue injury to the right buttocks and lumbosacral spine. Dr. Soriano testified that Petitioner was at maximum medical

improvement and required no further treatment related to the accident. Dr. Soriano testified that Petitioner needed no further work restrictions and that Petitioner suffered no disability as a result of the accident. Dr. Soriano also testified that Petitioner had no impairment rating pursuant to the Sixth Edition AMA Guides.

On cross-examination, Dr. Soriano stated that the delay in Petitioner's bilateral lower extremity pains was significant. Dr. Soriano testified that the records demonstrated Petitioner was having various complaints, including upper extremity complaints and radiating pain into both lower extremities. Dr. Soriano also testified that the films did not show any clinically significant compression on the nerves. Dr. Soriano testified that his use of the term "alternating" lower extremity symptoms referred to Petitioner's reported right sided versus bilateral symptoms. Dr. Soriano confirmed that Petitioner told Dr. Finizio that the prescribed physical therapy had not helped. Dr. Soriano testified that Petitioner's subjective complaints did not have any objective basis.

On the advice of his attorney, Petitioner was seen by Dr. Seibly on August 29, 2016. Petitioner told Dr. Seibly that sitting, lying down, and standing made Petitioner's symptoms worse. Petitioner told Dr. Seibly that walking improved Petitioner's symptoms. Petitioner told Dr. Seibly that Petitioner had to force the truck door open with his right leg to get out, and soon thereafter, he felt pain in the right low back and hip area. Petitioner stated he had severe abdominal pain due to a seatbelt injury, which had improved. Petitioner told Dr. Seibly that 1-2 days after the injury, Petitioner noticed worsening back pain. Petitioner noted that the pain was very focal to the right low back and associated with pain down the back leg to the hamstring. Petitioner noted paresthesia going down the distal leg into the foot. There was no midline discomfort. Petitioner stated walking helped the discomfort. Petitioner stated he was recommended to have a L5-S1 fusion, but did not want the surgery. Petitioner told Dr. Seibly that he did not trust his right leg due to pain and paresthesia that comes and goes, and Petitioner would be fearful of driving a "big rig." Petitioner admitted to Dr. Seibly that he had intermittent back pain from time to time, and approximately one year before the accident, he did have an episode of back pain which was improved within several weeks.

On physical examination, Dr. Seibly noted no midline tenderness. Dr. Seibly noted focal tenderness over the right sacroiliac joint. Petitioner had positive sacroiliac joint provocation testing with a positive Faber test and pain with internal and external rotation of the hip, thrust maneuvers, and public impression. Petitioner's motor strength, sensation, and reflexes were full in the lower extremities. Petitioner was able to walk on his heels and toes with no difficulty. There was no decreased sensation to light touch, brisk, patella and Achilles reflexes, and no Hoffman's clonus, or Babinski sign. Petitioner's gait was steady. Petitioner appeared fairly comfortable in the office.

Dr. Seibly reviewed the imaging studies and found no high grade foraminal and central stenosis. Petitioner's L5-S1 disc height was robust, with only moderate degenerative changes throughout the lumbar spine. Dr. Seibly found no significant neural compression. Dr. Seibly noted only very minimal retrolisthesis at L5-S1. Dr. Seibly stated Petitioner would not benefit from a lumbar decompression and fusion, as recommended by Dr. Finizio. Dr. Seibly felt Petitioner's pain was coming from the right sacroiliac joint. Dr. Seibly recommended conservative measures treating the right SI joint. Dr. Seibly ordered physical therapy and anti-inflammatories. Dr. Seibly also recommended Dr. Glasgow perform a right-sided sacroiliac joint steroid injection. Dr. Seibly stated that Petitioner would need a functional capacity evaluation before returning to work as a semi driver. Dr. Seibly stated that Petitioner was not safe to drive. Petitioner could perform sedentary or desk work, and limit his lifting to 25 pounds. Dr. Seibly also stated that Petitioner needed to limit bending at the waist and twisting.

Petitioner presented for an initial evaluation at St. Vincent Salem Hospital for physical therapy on September 2, 2016. Petitioner reported "occasional pain/problems in right lower extremity." Petitioner

also reported he had physical therapy and epidurals earlier in the year and "neither of them helped." Petitioner reported he was now seeing a different doctor who said Petitioner was suffering from SI inflammation and that Petitioner needed epidurals in the SI joint area. On September 9, 2016, Petitioner told his therapist that he had been "misdiagnosed and mistreated in the past." On September 13, 2016, Petitioner told his therapist that his pain "moved from my right hip to left hip," and Petitioner reported a subsequent fall. Petitioner canceled his September 16, 2016 appointment due to illness and failed to appear for his September 19, 2016 appointment. On September 21, 2016, Petitioner reported that he continued to have increased pain with no real relief. Petitioner reported for the first time incontinence issues. Petitioner was advised to contact a doctor immediately for his new symptoms. Petitioner testified at trial that the physical therapy sessions were helping, despite Petitioner's statement to the therapist to the contrary.

Dr. Seibly testified by evidence deposition on October 31, 2016. Dr. Seibly is a board certified neurosurgeon, licensed to practice in Illinois. Dr. Seibly testified that he saw Petitioner on August 29, 2016 at Petitioner's attorney's request. Dr. Seibly testified that Petitioner told him that Petitioner had to force the door of his semi open with his right leg to get out of the truck on December 2, 2015. Dr. Seibly testified that several days after the accident, Petitioner had right-sided low back pain that worsened. Dr. Seibly recorded a normal neurological examination. Dr. Seibly testified that Petitioner had discomfort in the right sacroiliac joint region. Dr. Seibly's review of the films revealed that Petitioner had slight degeneration at L4-5 and L5-S1, but nothing that stood out as grossly abnormal. Dr. Seibly testified that Petitioner did not have any nerve root compression or lumbar radiculopathy. Dr. Seibly testified that Petitioner's pain was not coming from degenerative disc disease or spondylolisthesis. Dr. Seibly testified that Petitioner's pain was coming from the right SI joint. Dr. Seibly testified that Petitioner's SI joint injury was a result of the December 2, 2015 accident, based upon the history provided by Petitioner. Dr. Seibly stated that when someone leans forward and twists, it puts a lot of strain on the joint. Dr. Seibly also found it significant that Petitioner had to force the door open with his right leg, which was consistent with where Petitioner's pain was located. Dr. Seibly recommended a S1 joint intraarticular steroid injection and physical therapy. Dr. Seibly testified that Petitioner may get better without intervention with continued ice, anti-inflammatories, and rest. Dr. Seibly recommended that Petitioner not drive a semi-truck because he was concerned whether Petitioner would be dangerous on the road.

On cross-examination, Dr. Seibly denied having reviewed the engagement letter from Petitioner's attorney. However, Dr. Seibly admitted that he drafted his report with litigation in mind and that Dr. Seibly did not actually treat Petitioner. Dr. Seibly testified he does not look at prior records because he does not want them to bias him one way or the other. Dr. Seibly also testified that he received correspondence from Petitioner's attorney on September 1, 2016, asking Dr. Seibly to write an addendum placing Petitioner on work restrictions. Although Dr. Seibly initially denied reviewing letters from Petitioner's attorney, Dr. Seibly testified that his addendum report was consistent with having reviewed the letter from Petitioner's attorney and drafting the response specifically to address the questions posed by Petitioner's attorney. Dr. Seibly's neurological examination revealed the exact same findings as Dr. Soriano's examination. Dr. Seibly did not perform any Waddell's testing. Dr. Seibly admitted that Petitioner's objective presentation was normal, and Dr. Seibly was relying entirely on Petitioner's veracity and subjective complaints. Dr. Seibly agreed with Dr. Soriano that Petitioner did not require a fusion surgery and that Petitioner had no symptoms from his lumbar spine. Dr. Seibly also agreed with Dr. Soriano that there was no evidence of nerve irritation. Dr. Seibly also stated that he had not reviewed physical therapy records and did not have the prior neurosurgeon's records for review. Dr. Seibly did not know whether any prior doctors had ruled out SI joint pain; however, Dr. Seibly stated that if the prior doctors believed the SI joint was the genesis of Petitioner's problems, they would have prescribed appropriate treatment modalities for the diagnosis. On that basis, Dr. Seibly testified that his SI joint dysfunction diagnosis was new. Dr. Seibly testified that he presumed driving a semi was more strenuous and that is why he restricted Petitioner from semi-truck driving, but allowed Petitioner to drive his

personal motor vehicle. Dr. Seibly speculated that driving a semi-truck is more physically demanding, but admitted he has "no idea how semi-trucks work." Dr. Seibly specifically agreed with Dr. Soriano that Petitioner did not require a lumbar surgery as a result of the accident. Dr. Seibly also agreed with Dr. Soriano that Petitioner's pre-existing spondylolisthesis was not aggravated by the accident. Dr. Seibly believed that Petitioner did not have bilateral lower extremity pain, thus Petitioner's condition was inconsistent with spondylolisthesis. Dr. Seibly agreed with Dr. Soriano that Petitioner's complaints were not associated with any neurological deficits. Dr. Seibly testified that Petitioner told him all of Petitioner's symptoms were right-sided. Dr. Seibly testified that he does not have the expertise in the field of semi-truck drivers to determine whether they are medically capable of driving a truck. Dr. Seibly defers to a DOT physician to make that determination. As part of Dr. Seibly's deposition, Petitioner introduced three exhibits, Dr. Seibly's curriculum vitae, the narrative report signed by Dr. Seibly on September 6, 2016, and the engagement letter from Petitioner's attorney from August 2, 2016. Respondent introduced three exhibits. The "form report" from Petitioner's attorney, the correspondence from Petitioner's attorney to Dr. Seibly dated September 1, 2016, and Dr. Seibly's narrative report signed on August 31, 2016.

Dr. Soriano prepared a supplemental report dated November 30, 2016. Dr. Soriano reviewed additional records and Dr. Seibly's testimony. Dr. Soriano noted the discrepancy that Petitioner told Dr. Seibly that Petitioner had only right-sided symptoms. Dr. Soriano found no reason to change his opinions. Dr. Soriano specifically stated that the symptoms Petitioner had during his examination with Dr. Seibly were distinctly different than Petitioner's previous symptoms. Dr. Soriano noted Petitioner complained of worse symptoms while lying down and sitting, but felt better when walking and weight bearing. Dr. Soriano opined Petitioner's aggravating and relieving factors are inconsistent with SI disease.

Petitioner was the only lay witness to testify at trial. Petitioner did not testify that he twisted his right leg to open the semi door, as Petitioner told Dr. Seibly. Petitioner testified that he used his right leg to push against the truck dash so he could unbuckle his seatbelt. Petitioner testified that he stood vertical in the cab and opened the truck door by pushing overhead with his arms, not by using his right leg. Petitioner also testified that he received no "real treatment" until seeing Dr. Clunie on December 9, 2015, despite the records to the contrary. Petitioner specifically testified that he had never made any upper extremity complaints to anyone. Petitioner testified that physical therapy, which started on January 21, 2016, was helpful.

Petitioner also testified that Dr. Soriano did not "really examine" Petitioner. Petitioner testified that his new course of physical therapy ordered by Dr. Seibly concentrated on Petitioner's lower back, rather than his upper back. Petitioner testified the new therapy was helping. Petitioner testified that he has been borrowing money and selling tools and tractors to pay bills. Petitioner testified there was no real change in his condition and at trial Petitioner was still experiencing back pain and right hip/leg pain. Petitioner testified to his prior back injuries, but denied having hired a lawyer or filing a formal claim for his prior injuries. Petitioner testified his prior employer "knew (Petitioner) was hurt, and that's all that mattered." Petitioner testified that he now walks to relieve pain and that he cannot sit for extended periods of time. Petitioner believes he cannot work because of his pain. Petitioner drove 200 miles to the hearing, stopping at Columbus and Indianapolis, Indiana on the way. Petitioner testified that he wants the treatment offered by Dr. Seibly.

On cross-examination, Petitioner admitted that the Form 45 completed by Randy Bahler was accurate, except Petitioner denied telling Randy that Petitioner forgot to set the truck brakes. Petitioner admitted to prior low back pain and bilateral leg symptoms in April 2006. Petitioner testified he had a nerve block in 2008. Petitioner also admitted that he had another back injury, with bilateral leg pain, in 2014. Petitioner denied taking any over the counter medicines for aches and pains between 2014 and

2015. Petitioner stated that he had been looking for work within Dr. Seibly's restrictions, but had no proof or resume. Petitioner has not tried to take a DOT examination. Petitioner denied telling the nurse and doctor at the emergency room on December 2 that Petitioner helped capture the hogs. Petitioner disagreed with the December 2 emergency room records that Petitioner had a normal range of motion and normal gait. Petitioner testified that he received no diagnoses from the emergency room on December 2. Petitioner also denied having diagnostic images taken at Harrison County Hospital on December 6. Petitioner testified that he told his doctors that his hernia was a pre-existing condition. Petitioner disagreed that he had a normal range of motion and normal gait when he saw Dr. Clunie on December 9. Petitioner also disagreed with Dr. Gonzaba recording a normal range of motion on December 15. Petitioner testified that the medical records referencing bilateral leg symptoms are in error. Petitioner denied describing an "electrical fence" sensation down both legs to his physical therapist. Petitioner also denied that his right hip pain has changed to left hip pain as reported in the September 2016 physical therapy records. Petitioner testified Dr. Finizio was wrong with his diagnosis and treatment. Petitioner admitted to telling Dr. Seibly that all of Petitioner's symptoms had been right-sided. Petitioner testified that the records of Petitioner complaining of bilateral shoulder pain are in error. Petitioner denied telling Dr. Soriano, Dr. Finizio, and Dr. Seibly that physical therapy had not helped. Petitioner admitted no prior doctors had diagnosed an SI joint problem. Petitioner testified that he had never been tested previously for an SI joint problem. Petitioner testified that he developed an incontinence problem in June 2016. Petitioner believed he told Dr. Seibly about the incontinence problem. Although Petitioner testified that there were no problems receiving benefits for his prior workers' compensation injuries, and he filed no prior claims, Petitioner admitted that he signed a request for assistance to the Indiana Workers' Compensation Board. Petitioner testified that the allegations made on his request for assistance were not true.

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material fact in support of the following conclusions of law:

In support of the Arbitrator's Decision regarding F, "Is Petitioner's current condition of ill-being causally related to the injury," the Arbitrator finds as follows:

The parties agree Petitioner suffered a work-related accident on December 2, 2015. The primary issue before this Arbitrator is whether Petitioner's current condition of ill-being, namely alleged sacroiliac joint dysfunction and Petitioner's continued subjective complaints, is causally related to the December 2, 2015 work accident. The remainder of the issues are dependent upon this question.

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to the December 2, 2015 accident. In making this finding, the Arbitrator specifically finds Petitioner's testimony regarding Petitioner's statements given to his medical providers, his subjective complaints, and his history incredible in light of the contradictions between the inherently reliable medical records and Petitioner's testimony. The Arbitrator also specifically finds Dr. Soriano, the Section 12 examiner, more persuasive than Dr. Seibly, Petitioner's IME doctor, based upon the medical evidence taken in its entirety and the nature of the two doctor's relationship to this litigation. The Arbitrator adopts Dr. Soriano's opinion that Petitioner's injuries attributable to the work accident are a soft-tissue injury to the low back and a contusion of the right buttock and that any work-related injuries were resolved by the date of Dr. Soriano's examination on April 13, 2016. As Petitioner was at maximum medical improvement as of April 13, 2016, and no diagnosis of SI joint dysfunction was rendered until August 29, 2016 by any doctor (in fact having specifically been ruled out by Petitioner's treaters), Petitioner's current alleged SI joint dysfunction and subjective complaints are not causally related to the December 2, 2015 accident.

Petitioner has the burden of proving by a preponderance of the evidence the elements of his claim. It is the function of the Commission to decide questions of fact and causation, to judge the credibility of witnesses, and to resolve conflicting medical evidence. *O'Dette v. Industrial Com.*, 79 Ill. 2d 249, 253, (1980). Petitioner did not meet his burden as none of Petitioner's prior treating doctors diagnosed SI joint dysfunction. Petitioner tried to overcome his proof deficiency by hiring Dr. Seibly and abandoning his treating doctors. In fact, Petitioner's reliance on Dr. Seibly is exclusive as Petitioner told his physical therapist and testified at trial that he had been "misdiagnosed and mistreated" prior to seeing Dr. Seibly. However, a thorough review of Dr. Seibly's testimony and the record shows that Dr. Seibly failed to review the entire record and his opinions are therefore unreliable. Even despite attempts to hire a favorable causation opinion, Dr. Seibly agreed Petitioner's SI joint dysfunction was a new condition nine months after the accident. Dr. Soriano's opinion is better supported and more persuasive, undercutting Petitioner's reliance on Dr. Seibly.

The Arbitrator finds that Petitioner's testimony was incredible. Petitioner contradicted his own history provided to Dr. Finizio, Dr. Soriano, and Dr. Seibly merely to try to match his account with the records. If Petitioner had told Dr. Finizio or Dr. Seibly the physical therapy ordered for Petitioner's low back complaints, not SI joint complaints, had been of such benefit, the Arbitrator finds that more of the same treatment modality would likely have been ordered. Instead, Dr. Finizio moved on to injections. Dr. Seibly reached an entirely new diagnosis because of the faulty history which was provided by Petitioner. Additionally, the Arbitrator finds Dr. Soriano concluded the injection prescribed by Dr. Finizio was reasonable because Dr. Soriano was also wrongly told by Petitioner physical therapy was not helpful.

There are myriad other inconsistencies between Petitioner's testimony and history, when compared with the record. Petitioner testified that he received no "real treatment" while in the emergency room on December 2, including no medications. Contrary to Petitioner's testimony, the record shows that Petitioner did receive a Toradol injection at the emergency room that day. The medical records show Petitioner had a full range of motion in his back, no gait problem, and no back pain upon examination. However, Petitioner testified that both the nurse and the doctor were incorrect. Although Petitioner testified he told the emergency room professionals that he had right leg symptoms, there is no evidence in the medical records of right leg symptoms on December 2.

Petitioner further testified that he received no "real" treatment at the Harrison County Hospital on December 6. However, the record demonstrates that Petitioner underwent an abdominal X-ray and CT scan, which were both negative. Petitioner denied the diagnostics were taken. Petitioner also denied having normal range of motion of his extremities, all which are documented in the medical records.

Again on December 9, December 15, and December 21, the medical records all showed a normal range of motion in Petitioner's back on examination. On December 9, a normal gait was recorded. At trial, Petitioner denied all of these findings. Throughout the medical records, Petitioner's recorded complaints are at odds with Petitioner's testimony. Petitioner testified at trial that he did not complain of bilateral leg complaints. However, the medical records show otherwise. Petitioner specifically denied telling his physical therapist that he had "electrical fence" sensations down both legs, despite it clearly appearing in the records. The fact that Dr. Seibly testified that Petitioner made only right-sided complaints further demonstrates that Petitioner's testimony was contrived to help Petitioner's case at trial.

Petitioner's incredibility is again demonstrated by Petitioner's testimony that he told all of his providers that his hernia was pre-existing. Nowhere in the post-accident records is it noted that Petitioner admitted to suffering from a ventral bulge prior to the December 2 accident, even though a pre-existing hernia is recorded in Petitioner's medical records just months before the accident date. In fact, the

records document Petitioner told his providers the "bulge" was new after the accident, which was not true. The records and Petitioner's arbitration testimony are contradictory. It is more likely, after seeing Respondent's exhibits, including prior medical records showing Petitioner's hernia pre-existed the accident, Petitioner contrived his new story to attempt to rectify the contradictions.

When Petitioner's own testimony is repeatedly contradicted by the record and there is no other competent evidence, then the claim should be disallowed. *Caterpillar Tractor Co. v. Industrial Com.*, 73 Ill. 2d 311, 315 (1978). Here, Petitioner's testimony is repeatedly contradicted by the record and there is not competent evidence given Dr. Seibly's limitations. The record shows that Petitioner's complaints vary wildly, from midline back pain with no radiation, to bilateral lower and upper extremity complaints. The sheer volume of discrepancies between Petitioner's testimony and reports to his doctors versus the objective findings and inherently reliable medical records are enough to undermine Petitioner's credibility.

The record also demonstrates that Petitioner showed signs of clinically significant symptom exaggeration. Dr. Soriano recorded in his examination Petitioner demonstrated three positive Waddell's signs, and was clinically significant for evidence of symptom exaggeration. Dr. Soriano testified that he uses Waddell's testing on his own patients to determine if they are portraying a condition of ill-being which does not exist on an organic basis. Dr. Soriano is not alone in finding Petitioner's subjective complaints do not match his physical findings. In numerous places, including the December 2 emergency room record, the December 6 record, the December 9 visit with Dr. Clunie, and the December 21 visit with Nurse Murphy, Petitioner complained of limited range of motion and testified he had trouble walking, but the physical examinations were normal. During his January 2016 physical therapy session, the therapist specifically noted that Petitioner's symptoms changed when Petitioner was distracted.

As Petitioner's testimony is incredible, the only other evidence introduced to support Petitioner's claim is Dr. Seibly's opinion. Dr. Seibly's sole reliance upon Petitioner's veracity robs Dr. Seibly of any foundation for his opinions. Dr. Seibly did not review the prior medical records and did not have an adequate basis for his causation opinion. Had Dr. Seibly been better informed about the prior history, he would have seen that Petitioner's symptoms were not the same as in the immediate post-accident period and that Petitioner's prior SI joint testing was within normal limits. Thus, even if Dr. Seibly's diagnosis was correct on August 29, 2016, Dr. Seibly admitted it was a new condition which did not exist when Petitioner was examined by Dr. Finizio, Dr. Glasgow, and Dr. Soriano. Dr. Seibly stands alone in his diagnosis, because Dr. Seibly's diagnosis rests entirely upon Petitioner's incredible history. Yet, Dr. Seibly had to conclude Petitioner's current condition is new so even Petitioner's self-serving history was not enough to salvage his claims.

Dr. Soriano is in a better position to give comprehensive opinions. Both Dr. Seibly and Dr. Soriano only saw Petitioner once, but Dr. Soriano had the benefit of the full record. Even had Dr. Seibly reviewed the records sent to him, which he testified he did not, Dr. Seibly was only provided four records according to Dr. Seibly's chart: the December 21 and 30 notes from Nurse Murphy, the December 30 MRI report, and the December 22 lumbar spine x-ray.

The Arbitrator finds Petitioner incredible for the reasons stated above. The Arbitrator adopts Dr. Soriano's opinion and finds him more persuasive than Dr. Seibly. Petitioner's conditions relatable to the December 2, 2015 accident are soft-tissue injuries to the low back and right buttocks. Petitioner's work-related conditions resolved by April 13, 2016. Petitioner's condition of ill-being at trial is not causally related to the December 2, 2015 work accident.

In support of the Arbitrator's Decision relating to J, "Were the medical services that were provided to Petitioner reasonable and necessary, Has Respondent paid all appropriate charges for all reasonable and necessary medical services," the Arbitrator finds as follows:

The Arbitrator's findings with respect to causal connection are incorporated herein. The Arbitrator finds Respondent is liable for the reasonable and related medical care alleged by Petitioner from December 2, 2015 through April 13, 2016 as outlined by Dr. Soriano in his report and introduced into evidence in Petitioner's exhibits 12 and 13. Specifically, the Arbitrator finds Respondent is responsible for the following bills, pursuant to the fee schedule amounts, which Petitioner entered into evidence:

St. Vincent Salem Hospital
DOS: 01/19/16-02/05/16

Norton Neurosurgical Institute
DOS: 02/15/16

Respondent's liability for the above bills is limited by the fee schedule and reduced by any payments Respondent has paid for such services. Respondent shall pay any outstanding amounts, subject to the fee schedule, directly to the providers for the bills which the Arbitrator finds Respondent liable.

Two bills submitted by Petitioner in Petitioner's exhibits 12 and 14 are specifically denied. As the Arbitrator finds that Petitioner was at maximum medical improvement as of April 13, 2016 for any work-related conditions, the Arbitrator denies the bills from St. Vincent Salem Hospital for service dates September 2, 2016 through September 21, 2016 in Petitioner's exhibit 12. The bill for Dr. Seibly's examination on August 29, 2016, introduced as Petitioner's exhibit 14 is denied for the same reason. Dr. Seibly's bill is also denied as it is clear from the record that Dr. Seibly's August 29 examination was for the purpose of preparing a litigation report, and Dr. Seibly testified he was not treating Petitioner. The Arbitrator finds Petitioner's attempt to submit Dr. Seibly's bill as Respondent's liability to be without merit.

In support of the Arbitrator's Decision relating to K, "Is Petitioner entitled to any prospective medical care," the Arbitrator finds as follows:

The Arbitrator's findings with respect to causal connection are incorporated herein. Petitioner was at maximum medical improvement as of April 13, 2016. Petitioner's history provided to Dr. Seibly, upon which Dr. Seibly solely relied to form his causation opinion, is incredible. Dr. Soriano's unrebutted opinion, based upon a complete review of the record, was Petitioner's symptoms on August 29, 2016, when Petitioner saw Dr. Seibly, were different than Petitioner's symptoms after the December 2, 2015 accident. Dr. Seibly even admitted that Petitioner's diagnosis of SI joint dysfunction was new and that, had the SI joint been Petitioner's symptom generator, it would have been diagnosed and treated by Petitioner's prior doctors. Petitioner's current condition of ill-being is not causally related to Petitioner's December 2, 2015 work accident. Petitioner's request for prospective medical care is denied.

In support of the Arbitrator's Decision relating to L, "What temporary benefits are in dispute," the Arbitrator finds as follows:

The Arbitrator's findings with respect to causal connection are incorporated herein. Petitioner has the burden of proving by a preponderance of the evidence the elements of his claim. It is unrefuted that Petitioner was not taken off work until December 21, 2015. Petitioner introduced no work slips and

the medical records conclusively prove Petitioner was not taken off work by any provider until December 21, 2015.

Petitioner was taken off work by Dr. Clunie and Nurse Murphy from the period of December 22, 2015 through December 28, 2015 initially, then through January 28, 2016. Dr. Clunie wrote a note that Petitioner had been off work since December 2; however, such note is simply a statement made after the fact. Nurse Murphy's December 21, 2015 note cannot retroactively provide work restrictions for a time period before Petitioner was ever examined by Nurse Murphy.

Dr. Finizio took Petitioner off work from January 18 through February 15, 2016. No further work restrictions were issued until Dr. Seibly saw Petitioner on August 29, 2016, a fact Petitioner admitted at trial. However, consistent with the Arbitrator's findings adopting Dr. Soriano's opinions, Petitioner was capable of returning to work as of April 14, 2016. Not only was Dr. Seibly's evaluation after that date, Dr. Seibly has no basis to form an opinion whether Petitioner can return to work as Dr. Seibly testified that he has "no idea how semi trucks work." Dr. Seibly testified:

Q: I just want to clarify that last sentence. You determine when they're medically stable. You don't have the expertise to determine whether they're medically capable to drive a truck or fly a plane or drive a bus?

A: That is correct, because each of those jobs has specifics that I don't know the details of. So I allow the Department of Transportation physician to make that determination because that's what they do.

Based upon the Arbitrator's findings with respect to causal connection, the adoption of Dr. Soriano's opinions, the evidence in the record, and Dr. Seibly's testimony, the Arbitrator finds Petitioner is entitled to temporary total disability from December 22, 2015 through April 13, 2016 when Dr. Soriano opined that Petitioner was at MMI,(R EX 2, pp 28, ln 20) . Petitioner was temporarily totally disabled for 16 2/7 weeks and, at the stipulated average weekly wage of $1,999.18, the Arbitrator finds Petitioner's TTD rate is $1,332.79. Respondent is liable for a total of $21,705.44 in TTD benefits. As the parties stipulated to Respondent's payment of $22,276.64 in TTD benefits, the Arbitrator finds Respondent is entitled to a credit of $562,20 representing a TTD overpayment.

In support of the Arbitrator's Decision relating to N, "Is the Respondent due any credit," the Arbitrator finds as follows:

The Arbitrator's findings with respect to causal connection are incorporated herein. As stipulated by the parties, Respondent is entitled to a credit for any medical which has been paid by Respondent and a Section 8(j) credit for payments made, if any, by group health. As mentioned above Respondent is entitled to a credit of $562.20 for an over payment of TTD.

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

Jose Antonio Gonzalez Jr.,

Petitioner,

vs.

NO: 13 WC 26713

17IWCC0633

Contract Furniture Services
and State of Illinois Treasurers' Office as
Ex-Officio Custodian of the
Injured Workers' Benefit Fund,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 27, 2016 is hereby affirmed and adopted.

17IWCC0633

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 $53,100.00. 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: OCT 11 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

D100317
CJD/rlc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GONZALEZ JR, JOSE
Employee/Petitioner

Case# **13WC026713**

CONTRACT FURNITURE SERVICES & STATE OF ILLINOIS TREASURERS' OFFICE AS CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0633

On 10/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

4128 RUBENS AND KRESS
ROBERT B PAWLOWSKI
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0000 CONTRACT FURNITURE SERVICES
3021 W HARRISON ST
CHICAGO, IL 60612

5855 ASSISTANT ATTORNEY GENERAL
KATHLENN C HAGAN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17 IWCC 0283

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

Jose Gonzalez Jr.
Employee/Petitioner

v.

Case # 13 WC 26713

Consolidated cases: _____

Contract Furniture Services & State of Illinois Treasurers' Office as 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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 19, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$729.10**; the average weekly wage was **$37,913.20**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **2** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $38,048.80, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $486.07/week for 30.74 weeks, commencing December 20, 2012 through July 22/13, as provided in Section 8(b) of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a laborer and a United States National Guard Reservist at the time of the accident and that he *is* not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes Petitioner is no longer capable for standing for extended periods of time thus preventing him from returning as a laborer. In addition, due to Petitioner's injuries, he was honorably discharged from the United States National Guard. Because of this, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 23 years old at the time of the accident. Because of this, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner is unable to return to either employment with CFS or the National Guard. In addition, Petitioner has had difficulty maintaining employment with his current state of ill being, as shown by his brief employment working construction in 2014, as he was unable to continue working due to pain in his left foot. Because of this, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes due to lack of insurance, Petitioner's treatment was hindered. Had there been insurance coverage, Petitioner's treatment would have been far more extensive. This Arbitrator finds credibility in Petitioner's testimony as to the extent of Petitioner's disability. Because of this, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 70% loss of use of Petitioner's left foot pursuant to §8(e)(11) of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

10.26.16
Date

OCT 27 2016

17 I W CC 0633

JOSE GONZALEZ, JR. v. CONTRACT FURNITURE AND STATE OF ILLINOIS TREASURER'S OFFICE AS CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND

13 WC 26713

MEMORANDUM OF DECISION OF ARBITRATOR

Findings of Fact

The Petitioner in this matter was employed as a laborer by Contract Furniture Services ("CFS"), a Respondent in this matter. The Petitioner testified that he was initially hired by CFS on October 23, 2012. As a laborer for CFS, Petitioner testified that his duties varied on a day-to-day basis. Some of the tasks Petitioner was assigned to do consisted of decommissioning floors of office buildings, "build outs" of offices, moving furniture, hanging/patching dry-wall, delivery driver helper, painting, and demolition work.

In addition to working for CFS, Petitioner also had concurrent employment as a reserve in the United States National Guard. Petitioner testified that his enlistment date was December 27, 2007 and that he informed the owners of CFS, Dean Theo and Jim Stivers, of his concurrent employment at the time of his hire.

On December 19, 2012, Petitioner was delivering furniture in Oak Lawn, Illinois for CFS. Petitioner testified that after he got to the jobsite, Petitioner and another co-worker began loading up furniture on carts to be taken into the building. As Petitioner and his coworker began to lower the cart down from the truck, the cart started to slip. Petitioner was able to hold on to the cart for brief period of time in an effort to prevent it from falling, but ultimately had to jump out of the way due to the weight of furniture on the cart. While Petitioner was trying to maneuver out of the way of the cart, the cart struck Petitioner's left leg. After the cart struck Petitioner's leg, he felt immediate pain in his left leg. The Petitioner then attempted to get up off of the ground, but was unable to put weight on his leg. As a result of the injuries, paramedics were called to the scene of the accident.

The Roberts Park Fire Department arrived shortly after the accident and attended to Petitioner's injuries (Pet Ex. 1). The ambulance record indicates upon arriving at the scene, Petitioner's ankle was so swollen that they attempted to cut off his boot and sock, but were unable to do so due to the pain it caused Petitioner (Pet Ex. 1, P. 6). The paramedics then applied ice to Petitioner's left ankle and transported him to Christ Hospital (Pet Ex. 1, P. 6).

On December 19, 2012, Petitioner was seen in the emergency room of Christ Hospital (Pet Ex. 2, P. 7). At the emergency room, a history was taken in which the Petitioner reported a work related injury to his left ankle due to a cart carrying heavy furniture landing on his foot (Pet Ex. 2, P. 10). At the hospital, initial x-rays were taken which indicated a transverse fracture of the distal fibula and comminuted oblique fracture of the medial malloelus (Pet Ex. 2, P. 12). Petitioner was diagnosed with a bimalleolar fracture dislocation of his left ankle and was immediately sent to surgery with Dr. Jose R. Perez-Sanz (Pet Ex. 2, P. 19). Petitioner underwent an open reduction internal fixation surgery with the placement of hardware, including two plates and multiple screws (Pet Ex 2, P. 12).

On January 7, 2013, Petitioner followed up with Dr. Perez-Sanz at Midwest Bone and Joint Institute (Pet Ex 3, P. 10). On that visit, it was noted Petitioner was doing very well, his wound was clean and dry, staples were removed, a sterile dressing was applied, and Petitioner was placed in a non-weight bearing cast (Pet Ex 3, P. 10). Petitioner was instructed to follow up in two weeks and he would be transitioned into a weight bearing cast (Pet Ex 3, P. 10). Lastly, Petitioner was given sedentary restrictions (Pet Ex 3, P. 10).

On January 21, 2013, Petitioner returned to Dr. Perez-Sanz (Pet Ex 3, P. 13). At that visit, Petitioner was instructed to begin physical therapy for four to six weeks and return upon completion (Pet Ex 3, P. 13).

On April 25, 2013, Petitioner was seen for an initial physical therapy evaluation at Northwestern Medical Faculty Foundation (Pet Ex 4, P. 3). During the time period of April 25, 2013, through May 28, 2013, Petitioner underwent four physical therapy sessions at Northwestern Medical Faculty Foundation (Pet ex 4). Petitioner testified that due to the lack of any type of insurance and financial reasons, he was unable to complete the physical therapy recommended by his treating physician.

Petitioner followed up again at Midwest Orthopedic Consultants on May 2, 2013 (Pet Ex 3, P. 14). The records indicate that Petitioner was doing well and had no new complaints (Pet Ex 3, P. 14). Petitioner was instructed that he may begin weight bearing, was given another script of physical therapy, told to follow up in eight weeks, and given no running restrictions for his employment with the National Guard (Pet Ex. 3, 14).

On July 22, 2013, Petitioner returned again to see Dr. Perez-Sans, who at this point had switched practices to Advanced Orthopedic and Spine Care (Pet Ex. 5, P. 3). At this visit, it was noted that Petitioner was no longer improving, and still suffering from pain to his proximal edge of the medial fixation with prolonged standing or walking (Pet Ex 5, P. 3). Dr. Perez-Sans thought Petitioner's left ankle looked good, but thought Petitioner may benefit from being examined by a foot and ankle specialists and a few additional weeks of physical therapy (Pet Ex 5, P. 3). Lastly, Dr. Perez-Sans discharged Petitioner and instructed him to return PRN (Pet Ex 5, P.3).

(A)

Based upon Respondent's last known address of 3021 W. Harrison Street, Chicago, Illinois, 60612 and the argument made in paragraph (B) of this Memorandum, this Arbitrator finds that an employer-employee relationship existed between Petitioner and Respondent CFS, and thus CFS was operating under and subject to the Illinois Workers' Compensation Act on December 19, 2012.

(B)

The Respondent has placed the issue of whether an employee-employer relationship existed between the Petitioner and Respondent into dispute. With regard to this issue, the Petitioner testified that he was hired as a laborer by CFS on October 23, 2012.

The Petitioner testified that he would receive his work assignments from the owners' assistant Shelby. Shelby worked directly for Jim Stivers and Dean Theo and handled all of the scheduling for

The Petitioner testified that he was paid by check weekly. Petitioner testified that taxes were deducted from his check. This is supported by the W-2 from CFS submitted into evidence as Petitioner's Exhibit 7.

Finally, the Petitioner testified that he was supplied with CFS clothing, including CFS shirts and jacket, to wear while working for the Respondent in this matter.

Taken as a whole, it is clear to the Arbitrator that the Petitioner was an employee of the Respondent. There is no evidence to rebut the employee-employer relationship that the Petitioner has described. Accordingly, the Arbitrator finds that the Petitioner was an employee of the Respondent CFS at the time of his December 19, 2012 injury.

(C)

The Respondent has also placed the issue of whether the Petitioner's injury arose out of and in the course of his employment. The record is clear that the Petitioner suffered a bimalleolar fracture of his left foot while attempting to prevent a cart carrying furniture from falling on the behalf of the Respondent. The Arbitrator finds that there is no credible evidence to rebut the fact that the Petitioner's injury arose from and in the course of the Petitioner's employment.

(D)

The Respondent has placed the issue of whether the Petitioner suffered an injury on December 19, 2012, into dispute. All of the records, including Roberts Park Fire Department, Christ Hospital, Midwest Orthopedic Consultants, Northwestern Medical Faculty Foundation, and Advanced Orthopedic and Spine, are clear that the Petitioner sustained a work related injury on December 19, 2012. Accordingly, the Arbitrator finds that the Petitioner did suffer an injury on December 19, 2012.

(E)

The Respondent has placed notice into dispute in this matter. It is the Petitioner's unrebutted testimony that he informed Jim Stivers, a co-owner of CFS, on December 23, 2012, of his accident. Accordingly, the Arbitrator finds that the Petitioner provided sufficient notice to his employer that he had suffered a work-related injury on December 19, 2012.

(F)

The Respondent has placed the issue of whether there is a causal connection between the Petitioner's work injury and his current state of ill-being into dispute. The Arbitrator adopts the opinions of Dr. Perez-Sans that the Petitioner's current state of ill-being with regard to his left foot is causally related to the injury of December 19, 2012.

(G)

The Respondent has placed the Petitioner's earnings into dispute in this matter. The Petitioner testified that he filed his 2012 federal and state income taxes for wages earned at CFS. Petitioner's

Exhibit 7 shows Petitioner earned $5,398.50 for the 2012 tax year (Pet Ex.7, P. 2). Petitioner testified that he was hired on October 23, 2012 and the last day he worked for the Respondent was the date of injury of December 19, 2012. Petitioner testified that the W2 submitted into evidence was the total amount earned by Petitioner while working for CFS. This Arbitrator notes the time period of October 23, 2012, through December 19, 2012, is 8.286 weeks. Accordingly, this Arbitrator finds that Petitioner's average weekly wage for his employment with CFS is $651.52.

In addition to his employment with CFS, Petitioner also had concurrent employment with the United States National Guard. Petitioner testified that his enlistment date was December 27, 2007, and that during his interview with CFS, he informed them of his concurrent employment. Petitioner testified that his wages vary for the National Guard depending on how many training exercises he completes and what his current rank is at the time of involvement. Petitioner submitted into evidence his W2s for earnings for the National Guard indicating he earned $4,034.46 for the 2011 tax year (Pet Ex 7, P. 1). Petitioner also testified that both his involvement and rank increased following the 2011 year and that he earned more in the year 2012. This Arbitrator finds Petitioner's testimony credible, but without actual 2012 earnings, this Arbitrator must use the earnings from 2011 as a baseline for Petitioner's earnings. Accordingly, though Petitioner may have earned more in 2012, this Arbitrator finds Petitioner's average weekly wage for his concurrent employment with the National Guard to be $77.58.

Taking into account Petitioner's concurrent employment, this Arbitrator finds that the Petitioner's overall average weekly wage $729.10 per week.

(H) and (I)

The Respondent has placed all issues into dispute in this matter. Accordingly, this Arbitrator must address Petitioner's age and marital status at the time of the accident. Based upon Petitioner's testimony and exhibits submitted into evidence, this Arbitrator finds that Petitioner was 23 years old and single at the time of the accident.

(J)

Having found that the Petitioner's injury was causally related to his work accident and that his current state of ill-being is causally related to his work injury, the Arbitrator awards the following bills pursuant to the Illinois Workers' Compensation Fee Schedule:

Roberts Park Fire Department	$ 1,179.80
Christ Medical Center	$ 29,685.00
Midwest Orthopedic Consultants	$ 5,898.00
Northwestern Medical Faculty Foundation	$ 1,002.00
Advanced Orthopedic and Spine Care	$ 284.00
Total:	$ 38,048.80

(K)

The Petitioner was restricted from work by Dr. Perez-Sans during his treatment. There is no medical opinion in the record to rebut Dr. Perez-Sans with regard to the Petitioner's work status. This Arbitrator does note that Petitioner was given light duty on January 7, 2013. Petitioner credibly

testified that he gave his light duty restrictions to his employer, but was informed that there was no work for him unless he was full duty, as Respondent did not have an accommodated position for him. Petitioner's testimony is supported by a lack of written notice from Respondent to Petitioner indicating Respondent had an accommodating position for his restrictions. Accordingly, the Arbitrator awards temporary total disability from December 20, 2012, to July 22, 2013.

(L)

Having found that that the Petitioner did sustain an accident that arose from his employment on December 19, 2012 and his current state of ill-being is causally related to that accident, the Arbitrator must award the Petitioner permanent partial disability as a result of the injuries sustained.

Because the nature and extent of the Petitioner's injury is in dispute, and the accident occurred after September 1, 2011, the guidelines of Section 8.1b must be followed to determine how much permanent partial disability benefits to award.

Pursuant to Section 8.1b of the Act:

> In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of [an AMA impairment rating];
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. 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.

In this matter, (i) No AMA impairment rating was submitted by either party; (ii) the Petitioner was employed as a laborer and Army National Guard Reservist; (iii) the Petitioner was 23 years old at the time of the accident; (iv) the Petitioner's future earning capacity has been significantly diminished as he is no longer employed by the Respondent CFS or the United States National Guard due to the severity of his injuries and Petitioner's restrictions; (v) Petitioner continues to experience significant pain in all aspects of his life, specifically Petitioner is no longer capable of standing for significant periods of time, has a hard time completing chores around the house, can no longer partake in recreational activities as once previously, cannot partake in social activities such as dancing, and was forced to be honorably discharged by the United States National Guard due to his injuries.

For these reasons, the Arbitrator awards the Petitioner 70% loss to Petitioner's left foot with regard to his permanent partial disability.

(O)

Respondent has placed whether Notice of Hearing to the employer is proper. This Arbitrator notes Petitioner's Exhibit 8, a Notice of Hearing setting this matter for trial on September 8, 2016 at 9:00 a.m. at the Illinois Workers' Compensation Commission, was sent via certified mail to Respondent

CFS' last known address. Said Notice was sent on August 23, 2016, and received and signed for on behalf of CFS by Nancy Dennis on August 26, 2016. Accordingly, this Arbitrator finds Notice of this Hearing to Respondent CFS proper.

Lastly, the Respondent has placed at issue whether or not the Injured Workers' Benefit Fund is liable. This Arbitrator notes Petitioner's Exhibit 6, a certification from NCCI, Inc., indicating that on the date of Petitioner's accident, December 19, 2012, CFS did not have workers' compensation insurance. Accordingly, this Arbitrator finds the Injured Workers' Benefit Fund is liable.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSION

☒ 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

Barbara Holley,
Petitioner,

vs. NO: 10 WC 35944

Clarice's Home Care Services, Inc.,
Respondent.

17IWCC0634

DECISION AND OPINION ON REVIEW

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

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

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

17IWCC0634

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 $1,800.00. 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: OCT 11 2017

Joshua D. Luskin

L. Elizabeth Coppoletti

Charles J. DeVriendt

o-10/03/17
jdl/wj
68

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

HOLLEY, BARBARA
Employee/Petitioner

Case# **10WC035944**

CLARICE'S HOME CARE SERVICES INC
Employer/Respondent

17IWCC0634

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

If the Commission reviews this award, interest of 0.34% 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:

4260 NORSIGIAN LAW OFFICE LLC
HRANT "HUD" NORSIGIAN
220 E STATE ST SUITE C
O'FALLON, IL 62269

1454 THOMAS & ASSOCIATES
ROBERT HOFFMAN
500 W MADISON ST SUITE 3000
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

BARBARA HOLLEY
Employee/Petitioner

v.

CLARICE'S HOME CARE SERVICES, INC.
Employer/Respondent

Case # 10 WC 35944

Consolidated cases: _____

17IWCC0634

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0634

FINDINGS

On the date of accident, **April 17, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$14,472.01**; the average weekly wage was **$295.35**.

On the date of accident, Petitioner was **53** 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 **$32,138.23** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$32,138.23**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to her lumbar spine is not causally related to her accident at work on April 17, 2010. Petitioner reached maximum medical improvement on August 6, 2012. All benefits after that date are denied.

Respondent shall pay outstanding medical bills from Dr. Peck at Back & Neck Pain Center for services rendered from July 30, 2010, through November 2, 2010, in the amount of $4,315.00, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Petitioner's average wage is $295.35. Respondent shall pay temporary total disability benefits from April 18, 2010, through August 6, 2012, a total of 120 2/7 weeks, at the statutory minimum rate of $245.33, for a total of $29,509.69. Respondent shall receive credit for amounts previously 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 2, 2016
Date

ICArbDec19(b)

JUL 7 - 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

BARBARA HOLLEY
Employee/Petitioner

17IWCC0634

v.

Case #: 10 WC 35944

CLARICE'S HOME CARE SERVICES, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident, Petitioner was 53 years old, married, with no dependent children. She was employed by Clarice's Home Care Services as a home care giver, and had been so employed for about two and a half years. She had been in the home care attendant field for 15 years. Her duties included light housekeeping, laundry, meal preparation, taking the client shopping and to appointments, helping the client bathe, moving the client to and from the bed to a wheelchair, and the like. Petitioner testified that prior to her accident she was able to perform all her duties, including lifting clients when needed, and that she had never seen a doctor for any time of back pain, had never had pain shooting down her left or right leg, and had never been diagnosed with any low back problem.

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of her employment which caused injury to her lower back.

Petitioner testified that on April 17, 2010, she was working with client Alberta Heineke, who weighed about 185 to 190 pounds. The client wanted to rest and Petitioner assisted her into the bedroom and onto the bed. She put her legs up onto the bed, then walked around to the other side and began pulling the client further onto the bed. She reached across the bed, put her hand under the client's hip and thigh, and pulled her back. The client was having a hard time getting comfortable, and Petitioner pulled her back about five times. Petitioner testified that on about the sixth attempt to pull the client back, as she was pulling and lifting, something popped in her back. She felt pain and could not move, and had to lie on the client's bed for a few minutes. Her pain was in the left lower back area and down her left leg.

Petitioner testified she rested for awhile and finished her shift, but was unable to do anything other than fix the client dinner and clean up. She called her employer before leaving

the client's house. When she arrived home her husband helped her into the house, and she took some Tylenol and went to bed. She testified she believed she had pulled a muscle in her back. The next day was Sunday, and she rested her back most of the day. She testified that when she awoke on Monday, April 19, 2010, her back was worse. She called her employer again and advised she was going to the emergency room due to the pain.

Petitioner testified that since the accident she has had various types of treatment, including pain medication, muscle relaxers, two courses of physical therapy, multiple spinal injections, and chiropractic care. She was treated by an orthopedic surgeon and a neurosurgeon, and is currently being treated by another orthopedic surgeon who is recommending surgery. Petitioner testified that the first injection helped her pain for about a week, and that the chiropractic care seemed to help the most. Other than that, none of the treatments relieved her pain for very long, and the pain always came back.

Petitioner testified she continues to have constant pain in her lower back, down her left hip and left leg, to her foot. She has days where she cannot get out of bed. She described the pain down her left leg as being like needles that poke her all the way down her leg, into her little toe. She also has burning, numbness, and weakness. Nothing makes it better, and it is worsened with prolonged activity, including prolonged standing or sitting.

During her testimony, Petitioner demonstrated her ability and restriction with regard to walking. The Arbitrator noted she walked to her attorney and back with the use of a cane. Her gait was very slow and she favored her left leg. She testified she was unable to turn around toward her left side, and rather turned toward her right side. Her attorney requested she bend forward which the Arbitrator would not allow, due to concern for her safety and due to the fact that such movements were in line with medical testing of range of motion. The Arbitrator noted medical records would be relied upon for such testing. Petitioner testified she was unable to squat, or to lift anything over five to ten pounds.

Petitioner testified she was no longer on pain medication, as Dr. Gornet had asked her to wean off of it. Prior to that, she took Vicodin throughout the day. She still takes Aleve, which sometimes helps and sometimes does not. She did not take any Aleve the day of trial. She also uses a heating pad regularly. She testified she is unable to complete chores around the house, such as washing dishes or cooking, and that she will start something and her husband or son will have to finish. Her husband helps her get dressed because she cannot bend very well. Petitioner testified that her pain has gotten worse since her accident, that it is constant, and that it prevents her from getting a good night's sleep. She has been unable to work as a home care attendant or at any job since her accident. She testified there is no light duty in the home care attendant field.

Petitioner testified she began treating with Dr. Matthew Gornet on December 15, 2014, that he is recommending surgery to her lower back, and that she would like to have the surgery. Prior to treating with Dr. Gornet she treated with a neurosurgeon, Dr. Yazdi, who moved to a different state in 2014. Dr. Yazdi sent her for a Functional Capacity Evaluation. Petitioner testified it did not go well. She sat for an hour or hour and a half, and when she got up to walk across the room she could not move due to the pain.

Petitioner testified she attended three IME appointments with Dr. Chabot. Her attorney questioned her specifically about the second evaluation. She testified that her husband and her son went into the second examination. She testified that Dr. Chabot asked her to stand, and that her husband and son were on either side of her to help her up. Dr. Chabot requested that they not assist, and that Petitioner stand on her own. Petitioner testified she stood up and turned around, and that Dr. Chabot examined her right side but not her left. She testified she got on the examination table at his request, but that he did not do any further examination. She testified he did not test reflexes or strength in her legs, did not have her straighten her leg, did not stimulate the soles of her feet, and did not touch her arms, legs or feet at all.

Petitioner disputed several things noted by Dr. Chabot in regards to that examination. She denied telling Dr. Chabot that she took about one Vicodin a month. She denied telling him she returned to light duty, and testified there is no light duty in her field. Dr. Chabot mentioned a review of records from Dr. Imdad, and Petitioner testified she had no idea who that was. He mentioned a past medical history of back pain, and Petitioner testified that if he was referring to prior to the work accident, he would be incorrect. She denied having any back issues before the accident. Dr. Chabot noted he performed an examination which included feeling Petitioner's stomach, a hip log rolling test, a lower back examination, leg strength testing. Petitioner testified he did not do any of those during the appointment. Petitioner disagreed with Dr. Chabot with respect to any assertion that she was exaggerating or embellishing her symptoms. She further disagreed with his characterization that she had been treated for an emotional or psychiatric disorder, and denied same. She testified she had been to a psychiatrist once in her life, at the request of the insurance company before she had the discogram by Dr. Yazdi.

On cross-examination, Petitioner confirmed that she started working for Respondent in October 2008, and that she had been a home care provider for ten or fifteen years prior to that. Following her initial trip to the emergency room after the accident, she followed up with her family physician, Dr. Birner. Dr. Birner obtained an MRI, and eventually referred her to Dr. Wilkey, an orthopedic surgeon. She had an epidural steroid injection about a month after the accident. Petitioner testified Dr. Wilkey wanted to send her to Decatur for pain management, but it was too far to drive, and she declined. Instead, she started treating with Dr. Peck, a chiropractor. Dr. Peck eventually referred her to Dr. Yazdi, whom she treated with from around the fall of 2010 until the fall of 2013. Dr. Yazdi sent her to other doctors, who performed several injections. Respondent's counsel asked if one of those doctors was possibly Dr. Imdad. Petitioner did not know the names of the doctors who administered the injections, but did not believe it Dr. Imdad. Petitioner testified she last saw Dr. Yazdi in October 2013.

Petitioner first saw Dr. Gornet in December 2014, which she acknowledged was 14 months after last seeing Dr. Yazdi. She testified she has seen Dr. Gornet four times, with the most recent visit being in August 2015. She confirmed he is recommending surgery.

Petitioner's next witness was Matthew McCoy, Petitioner's son. Mr. McCoy is employed as the Admissions Coordinator at Columbia Rehab and Nursing and is also a certified nursing assistant. He testified he has observed his mother at home and that she attempts to do household chores such as laundry and cooking, but cannot finish. He has observed that she can stand for 15 to 30 minutes. Mr. McCoy testified that he and his father accompanied Petitioner to

her appointment with Dr. Chabot on August 6, 2012, and that both of them went into the examination room with her. He testified he observed what Dr. Chabot did with regard to his mother, that he asked her to do certain things, but kept his back to her as he was writing so was unable to observe her. He testified he did not observe Petitioner remove her shoes, and did not observe Dr. Chabot stroke the bottoms of her feet, or do any strength or reflex testing of her arms or legs. He observed Dr. Chabot examine her right lower back, but not the left.

Following the accident, Petitioner first sought medical treatment on April 19, 2010, when she presented to the emergency room at Red Bud Regional Hospital. She gave a history of moving a patient two days prior when she felt a pop in her back, and reported low back pain with radiation and numbness down her left leg since that time. Activity and sitting made her symptoms worse and lying down made them better. She denied any prior symptoms, but reported she had prior fixation at C5-6 secondary to an automobile accident. She rated her pain at 7/10, which decreased to 3/10 after administration of pain medication in the hospital. Petitioner was diagnosed with back pain and was instructed to follow up with her primary physician Dr. Birner. She was not to work until cleared by Dr. Birner. PX1, Dep. PX3.

On April 23, 2010, Petitioner presented to Dr. Nancy Birner at Red Bud Internal Medicine & Pediatrics and gave a consistent history of the accident. She complained of continued pain in her left low back, with numbness and tingling down the left leg, and decreased sensation and strength. She reported she had a difficult time walking and had poor flexion and extension of the spine. On examination, she had tenderness to palpation over the left lumbosacral region, positive muscle spasm, and positive straight leg raise. Dr. Birner noted Petitioner actually had decreased strength in the right leg, but she was not sure if it was actual decreased strength or secondary to pain. Strength in the left leg was normal. Petitioner had poor flexion and extension of the spine and an antalgic gait, secondary to pain. Dr. Birner's assessment was questionable herniated disc with nerve compression. She administered Kenalog and Toradol in the office, prescribed Ultram, Neurontin, Motrin, and Norflex, and ordered an MRI. Petitioner was to return in two weeks. PX1, Dep. PX3.

On May 5, 2010, Petitioner underwent a lumber MRI. The findings were: (1) L5-S1 small broad disc osteophyte complex eccentric towards the left, left facet hypertrophy, and mild left neuroforaminal narrowing; and (2) multi-level osteophyte complexes and minimal bulges, with no evidence of significant stenosis at remaining levels. PX1, Dep. PX3.

Petitioner returned to Dr. Birner on May 11, 2010, and reported continued left low back pain which radiated down the buttock and leg to the foot, which increased with activity. She reported that it hurt to sit down or lie down, and that she was not sleeping. She noted weakness and trouble balancing, but stated she had not fallen. She had not started physical therapy. Examination showed tenderness to palpation over the left lumbosacral region with positive straight leg raise on the left, decreased strength, and limited range of motion. Dr. Birner's assessment was lumbar degenerative disc disease. She noted the MRI showed a disc bulge compressing L5, which was where Petitioner's numbness and tingling was. Dr. Birner administered a shot of Toradol in the office, prescribed physical therapy, and referred Petitioner to Dr. Wilkey. She was to follow up in two to three weeks; however, a subsequent chart entry on

May 25, 2010, noted she was instructed there was no need to return since she was seeing a specialist. PX1, Dep. PX3

On May 21, 2010, Petitioner presented to Dr. Keith Wilkey at Orthopedic Associates, upon referral by Dr. Birner. She reported a consistent history of the accident. She complained of pain in her back and leg, aggravated by activity and improved with rest, and requested more pain medication. Petitioner reported a prior anterior cervical decompression and fusion in 2002 with a successful outcome, and reported no prior treatment for a back or leg problem. On examination, it was noted Petitioner had a right shift, unloading the left leg. She was tender to palpation in the lower central lumbar area, left SI joint, and posterolateral portion of the left leg, but had no buttock pain and no muscle spasm. Range of motion was guarded and limited in all planes. Straight leg and sitting straight leg tests were normal. Petitioner's gait was antalgic and gait giving way was noted. She had weakness to the left ankle. Sensation exam was entirely normal, with normal light touch sensation reported. Dr. Wilkey noted the lumbar x-rays showed no evidence of significant abnormalities but did show some mild osteophytic changes of the posterior facet joints. He noted the MRI showed a small broad disc osteophyte complex with eccentricity to the right, causing left neural foraminal narrowing, and mild changes at other levels. Dr. Wilkey's assessment was left leg radiculopathy. He noted the mechanism of Petitioner's injury fits for a problem that could cause symptoms similar to what she was having. He noted there was weakness in the left ankle evertor which corresponded to the level involved by the MRI report. Dr. Wilkey administered an epidural steroid injection at the left L4-5 interspace, prescribed Demerol, and instructed Petitioner to remain off work. PX1, Dep. PX3.

On May 24, 2010, Petitioner underwent an initial physical therapy evaluation at Sparta Physical Therapy and Sports Medicine. Her main complaint was severe pain in the left side of her low back running into the left buttock and leg, and numbness which started at about the knee and ran to the outside of her left foot and fourth and fifth toes. She reported the epidural injection on May 21provided slight relief. Petitioner was unable to sit and bend toward the left, and leaned onto her right buttock. Examination showed ambulation with forward flexed and right side bent posture and an antalgic gait. Petitioner had limited range of motion and was unable to stand completely upright. She also had decreased strength in the left lower extremity. Transfers were slow and painful and Petitioner had palpable tenderness and sensitivity in the left gluteal and lateral thigh region. Petitioner attended physical therapy on May 26 and 28, and June 1, 2, and 3. It was noted on June 3 that very little progress had been made thus far and that Petitioner tried to perform exercises but had great difficulty with them. PX1, Dep. PX3.

Petitioner returned to Dr. Wilkey on June 4, 2010, and reported that the injection did not help. Dr. Wilkey noted she did not tolerate the injection around the nerve root and that it was perhaps a missed injection. Petitioner reported the Demerol made her sick, the Vicodin helped, and the physical therapy was helpful because they had initiated ice treatments which seemed to provide her the most relief. On examination, Petitioner had soreness in her low back and a right shift to avoid weight bearing on the left leg. She had a positive straight leg raise, no evidence of progressive weakness, and giving way. Assessment was left leg radiculopathy. Dr. Wilkey administered a second epidural steroid injection into the left L4-5 interspace. PX1, Dep. PX3.

Petitioner attended physical therapy on June 7, 2010, and reported the injection and change in medication had helped decrease her pain. She moved very slowly throughout the session. She returned on June 9 with severe pain at a 7/10. She was unable to perform all of the exercises due to pain. On June 11 she reported no relief from the second injection and continued numbness from her left knee to her foot. She had significant antalgia in her left leg. Petitioner attended therapy on June 15, 16 and 17 and continued to complain of severe pain and weakness, and transferred weight to her right side. The progress note of June 17, 2010, indicates Petitioner's reported pain was just as bad as it was initially. Her gait and transfers were poor and there were two instances of her left leg giving out when taking steps. Her left lower extremity strength was poor, her gait was unsteady, and her left lower extremity stance phase was significantly decreased. It was noted that Petitioner had made poor progress in therapy and that further physician intervention may be needed. PX1, Dep. PX3.

On June 18, 2010, Petitioner returned to Dr. Wilkey, who noted in his record that, "Ms. Holley is perplexing me." She reported she got no benefit from the second injection, yet Dr. Wilkey noted she described fairly classic left leg radiculopathy. She reported numbness from the buttock down to her toes, associated with weakness and functional foot drop. On examination, Petitioner favored her left leg when sitting and standing and there was a shift. She was sore in the lower lumbar spine, left buttock, and posterolateral portion of the left leg. Straight leg raise was positive and she had weakness and numbness on the left side. Assessment was left leg radiculopathy and low back pain. Dr. Wilkey ordered EMG studies, continued therapy, and medications to include Vicodin, Tramadol, and a nonsteroidal. Petitioner was to remain off work. PX1, Dep. PX3.

On June 23, 2010, Petitioner began physical therapy at Red Bud Regional Hospital. She gave a consistent history of the accident and reported she could not raise and wiggle her left toes or the front of her foot very easily. She reported ice and medications provided a little relief for her symptoms.

On June 24, 2010, Petitioner underwent an EMG/NCS of the left lower extremity by Dr. Latha Ravi. The findings were all within normal limits. PX1, Dep. PX3; RX3.

On July 6, 2010, Petitioner returned to Dr. Wilkey and reported continued buttock and left leg pain. She described sciatic nerve pain that was "always there" and that radiated from the back down the posterior portion of the left leg, though she had less numbness in the foot. Her main complaint was back pain. Her examination was unchanged, with a right shift as she sat and stood. She had an antalgic gait and was significantly guarded in her range of motion. She had soreness in her back, left buttock, posterolateral portion of the left leg, and had diffuse weakness with giving way of the left foot. Dr. Wilkey noted, however, that he could not isolate a specific motor group that was weak. Assessment remained left leg radiculopathy and low back pain. He noted the EMG studies were negative and that Petitioner had a nonfocal weakness to the left leg. Her radiculopathy was minimal or improved. He noted Petitioner's main problem was back pain and stated, "I have no specific reason for this from the MRI study." Dr. Wilkey recommended a CT myelogram to rule out any residual lateral stenosis or occult herniated disc not noted on the MRI. PX1, Dep. PX3.

On July 14, 2010, Petitioner underwent a lumbar myelogram and post-CT. The findings were moderate left-sided foraminal narrowing due to bony vertebral body osteophytes at L5-S1 on the left, with no evidence of spinal canal stenosis. PX1, Dep. PX3; RX2.

Petitioner returned to Dr. Wilkey on July 16, 2010, at which time she reported she still had back and left buttock pain, and pseudo left leg radicular pain, but that her left leg pain was slightly better. On examination she still had difficulty getting out of the chair and she still had a right shift, favoring the left leg. She had an antalgic gait and weakness of the ankle evertor and tibialis anterior. Dr. Wilkey reviewed the CT myelogram and noted the findings. His assessment was left leg radiculopathy and SI joint dysfunction. Petitioner was very tender over the left SI joint and Dr. Wilkey administered a trigger point injection into the area. He kept her off work and wanted her to continue therapy and Naprosyn. He believed Petitioner would be able to get back to light duty after three to four weeks of continued care. PX1, Dep. PX3.

Petitioner attended therapy until July 29, 2010, during which her complaints remained the same and she reported little benefit from the therapy. The summary report of July 29 noted subjective findings of no change in her radicular symptoms, continued pain level at 7-10/10, and continued difficulty getting around. It noted objective findings of transfers that remained guarded and slow, use of a cane when walking, leaning, and decreased cadence. The therapist noted that without a change in Petitioner's pain level, she was not sure how much benefit further therapy would provide. PX1, Dep. PX3.

On July 30, 2010, Petitioner returned to Dr. Wilkey. She had not responded to any injections and he noted that, "Ms. Holley is getting difficult for me to understand." She had moderate stenosis at L5-S1 which could cause her leg radiculitis, but she had normal EMG studies. Physical therapy had plateaued and the therapist did not think she could help Petitioner. Dr. Wilkey stated he was "at a loss for what to do" other than send her to another physician, and noted he was going to send her to Dr. Randall (specialty unspecified) for his thoughts on a diagnosis and potential treatment. On examination, Petitioner still limped, still favored the left lower extremity, and still had difficulty getting out of the chair. She was sore in the left buttock and posterolateral portion of the left leg. On muscle testing, there was "cogwheeling", which made it difficult to determine her actual motor strength. Petitioner was referred to Dr. Randall and was kept off work. Dr. Wilkey did not believe she would be at maximum medical improvement for another three to six months. PX1, Dep. PX3.

On July 30, 2010, Petitioner also saw Dr. Anthony Peck, a chiropractor. She reported a consistent history of the accident and her treatment to date. She stated the injections she received had not helped, and that ice, topical analgesics and medication gave her some temporary relief but the pain returned. Any activity worsened the pain. She reported pain that was sharp and numbness in the left buttock and lower extremity. She rated her pain at 5/10. On examination, her range of motion was restrictive and painful in all directions. She had tenderness in the lumbar spine and spasm in the lumbar paravertebral musculature. Her gait was forward antalgic and she used a cane to ambulate. Dr. Peck recommended Petitioner be seen daily until there was a significant reduction in pain, and then twice a week thereafter, for a total of four to six weeks. Dr. Peck's records reflect Petitioner was seen on a regular basis throughout the month of August and into September. On August 19, 2010, he completed a "Persons with

Disabilities Certification for Parking Placard", and noted Petitioner's diagnosis was degenerative arthritis, sciatica, and lumbago. He marked that her disability was permanent. PX1, Dep. PX3.

On September 9, 2010, Petitioner had a re-evaluation by Dr. Peck. She continued to complain of having a lot of pain and trouble sleeping, but stated that overall the chiropractic treatment had helped the most. Her lumbar range of motion had improved but was still restrictive and painful. She had less tenderness in the lower lumbar area, but still had quite a bit of tenderness in the left SI joint and buttock musculature. Dr. Peck noted her progress was slower than expected and he was concerned about the referral of pain and weakness she periodically had. He believed an evaluation by a neurosurgeon was in order, and he referred Petitioner to Dr. Joseph Yazdi. He was going to continue to treat her until Dr. Yazdi could see her. He did not believe Petitioner was able to work. PX1, Dep. PX3.

A Utilization Review was performed with regard to ongoing chiropractic care by Dr. Peck. The Review was done by peer review chiropractor, Dr. Gary Ierna on September 20, 2010. Dr. Ierna recommended non-certification of additional chiropractic care, as Petitioner had already received medications, rest, two epidural injections, trigger point injections, and physical therapy, all of which failed to provide any clinically meaningful benefit. In addition, Petitioner had completed 12 chiropractic visits and it was noted that Dr. Peck failed to provide sufficient documented evidence of functional and symptomatic improvement. Dr. Ierna noted there were no valid and reliable outcome assessment measures which demonstrated benefit from the chiropractic care. Further, Petitioner had been referred for a neurosurgical consultation and if the chiropractic treatment was bringing about clinically meaningful benefit, a neurosurgical consultation would not be clinically indicated. Dr. Ierna cited the Official Disability Guidelines 2010 Low Back Pain Chapter, which states there should be measured improvement within the first few weeks of chiropractic treatment. If the treatment is going to be effective, the ODG states there should be some outward sign of subjective or objective improvement within the first six visits. The ODG recommendation for chiropractic care for low back pain is "6 visits over 2 weeks and, with evidence of functional improvement, up to 18 visits over 6-8 weeks". The treatment rendered and/or proposed by Dr. Peck exceeded the ODG recommendations. The Review was sent to Dr. Peck, with a copy to Petitioner and her attorney. PX1, Dep. PX3.

Petitioner continued receiving chiropractic treatment by Dr. Peck throughout September and October 2010. Her complaints remained constant during that time. PX1, Dep. PX3.

On November 2, 2010, Petitioner presented to Dr. Joseph Yazdi at Southern Illinois Brain and Spine Center, upon referral by Dr. Peck. She reported a consistent history of the work accident and her treatment to date. She complained of pain in the left lower back that radiated down the left hip and thigh to the knee, as well as numbness in the left lateral calf and foot. She described the pain as constant, sharp and 6-10/10 in severity. She reported that two rounds of physical therapy did not help, but that the chiropractic treatment was helping. On examination, sensation was decreased in the left lateral calf and lateral foot, and she had difficulty with left hip flexion. It was noted Petitioner walked very slowly and needed to use her cane because of the significant pain she was in. Dr. Yazdi did not attempt lumbar range of motion testing, due to the pain Petitioner was in. Dr. Yazdi reviewed the injections done by Dr. Wilkey, the MRI, and the CT myelogram. The MRI and CT myelogram showed slight deterioration at L5-S1, including

some facet arthropathy. Dr. Yazdi's impression was significant lower back pain with left leg radiculopathy. The only area of concern he saw on the MRI was at L5-S1. He noted Petitioner had already had epidural blocks, and he recommended referral to pain management for bilateral L5-S1 facet blocks. He stated if the injections did not work, he had nothing else to offer Petitioner. PX2, Dep. PX2.

Petitioner continued to receive chiropractic treatment twice a week on average throughout November, and once a week on average in December 2010. Her complaints waxed and waned, as did her reported ability to walk longer without the cane. PX1, Dep. PX3.

On January 6, 2011, Petitioner underwent bilateral L5-S1 intraarticular facet joint injections by Dr. Naseer at St. Elizabeth's Hospital. She had repeat injections at the same level bilaterally on January 20, 2011, by Dr. Naseer. PX1, Dep. PX3.

Petitioner continued to receive chiropractic treatment once or twice a week throughout January 2011. On January 11 she reported she had undergone injections which had helped. Dr. Peck noted she appeared to be ambulating much better than in the past. On January 18 she reported she was able to walk for longer distances but that the pain returned. PX1, Dep. PX3.

On January 26, 2011, Petitioner returned to Dr. Yazdi. She reported that the first injection only lasted about a week, and that the second one was holding after about a week. She reported she was significantly better. She was not limping but indicated if she walked long enough she would limp. Dr. Yazdi noted that since Petitioner had a good response to both facet blocks, the next recommendation would be for an RFA. Included with Dr. Yazdi's narrative report is a "Progress Note", indicating the diagnosis was L5-S1 facet arthropathy and noting that Petitioner was 40% better after the bilateral L5-S1 facet blocks. The Progress Note was electronically signed by "Faria Imdad". The Arbitrator notes this is the name of the individual referred to in Petitioner's testimony, with respect to the name occurring in Dr. Chabot's report. In reviewing all of Dr. Yazdi's records, there are similar Progress Notes throughout, which appear to actually be the nurse's notes. PX2, Dep. PX2; RX4.

On February 9, 2011, Dr. Yazdi spoke with Petitioner on the phone. She was complaining of low back pain that started again about a week and a half after her second facet block. She related the pain was mostly in her back, on the left, and that it was about 8/10 in severity. Dr. Yazdi noted that since the injections temporarily helped, he recommended bilateral RFA at L5-S1. PX2, Dep. PX2.

On April 6, 2011, Petitioner underwent left L3, L4, L5, and S1 medial branch radiofrequency denervation (ablation) by Dr. Naseer. She underwent the same on the right on April 19, 2011. The postoperative diagnoses were lumbar facet arthropathy and lumbar degenerative disc disease. On May 3, 2011, Petitioner underwent a left sacroiliac joint injection. PX1, Dep. PX3.

On May 24, 2011, Petitioner returned to Dr. Yazdi following the radiofrequency ablations. She reported that the RFA's did not help and in fact she had extreme pain afterward. She reported she went back and got a left SI joint injection, which was also not really helping.

She felt there was something catching in her back when she walked at a regular pace. The pain was most severe in the left lower back and buttock area, with pain radiating down through the left lateral leg. Dr. Yazdi noted Petitioner was exquisitely tender at the lumbosacral junction and over the left buttock area, including the SI joint. Her strength was intact but she limped when she walked. His impression was L5-S1 degenerative disc disease with left-sided disc bulge, which seemed to be the source of her pain. He noted the only option left besides surgery was a combination of a left L5-S1 epidural block and Neurontin, and he ordered both. He noted if she was not better after the block, the only option left would be an L5-S1 fusion. PX2, Dep. PX2.

On June 29, 2011, Petitioner underwent a left L5-S1 interlaminar epidural injection by Dr. Naseer. The diagnoses were lumbar degenerative disc disease, facet arthropathy, and spondylosis. PX1, Dep. PX3.

Petitioner returned to Dr. Yazdi on July 13, 2011, and continued to report significant pinching pain in her lower back, radiating down the left lateral leg to her ankle. She reported the Neurontin helped with the burning pain, but she continued to have quite a lot of pain. On examination, she had a hard time standing up and needed her cane to ambulate. Dr. Yazdi noted Petitioner had undergone numerous injections and other conservative care and continued to have significant symptoms. He recommended a minimally invasive L5-S1 transforaminal lumbar interbody fusion, posterior fusion, and pedicle screw fixation. He indicated the fusion would get rid of the disc herniation that was pushing on the nerve and causing Petitioner's significant pain, and would also help with segmental instability at the L5-S1 interspace. PX2, Dep. PX2.

On July 27, 2011, Dr. Yazdi spoke with Petitioner by phone. His record indicates that he and the physician reviewing her worker's comp case had a difficult time getting in touch with each other, and that a denial of the surgery had been sent. Dr. Yazdi reviewed the denial letter and noted it would be prudent to get a lumbar discogram to solidify his opinion as to why she would benefit from a lumbar fusion surgery. He discussed the discogram with Petitioner and advised he would refer her to pain management for the procedure. PX2, Dep. PX2.

On September 9, 2011, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Michael Chabot of Orthopedic Specialists. She gave a consistent history of the accident and her treatment to date. At the time of the exam, she reported severe, excruciating pain in her low back that radiated into her left lower extremity down to the calf. She rated the pain at 10/10. She also complained of burning, aching pain involving her left leg. She related she had difficulty walking and felt like something was catching when she walked. She used a cane to ambulate, to support herself and to minimize the risk of falling. RX5; PX1, Dep PX3.

Dr. Chabot reviewed medical records from Petitioner's treatment to date, although it is not clear if the records included those from Dr. Peck. On examination, Dr. Chabot noted Petitioner used a cane to ambulate, kept her left leg flexed at the knee, and walked with a limp favoring her left lower extremity. There was tension involving the bilateral paraspinal musculature. Petitioner sat in the chair at 90 degrees. She had forward flexion to 20 degrees, extension to 10 degrees, and side bending to 15 degrees. She had diffuse tenderness to palpation over the left SI region to very light touch. She had hamstring tightness bilaterally, and complained of low back pain with hamstring testing. Hip log roll testing was negative, hip range

of motion was full, and Fabere's test was negative. Calf girth was equal bilaterally with no atrophy. There was decreased sensation over the left lateral calf. Straight leg raise was negative. Dr. Chabot noted Petitioner had to be coaxed to maximize effort. RX5; PX1, Dep PX3.

Dr. Chabot's impression was: (1) chronic back pain; (2) chronic SI dysfunction; (3) disc degeneration; (4) facet degenerative joint disease; and (5) history of lumbosacral strain. Dr. Chabot noted that the medical records document Petitioner sustained a work injury on April 17, 2010, and had had persistent back pain complaints since then. He noted she had undergone a multitude of various treatments which had not given her any lasting improvement. Dr. Chabot opined that Petitioner's complaints were causally related to her work accident, based on his review of the medical records. With regard to her continued need for medical treatment, he opined that the discogram suggested by Dr. Yazdi was reasonable and necessary in order to determine the origin of Petitioner's complaints. He recommended the study be performed to at least three lumbar levels. Dr. Chabot opined that Petitioner should also undergo psychological testing prior to the discograms. RX5; PX1, Dep PX3.

Dr. Chabot opined that with regard to Petitioner's degree of disability, her perception of back pain complaints was severe. He noted that her examination revealed restrictions in range of motion and "an excessive pain response to palpation in the left lumbosacral region". He noted there was a suggestion of inconsistencies with respect to Petitioner's active range of motion and perceived range of motion of the lumbar spine during the examination. Dr. Chabot opined Petitioner should return to limited work duties that require lifting no more than ten pounds and allow her to alternate sitting and standing every 20 to 30 minutes. Dr. Chabot noted he would not recommend any surgical intervention unless Petitioner underwent a discogram first, and then only if the discogram revealed evidence of concordant pain response at a single level. If the discogram did not reveal concordant pain, or if Petitioner had a positive response at multiple levels, Dr. Chabot opined that she would not be a surgical candidate. RX5; PX1, Dep PX3.

On September 27, 2011, Petitioner returned to Dr. Yazdi. He noted he had spoken to "one of the insurance company doctors, who flat out refused to allow any more treatments through Workman's Comp". He further noted that Petitioner's attorney had not had any success either, and that he could not proceed with anything until he heard from Petitioner's attorney. He and Petitioner discussed the matter for about 15 minutes, but it is unclear whether an actual examination was performed on that date. PX2, Dep. PX2.

Petitioner returned to Dr. Yazdi on November 1, 2011, and continued to complain of significant lower back and left leg pain. She reported about 90% of her pain was in her lower back. On examination, her strength was intact. Her gait was with a cane, as she could not bear much weight on her left leg, and it was slightly flexed at the hip. Dr. Yazdi noted that Dr. Chabot recommended a psychiatric evaluation before the discogram, and that he would refer Petitioner for that. PX2, Dep. PX2.

On November 23, 2011, Petitioner was examined by Neil Horowitz, Ph.D., Clinical Psychologist. Petitioner gave a consistent history of her accident and treatment to date. She rated her pain at 10/10 almost all the time, but stated it may get down to 7/10 if she was resting in a supine position. She described the pain as sharp or burning, radiating from her low back

down her left leg. Dr. Horowitz noted Petitioner "describes herself as totally disabled; unable to work, drive, clean house, do dishes, or even walk other than with assistance and very slowly". She related she felt bad she was unable to "do stuff" with her family, especially her grandchildren. She described her family as supportive. PX2, Dep. PX6.

Petitioner was administered the BHI-2 to assess her psychological adjustment to her injury and pain. Dr. Horowitz noted that her BHI-2 profile "presented some paradoxical findings". She reported an unusually low, almost nonexistent, level of psychological problems or distress. Yet, she reported a rather high level of functional complaints and extremely high pain level. Petitioner related that even the mildest pain she experienced in the past month was intolerable and disabling. Dr. Horowitz opined it was unlikely she could have experienced any periods of "wellness" during that time span, and that it was incongruent that she would also then report no psychological distress. He noted Petitioner's reports of anxiety and hostility were so low, as to place her in the first percentile of patients. Petitioner claimed she was able face life as it is with extraordinary calm, patience, and tolerance. Dr. Horowitz questioned whether this demeanor was consistent with her history, or if she was feeling emotionally immobilized by her pain. He noted, "Although she reports very low levels of depression, the high number of physical symptoms she reported suggests that a vegetative depression may be present." Dr. Horowitz noted Petitioner's response to four "Critical Items" statements as follows: (1) If people are totally healed, somebody should pay them for the rest of their lives. AGREE. (2) I need medicine to kill my pain. AGREE. (3) Sometimes my pain gets worse, but it never gets better. AGREE. (4) I can't work. STRONGLY AGREE. PX2, Dep. PX6.

Dr. Horowitz opined that, taken at face value, the assessment revealed no contraindications for Petitioner to pursue neurostimulations for pain management. She was able to understand the process and limitations of neurostimulation, and understood what was expected of her. She indicated she had strong social support. Dr. Horowitz also opined, however, that if Petitioner's perception of her limitations and her experience of pain exceeded what would be expected, based on objective findings, that "she may have gravitated toward being totally disabled, even if she is not". He noted she had almost complete absence of affective distress and that she may be reluctant to express frustration. He opined that she "would do best with any pain management technique if she is required to be actively engaged in the process". PX2, Dep. PX6.

On December 7, 2011, Petitioner underwent a four-level lumbar discography, at L2-3, L3-4, L4-5, and L5-S1. At L2-3 there was slight degeneration but no tears noted. At the other three levels, there was marked degeneration at each disc, as well as a grade 1-2 left annular tear at each level. It was noted Petitioner had concordant pain symptoms at L4-5 with similar pain at all other levels, with mild palliation of her pain symptoms with local anesthetic injections at levels L4-5 and L5-S1. Petitioner also underwent a lumbar CT with contrast the same day, which showed: (1) L2-3 mild degeneration; (2) L3-4 and L4-5 marked degeneration without evidence of definite annular tear; (3) L5-S1 central, left paracentral, and left lateral protrusion, associated annular rents, and narrowing of the left lateral recess and the left L5-S1 foramen; (4) arthritic changes; and (5) levoscoliosis. PX1, Dep. PX3 and PX2, Dep. PX3.

Petitioner followed up with Dr. Yazdi on December 14, 2011, at which time she continued to have significant back pain. She related 80% was in her back and 20% was down

the left leg. She had a hard time transferring from sitting to standing, and she used her cane and had help from her husband to get up. Dr. Yazdi noted the discogram showed 10/10 pain at all four levels tested, and indicated Petitioner's pain was coming from more than just one focal area in her lower back. Dr. Yazdi stated this indicated that a fusion surgery would not be an option for her, and that the best thing would be to test her for a dorsal column stimulator. He indicated he would refer Petitioner to pain management for a trial period. PX2, Dep. PX2, RX4.

On February 1, 2012, Dr. Yazdi made a chart entry which indicated the trial for a dorsal column stimulator had been denied, and that he was at a loss as to what else to do. He opined Petitioner would be at maximum medical improvement if they were not allowed to do any other types of treatments. He noted it was important to understand what Petitioner's limitations were, and he ordered an FCE to determine that. PX2, Dep. PX2.

On February 20, 2012, Petitioner underwent a Functional Capacity Evaluation. The Summary Report indicates that the test findings were inclusive, as the testing was stopped. Petitioner had been sitting for 1 hour and 23 minutes, performing the intake interview and pain questionnaire. When she was asked to stand to perform a test at another table, she was unable to stand and reported severe pain in her low left back. She asked to lie down to allow the pain to subside, and she was assisted onto a treatment table to do so. Testing was stopped at that point, due to increased pain and inability to safely perform the tasks of an FCE. It was noted that Petitioner's job as a Home Attendant was in the Medium physical demand level, and that she was not capable of performing the physical demands of that job. PX2, Dep. PX4.

On August 6, 2012, Petitioner was re-evaluated by Dr. Chabot, at Respondent's request. She complained of burning, aching pain in the low back which radiated into the left leg and down to the foot and little toe. She rated her complaints in the moderate range and described sharp, localized, burning pain radiating predominantly into the left leg to the knee. She also complained of weakness in the left leg, and she used a cane to ambulate for that reason. Petitioner related she stopped seeing the pain management specialist in December 2011. She had been using Vicodin, which was prescribed in December 2011, and reported she "may use 1 tablet per month". She stated she had applied for Social Security Disability but had not worked a sufficient number of quarters to qualify. RX5; PX1, Dep PX3.

Dr. Chabot reviewed updated medical records since his previous exam, including the Functional Capacity Evaluation of February 20, 2012, the discogram study of December 7, 2011, and recent records from Dr. Yazdi. Dr. Chabot also referenced "Records from Dr. Imdad", which was a note from January 26, 2011. As previously discussed, the Arbitrator notes that the note referred to was part of Dr. Yazdi's record from the same day. It appears to refer to the nurse's note, and the nurse's name was "Faria Imdad". It was simply misidentified by Dr. Chabot in his review of records. Dr. Chabot noted Petitioner had never treated for an emotional or psychiatric disorder. RX5; PX1, Dep PX3.

On examination, it was noted Petitioner ambulated with a limp, favoring her left leg, and that she was able to walk without her cane. Hip log roll testing was negative, the hip range of motion of was full, and Fabere's test was negative. It was noted there was tension involving the bilateral paraspinal musculature. Petitioner was able to sit on the examination table at 90

degrees; however, when asked to forward flex in the standing position, she stated she was unable to. When asked to actively extend and to actively side bend, Petitioner stated she was unable to. There was tenderness to palpation involving the bilateral SI region, and symptoms were aggravated with direct pressure. RX5; PX1, Dep PX3.

Based on review of all records, Petitioner's verbal history, and her physical examination, Dr. Chabot opined that Petitioner had persisting functional deficits that could in part be related to her work injury of April 17, 2010. He stated, however, that there appeared to be evidence of symptom embellishment, as evidenced by the following: (1) She rated her pain as excruciating, 10/10, and stated it was unchanged from her complaints shortly after the accident. (2) Medical records document a suggestion of symptom magnification. Her discogram revealed 10/10 provocation of pain at each of the four lumbar levels tested, with no adequate control determined. Her performance at the FCE strongly suggests symptom magnification. Her examination by Dr. Chabot contained inconsistencies, as she stated she was unable to actively bend forward, to the sides, or extend, yet she was able to sit in a chair and on the examination table at 90 degrees. (3) Petitioner's neurologic examination revealed sensory changes involving the left lower extremity that did not follow any specific dermatomal pattern. (4) Diagnostic studies failed to reveal evidence of neurologic compromise. RX5; PX1, Dep PX3.

Dr. Chabot opined that Petitioner had reached maximum medical improvement and that there was a strong suggestion for symptom embellishment or magnification. He believed Petitioner could return to limited work duties, with no lifting more than 20 pounds and no repetitive bending and twisting. He opined that additional medical treatment was not warranted, as Petitioner had failed all attempts of treatment. She would most likely require additional use of pain medication in the future, which should be prescribed and closely monitored by her treating physician. Dr. Chabot did not believe Petitioner was a candidate for surgical intervention. He opined it was unlikely that surgery at any level of her lumbar spine would have any potential for improving her complaints, based on her level of subjective complaints, the inconsistencies in her examination, and the results of her discogram. RX5; PX1, Dep PX3.

Dr. Chabot noted that the initial diagnostic studies performed revealed evidence of advanced degeneration involving the three lower lumbar levels, with the most pronounced degenerative changes at the L5-S1 level. The degenerative changes were pre-existing and not related to her injury. However, Dr. Chabot noted that the medical records failed to document a clear history of pre-existing back pain or SI dysfunction. As such, Dr. Chabot opined that Petitioner's present diagnoses of chronic back pain, chronic SI dysfunction, and history of back strain were related to her work injury of April 17, 2010. RX5; PX1, Dep PX3.

The next record of Petitioner seeking medical treatment was October 1, 2013, when she returned to Dr. Yazdi. She had continued complaints of the same left-sided lower back pain that radiated down her left leg, through the lateral thigh and calf to the ankle. She had some numbness in the left lateral foot. She reported her pain level fluctuated at 5-9/10 in severity and was worse with any activity. The only thing that seemed to help was use of heating pads. It was noted she had gone through quite a bit of conservative care without help, and the only option was a dorsal column stimulator trial, but she had been unable to proceed with that. On examination, Petitioner was slow to stand up, she limped, and she used a cane. Her posture was slightly flexed

at the hip. Her left leg was very weak and limited by pain. She had decreased sensation in the left lateral thigh and foot, but the rest of her motor and sensory exams were intact. With regard to treatment, Dr. Yazdi noted Petitioner continued to complain of severe and chronic pain; however, he did not have anything to offer her for treatment except the stimulator trial. PX2, Dep. PX2; RX4.

Dr. Yazdi testified by way of deposition on February 28, 2014. He is a Board Certified Neurosurgeon, licensed in Illinois and New Jersey. Dr. Yazdi testified Petitioner was referred to him by a chiropractor, Dr. Peck. He testified consistent with his treating records. PX2.

Dr. Yazdi first saw Petitioner on November 2, 2010. He testified he performed an examination and reviewed her MRI of May 5, 2010 and her CT myelogram. The Arbitrator notes that Petitioner's CT myelogram did not take place until December 7, 2011, more than a year after Dr. Yazdi's initial examination. Dr. Yazdi testified that both the MRI and the CT myelogram showed disc degeneration at L5-S1 and some arthritic changes in the facet. He referred Petitioner for facet blocks, which she had. She returned on January 26, 2011, and reported she got a lot better after each facet block for about a week. She was not limping as bad, but she still had numbness. Dr. Yazdi then recommended radiofrequency ablation (RFA), which burns the nerve endings and gives pain relief for six to twelve months. Petitioner had the RFA and returned to Dr. Yazdi on May 24, 2011. She reported the RFA did not help, and in fact made her worse. Dr. Yazdi wanted to try a different injection, an epidural with Neurontin added. He testified he was "just searching", to try to maximize the nonsurgical issues. Dr. Yazdi explained that Neurontin is actually a medication for seizures but that it works better for neuropathic pain, as it calms the nerves. He testified he was trying to avoid surgery, but contemplated surgery at L5-S1, as that was the only place he saw that was bad on Petitioner's films. PX2.

Dr. Yazdi next saw Petitioner on July 13, 2011, and she continued to have a lot of back pain going down her leg at that time. The Neurontin had helped but not enough, and he talked with Petitioner about a fusion at L5-S1. Two weeks later he talked with Petitioner on the phone regarding the denial letter for the proposed surgery, and at that time he recommended proceeding with a lumbar discogram. Dr. Yazdi testified the insurance carrier ultimately approved the discogram, but required Petitioner to undergo a psych evaluation first. PX2.

The discogram was performed, and Dr. Yazdi testified that it "did not show us what we expected". It showed a much more diffuse area of pain involvement, not just L5-S1, and every disc that was tested was positive. Dr. Yazdi explained that the purpose of a discogram is to test the disc from the inside, and to show the location of the abnormality that is causing the functional disability. During a discogram a needle is put inside a number of discs, some presumably normal or "good" discs. The discs are tested by putting pressure on the inside to simulate as if the patient was standing up, to see which disc causes pain. With Petitioner, it was thought that he L5-S1 was the disc level involved, and so the three discs above that were the controls. Dr. Yazdi testified it would be a good test to proceed with a fusion if those three normal discs did not elicit pain, and only the L5-S1 disc elicited pain, which would be referred to as a positive test result. That is what he expected to see on Petitioner's discogram; however, she was positive on all four levels. At L2-3 she said the pain was similar to her regular pain and was 8/10 severity. At L3-4 she said the pain was her normal pain that radiated down her low back to

her left leg and was 8/10 severity. At L4-5 and L5-S1 she said the pain was the same as the worst pain going down her back into her leg and was 9/10 severity. PX2.

Dr. Yazdi testified that the second part of the discogram involves injecting Lidocaine into the area near the disc to see if it helps decrease the pain that was caused by the first injection. With Petitioner, she had no change in her significant pain at L2-3 and L3-4. She had a 30% decrease in pain at L4-5 and a 50% decrease in pain at L5-S1, which Dr. Yazdi characterized as good. He testified he was concerned about the controls with the discogram, as they should have been good and should not have caused pain, or the Lidocaine should have gotten rid of the pain. Dr. Yazdi testified Petitioner had everything positive, yet it was not a positive test, and therefore he would not proceed with a fusion. PX2.

Dr. Yazdi testified that the discogram told him that Petitioner either had diffuse pain or that she was extremely sensitive to pain. It did not tell him how he could fix her pain by just operating at L5-S1, which was the only main anatomical problem he saw. He noted Petitioner did have tears at multiple levels, but testified that most surgeons do not operate on just tears, and that it caused him to pull back to try and think of something else. He testified again that he was very concerned about the way the controls turned out and did not want to do a fusion. A multi-level fusion would not get Petitioner out of pain and the probability of success with such a surgery was less than 50 percent. PX2.

At that time, on December 14, 2011, he recommended a dorsal column stimulator because it worked differently. Dr. Yazdi explained it does not matter where the pain is coming from as much, because the stimulation causes a short-circuit in the nerve pathways where the pain fibers are that make a person feel pain. The pain fibers that carry the pain sensation from your body to your brain are turned down to a level where the patient can feel some pain but not as much, and so can become a lot more functional. PX2.

Dr. Yazdi next saw Petitioner on February 1, 2012, at which time he recommended a functional capacity evaluation be done by an occupational therapist, to determine what Petitioner's limitations were. Petitioner had the FCE, and Dr. Yazdi testified that the results told him Petitioner could not really do much. He noted the testing stopped because Petitioner was in too much pain to participate, that the FCE was inconclusive as to any light duty capabilities, and that she was not capable of performing her normal job. PX2.

Petitioner's final visit with Dr. Yazdi was October 1, 2013. At that time she still had horrible back pain which went down the leg, numbness in her left lateral foot, and weakness, and still used the cane. PX2.

Dr. Yazdi testified that throughout her treatment, Petitioner was pretty consistent with where her pain was. Specifically, she had pain in the lower left back, left hip, left thigh, left calf, and left foot. He testified she also had numbness down in her left foot. The pain in the lateral aspect of her leg was the typical distribution of the L4-5 level. He testified that Petitioner's reported level of pain was also pretty consistent throughout her treatment, having been described as severe, significant, and ranging from 5/10 to 10/10. He further testified that Petitioner was

consistent in her ability to walk, her limping, and her reliance on a cane. There was only one instance when Petitioner was not as bad, which was after the first facet block. PX2.

Dr. Yazdi testified that his final diagnosis of Petitioner's low back problem was chronic pain, based on the nearly four years of pain she had experienced. He could not call it discogenic pain because the discogram did not prove that. He also could not call it facet pain because the RFA did not work. Petitioner simply had chronic pain. He testified that the discogram did not help in diagnosing Petitioner as it usually proves that a certain disc is the problem, and she had diffuse pain everywhere. Dr. Yazdi could not testify that annulus tears caused discogenic pain, and stated that the data on that was "murky". His belief was that the tears are probably a lot more common and do not always cause pain. PX2.

Dr. Yazdi testified that Petitioner's current chronic low back pain was causally related to her work accident of April 17, 2010. He noted she did not have the pain before, had an acute onset of pain, and had pain afterwards. At Petitioner's final examination, she was in pain, limping, and using a cane. Dr. Yazdi testified she was in so much pain that he could not get a very good motor exam on the left leg. He opined that her condition was probably going to be permanent if nothing else was done. Besides a dorsal column stimulator, the only other treatment could be a morphine pump, but he did not believe Petitioner would be a candidate for that. The dorsal column stimulator would block the pain. There would be a trial done first, which would last five to seven days. The patient would need to have at least 50 percent pain reduction for it to be a good trial. A permanent implant would not be done without the trial. Dr. Yazdi recommended the trial, and if it worked he would recommend a permanent implant. He testified he had not done the trial because it had not been approved by the insurance company. He did not believe it was prudent to operate on three or four levels of the lower back for pain only. He testified Petitioner was at maximum medical improvement, not because she was healed, but rather because there is nothing else that can be done that would be allowed by the insurance company. PX2.

Dr. Yazdi testified he had an understanding of Petitioner's job as a home care attendant, and he did not believe Petitioner was able to work in that capacity. His opinion was based on seeing her. He noted Petitioner could barely walk, and could not lift anyone, as would be required. Dr. Yazdi opined that Petitioner's pain had lasted almost four years and that he did not see any reason why it would change in the future. PX2.

Dr. Yazdi was asked to explain the significance of the FCE notation that Petitioner scored four out of five positive on the Waddell's test. He testified he does not personally use that test, but he knows that physical medicine and rehab doctors do. He explained it was a way of trying to figure out who is more sensitive to pain or not. Some people are less sensitive to pain and more pain tolerant, while others are minimally pain tolerant. Someone with a higher Waddell test is minimally pain tolerant. Dr. Yazdi testified that does not mean the person is faking it, it just says that their brain perceives a lot of pain any time they have any pain. Petitioner had a high score, which meant she had a very low tolerance for pain. PX2.

Dr. Yazdi testified he last saw Petitioner four months prior and as of that time she could not work. He opined that nothing had changed between 2010 and 2013, and if her symptoms do not change going forward, she would not be able to go back to work. PX2.

On cross-examination, Dr. Yazdi confirmed he had not examined Petitioner prior to November 2010 and had not reviewed any of her prior medical records. His opinions with regard to her condition or problems or lack of pain prior to November 2, 2010, were based on what Petitioner had told him. Dr. Yazdi confirmed he reviewed the actual films for the MRI and post discogram CT scan, and the reports of the discogram. He agreed that the findings on those tests were all findings that could be associated with degenerative/arthritic changes, that the degenerative changes were present before Petitioner's work accident, and that they were not caused by the accident. PX2.

Dr. Yazdi acknowledged that Petitioner's body mass index was 42.5, which was considered morbidly obese. He was asked whether an obese person with back pain could alleviate some or all of their back pain if they lost weight. Dr. Yazdi testified that in most cases he deals with, including Petitioner's, by the time the person is injured losing weight will not reverse the injury. Reducing the stress on the back with weight loss may or may not alleviate some of the back pain. Dr. Yazdi testified he has had patients who lose 100 pounds but continue to have back pain. PX2.

With regard to objective findings, Dr. Yazdi testified that the only test done on Petitioner that was functional was the discogram, which showed pain everywhere. He explained the CT, CT myelogram, and MRI were all anatomical tests that did not show function. His examinations of Petitioner showed objective findings of weakness and numbness. He conceded that he noted no atrophy on Petitioner, but testified that atrophy would not be expected if a patient were walking around a little here or there, versus being bed bound. PX2.

Dr. Yazdi acknowledged that his treatment spanned from November 2010 until February 2012. He testified that as of February 2012 he was at a loss as to what else to do, as he was not allowed to proceed with anything else. He acknowledged that there was a gap between February 1, 2012, and October 1, 2013, when he did not see Petitioner. His notes did not reflect why she returned at that point. His notes also did not reflect the results of Petitioner's psych evaluation and he had no independent recollection of what it said. PX2.

Dr. Yazdi agreed that during the FCE Petitioner did some of the intake process but did not actually perform any of the tests. He testified she sat there for almost an hour and a half, which he understood to actually be one of the tests, that being how long a person can sit before needing assistance out of the chair. Dr. Yazdi conceded that what Petitioner said with regard to her pain or demonstrated with regard to her ability was controlled by her, and that there was no way to independently know whether that was an accurate statement of her condition. Dr. Yazdi agreed that the pain scale was a simplistic way of trying to explain what the person perceives their pain to be. He used the scale over a span of time, to compare a patient's perceived pain at one visit as compared to the last. If a patient said their pain was nine out of ten (9/10), Dr. Yazdi testified that was an indication of how bad their pain was, because it was their perception of how

bad their pain was. He testified that pain was a perception, so a person's perceived level of pain is their actual level of pain. PX2.

Dr. Yazdi testified he relies on FCE's when determining whether a patient is able to work, unable to work, or able to work with restrictions. He disagreed that Waddell's is a test that is used to determine whether a person has symptom magnification, in that each person perceives pain differently. He does not use the test personally, but is aware of others who do. PX2.

Dr. Yazdi testified that his understanding was that Petitioner had been working and performing her job tasks prior to the accident. He further testified that the accident aggravated her pre-existing condition at L5-S1 but also injured "that whole region". He was not aware of nor presented with any medical records prior to Petitioner's date of accident indicating a previous history of back issues. The general population over the age of 25 has degeneration but most are asymptomatic. With regard to Petitioner, Dr. Yazdi testified that if she was working and not complaining of pain prior to the accident, she was asymptomatic despite having degeneration in her back at the L5-S1 level. In addition to aggravating that level, Petitioner had pain at multiple levels, all over the left side of her spine. He testified that her pain was not at one specific area that he could do surgery on and fix. PX2.

Dr. Yazdi acknowledged he sees a lot of patients with degenerative back pain, and that some of them have pain as a result of trauma and some have it just because of the advancing degenerative arthritic changes and may have simply woken up one morning in pain. PX2.

On December 15, 2014, Petitioner presented for an initial examination with Dr. Matthew Gornet of The Orthopedic Center of St. Louis. Dr. Gornet noted she had been referred to him by Dr. Nancy Birner, her medical doctor. The Arbitrator notes, however, that medical records in evidence from Dr. Birner do not contain information with regard to such a referral. Petitioner complained of low back pain to the left side, left buttock and hip, down the left leg to her ankle, with a burning pain down her left leg to her foot. She related her problem began on April 17, 2010, and gave a consistent history of the work accident. She brought with her over 400 pages of medical records for review, including the MRI and CT myelogram reports. Dr. Gornet noted they did not include the actual images. Petitioner reported constant pain and denied any intervening slips, falls, or trauma. She reported she had been taking at least four Vicodin per day, although Dr. Gornet noted the website was inconclusive regarding this. She reported her symptoms were constant, worse with prolonged sitting, walking, or standing, and better with lying on her right side. PX1, Dep. PX2.

On examination, Dr. Gornet noted Petitioner was obese and ambulated with a cane. She motioned her pain was in the low back, buttock and hip, and down her left leg. She had decreased EHL, ankle dorsiflexion, and plantar flexion on the left. Sensation was decreased to L5 and S1 dermatomes on the left. PX1, Dep. PX2.

Dr. Gornet reviewed medical records and commented on several, including Dr. Chabot's reports of September 9, 2011, and August 6, 2012. Lumbar x-rays taken that day revealed a subtle scoliosis. They also showed "obvious collapse and loss of disc height of L5-S1 with foraminal narrowing". The only imaging tool available for review was the discogram of

December 7, 2011, which showed relatively normal facets at L3-4 and L2-3. At the L4-5 level it showed mild facet changes on the right, but not on the left. At L5-S1 there was definite foraminal narrowing and facet narrowing, causing severe foraminal stenosis. PX2, Dep. PX2.

Dr. Gornet opined that Petitioner had "clear pathology that could be the source of her current pain and complaints at L5-S1". He asked her to obtain the previous MRI films and previous CT myelogram. He recommended a new MRI, and noted she may require a new CT myelogram. Depending on the results, consideration could be given to a simple foraminal decompression. He requested Petitioner wean off narcotics. Based on his review of the medical records and objective studies, Dr. Gornet opined that Petitioner's current symptoms were causally related to her work injury, and that she may have suffered a disc injury as well as an aggravation of her foraminal stenosis at L5-S1. He noted "her work status remains unchanged", but did not give any specifics in that regard. He opined Petitioner had obvious findings on films that were potentially amenable to a simple decompression, which had not previously been offered to her, and as such she was not at maximum medical improvement. PX2, Dep. PX2.

On December 17, 2014, Petitioner was re-evaluated by Dr. Chabot, at Respondent's request. Dr. Chabot summarized his previous two examinations and reports before noting Petitioner's updated verbal history. She related she had not been further evaluated by Dr. Yazdi, since he left the local area, and that she saw Dr. Birner occasionally to obtain medications to moderate her symptoms. She stated her attorney had referred her to Dr. Gornet, who she had seen a few days prior, and was to follow up with him in February 2015. She also related she had applied for Social Security Disability but had not accrued a sufficient amount of employment time to qualify. She added that her husband was employed. RX5.

Petitioner complained of low back pain radiating into her left lower extremity and numbness in her left foot which caused trouble walking. She ambulated with the use of a cane. She related her husband had to help her with daily care needs, including showering and dressing. Dr. Chabot noted Dr. Yazdi last saw Petitioner on October 1, 2013, and his record reflected he had nothing further to offer except for a dorsal column stimulator trial. It was noted Petitioner had not worked since her accident of April 17, 2010. Dr. Chabot noted, "She has been treated for an emotional/psychiatric disorder...She has undergone ECT treatment." The Arbitrator notes Petitioner disputed this statement in her testimony. The Arbitrator further notes that Dr. Chabot's prior report of August 6, 2012, stated, "She states that she has never been treated for an emotional/psychiatric disorder." It is unclear whether the report of December 17, 2014, is incorrect, or whether Petitioner's psychiatric status did in fact change. RX5.

Dr. Chabot noted that Petitioner's son was present during the examination. Petitioner moved about the room in a cautious manner. She got out of the chair and onto the examination table with the assistance of a cane. It was noted that her son removed her socks. She ambulated with a mild limp, favoring the left lower extremity, and could heal and toe stand with the use of her cane. It was noted that range of motion of the cervical spine was reduced in all directions. Hip log roll testing was negative, hip range of motion was full, and Fabere's test was negative. There was mild bilateral hamstring tightness. With regard to the lumbar spine, Petitioner had forward flexion to 70 degrees with the use of her cane, extension to 20 degrees, and side bending to 35 degrees. Her lower extremity neurologic exam showed decreased sensation involving the

left anterior and lateral thigh, left lateral calf, left dorsal foot, and left lateral foot. There was slightly diminished left EHL strength. Reflexes were symmetric and straight leg raise testing was negative. RX5.

Dr. Chabot's impressions were chronic back pain, disc degeneration, history of back strain, and SI joint degeneration. His conclusions remained unchanged from his prior reports. He opined that Petitioner's perceived level of subjective complaint had a poor correlation with her prior diagnostic studies. He further opined that there was a significant degree of symptom magnification/embellishment. He noted Petitioner's response to the discogram revealed 10/10 provocation of pain at all four lumbar levels tested. In addition, her physical examination revealed inconsistencies that suggested underlying psychosocial issues versus symptom embellishment/magnification were playing a role in her perceived disability and general physical condition. His opinion was unchanged that Petitioner had reached MMI, was in no need of further medical treatment, and was not a candidate for surgical intervention. He opined that Petitioner could return to work with restrictions of no lifting over 20 pounds and no repetitive bending and twisting. RX5.

On February 23, 2015, Petitioner returned to Dr. Gornet for an updated MRI and follow-up examination. The MRI was taken at MRI Partners of Chesterfield and reviewed by Dr. Gornet. He indicated the MRI revealed some collapsing of the disc at L5-S1, particularly on the left side, with Modic changes and an annular tear, as well as foraminal stenosis at L5-S1 left. The MRI also showed a central disc herniation at L3-4. Dr. Gornet compared the updated MRI to the MRI of May 5, 2010. He noted the previous film showed a central annular tear at L5-S1 but no significant disc pathology at L3-4. It also showed facet changes and a facet cyst on the left L5-S1, as well as the central annular tear, which resulted in foraminal stenosis. Based on the comparison, Dr. Gornet opined that Petitioner clearly had a disc injury at L5-S1, which was the main source of pain in her buttock, left hip, and left leg, as well as the burning down her left leg to her foot. He further opined that the findings at L3-4 were not part of her work-related issue, as there was no significant pathology present at that level on her first MRI. PX1, Dep. PX2.

Given Petitioner's previous failed conservative care, Dr. Gornet opined that her option in treatment was a spinal fusion at L5-S1, performed anteriorly/posteriorly, with a decompression posteriorly on the left at L5-S1. He opined that Petitioner's current symptoms were causally connected to her work accident, which was consistent with her other treating physicians. He stated Petitioner would have to be weaned off all narcotics prior to any treatment. Dr. Gornet opined that he could improve Petitioner's medical condition, thought not make it perfect, and that she would require some level of permanent restrictions. PX1, Dep. PX2.

Petitioner followed up with Dr. Gornet on May 21, 2015, and reported she had weaned off all narcotics since her last visit. She continued to have pain in her low back, left buttock, left hip, and left leg, and reported that it affected all aspects of her life. Dr. Gornet continued to recommend an AP fusion at L5-S1, which he related to Petitioner's accident, and opined that a delay in care may affect her overall outcome. Petitioner's exam was unchanged, and she was unable to work. She returned to Dr. Gornet on August 24, 2015, with continued pain in the back, buttock, and hip. She reported that she felt her pain was getting worse and that it continued to

affect her quality of life. Dr. Gornet continued to recommend an AP fusion at L5-S1, and related it to Petitioner's work accident. PX1, Dep. PX2.

Dr. Gornet testified by way of deposition on September 14, 2015. He is a Board Certified Orthopedic Surgeon and is licensed in Missouri. He testified Petitioner brought 400 pages of medical records with her to the initial examination, and brought prior studies with her to the next visit. Dr. Gornet testified consistent with his treating records. PX1.

Dr. Gornet testified that the main findings on Petitioner's first examination were decreased EHL, ankle dorsiflexion, and plantar flexion on the left at 4 to 4 minus over 5, as well as decreased sensation of L5-S1 dermatome left. His general impression, based on the medical records, previous tests, and x-rays taken that day, was there was clear pathology at L5-S1 which was consistent with her findings on examination and with her pain complaints. He opined Petitioner had suffered a disc injury at L5-S1 and an aggravation of her preexisting foraminal stenosis. She was not at maximum medical improvement and would benefit from further treatment. PX1.

Dr. Gornet recommended a new MRI, which was done on February 23, 2015. He testified the new MRI revealed collapsing of the disc at L5-S1, particularly on the left, with Modic changes and an annular tear. There was also foraminal stenosis on the left L5-S1. The MRI also showed a central herniation at L3-4, which was not present on the previous MRI of May 5, 2010. Dr. Gornet testified Petitioner had a disc injury at L5-S1 and that it was the main source of the pain in her back, buttock, hip, and left leg. The findings at L3-4 were not related to her work accident. Her disc pathology at L5-S1 objectively correlated with her subjective physical complaints. He opined that Petitioner's work accident, as she described, caused her injury and requirement for treatment. PX1.

Dr. Gornet recommended spinal fusion at L5-S1 and a decompression on the left at L5-S1, which he opined was reasonable and necessary to cure or relieve the effects of Petitioner's injury. He indicated Petitioner would have to wean off narcotics. He opined surgery could improve Petitioner's function and that she would then be able to work at some level, but that she would require permanent restrictions. She was currently temporarily totally disabled from work, and Dr. Gornet opined that without further treatment she would be incapable of work. PX1.

On cross-examination, Dr. Gornet acknowledged that the records Petitioner brought with her to the initial visit were summarized and provided by her attorney, and presented to him at that visit. He had not discussed her case with any of Petitioner's prior treating physicians. PX1.

Dr. Gornet testified Petitioner sustained an annular tear at L5-S1 in the accident, and also aggravated preexisting foraminal stenosis at that level. He opined that the combination of the two things was causing her pain and burning in the left buttock and leg. Dr. Gornet testified an annular tear is not the same thing as a herniation, which Petitioner also had. He explained that an annular tear is a tear in the ring of the disc. It is possible to have a tear in the annulus without a significant disc nucleus coming through the ring. Dr. Gornet agreed that the herniation at Petitioner's L3-4 disc was not related to the work accident of April 17, 2010. PX1.

Dr. Gornet testified that even with surgery Petitioner would have some permanent restrictions, which he anticipated would be between a sedentary level and a moderate level, with a 25 pound limit and no repetitive bending. He opined she would not be able to work full duty. He testified he is recommending surgery to improve Petitioner's quality of life and to move her from being disabled to functioning at a better level. PX1.

Dr. Gornet testified that Petitioner had a structural injury to the disc and disc mechanism, and that she had clear disc pathology on the MRI which correlated to her symptoms. He opined that the recommended surgery would not only help her radicular pain, but would also substantially help her back pain. He testified the goal with surgery was not to cure her of all her symptoms, as Petitioner is 59 years old, but rather to improve her symptoms and bring her to a more functional level. PX1.

Dr. Gornet agreed that a patient's motivation to recover was significant in the nature and extent of recovery post surgery. He believed patients who are more motivated do better with surgery than those who are less motivated. Dr. Gornet did not necessarily agree that someone who already thinks they are permanently disabled is less motivated to recover, as that would not speak to future motivation. Dr. Gornet acknowledged that the first time he saw Petitioner was more than four years after her work accident, and that he had no knowledge of her activities during that period of time. PX1.

When asked if the type of injury Petitioner had could be caused without a significant trauma, Dr. Gornet testified that the majority of his patients have some causal connection between their condition and an event in their life, where they placed a mechanical load on their back which caused the structure to fail. He estimated that less than five percent of his patients did not recall any event at all. With regard to the mechanical load, he testified a disc injury could result from anything that exceeded what the disc could handle. With regard to Petitioner, her description of assisting a patient while moving generally requires a bending and applied load. PX1.

Dr. Gornet testified that he believed Petitioner's delay in treatment had a known deleterious effect. He testified that delay in treatment has a significant effect and is probably the number one factor that overall determines outcome. He opined that did not mean Petitioner could not improve her condition, but it may impact how far she improves. PX1.

On February 3, 2016, Dr. Chabot authored a report after reviewing Petitioner's updated MRI of February 23, 2015. He noted the following findings on the MRI: (1) multi-level disc degeneration with disc desiccation throughout the lumbar spine; (2) L2-3 disc desiccation and minimal bulge; (3) L3-4 broad disc bulging asymmetric to the right, facet degeneration, and mild right neuroforaminal narrowing; (4) L4-5 broad disc space bulging with mild facet degeneration, and no evidence of a focal disc herniation or neural compression; and (5) L5-S1 disc space height loss and asymmetric bulging to the left, with no disc herniation. RX5.

Dr. Chabot again reviewed Petitioner's prior MRI of May 5, 2010, and noted the following findings: (1) disc desiccation at L3-4, L4-5, and L5-S1, and to a lesser extent at L2-3; (2) L3-4 minimal bulging and facet degeneration left greater than right, with no herniation or

annular tear; (3) L5-S1 minute annular tear centrally with bulging and degeneration, as well as facet degeneration left greater than right; (4) no evidence of acute changes or significant neural compression. RX5.

Dr. Chabot compared the findings of the 2010 MRI with those of the 2015 MRI and noted the following: (1) the disc space height was better in 2010, suggesting interval changes in the interim; (2) the L3-4 level in 2015 had more pronounced disc bulging asymmetric to the right, suggesting significant progression of degenerative disease at that level. RX5.

Dr. Chabot also discussed the post-discogram CT of December 7, 2011, which suggested evidence of a left lateral protrusion at L5-S1. He noted the radiologist did not have the benefit of reviewing the prior lumbar CT, which showed calcification of the annulus at L5-S1 central and to the left, extending into the left neural foramina. Dr. Chabot opined it would be very easy to misconstrue the increased signal from the calcified disc as evidence of a dye material extending to the left lateral margins of the disc space at L5-S1. Dr. Chabot also noted that Petitioner had positive provocative responses at 10/10 to all four lumbar levels, L2 through S1. As such, it could not be used as a diagnostic tool, as no control level was determined. RX5.

Dr. Chabot concluded that after reviewing the recent 2015 MRI, there appeared to be significant advanced degenerative disease with more pronounced disc bulging at L3-4 and more significant degenerative disease at L5-S1. His continued opinion was that Petitioner was a poor surgical candidate, as the origin of her back complaints was poorly defined. RX5.

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.

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of her employment on April 17, 201, and that she injured her low back as a result.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally connected to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994). Liability cannot be premised upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

It is the function of the Commission to judge the credibility of witnesses, draw reasonable inferences from the testimony, and determine the weight the evidence is to be given. *Caterpillar Tractor Co. v. Industrial Comm'n*, 124 Ill.App.3d 650, 653 (4th Dist. 1984).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that her current low back condition is causally related to her work accident of April 17, 2010. In so concluding, the Arbitrator finds significant the exhaustive treatment rendered by Dr. Wilkey and Dr. Yazdi, the opinions of Dr. Wilkey, Dr. Yazdi, and Dr. Chabot that they could not explain Petitioner's severe complaints of pain, the concern of physicians regarding symptom magnification, gaps in treatment, and the Arbitrator's own observations and impressions.

It is undisputed that Petitioner sustained a compensable accident which caused an injury to her low back. She sought medical attention within two days of the accident at Red Bud Regional Hospital, and followed up with her primary physician Dr. Birner the following week. Dr. Birner administered shots of Toradol on April 23, 2010, and May 11, 2010, which Petitioner reported did not help. After obtaining an MRI, Dr. Birner referred Petitioner to Dr. Wilkey, an orthopedic surgeon. Petitioner's history of the accident and her complaints were consistent.

Dr. Wilkey administered epidural steroid injections on May 21, 2010, and June 4, 2010, which Petitioner reported did not help. Dr. Wilkey made several notations in his records regarding a lack of explanation of Petitioner's reported complaints. On June 18, 2010, he noted, "Ms. Holley is perplexing me." She reported she had gotten no benefit from either epidural steroid injection he had administered, yet he noted she described fairly classic left leg radiculopathy, which the injections should have addressed. On July 6, 2010, Petitioner reported soreness in her back, left buttock, and left leg, as well as diffuse weakness. Dr. Wilkey noted, however, that the EMG studies were negative and that he could not isolate a specific motor group that was weak. Petitioner reported her main problem was back pain, and Dr. Wilkey noted, "I have no specific reason for this from the MRI study."

In an effort to explain her complaints, Dr. Wilkey ordered a CT myelogram, which found moderate left-sided foraminal narrowing due to osteophytes at left L5-S1. Due to continued complaints, he administered a trigger point injection into the SI joint on July 16, 2010. When Petitioner returned to Dr. Wilkey on July 30, 2010, however, she reported no relief of symptoms from the SI injection. Dr. Wilkey noted, "Ms. Holley is getting difficult for me to understand." He reported she had moderate stenosis at L5-S1, which could cause her leg radiculitis, yet her EMG was normal. He noted Petitioner's physical therapist reported she did not think she could help Petitioner. Dr. Wilkey stated he himself was "at a loss for what to do", other than send her to another physician. He referred Petitioner to Dr. Randall for a second opinion, yet Petitioner testified she did not see Dr. Randall and instead started treating with a chiropractor, Dr. Peck.

The Arbitrator finds it significant that Petitioner switched her treatment from an orthopedic surgeon who could not explain her complaints to a chiropractor who began manipulations, acupuncture, and the like. The Arbitrator further finds it significant that Petitioner's first visit with Dr. Peck was July 30, 2010, and that by August 19, 2010, three weeks later, Dr. Peck had already issued a certification for Petitioner to obtain a "Disabled" parking placard and that he marked that her disability was "permanent". This was only four months after Petitioner's accident. Even Dr. Peck, however, noted Petitioner's unexplained lack of progress and referred her to Dr. Yazdi, a neurosurgeon.

Similar to Dr. Wilkey and Dr. Peck, Dr. Yazdi noted a lack of explanation of Petitioner's reported complaints. At Petitioner's initial evaluation, Dr. Yazdi noted she had undergone several injections, physical therapy, and chiropractic treatment, and still reported constant severe pain. His impression was significant low back pain with left leg radiculopathy and he recommended bilateral L5-S1 facet blocks. He noted if the injections did not work he had "nothing else to offer" Petitioner.

Petitioner had the facet blocks and reported to Dr. Yazdi that they helped and that she was significantly better. Dr. Yazdi recommended radiofrequency ablations to further improve Petitioner's condition. Interestingly Petitioner called his office about a week later and reported her pain had returned to an 8/10 severity. She had the ablations, which she said caused extreme pain, for which she had to get an SI joint injection. Dr. Yazdi again noted he did not know why Petitioner was having the pain she was reporting, and ordered an epidural block with Neurontin. He indicated "the only option left" after that was a fusion at L5-S1.

Petitioner reported the epidural block did not help. Surgery was recommended but was denied, and Dr. Yazdi noted it would be prudent to get a lumbar discogram to solidify his opinion regarding surgery. Dr. Chabot agreed the discogram was reasonable, but recommended Petitioner undergo psychological testing prior to the procedure, which she did. Dr. Horowitz reported that Petitioner's BHI-2 profile "presented some paradoxical findings". She indicated she had unrelenting pain, yet also indicated she had absolutely no distress. Dr. Horowitz opined it was incongruent that she would have disabling pain for a year and a half, yet have no psychological distress. He went on to state that if Petitioner's perception of her limitations and her experience of pain exceeded what would be expected based on objective findings, that "she may have gravitated toward being totally disabled, even if she is not". The Arbitrator again notes that four months after the accident Dr. Peck had already characterized Petitioner as being "permanently disabled" when certifying her for a parking placard. Dr. Horowitz also stated that Petitioner would do best with pain management if she was required to be actively engaged in the process. The Arbitrator notes that the record is void of Petitioner being so engaged.

Petitioner underwent a four-level discography, which Dr. Yazdi testified "did not show us what we expected", in that Petitioner reported pain everywhere, and as a result there were no good controls. He expressed a great deal of concern with this and testified that, based on the discogram, operating at the L5-S1 level would not fix Petitioner's pain. He further testified that a multi-level fusion would not relieve Petitioner's pain and that the probability of success with such a surgery was less than 50 percent.

On August 6, 2012, Dr. Chabot also expressed concerns with Petitioner's symptom magnification, noting several things. Her reported level of pain was 10/10, "excruciating", and had essentially not changed since the day of the accident nearly a year and a half earlier. He noted the discogram results and Petitioner's performance at the FCE as further documentation of symptom magnification. Dr. Chabot also expressed concern with inconsistencies in Petitioner's examination. She stated she could not actively complete range of motion testing, yet she sat at 90 degrees for a period of time in a chair and on the exam table. Her neurologic exam revealed sensory changes in the left leg that did not follow any specific dermatomal pattern, and her diagnostic studies showed no neurologic compromise.

In addition to the lack of medical explanation for Petitioner's extreme pain and the evidence of symptom magnification, the Arbitrator finds significant the very large gaps in time during which Petitioner sought no medical treatment. Petitioner presented to Dr. Yazdi on February 1, 2012, and then not again until October 1, 2013, a gap of 20 months. She then did not present to any physician until December 15, 2014, when she saw Dr. Gornet 14 months later. In a period of 34 months, nearly three years, Petitioner saw her treating physician on only two occasions. The Arbitrator finds this significant and finds it inconsistent with Petitioner's complaints and testimony regarding her pain.

The Arbitrator also finds significant Petitioner's presentation and testimony at trial. She and her attorney took great issue with Dr. Chabot's second examination and report of August 6, 2012, in an attempt to discredit Dr. Chabot and his findings. She testified that both her husband and her son were in the examination room, and they attempted to help her get up out of the chair. Dr. Chabot's report makes no indication of either their presence or their assistance. Conversely, in his report of December 17, 2014, Dr. Chabot noted that Petitioner's son was present during the examination, and noted that he removed her socks. The Arbitrator notes it is customary for physicians to record the presence of others when they attend an examination with a patient, particularly when it is an independent medical evaluation. The fact that Dr. Chabot did so on December 17 would evidence his practice to so record when others attend.

Petitioner also testified that during the examination of August 6, 2012, Dr. Chabot did not do any testing and did not even lay hands on her. Dr. Chabot's report certainly contradicts these statements and, in fact, documents that on examination Petitioner had tension involving the bilateral paraspinal musculature, which was a positive finding. The Arbitrator finds significant Dr. Chabot's report that when Petitioner was asked to actively forward flex and to actively extend and to actively side bend, she stated she was unable to do so and declined to try.

Petitioner and her attorney also sought to discredit Dr. Chabot by pointing out his reference to a record from "Dr. Imdad", whom Petitioner had never heard of. In fact, as detailed in the Arbitrator's Findings of Fact, the record referred to was a nurse's note authored by Faria Imdad, in Dr. Yazdi's office. While the title of "Doctor" was incorrect, the contents of that note were not misstated or misconstrued by Dr. Chabot.

Petitioner and her attorney further sought to discredit Dr. Chabot with regard to his statement of December 17, 2014, that Petitioner had been treated for an emotional/psychiatric disorder. As detailed in the Arbitrator's Findings of Fact, it is unclear whether this statement is incorrect, or whether Petitioner's psychiatric status had changed. As such, the Arbitrator gives no weight to this statement, and does not discount Dr. Chabot's findings as a result thereof.

Petitioner and her attorney also questioned Dr. Chabot's statement of August 6, 2012, that Petitioner told him she "may take 1 (Vicodin) tablet per month" and that her prescription was from December 2011. Petitioner denied ever saying this, and testified that prior to Dr. Gornet's instruction on December 15, 2014, to wean off the Vicodin she was taking four to six tablets a day. She did not testify, however, as to who prescribed the Vicodin, and the record is void with regard to any physician prescribing Vicodin on an ongoing basis. The Arbitrator also

notes that there are no bills for prescriptions either in Respondent's exhibit of paid bills or in Petitioner's exhibit of unpaid bills. In addition, Dr. Gornet stated on December 15, 2014, that, although Petitioner reported she was taking at least four Vicodin a day, "the website was inconclusive regarding this". In that narcotic prescriptions are required to be recorded on the website, the Arbitrator finds this "inconclusive" finding to be suspect and very significant. The Arbitrator finds it impossible to reconcile Petitioner's claim of taking four to six pills a day with the lack of any record of prescriptions being filled on a regular basis. Given that lack of record, Dr. Chabot's report of August 6, 2012, appears accurate and credible on the issue, and Petitioner's testimony does not.

In light of the overwhelming medical evidence, the Arbitrator questions the veracity of Petitioner's complaints with regard to the severity and extent of her pain and the amount of disability it seems to cause her. The Arbitrator does not question that Petitioner believes she is in pain, that she is completely disabled, and that she needs surgery. The medical evidence, however, does not support her beliefs. The Arbitrator also finds compelling the fact that Petitioner is not eligible for Social Security Disability benefits, and therefore has incentive to maximize her worker's compensation claim.

Petitioner has undergone a multitude of tests, injections, and procedures. Dr. Wilkey, an orthopedic surgeon, saw her six times in two months and could not find any objective medical reason for her extreme pain and symptoms. Dr. Yazdi, a neurosurgeon, treated her for two years and could not find any objective medical reason for her extreme pain and symptoms. He ultimately diagnosed her with chronic pain and testified that surgery would not fix the pain and probability of success with surgery was less than 50 percent. The only physician calling for surgery is Dr. Gornet, who first saw Petitioner four and a half years after her work accident, and who recommended surgery at her initial examination.

The Arbitrator is not persuaded by the opinions of Dr. Gornet or by Petitioner's testimony. Rather, the Arbitrator finds the reverberation of medical opinions of Dr. Wilkey, Dr. Horowitz, Dr. Yazdi, and Dr. Chabot to be compelling and persuasive.

The Arbitrator finds Petitioner reached maximum medical improvement on August 6, 2012, that being the date of Dr. Chabot's evaluation and his declaration of MMI. Petitioner has failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her work accident of April 17, 2010.

In support of the Arbitrator's decision relating to issue (G), Petitioner's earnings, the Arbitrator finds the following:

Pursuant to Section 10 of the Act, overtime is to be excluded in calculating an employee's average weekly. Overtime hours include 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 Worker's Compensation Comm'n*, 372 Ill.App.3d 549, 554 (1st Dist. 2007).

The Arbitrator finds in the year preceding the April 17, 2010, injury, Petitioner earned $14,472.01 in regular earnings, for an average weekly wage of $295.35. In so concluding, the Arbitrator notes that both parties submitted into evidence the same Wage Statement. PX3, RX6. The Wage Statement included both regular hours and overtime hours over a 52 week period. There was no evidence introduced to show that overtime was mandatory for Petitioner, and the record reflects that she did not work overtime consistently or in a majority of the weeks worked. Her overtime earnings, therefore, are excluded from the calculation of her average weekly wage. In addition, weeks 31 and 45 are excluded as Petitioner did not work during those weeks. Week 52 is excluded as it was the week of Petitioner's accident and the only day she worked during that period was the day she was injured. For weeks 1 through 26 Petitioner's regular earnings were $7,928.01. For weeks 27 through 52 her regular earnings were $6,544.00. Her total regular earnings for 49 weeks were $14,472.01, which yields an average weekly wage of $295.35.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

The parties stipulated that the only outstanding medical bill in dispute was that of Dr. Peck at Back & Neck Pain Center. The outstanding balance was $7,095.00 for dates of service July 30, 2010, through February 17, 2011.

The Arbitrator finds that Dr. Peck's treatment from July 30, 2010, through November 2, 2010, was reasonable and necessary in Petitioner's care and treatment relative to her accident of April 17, 2010. The Arbitrator recognizes that Utilization Review non-certified treatment beyond September 20, 2010, and that it does not appear Dr. Peck appealed the non-certification. The Arbitrator also recognizes, however, that when Dr. Peck referred Petitioner to Dr. Yazdi, she was unable to be evaluated by Dr. Yazdi until November 2, 2010. The Arbitrator finds it was reasonable for Petitioner to continue under Dr. Peck's care until such time as care was taken over by Dr. Yazdi on November 2, 2010.

The Arbitrator finds that Respondent is liable for outstanding medical bills as set forth in Petitioner's Exhibit 5 for dates of service July 30, 2010, through and including November 2, 2010, in the amount of $4,315.00, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

In light of the Arbitrator's finding above with respect to issue (F), and having found that Petitioner was at maximum medical improvement on August 6, 2012, the Arbitrator finds that Respondent is not liable for medical bills after that date. Specifically, Respondent is not liable

for medical bills from Dr. Matthew Gornet/The Orthopedic Center of St. Louis or MRI Partners of Chesterfield.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care for her lumbar spine.

In support of the Arbitrator's decision relating to issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In light of the Arbitrator's finding above with respect to issue (F), and having found that Petitioner was at maximum medical improvement on August 6, 2012, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits beyond that date. The Arbitrator recognizes that Dr. Chabot, in finding Petitioner at MMI, believed it was reasonable to place restrictions on her work of no lifting over 20 pounds and no repetitive bending or twisting. While the FCE report and Petitioner's testimony regarding her work duties indicates her job likely did not fall within those restrictions, there is no evidence that Petitioner ever attempted to contact Respondent regarding work availability and no evidence that she ever attempted to find another minimum wage job within those restrictions.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from April 18, 2010, through August 6, 2012, a total of 120 2/7 weeks. Having previously found that Petitioner's average weekly wage is $295.35, the Arbitrator finds Petitioner's temporary total disability rate is $245.33, the statutory minimum in effect at the time of her injury. Respondent is liable for temporary total disability benefits of $29,509.69 and is entitled to credit for amounts previously paid.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Beverly Dewitt,
Petitioner,

vs. No: 12 WC 15752

Kelly Services,
Respondent.

17IWCC0635

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

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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 12, 2016, is hereby affirmed and adopted.

17IWCC0635

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.

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: OCT 11 2017

Joshua D. Luskin

o-10/03/17
jdl-wj

68

Charles J. DeVriendt

Kevin W. Lamborn

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

DEWITT, BEVERLY
Employee/Petitioner

Case# 12WC015752

KELLY SERVICES
Employer/Respondent

17IWCC0635

On 5/12/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2674 BRADY CONNOLLY & MASUDA PC
NOAH HAMANN
211 LANDMARK DR SUITE C-2
NORMAL, IL 61761

STATE OF ILLINOIS)
)SS.
COUNTY OF MCCLEAN)

☐ 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)

BEVERLY DEWITT,
Employee/Petitioner

v.

KELLY SERVICES,
Employer/Respondent

Case # 12 WC 15752

Consolidated cases: _____

17IWCC0635

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **4/20/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/14/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$9,017.44**; the average weekly wage was **$396.97**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left hand that arose out of and in the course of her employment by respondent on 3/14/12.

The petitioner's claim for compensation is denied

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

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

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

Signature of Arbitrator

5/6/16
Date

ICArbDec19(b)

MAY 12 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 47 year old staffing agency employee for Kelly Services, alleges she sustained an accidental injury to her left hand that arose out of and in the course of her temporary employment by respondent while working at Kerry Sweet Ingredients on 3/14/12. Petitioner had bilateral carpal tunnel syndrome in 2002.

Petitioner was hired by Kelly Services, a staffing agency in August of 2011. On 8/9/11 petitioner signed an Employee Handbook Acknowledgement form. It stated upon other things that the petitioner specifically understood and agreed that "If injured at work, I will immediately notify both the customer supervisor and Kelly." (RX3) Petitioner agreed that she signed this sheet, but denied that she put an "X" next to any of the items. She claims that it must have been done by someone else. Petitioner testified that although she signed the form she is not sure she read it in its entirety.

On 10/11/11 petitioner was placed by respondent at Kerry Sweet Ingredients as an assembly line employee. Although petitioner was an employee of Kelly Services, she was assigned temporary employment with Kerry Sweet Ingredients. Petitioner had supervisors at both Kelly Services and Kerry Sweet Ingredients, that she reported to. Petitioner's supervisors with Kerry Sweet Ingredients were Mike Ruble and Gavin Rushey. For Quality she reported to Carla and Kathy, and for Safety she reported to Doug Cox. She also testified that there were numerous line leads and operator she worked with at Kerry Sweet Ingredients.

Petitioner testified that after she began working for Kerry Sweet Ingredients, she never filled out any paperwork for Kelly Service. However, after her progress reports and wage increases were determined by Kerry Sweet Ingredients, Kerry Sweet Ingredients would provide this information to Kelly Services and Kelly Services would call her and discuss these progress reports and wage increases with her. Petitioner underwent a half day orientation at Kelly Services when she was first hired.

While working for Kerry Sweet Ingredients, at times petitioner's checks from Kelly Services did not come on time. She would report this to her supervisors at Kerry Sweet Ingredients and they would contact Kelly Services. Petitioner testified that if she had any issues while working for Kerry Sweet Ingredients she would report them to her supervisors at Kerry Sweet Ingredients.

While employed as a temporary employee for Kerry Sweet Ingredients petitioner performed many different duties on several different lines. Petitioner worked several different lines, but was a "boxer" on most lines. Petitioner would fill boxes that weighed 10 to 500 pounds. While on the boxing line she

would get a box, place the product under the "product shoot" to fill the box, test the product to make sure it contained no metal, seal the bag and box, and send it down the conveyor belt. Every day petitioner used her left hand in some capacity from pushing a button to working on a 700 pound line. Petitioner only worked the 700 pound line for a short time before asking to be moved to a different line.

Petitioner testified that her duties varied depending on which line she worked. Petitioner worked on a lot of different lines and each line dealt with a different product. On each line in the boxing area petitioner would push a button, measure cereal puff, and bag the product. Petitioner moved constantly around the plant from line to line.

From 3/14/12 until May of 2012 petitioner was not pushing boxes on a day to day basis. She would only push boxes if something was stuck. Petitioner would lift boxes and place them on a pallet. Petitioner could fill a pallet in about an hour.

On 3/14/12, petitioner was working on line 3 or line 1. Her duties that day were moving boxes weighing 500 pounds or more. She would place the box under the product shoot and fill it with the necessary amount of product. She would then test it for metal, seal the bag, and then send it down the conveyor belt. After the box was filled and sealed and moving along the conveyor belt it would come up to a 90 degree turn and go to the forklift operator. This was the 90 degree angle where the box did not always turn correctly. If the box got stuck she would yell for help from other operators or forklift drivers so that she could get the box turned at the angle properly. She would have to shove the box from a 45 degree angle to the 90 degree angle. Petitioner reported problems with this all day on 3/14/12.

After lunch on 3/14/12, after dealing with problems with the boxes properly turning 90 degrees around the angle, petitioner had soreness in her left wrist and hand. She put an ice pack on it. Petitioner continued working the rest of the day and when Carla from quality came over to her line she reported the injury to her.

When petitioner got home that night she noted that it was swollen. She took Ibuprofen. Overnight her symptoms worsened and she put an ACE bandage on it the next day when she went to work. She thought she had a strain or sprain.

On 3/15/12 petitioner worked all day with the ACE bandage on. During the day she stuffed ice packs in the ACE bandage. Petitioner worked a different line this day. Petitioner testified that Carla approached her on 3/15/12 and asked her how she was doing. She also testified that Mike Ruble, her supervisor, asked her how she was at lunch. She testified that she told him that she thought she sprained

it. After lunch on 3/15/12, she reported the injury to Gavin. Despite reporting her injury to all these supervisors, she testified that not one of them told her that she needed to give notice to Kelly Services. Petitioner testified that she reported the injury, per Kerry Sweet Ingredients protocols. Petitioner testified that she understood that she was to report her injuries to Kerry Sweet Ingredients. She testified that she did not know she was to report them to Kelly Services. At no time did petitioner report her injuries to Kelly Services.

Over time petitioner's left wrist did not improve. On 3/27/12 she presented to Dr. Swink at OSF Medical Group. She complained of left wrist pain for one month. She also reported decreased range of motion. Dr. Swink examined petitioner and assessed left wrist pain. Dr. Swink ordered an x-ray of the left wrist, and prescribed ibuprofen. Petitioner was also instructed to ice. The results of the x-rays were that no acute traumatic skeletal abnormality indentified.

On or about 4/8/12 petitioner alleged that she reported her injury of 3/14/12 to Cox. She reported that she injured her left wrist while trying to push boxes weighing up to 500 pounds that were stuck on the conveyor belt. She reported that she was doing it by herself because no one was available to assist her. She stated that she was trying to move the stuck box before the product dropped into the next box. She testified that sometimes the forklift operator would come running up to help her and had to rip open the box to move it. Petitioner testified that she believed Cox's demeanor appeared as if he was just blowing off the accident. She testified that she felt he thought it was a joke and appeared to be happy that the injury happened while she was still a temporary employee with Kelly Services and not a full time employee of Kerry Sweet Ingredients.

On 4/15/12 petitioner's temporary employment with Kerry Sweet Ingredients ended. On 4/16/12 she transitioned from a temporary employee to a full time employee of Kerry Sweet Ingredients. Petitioner testified that in November of 2011 Ruble came to her and told her that Kerry Sweet Ingredients that they wanted to hire her but were going through some management changes, so it would have to wait until this process was over. She testified that Ruble told her they would hire her later.

On 4/19/12 petitioner returned to Dr. Swink's office with complaints of left wrist/hand pain and left hand numbness. Dr. Swink examined petitioner and assessed left wrist pain and hand numbness. Dr. Swink ordered an EMG. He also prescribed hydrocodone. Dr. Swink noted that he was sending petitioner for an evaluation because her symptoms pointed to another nerve entrapment. He gave petitioner a splint. Dr. Swink did not authorize petitioner off work.

On 5/1/12 petitioner presented to Dr. Bryne Willey, a chiropractor. She complained of constant, left-sided, sharp/stabbing pain, tingling, numbness, weakness, restriction in the wrist that began on 3/14/12. She reported that the condition caused radiation of pain to the left elbow. She rated her pain at a 5/10. She reported that the application of ice, resting and pain medication helps her condition. Petitioner reported that she had missed work as a result of her condition. She claimed her condition was work-related. Petitioner reported that she works on a factory line and was pushing boxes weighing hundreds of pounds. The boxes were not being assembled properly, and were getting stuck on her line throughout the day. She stated that her and her co-worker were pushing them down the line all day, with her wrists being forced into hyperextension under load all day. She did not feel a specific point of pain that day, but the onset of pain did not seriously begin until the following day after some mild soreness that night. She noted that she tried to work through the pain, but it became too much for her to bear, and has limited her since. She reported that her activities of daily living are affected by carrying items, computer use, cooking, household chores, lifting, reaching, sleep, washing body, work, and yard work.

On 5/4/12 petitioner filed her original Application for Adjustment of Claim. The respondent was identified as Kerry Sweet Ingredients. The accident date was identified as 3/14/12. She indicated that the accident occurred while she was pushing boxes on a conveyor. She alleged injuries to her back, left hand, and whole person. Petitioner signed this Application on 4/25/12.

On 5/11/12 Dr. Willey placed petitioner at sedentary activity as of 5/25/12.

On or about 5/15/12, after working with restrictions for about a week, petitioner's temp job with Kerry Sweet Ingredients ended. Petitioner testified that Will Trainor told her that Irene in Safety told him to walk her to the time clock, and have her clock out. He also told her there was no light duty available for her.

Petitioner followed up with Dr. Willey 12 times through 6/6/12. On 5/4/12 she reported that she worked 8 hours the day before and had to leave because of the intensity of her pain. On 6/6/12 petitioner rated the left-sided pain, tingling, stiffness in the wrists at a 4-5/10. She told Dr. Willey that she felt she was benefiting from chiropractic care. She felt her range of motion was much better than when she started. She felt like the pain was localized more to the posterior wrist instead of from the entire forearm down. Dr. Willey was of the opinion that petitioner's condition appeared to be responding slowly but consistently.

On 6/26/12 petitioner underwent an EMG/NCS performed by Dr. Edward Trudeau. Petitioner gave a history of being injured in the course of working on 3/14/12. The results revealed moderately severe carpal tunnel syndrome at the left wrist; no evidence of left ulnar neuropathy; no evidence of left posterior interosseous neuropathy; no evidence of other entrapment neuropathy, cervical radiculopathy brachial plexopathy.

On 8/2/12 petitioner presented to Dr. Oakey for her left wrist pain. She reported that she had been working for Kerry Foods in March 2012, where she had been for two months, and a portion of her job was aligning heavy boxes on a conveyor belt that were getting stuck and she had to do a lot of forcing, as she pantomined with her left wrist in extended position and the elbow extended. She began after that date to notice more and more pain associated with swelling that radiated up to the forearm and radiated over to the CMC joint on the left thumb. She stated that this was associated with substantial swelling, and a little bit of tingling in her small and ring finger distribution as well. Following an examination and x-rays Dr. Oakey's impression was that the most likely area of symptomatology and pain generator was the TFCC of her left wrist. He also believed she may also have some irritation of her ulnar nerve causing tingling from either the swelling or from a cyst. Dr. Oakey was of the opinion that the findings on the EMG could be a remnant of her old carpal tunnel syndrome. He diagnosed left ulnar sided wrist pain. He prescribed a therapy fabricated wrist splint to replace the one she was wearing. He restricted her to one pound of lifting with the left upper extremity. He ordered an MRI of the left wrist with a diagnosis of TFCC tear. He believed the injury he was treating her for was causally related to the injury she described as having at work.

On 10/22/12 petitioner was seen by Dr. Swink. She made no complaints regarding her left wrist. She was seen for unrelated problems.

On 10/31/12 petitioner underwent an MRI of the left wrist. The impression was findings of moderate ulnolunate impingement with marked cartilage loss, subchondral degenerative cysts, bone edema and sclerosis of the lunate proximally and ulnarly. Also noted was moderate fraying of the central TFCC, partial thickness and small area of full-thickness cartilage loss of the distal radius ulnarly.

On 11/5/12 petitioner filed an Amended Application for Adjustment of Claim. On this amended Application for Adjustment of Claim, petitioner changed the respondent's name from Kerry Sweet Ingredients to Kelly Services. No other changes were made.

On 11/12/12 petitioner followed-up with Dr. Oakey. She reported that her pain was present in the ulnar aspect of the wrist, radiating proximally and distally along the ulna, and associated with some tenderness in the thenar block and in the middle finger having pain that radiates without frank catching and clocking. Dr. Oakey examined petitioner and reviewed the results of the MRI. He recommended conservative treatment that included an injection into the left wrist, that he did that day. He continued her restrictions.

On 11/27/12 there was a Status Change Form in petitioner's personnel file that indicated that petitioner was on a leave of absence effective 11/27/12. (RX2)

On 12/10/12 petitioner returned to Dr. Oakey. She reported that the injection made things worse transiently and was not helpful in alleviating her symptoms. She reported pain in the left ulnar aspect of her wrist that radiated proximally along the course of the ulna, as well as distally. It was associated with some occasional tingling in the middle and ring fingers. Following an examination Dr. Oakey assessed a left wrist TFCC tear with ulnar carpal abutement. He recommended a left wrist arthroscopy with TFCC debridement and ulnar wafer resection.

On 2/4/13 Petitioner followed-up with Dr. Oakey for her left wrist. She reported that her left wrist continued to bother her, more on the ulnar aspect. She stated that the pain was not constant. Following an examination Dr. Oakey was of the opinion that she may have a little bit of irritation of the ulnar nerve at the elbow, but certainly nothing that he would advocate treating. He was of the opinion a wrist arthroscopy was going to go a long way towards getting her better use of the left upper extremity which was going to allow other issues to sort themselves out. Dr. Oakey kept petitioner on her work restrictions.

On 11/21/14 the evidence deposition of Dr. Oakey was taken on behalf of the petitioner. Dr. Oakey was of the opinion that a TFCC tear can occur either through an individual trauma or through a series of wear and tear type activities. Dr. Oakey testified that her injection could be diagnostic and therapeutic in that if she had aggravation from hitting the boxes in March, that an injection can get rid of inflammation and put her back to her preexisting state. Dr. Oakey opined that the injury, TFCC tear, ulnar carpal abutment for which he was treating her, is causally connected to the work situation she described at her initial visit. He further opined that the work restrictions were necessitated because of the workplace injury.

On cross-examination Dr. Oakey stated that he did not have any idea how much the boxes petitioner was moving when she was allegedly injured weighed. However, he further stated that they were heavy enough. When asked what he defined as heavy he stated "that would be more than one pound and less than a thousand". Dr. Oakey also had no knowledge as to how petitioner was moving her wrist when the alleged injury occurred. Dr. Oakey was of the opinion that petitioner either had a preexisting ulnar carpal abutment, TFCC tear that became symptomatic with this injury, or she had an acute tear of her TFCC with the injury she described. He was of the opinion that something acute happened on that day, or she kind of permanently aggravated a preexisting condition. He stated that either way, on 3/14/12, her pain began. Dr. Oakey did not review the records of Dr. Swink. Dr. Oakey testified that if the pain started in February as opposed to March 2012 that would be inconsistent with the history petitioner provided.

When asked how quickly the symptoms arise when somebody injures themselves under the scenario petitioner provided, Dr. Oakey was of the opinion that it can vary. He stated that sometimes people will have an injury, and then the swelling does not come on and they don't really notice the pain until a couple days later. Dr. Oakey opined that typically people will notice a difference within a day or two.

On redirect examination Dr. Oakey testified that the reason he put the range of heavy at one pound to thousands is because what he would consider a heavy box, relative to how much petitioner lifts, is important for how much force she had to impart on it.

On 2/19/16 petitioner returned to Dr. Oakey. This was her first visit since 2/4/13. She was still complaining of left wrist problems. Petitioner reported a moderate achy pain at the ulnar aspect of the wrist for the several years. She stated that it extended from a work injury. She reported good and bad days with constant mild pain aggravated with moderate to severe without any specific provocative. She stated that a brace and anti-inflammatories are radically helpful in relieving her symptoms. She also related some ring and middle finger tingling on the left. X-rays of the left wrist were taken that showed no fracture, no dislocation, joint spaces well preserved, and normal alignment. Also noted was ulnar positive wrist with assistant lunate consistent with ulnocarpal abutment. Dr. Oakey was of the opinion that the MRI from 10/31/12 suggested ulnar lunate impingement with fraying of the TFCC that was consistent with ongoing symptoms from ulnocarpal abutment and a TFCC tear. He was of the opinion that she had failed conservative measures, and her EMG previously did not suggest an etiology of the ring and middle finger tingling. For her wrist pain, Dr. Oakey discussed arthroscopy with TFCC debridement and ulnar wafer procedure. He reiterated that the injury he was treating her for was casually connected to the injury she described having at work.

Respondent offered into evidence a Time Detail Sheet for petitioner from 4/11/12-7/14/15. Also included was a letter to petitioner dated 3/3/14 from Katie Thiele, Human Resource Manager. (RX2). Petitioner was marked as unpaid/absent on 4/19/12, 5/12/12, 5/21/12, 5/22/12, 5/25/12, 5/30/12, 5/31/12, It was noted that as Thiele was in the process of going through records, she came across a letter that petitioner had received 5/24/12, indicating that she would be terminated upon her accumulation of 7 points per the attendance policy. She indicated that petitioner received points for the 4/19/12 (leave early - .5 pts); 5/3/12 (leave early - .5 pts); 5/16/12, 5/17/12, 5/21/12, 5/25/12, 5/26/12, 5/27/12 (absent - 1 pt each). It was noted that petitioner last worked on 5/15/12 for record keeping purposes, and the notice was confirmation of her termination date of 5/27/12. Petitioner was told that if she had any questions regarding her benefit termination she could reach out to Kerry HR Service Center.

Currently, petitioner testified that her left wrist is not very good. She testified that she can no longer lift anything over a pound with her left wrist.

Petitioner testified that she started looking for alternate employment in August of 2012 at several places. She testified that she kept a record of 5 places a week for a year, while she received unemployment. After her unemployment was terminated she did not keep any records of her job searches. Petitioner testified that she received unemployment from August of 2012 through August 2013. She stated that the last job she applied for was at Baird Optical in Pontiac, IL in the fall of 2015. Petitioner has sought no employment since fall 2015 because she was tired of being rejected. Petitioner testified that she was denied employment because they told her she was a liability and if she hurt her left wrist again, it would be on them.

Petitioner testified that she would like to undergo the surgery recommended by Dr. Oakey. Petitioner testified that if her wrist is repaired she has no desire to return to full duty work at this time because she is in nursing school. She is only interested in part time duty. She also testified that she took some time off because she was helping her son with his custody case.

Jahan Melton, District Manager for Kelly Services, was called as a witness on behalf of respondent. She testified that she has worked for respondent for 15 years, and has been the District Manager for Kelly Services in Bloomington for the past 10 years. Her duties include handling operations, recruiting, sales and customer service.

Melton testified that all employees are given a handbook when they have a face to face meeting. The 15-20 page handbook contains procedures and policies regarding injury or harassment, payroll and

benefits. She testified that all employees are instructed to report absences, issues and concerns, and accidents. She also reported that all employees undergo safety training, watch a video, and are instructed to report all accidents and incidents to Kelly Services, whether they are minor or major.

Melton testified that petitioner underwent training at Kerry Sweet Ingredients as part of her orientation. Since Kerry Sweet Ingredients was an important client, Melton participated in their orientation. She testified that if an employee of Kelly Services is injured they must report the injury to Kelly Services. She admitted that Kerry Sweet Ingredients was also supposed to report the injury of any Kelly Services employee to Kelly Services, but that did not always happen.

Petitioner denied that she was not trained by Kelly Services regarding reporting accidents. However, when confronted with an orientation sheet that indicates she was told about reporting injuries to Kelly Services, she stated that she signed the form, but never placed any "X" next to each item listed on the sheet. Melton had no recollection of specific orientation with petitioner. In fact, Jordan Ackman, staffing supervisor, was the one that signed the list that petitioner signed. (RX3) Melton testified that at the end of the week of training, she reviews the employees files to make sure all paperwork is completed and entered into the system. She did the audit of petitioner's paperwork and noted that she signed the form that listed she had been instructed on how to report an injury.

Melton testified that Kerry Sweet Ingredients did not notify Kelly Services of petitioner's injury on 3/14/12. Melton testified that Kelly Services first found out about petitioner's injury when she got the Application for Adjustment of Claim in the mail in January 2014. The original Application for Adjustment of Claim was originally filed on 5/4/12, with Kerry Sweet Ingredients identified as the respondent. On 11/5/12 the Application was amended and the respondent was changed to Kelly Services.

Melton testified that she would visit Kerry Sweet Ingredients work site on a monthly basis and talk with the Human Resource Manager to see how things are going with the employees, and check on their performance face to face, or on the phone. Melton testified that she had these meetings while petitioner was working at Kerry Sweet Ingredients.

Melton testified that there was a customer service agreement between Kelly Services and Kerry Sweet Ingredients on 3/14/12 stating that Kerry Sweet Ingredients should report any injuries of Kelly Service employees to Kelly Services and part of the practice is to indemnify Kerry Sweet Ingredients for injuries of Kelly Services employees.

On 5/24/13 the deposition of Dr. Oakey was taken on behalf of petitioner. The respondent was identified as Kelly Services. The respondent attorney that presented for the deposition was Jasmani Francis from Keefe, Campbell and Associates. However, Keefe, Campbell and Associates were not the attorney of record for Kelly Services, but were the attorney of record for Kerry Sweet Ingredients. This deposition is being offered for the sole purpose of showing that Keefe, Campbell and Associates represented Kerry Sweet Ingredients.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner claims she sustained an accidental injury to her left hand that arose out of and in the course of her employment by respondent on 3/14/12. Petitioner was given temporary employment at Kerry Sweet Ingredients on 10/11/11 as an assembly line employee. Petitioner had supervisors at both Kelly Services and Kerry Sweet Ingredients that she reported to. Her supervisors at Kerry Sweet Ingredients were Mike Ruble, and Gavin Rushey. For Quality she reported to Carla and Kathy, and for Safety she reported to Doug Cox. She also testified that there were numerous line leads and operators she worked with at Kerry Sweet Ingredients.

Petitioner testified that while she was working as a temporary employee for Kerry Sweet Ingredients she performed many different duties on several different lines, but was mainly a "boxer" on most lines. Petitioner testified that she would fill boxes that weighed from 10 to 500 pounds. Petitioner testified that on each day she would use her left hand in some capacity from pushing a button to working on a 700 pound line. Petitioner only worked on the 700 pound line for a short time before asking to be moved to a different line.

On 3/14/12 petitioner testified that she was not sure what line she was working on. She stated that it could have been line 1 or 3. She stated that her duties that day were moving boxes weighing 500 pounds or more. Petitioner testified that after she filled a box it would move along the conveyor belt until it hit a 90 degree turn where it was supposed to turn and continue down the conveyor belt to the forklift operator. Petitioner testified that sometimes the box did not always turn correctly at the 90 degree angle. She testified that at times the box would get stuck at the 90 degree angle and not automatically turn. When this happened she would have to shove the box from a 45 degree angle to a 90 degree angle so that it could continue along the conveyor belt.

After lunch on 3/14/12 petitioner testified that after dealing with problems with the boxes properly turning at the 90 degree angle that day her left wrist and hand were sore. She stated that she put an ice

pack on it. She stated that she continued working after lunch and at some point Carla from Quality came over to her and she stated that she reported the injury to her. Petitioner then testified that her symptoms worsened overnight and she returned to work on 3/15/12 with an ACE bandage on her left hand with ice packs shoved in, and continued working. She testified that Carla again approached her and asked her how she was doing. She also testified that Mike Ruble asked her at lunch how she was doing, and she stated that she thought she sprained her hand. Petitioner stated that after lunch she reported her injury to Gavin. Despite petitioner claiming she reported her injury to three different supervisors at Kerry Sweet Ingredients on 3/14/12 and 3/15/12, the arbitrator notes that at no time during her testimony did petitioner testify as to what she actually reported to each of these supervisors. Additionally, petitioner failed to offer into evidence any accident report for her alleged injury at work on 3/14/12. She also failed to call any of these supervisors to corroborate her testimony. Petitioner admitted that she did not report her accident to anyone at Kelly Services. Despite all these alleged reports of injury to representatives at Kerry Sweet Ingredients, petitioner continued working her regular duty job for respondent.

Additionally, petitioner did not seek any treatment for her alleged injuries until almost two weeks later on 3/27/12. On that day petitioner presented to Dr. Swink at OSF Medical Group. The only history petitioner provided was that she had left wrist pain for one month. There is no history in Dr. Swink's records that petitioner reported a work injury on 3/14/12. Petitioner testified that she reported a work accident to him, but he did not document it. However, petitioner made no effort to ask Dr. Swink to amend his report, nor did she depose Dr. Swink to address this issue. Additionally, based on the history provided to Dr. Swink, it appears that petitioner's left wrist pain was present since the end of February 2012, which would have a been a few weeks prior to the date of her alleged injury.

On or about 4/8/12 petitioner claims she reported her alleged injury to Doug Cox, who was a supervisor in the Safety Department. She claims she told Cox that she injured her left wrist while trying to push boxes weighing up to 500 pounds that were stuck on the conveyor belt by herself. Again, petitioner did not complete an accident report and did feel that it was necessary to call Doug Cox as a witness to corroborate her conversation with him on 4/8/12.

On 4/19/12 petitioner followed-up with Dr. Swink and again made no mention of any alleged work injury being the cause of her left hand problems.

On 4/25/12 petitioner had secured legal representation and signed her original Application for Adjustment of Claim alleging an accident occurred on 3/14/12 while she was pushing boxes on a conveyor.

On 5/1/12 petitioner presented to Dr. Willey, a chiropractor. This was petitioner's first visit to a healthcare provider after securing legal representation and filing her Application for Adjustment of Claim. This was also the first documented evidence of an alleged work injury on 3/14/12. Petitioner gave a history that she worked on a factory line and was pushing boxes weighing hundreds of pounds, that were getting stuck on the line throughout the day. Petitioner reported that she did not feel a specific point of pain on 3/14/12, put felt a serious onset of pain the next day after some mild soreness the night before. She stated that she and her co-worker were pushing them down the line all day, with her wrists being forced into hyperextension under load all day. The arbitrator finds it significant that petitioner did not call this co-worker as a witness to corroborate this accident history she provided Dr. Willey. Additionally, the arbitrator finds it significant that petitioner's accident history to Dr. Willey appears to be more of a injury due to repetitive work activities rather than a specific injury given the fact that she reported that she did not feel a specific point of pain on 3/14/12.

On 8/2/12 petitioner presented to Dr. Oakey. Petitioner stated that in March of 2012, after working for Kerry Sweet Ingredients for two months, she sustained an injury. The arbitrator notes that this testimony regarding her start date is inconsistent with the credible evidence that shows she started working for Kelly Sweet Ingredients on 10/11/11. Petitioner gave Dr. Oakey a history of working a job where a portion of it was aligning heavy boxes on a conveyor belt that got stuck. She reported that she had to do a lot of forcing with her left wrist in an extended position and the elbow extended. Petitioner pantomined this activity for Dr. Oakey. Petitioner stated that after that date she began to notice more and more pain associated with swelling that radiated up to the forearm and radiated over to the CMC joint on the left thumb. Petitioner did not provide a specific date or specific incident that caused her injury to Dr. Oakey. She only reported an incident in March of 2012. Dr. Oakey testified that he did not have any idea how much the boxes petitioner was moving weighed when she allegedly injured her left hand, but stated that they were heavy enough, and that heavy enough would be more than one pound and less than a thousand.

The arbitrator notes that the burden is on the petitioner to prove by a preponderance of the credible evidence all elements of her claim. In the case at bar, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained a specific accidental injury to her left hand on 3/14/12 that arose out of and in the course of her employment by respondent. The arbitrator bases this opinion on the fact that there are inconsistencies in the credible record for which petitioner did not feel it

was necessary to offer corroborating evidence, especially as it relates to her reporting her alleged injury to her supervisors and her healthcare providers before filing her claim.

Additionally, the arbitrator finds it significant that petitioner reported to Dr. Willey that she was working with a co-worker on 3/14/12 pushing boxes weighing hundreds of pounds that got stuck on the line throughout the day, but again saw no reason to call this co-worker, to corroborate the accident history she provided Dr. Willey, after she had secured legal representation and filed her Application for Adjustment of Claim.

The arbitrator finds the petitioner's testimony less that credible when she claims she reported her accident to four supervisors, Carla on 3/14/12 and 3/15/12, Doug Ruble and Gavin Rushey on 3/15/12, and Doug Cox on 4/8/12, but could offer no credible evidence to corroborate these claims other than her own testimony. Petitioner also claims she reported a specific accident to Dr. Swink on 3/27/12, despite the fact that Dr. Swink's record contain no such history. The arbitrator finds it significant that the only only evidence that corroborates petitioner's testimony with respect to her alleged accident was not provided until after she had already secured legal representation and filed her Application for Adjustment of Claim.

Although the arbitrator had questions regarding the credibility of the petitioner, these may have been resolved had petitioner been able to corroborate with credible evidence even one claim that she reported a injury to Kerry Sweet Ingredients supervisors, a co-worker, or to a healthcare provider prior to securing legal representation and filing her Application for Adjustment of Claim.

Had petitioner offered any corroborating evidence on the issue of accident prior to the date her original Application for Adjustment of Claim was filed, the arbitrator may have found the burden of proof then shifted to the respondent at that point to rebut that evidence. However, since petitioner failed to provide any credible evidence to corroborate her claim that she reported her alleged injury to four supervisors at Kerry Sweet Ingredients, to a co-worker, and to Dr. Swink, prior to securing legal representation and filing her Application for Adjustment of Claim, and there exists inconsistencies in the injury histories she provided to her healthcare providers , the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left hand that arose out of and in the course of her employment by respondent on 3/14/12.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?
F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?
L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Having found the petitioner failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left hand that arose out of and in the course of her employment by respondent on 3/14/12, the arbitrator finds the petitioner's claim for compensation is denied and these remaining issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Gibbons,

Petitioner,

vs. NO: 13 WC 6983

17IWCC0636

State of Illinois/Shawnee Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2016, is hereby affirmed and adopted.

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

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

OCT 11 2017

DATED:
TJT:yl
o 10/3/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GIBBONS, GARY
Employee/Petitioner

Case# **13WC006983**

SHAWNEE CORR CENTER/STATE OF ILLINOIS
Employer/Respondent

17IWCC0636

On 6/29/2016, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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

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

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

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

JUN 29 2016

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

17IWCC0636

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

GARY GIBBONS
Employee/Petitioner

v.

SHAWNEE CORR. CENTER / STATE OF ILLINOIS
Employer/Respondent

Case # **13** WC **06983**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **March 9, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0636

FINDINGS

On **December 30, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$58,080.00**; the average weekly wage was **$1,116.92**.

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

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

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

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

Respondent is entitled to a credit of **$any benefits paid through applicable group carrier** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove he sustained accidental injuries arising out of and in the course of his employment with the Respondent on December 30, 2012.

The Arbitrator finds that the Petitioner has failed to prove that his bilateral carpal tunnel syndrome conditions are causally related to his work duties with the Respondent.

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

June 23, 2016
Date

ICArbDec p. 2

JUN 29 2016

STATEMENT OF FACTS

The Petitioner was employed as a corrections officer at the Shawnee Correctional Center (Shawnee) from 1998 through 2011, and at its satellite facility, the Hardin County Work Camp (Hardin County), from 2011 through 2015. When the latter facility shut down on 12/31/15, he returned to Shawnee. Shawnee is a medium correctional facility.

Petitioner testified he spent approximately 85% of his time at Shawnee working as a gallery officer. The facility has a total of 15 wings with 56 cells per wing, usually with double occupancy. There are additional cells in segregation units. Petitioner testified he was, and presumably is again, responsible for two wings, so 112 cells. Wing doors are steel with older worn locks, opened using a small house-type key. His day would begin with a morning count by unlocking and locking each cell door to verify inmate presence. Every 30 minutes thereafter, an officer does a wing check, during which he does a visual cell inspection and pulls on cell doors to make sure they are locked. If he cannot see an inmate, he has to unlock and open that cell. At the end of the wing check, a padlocked log box is unlocked and relocked at each wing, and the log is documented.

An officer performs one "shakedown" every morning, involving moving and lifting a property box weighing up to 70 pounds, lifting and moving a mattress and generally searching for contraband. The Petitioner testified that he has cuffed and uncuffed inmates "quite a bit", particularly when the facility is on lockdown and inmates have to be handcuffed prior to any location movements.

Petitioner testified that 40% to 50% of his time as a wing officer was spent in segregation. In that unit, cells have chuckholes to provide or take various items, and the locks of which are operated by a Folger type key. Petitioner testified that it required force and grip to open the chuckholes because they don't work smoothly. There are no bars on the segregation doors. In a segregation unit, he testified that inmates had to be handcuffed and uncuffed for any trip to and from the showers.

When on a major Level one lockdown, a wing officer's job duties increased, as all inmate movement was cuffed. Additionally, because no inmate workers were provided, officers had to perform normal inmate duties, such as laundry, trash and meals. This occurred on average less than once per year.

The Petitioner testified that he transferred to Hardin County, a low level offender facility, following a knee surgery because the job was "more relaxed" with fewer stairs and was easier on his knee. It is a "dormitory" type facility, with three units and 15 to 20 inmates per room. His job title remained correctional officer, 90% of this as a wing officer. He would still perform a daily shakedown. There are no cell bars or segregation units at Hardin County. Petitioner testified that inmate road crews went out daily. He would fill out paperwork, then open the doors to his wing and let the inmates out. Petitioner testified the inmates would be locked back up at 9:30 a.m. for another count, and at 11 a.m. they would be locked up and released one wing at a time for chow. After chow was over, the inmates were let back out into the yard. Another count would be performed at 2:30 p.m.

The Petitioner testified that at Hardin County some locks would open pretty easy, but some would need to be manipulated or he would need to try different keys to try to open such locks. Petitioner testified this happened more so at Hardin County Work Camp than Shawnee Correctional Center. Petitioner testified he has to qualify once a year with firearms, and he practices when he can.

Petitioner estimated that during his employ with the Respondent he turned hundreds of thousands of keys, opened hundreds of thousands of doors, and opened thousands of chuckholes.

Petitioner began experiencing symptoms in his hands and arms while performing his job duties at Hardin County. He testified that his hands would cramp up and tingle.

Petitioner called Respondent's witness, Terry Grissom, a shift supervisor at Shawnee. He testified that he had been Petitioner's direct supervisor, that the Petitioner is a good employee, and that he heard the Petitioner's testimony regarding the job duties and believed it to be accurate.

The Petitioner testified that on 12/30/12 he went to complete an inmate count. He testified: "I stuck the key in, had the clipboard tucked under my arm, and I put the key in the door. And just as soon as I kind of had to jerk the key a little bit, and I opened the door, and it's just – my hand just locked up, and I had a – just a real shooting, burning pain from right in the palm of my hand, center of my hand, up to my elbow. And I mean, I just dropped the keys and everything." He had no prior difficulties with that particular door lock. He was able to get the door open using his other hand, but he had difficulty gripping and on and off pain in the left hand the rest of the day. The Petitioner testified that he is left handed, and so always turned keys with that hand. The only thing he did right-handed was handwriting.

He reported the incident and completed an incident report. (Px10). The report states: "On the above date & approx. time r/o Gibbons was locking doors in Unit 1 (illegible) when this officer lost feeling in left hand and pain go up left forearm to elbow." The copy of this report submitted by Respondent (Rx5) has additional handwriting indicating Major Marshall was notified by phone, that Petitioner was given a workers compensation packet, and that he stated he would follow up with his personal physician when possible, noting he then completed his shift.

On cross-examination, Petitioner testified that he had worked in multiple correctional officer positions at Shawnee besides wing or gallery officer, including outside patrol, control room, yard, and tower, and that his job had varied throughout the years. The wing doors at Shawnee use a key that is similar in size to a standard house key and the doors swing open on hinges. In his first 13 years at Shawnee he was mostly on the 7 a.m. to 3 p.m. shift. Petitioner testified that he would perform two counts on that shift, each taking about 30 to 40 minutes. He would only have to open a cell door on wing checks if he couldn't see an inmate. He would unlock a lock box padlock once per wing check to access the log book, and the key was similar to that of a standard house key. A Folgers-Adams key is only used in segregation and the cage door in health care. Inmates in segregation would be cuffed to go to the showers, and he believed they showered twice a week during the second shift, 3 p.m. to 11 p.m. The last time he had been assigned to segregation as part of his normal rotation was probably in 2008, and he was on the midnight shift. Segregation was the only area with chuckholes. Petitioner testified he did not perform any bar rapping at Shawnee or Hardin County.

At Hardin County, there were three units. Unit One had four rooms, Unit Two had five rooms, and Unit Three had five rooms, and there were approximately 15 to 20 inmates per room. To perform an inmate count there, he would handle one unit, so there would be four or five doors that he opened/unlocked and closed/relocked. The keys at Hardin County similar to a standard house key, and there were no Folger-Adams keys at Hardin County.

Petitioner suffers from hypertension and diabetes, and he takes medication for both. He has diabetic neuropathy symptoms in his feet and takes Neurontin for the pain and numbness, which he said helped "a little bit sometimes." As to whether he had such diabetic symptoms in his hands and wrists, he testified: "Not that I've been told I've had any kind of -- I've never really had any problems."

Petitioner testified that he had recently undergone gastric bypass surgery and prior to that weighed 315 pounds. He uses insulin for diabetes, and had a toe amputated due to diabetic problems. He has smoked about a pack of cigarettes a day for 25 years. He has coronary artery disease and has undergone multiple stent placement procedures. Petitioner testified that he suffers from hypertension. His hobbies include hunting, fishing, and woodworking, and when he woodworks he uses manual hand tools and power tools.

Petitioner testified that he was a volunteer firefighter from 1995 to 2015, which involves using a high pressure water hose, and that the amount of time he worked as a volunteer firefighter would vary.

The Petitioner testified that he did not have elbow problems while working at Shawnee or Hardin County. He learned of his elbow problems when he saw Dr. Young.

The Petitioner eventually sought treatment, initially with Dr. Knight, his family doctor. (Px3). The initial report in the record is dated 4/2/13, but indicates the Petitioner was there for follow up of previous treatment. An EMG/NCV test was obtained by Dr. Guyton on referral from Dr. Knight on 3/25/13. (Px5). The report notes a history of pain and numbness in his hands and arms with reduced grip strength, and references the 12/30/12 incident (dating it to 12/31/12) as: "he was trying to unlock a door when his hand 'drew up'. He has had significant problem with his left hand and no problem with his right hand." Dr. Guyton reported that the testing reflected carpal tunnel syndrome affecting both the motor and sensory components, slowing of the ulnar nerve across the right elbow, and a superimposed peripheral neuropathy in both upper extremities affecting both the motor and sensory stimulations. (Px5). The 4/2/13 assessment noted left sided wrist symptoms, but only diagnosed right carpal and cubital tunnel. The Petitioner was referred to orthopedic surgeon Dr. Davis. (Px3).

The Petitioner saw orthopedic surgeon Dr. Young, indicating this was on referral from Dr. Knight, on 4/16/13. The Petitioner reported numbness and tingling in the bilateral extremities, with some pain into the hand area, on the right since December 2012 and on the left since March 2013. The Petitioner stated that he was a correctional officer and really noticed an increase in symptoms after using his keys. Dr. Young reported his exam findings and noted the NCV testing was consistent with bilateral carpal tunnel, ulnar compression at the right elbow and peripheral neuropathy in both upper extremities. Conservative splinting was recommended. (Px6). The intake form of Dr. Young's office notes the Petitioner had left sided symptoms similar to the right since 3/26/13, when he was tugging on a property box. Additional forms note Petitioner reported doing counts 4 times, locking and unlocking doors 40 times per day, and writing reports. His symptoms increased at work "when using my hands" and turning keys, and that the increase would occur after the first lock. His hobbies were noted to be hunting, fishing and woodworking. (Px6).

At a 4/30/13 follow up, Petitioner reported no improvement. Dr. Young noted that, given his diabetes, Petitioner could have a component of diabetic neuropathy in his upper extremities, and that he already had this in the lower extremities, but that he still should obtain some relief from surgery. Bilateral carpal tunnel releases and ulnar nerve transpositions were recommended. (Px6).

A 5/21/13 nurse's note from Dr. Young's office indicated that Petitioner was in his cardiologist, Dr. Le's office, complaining of chest pain, and thus that scheduled surgery had to be canceled. On 5/30/13, the Petitioner underwent cardiac testing at Memorial Hospital of Carbondale, it appears based on having symptoms of chest pain and shortness of breath. This also appears to have been part of his pre-surgical clearance process. He was noted to be 6'2" and 313 pounds. The report noted that he'd had a total of 12 to 13 stents over the years, along with high blood pressure, high cholesterol and diabetes. He had quit smoking 4 months prior. The results indicated overall low risk, but did note a small to moderate perfusion abnormality consistent with diaphragm attenuation.

On 6/3/13, Dr. Le indicated the Petitioner was sent to him for cardiac clearance, noting a history of extensive coronary artery disease with two prior heart attacks, and listed the multiple stent placements he'd undergone. He reported occasional twinge of chest tightness and shortness of breath if he overexerts himself. He had quit smoking but had gained 20 to 25 pounds in the last four months. He had been started on a nitroglycerin patch on 5/21/13 due to his report of chest discomfort. The report also noted the Petitioner had a history of Type II diabetes treated with an insulin pump. After a medication adjustment, Dr. Knight opined that the Petitioner was cleared for surgery. (Px7).

Surgery was performed on the right on 6/5/13. The report noted moderate to severe thickening of the transverse carpal ligament. Dr. Young stated that Petitioner was felt to have severe compression on the ulnar nerve deep to the ligament of Osborne, as well as the triceps fascia, and mild to moderate bulbous enlargement of the nerve in that area. (Px6). The same procedures were performed on the left upper extremity on 7/10/13, noting moderate thickening of the transverse carpal ligament, and moderate to severe pressure on the ulnar deep nerve with mild bulbous enlargement of the nerve. (Px6). The Petitioner was initially released to light duty, then on 8/31/13 to full work duties. There was no actual 8/31/13 report from that date in the record. (Px6). The Petitioner testified that he had improvement with surgery.

Dr. Sudekum evaluated the Petitioner on behalf of the Respondent on 1/9/14. (Rx9). He noted the Petitioner had worked at Shawnee for approximately 12 years, and for the past three years worked at Hardin County, as a correctional officer. The Petitioner complained of continued numbness in his left and right hands and felt he had a reduction in both hands. Dr. Sudekum noted Petitioner suffered chronic diabetic related conditions including bilateral upper and lower extremity peripheral neuropathy and chronic foot pain, with amputation of the right second toe due to chronic diabetic ulcer and osteomyelitis. Dr. Sudekum noted Petitioner had chronic conditions including morbid obesity, diabetes mellitus, coronary artery disease, hypertension, hypercholesterolemia, angina, chest pain, sleep apnea, and tobacco use disorder. He had undergone post-surgical gastric bypass surgery in December 2013. The Petitioner had full range of motion of his bilateral elbows, wrists, and fingers. X-rays of Petitioner's bilateral hands, wrists, and elbows which showed bilateral thumb CMC arthritis, right worse than left. Dr. Sudekum also performed bilateral upper extremity NCVs which showed findings indicative of chronic persistent peripheral polyneuropathy affecting the bilateral median and ulnar nerves. (Rx9).

Dr. Sudekum also reviewed job descriptions for a correctional officer at Hardin County and Shawnee, as well as a job site analysis including a video of job duties and manual tasks routinely performed by correctional officers at Shawnee (Rx9).

Dr. Sudekum noted that Petitioner had multiple significant comorbid medical conditions and risk factors for the development of carpal and cubital tunnel syndrome including chronic severe insulin-dependent diabetes mellitus, diabetic peripheral polyneuropathy, morbid obesity, neck and back problems, cervical disc disease, bilateral basilar joint arthritis, hypertension, hypercholesterolemia and coronary artery disease. He noted that these conditions would put Petitioner at an extremely high risk for the development of carpal and cubital tunnel syndrome, regardless of his work duties. (Rx9).

Dr. Sudekum reported that Petitioner's 3/25/13 NCV revealed superimposed peripheral neuropathy in both upper extremities affecting the motor and sensory stimulations. He opined this was indicative that Petitioner suffered from generalized systemic peripheral polyneuropathy secondary to diabetes mellitus. He further opined that the job activities performed by a correctional officer at either facility would not serve to cause or aggravate carpal tunnel syndrome, cubital tunnel syndrome, or upper extremity repetitive trauma injuries in general. (Rx9).

On 9/8/14, Dr. Young noted Petitioner had improvement with surgery, and while he was doing well afterwards, he still had right hand cramping and "issues" with the left hand. Dr. Young also stated: "he has seen the physician in St. Louis who stated he had no improvement. Patient states this is wrong, he has had improvement. He just still has some cramping and pain as well as some numbness." A repeat EMG/NCV was requested. (Px6).

Dr. Guyton performed repeat EMG/NCV on 10/22/14, reporting that this showed remaining mild bilateral carpal tunnel that was much improved versus 3/25/13, while the underlying peripheral neuropathy findings had not changed. (Px5).

Petitioner testified the surgery improved his condition. He missed about three months of work after surgery, then returned to work full duty, is able to perform his job satisfactorily, and has not missed any work since that time for his hands and elbows. He is not required to wear any protective devices or braces. Petitioner testified that he has had no complaints from his supervisors and his performance evaluations since his return to work has been good. He is not required to wear any protective devices or braces. Petitioner testified that he has had no complaints from his supervisors and his performance evaluations since his return to work has been good.

Petitioner testified he only experienced symptoms in his hands while performing his job duties, not in his elbows. He testified that he did not have elbow problems while working at Shawnee or Hardin County. He learned of his elbow problems when he saw Dr. Young. He doesn't feel he has any ongoing problems with the elbows. He gets an occasional shooting pain in one of his left fingers that lasts for a few seconds. He does report ongoing cramping in the right hand. The symptoms in his hands are nothing like what he has in his feet. Petitioner testified that he does not take any medication for his hands currently.

Dr. Young testified via deposition on 7/28/15. (Px12). A board certified orthopedic surgeon specializing in the upper extremity, he testified that he performs 400 to 500 surgeries per year. With regard to carpal and cubital tunnel, he indicated that there are multiple risk factors, including occupational, as well as nonoccupational. The former category includes repetitive forceful pinching and gripping, prolonged elbow flexion and prolonged wrist extension or flexion, and the use of vibratory tools. The latter category includes increasing age, obesity, diabetes, smoking, rheumatoid arthritis and low thyroid function. (Px12).

He reviewed a detailed corrections officer job description, as well as a report of Dr. Sudekum. He testified that Petitioner initially saw his assistant on 4/16/13, and Petitioner reported numbness and tingling of the bilateral upper extremities, since summer 2012 on the right and March of 2013 on the left. The pain was aching and burning, the numbness and tingling constant. He reported increased symptoms using keys in his job. He also reported that he was insulin pump dependent due to diabetes. (Px12).

He testified that diabetic neuropathy is disease of the nerve, while cubital/carpal tunnel involves nerve compression. Both can happen simultaneously. He testified: "In that instance where there is an underlying diabetic neuropathy if the peripheral compression is released the patient may not exhibit 100% improvement." (Px12, p. 12). His testimony was consistent with his records, as noted above, with regard to findings, diagnosis and treatment.

Dr. Young testified that the surgical findings of thickened carpal ligaments and compression of the ulnar nerves at the elbows were indicative of compression neuropathies, not diabetic neuropathies, noting he would not have expected such findings with diabetic neuropathy. (Px12).

Following the surgeries, the Petitioner had improvement, but not 100%, and he had lingering symptoms at a one year follow up. Dr. Young testified that this was not surprising: "The underlying peripheral neuropathy likely due to the diabetes would have created continued symptoms that persisted after the surgery." (Px12, p. 18).

The Petitioner reported that locking and unlocking doors, writing reports and driving aggravated his symptoms. Dr. Young testified: "I believe if the symptoms are worsened while performing the job duty then that would be supportive of the activity that's contributing to the compression neuropathy." (Px12, p. 20-21). When asked about whether the Petitioner's hobbies (hunting, fishing, woodworking) could be contributing factors, he testified that it was fair to say he needed more information with regard to how often he performed these activities. (Px12).

In reviewing the Petitioner's handwritten job description (Px11) and the Corvel job site analysis, Dr. Young opined that locking and unlocking doors 45 to 50 times per shift (double that with a double shift), and lifting and push/pulling if done frequently, could be contributing factors in the Petitioner's upper extremity conditions. Dr. Young continued: "I believe that the repetitive and cumulative pinching, gripping, lifting over 14.5 years has at a minimum contributed to the development of the pathology." (Px12, p. 25). He opined that a latency period could apply to the Petitioner's conditions, meaning that the pathology could develop to cause a problem, even though the symptoms have not yet manifested. He also testified that the Petitioner has a number of nonoccupational risk factors, including obesity, diabetes and age, as well as smoking if the Petitioner is, in fact, a smoker. (Px12).

With regard to Neurometric testing, as performed by Dr. Sudekum, he testified that the test evaluated nerve condition velocity, though one could potentially argue that its not quite as good as EMG/NCV testing. (Px12).

On cross-examination, Dr. Young testified that it was his understanding Petitioner locked and unlocked doors 40 times per shift, and didn't know if the Petitioner's indication in his questionnaire of opening and closing doors 15 times was included in this figure. He believed it takes less than 10 seconds to lock or unlock a door. He also had to lift and/or push/pull property boxes 1 to 2 times a day, weighing up to 50 pounds, but that it was unlikely this activity would have contributed or carpal or cubital tunnel. As to report writing, he opined that it depended on how much writing was done, but if the handwriting was less than 45 minutes of his shift, it was unlikely to be contributory. Given the Petitioner did not indicate significant cuffing and uncuffing activities, Dr. Young did not believe that such activity would impact carpal or cubital tunnel. Dr. Young testified that he did not review Petitioner's detailed job description until the month prior to the deposition. He opined that the pinching of the keys, the force required to turn them and "potentially the position at the elbow" were what contributed to the Petitioner's carpal and cubital tunnel conditions. As to the elbow, the position he was referring to was a flexed position, but he testified he didn't know what position the Petitioner's elbow was in. Given the Petitioner's statement in the questionnaire that he had symptoms immediately after turning his first lock of the day at work, Dr. Young testified that it would be hard to say with certainty, but it was likely Petitioner was experiencing symptoms while doing activities outside of work, and that symptoms immediately after one lock that was probably just exacerbating symptoms. Dr. Young defined exacerbating a symptom as something that makes the symptoms worse without contributing to the underlying pathology. Exacerbating a condition would be contributing to the development of the underlying pathology. (Px12).

All Dr. Young knew about Petitioner's job title is that he was a correctional officer, and he assumed a wing officer the majority of the time based on Petitioner's statements, but was aware that corrections officers have other assignments besides a wing. If he was in a position where there was little to no use of keys, Dr. Young testified his causation opinion could change. (Px12).

Dr. Young testified he that he had not personally been to any Illinois prison facility, didn't recall viewing a Shawnee or Hardin County work video, and hadn't turned a prison key himself. Dr. Young testified that he did not know which shift Petitioner worked or if he had any outside employment. He did not know what types of keys are used at the facilities. He did not know how often Petitioner used restraints while at work. The Petitioner did not discuss what occurred during lockdowns with Dr. Young. (Px12).

Dr. Young testified that Petitioner's post-surgical symptoms were likely due to the diabetic polyneuropathy. He testified that a variety of things could have contributed to Petitioner's compression neuropathies: obesity, diabetes, hypertension, coronary artery disease and nicotine use. He testified that Petitioner's prior cervical surgery, if it involved post-surgical right hand numbness, could contribute to the Petitioner's right hand tingling. (Px12).

With regard to the EMG/NCV findings, Dr. Young indicated that the first part of the report noted the compression component, and the superimposed peripheral neuropathy, likely due to diabetes, indicates the nerve fibers themselves had been diseased or damaged. He agreed that the Petitioner's upper extremity symptoms of pain, numbness and tingling are symptoms of diabetic neuropathy, and that Petitioner had these complaints both before and after surgery. (Px12).

As to the indication in his operative reports of thickening of the carpal ligaments and stenosis of the ligaments of Osborne, Dr. Young agreed that, given the Petitioner's other risk factors for neuropathy, "he may have developed those problems, both carpal as well as cubital tunnel syndrome, without ever having worked." He couldn't say if it was more likely than not that he would have developed the conditions without working, but he was definitely at high risk, and "it would not be surprising if he would have developed those problems." Dr. Young also was unable to say if the Petitioner's jobs as a corrections officer at Shawnee and Hardin County were significantly different or not. (Px12).

Board certified surgeon Dr. Sudekum testified via evidence deposition on 7/7/14. (Rx10). He testified that carpal tunnel syndrome is the most common peripheral neuropathy that affects the upper extremity, and cubital tunnel syndrome is the second most common. Dr. Sudekum testified that he performed a physical examination of Petitioner and reviewed medical records, job descriptions, post descriptions, a job site analysis, and job DVDs. (Rx10).

Dr. Sudekum testified that Petitioner gave a history of experiencing pain in his left hand on 12/31/12 when turning a key. He reported having experienced symptoms prior to that, but also developed cramping and numbness in his left hand. Dr. Sudekum testified that Petitioner indicated that he was pulling a property box and experienced similar symptoms on the right side. When he saw the Petitioner, he had already undergone bilateral surgeries, indicating some improvement on the left, but that he had actually worsened somewhat on the right, and continued to have numbness and tingling in his right (3^{rd} to 5^{th}) and left (2^{nd} to 4^{th}) fingers, as well as difficulties with some fine motor activities and intermittent cramping of the palms that was worse than before surgery as well. Dr. Sudekum noted that Petitioner's complicated medical history included a longstanding cardiac history involving multiple stenting procedures and two MIs, poorly controlled insulin dependent diabetes mellitus diagnosed 15 years prior, chronic diabetic peripheral polyneuropathy, right second toe amputation for treatment of chronic diabetic ulcer and osteomyelitis, cervical disc disease including c-spine surgery, two lumbar disc surgeries, morbid obesity, coronary artery disease, hypertension, hypercholesteremia, angina, sleep apnea, chest pain, and a history of tobacco use. Dr. Sudekum testified Petitioner had also undergone gastric bypass surgery six weeks prior to his examination. (Rx10).

Dr. Sudekum testified that Petitioner reported that at his job in the residential wing at Hardin County, there were five rooms on the wing he worked on and he did inmate checks where he opened and closed the doors three times per shift, locking and unlocking the doors using a standard key. Dr. Sudekum testified that Petitioner also indicated he wrote incident reports, logged inmate checks into the logbook, wrote tickets, and did minimal phone work. Dr. Sudekum testified that Petitioner worked at Hardin County for approximately three years at the time he saw him and prior to that he was a housing wing officer at Shawnee. Dr. Sudekum testified that Petitioner described his job duties at Shawnee as performing wing check every 30 minutes and logging them. Dr. Sudekum testified that Petitioner indicated that those checks did not typically involve opening and closing all the doors, but to visually identify that the inmates were where they were supposed to be in their rooms. Dr. Sudekum testified that Petitioner described his other job duties as count inmates three times a day, transferring inmates from place to place within the facility and occasionally outside of the facility, cuffing and un-cuffing inmates intermittently, and using a control panel and computer screen to open and close doors. (Rx10).

Dr. Sudekum testified that based on his review of the medical records, Petitioner's diagnosis was diabetic peripheral polyneuropathies, including bilateral carpal and cubital tunnel syndrome. He testified that Petitioner had multiple non-occupational risk factors for the development of carpal and cubital tunnel syndromes such as diabetes which can significantly predispose a person to develop these types of neuropathies, diabetic peripheral polyneuropathies affecting the upper and lower extremities, an elevated BMI as patients with a BMI greater than 30 are more than three times as likely to have upper extremity peripheral neuropathies, Petitioner's age as patients over 40 or more likely to develop carpal and cubital tunnel syndromes, hypertension, hypercholesteremia, cervical disc disease, and tobacco use. Based on these, the Petitioner was at high risk for the compressive neuropathy conditions he had. (Rx10).

Dr. Sudekum testified that environmental factors that could cause or aggravate carpal tunnel syndrome include the use of vibratory tools, sustained heavy pinching, gripping, grasping, pounding of the hand, and sustained abnormal postures of the hand. Based upon the history he took from Petitioner and the multiple job descriptions, job analyses, and DVDs he reviewed, it was his impression that Petitioner's job activities that he performed at Shawnee and Hardin County would be considered benign and non-pathologic, non-causative of carpal or cubital tunnel syndrome. Dr. Sudekum testified that the nature of the manual activities performed by Petitioner did not rise to the level of causation for either carpal or cubital tunnel syndrome. The Petitioner did not report to him or any other physicians that he performed bar rapping, being on the tactical team, had difficulties with any of the locks at Hardin County or Shawnee, or worked in segregation. Dr. Sudekum testified that the CMS Demands of the Job form indicated Petitioner performed gross manipulation with his hands for zero to two hours and fine manipulation with his hands for zero to two hours. Dr. Sudekum further testified that Petitioner's employment activities at Hardin County and at Shawnee did not cause, contribute, or aggravate the development of carpal or cubital tunnel syndromes. (Rx10).

As such, the surgeries performed by Dr. Young were also not related. Dr. Sudekum believed that Petitioner was capable of working full duty with no restrictions. (Rx10).

Dr. Sudekum testified that Petitioner continued to have significant subjective symptoms after his surgeries, and this was indicative of persistent chronic bilateral upper extremity peripheral polyneuropathies, which was verified by the nerve conduction studies he performed. Dr. Sudekum testified that he believed Petitioner had ongoing diabetic peripheral polyneuropathies and those symptoms would not resolve until Petitioner's diabetes mellitus became under better control, noting that continued weight loss would also help the Petitioner's symptoms to improve or resolve. Dr. Sudekum added that the CMC arthritis of the bilateral thumbs he saw in x-rays could cause symptoms including soreness of the palms, numbness, and tingling. (Rx10).

On cross-examination, Dr. Sudekum testified that he was not aware that Petitioner underwent an EMG/NCV subsequent to his examination. Dr. Sudekum testified that there is not necessarily a latency period in the development of carpal or cubital tunnel syndromes. He was aware that the Petitioner worked first shift at Shawnee, and that at times he would have to work more than one wing, and he would not be surprised if day shift was the busiest shift. Dr. Sudekum testified that turning 300 locks a shift would not normally rise to the level of aggravation of carpal or cubital tunnel syndrome, except in extenuating circumstances where one is turning very difficult locks requiring lots of force 300 times a day, several times a week, then it could potentially aggravate a condition like carpal tunnel syndrome. (Rx10).

Dr. Sudekum testified that on 12/30/12, Petitioner was unlocking a door when he experienced pain in his left hand, followed by numbness, and that while he had symptoms prior to this, the Petitioner felt he experienced a worsening of his symptoms. Dr. Sudekum testified that Petitioner did not mention anything about the key getting stuck in the lock or the lock being difficult to open. The Petitioner did not mention any difficulty with his right upper extremity on the form he filled out on 12/30/12. Dr. Sudekum testified that there was no mention in any of the information or records he reviewed that the locks were difficult and required a lot of force to turn at either Shawnee or Hardin County. (Rx10).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The issues of accident and causation in a repetitive trauma claim are significantly intertwined, so the Arbitrator makes findings here on both issues together.

First, the Arbitrator does note that the Petitioner appears to also be alleging a specific trauma occurring on 12/30/12. He testified that he was turning a lock at Hardin County on that date, and the lock was difficult to operate, so he used additional force, and in doing so developed pain in his left hand and wrist area. The Arbitrator finds that while the 12/30/12 incident caused symptoms in his left wrist, this incident did not cause or contribute to the Petitioner's bilateral CTS conditions, for the reasons which follow. Instead, this simply appears to be the manifestation of symptoms of an unrelated pathologic condition. Dr. Young indicated that the Petitioner reported bilateral numbness and tingling in the upper extremities since the summer of 2012. He also testified that exacerbating a symptom is something which makes the symptoms worse without contributing to the underlying pathology, and the Arbitrator finds that this is what occurred on 12/30/12.

The Petitioner has the burden of proving both accident and causation in this case. While it is possible that his duties as an officer at Shawnee several years prior to symptom onset was a contributing cause of his carpal tunnel condition, that scenario simply does not appear to the Arbitrator to be more likely than not in this case.

A key problem with the proofs in this case for the Petitioner is the gap between 2011 and 12/30/12, when he was working at Hardin County. The evidence indicates that a correctional officer's job at Hardin County, with regard to hand/wrist use, and in particular key usage, is significantly less stressful. The number of key turns at Hardin County appears to the Arbitrator to be a very small percentage of what it was at Shawnee.

The Arbitrator notes the opinion of Dr. Young with regard to a latency period. However, after seeing numerous carpal tunnel cases, the Arbitrator is aware that causal connection opinions are very often based upon complaints that gradually occur during the performance of the alleged provocative activities. Dr. Sudekum's point is well taken with regard to how far the latency argument can potentially be taken in terms of a gap period between the alleged causative activities and the onset of symptoms. Here, the gap period of one to two years between the performance of the most stressful of Petitioner's two position locations and the onset of symptoms is significant.

It is particularly relevant where, as here, the claimant has multiple significant comorbidities that can contribute to upper extremity compressive neuropathy. Primary in this case is the Petitioner's diabetes. Dr. Sudekum indicated that the Petitioner's sugar levels were not well controlled per the records he reviewed, and that the fact he used an insulin pump indicated a significant degree of the disease. Further, the Petitioner has had severe enough problems in his feet to have to have a toe amputated. Upper extremity EMG/NCVs clearly indicate a diabetic peripheral neuropathy exists in the arms. Taking that along with the large number of relevant causative medical comorbidities (obesity, coronary artery disease, hypertension, tobacco use, arthritis, cervical disc disease) the Petitioner has leads the Arbitrator to the conclusion that the performance of the Petitioner's job duties did not cause or contribute to his bilateral carpal tunnel conditions.

Dr. Young's testimony indicated he had a limited knowledge of the work-related risk factors for carpal tunnel are repetitive forceful pinching and gripping, prolonged wrist extension, and for cubital tunnel, prolonged elbow flexion. However, Dr. Young did not report or testify to facts which would support that these activities occurred in the Petitioner's job, particularly at Hardin County.

As noted, the number of times the Petitioner had to use a key to open and close locks at Hardin County was relatively minimal for an entire shift given the low level of security for the inmates at that facility, and in no way appeared to be repetitive. The Petitioner testified that there was virtually no bar rapping at either the Shawnee or Hardin County facilities. Dr. Young agreed that the limited amount of handling of property boxes, cuffing and uncuffing or inmates and handwriting at Hardin County made it unlikely that these activities contributed to Petitioner's carpal tunnel. This really leaves the key usage as the primary alleged cause, and the Arbitrator just does not see significant enough key activities to be considered as forceful repetitive activity.

The Arbitrator finds the testimony of Dr. Sudekum to be more persuasive than that of Dr. Young with regard to causation and the impact of Petitioner's diabetic neuropathy on his upper extremities. Dr. Sudekum testified that Petitioner continued to have significant subjective symptoms after his surgeries, and this was indicative of persistent chronic bilateral upper extremity peripheral polyneuropathies, which was verified by the nerve conduction studies he performed. Both Dr. Young and the Petitioner emphasized that the surgery provided the Petitioner with significant relief, but the evidence appears to the Arbitrator to indicate very similar ongoing problems. The severity may have been reduced, but the symptoms certainly appear to remain. The Arbitrator believes that there is a greater likelihood that the original problem and ongoing symptoms are related to diabetes and his other comorbidities.

Of additional note is that the Petitioner testified he had no real problems with his elbows. The medical records support this, and it appears that it was only because he had positive findings on an EMG/NCV regarding the elbows that the issue in this anatomic area even came up.

It's clear to the Arbitrator that, based on the evidence, the Petitioner's diabetic neuropathy is impacting his upper extremities along with his lower extremities. It also appears that both Dr. Young and Dr. Sudekum agree that the Petitioner's ongoing symptoms are due to this diabetic neuropathy. Where they disagree is whether the

pre-surgical problems, including carpal tunnel, are due to the Petitioner's comorbidities and his work duties, or whether it is due to the comorbidities alone and/or is idiopathic. In reviewing all of the evidence in the record, the Arbitrator finds it difficult to believe that Dr. Young can parse out a simultaneous carpal tunnel and diabetic neuropathy to pinpoint the Petitioner's job duties as causative. While he testified that there is a difference in that one is a compressive issue and the other involves disease of the nerves, it is unclear how this can involve separate issues when both doctors acknowledge that diabetes can be causative of carpal tunnel. As noted above, this is made even more significant by the fact that the symptoms appear to have initially arisen after the Petitioner took on a job he himself agreed was less strenuous than his prior job at Shawnee. Both doctors agreed that it would not have been surprising if the Petitioner developed his conditions had he never worked at all, given the high risk level of his comorbidioties for compressive neuropathies, regardless of whether that work would have been at Shawnee or Hardin County or otherwise. The Arbitrator believes that it is significantly more likely than not that the compressive neuropathies in the wrists and hands were due to non-occupational factors in this case. While all the Petitioner needs to prove is that the work duties were a cause of the conditions, not the sole or primary cause, the facts in this particular case simply do not support the work duties as being causative, in the Arbitrator's view.

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:

While no medical benefits are awarded based on the Arbitrator's findings on the issues of accident and causation, the Arbitrator notes that at the hearing, the parties stipulated that the Respondent had either paid, or would pay, all causally related medical bills directly to the providers. As such, the parties did not indicate medical expenses as an issue to be determined via evidence from the hearing itself.

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:

Based on the findings of the Arbitrator with regard to accident and causation, this issue is moot, and no benefits are awarded.

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

Based on the findings of the Arbitrator with regard to accident and causation, this issue is moot, and no benefits are awarded.

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	Medical Expenses	☐ PTD/Fatal denied
	☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brenda Crackel,

Petitioner,

v. NO: 10 WC 6854

SIH/Memorial Hospital of Carbondale,

17IWCC0637

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 all of the issues, and being advised of the facts and law, reverses the decision of the arbitrator and substitutes the findings that follow.

Findings

The Commission adopts the arbitrator's conclusions that Petitioner suffered an accident on October 3, 2009, arising out of and in the course of her employment with Respondent; that Respondent has paid all appropriate temporary total disability payments and is entitled to certain credits; and that Petitioner is entitled to permanent partial disability benefits in the amount of $245.33 per week for 137.5 weeks for the 27.5% loss of her person as a whole. The Commission reverses the arbitrator's decision and findings, and substitutes its own below findings, on the medical expenses issues that form the basis for Respondent's petition for review. The Commission also adopts the factual recitation contained in the arbitration decision, with additions as needed below.

Respondent's brief on review challenges (1) the arbitrator's finding that Petitioner's current condition of ill-being at the L2-L3 and L4-L5 levels of her spine were caused by a workplace accident; (2) the arbitrator's finding that the three-level fusion she underwent was reasonable and necessary; and (3) the arbitrator's award of medical expenses related to St. Francis Medical Center in the absence of evidence that those yet-unpaid expenses are reasonable and customary.

Respondent's first argument on appeal is that Petitioner's current condition of ill-being is not causally related to her workplace accident. A claimant bears the burden of proof to establish the elements of his right to compensation. *Navistar International Transportation. Corp. v. Industrial*

17IWCC0637

Comm'n, 315 Ill. App. 3d 1197, 1202-03 (2000) (citing *Board of Trustees of University of Illinois v. Industrial Comm'n.*, 44 Ill.2d 207, 214 (1969)). To obtain compensation under the Act, a claimant must prove by a preponderance of the evidence that "some act or phase of his employment was a causative factor in his ensuing injuries." *Land and Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005).

In pressing this first argument, Respondent emphasizes that diagnostic imaging and other evidence establish that Petitioner had pathology only at the L3-L4 level, not at the L2-L3 or L4-L5 levels that were also included in her surgeries and now underlie part of her ongoing functional restrictions. Although there is limited evidence—in the form of Dr. Fonn's notes regarding some problems at the L4-L5 level—of pathology outside the L3-L4 level, neither Petitioner nor the arbitrator's decision appear to rely on a three-level injury. Rather, Petitioner's theory of the case appears to be that surgery to all three levels was necessary to address the work-related injury predominantly to the L3-L4 level. Respondent does not contest that Petitioner suffered an injury to the L3-L4 level, that Petitioner has continued symptoms that trace to that injury, and that Petitioner requires some treatment for the injury. Thus, the issue of whether her current L2-L3 and L4-L5 impairment is causally related to her accident turns on the reasonableness of the three-level fusion surgery Petitioner underwent. That issue is addressed in response to Petitioner's second argument, discussed just below.

This second argument forms the crux of the parties' dispute regarding the medical evidence. Respondent contends that the arbitrator erred in finding that Petitioner's three-level fusion was a compensable medical expense. Instead, Respondent would have the Commission limit medical expenses to those necessary for the single-level discectomy recommended by its medical examiner and utilization reviewer, Drs. Vaught and Smith.

"Pursuant to section 8(a) of the Act, a claimant is entitled to recover only reasonable medical expenses that are causally related to a workplace accident. *University of Illinois v Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1992). "The award should only reflect those services which were determined to be required to diagnose, relieve, or cure the effects of [a] claimant's injury." *Id.* "As is the case with any element of a workers' compensation claim, the claimant bears the burden of proving, by a preponderance of the evidence, his entitlement to an award of medical expenses under section 8(a)." *Max Shepard, Inc. v. Industrial Comm'n*, 348 Ill. App. 3d 893, 903 (2004).

To support her position that the three-level fusion was reasonable and necessary, Petitioner presents the testimony of her treating physician, Dr. Fonn, who, based on MR imaging, saw instability in the levels adjacent to L3-L4 that indicated a microdiscectomy would risk further destabilization. He also opined that a microdiscectomy would not address Petitoner's primary symptoms. Thus, in his view, a fusion at those additional levels was inevitable, and preferred. Petitioner might also note that Dr. Fonn began with more conservative treatment, in the form of epidural injections and further testing, before proceeding with the fusion.

Respondent emphasizes the opinions of its independent medical examiner, Dr. Vaught, and its utilization reviewer, Dr. Smith. Those doctors agreed that Petitioner's best course of action was a microdiscectomy at the L3-L4 level. They agreed that that less invasive procedure would not

17IWCC0637

endanger adjacent levels of her spine, because MR imaging of those levels did not demonstrate sufficient instability to trigger a concern. They also noted that a successful microdiscectomy would allow a more complete recovery than the three-level fusion Petitioner underwent, and they claimed support from treatment records of Dr. Matz recommending their course of action. Respondent also offers several persuasive reasons for crediting its experts over Petitioners. Respondent further notes that Dr. Fonn's initial course of treatment focused exclusively on the L3-L4 level, and that Dr. Fonn never cited any symptoms related to the adjacent two levels. Respondent further observes that Dr. Fonn stated that, following the L2-L5 three-level fusion, he would have to monitor the L1-L2 and L5-S1 levels to ensure that they did not require future surgical intervention. As Respondent notes, with that risk present, the preventative logic Dr. Fonn cited in operating on L2-L3 and L4-L5 would have dictated extending the fusion to those levels as well. That issue illustrates well one of Dr. Vaughn's major criticisms of Dr. Fonn's approach: if Petitioner's fusion were expanded to preempt future problems, the larger fusion would cause additional stress on the levels adjacent to it, so that those levels would also be included. Dr. Vaughn said that, under Dr. Fonn's logic, Petitioner might have undergone a seven-level fusion, despite the fact that fusions generally allow for a less complete medical and functional recovery.

Based on the above, the Commission finds Respondent's points to be persuasive and its experts to be credible on this point. For that reason, the Commission reverses the arbitrator's finding and finds that Petitioner failed to sustain her burden to demonstrate that the all of her medical expenses incurred were reasonable and necessary. Instead, the Commission finds reasonable and necessary only medical expenses to the extent that they would have been incurred for the single-level microdiscectomy Respondent's experts recommended.

Respondent's third argument on review is that the arbitrator erred in admitting into evidence and basing a medical expense award on certain unpaid medical expenses. Except when the Act provides otherwise, the Illinois rules of evidence govern proceedings before the Commission and its arbitrators. *Land and Lakes*, 359 Ill. App. 3d at 590.

> "In order to recover for medical expenses, the plaintiff must prove that he or she has paid or become liable to pay a medical bill, that he or she necessarily incurred the medical expenses because of injuries resulting from the defendant's negligence, and that the charges were reasonable for services of that nature. When evidence is admitted, through testimony or otherwise, that a medical bill was for treatment rendered and that the bill has been paid, the bill is prima facie reasonable. A party seeking the admission into evidence of a bill that has not been paid can establish reasonableness by introducing the testimony of a person having knowledge of the services rendered and the usual and customary charges for such services." (Internal citations omitted). *Baker v. Hutson*, 333 Ill. App. 3d 486, 493 (2002); see *Land and Lakes*, 359 Ill. App. 3d at 591 (applying *Baker*).

In its brief, Respondent argues that bills for unpaid medical expenses from several sources should be disregarded for Petitioner's failure to meet the foundational requirements for their admissibility. At the arbitration hearing, however, Respondent expressly limited its objection to the St. Francis Medical Center bills. In so doing, Respondent waived the objections it specifically disclaimed. *Eg., Docksteiner v. Indus. Comm'n (Peabody Coal Co.)*, 346 Ill. App.

17IWCC0637

3d 851, 855 (2004); see *Dawson v. Ill. Workers' Comp. Comm'n*, 2016 IL App (5th) 150195WC-U, P28 (non-precedential Rule 23 Order) (citing *Barreto v. City of Waukegan*, 133 Ill. App. 3d 119, 130, 478 N.E.2d 581, 88 Ill. Dec. 266 (1985) ("Specific objections to evidence, based solely on particular grounds, are a waiver of objections to all grounds not specified or relied upon.")). Respondent's challenge to the admissibility of unpaid medical bills must be confined to those for St. Francis Medical Center.

Regarding the St. Francis bills, Respondent correctly notes that Petitioner presented nothing to show that the bills were usual and customary. The arbitrator nonetheless relied on them to set a medical expense award, on the basis that Respondent offered no evidence to contest their reasonableness. Under the above case law, however, before an arbitrator can consider whether the reasonableness of unpaid medical bills has been effectively rebutted, the bills' proponent must present some evidence of their reasonableness to render them admissible in the first place. Without that evidence in this case, the St. Francis bills were not admissible, and they could not be relied on standing alone to fix Respondent's liability for medical expenses.

The parties agree that, in the event the Commission deems the St. Francis bills inadmissible, the case may be remanded to the arbitrator for a determination of the reasonable amount of Respondent's liability for the challenged bills. See also *Land and Lakes*, 359 Ill. App. 3d at 591 (stating that the appropriate remedy in this situation is a remand for another hearing on the reasonableness of medical expenses). The Commission follows that course and remand this case to the arbitrator for the calculation of the amount of medical expenses due to Petitioner in light of the findings stated herein.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 4/6/16 is reversed on the issue of medical expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner receive medical expense benefits limited to the amount that would have been paid for a single-level discectomy.

IT IS FURTHER ORDERED BY THE COMMISSION that the case be remanded to the arbitrator for calculation of medical expenses consistent with the findings stated herein.

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.

OCT 11 2017

DATED:
o:9/28/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRACKEL, BRENDA J
Employee/Petitioner

Case# **10WC006854**

SIH/MEMORIAL HOSPITAL OF CARBONDALE
Employer/Respondent

17IWCC0637

On 4/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0693 FEIRICH MAGER GREEN & RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

17IWCC0637

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

Brenda J. Crackel
Employee/Petitioner

v.

SIH/Memorial Hospital of Carbondale
Employer/Respondent

Case # **10** WC **6854**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 3, 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.

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

In the year preceding the injury, Petitioner earned **$20,823.86**; the average weekly wage was **$400.46**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

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

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

The parties stipulated at the time of arbitration that all temporary total disability benefits had been appropriately paid, and that Respondent was entitled to a credit of $2,402.73 for temporary total disability benefits paid as well as a credit of $12,503.85 for other benefits paid under Section 8(j) of the Act.

The parties stipulated at the time of arbitration that Respondent was entitled to a credit for any and all medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of **$245.33/week** for a further period of **137.5 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused **27.5% loss of use of the person-as-a-whole.**

Respondent shall pay **$448,846.00** for medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent is entitled to a credit of **$2,402.73** for temporary total disability benefits paid as well as a credit of **$12,503.85** for other benefits paid under Section 8(j) of the Act.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

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

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

Melinda M. Pope Gillman

Signature of Arbitrator

4/1/16

Date

APR 6 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Brenda J. Crackel
Employee/Petitioner

Case # **10** WC **6854**

v.

Consolidated cases: **N/A**

SIH/Memorial Hospital of Carbondale
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she working at Respondent in October of 2009, and that on the 3rd she had an accident in which she was cleaning up a birthing room and injured her low back. She testified that it caused problems with her low back and that she had pain into her left leg for which she sought medical treatment with her family physician, Dr. Jones. She testified that Dr. Jones gave her a referral to go see a neurosurgeon named Dr. Sonjay Fonn in Cape Girardeau.

Petitioner testified that when Dr. Fonn first saw her, he reviewed MRI films and prescribed injections. She testified that she underwent three injections, but they were not helpful. She testified that Dr. Fonn wanted her to undergo the injections, therapy and medication first, but after those were unsuccessful he made a surgical recommendation.

Petitioner testified that Respondent's insurer sent her to an independent medical exam with another neurosurgeon in Cape Girardeau by the name of Dr. Kevin Vaught in August of 2010. She agreed that Dr. Vaught took her history, looked over her records and recommended an L3-4 hemilaminectomy and microdiscectomy. She testified that Dr. Fonn had a different recommendation to address levels L2-3, L3-4 and L4-5 with a decompression and fusion. She testified that at L2-3 and at L4-5, she had had previous microdiscectomies done on those levels in the past in approximately 1981 and 1995 or 1996.

Petitioner testified that after seeing Dr. Vaught and seeing Dr. Fonn again, she opted to go through with the surgical procedure recommended by Dr. Fonn. She testified that on December 11, 2010, Dr. Fonn did the L2-3, L3-4 and L4-5 decompression and fusion procedure. She testified the surgery somewhat fixed her problems with her back. She testified that there were problems in getting physical therapy approved after surgery, and that months had passed before she eventually had the physical therapy. She testified that she underwent a CT in March of 2011 to see whether the fusion had been successful and whether it was healing correctly. She testified that she then underwent a functional capacity examination on June 11, 2012, which showed that she was unable to return to her previous job at the hospital, which had been labeled as a very heavy physical demand level job. She testified that the functional capacity examination showed that she was capable and placed at a light level physical demand capability. She further testified that after the functional capacity examination, Dr. Fonn eventually gave her permanent restrictions based on the functional capacity examination. She also testified that she was sent back for a second visit with Dr. Vaught where he also evaluated the functional capacity examination and gave an opinion regarding her permanent restrictions.

Petitioner testified that currently she is not in excruciating pain like she was after the accident, but because of the injury and the subsequent surgery she no longer does things like taking care of her house and cooking the meals she typically cooked. She testified that she can no longer take long trips and that her life has had to be adjusted greatly because of the injury. She also testified that she did not have insurance at the time to pay for the treatment rendered by Dr. Fonn and that the bills are currently still outstanding.

On cross-examination, Petitioner agreed that she was referred to Dr. Fonn by her primary care physician, Dr. Jones. She agreed that Dr. Jones initially wanted to refer her to a different neurosurgeon named Dr. Jeffrey Jones, but testified that she did not recall whether she called Dr. Jones' office and said she specifically wanted to be seen by Dr. Fonn. She agreed, however, that if Dr. Jones' medical records indicated that she called and specifically requested Dr. Fonn, she would not disagree with the records. She agreed that she lived about 13 miles from her residence in Goreville to Herrin, and that it took about 15-20 minutes to get to Herrin. She further agreed that she knew that Dr. Jones' office was located in Herrin. She agreed that it was approximately 50 miles one way to get to Dr. Fonn's office, and that it took a little under an hour to get there.

On cross-examination, Petitioner agreed that she was aware that Dr. Jones was a board certified orthopedic surgeon and that Dr. Fonn was not. She agreed that she saw Dr. Vaught in August of 2010 and that he recommended a single level lumbar procedure for her, but that Dr. Fonn offered and performed a three-level procedure. She recalled seeing Dr. Matz on one occasion in April of 2010, but testified that he did not make any surgical recommendations to her.

On cross-examination, Petitioner agreed that she testified that she had a lot of issues including taking care of the home, cooking and taking long trips that she has had to change as a result of the surgery that she underwent. She denied having any knowledge of the results of a lumbar fusion nor did she have any knowledge of the differences in permanent restrictions or the ability to do things on a three-level fusion versus a single level microdiscectomy.

On redirect examination, Petitioner testified that she chose to see Dr. Matz.

The Application For Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of October 3, 2009 while Petitioner was moving a bed, related to which she allegedly sustained injured to her low back. (AX2).

The medical records of Memorial Hospital of Carbondale were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on October 3, 2009 in the Emergency Department. Petitioner complained of low back pain after cleaning rooms and moving furniture. Petitioner was assessed with acute low back pain with sciatica. (PX1).

The records of Memorial Hospital of Carbondale reflect that Petitioner underwent x-rays of the left hip on October 6, 2009, which were interpreted as revealing no radiographic abnormality of the left hip. Petitioner underwent x-rays of the lumbar spine on October 6, 2009 after a lifting injury, which were interpreted as revealing (1) no acute fracture or subluxation; (2) degenerative changes of the lumbar spine. (PX1).

The records of Memorial Hospital of Carbondale reflect that Petitioner underwent an MRI of the lumbar spine on December 2, 2009, which was interpreted as revealing (1) hypoplastic twelfth ribs; (2) surgical changes at L2-3 and L4-5; (3) mild lumbar dextroscoliosis, minimal spondylosis, mild facet

arthropathy and multilevel disc disease; (4) moderate central canal stenosis, marked left lateral recess stenosis (compression of the left L4 descending nerve root), and moderate left foraminal stenosis with posterior displacement of the left L3 nerve root making L3 the most likely level to be symptomatic; (5) multilevel foraminal stenosis; (6) probable benign left renal cortical cyst. (PX1).

The records of Memorial Hospital of Carbondale reflect that Petitioner was seen at WorkCare Occupational Health beginning October 6, 2009, and that she was recommended to undergo physical therapy. Various Work Status/Treatment Reports were generated, allowing Petitioner to return to modified work. It was noted at the time of the November 6, 2009 visit that Petitioner was showing functional improvements in range of motion but had not yet returned to baseline for the left lumbosacral strain and left leg sciatica, and that she was showing functional improvements with physical therapy for the left hip joint strain. It was noted on December 28, 2009 that Petitioner was treating with another physician. (PX1).

Included within the medical records of Memorial Hospital of Carbondale were the physical therapy records of Outpatient Rehabilitation Services. Petitioner underwent a Therapy Evaluation on October 19, 2009, at which time the date of onset was noted to be October 3, 2009 when Petitioner had been cleaning and lifting heavy linen bags. It was noted that Petitioner started having low back pain and left hip pain, and went to WorkCare three days after the injury. (PX1).

The medical records of Dr. Roger Jones were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that on March 8, 2010 Petitioner called because her pain medications were not working any longer and she requested something stronger. Petitioner was seen on December 15, 2009, at which time Petitioner presented for follow-up on the MRI. Petitioner stated he was still having a lot of pain radiating down her left leg to the point that it was affecting her life. Petitioner was referred to Dr. Jeff Jones. It was noted on December 17, 2009 that in order for Petitioner to see Dr. Jones, Petitioner must contact Worker's Compensation and get a letter stating the date of accident and approval to see a neurosurgeon. The notation of January 29, 2010 noted that office notes and records were released to Prince Law Firm. The March 5, 2010 note indicated that Petitioner wanted a referral to Dr. Fonn in Cape Girardeau, Missouri. (PX2).

The records of Dr. Jones reflect that on November 20, 2009, Petitioner was seen and reported that on October 3rd after lifting some heavy items she developed pain. It was noted that Petitioner was seen by the company physician, who recommended she undergo physical therapy. Petitioner stated it had not helped and seemed to be making her symptoms worse. Petitioner stated initially when she was trying to move a bed, she noticed a sharp pain and pain down her left leg, which was rather persistent. An MRI was ordered at that time, and Petitioner was instructed to stop physical therapy. (PX2).

The records of Dr. Jones reflect that Petitioner was seen on August 14, 2009, at which time she was seen as a new patient. Petitioner had a history of leg pain, and she had a little lump. Petitioner had right greater trochanter bursitis, and an injection was an option. Also included within the records was a note dated March 19, 2010 directed to Brian McGarry, indicating that Petitioner needed to be off work from November 20, 2009 to April 2, 2010. (PX2).

The medical records of Dr. Matz/Brain & Spine Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The Summary Report noted a provisional diagnosis of degenerative lumbar disc, and indicated that Petitioner could not return to work. The Report noted that Petitioner was recommended to undergo an MRI without contrast of the lumbar spine to evaluate for disc fragments, and that her ability to return to work was dependent on the results of the scan. (PX3).

The medical records of Dr. Fonn/Midwest Neurosurgeons were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. aPetitioner was seen on May 13, 2010, at which time it was noted that she had undergone a microdiscectomy at the L2/3 and L4/5 levels in 1982 and 1985 and was much better with very minimal residual symptomatology. Petitioner reported that on October 3, 2009 while working as a technician in the operating room at Carbondale Memorial Hospital she was doing a lot of heavy lifting and developed severe pain in her back radiating down to her left leg into the calf and feet regions. Petitioner had paresthesia and weakness secondary to pain, and that the left was worse than the right and that the back was just as bad as the legs. It was noted that Petitioner had undergone physical therapy but no epidural injections. It was further noted that she had been on medication for the pain with minimal relief. The records reflect that the MRI was reviewed, which revealed a large traumatic disc herniation with inferior migration causing irritation and impingement of the descending L4 nerve root, and that at the L5/S-1 level there was a broad-based disc herniation central with a large traumatic tear in the annular fibers posteriorly. The assessment was that of L4 radiculopathy secondary to a large traumatic inferiorly displaced disc herniation at the L3/4 level, and Dr. Fonn recommended Petitioner undergo a CT myelogram of the lumbar spine to confirm the diagnosis. (PX4).

The records of Dr. Fonn reflect that Petitioner underwent a lumbar myelogram on May 27, 2010 for a post-operative diagnosis of lumbar radiculopathy. Petitioner was next seen on June 2, 2010, at which time it was noted that her history and review of symptoms were unchanged from the previous visit. It was noted that based on the CT myelogram, Petitioner was recommended to undergo a course of epidural injections at the L3/4 and L4/5 levels on the left. Petitioner underwent the first epidural injection on June 17, 2010, she underwent the second epidural injection on June 24, 2010, and she underwent a third epidural injection on July 1, 2010. (PX4).

The records of Dr. Fonn reflect that Petitioner underwent a discogram on July 8, 2010 with a post-operative diagnosis of L1/2, L2/3, L3/4, L4/5 and L5/S1 discogenic pain. The post discogram CT scan of the lumbar spine was interpreted as revealing extravasation of dye at the L1/2, L2/3, L3/4, L4/5 and L5/S-1 levels suggestive of annular tears at these levels. A work slip was issued on July 15, 2010, noting that Petitioner was awaiting approval for surgery and her estimated date of return to work was unknown at that time. (PX4).

The records of Dr. Fonn reflect that Petitioner was seen on July 14, 2010, at which time it was noted that the discogram showed concordant levels from L1-S1 with 10/10 pain and extravasation. It was noted that due to the non-diagnostic nature of the discogram they were not able to use the results. Dr. Fonn indicated that based on the MRI, CT myelogram, discogram, examination and pathology, he recommended that Petitioner have only a three-level fusion at the L2/3, L3/4 and L4/5 levels. It was noted that Petitioner had prior surgery at the L2/3 and L4/5 levels and had severe degenerative changes at these two levels. It was noted that the L3/4 level would need to be addressed because it would be bordered by a fused level and would not hold up well to a microdiscectomy. (PX4).

The records of Dr. Fonn reflect that Petitioner was seen on September 23, 2010, at which time it was noted Petitioner wanted to proceed with surgical intervention using her own insurance. Included within the medical records was a letter dated December 9, 2010 pertaining to a bone growth stimulator, which appears to have been recommended to increase the prognosis of bony fusion at the surgical site by stimulating osteoblasts. Also included within the medical records was a letter dated December 9, 2010 pertaining to a TLSO. The records further reflect the Petitioner was seen on December 9, 2010 as well, at which time it was noted that she was scheduled for a PLI F at the L2/3, L3/4 and L4/5 levels with right iliac crest on December 10, 2010. It was noted that Petitioner was fitted for a brace and a bone growth stimulator and that proper fitting and usage was verified. (PX4).

The Operative Report dated December 11, 2010 indicated that the procedure performed was that of (1) L2-3, 3-4, 4-5 bilateral laminotomies with decompression of nerve roots, partial facetectomy, foraminotomy and excision of herniated intervertebral disc using microsurgical dissection techniques; (2) L2-3 left and L4-5 bilateral revision and re-exploration with removal of significant amount of scar tissue; (3) arthrodesis, posterior interbody technique to prepare interspace other than for decompression; (4) application of inter-vertebral biomechanical device with placement of silver nitride interbody spacers, two and three per each level; (5) posterior fixation using Genesys Spine; (6) arthrodesis, posterior lateral technique; (7) autograft morselixation of local bone and right iliac crest bone graft harvest through separate fascial incision for bone grafting; (8) injection of narcotics, subarachnoid space; (9) transcatheter therapy, placement of local anesthetic pain pump; (1) intraoperative fluoroscopy x three hours. (PX4). The post-operative diagnosis was noted to be that of L2-3, 3-4, 4-5 degenerative disc disease and disc herniations with prior microdiscectomy at the L2-3 level on the left and 4-5 level bilaterally; significant amount of scar developed at the L2-3 level on the left and 4-5 level bilaterally. (PX4).

The records of Dr. Fonn reflect that Petitioner was seen on January 12, 2011 at which time it was noted she was progressing very well. It was noted that the pre-operative signs and symptoms had significantly resolved, and that x-rays of the surgical site showed good placement of the hardware in spacers with no subluxation, migration or fracture of the instrumentation. It was noted that Petitioner would be advanced to driving and a 20-pound weight limit with no excessive bending or stooping of the surgical site. It was noted that Petitioner was having some episodes of dizziness, so she was sent for blood work. Petitioner was also referred to an ENT physician for a consult for vertigo. (PX4).

The records of Dr. Fonn reflect that Petitioner was seen on March 30, 2011 at which time it was noted that she was doing very well with continued good resolution of pre-operative symptoms. It was noted that a CT of the surgical site showed good fusion occurring and with good placement of the instrumentation. Petitioner was sent for physical therapy for post-operative rehabilitation with Dr. Baxter. It was noted that Petitioner was expected to heal for up to one year from surgical intervention. The interpretive report for the CT scan of the lumbar spine performed on the same date was interpreted as revealing successful fusion with instrumentation of the surgical site. The BGS compliance report also dated March 30, 2011 showed Petitioner used it 75 sessions out of 107 sessions. (PX4).

The records of Dr. Fonn reflect that Petitioner was seen on August 10, 2011, at which time it was noted that Petitioner was unable to be approved and had not been attending physical therapy. Petitioner reported that her symptoms had continued to be relieved, however, but that she had some stiffness. A work hardening program was also recommended to be followed by functional capacity evaluation to determine her return to work status. Petitioner was also seen on December 21, 2011, at which time she continued to have some stiffness, numbness and tingling of her left leg which might be permanent. It was noted that Dr. Fonn continued to recommend that Petitioner be off work until she had completed her course of physical therapy and work hardening followed by a functional capacity evaluation to determine her return to work status. (PX4).

The records of Dr. Fonn reflect that Petitioner was issued a returned to work slip on March 21, 2012, indicating that she was to return to work on April 18 but this was subject to change. Petitioner was seen on March 29, 2012, at which time it was noted she was to continue to remain off work until she had completed a course of physical therapy and work hardening followed by a functional capacity evaluation. An additional work slip was issued on June 27, 2012, indicating that Petitioner could return to work with a sedentary physical demand level. Petitioner was seen on June 27, 2012, at which time it was noted her functional capacity evaluation showed that she could perform in a sedentary physical demand level. It was noted that her physical examination was essentially normal other than the fact that Petitioner had continued pain, and it was noted she had continued stiffness, numbness and tingling of the left leg which may be permanent. Petitioner was released at that time. The records reflect that Petitioner was also seen

on May 29, 2013, at which time it was noted she continued to have stiffness, numbness and tingling in her left leg. It was noted that Petitioner had a sedentary physical demand level given to her by the functional capacity evaluation, and she was continued to be released. It was noted that her physical examination remained unchanged. (PX4).

The medical records of St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The Discharge Summary noted that Petitioner presented on December 10, 2010 for elective posterior lumbar interbody fusion stabilization with lumbar laminotomy at L2-L3, L3-L4 and L4-L5 with iliac crest bone harvest with neurophysiological monitoring. It was noted that Petitioner complained of difficulty swallowing after extubation, and speech therapy was consulted. It was noted that Petitioner was discharged home on December 13, 2010. (PX5).

The medical records of Occupational Performance & Rehab were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent a physical therapy initial examination on April 12, 2012, with a history of present condition of back pain and reduced tolerance to activity. It was noted that Petitioner had persistent and relatively constant dizziness as well as some associated imbalance that had been present since her lumbar fusion. It was noted at the time of the May 1, 2012 physical therapy session that Petitioner tolerated all aspects of therapy poorly on that date, but she was able to walk after the session with good posture carrying a large purse. At the time of the physical therapy visit on June 11, 2012, it was noted that Petitioner had a very busy weekend and that she was able to prep and freeze produce from her garden. It was noted at the time of the June 18, 2012 physical therapy session that Petitioner felt better on that date but continued with weakness as she had been unable to eat. At the time of the June 21, 2012 physical therapy session, Petitioner reported that she felt better on that date and that her low back pain was 2-3/10. It was noted that Petitioner reported that she continued baking bread after the last treatment and had baked nearly 40 loaves of bread that week. It was noted that during light conversation while performing sit to stand transfers, Petitioner stated "Don't let me fall. I would have to sue you." At the time of the June 25, 2012 physical therapy session, Petitioner reported that she went to a gun show the prior weekend and walked around for three hours with two seated rest periods. (PX6).

The records of Occupational Performance & Rehab reflect that at the time of the June 26, 2012 physical therapy session, Petitioner requested to shorten the session due to needing to take her grandson to a school-related athletic event. Petitioner reported that she experienced increased pain and discomfort following a road trip that consisted of riding in a car for two hours, walking on concrete with three rest breaks for three hours and an additional two-hour car ride over the weekend. At the time of the July 26, 2012 visit, it was noted that Petitioner had made minimal progress as her pain levels persisted, and she was being discharged secondary to the referring physician discharging Petitioner from his care and lack of insurance authorization. It was noted that Petitioner's prognosis at that time was poor secondary to limited progress with decreasing pain and increasing activity tolerance. (PX6).

The records of Occupational Performance & Rehab reflect that at the time of the June 4, 2012 physical therapy visit, Petitioner indicated that she was suffering from lupus-related difficulties on that date and felt her stomach was upset. Petitioner further reported that she was concerned about exacerbating lupus-related symptoms with moderate activity on that date. At the time of the June 7, 2012 physical therapy visit, Petitioner reported that she experienced markedly increased pain and soreness in her low back that date secondary to functional testing at the last visit. Petitioner also indicated that she made pies and packaged berries for freezing that week at home. Petitioner canceled her physical therapy session scheduled for June 14, 2012 due to a spider bite to which she had a bad reaction. The June 19, 2012 visit noted that Petitioner reported that she and her husband baked 20+ loaves of zucchini bread the day before. (PX6).

The transcript of the evidence deposition of Dr. Sonjay Fonn was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Dr. Fonn testified that he is a neurosurgeon specializing in spine surgery and is board eligible, and that he has been in practice for nearly 7 years. (PX7).

Dr. Fonn testified that he first saw Petitioner on May 13, 2010, at which time she reported a chief complaint of back and left leg pain that had occurred after being at work on October 3, 2009 in the capacity as a technician in the OR at Carbondale Memorial Hospital doing a lot of heavy lifting. He testified that Petitioner reported that she had developed severe pain in the back, moving down to the left leg to the calf and feet region with paresthesia and weakness because of the pain. He testified that Petitioner reported that the left leg was worse than the right and that her back was worsening. He testified that Petitioner reported having some physical therapy but no medications, and she also gave a prior history of having back surgery in 1982 in 1995 but had returned to work without any problems. (PX7).

Dr. Fonn testified that on physical examination, he found weakness in the L4 distribution on the left, and Petitioner also had some decreased sensation in the L4 nerve root on the left and loss of patellar reflex. He testified that he felt at that time that Petitioner presented with an L4 radiculopathy. He testified that based on the MRI that Petitioner had given to him at that time which showed a large disc herniation at the L3-4 level with inferior migration with impingement of the left L4 nerve root, he felt that the disc herniation was causing the L4 radiculopathy. He testified that he felt they needed to confirm the diagnosis with a CT myelogram of the lumbar spine, and once it was confirmed they would proceed with conservative treatment which would be a course of injections on the left L3-4 level and, if Petitioner failed all conservative modalities, she would be a surgical candidate. He further testified that the CT myelogram confirmed collapse of the L4-5 level, the prior surgery at the 2-3 and 4-5 level and the disc herniation with inferior migration at the L3-4 level causing impingement and irritation of the descending L4 nerve root. He further testified that the CT myelogram also showed an L5-S1 broad-based disc herniation. (PX7).

Dr. Fonn testified that Petitioner underwent injection therapy, which consisted of three injections, once per week for three weeks. He testified that Petitioner reported that the injections had not worked and that she wanted to proceed with surgical intervention as of the time of the September 23, 2010 visit. He testified that surgery was ultimately performed on December 11, 2010, and was uneventful and without complications. He testified that he felt that Petitioner had a significant finding of compression of the L4-5 nerve root, which was concerning because she had weakness. He testified that Petitioner had pretty much failed conservative treatment and continued to do poorly, so he thought that surgery was the best option. He testified that he had definitive concerns with a microdiscectomy, which he thought would only relieve her symptoms temporarily at best as well as the potential for a recurrent disc herniation causing the need for further surgery. He also testified that Petitioner had multiple levels operated above and below the level, which also concerned him because an additional microdiscectomy would further destabilize the spine. (PX7).

Dr. Fonn testified that the first post-operative visit took place on January 12, 2011, at which time Petitioner reported that the pre-operative symptoms had resolved and she was progressing well. He testified that she was advanced to light duties, driving and that she had some episodic dizziness for which she was sent to an ENT. He testified that at the time of the March 30, 2011 visit, Petitioner reported good resolution of her symptoms and the imaging studies showed continued good placement of the hardware and good healing. He testified that physical therapy had been recommended, but apparently was not approved. He testified that he continued to recommend physical therapy and/or a work hardening program and eventually a functional capacity evaluation. He testified that he released Petitioner on a permanent restriction of the sedentary physical demand level, and that she continued to have some stiffness, numbness and tingling of the left leg which he felt could be permanent based on the possible permanent damage done by the disc herniation. (PX7).

Dr. Fonn testified that he last saw Petitioner on May 29, 2013, where he continued to reflect the permanent restriction of sedentary physical demand level which was based upon a functional capacity evaluation. He testified that he did not believe that Petitioner ever had an appropriate physical therapy or work hardening course due to lack of insurance approval. He testified that he thought physical therapy, especially post-operatively, was absolutely critical in the healing process, and if not allowed to do it may result in the patient continuing to have a less than ideal outcome, continued symptoms and possibly worsening of symptoms as she progressed. He confirmed that for a period of 9-10 months post-operatively Petitioner had not been able to go through the traditional recovery as prescribed by him given the lack of physical therapy authorization. He testified that he did not have plans to see Petitioner again as she was released at the time of the May 29, 2013 visit. (PX7).

Dr. Fonn testified that his billings were based on the use of an external company that provided them with a fee schedule. He testified that research was done in the geographical area, and that the fee schedule was based on what other similar providers were doing. He testified that the company provided him with a range of what the fee could possibly be, and he utilized the 70th percentile of that range. (PX7).

On cross-examination, Dr. Fonn confirmed that he did not have a copy of the current billing at the time of the deposition but testified that he had reviewed his bill for Petitioner prior to the deposition. He agreed that he had not reviewed the billing in preparation for the deposition, but it was his typical practice to weekly review all patients and outstanding bills on a weekly basis at finance meetings. He testified that he did not review Petitioner's billing that week as part of his review. (PX7).

On cross-examination, Dr. Fonn testified that his charges were usual and customary for his geographical region. He testified that the fee schedule was developed based on usual and customary charges. He testified that the fact that he did not have the bill in front of him had no bearing or relationship to the fact that the current billing, whatever it might be, was usual and customary for the area. He testified that the external company used to create the fee schedule was called ECMC Squared. He further testified that the company was utilized by pretty much all neurosurgeons across the country, and that it provided data in numbers and a fee schedule based on the research performed for the particular geographical area based on the zip code. (PX7).

On cross-examination, Dr. Fonn agreed that he first saw Petitioner on May 13, 2010 at which time he noted a traumatic disc herniation at L3-4. He agreed that he noted prior lumbar surgeries at L2-3 and L4-5. He agreed that at the time of the May 13, 2010 visit, his treatment plan was the epidural injection at the 3-4 level, but not at either the L2-3 or L4-5 levels. He agreed that at the time of the July 14, 2010 visit, he recommended a three-level fusion on that date. When asked if as of July 2010 he did not necessarily disagree that Petitioner could have had a microdiscectomy at L3-4, Dr. Fonn responded that Petitioner could have had a myriad of different treatment options but his goal was to make the diagnosis and create the best treatment plan for her that included multiple aspects. (PX7).

On cross-examination, when asked about his discussion that the L5-S1 and L1-2 levels would be levels that he would need to keep an eye on because they would need possible treatment down the road, Dr. Fonn responded that his concern was the fact that Petitioner had a three-level fusion and sometimes the levels above and below could wear out which would mean treatment down the road. He testified that a microdiscectomy was a temporary surgery that treated only leg pain, and had nothing to do with back pain. He agreed that a three-level fusion was a far more invasive procedure than a microdiscectomy at one level, but testified that the healing time from a one-level microdiscectomy versus that of a three-level fusion was really the same. (PX7).

On cross-examination when asked what would be the difference in recovery time between a three-level fusion and a single-level microdiscectomy, Dr. Fonn responded that they were different surgical interventions at different levels and were more akin to apples and oranges. He further testified that there was obviously going to be a difference in the two surgeries because they were two completely different surgeries at multiple levels. He testified that the only information he could give was based on his recommendation to his patients, which typically included advancing them to driving and light duties in 2-4 weeks, after which they would be seen 14 weeks later with x-rays and advanced to either physical therapy or a functional capacity evaluation. (PX7).

On cross-examination when asked whether the testimony of Dr. Vaught and Dr. Smith, both board-certified neurologists or neurosurgeons who testified that Petitioner did not need a three-level fusion but rather needed a single-level microdiscectomy at L3-4 and whether that gave him cause for concern, Dr. Fonn responded that it did not. He testified that he based his information and recommendations for Petitioner on what he perceived as what was ailing the patient and attempted to definitively treat her symptoms. (PX7).

On redirect examination, Dr. Fonn agreed that his opinion was that the levels at L2-3 and L4-5 were in such a state that if a single-level microdiscectomy was done at L3-4, it would not have had long-term lasting results. He agreed that his recommendation to do the three-level fusion as opposed a single-level microdiscectomy was based on his desire to get the best possible results long-term for Petitioner. He testified that he understood that the prior procedures performed at the L2-3 and the L4-5 levels were microdiscectomies, which meant that they were weakened and might cause destruction of the facets, ligaments, joints and disc space. He testified that this set the level up for a possible significant deterioration if the one-level fusion was performed between that microdiscectomy, and that Petitioner would almost certainly need to come back for additional surgery, probably a fusion down the road at the level above and below. He testified that he thought there was no point in having to do multiple surgeries for a patient that could easily be done in one. He testified that he did not feel there was any way he could safely perform a microdiscectomy or a fusion at one level given the fact that Petitioner had a microdiscectomy at the levels above and below. (PX7).

On further cross-examination, Dr. Fonn agreed that he consented to be reprimanded by the State Medical Board of Ohio regarding making factual misstatements in connection with renewal of his osteopathic training certificate in the state of Missouri in order to proceed with obtaining his Missouri license. (PX7).

On further redirect examination, Dr. Fong testified that all bills were generated based on the procedure performed and had nothing to do with the patient. (PX7).

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

The Functional Capacity Examination of June 6, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The report noted that Petitioner demonstrated the ability to perform 41.2% of the physical demands of her job as a C-section technician. The report noted that the return to work test items that Petitioner was unable to achieve successfully during the evaluation included occasional squat lifting, occasional powerlifting, occasional unilateral lifting, occasional bilateral carrying, bending, squatting, sustained squatting, static balance and total standing. The report further noted that Petitioner demonstrated the ability to perform within the Light physical demand level based on the definitions developed by the U.S. Department of Labor and outlined in the Dictionary of Occupational Titles. (PX9).

The medical records of Memorial Hospital of Carbondale were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The records were effectively duplicative of those as contained in Petitioner's Exhibit 1. (RX1).

The medical records of WorkCare/Dr. Austin were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records were effectively duplicative of those as contained in Petitioner's Exhibit 1. (RX2).

The medical records from Herrin Hospital pertaining to diagnostic imaging performed on October 6, 2009 were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner underwent x-rays of the lumbar spine, which were interpreted as revealing (1) no acute fracture or subluxation; (2) degenerative changes of the lumbar spine. The records further reflect that Petitioner underwent x-rays of the left hip, which were interpreted as revealing no radiographic abnormality of the left hip. (RX3).

The medical records of SIH Rehab Unlimited-Carbondale were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records pertain to physical therapy performed during the timeframe of October 19, 2009 through November 12 2009. (RX4).

The medical records of Dr. Roger Jones were entered into evidence at the time of arbitration as Respondent's Exhibit 5. While the majority of the records were duplicative of those as contained in Petitioner's Exhibit 2, there was also included an office note dated April 1, 2010 which noted that Petitioner stated that the pain she had been experiencing in the back seem to be getting more constant. It was noted that she was getting more jittery and having trouble sleeping. It was noted that Petitioner got up and tried to walk around but could not do much, and that her activity level had gone down so therefore she had gained weight. The assessment was that of chronic back pain, reflux and insomnia. It was noted that Petitioner was to see the neurosurgeon the following day. (RX5).

The record of Dr. Paul Matz dated April 2, 2010 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report noted that Petitioner worked as a C-section technician and was bending on October 3, 2009 when she felt a pop in her left leg. It was noted there was sharp pain that radiated in the left leg, which was worse with flexion and activity. It was noted that Petitioner had been through a course of muscle relaxants, and that the pain had changed and was fairly constant. It was further noted that she had some tingling into the top of the left foot. It was noted that Petitioner underwent a lumbar laminectomies in 1982 and 1986. The assessment of Dr. Matz was that of radiculitis with weakness in the left leg which was very mild. He recommended that Petitioner undergo another MRI, and if the free fragment was there he thought it would warrant removal, but if it had reabsorbed then he would choose a non-operative route. (RX6).

The evidence deposition of Dr. Kevin Vaught was entered into evidence at the time of arbitration as Respondent's Exhibit 7. Dr. Vought testified that he is a board-certified neurosurgeon practicing in Cape Girardeau, Missouri at Regional Brain & Spine. He testified that he has been in private practice since 1999, was initially board-certified in 2005 and then was re-certified in 2014. (RX7).

Dr. Vaught testified that he examined Petitioner on August 4, 2010 and on January 4, 2012. He testified that following his reports he had occasion to review an additional CT scan performed on March 20, 2012, and that he prepared a report of his findings and conclusions following the review. (RX7).

Dr. Vaught testified that with respect to the IME report dated August 5, 2010, he noted that Petitioner complained of sharp pain in her low back which radiated into her left leg that began after a work-related injury on October 3, 2009 when she was working as a surgical technician and was cleaning

up a room after deliveries in the OB. He testified that Petitioner stated the pain had persisted and continued to be severe, and that she described it as an aching and stabbing pain that was aggravated with standing, sitting, bending, lifting and walking. He testified that he further noted that Petitioner reported some weakness in her left leg and foot, and had stumbled on several occasions due to the weakness in the left leg. He testified that Petitioner reported to him that she had been evaluated by a neurosurgeon and that a lumbar fusion had been recommended. (RX7).

Dr. Vaught testified that Petitioner reported to him that she had undergone two previous lumbar procedures, one of which was a laminectomy by Dr. Geise in either 1981 or 1982. He further testified that Petitioner reported a second lumbar laminectomy by Dr. Mollman that was performed in either 1995 or 1996. He testified that Petitioner stated she had done well from both of those procedures. He testified that his review of the MRI performed at Carbondale Memorial Hospital in December of 2009 showed post-operative changes from a previous left L2-3 and right L4-5, and that the surgical interventions did occur prior to the work accident at issue. He testified that Petitioner had an acute free fragment disc herniation at L3-4 on the left which had migrated inferiorly behind the L4 vertebral body, and that she also had some foraminal stenosis at the same level. He testified that Petitioner had a very small central disc protrusion at L5-S1 with no significant nerve root impingement. He also testified that he did not see any evidence of recurrent disc herniations at her two previous surgical sites. (RX7).

Dr. Vaught testified that with the inferiorly migrated free fragment, and implied that there was a more substantial disc herniation and in that location as it was traveling behind the vertebral body at L4, it was generally causing significant pressure on the nerve root. He testified that patients with this pathology often times were in excruciating pain and could develop motor or sensory complaints or even deficits because of the pressure on the nerve. He testified that the L4 nerve root was being compressed in this case. He further testified that with the L5-S1 area that showed a small central disc protrusion without significant nerve root impingements, there was some pathology at that level but nothing that rose to the level of clinical importance or would fit with Petitioner's pain complaints. He testified that the pathology on the MRI at L3-4 fit with the pain complaints that Petitioner was having and with her physical findings on examination. (RX7).

Dr. Vaught testified that the physical examination performed in August 2010 revealed that Petitioner had weakness in her tibialis anterior and halluces on the left that would cause weakness in the distal leg. He testified that Petitioner complained of decreased sensation to light touch in pinprick in the left L4 dermatomal pattern which would correlate with her disc herniation, and that her straight leg raise was positive on the left at 85°. He also testified that Petitioner had a positive reverse straight leg raise on the left. He testified that the physical findings were consistent with the pathology he observed at the L3-4 level, namely the acute free fragment disc herniation. (RX7).

Dr. Vaught testified that with respect to Dr. Matz's records, the only difference noted on the physical examination was that he appreciated weakness in the left hip flexor and left quadriceps but otherwise his impression, diagnosis and treatment recommendations were essentially the same. He testified that Dr. Matz agreed with him about the MRI showing the acute free fragment at L3-4, and that Dr. Matz's referral to the removal of the free fragment was a surgical procedure known as a microdiscectomy. He confirmed that Dr. Matz did not recommend a fusion at L3-4, nor did he recommend a fusion at any level of Petitioner's lumbar spine. (RX7).

Dr. Vaught testified that based on the history given by Petitioner, her subjective complaints, his objective physical findings and his review of Petitioner's records and the MRI, his assessment of Petitioner's condition was that she suffered a work-related injury, and that he felt that she had had reasonable care to that point in terms of conservative care but unfortunately it had not been successful. He testified that he felt Petitioner's best opportunity for getting better was to undergo a microdiscectomy at

L3-4 on the left, which was the same procedure that Dr. Matz had discussed with Petitioner. He testified that he did not recommend intervention at any other level of Petitioner's spine. (RX7).

Dr. Vaught testified that the L4-5 epidural injections were reasonable to treat Petitioner's condition as it related to her work accident, although he did note that L4-5 was not where her pathology was. He testified that he was of the opinion that the CT myelogram was not necessary for Petitioner's condition nor was the discogram, given that Petitioner had radicular complaints from a disc herniation. He testified that surgical intervention should have been entertained after the December MRI, and that the intervention was that of the microdiscectomy. He testified that when he saw Petitioner in August of 2010, she was not a candidate for a lumbar fusion at L3-4 because there was no indication for a fusion. (RX7).

Dr. Vaught testified that generally a person who has a microdiscectomy goes home within 24 hours of the surgery, and that generally the length of the surgery is less than one hour. He testified that with the microdiscectomy, the average blood loss is usually minimal, there is no need for blood transfusions, and the overall recovery by six weeks is that most people are able to return to most of their normal routine and that by 10-12 weeks they should be doing anything they want with no long-term restrictions. He testified that with respect to the fusion, in this case the surgery took over six hours, Petitioner was in the hospital for 3-4 days, she required blood transfusions, and then did not return to work. He testified that the average healing time for a fusion was 4-6 months. He testified that a microdiscectomy did not render any long-term restrictions and did not change an individual's range of motion, but a lumbar fusion would eliminate all the motion at the joint segments and typically brought with it permanent lifting restrictions. He testified that the loss of range of motion had substantial effects on people when it was more than two levels, and that most people after a three-level fusion did not have any chance of going back to work and oftentimes were very limited in their activities because of the effects on their spine from not being able to bend or twist. (RX7).

Dr. Vaught testified by the time he saw Petitioner in January 2012, she had undergone surgical intervention which consisted of an L2-3, L3-4 and L4-5 decompression and fusion. He agreed that this was not the surgery that he recommended. He testified that at the time that he saw Petitioner in January of 2012, she complained of persistent back pain and described an aching sensation with stabbing pain along her buttocks and hips. He testified that Petitioner also reported experiencing numbness and pain in her legs, left greater than right. He testified that Petitioner stated her pain would increase with sitting, walking lifting and bending, and that she stated she could not ride in a car for any length of time due to back pain. He further testified that Petitioner had noticed that she had very little range of motion in her lumbar spine, and that she had not been able to return to work. (RX7).

Dr. Vaught testified that the physical examination performed revealed that Petitioner had 4+/5 weakness in the left quadriceps, she had decreased sensation to pinprick of the entire left lower extremity as compared to the right, she had a trace left patellar reflex, and she had tenderness to palpation diffusely over her lumbar spine and over her SI joints bilaterally. He testified that the severe leg pain that Petitioner had prior to the surgery was better, but the complaints of limited range of motion were to be expected with the three-level lumbar fusion. He testified that a lot of her persistent mechanical back pain complaints were attributable to Petitioner's lumbar fusion. He testified that he did not believe that the three-level fusion was reasonable and necessary for the condition that he causally related to the work accident. He further testified that the complaints of limited range of motion and chronic back pain were related more to her fusion than the work accident. (RX7).

Dr. Vaught testified that his belief that Petitioner would unlikely be able to return to her previous job was due to the three-level fusion and not the work accident. He testified that physical therapy following the three-level fusion would not have changed anything in terms of Petitioner's ability to return to work or range of motion. He testified that it was not reasonable and necessary to perform fusions at L2-

3 and/or at L4-5 simply because prior surgical interventions had been performed at those levels, and he testified that it would not have been necessary to fuse all of those levels just to treat L3-4 because of the prior surgical intervention. He testified that a doctor could have been able to safely treat Petitioner at L3-4 without treating the levels above or below. He testified that a future possibility of additional surgery including a fusion was always possible, but there was nothing in Petitioner's imaging or examination that suggested she needed a fusion at the present time. (RX7).

Dr. Vaught testified that the CT scan performed in January 2012 confirmed that Petitioner had achieved a solid fusion at all three levels, and was important just to make sure that she had indeed fused. He testified that by confirming that Petitioner was fused, they knew that there was no treatable cause of her back pain such as a non-union. He testified that Petitioner was at maximum medical improvement as of that date, and he recommended a functional capacity evaluation to determine Petitioner's work restrictions. He testified that he attributed the work restrictions to the three-level fusion and not the work accident. He testified that based on his experience, the vast majority of people with a one level fusion who healed from surgery generally were able to resume their normal activities and resume their previous occupation. He testified that typically for a microdiscectomy, an individual could usually go back to work somewhere in the 6-10 week range. (RX7).

Dr. Vaught testified that as a board-certified neurosurgeon performing lumbar surgery in and around the Cape Girardeau area, his group used a national fee analyzer that was published by Ingenix in order to determine what usual and customary charges were in the area and that they also had at their disposal Medicare charges and payments. He testified that Deposition Exhibit 5 was a coding comparison of the charges from Dr. Fonn and his group, Regional Brain & Spine. He testified that there was a listing of the payments for each CPT code, and that there were some CPT codes that were used in Dr. Fonn's billing that were not allowed. He testified that on page 3 of Exhibit 5, the total of $73,528.08 represented the usual and customary charges in the area for the procedure that Petitioner actually underwent and was based on a national fee analyzer which represented usual and customary charges of the 75th percentile. (RX7).

Dr. Vaught testified that a one-level microdiscectomy was going to cost less than a three-level fusion. He testified that page 4 of Exhibit 5 showed a reasonable estimate of what the expected charges would have been for a one-level microdiscectomy, and that the amount of $8,840.16 was the usual and customary charge for the surgery that he recommended which did include the surgeon and an assistant surgeon. He confirmed that the charges were prior to any reduction under the Illinois medical fee schedule. He testified that he currently performed surgery at two locations, one of which was West Park Surgery center in Cape Girardeau and the other was at Southeast Hospital also in Cape Girardeau. He testified that the usual and customary charge for the procedure at West Park Surgery Center was $19,954, and that the current charge at Southeast Hospital for the procedure was $56,000. He further testified that those amounts were before any reduction under the Illinois medical fee schedule. (RX7).

On cross-examination, Dr. Vaught testified that the difference between the amounts for Southeast Hospital and West Park Surgery Center reflected the common difference between any hospital and any surgery center. He testified that the surgery center was an entity that charged fees for its services rendered to the patient, while the hospital typically inflated their charges because they were not going to get paid by a number of the patients they treated. (RX7).

On cross-examination, Dr. Vaught agreed that it was fair to say that it was impossible to know exactly what the results would have been had Petitioner undergone the microdiscectomy. He testified that if the microdiscectomy was not successful, a variety of treatment options existed including medications or a repeat microdiscectomy if there was a recurrence of a disc herniation. He testified that if Petitioner had exhausted treatment and was ready for a one-level fusion, he would have only included the L3-4 level

because there was nothing at the adjacent levels on imaging that he felt warranted a fusion. He testified that he had been impressed with how poorly patients generally did with three-level lumbar fusions, and he typically tried to avoid it as much as he could. He testified that if you fused three levels then you were putting the adjacent levels at a very high risk of developing adjacent segment disease and ultimately requiring those levels be incorporated into the fusion as well. He testified that adjacent segment disease got more amplified with the more levels you were doing. (RX7).

On cross-examination, Dr. Vaught agreed that a one-level fusion at L3-4 potentially caused problems with adjacent level disease for the two previous procedures that she had, but on the imaging he reviewed there were no signs that she needed a fusion at any level or that there was a high likelihood of the adjacent levels eventually requiring a fusion given there was no recurrence of symptoms from those levels. (RX7).

On redirect examination, Dr. Vaught testified that the one-level microdiscectomy did not have to be performed in a hospital, and with healthy patients under the age of 65 they were routinely done in surgery centers. He testified that the trend of doing them more in surgery centers over the years had been because of the cost savings to patients. He testified that Petitioner would have qualified as healthy and under 65 when she underwent surgery. (RX7).

The IME report of Dr. Vaught dated August 4, 2010 was entered into evidence at the time of arbitration as Respondent's Exhibit 8. The report noted a chief complaint of low back pain and leg pain, and the date of injury was noted to be that of October 3, 2009. It was noted that at that time, Petitioner was working as a surgical tech and was cleaning up the room after deliveries and developed a sharp pain in her low back which radiated into her left leg. Dr. Vaught noted that Petitioner reported that the pain had persisted and had continued to be severe, and she described it as an aching and stabbing-type pain. It was noted that Petitioner's pain was aggravated with standing, sitting, bending, lifting and walking, and that she had also noticed weakness in her left leg and foot. It was further noted that Petitioner had been seen and evaluated by a neurosurgeon, and that a lumbar fusion had been recommended. (RX8).

The IME report noted that Petitioner's MRI scan of the lumbar spine performed at Carbondale Memorial Hospital in December 2009 revealed previous surgical intervention on the left at L2-3 and on the right at L4-5, and that Petitioner had an acute free fragment disc herniation at L3-4 which had migrated inferiorly along the L4 vertebral body. It was further noted that Petitioner had some mild foraminal stenosis on the level on the left at this level, and that there was a small central disc protrusion at L5-S1 without significant nerve root impingement. (RX8).

The IME report noted that Dr. Vaught felt that Petitioner was symptomatic from her left L3-4 free fragment disc herniation, and that she had complaints of back and left leg pain with L4 radiculopathy on physical examination. It was noted that Petitioner had weakness of her dorsi flexion and extensor hallux longus on the left with sensory changes in an L4 dermatome. It was noted that Dr. Vaught opined to a reasonable degree of medical certainty that the prevailing factor for Petitioner's current symptoms was her work-related injury in October of 2009, that Petitioner was not at maximum medical improvement and that Petitioner was unable to work at that point in time. It was noted that a left L3-4 hemilaminotomy and microdiscectomy was recommended, and that there were no indications for a lumbar fusion. It was further recommended that prior to proceeding with surgery, it would be essential to review Petitioner's lumbar myelogram and discogram. It was further noted that surgical intervention should have been entertained after the MRI scan was performed in December of 2009. (RX8).

The IME report of Dr. Vaught dated January 4, 2012 was entered into evidence at the time of arbitration as Respondent's Exhibit 9. It was noted at that time that Petitioner underwent an L2-3, L3-4 and L4-5 decompression and fusion since the last independent medical examination, and that she

continued to have back pain complaints. It was noted that Petitioner described her back pain as an aching sensation with a stabbing pain along her buttocks and hips, and that she also experienced some numbness and pain in her legs, left greater than right. It was noted that Petitioner's pain would increase with sitting, walking, lifting and bending, and that she could not ride in a car for any length of time due to back pain. It was further noted that Petitioner noticed she had very little range of motion of her back, and that physical therapy had been recommended prior to her returning to work but had not been approved. (RX9).

The IME report noted that Dr. Vaught was of the opinion that the treatment rendered by Dr. Fonn was not reasonable or necessary, and that there were no indications for a lumbar fusion. It was noted that Dr. Vaught was unable to determine whether Petitioner had reached maximum medical improvement, and that they did not have a CT scan of the lumbar spine to review in order to assess whether she had developed a solid fusion. Dr. Vaught noted that should the CT scan demonstrate a solid fusion, he felt that Petitioner would be at maximum medical improvement. Dr. Vaught also noted that if Petitioner would have proceeded with the left L3-4 hemilaminotomy and microdiscectomy as previously recommended, she would not have lost three motion segments in her lumbar spine, and further suggested that the loss of three motion segments of the lumbar spine significantly affected her activity and working capabilities. (RX9).

The IME report noted that Dr. Vaught recommended a functional capacity evaluation to evaluate Petitioner's ability to return to work, and that he felt it was unlikely that Petitioner would be capable of returning to her previous job. It was noted that Dr. Vaught was of the opinion that if Petitioner would have proceeded solely with a microdiscectomy, her probability for returning to her normal job would have been significantly greater. The report further suggested that Dr. Vaught felt that Petitioner had significant limitations due to the procedure performed, and not due to the work-related injury which was a disc herniation at L3-4. (RX9).

The report of Dr. Vaught dated March 20, 2012 was entered into evidence at the time of arbitration as Respondent's Exhibit 10. The report noted that Dr. Vaught reviewed Petitioner's CT scan of the lumbar spine performed at Cape Radiology in January 2012, and that the study revealed the hardware and grafts to be improper location. He further noted that Petitioner appeared to have a solid fusion, and thus no additional surgical recommendations were made. The report noted that Dr. Vaught felt that Petitioner was at maximum medical improvement and that a functional capacity evaluation should be performed to determine work restrictions. (RX10).

The Midwest Neurosurgeons Coding Comparison as prepared by Dr. Vaught was entered into evidence at the time of arbitration as Respondent's Exhibit 11.

The transcript of the evidence deposition of Dr. Kenneth Smith was entered into evidence at the time of arbitration as Respondent's Exhibit 12. Dr. Smith testified that he has been board-certified by the American Board of Neurological Surgeons since 1969, that he started work at St. Louis University as an assistant professor and ultimately rose to be chairman of the division of neurosurgery until 2008 when he retired from neurosurgical practice. He testified that he performed a utilization review of a proposed a surgical procedure on or about September 1, 2010. (RX12).

Dr. Smith testified that as part of his utilization review, he had opportunity to review a report from Dr. Matz stated April 2, 2010. He testified that Dr. Matz documented that the MRI from Southern Illinois Healthcare performed December 2, 2009 indicated a left L3-4 disc fragment had ruptured and had gone down beneath the medial aspect of the left L4 pedicle. He testified that Dr. Matz in his physical examination noted that the left lower limb had slight weakness of the left hip flexor and left quadriceps, and that Petitioner's left knee reflex was absent which he testified indicated she had problems at the left

L3-4 nerve roots by the herniated disc. He testified that the physical examination performed on April 2, 2010 correlated with the pathology Dr. Matz stated he saw on the December 2009 MRI. (RX12).

Dr. Smith testified that he had opportunity to review the radiology report of for the MRI scan, and he was of the opinion that Dr. Matz's assessment was consistent with the report. He testified that there was nothing noted in Dr. Matz's physical examination to indicate that Petitioner was experiencing any symptoms attributable to either L2-3 or L4-5. He testified that Dr. Matz recommended a repeat MRI as it had been four months since the MRI had been performed. He noted that Dr. Matz indicated that if the free fragment was there, he thought Petitioner should have surgery but if the fragment had resorbed then non-operative treatment would be recommended. He further testified that Dr. Matz indicated that the surgical intervention would consist of an L3-4 microdiscectomy on the left. He testified that there was no surgical recommendation for any sort of treatment or surgical intervention at L2-3 or L4-5. (RX12).

Dr. Smith confirmed that he also had opportunity to review Dr. Vaught's record of August 4, 2010 as part of his utilization review. He testified that Dr. Vaught's review of the December 2009 lumbar MRI scan revealed previous surgical intervention on the left at L2-3, right at L4-5, that there was an acute disc fragment herniation at L3-4 which had migrated inferiorly along the L4 body, and that Petitioner did have some mild foraminal stenosis on the left at this level. He testified that this was consistent with Dr. Matz' impression of the 2009 lumbar MRI, and was also consistent with the radiology report for the MRI. (RX12).

Dr. Smith testified that the physical findings that Dr. Vaught documented in his note correlated to the pathology observed at L3-4 on the lumbar MRI scan, but that the tibialis anterior left at 4/5 and extensor hallicus longus on the left at 4/5 was usually more L5 nerve root but could be L4. He testified that Dr. Vaught recommended a left L3-4 hemilaminectomy and microdiscectomy, and that there were no indications for a lumbar fusion. He testified that this was the same surgery as recommended by Dr. Matz. He testified that an indication for a lumbar fusion would include instability or misalignment of the vertebral bodies, as well as severe bilateral foraminal stenosis or central stenosis but noted that none of those things were present in this case. He testified that there was nothing in the medical records in this case that would potentially indicate a lumbar fusion. (RX12).

Dr. Smith testified that Petitioner came under Dr. Fonn's care on or around May 13, 2010. He noted that the physical findings on that date included neurological findings showing decreased sensation in the L4 distribution on the left and loss of patellar reflex. He testified that these physical findings were consistent with the L3-4 pathology. He testified that he agreed with Dr. Vaught's statement that following the 2009 lumbar MRI that a microdiscectomy was reasonable and necessary, and that the need for surgery was clear and apparent. He testified, however, that Dr. Fonn recommended several epidural injections, as well as a CT myelogram to confirm the diagnosis. (RX12).

Dr. Smith testified that he thought the official guidelines indicated that a CT myelogram was not necessary if you had a clear-cut diagnosis on the MR, and he agreed that Petitioner had a clear-cut diagnosis on her MRI in this case. He testified that he agreed with Dr. Vaught that Petitioner needed surgery, and he was of the opinion that delaying and doing injections was certainly not necessary. He testified that he agreed that the microdiscectomy at L3-4 as recommended by Dr. Vaught and Dr. Matz was the appropriate procedure. He testified that with respect to the discogram, it was not reasonable and necessary treatment because the official guidelines stated that discograms were not indicated because they were not accurate or helpful. (RX12).

Dr. Smith testified that in many cases, a patient undergoing a microdiscectomy goes home the very same day and is back to work in a light duty capacity in 2-3 weeks but that a patient with a fusion is typically in the hospital for two or three days and is disabled for months. He testified that there were

many risks to a fusion that were not present when undergoing a microdiscectomy, including paralysis, pain and nerve irritation. He testified that a three-level fusion was also going to result in more loss of range of motion than you would have with a simple microdiscectomy. (RX12).

Dr. Smith testified that Dr. Fonn recommended a fusion at L2-3, 3-4 and 4-5. He testified that based upon all of the records that he reviewed as part of the utilization review, he did not believe that that surgical intervention was reasonable and necessary treatment for Petitioner. He testified that he believed a single-level microdiscectomy at L3-4 would have been reasonable and necessary. He testified that the microdiscectomy had a 90-95% chance of success in a patient that had a bona fide herniated disc and that the fusion was highly variable. He further testified that some cases had less than 50% with a good result from a fusion. (RX12).

The Utilization Review dated September 1, 2010 as prepared by Dr. Kenneth Smith was entered into evidence at the time of arbitration as Respondent's Exhibit 13. The review noted that the recommendations were to non-certify the three-level fusion proposed by Dr. Fonn at L2-3, L3-4 and L4-5 as not being reasonable or necessary to treat Petitioner for injuries she received as a result of the incident of October 3, 2009. It was noted that the Official Disability Guidelines indicated that a fusion was not recommended for patients who had less than six months of failed recommended conservative care unless there was objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but was recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise. (RX13).

The transcript of the evidence deposition of John Brogan with Rising Medical Solutions was entered into evidence at the time of arbitration as Respondent's Exhibit 14. Mr. Brogan testified that he is the technical assurance director at Rising Medical Solutions, and that his responsibilities include the technical guidelines, rules and procedures for medical bill audits for worker's compensation, auto and other forms of insurance. He testified that as part of his job, he reviews medical bills for the purpose of obtaining usual and customary charges, and that he has experience with the Illinois medical fee schedule. He testified that he also did estimates of prospective costs for prospective medical treatment. (RX14).

Mr. Brogan testified that he has worked for Rising Medical for almost 10 years, and that prior to that he managed a third party administrator who did their own bill audits in-house. He testified that he has worked in the medical billing industry for approximately 25 years. He testified that he was asked to perform an estimate of costs for a lumbar hemilaminectomy, which consisted of the estimated costs for the surgeon, hospital and anesthesia. (RX14).

Mr. Brogan testified that the location he was asked to review was that of Cape Girardeau, Missouri. He testified that he used the 80th percentile as determined from the Ingenix/FAIR Health database. He testified that the FAIR Health database was a non-profit company that maintained a database of charged data, which was broken down by procedure and geographic area. He testified that the 50th percentile would be the average, and that the 80th percentile represented 80% of the bills billed by other providers in that geographic area were at or less than the amount shown. He testified that the Ingenix database was used by many entities, including the federal government, for determining fees. (RX14).

Mr. Brogan testified that based on his review of the Ingenix data for the Cape Girardeau, Missouri area, the cost for a surgeon for a laminectomy was that of $8,313.56, and for the assistant surgeon it was $1,662.71. With respect to the hospital fee of $29,861.38, Mr. Brogan testified that they did not have usual and customary data for inpatient hospitals so he provided the Illinois fee schedule rate as if the surgery had been done in-state. He testified that in Illinois the fee schedule was based upon DRG, and that there was a fee schedule rate linked to each DRG code in the Illinois fee schedule. He testified

that for the laminectomy the correct DRG code was 490, and that the fee schedule rate for that DRG code was $29,861.38. He testified testified that all of the numbers contained in his report represented usual and customary charges are for the laminectomy procedure. (RX14).

The Cost Estimate Report as prepared by John Brogan was entered into evidence at the time of arbitration as Respondent's Exhibit 15.

The Reprimand issued by the State Medical Board of Ohio pertaining to Dr. Fonn was entered into evidence at the time of arbitration as Respondent's Exhibit 16. According to the Consent Agreement, Dr. Fonn admitted that he failed to inform the Board in his training certificate application that he been warned by his residency program director that conflict with personnel could lead to a non-renewal of his residency contract, and that Dr. Fonn made factual misstatements regarding the conflicts in his residency program and the residency director's response when deposed by the State Medical Board of Ohio in April of 2007. (RX16).

The listing of medical bills paid by worker's compensation was entered into evidence at the time of arbitration as Respondent's Exhibit 17.

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on October 3, 2009, Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that her current condition of ill-being is causally related to the work accident of October 3, 2009.

The Arbitrator notes that the primary dispute as it pertains to the issue of causation is not whether Petitioner's need for surgery was causally related to the underlying accident that occurred on October 3, 2009, but rather the specific type of surgical procedure that Petitioner should have undergone as a result of the injury sustained in the underlying accident. While the Arbitrator notes that Respondent is of the position that Petitioner should have undergone the microdiscectomy procedure at L3-4 on the left as recommended by both Dr. Vaught and Dr. Matz as well as the utilization review physician, Dr. Smith, Petitioner ultimately underwent the three-level fusion as recommended by her treating physician, Dr. Fonn. The Arbitrator notes that there does not appear to be a dispute that Petitioner sustained an L3-4 free fragment disc herniation as a result of the accident on October 3, 2009, or that Petitioner previously underwent microdiscectomies at L2-3 and L4-5 in 1982 and 1995, respectively.

In so finding that Petitioner's current condition of ill-being is causally related to the work accident of October 3, 2009, the Arbitrator finds that Dr. Fonn testified credibly regarding the basis for his recommendation that Petitioner undergo the three-level fusion procedure instead of the microdiscectomy procedure at L3-4 on the left as recommended by Drs. Vaught, Matz and Smith. Dr. Fonn testified that he found weakness in the L4 distribution on the left, that Petitioner also had some decreased sensation in the L4 nerve root on the left and loss of patellar reflex, and that Petitioner presented with an L4 radiculopathy. Dr. Fonn testified that based on the MRI which showed a large disc herniation at the L3-4 level with inferior migration with impingement of the left L4 nerve root, he felt that the disc herniation was causing the L4 radiculopathy. Dr. Fonn testified that he felt they needed to confirm the diagnosis with a CT myelogram of the lumbar spine, and that the CT myelogram ultimately confirmed collapse of the L4-5 level, the prior surgery at the 2-3 and 4-5 level and the disc herniation

with inferior migration at the L3-4 level causing impingement and irritation of the descending L4 nerve root, as well as an L5-S1 broad-based disc herniation. Dr. Fonn further testified that he had definitive concerns with a microdiscectomy, which he thought would only relieve her symptoms temporarily at best. Dr. Fonn also testified that Petitioner had multiple levels operated above and below the level, which also concerned him because an additional microdiscectomy would further destabilize the spine. (PX7). The Arbitrator finds Dr. Fonn's testimony as to the basis for the performance of the three-level fusion to be reasonable, and, as such, places greater weight on his opinion on the proper procedure to have been performed.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident of October 3, 2009, and that the care and treatment rendered by Dr. Fonn was reasonable and necessary for the injuries sustained by Petitioner on October 3, 2009.

With respect to disputed issues (J) pertaining to necessary medical services and (O) pertaining to usual and customary charges, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

While the Arbitrator finds that the care and treatment rendered by Dr. Fonn was reasonable and necessary for the injuries sustained by Petitioner, the Arbitrator finds that the charges issued by Dr. Fonn were not usual and customary for the procedure that was performed. The Arbitrator places greater reliance upon the opinion of Dr. Vaught as to the usual and customary charges for a three-level fusion in the same geographic region. As such, the Arbitrator finds that Respondent shall pay $73,528.08 for the physician component of the procedure performed, subject to the fee schedule and any applicable 8(j) credit.

With respect to the billing at St. Francis Medical Center, because no contrary evidence was offered as to the usual and customary charges for a three-level fusion in the same geographic region, the Arbitrator finds that Respondent shall pay $355,660.39 for the hospital component of the procedure performed, subject to the fee schedule and any applicable 8(j) credit.

With respect to the remaining bills as contained in Petitioner's Exhibit 8, the Arbitrator awards the following, subject to the fee schedule and any applicable 8(j) credit:

- Memorial Hospital of Carbondale, in the amount of $4,898.33;
- Roger D. Jones, MD, in the amount of $176.00;
- St. Francis MC Anesthesia, in the amount of $3,784.00
- Hospitalists of Cape Girardeau, in the amount of $556.00;
- Cape Radiology Group, in the amount of $71.00;
- Cape Lab and Pathology, in the amount of $1,368.00;
- Occupational Performance & Rehab, in the amount of $8,804.20.

With respect to the billing at Goreville Professional Pharmacy, the Arbitrator notes that Petitioner claimed $147.56 in prescription costs from Goreville Professional Pharmacy but no evidence was offered regarding the reasonableness, necessity or causal relationship of these prescriptions. As the Arbitrator declines to speculate, Petitioner's claim for $147.56 is denied.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that the parties stipulated at the time of arbitration that Respondent has a policy of accommodating light duty work restrictions, and that Respondent would have accommodated Petitioner's work restrictions under that policy. Based on the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 27.5% loss of use of the person-as-a-whole as provided in Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dale Dougherty,

Petitioner,

vs.

NO: 10 WC 38790

17IWCC0638

Transport America,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission following the remand order of Vermilion County 5th Circuit Court Judge Derek J. Girton reversing the Commission's finding on the issue of accident and remanding case for further proceedings. The Commission, after considering the issues of accident, notice, causation, medical expenses, temporary total disability and nature and extent, reverses the Decision of the Arbitrator, for the reasons stated below.

Findings of Fact

I. Procedural History

In a decision filed November 5, 2014, the Arbitrator "… conclude[d] that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on April 16, 2010." (Arb.Dec.[Addendum], p.4). In support of this finding, the Arbitrator noted that "Petitioner's act of returning to his truck to retrieve his personal belongings did not arise out of his employment for Respondent. While Petitioner was a traveling employee, he had already completed his route and was no longer on duty when he returned to the truck. Petitioner's testimony that he also returned to the truck to complete paperwork was not credible. Petitioner did not report this alleged activity to either Catherine Axtell or Paula Smith. Further, while Petitioner testified that his wife waited for him for approximately 30 to 40 minutes while he completed paperwork, she did not testify at trial." (Id.). The Arbitrator also noted the remaining issues were rendered moot in light of his finding as to accident. (Id.).

17IWCC0638

Petitioner filed a Petition for Review. In a Decision and Opinion on Review dated July 16, 2015 (15 IWCC 540), the Commission unanimously affirmed and adopted the Arbitrator's decision.

Petitioner subsequently appealed the Commission's decision to the circuit court. In an Order filed June 6, 2016, Vermilion County Associate Judge Derek J. Girton noted the following:

"After considering the arguments raised by both parties in their briefs and at oral arguments, the court finds:

1) The appropriate standard of review is *de novo*.
2) The Commission determined and it is undisputed that Petitioner Dale Dougherty was a traveling employee.
3) The test for determining whether an injury to a traveling employee arises out of and in the course of his employment is the reasonableness of the conduct in which he was engaged and whether the conduct might normally be anticipated or foreseen by the employer.
4) The Petitioner's injury arises out of and in the course of his employment because it was reasonable and foreseeable that he would return to the company-owned truck in order to gather his personal belongings for the weekend.

It is Hereby Ordered that the Commission's decision on the issue of accident is Reversed and the case is Remanded back to the Commission for further proceedings consistent with the ruling of this court."

II. Facts

Petitioner, a 55-year old over-the-road truck driver and resident of Danville, testified that he had worked for Respondent for more than five years. He indicated that as part of his job he would leave on a Sunday or Monday of a given week, pick up and deliver loads all week, and return to Danville on Friday or Saturday. He noted that he kept his truck on a "shut down" street at Main and Jackson in Danville, about three (3) miles from his home, given that ordinances and a lack of space kept him from parking at his home. He testified that Respondent knew where the truck was parked and had to know this information in case they needed to recover the truck. Petitioner indicated that his wife would pick him up and drop him off at the truck. He also noted that he would bring clothing, food and bedding and that he would sleep in the truck sleeper. (T.14-19).

Petitioner testified that he had no set schedule and that his route, miles and hours away from home would vary week to week. He noted that he would get a dispatch with pick up location information and how long he had to deliver it. He indicated that he generally did five (5) loads per week, but that it varied. He also noted that he was paid by the mile. (T.19-21).

Petitioner testified that while away from home he would take breaks for food, hygiene, sleep, or just for a break. He also indicated that he would sometimes perform personal errands. He noted that he was able to determine when to take breaks and how long they'd last, and that some of the breaks involved exiting and reentering the truck five (5) to ten (10) times a day. (T.21-23). He noted that he had to complete and turn in paperwork called "trip sheets" on a weekly basis.

17IWCC0638

Petitioner testified that these were "supposed to be done at the end of every load, but I wouldn't do them until the end of the week." He also indicated that a trip sheet had to be completed for each trip between destinations, and that in order to get paid they had to be turned in by midnight Saturday night. Petitioner stated that he would turn these in via a Transflo (fax) machine at the Pilot gas station in Covington, Indiana, since it was the closest truck stop that had one. He indicated that he would typically do this on Saturday. (T.23-27). He indicated that Respondent owns the truck that he drives.

Petitioner testified that on the date of the alleged accident, Friday April 16, 2010, he returned to Danville between 5:00 p.m. and 6:00 p.m. after driving his truck and parked it in his usual spot at Main & Jackson. He noted that his wife was waiting. He stated that he got out, inspected the truck, got in his wife's car and went to a steakhouse to eat. Petitioner testified that they then stopped at K-Mart "just to stretch my legs, walk around, look around." He indicated that he subsequently went back to the truck around 9:00 p.m. "to retrieve some personal belongings and to finish my paperwork", including three (3) trip sheets. When asked why he waited until then to fill them out, Petitioner responded: "it's just my standard way of doing everything every week." He indicated that it took 30-40 minutes to complete these forms. (T.27-31).

Petitioner testified that as he gathered his belongings and exited the truck, his left foot slipped off the top step and he fell approximately three-and-a-half (3.5) feet to the ground, landing on his left hip and elbow and resulting in pain in his left shoulder and ribs. He noted that he "couldn't move my arm" and that he "heard something kind of rip and snap when I hit the ground." He stated that his wife wanted to help him up, but that he declined the assistance. Petitioner noted that his sister and her boyfriend then came and tried to help, but that he eventually got up on his own and went to the Provena emergency department where he had elbow and shoulder x-rays and was given medication. Petitioner indicated that he did not make an appointment for follow-up care at that time because he was told he had a very deep bruise and it would take two (2) to three (3) weeks to feel better. Instead, he noted that his condition got worse. (T.31-36).

Petitioner agreed that he did not immediately report the incident to his employer, noting that he had "... already had a couple of workman's comp cases, and I was concerned about what that would do with my job." As a result, he noted that he provided E.R. staff with his group health insurance (BC/BS) information. Petitioner stated that Respondent contributes to the payment of these group insurance premiums. Petitioner indicated that did not know exactly when he told Respondent about the accident but that he would not dispute the medical record if it contains a note referencing the fact that it was about three (3) weeks afterwards. He noted that he did so because BC/BS was disputing payment of the bill, and that he needed a denial letter from workers' compensation and his auto insurance in order for them to pay it. Petitioner stated that he eventually got a denial letter from Respondent. (T.36-39).

A First Report of Injury dated July 15, 2010 reflects that Petitioner claimed he was injured on April 14, 2010 and that Respondent was notified on July 15, 2010. This report also noted that Petitioner related that "[h]e was not on duty and on home time. He went to remove his bag of dirty clothes from the truck that was parked in a parking lot near his home." (RX2).

17IWCC0638

Respondent's health and safety administrator, Catherine Axtell, was called to testify. Ms. Axtell noted that she had worked in this capacity for thirteen (13) years and that she handled workers' compensation claims for the company. Ms. Axtell testified that Respondent's policy is to report work injuries immediately. She noted that this information is contained in the driver's manual and that employees are told about it at orientation. She indicated that injuries are to be reported initially to the supervisor, who brings it to her attention. She stated that she then takes the information from the worker, helps them to get treatment if needed, completes the First Report of Injury and then submits it to the WC carrier (Zurich). (T.72-76).

Ms. Axtell testified that she first learned of Petitioner's accident in late June of 2010. She noted that Petitioner had evidently contacted LeaAnne at the Janesville facility, who in turn gave the information to Respondent's benefits manager, Joyce Ommen. (T.76-77). Ms. Axtell stated that she and Petitioner "... had talked to each other before at different times, so he initially wanted to know what could be done. That there was some confusion with his medical from BC/BS denying it, said that he – it wasn't work related, that he was home on his home time, and that he was removing some stuff from the truck." As to whether he told her about the accident when she first spoke to him, Ms. Axtell testified that Petitioner told her "... that he had been to the doctor in April, and that he was getting the bills for that, that they were denying it, saying that it was work related." She noted that when she asked him why BC/BS thought it was work related, Petitioner said he was taking something ("laundry") out of the truck, and that he had hurt his shoulder. She also indicated that Petitioner needed a denial letter in order for them to pay this bill.

Ms. Axtell testified that she had dealt with Petitioner on prior workers' compensation claims that he had filed, and that he gave immediate notice on those. She noted that Petitioner received some short-term disability while he was off work for this alleged accident, and that he was eventually terminated on September 28, 2010 because his FMLA benefits had expired. (T.77-83).

Petitioner did not recall speaking to Ms. Axtell. However, he agreed that if the recorded statement referred to the fact that he had talked to her, then it's likely he did so. He indicated that he knows her and has talked to her about his prior workers' compensation claims. He also testified that he was "not sure" what Respondent's injury reporting policy is, and that he doesn't recall being counseled about it by Respondent. However, he agreed that he had immediately reported his prior claims. (T.61-66).

Zurich workers' compensation adjustor Paula Smith testified that she was dedicated to Respondent's account. She testified that she received an electronic report from Respondent on or about July 15, 2010 for a new claim concerning the Petitioner. She noted that typically, the only person that reports WC claims to her is Ms. Axtell. She noted that per her notes, Ms. Axtell told her that Petitioner had reported a claim because his health care provider had denied payment. She indicated that Zurich needed to investigate whether the claim was workers' comp, and if it wasn't they would issue a denial letter so he could get his bills paid. (T.96-99).

Ms. Smith testified that she took a recorded statement from Petitioner on July 19, 2010. She noted that she had gone back and listened to the tape of the conversation the day before trial and that Respondent's exhibit was an accurate and complete transcript of that statement. (T.99-101). Ms. Smith noted that Petitioner reported that between 8:30 p.m. and 9:00 p.m. on April 16,

17IWCC0638

2010 he was in his truck, which was in a parking lot at Jackson & Main, not on Respondent's property, "and that he was in his off time." She noted that he claimed he was retrieving some stuff from the truck to take home ("clothing and a thermos"), and that upon getting in his truck he slipped off the steps, fell and landed on his left side. She also indicated that Petitioner never said he had gone to the truck to complete paperwork, or that he sat in the truck doing so for 30-40 minutes. (T.101-103). Ms. Smith stated that she asked him when he first reported this to Respondent, and that he said about 3 weeks prior, or after BC/BS had denied payment of his claim. Ms. Smith denied Petitioner's claim and sent him a denial letter (RX1) on July 20, 2010.

The recorded statement was admitted at RX6. In that statement, Petitioner noted that on April 14, 2010, at around 8:30 p.m./9:00 p.m., his truck was "parked where I, where I always park for time off at home" at Jackson and Main; that he was retrieving stuff out of his truck and slipped off the steps; that he weighs 300 pounds; and that he got home that day around 5:00 p.m./6:00 p.m., went shopping with his wife at the grocery store and came back to the truck. He noted that the step was damp or he just lost his footing and fell. He also indicated that he was carrying a coffee thermos and a sack with clothes "and stuff" that he was taking out so he could do his laundry and have coffee when he left. When asked when he first told Respondent about the incident, Petitioner responded "oh it[']s been about, oh, ah, three weeks ago," after BC/BS denied the claim and said it was a work related injury or would have to go through his car insurance. (RX6).

Petitioner agreed that he gave a recorded statement to Respondent's insurer. He noted that it was by phone, but that he could not recall the date. He indicated that he was asleep right before the insurer called him and that he did not recall exactly what he said. However, he did not believe that he told the person about going back to the truck to complete his trip sheets at that time, noting that he "... didn't think it was important, and I wasn't asked". (T.39-40).

On cross examination, Petitioner stated that he did not recall whether he was at home when he gave the statement, but noted that he was pretty sure he had been asleep in his truck out on a run at the time. He agreed that the statement shows he reported getting clothes and a coffee thermos from the truck, and that it does not say anything about completing paperwork. Petitioner testified that he "... just didn't think it was that important" and that he "was asked what [he] had in [his] hands." He agreed that he described "... retrieving some stuff out of my truck and just, you know, take home and, ah, on, on the, upon getting out of the truck I slipped off the steps and fell . . ." He also agreed that he said nothing about getting paperwork at the time. Petitioner acknowledged that the paperwork should have already been completed, given that Respondent wants it done right after each trip. However, he noted that "[t]hat may not have been the end of a trip. I may have been on a trip at that time. I believe I was on a trip. Usually, when I came home, I'm coming home loaded, so I'm – I'm on Monday's delivery trip." He indicated that he is usually home on the weekend for about 34 hrs. He stated that he believed he was in the middle of a trip. When asked why he would have then completed paperwork if he was in the middle of a trip, Petitioner responded: "[t]his is just what I got used to and the way I have always done it. (Respondent) didn't seem to have a problem with it". (T.51-58).

On re-direct, Petitioner testified that in terms of him being "in the middle of a trip" when he returned to Danville on the date of the accident, "a lot of times they don't want to dead head you home, so they will find you a load, maybe out of Chicago going to, let's just say for lack of

knowing exactly where I was going, Tennessee, and its going through the house, so I'm already loaded, and then I'm on my way to Tennessee for like a Monday morning delivery." He indicated that the paperwork he completed on April 16, 2010 was for the loads he delivered the prior week through Friday. He once again noted that Respondent wanted the forms completed after each trip, but that it wasn't due to be turned in until Saturday at midnight. He indicated that if he failed to do that he wouldn't get paid, but that he was never penalized by Respondent for turning in his sheets late. (T.67-70).

On re-cross, when asked if Respondent's policy was to receive the trip sheets after each trip or once a week, Petitioner testified that "[t]hey like for you to turn them in after every trip, but I always saved mine til the end of the week, and that seemed to be okay because they never questioned it." (T.70-71).

Petitioner testified that following the accident he saw his primary care physician, Dr. Hensold. In Provena USMC records dated April 16, 2010 it was noted that Petitioner had fallen off a semi and complained of severe left shoulder pain. The diagnosis was left shoulder/elbow contusion. X-rays of the left shoulder taken on that date were normal, while x-rays of the left elbow revealed no fracture or dislocation, although a radiodense foreign body was noted on the lateral aspect posterior to olecranon in the soft tissues. (PX2).

In Christie Clinic records dated July 22, 2010, it was noted that Petitioner presented for evaluation of pain in his neck and shoulders after falling off his semi in April. It was noted that he fell onto his left arm and experienced immediate left arm pain and an inability to raise it. It was noted that he was still having a lot of problems with his left arm, although he has been working with it. The diagnosis at that time was arthralgia left shoulder, diabetes 2, hyperlipidemia and essential hypertension. An MRI of the left shoulder was prescribed at that time. (PX3).

An MRI of the left shoulder performed on July 30, 2010 revealed 1) a full thickness cuff tear involving the entire supraspinatus, retracted; 2) partial tears of the infraspinatus and subscapularis tendons w/o significant retraction; and 3) partial subluxation of the biceps from the bicipital groove. (PX4).

In Christie Clinic records dated August 27, 2010, it was noted that Petitioner related left shoulder pain off and on for 10 years, but that it was worse after a fall out of a semi while he was at home in April. Since then, he reported decreased range of motion and strength. It was noted that he had received an injection with Dr. Hensold about a year ago, but that it did not help and the medication provided only minimal relief. It was noted that the MRI showed a cuff tear and degenerative arthritis of the AC joint. The diagnosis was complete cuff tear, impingement, degenerative arthritis of the AC joint, left shoulder pain. Petitioner was then referred to orthopedic surgeon Dr. Kolb for surgical consult and told that he could use the arm as tolerated. (PX3).

X-rays of the left shoulder performed on August 27, 2010 revealed degenerative arthritic changes at the AC and glenohumeral joints as well as lateral downsloping of the acromion which could contribute to clinical impingement. Degenerative subchondral cyst formation was also noted in the superolateral humeral head. (PX3).

Board certified orthopedic surgeon Dr. Edward Kolb testified that he first saw Petitioner on September 20, 2010 following a referral from Christie Clinic. He recorded a history wherein Petitioner fell out of a truck in April of 2010, landing awkwardly on his left side and experiencing an immediate onset of sharp left shoulder pain. Dr. Kolb also noted that the patient had a history of left shoulder pain on and off for ten (10) years, worse after the fall. Following his examination and review of the July 30, 2010 MRI, Dr. Kolb's diagnosis was left full thickness and retracted rotator cuff tear per MRI with partial tears of the infraspinatus and subscapularis as well as partial subluxation of the biceps tendon from the bicipital groove. (PX1, pp.4-9).

Dr. Kolb subsequently performed surgery on September 30, 2010. (PX1, pp. 9-11). At that time the following diagnosis was noted: 1) rotator cuff tear, 2) SLAP tear, 3) impingement syndrome, 4) extensive anterior labral tearing. (RX6). Surgery consisted of 1) arthroscopy with rotator cuff repair using sutures and anchors, 2) SLAP repair using sutures and anchors, 3) subacromial decompression, and 4) extensive debridement of torn anterior and posterior labral tissues. (PX6).

Petitioner underwent physical therapy at Christie Clinic from October 21, 2010 through February 8, 2011. (PX8). He also underwent a Functional Capacity Evaluation on June 30, 2011. (PX9).

Dr. Kolb testified that he reviewed some of Petitioner's prior records, including records dated November 21, 2008 and December 18, 2009. Dr. Kolb opined that while Petitioner may have had some preexisting left shoulder problems, the accident in question was at least an aggravating factor which contributed to the need for left shoulder surgery. (PX1, pp.14-16). On cross examination, Dr. Kolb indicated that he had no opinion as to whether Petitioner would have needed surgery regardless of the accident. (PX1, pp.17-18).

Petitioner acknowledged that had had left shoulder problems prior to the accident in question. He noted that he "... believed it to be arthritis... It was just like a small pain in the back of my shoulder that would irritate me more at night while I was trying to sleep." He indicated that currently the pain is "harder" and is located in the top front of his shoulder. In addition, Petitioner acknowledged that he had been involved in a car accident in April of 2006. He noted that following this accident he experienced left shoulder pain and was treated by Dr. Hensold at Provena Occupational Medicine. He indicated that he received an injection in his shoulder at that time that "helped quite a bit." Petitioner also indicated that he may have visited Dr. Hensold one other time between December of 2009 and the pril 16, 2010 accident, "... but didn't do anything for it." (T.47-50).

Dr. Kolb noted that Petitioner was taken off work as of the date of surgery and eventually prescribed light duty work on November 15, 2010 consisting of no lifting with left arm, no overhead activities and no truck driving. Dr. Kolb noted that Petitioner was ultimately released to return to work on February 14, 2011 but that he continued to treat Petitioner thereafter. He indicated that he prescribed a Functional Capacity Evaluation on July 30, 2011, and that he last saw Petitioner on July 22, 2011. Dr. Kolb testified that as of that visit he "... did feel he may require some restrictions based on the functional capacity evaluation," including restrictions on lifting and overhead work. (PX1, pp.11-14).

17IWCC0638

Petitioner testified that he was held off work from September 30, 2010 until February 14, 2011 and that he received short term disability benefits from October 7, 2010 through January 5, 2011 totaling $5,200. (See RX3) (T.40-42).

Conclusions of Law

Based on the above, and pursuant to the express order of the circuit court, the Commission reverses the decision of the Arbitrator and finds that Petitioner sustained accidental injuries arising out of and in the course of his employment on 4/16/10.

The Commission also finds that Petitioner provided adequate notice of the injury to Respondent. Along these lines, Petitioner testified that he did not immediately report the injury to Respondent because he had already had a few work comp cases and was worried about his job. Instead, he tried to get his group carrier (Blue Cross) to take care of it. He testified that he eventually told his employer that he had fallen out of the truck and injured his left shoulder, but could not recall exactly when he told them as much. (T.37). However, he had no reason to dispute the medical record if it contains a reference to the fact that he told his employer about three (3) weeks after the accident. (T.37). He testified that he told his employer at that time because he needed a denial letter from workers' comp so that Blue Cross would pay for it. (T.37-38). Respondent submitted into evidence a letter from Blue Cross Blue Shield of Minnesota dated June 7, 2010 indicating that it would not cover medical for which another insurer might be liable. (RX5). Petitioner indicated that he likely advised Respondent of the accident sometime after he received this letter. Respondents Safety and Health Administrator, Catherine Axtell, testified that she became aware of the accident on June 23, 2010 through a series of emails. (RX4). The Commission notes that this period – from the date of the alleged accident on April 16, 2010 through June 23, 2010 – exceeds the 45-day notice requirement of §6(c) of the Act. However, the Commission finds that Respondent failed to show that it was somehow prejudiced by any deficiency in said notice, and as such Petitioner's claim is not barred.

In addition, the Commission finds Petitioner's current condition of ill-being with respect to his left shoulder condition is causally related to the accident on 4/16/10. The Commission notes that while Petitioner suffered from a pre-existing left shoulder condition, there is no evidence to suggest that he was actively treating for same or had lost any significant time from work during the period leading up to the date of accident as a result of any left shoulder complaints. Likewise, Dr. Kolb – the only medical opinion offered into evidence – testified that while Petitioner may have had some preexisting left shoulder problems, the accident in question was at least an aggravating factor which contributed to the need for left shoulder surgery. (PX1, pp.14-16). Based on the above, and the record taken as a whole, particularly the opinion of Dr. Kolb, the Commission finds that Petitioner's current condition of ill-being with respect to his left shoulder is causally related to the aggravating injury he sustained on April 16, 2010.

Furthermore, the Commission finds that Petitioner was temporarily totally disabled from September 30, 2010 through February 14, 2011, for a period of 19-5/7 weeks. Along these lines, the record shows that Dr. Kolb restricted Petitioner from work as of the date of surgery, September 30, 2010, and ultimately released him to return to work on February 14, 2011.

The Commission further finds that Petitioner is entitled to reasonable and necessary medical expenses relating to accident in question and relative to the left shoulder as set forth in PX12 through PX18, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act, with a credit to Respondent for any and all amounts paid pursuant to §8(j).

Finally, the Commission finds that as a result of his left shoulder injury, Petitioner suffered the permanent partial loss of use of 20% person-as-a-whole pursuant to §8(d)2 of the Act. In support of this finding, the Commission notes that on the date of the accident, Petitioner was a 55-year old truck driver. He injured his left shoulder and left elbow when he slipped on the top step existing his truck and fell approximately 3.5 feet to the ground. X-rays of the left shoulder were normal, and x-rays of the left elbow revealed no fracture or dislocation, although a radiodense foreign body was noted on the lateral aspect posterior to the olecranon in the soft tissues. The record also shows that Petitioner had had left shoulder problems off and on for ten years, which he testified had been made worse by the accident.

An MRI of the left shoulder revealed 1) a full thickness tear involving the entire supraspinatus, retracted; 2) partial tears of the infraspinatus and subscapularis tendons w/o significant retraction; and 3) partial subluxation of the biceps from the bicipital groove.

Dr. Kolb eventually performed surgery on September 30, 2010 consisting of arthroscopy w/rotator cuff repair using sutures and anchors; SLAP repair using sutures and anchors; subacromial decompression; extensive debridement of torn anterior and posterior labral tissues. The post-operative diagnosis was 1) rotator cuff tear; 2) SLAP tear; 3) impingement syndrome; and 4) extensive anterior labral tearing.

Petitioner underwent physical therapy post-operatively from 10/21/10 through 2/8/11. Dr. Kolb eventually released him to return to full duty work as a truck driver on 2/14/11.

An FCE performed on 6/10/11 noted that Petitioner had cooperated and provided maximal effort. It also showed that he demonstrated limitations in left shoulder range of motion and strength and tested out at a MEDIUM physical demand level. However, the therapist was unable to fully assess Petitioner's ability to return to work given that a job description was not available.

Dr. Kolb last saw Petitioner on 7/22/11. At that time, he noted that the FCE showed Petitioner had some limitations, but that he would likely be able to drive a truck. (PX5). Dr. Kolb noted that Petitioner related "... that he does have someone else loading and unloading trucks about 97% of the time. He would be appropriate to return to work involved primarily only driving the trucks. However, with unloading or loading of the trucks, he would have lifting restrictions as noted on pages four and five of the functional capacity evaluation... At this point, I do feel that Mr. Dale Dougherty is at maximum medical improvement. I would recommend following the specific restrictions placed once again on pages four and five of the functional capacity evaluation... He does continue to take ibuprofen about 600 mg twice per day which is for a combination of soreness in his left shoulder and occasional aches he has in other parts, including his back and bilateral knees I did place him through an aggressive range of motion in the office today. He does have slightly limited motion of the left shoulder relative to the [indecipherable]. He is able to forward elevate approximately 160° on the left, externally rotates 45°, and internally

17IWCC0638

rotates to approximately the lower thoracic spine. His motions do appear to be full on the right side. I will once again be happy to continue seeing Mr. Dale Dougherty on an as needed basis at this time." (PX5).

Petitioner testified that it "... it took a long time to get better [after surgery], it took me a year and a half to actually get back to work." Prior to that, Respondent terminated Petitioner's employment. Petitioner eventually returned to work for another trucking company. (T.42-44). He testified that he still experiences daily left shoulder pain, noting that "... it's like a muscle ache. It just aches." (T.44). He also noted that his left shoulder is not as strong as his right shoulder when he drives a truck, and that it fatigues faster. (T.44). He indicated that he takes ibuprofen daily – three tablets in the morning, three tablets in the afternoon and "... sometimes through the middle of the day, but not every day." (T.44). Petitioner stated that he is not able to use his left shoulder the same way as he could prior to the 4/16/10 injury. (T.44). He noted that he cannot do certain work activities with his left arm anymore, such as pulling the fifth wheel and using the trailer pins/slider release. (T.44-45). Instead, he uses his right hand now where in the past he would use his left hand. (T.45). Petitioner indicated that he presently is not able to move his left arm as freely as his right arm, which he demonstrated at trial. (T.45-46). He denied having any of these limitations with respect to his left arm prior to the accident in question. (T.47). He testified that he believed his prior problems with his left shoulder were due to arthritis, noting that "... it was just a small pain in the back of my shoulder that would irritate me more at night while I was trying to sleep" and that the pain following the accident was "harder" and that it is now in the top and front part of his shoulder." (T.48).

Based on the above, and the record taken as a whole, the Commission finds that as a result of his left shoulder injury, Petitioner suffered the permanent partial loss of use of 20% person-as-a-whole pursuant to §8(d)2 of the Act.

As an aside, the Commission notes that the date of accident in the present claim (4/16/10) predates the effective date of the amendment (9/1/11), and as a result an analysis pursuant to §8.1b is not required.

All other aspects of the Arbitrator's decision are otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $620.75 per week for a period of 19-5/7 weeks, from 9/30/10 through 2/14/11, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the reasonable and necessary medical expenses set forth in PX12-18 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $558.68 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 20% person-as-a-whole relative to the right shoulder.

17IWCC0638

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including a credit pursuant to §8(j) for non-occupational disability benefits paid.

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: OCT 11 2017
o:9/18/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

While I recognize the need to follow the circuit court's order and find that Petitioner sustained accidental injuries arising out of and in the course of his employment, I dissent in order to voice my disagreement as to the basis for the court's reversal of the Commission's previous decision. More to the point, I believe that the appropriate standard of review was not *de novo*, as utilized by the circuit court, but instead was one of *manifest weight*.

The *manifest-weight* standard applies to questions of fact, and the court will reverse if an opposite conclusion is clearly apparent. *Durand v. Industrial Commission*, 224 Ill.2d 53, 64 (206). However, if the facts are truly undisputed and subject to but a single inference, the *de novo* standard of review applies. *Mlynarczyk v. Illinois Workers' Compensation Commission*, 2013 IL App (3d) 120411, ¶ 15; *Johnson v. Illinois Workers' Compensation Commission*, 2011 IL App (2d) 10418WC, ¶ 17; *Schroeder v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160192 WC, ¶ 22. The *de novo* standard also applies to questions of law. *Diaz v. Illinois Workers' Compensation Commission*, 2013 IL App (2d) 120294WC, ¶ 21.

Even in cases where the facts are undisputed the court must apply the manifest-weight standard if more than one reasonable inference might be drawn from the facts. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill. 2d 542, 549, 578 N.E.2d 921, 161 Ill. Dec. 275 (1991); *Baumgardner v Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 274, 279, 947 N.E.2d 856, 349 Ill. Dec. 842 (2011). "It is only in those cases where the undisputed facts are susceptible to but a single inference that the inquiry becomes one of law and subject to de novo review." *Baumgarder*, 409 Ill. App. 3d at 279; see also *Illinois Consolidated Telephone Co. v.*

Industrial Commission, 314 Ill. App. 3d 347, 349, 732 N.E.2d 49, 247 Ill. Dec. 333 (2000).

The facts in the present case were not "truly undisputed and subject to but a single inference" and otherwise did not involve a question of law. In fact, the Commission's previous decision, affirming the Arbitrator's denial of benefits, was based in no small measure upon a finding that Petitioner's version of events was lacking in credibility. As a result, the facts in this case were most assuredly disputed and subject to an alternative inference, and as such the proper standard of review was and remains one of *manifest weight*.

For that reason, I dissent.

Kevin W. Lamborn

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Frederico Corral ,

Petitioner,

vs.

NO: 12 WC 41360

17IWCC0639

Kerry, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, as well as a post-arbitration "Petition for Additional Compensation Pursuant to §19(l) and §19(k) and Attorneys' Fees Pursuant to §16 of the Act" filed by Petitioner, the Commission, after considering the issue of penalties, and being advised of the facts and law, denies Petitioner's post-arbitration Petition, modifies the Decision of the Arbitrator as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission finds that the Arbitrator improperly allowed a credit to Respondent for the payment of previously underpaid TTD in the amount of $9,629.81 given that no evidence and/or stipulation of any such payment was introduced into evidence at or prior to the close of proofs at arbitration. In fact, it appears the amount in question was paid subsequent to the close of proofs, and that the Arbitrator was made aware of said payment via Respondent's proposed findings. As a result, information relative to this payment would constitute the introduction of additional evidence on review in contravention of §19(e) of the Act. However, that is not to say Respondent would be prohibited from claiming said credit, subject to proof, as part of any future proceedings at arbitration.

In any event, the Commission finds that the Arbitrator erred in applying the aforementioned credit in the calculation of penalties and attorneys' fees in the current §19(b) proceedings. As a result, the Commission modifies the decision of the Arbitrator to find that Petitioner is entitled to additional compensation pursuant to §19(l) in the amount of $10,000.00 (statutory maximum) and §19(k) in the amount of $37,988.35 (50% of the benefits awarded less TTD paid, or .5[$89,356.27 - $13,379.56]). In addition, the Commission finds that Petitioner is entitled to attorneys' fees pursuant to §16 in the amount of $7,597.67 (20% of the §19(k) penalties, or .2[$37,988.35]).

Furthermore, the Commission finds the filing of Petitioner's "Petition for Additional Compensation Pursuant to §19(l) and §19(k) and Attorneys' Fees Pursuant to §16 of the Act" filed on August 12, 2016 to be improper, or at least premature under the circumstances, given that said Petition concerns conduct that allegedly occurred following the close of proofs at arbitration. Once again, as with the issue of Respondent's claimed credit for benefits paid subsequent to the close of proofs at arbitration, Petitioner's request for additional penalties for failure to pay the award would necessarily involve consideration of additional evidence on review, and as such is prohibited under §19(e) of the Act. Accordingly, Petitioner's Petition for additional compensation and attorneys' fees is hereby dismissed without prejudice.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 4/20/16 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $533.33 per week for a period of 123-5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $23,375.73 for necessary medical expenses as well as out-of-pocket expenses in the amount of $115.00, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment in the form of fusion surgery prescribed by Dr. Lorenz, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation in the amount of $37,988.35, as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation in the amount of $10,000.00, as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for the Petitioner legal fees in the amount of $7,597.67 as provided in §16 of the Act;

17IWCC0639

the balance of attorney fees to be paid by Petitioner to his attorney.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, excluding those amounts paid subsequent to the close of proofs, as discussed in the body of this decision; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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.

OCT 11 2017

DATED:
o:8/22/17
TJT/pmo
51

Thomas J. Tyrrell

Joshua D. Luskin

Kevin W. Lamborn

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

CORRAL, FREDERICO
Employee/Petitioner

Case# **12WC041360**

KERRY INC
Employer/Respondent

17IWCC0639

On 4/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5511 DeCARLO LAW GROUP
ANITA M DeCARLO
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

4136 ADELSON TESTAN BRUNDO ET AL
MARCY E BENNETT
125 S WACKER DR SUITE 1717
CHICAGO, IL 60606

17IWCC0639

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)

Frederico Corral
Employee/Petitioner

v.

Kerry, Inc.
Employer/Respondent

Case # **12** WC **041360**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **February 22, 2016 & March 16, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0639

FINDINGS

On **10/31/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,600.00**; the average weekly wage was **$800.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$13,379.56** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $533.33/week for 123 5/7 weeks, commencing 11/01/2012 through 11/12/2012; 07/18/2013 through 01/01/2014; and 04/30/2014 through 03/16/2016 as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $23,375.73, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further pay reimbursement of out of pocket expenses in the amount of $115.00.

Respondent shall authorize and pay for the fusion surgery as prescribed by Dr. Lorenz and any and all necessary and reasonable rehabilitative treatment needed.

Respondent shall pay to Petitioner penalties of $15,218.34, as provided in Section 16 of the Act; $33,230.95, as provided in Section 19(k) of the Act; and $10,000.00 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.

Findings of Fact

The disputed issues in this matter are; 1) accident; 2) notice; 3) causal connection; 4) average weekly wage; 5) earnings; 6) medical bills; 7) temporary total disability; 8) penalties; 9) attorney's fees; and 10) whether petitioner is entitled to prospective medical treatment. *See,* AX1.

This matter appeared before the Arbitrator for trial on February 22, 2016. At that time, Mr. Frederico Corral, (the "Petitioner") did not have documentation regarding his average weekly wage. Kerry Incorporated, ("Respondent") objected to the average weekly wage of $800.00 claimed by Petitioner therefore, the hearing was bifurcated and continued to March 16, 2016, to allow further evidence of Petitioner's wages, to be presented.

Petitioner's testimony

On direct examination, Petitioner testified that he began working for Respondent in November of 2011 and that his job title during his entire employment was that of "blender/mixer." His duties involved carrying fifty (50) pound bags of product approximately 10 feet; then lifting each bag from the floor and throwing it into the blender. When "throwing" the contents of the bag, his arms are at shoulder level. According to Petitioner, each batch of mix was 5,000 pounds and he typically mixed 16 batches of 50 bags each every day; lifting 800 bags, each weighing 50 pounds during a normal 8 hour shift. Upon cross-examination, the petitioner testified that he was working with a four (4) person crew and was not the only one lifting.

Upon the agreement of the parties, Petitioner did not testify to his regular and mandatory overtime work during the February 22, 2016 hearing. Petitioner was working for Respondent on October 31, 2012. On that day, he worked his normal 8 hour shift and lifted his normal 800 bags of product, each weighing 50 pounds, from 6:00 a.m. through 2:00 p.m. After 2:00 p.m., he began working his overtime position from 2:00 p.m. to 6:00 p.m. At that time, he was moved to another station that involved stacking pallets with 85 bags, each weighing 35 pounds. This involved lifting and stacking from the ground level to over his head. At approximately 4:30 p.m. he noticed pain in his back, while lifting. Since this was close to the end of his shift, he thought the pain would go away. He went home, took a hot shower and two Tylenol and went to bed. The next morning he could not get up and his right leg was completely numb. He took additional Tylenol and went to work, arriving at the job site at 5:00 a.m. on November 1, 2012. He talked to Arturo Gutierrez Velasquez, the general manager, who advised him to seek medical treatment.

Petitioner's treatment

That day Petitioner saw his general practitioner, Dr. Eduardo Cabrera, complaining of "back pain, radiating to right leg". The next day, November 2, 2012, he went to the emergency room at Resurrection St. Mary & Elizabeth Hospital, due to the pain. The history contained in those records state: "was doing heavy lifting at work last week and had acute onset of pain in the [right] lower back.

Feels tingling in toes worse with any movement/walking." He was diagnosed with a lumbar muscle strain and sciatica. He then continued to treat with Dr. Cabrera on November 5, 2012. On November 9, 2012, he underwent an MRI that showed "narrowing at the L3-4 and L5-S1 intervertebral spaces representing degenerative disc pathology. The L3-4 level demonstrated a broad based bulging of the disc margin, slightly more prominently on the left side. There appears to be some encroachment at the left L3-4 neural foramen. The L4-5 intervertebral space demonstrates a broad based central disc herniation". On November 21, 2012, Petitioner presented to Dr. Cabrera, who noted that his back pain had improved and that he was taking hydrocodone, as needed. PX1 & 2, p. 4-18, 27.

Petitioner testified that on November 9, 2012, Arturo Gutierrez Velasquez directed him to report to Concentra. The history provided was "I injured my back while picking up bags." The diagnosis was a lumbar strain, with radiculopathy. The petitioner was returned to work, with restrictions. PX3, pp. 4-7.

On November 13, 2012, Dr. Inderjote S. Kathuria at Concentra referred him to Advanced Medical Specialists, which is also part of the Concentra network. He saw Dr. Charles Mercier, on November 15, 2012. The doctor reviewed the MRI which was read to show "a large sequestered herniated disk at the L5 level" and was diagnosed with a "herniated disk at L5/S1, right". His medications of Vicodin and Flexeril were refilled and he was to follow-up in two weeks. He was subsequently referred to Dr. Salehi for a surgical evaluation. He was returned to work with restrictions. PX4, p. 8.

In the initial therapy evaluation on November 16, 2012, the history recorded, as to mechanism of injury is "patient reports he was performing his regular job on October 31, 2012. He experienced some LBP after work that day." Further, it reports that "patient was working at regular duty status prior to injury with no history of injuries or impairments to affected area." Petitioner had physical therapy until November 29, 2012. PX3 & 4 pp. 13-14.

He was referred by Dr. Cabrera to Hinsdale Orthopedics and presented to Dr. Michael Zindrick on January 9, 2013. At that time, his history was documented as "he was injured at work on October 31, 2012. He works at Kary [sic] Products as a general laborer. On October 31, 2012, he had finished working an 8 hour shift where he was repetitively lifting 50 pound boxes of products and then was sent to 4 hours of overtime into the wet cell. He was repetitively lifting and stacking 30 pound bags and had to stack 85 of these bags onto a pallet. During this repetitive bending, lifting and twisting he developed soreness into his lower back." Dr. Zindrick opined that Petitioner was "a candidate for an L4-5 lumbar laminectomy and discectomy". PX5, pp. 18-19.

On January 9, 2013, he was found to be at maximum medical improvement ("MMI"), was to return to work on January 10, 2013, with restrictions; and provided with a follow-up appointment in four (4) weeks. PX5, p. 20.

While waiting for surgical approval, Petitioner presented to Dr. Zindrick on February 6, 2013, with pain 7/10; April 17, 2013, his pain was 4/10; he was taking medication and working light duty. On May 16, 2013, his pain was rated 5-8/10, he was taking medication and working light duty. On June 13, 2013, his pain was 4-5/10; he was taking medication and working light duty. PX2, pp. 29-35.

On July 18, 2013, the petitioner underwent a right L5 laminectomy and discectomy at L4/5, with removal of an extruded caudal fragment. On December 27, 2013, after physical therapy and work hardening, he was released to return to work with permanent restrictions as follows: "no lifting greater than 35 pounds, sitting as comfort allows, standing as comfort allows, bending limited, kneeling as comfort allows, squatting limited, push/pull as comfort allows, overhead activity as comfort allows, driving (for personal use) as comfort allows, no repetitive bending, lifting, twisting, position changes as comfort allows".

Dr. Ajmani treated Petitioner on August 2, 2013, and noted that he was suffering from inflammatory polyarthritis and had been diagnosed with arthritis in 2007. Dr. Ajmani's records also note that the petitioner suffered from back pain and arthritis in 2005, pelvis and back pain in 2007, and inflammatory polyarthritis, joint pain and low back pain since July 2007. Throughout the years 2013, 2014 and 2015 Dr. Ajmani continued to treat the petitioner for active rheumatoid arthritis, pain in the hands, knees, hips and other joints. PX2 & 6 p. 19.

Dr. Zindrick saw the petitioner on August 30, 2013 and mentioned the petitioner's rheumatoid arthritis. Petitioner was seen by Dr. Cabrera on September 4, 2013 in follow-up; and was diagnosed with rheumatoid arthritis and trochanteric bursitis. When Dr. Zindrick saw Petitioner on December 27, 2013, he released the petitioner at MMI with a 35-pound lifting restriction. PX2& 5.

On January 2, 2014, Petitioner returned to work, with a light duty job purportedly within his work restrictions. According to the petitioner, the job entailed lifting, carrying and stacking from the floor to eye level.

On January 28, 2014, his first return to Dr. Zindrick, following his return to work, the doctor noted that the petitioner was still having pain that had increased since going back to work. "He returned to work one month ago... His symptoms are worse standing, bending and working... On weekends not working his symptoms resolved." He was advised to stay with the current restrictions and return to the clinic in six (6) weeks.

On March 11, 2014, Petitioner returned and it was noted that he was still is having pain that had slightly improved but he had tightness in the back and some pain radiating into his hips and right thigh. "He found that a 25 pound restriction works for better for him than 35 pound restriction." The impression was "ongoing low back pain". He was referred for lumbar facet injections L3-S2, bilaterally; and his lifting restriction was lowered to 25 pounds. PX5 pp. 121-133.

Petitioner testified that he was forced to continue to do increased work until April 15, 2014, when he noticed a lot of pain in his back along with numbness in the right leg. He returned to Dr. Zindrick, who took a history that the petitioner was not doing well. "He has increasing back and leg pain. He describes 50% back and 50% right buttock and leg pain with pain and numbness. His symptoms are worse sitting, bending, standing... He is uncomfortable after working which requires significant bending and twisting and goes home and just lays down." Further, as of April 29, 2014, Dr. Zindrick stated Petitioner could not return to light duty work. PX5, pp. 138-139.

An MRI performed on May 6, 2014, was read to find: "at L1-L2 patent canal and neural foramina; at L2-L3 patent canal and neural foramina; at L3-L4 there is a diffuse disc bulge extending into the bilateral paracentral and far lateral locations, more on the left. There is bilateral facet arthropathy. Mild left lateral canal narrowing is demonstrated. Mild bilateral foraminal compromise is also seen. At L4-L5 there is diffuse disc bulge with a 3mm right far lateral disc herniation. Associated right far lateral and posterior central canal narrowing. Mild bilateral facet arthropathy. Moderate right foraminal narrowing. At L5-S1 there is a diffuse bulge endplate spurring with a 4mm right paracentral disk herniation" and "right-sided epidural scar tissue formation."

On May 27, 2014 Dr. Zindrick diagnosed the petitioner as having a "post laminectomy with chronic back pain and radiculopathy and new pathology seen on MRI. New MRI scan shows persistent discs at L4-5 and L5-S1, degenerative changes are seen at L3-4". Dr. Zindrick referred the petitioner to Dr. Lorenz for possible surgical intervention. PX5, pp. 143-147.

Petitioner was first seen by Dr. Lorenz on June 12, 2014, who noted that: "the patient failed conservative care. He was sent for an IME, and the IME concurred with Dr. Zindrick's recommendation to proceed with a revision discectomy and a fusion from L4-S1". Dr. Lorenz also recommended a fusion from L4-S1. Dr. Lorenz has continued to recommend that surgery through December 16, 2015, the last treatment date prior to trial. PX5, pp. 150-152 & PX13.

Petitioner's testimony

Petitioner testified to being off work with notes from Dr. Cabrera from November 1, 2012 through November 12, 2012. He further testified to being off work with Hinsdale Orthopedics off work notes from July 18, 2013 through January 1, 2014. Hinsdale Orthopedics then prescribed Petitioner to be off work from April 30, 2014 through the last date of trial on March 16, 2016. PX2, 5 & 13.

Petitioner further testified to being examined by Dr. Kornblatt on April 29, 2013, at the request of the Respondent. The diagnosis of a right L4/5 herniated disc lying behind the body of L5 resulting in right L5 spinal stenosis was confirmed. Further, the doctor opined that "the condition is related to Mr. Petitioner's employment as he specifically states that he noted to have back pain after working and awoke the following day with severe right radicular leg pain and back pain, thus most likely while working, he experienced a sequestered right L4/5 herniated disc." He further stated "I do feel that the

employee's condition being a sequestered right L4/5 herniated disc with right sciatica and radiculopathy is causally related to the work episode occurring on October 31, 2012." The doctor also stated, in reference to the petitioner "his history is classic for onset of severe right sciatica secondary to extrusion of a herniated disc which did occur, in Mr. Petitioner's case, while working." Lastly, he stated "the traumatic incident did accelerate and aggravate the pre-existing condition of degenerative disc disease beyond the normal progression, as the MRI scan is consistent with a sequestered herniated disc fragment." Dr. Kornblatt also confirmed that the light duty restrictions and right L4/5 micro-decompression discectomy were both appropriate, as prescribed by Dr. Zindrick. PX13.

The second evaluation occurred on October 28, 2013 and that report contains similar findings regarding Petitioner, including confirmation of permanent work restrictions.

On June 9, 2014, Petitioner was examined by Dr. Kornblatt for a third time and was diagnosed as having failed back surgery syndrome; multi-level degenerative disc disease with mechanical low back pain; referred leg pain and chronic right lumbar radiculopathy was confirmed. He also confirmed that Petitioner continued to have subjective complaints and was not at MMI and needed more restrictive light duty work. PX13 & RX2.

On October 20, 2014, Petitioner was evaluated for the last time by Dr. Kornblatt, who now determined that Petitioner was "clinically improved" and was not in need of the surgery as prescribed by Dr. Lorenz. However, he stated "to be thorough, I would like to comment on the most recent laboratory tests as well as the bone scan with gadolinium, MRI scan, EMG nerve conduction velocity study and laboratory results." The petitioner was not evaluated by Dr. Kornblatt after October 20, 2014 and Dr. Kornblatt did not author any addendums or further reports; and there is no indication as to whether he was provided the diagnostic tests he wanted to comment on. PX13 & RX3.

The March 16, 2016 trial date

The respondent requested that the hearing be bifurcated in order to obtain the evidence of Petitioner's wages. On the second day of trial, March 16, 2016, Respondent did not amend Arbitrator's Exhibit 1, the Request for Hearing, to claim a different average weekly wage and did not present any evidence regarding the petitioner's wages.

Petitioner testified that he earned $13.50 per hour and his regular shift was Monday through Friday, 40 hours from 6:00 am through 2:00 pm. He testified that he then worked an additional 4 hours each day as overtime from 2:00 pm through 6:00 pm. He worked overtime every day and it was mandatory. Petitioner also testified that he worked all Saturdays for an additional 8 hour shift. This testimony is unrebutted.

Petitioner also testified that the following medical bills were outstanding: Dr. Cabrera $1,253.00; ATI $5,999.73; Hinsdale Orthopedics $15,974.00; DuPage Pathology $149.00. Further, he testified to out

17IWCC0639

of pocket payments to Dr. Cabrera in the amount of $40.00 and to Resurrection, in the amount of $75.00. Lastly, he testified that he desires to undergo the fusion surgery recommended by Dr. Lorenz.

Conclusions of Law

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

The Arbitrator concludes that the petitioner has proven, by a preponderance of the evidence, that the accident which occurred, arose out of and in the course of petitioner's employment by employer. This conclusion is based upon the unrebutted testimony of Petitioner and the supporting evidence in the form of medical documentation including all four of Dr. Kornblatt's Section 12 reports.

"In the course of" employment refers to the time, place and circumstances under which the accident occurred. *Metropolitan Water Reclamation District of Greater Chicago v. Industrial Comm'n.* (1995) 272 Ill.App.3d at 735, 650 N.E.2d at 674, 208 Ill.Dec. at 980. The testimony and medical records confirm that he was at the job site repetitively lifting for 12 hours on October 31, 2012 when he felt pain and numbness in his low back and right leg. As such, he has proven that his accident occurred at the location and during the time he was working for Respondent.

An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incidental to his assigned duties. *Metropolitan Water Reclamation District of Greater Chicago v. Industrial Comm'n.* (1995) 272 Ill.App.3d at 735, 650 N.E.2d at 674, 208 Ill.Dec. at 980. The testimony and medical records confirm that Petitioner was performing the acts he was instructed to perform at the time of his injury. Further, the Concentra medical records, including the four reports by Dr. Kornblatt, confirm that the accident arose out of Petitioner's employment. As such, Petitioner has proven, by a preponderance of the evidence, that his accident arose, which occurred out of and in the course of his employment.

The respondent presented no evidence in the form of testimony or documents to support its claim that the accident did not arise out of or in the course of Petitioner's employment on October 31, 2012. Further, the medical evidence and all four of Dr. Kornblatt's Section 12 reports state that this accident occurred at work.

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

The Arbitrator concludes that the petitioner has proven, by a preponderance of the evidence, that notice of the accident was given to the Respondent, within the time limits stated in the Act. This

conclusion is based upon the unrebutted testimony of Petitioner, the records from Concentra and other medical evidence presented.

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

For an employee's workplace injury to be compensable under the Workers' compensation Act, he must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. *See, Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. *See, Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill. 2d 207 at 214, 254 N.E.2d 522 (1969).

Proof of prior good health and change immediately following and continuing after an injury, may establish that an impaired condition was due to the injury. *Hopkins v. WSNS Telemundo*, 02 IIC 0946, 99 W.C. 42128 (2002). In determining that an employee was entitled to compensation for aggravation of a pre-existing injury in *Hopkins*, the Commission noted that petitioner was in good health prior to the fall, he had no restrictions prior to his fall; and following his fall he suffered a marked decrease in his health and ability to function at work.

The Arbitrator concludes that the petitioner has proven, by a preponderance of the evidence, that his present condition of ill-being regarding his back, is causally related to the accident of October 31, 2012. This conclusion is based upon the testimony of the Petitioner, the treating records and all four of Dr. Kornblatt's Section 12 reports. Based on the medical evidence presented, Petitioner suffered a back injury that resulted in an L4/5 discectomy on July 18, 2014 and permanent work restrictions. The evidence also supports the finding that Petitioner ended up with failed back syndrome and the need for a fusion surgery.

G. What were the Petitioner's earnings?

Petitioner testified, in an unrebutted manner, that his earnings were $41,600.00 in the 52-week period prior to his injury of October 31, 2012 and that he earned $13.50 an hour for 40 hours a week. He further testified that he worked regular and mandatory overtime of 20 hours a week. There was no evidence introduced by the respondent regarding this disputed issue therefore, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence, that his average weekly wage was $800.00.

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

The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the medical services he received were both reasonable and necessary. This conclusion is based upon the unrebutted testimony of the petitioner, the medical records of his treating doctors; as well as the four

section 12 reports of Dr. Kornblatt. No evidence was submitted to the contrary. As such, Respondent is ordered to pay the reasonable and necessary medical services of $23,375.73, as provided in Sections 8(a) and 8.2 of the Act. In addition, the respondent is ordered to reimburse Petitioner for his out of pocket expenses in the amount of $115.00.

K. Is Petitioner entitled to any prospective medical care?

The prospective medical prescribed by Dr. Lorenz for the fusion surgery is awarded. The Arbitrator concludes that the petitioner has proven by a preponderance of the evidence that he is entitled to the treatment as recommended. This conclusion is based upon the unrebutted testimony of the petitioner and an examination of the medical records, including the reports of Dr. Kornblatt.

L. What temporary benefits are in dispute?

After the accident of October 31, 2012, the unrebutted testimony of the petitioner, supported by medical records including all four Section 12 reports, support his testimony that he was temporarily totally and unable to work for 123 5/7 weeks, commencing 11/01/2012 through 1/12/2012; 07/18/2013 through 01/01/2014; and 04/30/2014 through 03/16/2016. The Arbitrator notes that the respondent has apparently paid the $9,629.81 underpayment of TTD.

As such, Respondent shall further pay Petitioner temporary total disability benefits ("TTD") of $533.33/week for 123 5/7 weeks, commencing 11/01/2012 through 1/12/2012; 07/18/2013 through 01/01/2014; and 04/30/2014 through 03/16/2016, as provided in Section 8(a) of the Act.

M. Should penalties or fees be imposed upon Respondent?

Petitioner's amended penalty petition

According to Petitioner, the Respondent has acted in bad faith throughout the pendency of this matter by consistently delaying payment of medical and TTD benefits; in addition to delaying authorization of medical treatment. Also, Petitioner contends that the respondent acted in bad faith when relying on an incomplete Section 12 report from Dr. Kornblatt and by not producing a 52-week wage statement. Further, that Respondent should have had actual knowledge of this accident arising out of and in the course of Petitioner's employment as well as the fact that timely notice was given; the fact that there was evidence of causal connection relating the accident to Petitioner's injuries and his average weekly wage ("AWW"); and the outstanding medical bills and TTD owed. Also, that even though all of this information was readily available to Respondent, these issues were placed into dispute.

Lastly, the petitioner alleges that because Respondent moved to only enter into evidence two (2) of Dr. Kornblatt's section 12 examinations dated June 9, 2014 and October 20, 2014 and objected to Petitioner's Exhibit 12, a rebuttal exhibit consisting of the complete subpoenaed records of Dr. Kornblatt, bad faith was exhibited.

17IWCC0639

Respondent's response to Petitioner's penalty petition

The respondent has filed its response to the Petition for Penalties and Attorney's Fees for the most part neither admitting nor denying the allegations of the petition. Of significant, is a showing of payment to the petitioner in the amount of $9,629.81 with a check dated March 16, 2016 and the statement that the respondent was not made aware of the disputed TTD underpayment until the morning of trial, on February 22, 2016. Also, the respondent alleges that documentation from the former attorney on this case is hearsay and should not be considered. The Arbitrator disagrees that the manner in which an insurance company and prior attorney handled a case, is hearsay or irrelevant, where a penalty petition is at issue.

Illinois courts have refused to assess penalties under sections 19(k) and (l) of the Act where the evidence indicates that the employer reasonably could have believed that the employee was not entitled to the compensation withheld. *See, Board of Education v. Industrial Commission*, 93 Ill.2d 1, 442 N.E.2d 861 (1982); *See also, Avon Products, Inc. v. Industrial Commission,* 82 Ill. 2d 297 (1980) and *Brinkmann v. Industrial Commission*, 82 Ill. 2d 462 (1980). "Where a delay has occurred in payment of workmen's compensation benefits, the employer bears the burden of justifying the delay, and the standard we hold him to is one of objective reasonableness in his belief." *Id. See also, City of Chicago v. Industrial Commission*, 63 Ill. 2d 99 (1976).

The Illinois Supreme Court has explicitly found an obligation on the part of Respondents to diligently obtain information regarding a Petitioner's claim in *Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982). In *Board of Educ.*, the court found that the Chicago Board of Education "had or should reasonably have had in its possession" sufficient evidence, that "would have disclosed that the grounds for challenging temporary total disability liability were insubstantial at best," and therefore fees and penalties were warranted. The Supreme Court also found that the Board's "failure to obtain that information did not entitle the Board to assert later that it acted in good faith because it was ignorant of the evidence in favor of the employee." *See, Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982).

The Arbitrator concludes that the respondent was not reasonable in its belief that the petitioner was not entitled to the benefits that were withheld nor was the delay in payment of TTD and medical benefits reasonable. Respondent was negligent in its handling of this matter and whether it was benign neglect or something more sinister, it resulted in an unreasonable and vexatious delay of this petitioner's payment of TTD and access to medical treatment.

Pursuant to Section 19(l), the respondent is ordered to pay penalties of $30 per day for delaying payment of TTD benefits, maintenance benefits and medical benefits. As such, the respondent is ordered to pay the maximum of $10,000.00.

17IWCC0639

Pursuant to Section 19(k), the respondent is ordered to pay penalties due to unreasonable and vexatious delay in the payment of TTD benefits and the delay in the payment of medical benefits in the amount of 50% of the amount payable at the time of the award. As such, the respondent is ordered to pay to petitioner $33,230.95.

The TTD awarded is $65,980.54 and the medical awarded is $23,490.73, for a total of $89,471.27. Subtracting the agreed credit of $13,379.56 and payment of $9,629.81 leaves a delayed payment of $66,461.90. Based upon the unreasonable and vexatious delay in payment of TTD benefits and medical benefits, Respondent is ordered to pay attorney's fees to Petitioner pursuant to Sections 16 and 16(a) of the Illinois Workers' Compensation Act (820 ILCS 305/16, 16(a)) in the amount of 20% of the delayed payment or $13,292.38.

17IWCC0639

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC41360
SIGNATURE PAGE

Signature of Arbitrator

April 19, 2016
Date of Decision

APR 20 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steve Goodson,

Petitioner,

vs. NO: 12 WC 28983

17IWCC0640

Carlisle Syntec, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, temporary total disability, medical expenses 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.

The Commission modifies the decision of the Arbitrator to find that the appropriate date of manifestation for Petitioner's repetitive trauma injuries was April 16, 2012, or the date Dr. Sola noted that the recent NCV had confirmed the carpal tunnel syndrome diagnosis that both he and Dr. Goggin had previously suspected. The Commission notes that while Dr. Sola's assessment on February 27, 2012 was carpal tunnel syndrome, he expressed no opinion as to its possible relationship to Petitioner's employment. Indeed, radiographs of the right and left wrists performed on that date revealed degenerative changes and possible scapholunate ligamentous tears. As a result, Dr. Solo ordered nerve conduction studies to evaluate for carpal tunnel syndrome. It was not until the office visit on April 16, 2012 that Dr. Sola was able to provide Petitioner with a definitive diagnosis of bilateral carpal tunnel syndrome. Based on the above, and the evidence taken as a whole, the Commission finds that this is the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. (See *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 531, 505 N.E.2d 1026, 1029 (1987)).

Furthermore, the Commission finds Petitioner provided proper and adequate notice to the Respondent on April 23, 2012, or the date of the accident report. The Commission notes that while this report indicates that Petitioner claimed to have reported the injury to Ms. Woker on April 7, 2012, Ms. Woker herself was unable to confirm the date on which this conversation took place. In any event, this conversation would have clearly preceded the definitive diagnosis made

17IWCC0640

by Dr. Sola on April 16, 2012. More importantly, even if there was a defect in said notice, Respondent provided absolutely no evidence that it was somehow prejudiced by same. Accordingly, the Commission finds that Petitioner provided notice well within the requirements of §6(c) of the Act given a manifestation date of April 16, 2012.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 6/1/16 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $705.17 per week for a period of 7-2/7 weeks, from 10/7/14 through 11/26/14, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $45,820.86 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $634.65 per week for 42.75 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 7.5% loss of use of the left hand and 15% loss of use of the right hand, respectively.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. 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: OCT 11 2017
o:8/1517
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOODSON, STEVE
Employee/Petitioner

Case# **12WC028983**

CARLISLE SYNTEC INC
Employer/Respondent

17IWCC0640

On 6/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1239 KOLKER LAW OFFICES PC
JASON CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

2396 KNAPP OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

17IWCC0640

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

Steve Goodson
Employee/Petitioner

v.

Carlisle Syntec, Inc.
Employer/Respondent

Case # **12** WC **28983**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 22, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 27, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$55,003.00**; the average weekly wage was **$1,057.75**.

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

The parties stipulated at the time of hearing that Respondent paid **$0** in TTD, **$0** in TPD, **$0** in maintenance, **$4,730.55** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

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

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

Respondent is entitled to a credit of **$2,825.88** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$705.17**/week for **7 2/7 weeks**, commencing October 7, 2014 through November 26, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay **$45,820.86** for medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to the providers. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall pay Petitioner the sum of **$634.65/week** for a further period of **42.75 weeks**, as provided in Section 8(e) of the Act, because the injuries caused **7.5% loss of use of the left hand and 15% loss of use of the right hand.**

Respondent shall be given a credit in the amount of **$2,825.88** for medical bills that have been paid through its group medical plan under Section 8(j) of the Act.

Respondent shall be given a credit in the amount of **$0** in TTD, **$0** in TPD, **$0** in maintenance, **$4,730.55** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

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

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

Melinda M. Rose Gullidea
Signature of Arbitrator

5/26/16
Date

ICArbDec p 2

JUN 1 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steve Goodson
Employee/Petitioner

Case # 12 WC 28983

v.

Consolidated cases: N/A

Carlisle Syntec, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on February 27, 2012 he was employed by Carlisle SynTec, that he started working there on July 28, 1980 and that he still works there today. He testified that he has worked a number of different jobs, including the mill or calendar line for approximately 8 years when he first started. He testified that he then went to mixing and then returned to calendar. He testified that he worked the calendar line 5-6 days per week. He testified that on the calendar line, the operation of the mill operator was to keep a knife in his hand and roll rubber on the breakdown mills to make it flow and break. He testified that it started out as cold rubber and he then started warming it up. He testified that from that point, he sent it up to the surge mill. He testified that many times the rubber did not flow, so he would stand there with a knife and run it back and forth to get it to flow, and then he would send it to the next mill which would be the feed mill.

Petitioner testified that after five years, his wife wanted to know why he had a knot on his wrist. He testified that when you held a knife like that all day long in rubber it got to where after about five or six years he would stand there and have to pry his fingers open to get his knife out. He testified that he then learned to use his left hand as well. He testified that he would sometimes spend 8 hours on Saturdays doing nothing but cutting and slabbing, and that he learned to work left-handed for a long time.

Petitioner testified that in mixing, chemicals were used to make rubber sheeting that was approximately 4 feet wide and about 3/8" thick and that the mills were five feet long. He testified that during the first 8 years he had to get certified in another area to be a team leader, so he went to the mixer and had to have a second job there to make sure that he qualified to be a team leader. He testified that compounding involved standing there with scoops and scooping chemicals into batches of zinc, sulfur and the like. He testified that the scoops were aluminum, and that he used both hands to scoop. He testified that they now have compound blenders. He testified that they scooped the compounds out of tubs that were about waist-high, and that a full scoop could weigh in the range of 6-10 pounds. He testified that he had four "tours" in the mixer area and worked in this area for about 8 years. He testified that the process was now automated.

Petitioner testified that the straining job was also part of the calendar line, which involved remixing batches that were not good the first time through. He testified that with the straining job, he had to literally grab it, make a cut, grab with his hand, stick a knife in it, pick it up and carry it. He testified

that the rubber weighed 40-60 pounds. He testified that he did this job for about 10 years, and that he would often do this on overtime and weekends.

Petitioner testified that for the TPO line, they would have to reach in and lift out rolls and that he did so holding the roll with one hand and using the other hand to lift straight up. He demonstrated at the time of hearing placing both of his palms at shoulder height and making an upward motion. He testified that the original bar was approximately 160 pounds, and that he would do this maneuver approximately 70 times per day. He testified that he worked approximately two years in total on the TPO line.

Petitioner testified that since 2012, he went back to "B" shift. He testified that he currently works the tape line, that he has 18-20 people that run various machines and that he helps to check and make sure things are done right and assist, when necessary.

Petitioner testified that he first started noticing that he had numbness and tingling in his hands when he went to the weekend shift in 2009, but that it kept getting worse. He testified that he sought treatment in 2012 because he got to the point he could not sleep at night. He testified that it got to the point there when his grandkids would hit his fingers and it felt like electricity running through them. He testified that he waited between 2009 and 2012 to seek treatment because he waited until his hands got to the point that he could not sleep anymore. He denied ever having any kind of one-time specific accident or trauma to either of his hands.

Petitioner testified that Dr. Goggin was his primary care physician, and that he referred him to Dr. Sola. He testified that Dr. Sola ordered a nerve conduction study, and that he returned to see Dr. Sola after the study. He testified that he did not remember if Dr. Sola offered him a carpal tunnel release on his right wrist at that time, but testified that he did not have surgery with him. He testified that he filled out the accident report after he found out what was wrong and then talked to "Jan" and told her that he needed to get them fixed. He testified that he was then informed that his claim was denied.

Petitioner testified that that he then started treating with Dr. Mall, who have him injections into his right and left wrists. He testified that the injections made an improvement. He testified that he returned to work, but that he then ultimately returned to Dr. Mall about six months later because the pain had returned. He testified that he then underwent surgery on the right, but that his symptoms did not resolve after the surgery was performed. He testified that ultimately he had a second surgery on the right, after which he felt "perfect." He testified that he underwent a release on the left as well, and that the surgery went "great." He testified that other than not being as strong as it used to be, his hand worked great. He testified that he was ultimately released with restrictions due to his right hand, including restrictions of no continuous pulling or twisting with the right hand. He testified that after he was issued the restrictions, he returned to work for Respondent. He testified that his job when he went back to work was that of "ASBM" and that the job was easier for his hands and was pretty automated now.

Petitioner testified that he told Ms. Woker about his hand complaints, and that he did so on April 7th as shown on PX10. He testified that he believed that John Edd filled out the accident report, and that he was there when John filled it out.

Petitioner testified that currently, his right hand was "basically scissors," that he could hardly cut and that he did not have the strength in his thumb to do it. He testified that he cannot hold a knife in his hand very long, and that he does not have a lot of strength in his hand to lift things. He testified that he has difficulty with gripping and pulling things and that he cannot hold on very long. With respect to his left hand, Petitioner testified that he uses his left hand to perform tasks for his right. He denied having any limitations with his left hand. He testified, however, that he does not have as much strength in his left hand as before but is pain-free.

On cross-examination, Petitioner testified that he did not return to Dr. Mall after his last appointment in January of 2015 because he did not have any reason to go back. He denied being fully functional with his hands and wrists. He agreed that he still deer hunts, and that he typically sits on the ground. With respect to the reference in the chiropractic notes regarding hurting his back sitting in a deer stand too long, Petitioner testified that the deer stand consisted of a hay bale feeder sitting on the ground.

On cross-examination, Petitioner testified that when he first saw Dr. Mill the visit was not paid for through worker's compensation. He denied having made a date with Dr. Sola for surgery.

On cross-examination, Petitioner agreed that his testimony regarding using a knife to cut hot rubber occurred while he worked on the calendar line. He testified that he worked his first 10 years between the mixer and the calendar. He agreed that most of the activities that he described doing -- including compounding, straining, and the calendar line -- occurred within the first ten years of his work. He agreed that the rubber that he cut while on the calendar line was warm, and that when he cut into it it would be soft.

On cross-examination, Petitioner agreed that around the middle of 2010 he started working in the mixer department and that was when he started working on the weekends. He testified that the other jobs that he had described were done during the week in addition to overtime. He agreed that when he worked in mid-2010, he was still the mixer job and that it was a Saturday/Sunday job.

On cross-examination, Petitioner agreed that he developed a knot on his right wrist. He testified that he asked Dr. Mall what it was. He agreed that Dr. Goggin was his family physician and had been so for years. He agreed that in all of the times he had seen Dr. Goggin, he never told him about the knot on his wrist. He agreed that he testified that he never had a specific incident at Respondent where something injured his right or left wrist for which he needed medical attention.

On cross-examination, Petitioner testified that when he was having problems with his hands and wrists around 2009 or 2010, he told his ex-wife. He testified that he could not remember if he told a doctor. He agreed that if he was asked if his hands were sore, he would have told Dr. Goggin in February of 2010. When asked if he was told at the time of the February 20, 2012 visit with Dr. Goggin that he had carpal tunnel syndrome, Petitioner responded that that was why he went to the doctor in order to find out what was wrong with his wrists. He agreed that Dr. Goggin told him at that time that he had carpal tunnel syndrome. When asked if he believed it was work-related, Petitioner responded that it came from repetition over a lot of years.

On cross-examination, when asked about the pleading referencing giving notice to John Cohen on September 21, 2011, Petitioner responded that he did not know who John Cohen was and that nothing happened on September 21, 2011. With respect to the pleading referencing that he gave notice to Joe Edd, Petitioner responded that it was John Edd.

On cross-examination, Petitioner agreed that his signature appeared on the accident report that was completed by John Edd. He agreed that he met with John Edd to fill out the accident report on April 23rd. He agreed that he was doing a job that is less physically demanding now. He agreed that he was an alternate team leader on the ASBM line. He agreed that he spent working weekends in the mixing department.

On cross-examination, Petitioner agreed that he no longer smoked and that he stopped on January 1, 2016. He testified that before that, he smoked about 30 years. He agreed that he filled out the patient information sheet for Dr. Mall on June 18, 2013. When asked why he put the date the symptoms started

as March 11, 2012, Petitioner responded that that was the date he could not sleep anymore with the pain at night and knew something was wrong. He agreed that the reference in Dr. Mall's note that he only recently moved to the weekend shift was not correct as he was working the weekend shift since 2010. He agreed that it was not true that he changed his shifts to two 12-hour shifts due to the fact that he had been having problems with his wrists.

On cross-examination, Petitioner denied doing hunting, fishing and light gardening for years. He testified that he has always hunted and first started fishing as a child. When asked why he denied doing any hunting, fishing or outside activities with Dr. Kostman, Petitioner responded that at that time he was not doing any outside activities because he could not do them.

On cross-examination, Petitioner agreed that whenever he worked the weekends, his regularly scheduled weekend shift totaling 24 hours was paid for 36 hours. When asked why he told Dr. Mall that he worked 1,000 hours of overtime a year, Petitioner responded that he told Dr. Mall that he had worked as much as 1,000 hours of overtime in a year.

On cross-examination, Petitioner agreed that in the mixing department that he worked from 2010 until the end of 2013, there were four different stations and that the first job involving him working on a panel pushing buttons. He agreed that in compound he used a scoop to scoop compound from a bag, and that he would do so between batches. He testified that you generally started scooping and tried to get it all done before you went on break or lunch so that you have plenty ahead of time. He testified that depending on the shift and how they rotated, he would rotate to the weight loader job where he operated a vacuum hoist. He testified that he would pick up bags with a hoist, and that he would grab the side of it and squeeze it to activate it. He testified that he also sat at a baler and cut bales, which involving pressing in with his hands and wrists. He testified that where there were only four people, you tried to get as much done as you could within the first 2-4 hours in order to be set up for the rest of the day. He testified that the rest of the shift they would load. He testified that the batch operator job involved cutting samples, that samples would be cut every fifth batch, and that it took about five minutes to make a batch. He testified that the fourth job was the utility job, where they moved skids around with product to make sure that each machine had product that it needed to do the process.

On cross-examination, Petitioner agreed that when he saw Dr. Mall in 2013 he issued a work status report that allowed him to return to work in mid-July of 2013 and that he had an excellent benefit from the injections he was given. He agreed that the next time he saw Dr. Mall after was not until April of 2014, at which time he told him that the hand problems had gotten worse over the last few weeks. He agreed that Barb Casey was his current supervisor, and that he had a review in May of 2015. He agreed that he had a good review. When asked if he told Ms. Casey of any problems he was having from a physical standpoint of being unable to perform his job, Petitioner responded that they had already talked about the restrictions and that she already knew of them. He agreed that at the time of the May 2015 evaluation, he did not tell Ms. Casey of any problems he had doing his job.

On cross-examination when asked about his September 2015 visit with Dr. Goggin, Petitioner stated that he did not recall whether he examined his extremities but that if he presented for stomach issues, he would have been seen by Dr. Goggin's assistant. He testified that he was not there about his hands on that date, but rather his stomach. He denied telling them that he had problems with his hands. He admitted that he went deer hunting this year, and that he went three days. He testified that he used a shotgun. He denied hunting for anything besides deer. He denied continuing to garden, and he denied doing any woodworking. He testified that his car repair-related activities included putting a quart of oil in the truck. He testified that he has a riding lawn mower. He denied having any employment beyond Respondent. He testified that he quit smoking because he loves his grandkids and wants to "stick around"

a while. He denied having pled guilty or having been convicted of any crimes. He testified that the only prescription medication he takes is that of an inhaler for his asthma.

On redirect examination, Petitioner testified that when he cut the rubber there was some resistance to the rubber even though it was soft. He agreed that he was currently on permanent restrictions with regard to his right hand and that Respondent was accommodating those restrictions.

On further cross-examination, Petitioner agreed that recalled a January 2012 incident involving walking on floors that were waxed. He agreed that during that conversation with Mr. Knuf he did not mention any complaints with his hands or wrists.

John Edd was called to testify at the time of arbitration as a witness on behalf of Respondent. He testified that he is employed by Carlisle SynTec and has worked there since December 13, 1979. He testified that he is an operations supervisor, and is familiar with Petitioner. He testified that he was somewhat familiar with Petitioner's work for Respondent.

Mr. Edd testified that the bid sheet was prepared around the time that Petitioner bid into the weekend shift, and that RX1 on page 1 showed him working Saturdays and Sundays for 12.5 hours per shift. He agreed that Petitioner was working overtime and that his regularly scheduled shifts were Saturday and Sunday.

Mr. Edd agreed that there were four areas in the mixing department, which included a panel operator, a weigh loader, a batch operator and a utility person. He agreed that he heard Petitioner's testimony. He testified that when you worked the mixer panel you were the person in charge of the mixing operation and that about every three minutes you would charge a batch of material to the mixer. He testified that the weigh loader made sure that the panel operator had the material to feed into the machine, and that they loaded the bales, polymer and sacks of clay onto the charge belt by use of a vacuum hoist. He testified that to operate the bagging system, one had to use their hands. He testified that there was a vice that you opened and closed with your hands that turned the suction on to the vacuum hose, and that the weigh loader would be lifting the bags every three minutes.

Mr. Edd testified that there were times when the panel operator would use a scoop to scoop compound into either a bag or sometimes onto the charge conveyor itself, and that you could probably only pick up about 1.5 pounds of material with the scoop. When asked how often the panel operator would be using the scoop, he responded that you had to put the same amount of chemicals into each batch which could be anywhere from 11-13 pounds, and that if you compounded it as each batch it would be every three minutes but oftentimes they would make up compounds in between the batches in order to be ahead so they would be able to continue the mixing process without delay.

Mr. Edd testified that the batch operator conveyed the material after it had been mixed onto a festoon and that the festoon was an area where there were a series of fans that blew onto the material as it came out of the dip tank to dry it off and cool it down so they could stack it without it sticking and being wet. He testified that cutting batches with a knife involved cutting a sample approximately 2"x 4" off the edge of the slab, and that it was then taken so the lab could test it for the cure rate. He testified that technically they sampled every batch. He testified that samples would be cut approximately every 1.5 minutes.

Mr. Edd testified that the utility job involved removing the completed skids from the festoon index and also being responsible for staging. He testified that the skids of stock were moved with a forklift. He testified that the four positions in the mixer job were rotated in the course of a shift, and that

he thought that every crew had their own rotation system. He testified that he thought the majority of the crews rotated every four hours, but there were crews that rotated every two hours.

On cross-examination, Mr. Edd agreed that it was his handwriting on the accident report where it said that it was reported April 7, 2012.

On redirect examination, Mr. Edd agreed that the information on the document was taken from Petitioner and that it was what Petitioner told him. He agreed that he received the information on April 23, 2012 and was the date the report was completed.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of February 27, 2012, that the accident occurred through "repetitive production work" and that Petitioner sustained injury to his right and left hands. The Application was signed by Petitioner on July 1, 2012. (AX2).

The medical records of Dr. Goggin were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on February 20, 2012 at which time the chief complaint was noted to be hand pain. It was noted that both hands hurt, and that the right was worse and was associated with thenar numbness. The impression was that of right hand pain likely mixed origin but likely carpal tunnel syndrome. Petitioner was referred to Dr. Sola and recommended to undergo x-rays of the hands. (PX1).

The medical records of Illinois SW Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on February 27, 2012 for a chief complaint of numbness and tingling in the bilateral hands and bilateral wrist pain. It was noted that Petitioner complained of numbness and tingling for well over a year, that the right was worse than the left and that it had progressed to where he had almost constant tingling in the radial three digits of the right hand. It was noted that Petitioner also complained of discomfort in the hand over the past year and a half, and that anything striking the tips of the digits caused pain in the palm of the hand. The assessment was that of carpal tunnel syndrome, and Petitioner was recommended to undergo nerve conduction testing. It was noted that Dr. Sola thought his pain was likely related to the degenerative changes in the wrist. (PX2).

The records of Illinois SW Orthopedics reflect that Petitioner was seen on April 16, 2012 for reevaluation of both hands, and no change in symptoms was noted. It was noted that the nerve conduction test was consistent with carpal tunnel syndrome, and that the assessment was that of carpal tunnel syndrome and bilateral hand pain. It was noted that Petitioner's hand pain was isolated specifically over the metacarpal head volarly on the long digit on both hands, which Dr. Sola though likely represented a tenosynovitis without developing a trigger digit. A cortisone injection was recommended. It was noted that Petitioner had fairly persistent symptoms of carpal tunnel syndrome on the right side, and that the left side was somewhat intermittent. It was noted that Petitioner wanted to proceed with surgery. (PX2).

The medical records of Greenville Regional Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner underwent x-rays of the left wrist on February 27, 2012, which were interpreted as revealing (1) degenerative changes of the radiocarpal, distal radial ulnar and carpal metacarpal joints; (2) widening of the distance between the scaphoid and the lunate usually associated with scapholunate dissociation and scapholunate ligamentous tear; (3) ulna negative variance; (4) if the patient was involved in wrist trauma and pain persists, consider repeating the study in 5-7 days; (5) mild wrist edema correlated with recent trauma; (6) incidental visualization of degenerative changes within the metacarpal phalangeal joints at the margins of the exam; (7) small rounded bony fragment dorsal aspect of the carpal region. Petitioner also underwent x-rays of the right wrist on February 27,

2012, which were interpreted as revealing (1) severe osteoarthritis of the radiocarpal joint with total loss of the joint space, and sclerosis and marginal osteophytosis; degenerative changes also present between the first, second and third metcarpal phalangeal joints; (2) ulnar positive variance; (3) widening of the scapholunate distance likely related to scapholunate disassociation and ligamentous tear; (4) deformity of the scaphoid; correlate with history of prior fracture and trauma; (5) if the patient was involved in wrist trauma and pain persists, consider repeating the study in 5-7 days; (6) there is a bony fragment dorsal aspect of the carpal region suggestive of a fracture of indeterminate age or etiology; MRI or CT would be helpful for further characterization. (PX3).

The records of Greenville Regional Hospital also reflect that Petitioner also underwent a nerve conduction study on March 13, 2012, which was interpreted as revealing an abnormal neurophysiologic examination, with evidence of a sensory motor median entrapment neuropathy seen at the level of the flexor retinaculum bilaterally. (PX3).

The medical records of Regeneration Orthopedics/Dr. Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on June 18, 2013, at which time it was noted that Petitioner had been working 33 years at a rubber manufacturing job and had had multiple jobs over the years. Petitioner stated that his initial nine years was on the calendar mill line in which he used scissors and knives to cut rubber, and that he developed a knot on his right wrist and subsequently had to start using his left wrist to cut with the knives rather than the right side. It was noted that Petitioner had moved to compounding using hand scoops, and that the job was now automated but when he did this, he had to do it by hand. It was noted that Petitioner had held other jobs including a molding-type job where he was putting props and taking rubber off; that he had had to pull rubber, use tape guns, lift bars overhead, etc. and had subsequently changed his shifts to two 12-hour shifts due to the fact that he had been having such problems with his wrist. Petitioner stated that he was laughed at while at work sometimes because he dropped scissors and other objects because of numbness in his right hand and some occasional numbness in the left hand. Petitioner stated that his right hand was pretty much numb all the time. It was also noted that Petitioner had pain in the wrist which was increased with activity but the numbness was present a lot of the time, and that Petitioner had previously been working 40-hour workweeks plus 1,000 hours of overtime per year. The assessment was that of (1) bilateral carpal tunnel syndrome; (2) right greater than left radiocarpal arthritis. The note also contained a causation opinion indicating that while Dr. Mall could not be 100% certain that the carpal tunnel syndrome was caused by his work, it definitely was an aggravating factor and likely contributed significantly to the development of carpal tunnel syndrome. It was noted that the wrist arthritis was likely secondary to a ligament injury that could have occurred at work and was caused by a work injury, but at the very least it was being aggravated by his current working environment in which he did a lot of heavy repetitive maneuvering causing him to do wrist flexion and extension maneuvers. With respect to treatment recommendations, Petitioner was recommended to undergo carpal tunnel injections to see what percentage of his pain was coming from the carpal tunnel versus his wrist arthritis, and he underwent such injections on that date. (PX4).

The records of Regeneration Orthopedics/Dr. Mall reflect that Petitioner was seen on July 16, 2013, at which time it was noted that Petitioner stated that after the injections he got significant relief and that his pain was continuing to improve as well as his symptoms of numbness and tingling. It was noted that he no longer had symptoms while driving his car or when he woke up first thing in the morning, but it was noted that he was dropping things. It was also noted that Petitioner was having reduced but still some continued tingling in the median nerve distribution. The assessment was that of bilateral carpal tunnel syndrome, and Dr. Mall thought that Petitioner would benefit from carpal tunnel release should his symptoms come back. A work slip was issued on that date, indicating that Petitioner could return to work in July 17, 2013 full duty. (PX4).

The records of Regeneration Orthopedics/Dr. Mall reflect that Petitioner was seen on April 11, 2014, at which time he reported right side more than left side numbness in his hands which was worse over the last few weeks. It was noted that Petitioner had been given injections in his bilateral carpal tunnels that gave him significant benefits and improvement that lasted for a good amount of time, but that it had returned. The assessment was that of bilateral carpal tunnel syndrome and Petitioner was recommended to undergo surgery. (PX4).

The records of Regeneration Orthopedics/Dr. Mall reflect that Petitioner was seen on November 19, 2014 for follow-up after right carpal tunnel release and median nerve exploration. The assessment was that of healing wound, status post procedure. Petitioner was recommended to continue doing his packing, and it was noted that he was to return in one week at which time it was anticipated that he may be allowed to return to work in a limited duty capacity. An off work slip was issued on that date as well. Petitioner was next seen on November 26, 2014, at which time he continued to state that the pain in his wrists was better, and that he still had some numbness in his hand. It was noted that Petitioner also had some muscle atrophy in the thenar eminence, which was present pre-operatively. The assessment was that of status post median nerve decompression and exploration. Petitioner was recommended to return to work full duty, and a work slip was issued on that date allowing him to return to full duty effective November 27, 2014. (PX4).

The records of Regeneration Orthopedics/Dr. Mall reflect that Petitioner was seen on January 7, 2015 for follow-up right carpal tunnel syndrome ad bilateral knee osteoarthritis. It was noted that the right carpal tunnel was related to a work injury, and that the bilateral knee osteoarthritis was through his private insurance. It was noted that Petitioner continued to have some numbness in his median distribution and that it was somewhat better than it was immediately following the other right carpal tunnel release and before the surgeries, but it was still fairly numb. Petitioner was recommended to undergo physical therapy to work on regaining his full range of motion in the hand and to improve some swelling. It was noted that Petitioner had had carpal tunnel syndrome for some time with dramatic numbness in his hand, and that some may be permanent and not respond to the procedure. It was also noted that Petitioner had undergone a second nerve exploration to fully evaluate the nerve, and that there were no areas of compression noted well up into the wrist. A work slip was issued on that date, placing Petitioner under light duty restrictions effective January 8, 2015 of no continuous pulling or cutting with the right hand. (PX4).

The records of Regeneration Orthopedics/Dr. Mall reflect that Petitioner was seen on November 3, 2014 for follow-up of bilateral carpal tunnel syndrome. It was noted that Petitioner's left side felt "great," and that the right side continued to feel some numbness in the median distribution. The physical examination performed revealed some weakness with his thenar muscles in the right thumb, and the assessment was that of continued median nerve dysfunction, status post carpal tunnel release. It was noted that Petitioner would require an exploration of his median nerve, as it appeared that the median nerve was still being compressed or was somewhat injured. It was noted that on the left side, Petitioner had an excellent result. It was also noted that Petitioner stated that the right side was much worse than the left side initially. (PX4).

The medical records of St. Luke's CDI were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner underwent x-rays of the right and left wrists pm June 18, 2013, which were interpreted as revealing (1) severe right and mild left osteoarthritis of the wrists; (2) scapholunate widening on the right consistent with a scapholunate ligament tear and proximal migration of the capitates is noted consistent with SLAC wrist; this is noted to a lesser degree on the left. (PX5).

The IME Report of Dr. Kostman was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The report dated May 27, 2014 noted that Petitioner described that he was a senior

production operator at a rubber processing plant and had been working at the plant for 34 years. Petitioner described that his job changed over the years, and that he initially was working on a mill line,as he described, cutting rubber with a wooden-handled knife. Petitioner noticed that his right hand along the radial styloid location developed swelling and pain, and then he switched to his left hand approximately 7 years after he started work. Petitioner described, after 9 years of work, switching to a compound mixing type of job where he lifted a plastic scoop of compound and lifted an 8-15 pound container approximately 40 hours a week. It was noted that Petitioner switched between the two jobs of cutting and mixing and occasionally would pick up 50-pound bales of rubber. Petitioner further described his symptoms worsening in 2007-2009 on a line that involved lifting from 160-200 pounds, which were not automated. Petitioner indicated that he now works on an automatic sheet building machine that he watches for defects, which involves pushing buttons. Petitioner described his first symptoms of hand numbness in 2009 and his first symptoms of wrist pain in 1985. Petitioner described bilateral wrist pain and numbness over the last 10 years. (PX6).

The report noted that Dr. Kostman opined that Petitioner's right and left wrist pain was secondary to scapholunate ligament insufficiency and secondary osteoarthritis of the wrists, and that he did not believe that his work activities were the direct cause of the symptoms. It was noted that the diagnosis was that of carpal tunnel syndrome bilateral hands, and that although Petitioner's activities in the past had involved cutting and heavy lifting activities, he described that he had transitioned his work to automated lines and therefore did not believe that his work activities as currently described were consistent with the cause of Petitioner's bilateral carpal tunnel syndrome. Dr. Kostman indicated that he believed that advanced osteoarthritis secondary to SLAC wrists can be aggravated by his work activities as described when he started work at Carlisle, however he did not believe that his current work activities would aggravate or accelerate his underlying condition of bilateral SLAC wrists and osteoarthritis. He further indicated that he believed that Petitioner's work activities as described when he started work at Carlisle could aggravate his carpal tunnel syndrome, however he did not believe his current activities aggravated his carpal tunnel syndrome. He indicated that he did not believe additional medical treatment was causally related to his work duties at Carlisle, and that he was at maximum medical improvement as related to his work activities. (PX6).

The deposition of Dr. Kostman was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Dr. Kostman testified that he is board-certified in orthopedics, and that he only treats extremity injuries and not the spine. He testified that he has performed carpal tunnel surgeries in the past, and has treated scapholunate ligament insufficiency and osteoarthritis of the wrist in the past. (PX7).

Dr. Kostman testified that with respect to the physical examination performed, Petitioner was noted to have some tenderness to palpation involving his right wrist along the radial aspect, both along the volar and dorsal surface; that he was noted to have some mild swelling to the same area; that his left wrist demonstrated tenderness involving the scapholunate interval dorsally and along the radiocarpal joint dorsally; that he demonstrated decreased sensation to light touch involving the left hand along the volar surface of the thumb, index and long fingers, and that on the right side he had decreased sensation to light touch involving the volar surface of the thumb, index, long, ring and little fingers. He testified that sharp testing demonstrated some increased sensitivity in the right both along the medial and ulnar nerve distribution of the right hand on the palmar surface and decreased sensation in the left along the median nerve distribution of the hand including the thumb, index and long finger of the hand in addition to some decreased sensation along the radial forearm and deltoid distribution proximally on the left. (PX7).

Dr. Kostman testified that other than Dr. Dawdy's examination on October 7, 1992, he did not note Petitioner making any complaints in his hands or wrists to a medical provider prior to February of 2012. He testified that the x-rays performed at his office revealed that the right side demonstrated advanced radiocarpal degenerative arthritis, scapholunate joint widening on the right consistent with end-

stage SLAC wrist and degenerative joint disease, and that the left wrist demonstrated mild to moderate radiocarpal degenerative changes, scapholunate interval widening and probable SLAC wrist. He testified that his reading of the x-rays were consistent with the x-rays that Petitioner underwent on February 27, 2012. He testified that it was possible for patients that have degenerative arthritis in their wrist to develop carpal tunnel syndrome or have an aggravation of carpal tunnel syndrome because of some wrist/joint swelling due to arthritis, and that you could have some compromise of the space available in the carpal canal for the median nerve. He testified that it was not, however, a one-to-one correlation. (PX7).

Dr. Kostman testified that the x-rays demonstrated a long-standing condition involving both wrists, both involving an old ligament injury and development of osteoarthritis involving the wrist joint. He testified that his experience was that the conditions were related to an old, prior injury but that Petitioner did not relate any old injury. He testified that the first complaint of bilateral wrist or hand complaints to a medical provider was Dr. Goggin on February 20, 2012, and that Dr. Goggin noted at that time that Petitioner was working part-time. He testified that based on his review of the medical records, the left and right wrist complaints first manifested on that date. When asked if he agreed with Dr. Sola's opinion in the records from February 27, 2012 that the pain in Petitioner's wrist was related to the degenerative changes in his wrist, Dr. Kostman responded that considering his two diagnoses, he believed that it would make sense that he had more symptoms secondary to arthritis of the wrist joint. (PX7).

Dr. Kostman testified that his impression was that Petitioner's right and left wrist pain was secondary to scapholunate ligament insufficiency and secondary arthritis of the wrist, and that he had a diagnosis of carpal tunnel syndrome of the bilateral hands. He testified that he did not believe that Petitioner's work activities were the direct cause of his symptoms involving his right and left wrist pain secondary to scapholunate insufficiency arthritis, and that he did not believe that his work activities as currently described were consistent with the cause of Petitioner's bilateral carpal tunnel syndrome. He testified that Petitioner described currently working on an automated line where he inspected product and pushed buttons, and that he did not believe that that activity for either of those conditions would be a significant contributor either by way of causation or aggravation. He further testified that Petitioner's initial employment described more heavy activities with cutting of rubber and lifting, and that these activities could aggravate those symptoms related to either of those conditions. (PX7).

Dr. Kostman testified that he believed that some of Petitioner's past work activities could have aggravated or accelerated his conditions in his bilateral hands and wrists, and that his understanding of Petitioner's job duties in 2012 when the symptoms manifested he was working more of a supervisory role where he was punching some buttons and not doing the type of work that he previously noted in the history provided. He testified that when the conditions manifested in 2012, they had nothing to do with his work at Carlisle. He testified that it was possible that smoking could aggravate or worsen symptoms as related to carpal tunnel syndrome, and that swelling secondary to arthritis can put pressure on the carpal canal and can aggravate carpal tunnel syndrome with getting less available space for the median nerve in the carpal canal. (PX7).

Dr. Kostman agreed that he took a history from Petitioner that he had pain in his hands since 1985 and had numbness since 2009. He testified that scapholunate advanced collapse was typically related to an initial trauma of some sort and not repetitive activities, and that the diagnosis was most commonly related to an initial event of trauma which was not related in any fashion to him during the exam. He further testified that carpal tunnel syndrome as a diagnosis was most commonly idiopathic, but that there had been studies that heavy use of vibratory tools could be related but that Petitioner's particular activities in 2012 did not, in his opinion, appear related. He also testified that Petitioner's past work activities may have aggravated his conditions but he had no record of that. (PX7).

On cross-examination, Dr. Kostman testified that he could not recall having treated or examined any other employees from Carlisle Syntec. He testified that he believed that Petitioner had bilateral carpal tunnel syndrome and that he needed to have surgery provided that he failed conservative treatment. He testified that Petitioner was a bilateral carpal tunnel release surgical candidate, and that conservative management could include a period of splinting or corticosteroid injection. (PX7).

When asked if he believed that Petitioner's work cutting rubber 40 hours per week was any factor at all in the diagnoses of carpal tunnel syndrome and the need for bilateral carpal tunnel releases, on cross-examination Dr. Kostman responded that it would depend on his examination at that time. He testified that he did not think that it would change the overall outcome of the condition, but that it could aggravate the condition. He testified that the problem was that he did not see an exam from that point in time nor were there any EMG/nerve conduction studies from that point in time, so he thought the question was difficult to answer for those reasons. He agreed that in his report the work activities when Petitioner started would include cutting rubber 40 hours per week, lifting scoops and mixing sulphur or zinc and lifting 8-15 pound containers 40 hours a week, and working on the TPO line that involved lifting form 160-200 pounds. He testified that the activities were not a factor, however, in his scapholunate ligament insufficiency. (PX12).

On cross-examination, Dr. Kostman agreed that he saw patients who came into him who he ultimately diagnosed with carpal tunnel syndrome who had lived with their complaints for a period of time. He agreed that carpal tunnel syndrome was a condition that could worsen over time. He agreed that it was impossible within a reasonable degree of medical certainty to tell the exact onset of Petitioner's bilateral carpal tunnel syndrome. He agreed that it was not possible for a practitioner to see Petitioner and stated that he or she knew exactly when the osteoarthritis started. (PX7).

On cross-examination, Dr. Kostman testified that when he used the term "manifestation" he was talking from a medical standpoint rather than a legal one. He agreed that the work activities of cutting rubber, scooping, lifting, and the TPO line could have aggravated the SLAC wrist and could have aggravated the carpal tunnel syndrome conditions. (PX7).

On redirect, Dr. Kostman agreed that he did not review any medical records nothing that Petitioner was having any bilateral hand or wrist complaints while he was cutting rubber, mixing, or working the TPO line when he was carrying 160-200 pounds. He agreed that his opinion was that these types of activities could possibly aggravate his wrist or hand conditions. (PX7).

On further cross-examination, Dr. Kostman testified that he did not have any independent knowledge about what Petitioner was experiencing from a pain standpoint when he was doing these jobs in the past. (PX7).

The medical records of Timberlake Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner underwent a right carpal tunnel release on October 7, 2014 with a pre- and post-operative diagnosis of right carpal tunnel syndrome. Petitioner underwent a left carpal tunnel release on October 23, 2014 with a pre- and post-operative diagnosis of left carpal tunnel syndrome. Petitioner also underwent a carpal tunnel release and median nerve exploration on November 4, 2014 for a pre-operative diagnosis of median nerve dysfunction and a post-operative diagnosis of residual band of flexor retinaculum and scar tissue, intact median nerve. (PX8).

The medical records of Hometown Chiropractic were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner was seen on February 3, 2015 for issues related to the low back, and he was also experiencing moderate pain in the right hand and numbness in the first through third finger on the right. It was noted that he had Petitioner had surgery last October and was still having

pain into his right hand, and that he was given physical therapy orders which would be addressed at the clinic. Petitioner underwent "soft tissue muscle work" on that date. Petitioner was also seen on February 6, 2015; February 9, 2015; and February 11, 2015, at which time he underwent "soft tissue muscle work" again. Petitioner was next seen on July 13, 2015, at which time he stated that his hands were constantly numb due to his carpal tunnel syndrome and that it was something he was used to. Petitioner was also seen on November 23, 2015 due to sharp pain his lower back and that he had been sitting in a deer stand in a twisted position for several hours on November 22, 2015. He was further seen on November 25, 2015 for complaints of dull pain in the lower back. (PX9).

The accident report was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report reflects that the accident was reported on April 7, 2012, and that Petitioner reported to Jan Woker that he was going through the test for carpal tunnel, that Petitioner went back to the doctor during the week of April 9th and that he confirmed that Petitioner suffers from carpal tunnel syndrome. The primary factor responsible for the accident was noted to be that of progressive use of the hands/wrists while working in the factory over the last 30 years. The date of the report was April 23, 2012 and was signed by Petitioner on that date. (PX10).

The medical bills exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The deposition of Dr. Mall was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Dr. Mall testified that he is an orthopedic surgeon, and that he is board-certified in orthopedic surgery and independent medical examinations. (PX12).

Dr. Mall testified that he first saw Petitioner on June 18, 2013, at which time the chief complaints was noted to be bilateral wrist pain and numbness. He testified that Petitioner told him about what he did for a living, which included using knives to cut rubber, using large scissors, and using hand scoops, and that his new job was rather automated and he was not having to do nearly as much of his pushing, pulling, lifting and grabbing-types of jobs as he was previously, and that the number of hours he had been working had been reduced over the last few years as well. He testified that on examination, Petitioner had some mild limitation in range of motion of the wrist moreso on the right than on the left, that he had some mild pain to palpation of the wrist moreso on the right than the left side, and that he had positive provocative signs for carpal tunnel at both wrists as well. (PX12).

Dr. Mall testified he performed injections on that date, and that Petitioner had carpal tunnel syndrome and SLAC wrist arthritis. He testified that people can have pain and even numbness symptoms related to arthritis, and that the reason to do the injections was to help differentiate the diagnosis into what was the source of his major complaint. He testified that when Petitioner returned on July 17, 2013, he reported significant relief from the injections, and that he was still dropping objects but had reduced symptoms. He testified that he felt the majority of Petitioner's symptoms were coming from his carpal tunnel syndrome rather than from his arthritis. He agreed that he sent Petitioner back to work full duty and recommended that he continue conservative care, and that if the pain returned he would recommend a release. (PX12).

Dr. Mall testified that Petitioner returned on April 11, 2014, at which time he indicated that his numbness and symptoms had returned. He testified that Petitioner had failed conservative treatment and that he recommended carpal tunnel releases. He testified that he ultimately performed a right carpal tunnel release on October 7, 2014. He testified that he took Petitioner off work on October 7, 2014. He testified that when Petitioner was seen post-operatively on October 20, 2014, he had some residual symptoms. He testified that Petitioner's left hand was still causing him problems for which he

recommended a left carpal tunnel release, and that it was performed on October 23, 2014 with no issues afterwards. He testified that he took Petitioner off work after the left surgery was performed. (PX12).

Dr. Mall testified that when he saw Petitioner on November 3, 2014, he reported that the left side felt great but that the right side continued to feel some numbness. He testified that as Petitioner had some decreased two-point discrimination in the median distribution he was concerned about the nerve, as well as the weakness into the thenar muscles which were controlled by the median nerve. He testified that he thought it required another procedure with the median nerve. He testified that there were two potential reasons for the nerve to still not be working well after a carpal tunnel surgery, that the nerve was injured during surgery or that the nerve was still being compressed by a band of tissue. He testified that this was something that can happen and was not unusual. He testified that when the second procedure on the right carpal tunnel was performed, there was a persistent band of the flexor retinaculum or transverse carpal ligament that was still present and that the nerve appeared to be compressed at that area. He testified that there was no evidence of any injury to the nerve. (PX12).

Dr. Mall testified that he was of the opinion that the second surgery on November 4, 2014 was reasonable and necessary. He testified that if someone were having persistent pain and symptoms, it needed to be addressed and that if it was not addressed, there could be worsening of symptoms. He testified that in this case Petitioner's nerve conduction seemed to be a little bit worse after surgery, so he thought that the added swelling from the surgery probably made it worse and the fact that the band was not completely cut worsened his symptoms for a period until the second surgery was performed. (PX12).

Dr. Mall testified that when Petitioner returned on November 11, 2014, he had some very mild wound issues, but that his symptoms had been improving in terms of the numbness. He testified that it was very common to see wound issues, and that it was nothing that was concerning. He testified that he had Petitioner off work on November 11th as well. He testified that Petitioner was seen on November 14th in order to keep an eye on the incision, at which time he again kept Petitioner off work. He testified that his concern about sending Petitioner back to work at that point was mostly the open wound area and the need to keep it clean and make sure no infection ensued. (PX12).

Dr. Mall testified that Petitioner was next seen on November 19th, at which time his wound looked better. He testified that Petitioner was then seen on November 26th, at which time the wound was pretty much completely healed. He testified that Petitioner was still having some pain in his wrist, but it was unlikely that they were going to make him completely pain-free given his arthritis diagnosis. He testified that he believed that Petitioner was well enough to go back to work. (PX12).

Dr. Mall testified that he next saw Petitioner on January 7, 2015 for a new, unrelated body part and that he also saw him in relation to the carpal tunnel syndrome as well. He testified that Petitioner reported that he had very mild tingling and numbness in his right side and a little bit of numbness in his median distribution but otherwise was fairly happy with his results and had improvement in his pre-operative status. He testified that he recommended physical therapy at the time of this visit, which he believed was reasonable and necessary given the presence of residual symptoms. He further testified that he placed Petitioner under permanent restrictions relating to the right hand and wrist given Petitioner's persistent symptoms and that there were some things that he had been doing at work that he felt he was having a hard time doing. He testified that Petitioner felt that pulling and cutting with his right hand was limited, so he felt it was a reasonable permanent restriction for him. He testified that without these activities, Petitioner could pretty much work a full duty job so he thought Petitioner would be able to work longer and be more active. (PX12).

When posed with a hypothetical question pertaining the Petitioner's job duties and asked whether this type of work history was a factor in his diagnosis of bilateral carpal tunnel syndrome, Dr. Mall

responded that Petitioner described repetitive gripping and grabbing of objects, which he considered to be contributing to the cause of carpal tunnel syndrome or at least the aggravation of carpal tunnel syndrome. He further testified that this type of work history was a factor in the treatment he rendered to Petitioner. (PX12).

Dr. Mall testified that he disagreed with Dr. Kostman's testimony that Petitioner's right and left wrist pain was secondary to scapholunate ligament insufficiency and secondary arthritis of his wrist given the injections that were performed and that the vast majority of his symptoms were coming from carpal tunnel syndrome rather than arthritis in his wrist, but he agreed with Dr. Kostman's testimony that Petitioner had a diagnosis of carpal tunnel syndrome, bilateral hands. He testified that he made the diagnosis of scapholunate deficiency and arthritis associated with that as well, but he did not feel that that was the major source of his symptoms. He testified that it was not concerning to him that at some point Petitioner stopped doing the long run of repetitive work and by his own admission did less repetitive work now. (PX12).

On cross-examination, Dr. Mall testified that he did about two carpal tunnel surgeries per week out of 10 surgeries performed, and that he currently performed about 100 carpal tunnel surgeries per year. When asked why the Regeneration Orthopedics website did not state anything about hand, wrist or carpal tunnel syndrome for body parts or conditions that they treat, Dr. Mall responded that he had not adjusted the website since he started back in 2012. (PX12).

On cross-examination, Dr. Mall testified that he did not know if Dr. Goggin ever referred a patient to him. He testified that he saw people from attorneys all the time, so he would not disagree if Petitioner had heard of his group through his attorney. He admitted that Petitioner's attorney did refer patients on occasion. When asked if Petitioner had ever told him that he had treated with Dr. Sola for his carpal tunnel syndrome back in 2012, Dr. Mall responded that he may have but he did not have it recorded so he would have to say no since it was not written down. (PX12).

On cross-examination, Dr. Mall testified that some of the risk factors for carpal tunnel included activity-related factors including repetitive gripping and grabbing of objects and typing in a non-ergonomic position, as well as physiological issues like thyroid issues, obesity, vitamin deficiencies and arthritis. He agreed that Petitioner was in the obese 2 category, which used to be referred to as morbidly obese. He agreed that being morbidly obese could be a risk factor for developing carpal tunnel syndrome. (PX12).

On cross-examination, Dr. Mall agreed that Petitioner reported at the June 18, 2013 visit that he recently moved to the weekend shift, where he worked two 12-hour shifts. He agreed that Petitioner stated that he had numbness and pain complaints in his wrist for a number of years preceding the transition to the weekend shift, and that he reported that his numbness and pain preceded his change in jobs. He testified that Petitioner did not give him the exact date of when he started having the numbness. (PX12).

When asked on cross-examination how an accurate history of a person's symptoms for carpal tunnel syndrome for when they began factored into an opinion on causation, Dr. Mall responded that he had to look at what they were doing, when the symptoms occurred and also what they were doing before the symptoms occurred because carpal tunnel did not typically occur in an acute fashion. He testified that carpal tunnel could be seen with an acute wrist fracture, but that the new acute trauma may have brought out some of the symptoms so the pre-symptom history was important as were other risk factors. (PX12).

On cross-examination, Dr. Mall testified that Petitioner reported that his new job was more automated, and that these job duties were not relevant to his causation opinion. He testified that he did

not review any of Petitioner's medical records or radiographs prior to June 18, 2013 and that it was based on the history provided by Petitioner. He agreed that he could not pinpoint exactly when Petitioner's work activities became aggravating factors and that he was relying solely on Petitioner's history. He testified that Petitioner did not give him any kind of a history of a ligament injury to his wrist at work, but that sometimes the ligament injury could be something that as more of a degenerative process that occurred with repetitive activities as well. He agreed that one can have a degenerative tear of the scapholunate ligament over time, but it was more commonly seen as an acute trauma injury. (PX12).

On cross-examination, Dr. Mall agreed that the last time that he saw Petitioner was on January 7, 2015 at which time he recommended physical therapy to improve Petitioner's range of motion and swelling in his hands. He testified that he called for eccentric strengthening of wrist flexors, range of motion stretching of the wrist and elbow and modalities as needed. He testified that he received physical therapy records from Phoenix Physical Therapy dated December 2, 2014, but this was for his knee pain, and that he did not see anything for his carpal tunnel. He testified that he did not have a problem with the therapy being done by a chiropractor as long as the things that he asked for were being done. After reviewing the records of Hometown Chiropractic, Dr. Mall testified that he did not know what chiropractic manipulations of the wrist and adjustments of the wrist were, but this was not what he ordered. He testified that the notation on January 7, 2015 that Petitioner was not at maximum medical improvement pertained to his wrist, and that he felt that Petitioner could probably get some improvement from the physical therapy. He agreed that he could not make that determination based on the information he received at the time of the deposition. (PX12).

The Time & Attendance – Detail Report and Job Bid were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The medical records of Illinois SW Orthopedics, Ltd. were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records were duplicative of those as contained in Petitioner's Exhibit 2. (RX2).

The medical records of Dr. Andrew Goggin were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was seen on April 7, 2005, at which time Petitioner denied any edema or sores in the extremities. Petitioner was seen for unrelated issues on April 14, 2005, May 4, 2005, June 22, 2005, January 16, 2007, April 27, 2007, February 7, 2008, January 29, 2009, January 22, 2010, February 16, 2010, February 19, 2010, May 19, 2010, January 26, 2011, and March 10, 2011. (RX3).

The records of Dr. Andrew Goggin reflect that Petitioner was seen on February 20, 2012, at which time he reported that both hands hurt, and that the right was worse and associated with thenar numbness. The impression was that of generalized arthritis and right hand pain, likely mixed origin but likely carpal tunnel syndrome. Petitioner was referred to Dr. Sola and ordered to undergo x-rays of the hands. (RX3).

The records of Dr. Andrew Goggin reflect that Petitioner was seen for unrelated issues on May 2, 2012, May 3, 2012, August 8, 2012, January 17, 2013, March 15, 2013, May 30, 2014, March 13, 2015and September 2, 2015. (RX3).

The Carlisle Syntec medical records of Dr. Dawdy dated October 7, 1992 were entered into evidence at the time of arbitration as Respondent's Exhibit 4. Petitioner was seen on that date for a physical examination. It was noted that Petitioner had a fracture of the left tibia a number of years ago and had no problems with that, and that he had occasional aching proximal to the left wrist. The assessment referenced, among other things, mild left tenosynovitis. (RX4).

The Sign Up Sheet for Weekend Shift dated April 28, 2010 was entered into evidence at the time of arbitration as Respondent's Exhibit 5. An Inter-Office Memo dated January 20, 2012 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The memo pertained to walking onto freshly waxed floors and signage-related issues. (RX6).

Documentation pertaining to Cigna payments were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The pay stubs for short-term disability benefits issued to Petitioner were entered into evidence at the time of arbitration as Respondent's Exhibit 8.

The Petition for an Immediate Hearing dated September 8, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The Petition alleged that notice of the accident was given both orally and in writing to John Cohen on September 21, 2011, and that the accident date was that of February 27, 2012. Also included within the exhibit was a Request for Hearing for December 14, 2015, which alleged that notice was given to Joe Edd on April 23, 2012 and that the date of accident was that of February 27, 2012. (RX9).

The transcript of the evidence deposition of Dr. Kostman was entered into evidence at the time of arbitration as Respondent's Exhibit 10, but was duplicative of Petitioner's Exhibit 7. The medical records of Hometown Chiropractic were entered into evidence at the time of arbitration as Respondent's Exhibit 11, but were duplicative of those as contained in Petitioner's Exhibit 9.

The e-mail exchange pertaining to the stipulation between the parties as to the testimony of Jan Woker was entered into evidence at the time of arbitration as Respondent's Exhibit 12. The parties stipulated that Jan Woker is the manager for Human Resources for Carlisle and was so in 2012; that her office is located at the Carlisle facility in Greenville, Illinois; that Petitioner mentioned to her sometime in 2012 some sort of problem that he was having with his hands or wrists and that this discussion occurred at the Carlisle facility in Greenville, Illinois; that Woker cannot recall the exact date of the discussion with Petitioner, but does know it was before he completed the accident report on April 23, 2012; and that when Petitioner mentioned this problem, she advised him to complete an accident report. (RX12).

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on February 27, 2012, and that his current condition of ill-being is causally related to his work activities for Respondent.

In so concluding that Petitioner's carpal tunnel syndrome in his bilateral hands is related to his work activities, the Arbitrator finds it to be significant that both Dr. Mall and Dr. Kostman have opined that Petitioner's earlier work activities for Respondent were sufficient to either cause or aggravate the carpal tunnel syndrome and/or SLAC wrist conditions. Related thereto, the Arbitrator notes that Dr. Kostman agreed that the work activities of cutting rubber, scooping, lifting, and the TPO line could have aggravated the SLAC wrist and could have aggravated the carpal tunnel syndrome conditions. (PX7; RX10). The Arbitrator further notes that on cross-examination, Dr. Kostman agreed that he saw patients who came into him who he ultimately diagnosed with carpal tunnel syndrome who had lived with their complaints for a period of time and that carpal tunnel syndrome was a condition that could worsen over time. (*Id.*). As a result thereof, the Arbitrator finds that Dr. Kostman's concessions, when combined with

the favorable causation opinion testimony proffered by Dr. Mall, necessarily results in Petitioner having met his burden of proof in this case.

In accordance with the opinions of Dr. Mall, the Arbitrator finds that Petitioner's job duties are sufficiently repetitive or cumulative to support a finding of causation for the carpal tunnel syndrome condition. Petitioner's job description and his own testimony demonstrated that his job duties performed up until the time at which he began working weekends in 2010 were forceful and required frequent gripping. The Arbitrator notes that Petitioner testified that he waited between 2009 and 2012 to seek treatment because he waited until his hands got to the point that he could not sleep anymore, and the Arbitrator points out that Petitioner appeared to testify in a credible and forthright manner at the time of arbitration. As a result thereof, the Arbitrator finds that the job duties as described and demonstrated by Petitioner at the time of arbitration -- which involved gripping and grasping of objects and tools-- were sufficient to cause or aggravate carpal tunnel syndrome.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on February 27, 2012, and that his current condition of ill-being is causally related to his work activities.

With respect to disputed issue (E) pertaining to notice, the Arbitrator notes that the accident report, which was entered into evidence at the time of arbitration as Petitioner's Exhibit 10, reflects that the accident was reported on April 7, 2012, and that Petitioner reported to Jan Woker that he was going through the test for carpal tunnel, that Petitioner went back to the doctor during the week of April 9th and that he confirmed that Petitioner suffers from carpal tunnel syndrome. The date of the report was April 23, 2012 and was signed by Petitioner on that date. (PX10). On cross-examination, Mr. Edd agreed that it was his handwriting on the accident report where it said that it was reported April 7, 2012. Ms. Woker via the stipulation indicated that Petitioner mentioned to her sometime in 2012 some sort of problem that he was having with his hands or wrists and that this discussion occurred at the Carlisle facility in Greenville, Illinois and that she could not recall the exact date of the discussion with Petitioner, but knew it was before he completed the accident report on April 23, 2012. (RX12). As the carpal tunnel syndrome diagnosis was definitively made by Dr. Sola at the time of the February 27, 2012 office visit, the Arbitrator finds that timely notice of the accident was given to Respondent.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment to his bilateral hands was reasonable, necessary, and causally related to his work accident of February 27, 2012. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services as set forth in Petitioner's Exhibit 11 ***solely with respect to the left and right hands/wrists***, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from October 7, 2014 through November 26, 2014. (AX1). Related thereto, the Arbitrator notes that on October 7, 2014, Petitioner underwent the first surgery on the right hand, that on October 23, 2014 Petitioner underwent the left carpal tunnel release, and that on November 4, 2014 Petitioner underwent the right carpal tunnel release and median nerve exploration procedure. (PX8). The Arbitrator notes that on November 3, 2014, Dr. Mall issued a Work Status Report taking Petitioner completely off work with noted surgery dates of October 7, 2014 and October 23, 2014; that on November 19, 2014, Dr. Mall issued a Work Status Report keeping Petitioner

off work with noted surgery dates of October 7, 2014 and October 23, 2014; and that on November 26, 2014, Dr. Mall issued another Work Status Report allowing Petitioner to return to full duty effective November 27, 2014. (PX4). The Arbitrator further notes that Dr. Mall testified that he took Petitioner off work on October 7, 2014; that when Petitioner was seen post-operatively on October 20, 2014, he had some residual symptoms; that Petitioner's left hand was still causing him problems for which he recommended a left carpal tunnel release; and that he took Petitioner off work after the left surgery was performed. (PX12). Therefore, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 7 2/7 weeks, commencing October 7, 2014 through November 26, 2014, given the Arbitrator's findings with respect to disputed issues (C) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to be employed by Respondent and testified that his permanent restrictions are being accommodated by Respondent. The Arbitrator finds that the nature and demands of his position will likely have minimal affect on his permanent partial disability and, as such, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 56 years old on his date of accident. Given the somewhat advanced age of Petitioner and the fact that his treating physician, Dr. Mall, gave him permanent restrictions of no continuous pulling or cutting with the right hand, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he cannot hold a knife in his right hand very long, and that he does not have a lot of strength in his hand to lift things. He testified that he has difficulty with gripping and pulling things and that he cannot hold on very long. With respect to his left hand, Petitioner testified that he uses his left hand to perform tasks for his right. He denied having any limitations with his left hand. He testified, however, that he does not have as much strength in his left hand as before but is pain-free. At his final office visit with Dr. Mall on January 7, 2015, it was noted that Petitioner continued to have some numbness in his median distribution and that it was somewhat better than it was immediately following the other right carpal tunnel release and before the surgeries, but it was still fairly numb. Dr. Mall recommended that Petitioner undergo physical therapy to work on regaining his full range of motion in the hand and to improve some swelling. Dr. Mall further noted that Petitioner had had carpal tunnel syndrome for some time with dramatic numbness in his hand, and that some may be permanent and not respond to the procedure. (PX4). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and purported limitations, were somewhat corroborated by his treating records at

the conclusion of his treatment with Dr. Mall. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the left hand and 15% loss of use of the right hand under Section 8(e) of the Act.

With respect to disputed issue (O) pertaining to the two provider limit, the Arbitrator notes the record in this case suggests that Petitioner's first choice of physician was his primary care physician, Dr. Goggin. The record is undisputed that Dr. Goggin referred Petitioner to Dr. Sola who, as a result thereof, necessarily would fall into the first referral chain. There appeared to be a dispute as to whether Petitioner was referred to or chose to be seen by Dr. Mall. Even construing the evidence against Petitioner on this issue and assuming that Petitioner's second choice of physician was, in fact, Dr. Mall, the Arbitrator notes that Dr. Mall at the time of the January 7, 2015 visit recommended that Petitioner undergo physical therapy to work on regaining his full range of motion in the hand and to improve some swelling. (PX4). The medical records of Hometown Chiropractic reflect that when Petitioner was seen on February 3, 2015 for issues related to the low back, he was also experiencing moderate pain in the right hand and numbness in the first through third finger on the right and that he was given physical therapy orders which would be addressed at the clinic. (PX9). That said, the Arbitrator finds that Petitioner's treatment solely for the bilateral wrists as performed at Hometown Chiropractic was within the second referral chain. As such, the Arbitrator finds that Petitioner did not exceed his choice of physicians.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alex Moll,
Petitioner,

vs. NO: 12 WC 42536

17IWCC0641

State of Illinois
Menard Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 8, 2016 is hereby affirmed and adopted.

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

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: OCT 11 2017

Joshua D. Luskin

o-10/04/17
jdl/wj
68

L. Elizabeth Coppoletti

Charles J. DeVriendt

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

MOLL, ALEX
Employee/Petitioner

Case# **12WC042536**

MENARD CORRECTIONAL CENTER
Employer/Respondent

17IWCC0641

On 7/8/2016, 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 0.34% 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:

4075 FISHER KERHOVER & COFFEY
JASON COFFEY
1300 1/2 SWANWICK ST
CHESTER, IL 62233

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JUL 8 = 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Alex Moll
Employee/Petitioner

v.

Menard Correctional Center
Employer/Respondent

Case # 12 WC 42536

Consolidated cases: N/A

17IWCC0641

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 26, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being -- ***as it relates to the left shoulder*** -- ***is not*** causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$45,816.16**; the average weekly wage was **$881.08.**

On the date of accident, Petitioner was **28** years of age, ***married*** with **1** dependent child.

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

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

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that his current condition of ill-being in the left shoulder is causally related to his accident of November 26, 2012. All benefits are denied, including the prospective medical treatment requested by Petitioner; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

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

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

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

Melinda M. Rose Gillivan

Signature of Arbitrator

7/5/16

Date

ICArbDec19(b)

JUL 8 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Alex Moll
Employee/Petitioner

Case # 12 WC 42536

v.

Consolidated cases: N/A

Menard Correctional Center
Employer/Respondent

17IWCC0641

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently 31 and is employed by the State of Illinois at Menard Correctional Center where he has worked for approximately 5½ years. He testified that he is a correctional officer.

Petitioner testified that on November 26, 2012, he suffered a work injury. He testified that he was retrieving a set of handcuffs and was making his way back to the north 2 armory with them, going from the front of 3 gallery down to the double gate area. He testified that he was walking down the stairs like he normally would, lost his footing and fell approximately seven steps, landing on his shoulders and upper back and hitting his head on the stairs. He testified that he did not remember details about the fall like whether his arms were stretched out, but that he remembered his feet coming out from under him and then sitting up on the very bottom step.

Petitioner testified that following the incident, he sought medical treatment and that he was ultimately referred to Dr. Gornet. He testified that he had shoulder complaints at that time, and that he was not treated for his any shoulder complaints because Dr. Gornet thought the pain that he was having in his shoulder was stemming from his neck. He testified that he ultimately underwent surgery, and that he followed up with Dr. Gornet afterwards but denied having any physical therapy. He testified that the surgery with Dr. Gornet did not alleviate his shoulder pain complaints.

Petitioner testified that he still has pain complaints in his left shoulder. He testified that he was referred to Dr. Paletta, one of Dr. Gornet's partners. He testified that Dr. Paletta indicated that he needed to have surgery to repair a SLAP tear in his left shoulder, which he wishes to undergo.

On cross examination, Petitioner denied having any prior problems with his left shoulder prior to the accident. He admitted that he was involved in a motor vehicle accident several years ago, but denied having any left shoulder problems after that accident. He further denied having had any injuries to his left shoulder since November 26, 2012.

On cross examination, Petitioner agreed that on November 28, 2012, he went to Sparta Hospital for his complaints and that he gave the emergency room nurses a history about what happened to him. He agreed that he told the emergency room personnel that he fell, landed on his back at work walking down the stairs and his foot slipped. He further agreed that he stated that he hurt in the middle of his back but

not on the side, head or neck. He agreed that he previously testified that his neck complaints did not come on until approximately three weeks after the accident.

On cross examination, Petitioner denied seeing any other physician for any of the problems from the November of 2012 accident from the time he went to the Sparta emergency room until he saw Dr. Gornet in January of 2013. He admitted that he recalled previously testifying when asked what kind of pain he was experiencing, that his answer was stiffness in his neck and that when he would turn or move his head around he would have pain in his neck.

On cross examination, Petitioner agreed that he completed the First Report of Injury, which was contained in Petitioner's Exhibit 1. He agreed that he wrote down that he hit his head and back, and indicated that he testified that he hit his shoulder blades. When asked if he testified on direct that he fell on his shoulders and whether he agreed that falling on his shoulders was different than hitting his head and back, Petitioner testified that he believed it would be all in the same area.

On cross examination when asked if when he saw Dr. Gornet in January of 2013 that his primary complaints were neck pain and pain radiating down his left arm, Petitioner responded that he had pain in his left shoulder and numbness in his arm. He agreed that the history that appeared in the initial record with Dr. Gornet referencing that he presented with a chief complaint of neck pain to the base of his neck, with pain between his shoulder blades and intermittent numbness in his left arm was accurate as to his chief complaint. He agreed that his treatment with Dr. Gornet also consisted of injections, and that he received those in his neck. He agreed that after the injections were performed, he ultimately had surgery with Dr. Gornet.

On cross examination, Petitioner testified that following surgery with Dr. Gornet, the pain in his neck went away but he was still having the pain in his shoulder and into his arm. He denied recalling telling Dr. Gornet that he had improved left shoulder complaints after the surgery. He denied receiving any other treatment from Dr. Paletta other than the MRI, and further denied having received any injections or physical therapy. He agreed that he was currently working full duty.

On redirect examination, Petitioner testified that the motor vehicle accident occurred in March of 2002, which was some ten years prior to this injury. He denied ever once in those ten years seeking medical treatment for his shoulder.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The amended Application alleged a date of accident of November 26, 2012, that Petitioner was walking down a flight of stairs, that his foot slipped and that he fell down ¾ of a flight of stairs and that the body parts affected were that of the back and neck as well as the left shoulder. (AX2).

The Group Exhibit of Transcript of Evidence on Arbitration was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The handwritten description of accident noted that Petitioner fell down approximately 7 steps landing on his upper back and back of his head, and that he felt immediate pain in the middle of his back between his shoulder blades. Petitioner agreed that he filled out the document, that his handwriting appeared on the page and that he signed it. (PX1, p.17; pp.85-86). The Authorization for Disability Leave and Return to Work dated November 28, 2012 noted that Petitioner had full range of motion of the back and shoulders. (PX1, p.29). The Sparta Community Hospital North Campus Progress Note dated November 28, 2012 noted that Petitioner was walking down stairs, lost his footing and fell down stairs, hit the back of his head on the stairs and hit his back and was complaining of center back pain. (PX1, p.31). The office noted of Dr. Gornet dated January 28, 2013 noted that Petitioner presented on that date with a chief complaint of neck pain to the base of his neck with pain between his shoulder blades and intermittent numbness in his left arm. It was noted that Petitioner

initially had more mid-back pain, but now had developed increasing neck pain into his left shoulder and left arm with headaches. (PX1, p.39). At the time of the first 19(b) arbitration hearing on April 3, 2013, Petitioner testified that he struck his back and head against the stairs during his fall. (PX1, p.77). When asked what were the symptoms in his neck, Petitioner responded that he had pain, numbness going into his left arm with pain in his left shoulder and stiffness in his neck, and he denied any right-sided symptoms. (PX1, pp.80-81).

The Group Exhibit of 19(b) Decision of Arbitration was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The 19(b) Decision of Arbitrator Granada found that Petitioner failed to meet his burden of proof that he sustained an accident on November 26, 2012 that arose out of and in the course of his employment with Respondent. (PX2).

The Group Exhibit of Decision and Opinion on Review was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The Decision and Opinion on Review reversed the 19(b) Decision and found that Petitioner proved that he suffered an accident in the course of and arising out of his employment as a correctional officer and that his current condition of ill-being was causally related to the accident. (PX3).

The transcript of the evidence deposition of Dr. George Paletta was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Dr. Paletta testified that he is an orthopedic surgeon and is board certified by the American Board of Orthopedic Surgeons. He further testified that he is fellowship-strained in sports medicine and that his practice focuses on mainly the upper extremity, the shoulder, the elbow and the forearm, as well as the knee. (PX4).

Dr. Paletta testified that Petitioner first presented to him for treatment on June 22, 2015 at the referral of Dr. Gornet. He testified that Petitioner gave a history of being a 30-year-old left hand dominant male whose injury dated back to November of 2012, and that he described a fall down approximately 10 steps at his place of work. He testified that Petitioner reported that he suffered injuries to his thoracic spine including enough of a trauma to result in a compression fracture of the thoracic spine and that also injured his neck and left shoulder. He testified that the initial attention was directed to his fracture of the thoracic spine and then subsequently to his neck, and that he had undergone disc replacements at two levels of the cervical spine. He further testified that it was initially thought that all of his arm and shoulder pain was due to his cervical problem, but that after he recovered from the neck surgery he had ongoing complaints of shoulder pain. He testified that Petitioner specifically told him that he did not have any history of shoulder problems predating the injury of 2012. (PX4).

Dr. Paletta testified that as Petitioner was under Dr. Gornet's care for the neck, he did not perform an in-depth examination of the neck. He testified that Petitioner's right shoulder exam was completely normal, so all positive findings were related to the left shoulder. He testified that Petitioner had several positive provocative tests, including two that suggested a tear of the superior labrum. He testified that Petitioner had good strength and good range of motion, but that he had a very prominent clunk in the shoulder which was an objective palpable sign. He testified that his impression was that Petitioner had a labral tear of the left shoulder, and recommended that Petitioner undergo an MR arthrogram to evaluate the labrum. (PX4).

Dr. Paletta testified that after Petitioner underwent the MR arthrogram, he was able to review the radiologist's report as well as review the films personally. He testified that his interpretation of the MRI of July 6, 2015 was that it showed a tear of the superior labrum and that it involved the entire biceps anchor but did not extend to the bottom front or bottom back. He testified that the rest of the examination was basically normal so his impression was that of a type II SLAP tear, for which he recommended that Petitioner undergo surgery to consist of either a debridement of the labral tear and a tenodesis of the

biceps or a formal repair of the labrum. He testified that he believed the MRI films confirmed his original clinical examination. (PX4).

Dr. Paletta testified that the fall that Petitioner described at Menard Correctional Center in November of 2012 might or could have caused his type II SLAP tear given Petitioner's significant trauma which was hard enough to fracture his thoracic spine in a 30-year-old male. He testified that this implied to him that there was significant force and trauma as a result of that, and the fact that Petitioner complained of left shoulder pain immediately in conjunction with the fall implied to him that he had some injury to the left shoulder. He testified that while Petitioner was not specific with regard to the mechanism other than a fall, the degree of trauma and the extent of injury would be appropriate for causing a type II SLAP tear. (PX4).

Dr. Paletta testified that he believed that the surgery he recommended was both reasonable and necessary in order to treat the injury. When asked to assume that Petitioner was involved in a motor vehicle accident in 2002 but that he did not seek any medical treatment for the shoulder and when asked whether the motor vehicle accident would change his opinion, Dr. Paletta responded that it would not. He testified that if Petitioner was involved in a motor vehicle accident some 10 years prior to the work injury and 13 years prior to his having been seen, he would have expected Petitioner to be symptomatic at some course over that time if the accident had resulted in a SLAP tear. He testified that a traumatic SLAP tear resulting from a motor vehicle accident 10 or 12 years earlier would be almost unheard of for it to asymptomatic for that length of time. (PX4).

On cross examination, Dr. Paletta testified that he did not have any medical records from the treatment Petitioner had prior to seeing Dr. Gornet. He testified that he was not aware of what kind of treatment Petitioner had for the compression fracture. He testified that he did not recall seeing any mention of a compression fracture in any of Dr. Gornet's records and believed that his treatment was directed primarily to the cervical spine. (PX4).

On cross examination, Dr. Paletta testified that the types of mechanism of injury that can cause a type II SLAP tear included repetitive microtrauma with repetitive overhead activity such as throwing, a similar mechanism in laborers or workers who do repetitive overhead activity, and acute SLAP tears which occur as a result of a single injury or trauma event such as where there is some type of distraction of the arm such as falling down the steps and grabbing a rail or as a result of falling on the shoulder directly where the humeral head is compressed into the socket and sheared upward. When asked if there was any way to tell on imaging studies whether or not the SLAP tear was a result of microtrauma or a single trauma, Dr. Paletta responded that if you had an MRI performed within the first couple of weeks after an injury and there was a lot of edema or inflammation, it could give a suggestion that it was acute but if the MRI was done any period of time six weeks or more after an injury, it could not be easily determined. He testified that he could not tell on the imaging study whether or not it was acute or something else. (PX4).

On cross examination, Dr. Paletta testified that the fall down 10 steps was enough of a distance that one would expect that he could have suffered significant trauma, and that the question of a thoracic compression fracture implied significant trauma. He testified that it was the degree of the fall, the degree of the associated trauma and the concomitant complaints of shoulder pain that led him to his conclusion. When asked if the shoulder complaints came on three weeks after the fall and whether this would change his opinion, Dr. Paletta responded not necessarily because Petitioner had a significant trauma to the spine enough to raise the question of a thoracic spine injury, and that the pain he was experiencing from those may have overshadowed any pain he was having in the shoulder. (PX4).

On cross examination, Dr. Paletta agreed that it was possible that Petitioner's problems were coming from his shoulder and not his neck but noted that in this case he did not have the ability to say one way or the other because he never saw Petitioner before he had his neck surgery done. He agreed that if Petitioner testified that he landed on the stairs with his head and the middle of his back and that he did not land on the shoulder, it would eliminate that particular potential mechanism. Dr. Paletta testified that it was his understanding that Petitioner had back, neck and shoulder pain, and that the severity of the injuries was prioritized in a way that the recommended treatment initially was for the thoracic spine and that he then had ongoing neck issues, which became the priority. He testified that Petitioner then had complaints of shoulder pain once Dr. Gornet treated the neck, so that led to the shoulder evaluation. (PX4).

On cross examination, Dr. Paletta denied that when he saw Petitioner on June 22, 2015 he had any complaints of numbness in his left hand and that he had some pain down to the elbow. Dr. Paletta testified that in his experience, as a general guideline if pain goes below the elbow all the way down the arm into the wrist or hand it is more likely to be the neck, and that if there were associated complaints of numbness and tingling that go down the arm, it is more likely the neck. He further testified that if the pain was confined to the shoulder and the upper arm, more often than not it was related to a problem in the shoulder. (PX4).

On cross examination, Dr. Paletta agreed that there were studies about the overuse of MRIs with shoulder injuries. He agreed that there were people that had abnormal MRI scans but had no shoulder symptoms. He agreed that it was a possibility that Petitioner had the shoulder condition, had been asymptomatic and had an injury to his neck and the MRI showed that he had a type II SLAP tear. (PX4).

The Group Exhibit of Medical Expenses was entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The document noted that Petitioner fell on his back and his head on the stairs, as well as the middle of his back just below the shoulder blades. (RX1).

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The document noted that Petitioner identified the body part(s) injured to include the middle of his back just below the shoulder blades and the back of his head. (RX2).

The Summary of Disability was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

The Workers' Compensation Witness Report was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The report completed by Bernard Yokom, Jr. on November 27, 2012 noted that Petitioner slipped and fell down the stairs on his back, hitting his head on the way down. (RX4).

The Incident Report was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The report noted that Petitioner lost his footing and fell down the rest of the stairs, hitting his head and back. (RX5).

The IME Report of Dr. James Emanuel was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report noted that Petitioner reported an injury of November 26, 2012 at which time he fell down a flight of steel stairs basically 3 steps from the top, and that all Petitioner could remember was that his feet were out in front of him and he landed and was told he sat up immediately. The report noted that Petitioner indicated that he had immediate discomfort in between his shoulder

blades, that he did not strike his head and that he had no loss of consciousness, but he could not describe the fall. The report noted that Petitioner indicated that there was a handrail but he did not recall reaching his arm out on the handrail nor did he recall landing on outstretched hands, and that he simply would not comment regards to how he may have injured his shoulder. The report noted that about 4-6 weeks after the injury he started to develop some issues with regards to his neck with radiating pain down into his left arm. The assessments were that of (1) shoulder pain; (2) bursitis, subacromial; (3) impingement syndrome, shoulder. The report noted that Dr. Emanuel cold not stated within a degree of medical certainty that Petitioner's left shoulder complaints were related to a SLAP lesion injury or that the Petitioner's left shoulder findings objectively by MRI scan were related to the work injury of November 26, 2012. The report further noted that Petitioner's physical exam was exaggerated, indicating body posturing, breakaway strength and outward expression of pain with just gentle active forward flexion and abduction. (RX6).

The transcript of the evidence deposition of Dr. James Emanuel was entered into evidence at the time of arbitration as Respondent's Exhibit 7. Dr. Emanuel testified that he is a board certified orthopedic surgeon and that his practice is primarily the treatment of shoulder injuries and conditions. He testified that he sees approximately 90 patients per week that had shoulder problems and that over the course of his career, he has performed more than 12,000 arthroscopic shoulder surgeries. (RX7).

Dr. Emanuel testified that he performed an IME of Petitioner, and that he prepared the corresponding written report dated November 19, 2015. He testified that on physical examination when he performed a very gentle sulcus test on Petitioner he had a very exaggerated reaction to the test, and that gentle active flexion and abduction movements caused a lot of body posturing, breakaway strength and outward expressions of pain that he thought were exaggerated. He testified that Petitioner had an intraarticular clunk that was found on both shoulders on exam. He also testified that he reviewed an MRI scan and arthrogram of the shoulder that had been performed on June 30, 2015. (RX7).

With respect to the MRI, Dr. Emanuel testified that his review of the films was that the rotator cuff was intact, the acromioclavicular joint and biceps tendon subacromial space was normal, and that he found on the axial view perhaps some separation of the labrum, anterior with some fraying, but could not find the evidence on the coronal views. He testified that in essence it was normal except for perhaps some change in the anterior superior labrum. As to the history provided by Petitioner, Dr. Emanuel testified that Petitioner described an injury of November 26, 2012 when he fell down a flight of steel stairs three steps from the top, but he could not really recollect any type of mechanism of injury regarding his shoulders. (RX7).

Dr. Emanuel testified that after the examination, his review of the films and records and the history provided by Petitioner, he diagnosed subacromial bursitis with some impingement symptoms. He testified that he believed that the incident of November 26, 2012 was not a causative factor for the shoulder problems that Petitioner has based on the fact that Petitioner could not describe his exact mechanism of injury with regards to a shoulder injury, his complaints of shoulder pain were significantly after the date of injury and were not really found until after he had neck surgery and there was nothing on objective findings by the MRI that could explain his physical exam and presentation. He further testified that there was also some history of an old injury in a motor vehicle accident at which time the force was significant enough that Petitioner struck the steering wheel with his chest that caused a collapsed lung, and Petitioner further gave a history of being a weightlifter. He testified that both of these issues could be potential causes for shoulder labral injuries, and that Petitioner had shoulder exams that demonstrated clicking and clunking in both shoulders and the exam was not consistent with a traumatic or symptomatic SLAP tear. He also testified that he did not recommend any further medical or surgical intervention to Petitioner's shoulder, and that Petitioner could work full duty. (RX7).

On cross examination, Dr. Emanuel testified that it was his practice to record his observations of individuals only when it was very obvious during his encounter during the physical examination, and that if it is significantly exaggerated that he thinks is out of proportion to what he would expect, he would report that. He testified that it was his practice to list all of the medical records that he reviewed in his report. (RX7).

On cross examination, Dr. Emanuel testified that he reviewed both the MRI films and the radiologist's report. He agreed that he was not convinced based on the examination and his review that Petitioner had a SLAP tear. He testified that there was one cut on the MRI scan that suggested some labral pathology and that Petitioner did have some clunking in his shoulder which was often a symptom of a SLAP lesion. He also noted that Petitioner had this in his other shoulder as well, so he was not 100% certain that Petitioner did or did not have a SLAP tear. He testified that Petitioner's testing was not very definitive, and that Petitioner had a very mildly positive O'Brien's test. He testified that typically individuals who had symptomatic SLAP lesions had very prominently positive testing, meaning they could not hold their arm up. He also testified that Petitioner's exam was exaggerated with just the simplest maneuvers of the shoulder that were not related to a SLAP lesion or bursitis. (RX7).

On cross examination, Dr. Emanuel testified that Petitioner's response to the exams was, in his opinion, way out of proportion to what he would expect, even from a very symptomatic condition such as a SLAP lesion. He agreed that he noted that Petitioner was involved in a motor vehicle accident in 2002, and that the accident might or could have played a role in his current shoulder pathology. He testified that typically in a motor vehicle accident of high impact the individual's hands were on the steering wheel, and that a force hard enough where he impaled his chest against the steering wheel that eventually led to a collapsed lung was a force great enough to cause labral injuries to the shoulder. He testified that he did not ask Petitioner if his arms were on the steering wheel, but that Petitioner indicated that he had impaled his chest against the steering wheel. He agreed that the motor vehicle accident occurred at least thirteen years ago. (RX7).

On cross examination when asked if a fall like Petitioner described at work could have aggravated a SLAP lesion, Dr. Emanuel testified that it could not, based on Petitioner's history. He testified that there was no history of Petitioner falling with an outstretched arm with a hyperabduction injury or holding onto a railing and getting the arm jerked away from the body, which would be mechanisms of injury that would potentially cause a SLAP lesion. He further testified that if it was an acute traumatic SLAP lesion, Petitioner would have been symptomatic in the shoulder immediately. (RX7).

On cross examination, Dr. Emanuel admitted that it was possible for a person to suffer a very quick, sudden fall and simply not remember whether his arms were extended, but that it was highly unlikely. He admitted that he did not ask Petitioner whether his arms were outstretched or hyperabducted at the time of the motor vehicle accident. He testified that he did not ask Petitioner how often he lifted weights, but he could tell that Petitioner had a powerful build in the chest and shoulders typical of someone who lifted weights. (RX7).

On cross examination, Dr. Emanuel testified that his reference to "vagueness" in the IME report as to the mechanism of injury to the left shoulder referred to Petitioner's repeatedly having been asked how he injured his shoulder and he could not recall reaching out with his arms on the handrail, he could not recall landing on an outstretched hand, and he just would not comment with regards to how he may have injured his shoulder which was not typical of an acute shoulder injury, and that people knew it when they tear the labrum or rotator cuff. He agreed that he indicated that if Petitioner did have a SLAP tear it was old and pre-existing, but that he did not see any treatment records whatsoever for the shoulder prior to the alleged injury. (RX7).

CONCLUSIONS OF LAW

The parties stipulated at the time of arbitration that on November 26, 2012, Petitioner sustained an accident that arose out of and in the course of his employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causation as related to the left shoulder, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being in the left shoulder is causally related to the accident of November 26, 2012.

The Arbitrator notes that Petitioner testified at the first 19(b) arbitration hearing before Arbitrator Granada on April 3, 2013 that he stuck his head and back against the stairs. (PX1). The Illinois Form 45 noted that Petitioner hit his head and back, and Petitioner's handwritten statement noted that he landed on his upper back and the back of his head, and that he felt immediate pain in the middle of his back between his shoulder blades. (PX1). The Decision and Opinion on Review noted that on November 26, 2012, Petitioner lost his footing and fell down seven metal steps, striking his back and head. (PX3). In short, nothing was mentioned in either witness testimony and/or evidentiary documentation at the time of the original arbitration hearing in this matter in April of 2013 to suggest that Petitioner injured his left shoulder during the course of the fall.

The Arbitrator further notes that at the time of the subsequent 19(b) arbitration hearing on May 12, 2016, Petitioner testified that he was walking down the stairs like he normally would, lost his footing and fell approximately seven steps, landing on his shoulders and upper back and hitting his head on the stairs. He testified that he did not remember details about the fall like whether his arms were stretched out, but that he remembered his feet coming out from under him and then sitting up on the very bottom step. (T. 17). This testimony, when coupled with the initial post-accident treatment documentation including the Authorization for Disability Leave and Return to Work dated November 28, 2012 -- which noted that Petitioner had full range of motion of the back and shoulders – and the Sparta Community Hospital North Campus Progress Note dated November 28, 2012 -- which noted that Petitioner was walking down stairs, lost his footing and fell down stairs, hit the back of his head on the stairs and hit his back and was complaining of center back pain – causes the Arbitrator to question the veracity of Petitioner's testimony as to the onset of left shoulder complaints in this matter. (PX1, p.29; PX1, p.31).

It is significant to note that the Arbitrator is further concerned by the notation and testimony of Dr. Emanuel in this case that Petitioner's physical exam was exaggerated, indicating body posturing, breakaway strength and outward expression of pain with just gentle active forward flexion and abduction. (RX6). The Arbitrator acknowledges that no medical records were entered into evidence at the time of either arbitration hearing suggesting that Petitioner had undergone any medical treatment for the left shoulder prior to the accident at issue, but regardless places greater weight on the opinions proffered by Dr. Emanuel in this case, who testified that there was no history of Petitioner falling with an outstretched arm with a hyperabduction injury or holding onto a railing and getting the arm jerked away from the body, which would be mechanisms of injury that would potentially cause a SLAP lesion. The Arbitrator further finds to be persuasive Dr. Emanuel's testimony that if it was an acute traumatic SLAP lesion Petitioner would have been symptomatic in the shoulder immediately, which the records in this case did not suggest was the case. In fact, the first post-accident treatment records at Sparta Community Hospital note that Petitioner had full range of motion of the back and shoulders on November 28, 2012. (RX7; PX1).

As a result of the foregoing, the Arbitrator finds that that Petitioner has not met his burden of proving that his current condition of ill-being in the left shoulder is causally related to the accident of November 26, 2012.

As the Arbitrator finds that Petitioner failed to prove that his current condition of ill-being is causally related to his accident of November 26, 2012, all benefits are denied, including the prospective medical treatment requested by Petitioner. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues. In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ryan Davis,
Petitioner,

vs. NO: 14 WC 11077

State of Illinois
Menard Correctional Center,
Respondent.

17IWCC0642

DECISION AND OPINION ON REVIEW

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

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

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

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: OCT 12 2017

Joshua D. Luskin

L. Elizabeth Coppoletti

Charles J. DeVriendt

o-10/04/17
jdl/wj
68

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

DAVIS, RYAN
Employee/Petitioner

Case# **14WC011077**

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

17IWCC0642

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

4075 FISHER KERHOVER COFFEY & ET AL
JASON COFFEY
1300 1/2 SWANWICK ST
CHESTER, IL 62233

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

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

1350 CENTRAL MANAGEMENT SYSTEMS
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAY 26 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RYAN DAVIS
Employee/Petitioner

v.

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER
Employer/Respondent

Case # 14 WC 11077

Consolidated cases: _____

17IWCC0642

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **March 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0642

FINDINGS

On the date of accident, **March 30, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,779.30**; the average weekly wage was **$1,168.83**.

On the date of accident, Petitioner was **39** 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 **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

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

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of his employment by Respondent. Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being is causally related to the accident on March 20, 2014. Petitioner reached maximum medical improvement on May 19, 2014. All benefits after that date are denied.

Respondent shall pay reasonable and necessary medical services through May 19, 2014, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

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 24, 2016
Date

ICArbDec19(b)

MAY 26 2016

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RYAN DAVIS
Employee/Petitioner

17IWCC0642

v.

Case #: **14 WC 11077**

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident Petitioner was 39 years old, married, with 3 dependent children. He as employed by the State of Illinois, Menard Correctional Center, as a correctional officer. Petitioner testified that March 20, 2014, he was opening a sliding cell door which jammed, causing his right shoulder to pop out of its socket. Petitioner was in the segregation unit and escorting a prisoner out to the yard. During this process, one officer keys the lock and the other officer pulls the door, which operates side to side. As Petitioner was pulling the door open, the door stuck in place and he pulled on it to dislodge it. Petitioner testified that the doors are solid and heavy, and some of them stick or get hung up. Petitioner testified the incident was witnessed by Officer Smith, and he reported the incident to Respondent.

Petitioner sought medical treatment with his primary care physician, Dr. Beckemeyer, and eventually underwent an MRI. Dr. Beckemeyer referred him to Dr. George Paletta, who recommended a series of injections. Petitioner ultimately sought a second opinion with Dr. Davis, who recommended viscosupplementation injections.

Petitioner testified he has had prior work related injuries at Menard Correctional Center, two of which involved his right shoulder. Those accidents occurred on April 29, 2009, and May 31, 2010. He treated with Dr. Paletta for both injuries, and underwent a total of two surgeries. The latest of the claims was tried and an Arbitration Decision was rendered on January 31, 2011. Petitioner testified he was not seeking any treatment at the time of that trial, and prior to this accident he had not treated for his shoulder since late 2010.

Petitioner testified he continues to have pain in his right shoulder and is willing to undergo the treatment recommended by Dr. Davis, in an effort to reduce his pain.

On cross-examination, Petitioner testified he worked in the North 2 cell house, and had been working in that location for five years. He admitted he had pulled on the particular door in question on a daily basis, and had no independent memory of it sticking prior to the date of his accident. He testified he was not aware of any foreign object or material in the door that caused it to jam. Following the incident, he and the other officer were able to get the door open. He acknowledged there is a locksmith assigned to the facility, as well as a maintenance person that fixes doors. He conceded he had not asked that a work slip be put in for the door in question.

Petitioner testified that the first surgery on his right shoulder was for a torn labrum and something torn in his AC joint. The second surgery on his right shoulder was for a torn rotator cuff and torn labrum. He testified that his only hobby is playing music and that he did not hunt and no longer lifted weights.

Petitioner reported his accident to his employer on the day it occurred, and completed an Employee's Notice of Injury and an Incident Report. He reported he was opening a cell door which stuck and his right shoulder popped. He felt immediate pain in his shoulder and numbness in his right hand. He indicated the incident was witnessed by Officer Virgil Smith, and Officer Smith completed a Witness Report which was consistent with Petitioner's reports. As well, the Supervisor's Report of Injury and the Employer's First Report of Injury were consistent with respect to what occurred. RX2.

Petitioner sought treatment on the day of the accident with Dr. Shawn Beckemeyer. He reported he was pulling on a cell door that morning when the door jammed, causing him to jerk his shoulder. He related that his shoulder popped out of place and back in. He complained of pain in his posterior right shoulder and numbness in his right hand. On examination, he had decreased range of motion and weakness in his right shoulder with adduction. His right shoulder popped and partially dislocated anteriorly with posterior movement against resistance. Assessment by Dr. Beckemeyer was right shoulder injury. It was noted Petitioner had two previous surgeries on this same shoulder. He recommended an MRI. Petitioner returned to Dr. Beckemeyer on May 31, 2014, at which time he advised that his shoulder was more sore and that his pain had increased to 7/10. It was noted he had been off work. PX1.

Petitioner underwent a right shoulder MRI on April 2, 2014, at Sparta Community Hospital. He gave a consistent history of the accident at that time. The MRI revealed (1) marked arthritic narrowing of the glenohumeral joint with large bony spur on the inferomedial aspect of the humeral head; (2) suspected prominent degeneration of labrum and probable tear involving the posterior portion of the labrum; (3) moderate shoulder joint effusion and a large amount of fluid in the biceps tendon sheath; (4) probable partial tear involving the distal subscapularis tendon; (5) probable focal bone contusion in upper posteromedial aspect of the humeral head; and (6) status post resection distal clavicle. PX1, RX2, RX6.

On April 9, 2014, Petitioner presented for treatment with Dr. George Paletta of The Orthopedic Center of St. Louis. Dr. Paletta noted he had previously treated Petitioner for problems related to his right shoulder in July 2009 and June 2010. He noted that in June 2010 Petitioner underwent arthroscopy, which demonstrated evidence of a full thickness chondral defect of the posterior aspect of the glenoid, with associated degenerative changes of the

glenohumeral joint. At that time, Petitioner underwent debridement and chondroplasty. It was noted he did well following the surgery and was doing relatively well up until three weeks ago, when he opened a cell door at work and felt pain in his shoulder. Petitioner related he felt his shoulder slip out of the socket and back in, and he had numbness down his arm. Since that time he had persistent pain in his shoulder, particularly with any activities above shoulder level. The numbness and tingling had gone away. It was noted that prior to this incident Petitioner did not have significant issues related to his right shoulder. On examination, Petitioner had moderate motion limitations with forward elevation, abduction, and external rotation. He had pain at the end of the ranges of motion. PX2, RX5.

Shoulder x-rays taken in the office that day were compared to x-rays taken in 2009 and 2010, which showed progression of osteoarthritis of the glenohumeral joint, a relatively large inferior osteophyte off the humeral neck, and slight narrowing of the inferior half of the glenohumeral joint. It was noted that the osteophyte was the most significant change from the previous x-rays. Dr. Paletta reviewed the MRI of April 2, 2014, which confirmed the x-ray findings of moderately severe glenohumeral joint osteoarthritis with a large bony osteophyte and the inferior aspect of the humeral neck. There was irregularity of the posterior labrum consistent with the previous labral debridement, but there did not appear to be evidence of focal detachment of the labrum and the biceps anchor was intact. There was moderate effusion, consistent with an acute aggravation of the underlying osteoarthritis. PX2, RX5.

Dr. Paletta's impression was acute exacerbation of underlying osteoarthritis, reactive effusion, and no acute labral tear. It was noted there was some progression of Petitioner's osteoarthritis and chondral abnormalities noted at the time of surgery in 2010. Dr. Paletta opined that, based on the reported mechanism of the injury, Petitioner had an acute exacerbation of the underlying degenerative joint disease. He noted that the large reactive effusion noted on the MRI was indicative of acute inflammation. Dr. Paletta recommended aspiration and injection of the right glenohumeral joint and Medrol dose pack, followed by two weeks of Indocin. Petitioner was to follow up four weeks after the injection, and Dr. Paletta was optimistic he would return to pre-injury baseline. PX2, RX5.

With regard to causation, Dr. Paletta noted that Petitioner was doing well until the incident three weeks prior, which was an aggravating factor for his underlying condition. He opined that Petitioner's current condition was causally related to the work incident of March 20, 2014, as was the need for further treatment. PX2, RX5.

On April 14, 2014, Petitioner presented to Dr. Helen Blake at Pain and Rehabilitation Specialists of St. Louis, upon referral by Dr. Paletta. He gave a consistent history of his work accident, as well as his treatment to date. Dr. Blake administered a right glenohumeral joint injection with ultrasound guidance. PX3.

Petitioner returned to Dr. Paletta on May 19, 2014. He reported that following the injection he got dramatic relief of his symptoms for the first couple days, but that over the course of the next week or two the effects wore off and he was back to post-injury baseline. He continued to note popping and grinding in his shoulder, as well as pain with his arm in an overhead position. He had no radiating pain or numbness or tingling. On examination, he had

minimal improvements in his overall range of motion and all provocative tests caused him discomfort. Dr. Paletta's impression was symptomatic osteoarthritis of the right shoulder. Treatment options were a second corticosteroid injection or a trial of viscosupplementation injection. Given the short term relief of the first corticosteroid injection, Dr. Paletta did not recommend a second injection, and rather recommended the viscosupplementation. PX2, RX5.

On May 30, 2014, a Utilization Review report was sent to Petitioner, with a copy to Dr. Paletta, and was contained within Dr. Paletta's records submitted at trial. The Utilization Review was conducted by Dr. Clarence Fossier, a Board Certified Orthopedic Surgeon. It was noted on the report that a peer-to-peer call was attempted to Dr. Paletta on May 28 and May 30, with messages left but no return call. Dr. Fossier reviewed records and the MRI and denied the requested Synvisc injection. The rationale for the denial was that ODG guidelines advise Synvisc injections are not recommended, as they have proven to be ineffectual in shoulder osteoarthritis, and as such are not medically necessary or appropriate. It was noted that recent research in the shoulder, as well as several recent quality studies in the knee, showed the magnitude of improvement was modest at best. Dr. Fossier cited the 2010 Saito study, the 2012 Maund study, and the 2013 Kwon study, all of which led to the downgrading of the recommendation for use in osteoarthritis, as any clinical improvement attributable to hyaluronic acid injections was likely small and not clinically meaningful. PX2, RX5.

On July 2, 2014, Dr. Paletta authored a letter to Petitioner's attorney, at his request. He summarized the treatment to date and opined that Petitioner's work incident was an aggravating or contributing factor in his shoulder condition. His impression on April 9, 2014, was an acute exacerbation of Petitioner's underlying osteoarthritis with reactive effusion. His recommendation for viscosupplementation injection was based on his diagnosis of symptomatic osteoarthritis of the glenohumeral joint. Dr. Paletta acknowledged he had received Dr. Fossier's Utilization Review report, and commented that the ODG Guides "are arbitrary at best". He notes that Dr. Fossier cited a study which indicated that "sodium hyaluronate was effective and well tolerated for the treatment of osteoarthritis but not a rotator cuff tear or adhesive capsulitis". He opined that given the fact that Petitioner's underlying diagnosis was osteoarthritis, the viscosupplementation was recommended. The Arbitrator notes that Dr. Fossier's report appears to discount the study that Dr. Paletta cited as supporting his recommendation. PX2, RX5.

Petitioner next sought medical treatment for his right shoulder on January 8, 2015, when he presented to Dr. J.T. Davis of The Orthopaedic Institute of Southern Illinois. Dr. Davis categorized the examination as a consultation, and noted that Petitioner was there for a second opinion. He noted Petitioner had a history of an injury at work several years ago, with surgeries in 2009 and 2010, and a new injury approximately a year ago with worsening of his underlying pain. He noted Dr. Paletta's recommendation of viscosupplementation prior to any joint replacement options. Dr. Davis did not include a detailed history of the accident in his office note, but rather stated, "Please refer to the patient chart and questionnaire and medical history, which he provided today, for the chief complaint, history of present illness, past medical and surgical history, allergies and medications, family and social history, as well as review of systems." The Arbitrator notes that the certified records submitted at trial did not include said patient chart, questionnaire, and medical history. PX4.

On examination, it was noted Petitioner was a muscular male in no acute distress, and the right upper extremity showed no atrophy, asymmetry, or deformity. Petitioner's motion was limited with external rotation to the side, forward elevation, and internal rotation. X-rays were taken in the office, which Dr. Davis interpreted as showing moderate to severe right shoulder glenohumeral joint osteoarthritis, as well as a prior clavicle resection. His assessment was "status post work injury with two subsequent surgeries and persistent pain with right shoulder glenohumeral joint osteoarthritis". PX4.

Dr. Davis noted he discussed with Petitioner the diagnosis, imaging studies, natural history of the disease process, and treatment options. Petitioner related he had been taking medications, modified his activities, had therapy, had two surgeries, and had persistent symptoms. He did not feel he could live with the pain. Dr. Davis opined that viscosupplementation was a viable option for current treatment, and that ultimately Petitioner would need a joint replacement. He indicated Petitioner was young and had a high activity level, and was a candidate for a hemiarthroplasty, but that "he would have to understand that the ability to perform his full work duties tackling bad guys in the prison and lifting weights would not be a viable list of activities after such a surgery". Dr. Davis recommended viscosupplementation prior to any joint replacement options. He noted in an attached Physician's Statement that the visit was a second opinion only and that Petitioner would continue to treat with Dr. Paletta. PX4.

Dr. Davis testified by way of deposition on June 25, 2015. He is a Board Certified Orthopedic Surgeon, with a subspecialty in sports medicine and arthroscopic surgery. At the time of his deposition, Dr. Davis had seen Petitioner on only one occasion. The Arbitrator notes, however, that he saw Petitioner on several occasions subsequent to his deposition. PX5.

Dr. Davis testified that he took a history from Petitioner, who indicated he had sustained a work injury to his right shoulder in March 2014, and that he had previous treatment for other issues on the same shoulder. He testified Petitioner filled out a patient questionnaire, but he did not have that questionnaire in front of him at the time of his deposition. He was asked by Petitioner's attorney to assume that Petitioner reported to his other treating physicians that he was attempting to dislodge or pull a lodged cell door within the prison at Menard. PX5.

Dr. Davis testified consistent with his office note of January 18, 2015. He noted the most significant finding on examination was Petitioner's limitations in motion of external rotation, forward elevation, and internal rotation. The x-rays showed moderate to severe arthritis and his examination of Petitioner was consistent with that. His diagnosis was right shoulder glenohumeral joint osteoarthritis. With regard to further medical treatment, Dr. Davis opined that nonoperative modalities would include protective body mechanics, medications, exercises, and injection therapy. Operative management would include arthroscopic debridement, which he felt had a limited role, or joint replacement options. PX5.

Dr. Davis testified he did not have Dr. Paletta's records, but did have the operative note from Petitioner's surgery on June 15, 2010. Dr. Davis opined that Petitioner's work injury on March 20, 2014, might or could have aggravated his condition, based on Petitioner's history. Petitioner's viable options for treatment were to live with the condition, injection therapy, or ultimately get his joint replaced. PX5.

Dr. Davis explained that joints in the body function through movement of one surface passed to the other, which involves a smooth coating of cartilage and natural lubricants. When arthritis progresses, the smooth coating is lost, which makes it difficult for the joints to glide, which causes pain. One option in treating this, which has been approved and is often executed in knee joint arthritis, is viscosupplementation. This involves injecting a substance called hyaluronic acid into the joint, and this lubricant allows for easier gliding of those rough surfaces by one another. Dr. Davis testified that arthritis in the shoulder joint is much less common than in the knee and he was unaware of any clinical trials that support evidence of the use of viscosupplementation in the shoulder. Anecdotally, he has had positive results using the injections on a limited basis. As with the knee, the injections are not a curative measure, but rather are intended to give symptomatic relief for months or even a year or more. Dr. Davis testified the viscosupplementation is not a guaranteed success in the knee and it likewise would not be in the shoulder, but it is a viable option in a young man trying to put off getting his shoulder joint replaced. He would encourage Petitioner to put off the joint replacement as long as he can, if the pain allows for that. PX5.

On cross-examination, Dr. Davis first clarified that he and the Petitioner are not related, even though they have the same surname. He testified that his practice is 60% shoulder treatment, versus knee treatment. He performs 150-200 shoulder surgeries a year, but has not done a shoulder replacement in one or two years. He explained that osteoarthritis is a wearing of the joint articular cartilage which takes years to develop. It is multifactorial, and can be related to trauma, wear and tear from overuse over the years, or it can be hereditary. Two prior injuries and shoulder surgeries could cause the osteoarthritis Petitioner has developed. PX5.

Dr. Davis noted on Petitioner's first visit that he had a new injury "with worsening of his underlying pain". Dr. Davis conceded that his interpretation of the office note, given the wording of the statement, was that Petitioner was not pain free after his surgeries in 2009 and 2010. He was unaware of whether Petitioner had been seeing a physician for continued pain. He testified he had not reviewed any medical records from Petitioner's family doctor and had not reviewed medical records from Dr. Paletta, other than the operative report from 2010. He did not show a record of having reviewed Petitioner's MRI's from 2010 or from 2014, following the most recent accident. PX5.

Dr. Davis explained that grading of chondral erosion has to do with the spectrum of wear of joint surfaces, and quantifying that wear. There are different methods of grading, but he is most familiar with the one used to grade Petitioner's joint at "Grade 3-4 chondral erosion", with 1 being the least severe and 4 being the most severe. Dr. Davis conceded, "Those numbers would indicate to me more moderate to severe wear of a joint." PX5.

Dr. Davis was shown the radiologist's report from the MRI taken on June 2, 2010, and conceded that the report indicated Petitioner had arthritis back in 2010. He testified that over the five years since that time, arthritis that was existent would continue to wear and progress with continued use of the extremity. Dr. Davis was unaware of whether Petitioner had activities outside of work that could have aggravated or exacerbated his shoulder condition. He agreed that weight lifting, and making the shoulder a weight bearing joint, would be hard on the joint.

Dr. Davis testified Petitioner completed a questionnaire, on which there was a question about hobbies or activities, but that he could not find the questionnaire in the chart. PX5.

Dr. Davis testified that it is possible that Petitioner's injury while pulling the cell door was a temporary exacerbation of his underlying preexisting osteoarthritis and that he had returned to baseline. However, given the fact that ten months had passed and Petitioner was still having an increase in pain, it is less likely that the incident was a temporary aggravation. He conceded that osteoarthritis can flare up on its own, without an accident or injury, and can also become symptomatic all of a sudden. PX5.

Dr. Davis testified that it would not be optimal for a 40 year old get his joint replaced, and that he would explore all alternative nonoperative measures to try and alleviate the pain. A joint replacement in Petitioner's case was a possibility and would help with his pain. However, it would not be a first choice treatment because the artificial parts would have to be replaced in the future, especially in a young person with a high activity level. Petitioner would likely receive a partial replacement, called a hemiarthroplasty, where a metal ball is placed in the ball and socket joint and the socket is left as its native state. The metal ball is fairly resilient in allowing people to return to activities such as weight lifting, tennis, or golf. If Petitioner were to have the surgery, he would be able to return to his job as a corrections officer, but would have to be aware that the harder he was on the artificial surface, the quicker it will wear out. PX5.

Dr. Davis testified that the Synvisc injection, which is the brand name for the generic substance hyaluronic acid, is basically a lubricant that goes in the joint space. With osteoarthritis, the cartilage wears away and the joint fluid breaks down and bone spurs may develop in either the knee or the shoulder. The Synvisc or viscosupplementation would replace the joint fluid and make it more viscus, thereby allowing the worn surfaces to glide. PX5.

Dr. Davis testified he has not seen any prospective randomized controlled studies that demonstrate the benefit or use of the Synvisc injection in the shoulder, and opined the reason is that arthritis in the shoulder is much less commonly seen than in the knee. He believed it to be more of a challenging injection in the shoulder if the physician does not do a lot of shoulder work, and that the numbers are not there to support the studies. He testified he has done it and had some success, but it does not work for everyone. Injection into the shoulder, however, is not an accepted standard of care in orthopedics. PX5.

Dr. Davis testified he had not seen the Utilization Review report regarding the denial of injections for Petitioner. Given the denial by worker's compensation, Dr. Davis was asked if his practice would be willing to do the injection and bill Petitioner's group health insurance. He testified that as a general rule he did not believe insurance companies paid for the injections in the shoulder, and that patients have paid cash for them, although he may have had some group insurance companies pay for some. He agreed that it was not just worker's compensation that denied these injections, based upon them not being an accepted standard of care. PX5.

Dr. Davis testified his role is to educate the patient on the management options which, in Petitioner's case, were either live with it, try injection therapy, or joint replacement. The

patient's role is to decide which of those he wanted to do. Dr. Davis would, personally, make joint replacement his last option. PX5.

Dr. Davis testified that he related the need for the joint replacement to the arthritis in Petitioner's shoulder joint and his pain complaints. However, he noted that before Petitioner's accident of March 20, 2014, his arthritic pain was not bad enough that he was considering joint replacement. If he now considered joint replacement, Dr. Davis opined that the injury aggravated the underlying condition and pushed Petitioner "over the hill", to the point he would now be willing to do something he wasn't ready to do before the injury. Dr. Davis testified he is basing his opinion completely on the fact that after the injury Petitioner's level of pain increased and had remained increased. Dr. Davis was asked whether Petitioner had indicated on the pain questionnaire how much pain he was experiencing and Dr. Davis testified that the questionnaire was not in front of him. PX5.

Dr. Davis testified that there are patients who have horrendous arthritic joints throughout their body and it doesn't really both them and they never need a joint replacement, and there are others whose arthritis is mild and is debilitating. He conceded that some patients with worker's compensations cases have symptoms that are magnified, as compared to the general population. He could not determine if Petitioner was one of those patients. PX5.

Dr. Davis did not have future visits scheduled for Petitioner, as treatment was pending approval. The proposed injections are done at his facility, by him. The cost would be $500 to $600 for the material itself, and $50 for the doctor. Results are very highly variable and can range from zero relief to a couple of months relief to over a year of relief. The procedure is generally well tolerated by patients. PX5.

Dr. Davis testified that whether or not he had reviewed any prior records his opinion would not change, in that it was based on Petitioner's presentation to him during the examination. Even if Petitioner was seen by other physicians prior to the injury and had been complaining of shoulder pain, his opinion would be the same, based on Petitioner's history that the injury made the symptoms worse. If the history was inaccurate, he did not know how he could make that determination. PX5.

On August 31, 2015, Petitioner returned to Dr. Davis and underwent an ultrasound guided hyaluronic injection into the right shoulder glenohumeral joint space. He had a second injection on September 9, 2015, and a third injection on September 17, 2015. PX4.

On September 16, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Michael Nogalski. Dr. Nogalski noted Petitioner had a fairly extensive history of shoulder problems, which was reviewed with Petitioner prior to discussing the incident of March 20, 2014. Petitioner related in 2009 he was escorting an inmate up stairs when he fell, catching his elbow on the handrail, which "ripped my arm". He related in 2010 he broke up a fight between two inmates and injured his shoulder again. Both incidents resulted in surgery. Petitioner related that after the second surgery, he never regained full range of motion, he continued to have pain, could not throw a ball or lift heavy objects, and could not really do any overhead activities. He did not have any permanent restrictions. RX3.

With regard to the accident of March 20, 2014, Petitioner related he was pulling a large heavy cell door, using his right arm to bring the door from left to right, when the door caught. He pulled harder and felt a sharp pain in his shoulder and he could not move his arm at all. His impression was that his arm "went out" and then right back in. He sought medical treatment the next day from Dr. Shawn Beckemeyer, who referred him to see Dr. Paletta, who had done his previous surgeries. He saw Dr. Paletta that week, who ordered an MRI and recommended viscosupplementation injections and a partial shoulder replacement. Petitioner related he had gotten a cortisone injection which did not really help. He saw Dr. Davis for a second opinion, and he had the same recommendations as Dr. Paletta. He related he had had the viscosupplementation injections. RX3.

On examination, it was noted Petitioner was very muscular and in no apparent distress. He demonstrated a maximum of only about 80 degrees in forward flexion and abduction, and had a fairly tight endpoint in both planes of motion. He had limitations in motion and had some increased pain and weakness above shoulder level. There was audible and palpable crepitus with resisted muscle tests, which appeared to come from the glenohumeral joint. The AC joint was only minimally tender. RX3.

Shoulder x-rays were done in the office and interpreted by Dr. Nogalski. They revealed evidence of a previous distal clavicle resection, as well as severe osteoarthritis of the glenohumeral joint with a large inferior osteophyte consistent with a "goat's beard" deformity. Dr. Nogalski reviewed past medical records, including operative reports and physical therapy records, as well as current medical records. RX3.

Dr. Nogalski's behavioral observations were neutral with respect to the shoulder findings. Petitioner did have tightness consistent with an osteoarthritic shoulder. He noted he did not find any distinct suggestions of symptom magnification and that there were findings consistent with Petitioner's significant osteoarthritic condition. Dr. Nogalski's diagnosis was right shoulder osteoarthritis. He opined there was no causal relationship between Petitioner's current objective findings and the reported accident. He opined that, rather, Petitioner's current objective findings and complaints were consistent with the advancing and progressive osteoarthritis. RX3.

Dr. Nogalski opined that the medical treatment rendered by Dr. Beckemeyer and Dr. Paletta appeared to be reasonable. He indicated that some form of injection to optimize shoulder function after an acute strain to Petitioner's shoulder appeared reasonable, and that viscosupplementation would be a reasonable course of treatment for his osteoarthritis. He did not identify any contraindication for such treatment in the literature and found some support for it. He believed it would be reasonable to try the injection in a young patient who had exhausted other conservative measures. However, Dr. Nogalski opined that the viscosupplementation would not be related to the work injury of March 20, 2014. The only other possible treatment would be anti-inflammatories and possibly physical therapy exercises. RX3.

Dr. Nogalski opined that Petitioner's prognosis was fair. He noted Petitioner was extremely large and strong and he believed that has allowed him to function well with his osteoarthritic shoulder for some time, despite intermittent symptoms due to the advancing

breakdown of his joint surfaces. Should Petitioner undergo physical therapy for three to four weeks, he would require evaluation to validate his shoulder function with respect to restraining and managing prisoners, and would be at maximum medical improvement at that time. Dr. Nogalski opined that further treatment would not be related to Petitioner's work accident of March 20, 2014. RX3.

Dr. Nogalski opined that Petitioner sustained a strain of his right shoulder in the work accident of March 20, 2014, and further opined that he did not demonstrate a significant mechanism of injury to validate a severe or permanent aggravation to his osteoarthritic shoulder condition. He disagreed with Dr. Paletta's assertion that the effusion seen on the MRI would document an acute injury. He further noted that the bone marrow signal changes in the humeral head were reasonable reactive changes below exposed bone in his osteoarthritic shoulder. RX3.

On September 17, 2015, Petitioner returned to Dr. Davis for his third viscosupplementation injection. He next followed up with Dr. Davis on November 9, 2015, at which time he reported he had some "decent relief" from the injections. He stated he still had sharp pains with overextension and quick movements of the arm, which was constant. He still had some stiffness, but the dull pain was improved. Dr. Davis's assessment remained right shoulder primary osteoarthritis of the glenohumeral joint. He discussed with Petitioner the diagnosis, natural disease history, and treatment options. Petitioner related that his pain was at a tolerable level for the most part, and that he was interested in repeat injections in four months if the pain continues to be tolerable. If that were to change, the next option would be arthroplasty. On February 6, 2016, Dr. Davis (via PA Jeremy Palmer) made a written request for approval of a series of three Supartz (viscosupplementation) injections. PX4.

Dr. Nogalski testified by way of deposition on January 25, 2016. He is a Board Certified Orthopedic Surgeon. He takes care of patients with predominantly shoulder and knee problems, which comprises about 80% of his practice. RX4.

Dr. Nogalski testified consistent with his report following his examination of Petitioner on September 16, 2015. Petitioner had limitations in forward flexion and abduction, as well as external and internal rotation. His motor strength tests were just slightly less than normal around the shoulder below chest level, with some increased pain on above shoulder level testing. He had audible and palpable crepitus with resisted muscle tests which appeared to come from the glenohumeral joint. X-rays taken in the office and reviewed by Dr. Nogalski showed severe osteoarthritis of the glenohumeral joint with a large bone spur or osteophyte off the humeral head, referred to as a "goat's beard deformity", which is a classic finding for osteoarthritis of the shoulder. Dr. Nogalski reviewed two MRI's reports. The first, taken June 2, 2010, revealed osteoarthritic disease with Grade 3-4 chondral erosion over the posterior portion of the glenoid articulation associated with a nondisplaced posterior-superior labral tear, proximal long head biceps tendinosis with intact supraspinatus and subscapularis tendinosis, and post-resection changes of the distal clavicle. The second MRI, taken April 3, 2014, revealed marked arthritic narrowing of the glenohumeral joint with large bony spurring in the inferomedial aspect of the humeral head (goat's head deformity), suspected prominent degeneration of the labrum and probable tear of the posterior portion of the labrum, moderate shoulder joint effusion and a large

amount of fluid in the biceps tendon sheath, probable tear of the distal subscapularis tendon, and probable focal bone contusion in the upper posteromedial aspect of the humeral head. RX4.

Dr. Nogalski testified within a reasonable degree of medical certainty that there was no causal relationship between Petitioner's osteoarthritic condition and his reported accident. He noted Petitioner had two previous issues with the right shoulder and that Petitioner himself indicated he had a lot of pain after the second surgery. Dr. Nogalski testified that after the second surgery Petitioner had significant changes of osteoarthritis which would reasonably be symptomatic even at rest. He opined that the mechanism of the injury as Petitioner described it, as well as the objective documentation including the MRI, did not support that Petitioner had an injury or significant aggravation on March 20, 2014. Rather, the findings merely supported that Petitioner had symptoms of osteoarthritis, given the significant changes on the x-rays and MRI. Dr. Nogalski testified that if Petitioner was his patient, he would recommend physical therapy for four to six weeks to optimize his shoulder function, after which he would be able to work full duty as a prison guard. RX4.

On cross-examination, Dr. Nogalski did not recall if he asked Petitioner the approximate weight of the cell door in question, how old the facility was, or how much force he was using to try and open the lodged door. Dr. Nogalski did not believe he reviewed the actual MRI film of April 3, 2014. Accepting the radiologist's finding to be true, he testified it was possible that the effusion could be related to Petitioner's work injury of March 20, 2014. Other than that, however, Dr. Nogalski testified the study was relatively similar to the prior MRI, given the radiologist's report from the 2010 MRI. RX4.

Dr. Nogalski testified he believed Petitioner to be credible, based on the knowledge he had from the examination and history. He confirmed that the treatment Petitioner had undergone was reasonable and necessary. He testified the condition of Petitioner's shoulder is not a common finding in a 41 year old male. Dr. Nogalski opined that the development of Petitioner osteoarthritis was inherent within him, and not related to his injuries or surgeries. RX4.

Dr. Nogalski explained that the effusion seen on the MRI is a reasonable amount of fluid in a shoulder with such severe osteoarthritis, and that it might or could be from his primary osteoarthritic condition, or it might or could be from a shoulder strain or event. It is more likely than not that someone with severe osteoarthritis could develop some increased fluid in the shoulder if they strained the shoulder. He testified within a reasonable degree of medical certainty that Petitioner's accident of March 20, 2014, did not progress his condition. RX4.

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 deliberation, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether Petitioner sustained an accidental injury that arose out of and in the course of his employment, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n.*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

The Arbitrator finds that Petitioner has met his burden of proof in establishing that an accident occurred which arose out of and in the course of his employment. In so finding, the Arbitrator finds significant that Petitioner reported the accident immediately and completed an Incident Report and an Employee's Notice of Injury, giving a consistent history as to the accident. The Arbitrator also finds significant that the accident was witnessed by another correctional officer, Virgil Smith. Officer Smith completed a Witness Report the day the accident occurred, stating that Petitioner had pulled the door to cell 8-27, that the door did not open, and that "c/o R. Davis grabbed his right shoulder in pain". Further, the Arbitrator finds significant that the medical records are entirely consistent with the history given by Petitioner when he reported the accident and when he testified at trial. Respondent presented no evidence to rebut the occurrence of a compensable accident.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994). Liability cannot be premised upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that the work-related accidental injury aggravated or accelerated the preexisting disease, such that the employee's current condition of ill-being can be said to have been causally connected to the work injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 204-206 (2003). The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill.App.3d 289, 296 (1st Dist. 1986).

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that his current right shoulder condition is causally related to his work accident of March 20, 2014. In so concluding, the Arbitrator finds the opinion of Dr. Nogalski to be more credible than that of Dr. Davis. Dr. Davis did not review any medical records from Petitioner's family physician or from Dr. Paletta, nor did he review the MRI's taken in 2010 and 2014. His causation opinion was based solely on Petitioner's statement that his pain level had changed after

an accident at work. Dr. Davis did not document nor testify as to how the accident occurred or the mechanism of the injury, and it is unclear from the record whether he was even aware of either. In both his record and his testimony, Dr. Davis referenced the patient's chart and questionnaire as providing his chief complaint and history of his present illness, yet he did not provide that documentation during his testimony and Petitioner did not submit such documentation at trial. The Arbitrator cannot speculate as to whether Dr. Davis was aware of how the accident occurred or the mechanism of Petitioner's injury. Further, Dr. Davis based his causation opinion on Petitioner's pain increasing, yet he admitted during testimony that Petitioner had a "worsening of his *underlying* pain", which he understood to mean that Petitioner was not pain free after his two prior shoulder surgeries, and prior to this accident. Without Dr. Davis having a clear understanding of Petitioner's prior treatment, how the accident occurred, the mechanism of the injury, or Petitioner's previous level of pain, the Arbitrator is disinclined to place great evidentiary weight on his opinion. In addition, Petitioner did not present to Dr. Davis for treatment until eight months after he had last seen a physician for his complaints, and ten months after the accident. The Arbitrator finds this gap in time to be significant.

Dr. Nogalski, on the other hand, clearly indicated the past and present records he reviewed in formulating his opinions. Further, he took a detailed history from Petitioner as to how the accident occurred and the mechanism of his injury. He noted Petitioner reported that he continued to have pain after his second surgery and that his range of motion never returned. Dr. Nogalski opined that Petitioner had sustained a strain of his right shoulder in the work accident of March 20, 2014, which had resolved, and that Petitioner's current condition was osteoarthritis. He further opined that the current objective findings and Petitioner's subjective complaints were consistent with advancing and progressing osteoarthritis, but did not support that he had an injury or significant aggravation. In that Dr. Nogalski had a clear understanding of Petitioner's prior shoulder problems, the details of how the work accident occurred, and the degree of Petitioner's extensive osteoarthritis, the Arbitrator is persuaded by his opinion with regard to the lack of causation.

Further, the Arbitrator finds significant the observations and notations by Dr. Davis and Dr. Nogalski with regard to Petitioner's muscular physique. Dr. Davis noted Petitioner was "a muscular male" and Dr. Nogalski noted Petitioner was "a very muscular man". In his Assessment, Dr. Nogalski also noted Petitioner was "extremely large and strong and I believe this has allowed him to function well with this osteoarthritic shoulder for some time." The Arbitrator notes that Dr. Nogalski examined Petitioner eighteen months after the work accident and finds it significant that Petitioner was still observed to be "very muscular". In addition, the Arbitrator's observation at trial, six months after Dr. Nogalski's exam and two years after the accident, was that Petitioner continued to be very muscular and appeared to be very strong. Although the Arbitrator found Petitioner to otherwise be credible, his testimony that he no longer lifted weights was lacking in credibility and is probative of a lack of causal relationship to the work accident. In addition, Dr. Davis testified that weight lifting would make the shoulder joint into a weight bearing joint, which would cause it to "wear" more.

The Arbitrator is mindful that Dr. Paletta opined that Petitioner's need for treatment was causally related to his work accident of March 20, 2014. However, Dr. Paletta saw Petitioner three weeks after the accident, in the acute phase of what Dr. Nogalski categorized as a shoulder

strain. It is expected and reasonable that treatment would be necessary and related at that time. The Arbitrator finds it significant, however, that Petitioner saw Dr. Paletta on only two occasions, the last being May 19, 2014, about two months after the accident. This actually coincides with Dr. Nogalski's testimony that Petitioner should have reached maximum medical improvement for his shoulder strain four to six weeks after the accident.

The Arbitrator is also mindful that Dr. Paletta, Dr. Davis, and Dr. Nogalski all opined that it would be reasonable for Petitioner to undergo viscosupplementation injections. However, the Arbitrator is persuaded by the opinion of Dr. Nogalski that the need for the injections was Petitioner's underlying and progressing osteoarthritis, and not related to the work accident of March 20, 2014. Both Dr. Davis and Dr. Nogalski testified that the injections were sort of a last resort, in an effort to put off a joint replacement. The Arbitrator finds it significant that on Petitioner's second visit with Dr. Paletta, only two months after the accident, Dr. Paletta was already recommending the injections. This would certainly seem to suggest that Petitioner's osteoarthritis was already well advanced, further confirming Dr. Nogalski's opinion that the need for the injections was Petitioner's osteoarthritis.

Based on the foregoing, and the record in its entirety, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill-being and need for treatment relative to his right shoulder are causally related to his work accident of March 20, 2014. The Arbitrator further finds that Petitioner reached maximum medical improvement on May 19, 2014, that being his second and final visit with Dr. Paletta.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

In light of the Arbitrator's finding above that Petitioner was at maximum medical improvement on May 19, 2014, the Arbitrator finds that any and all bills for medical services rendered beyond that date are denied. The Arbitrator finds that Respondent is liable for medical services rendered up through and including May 19, 2014, as set forth in Petitioner's Exhibit 6, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for medical benefits previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care for his right shoulder.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAMON ZARATE,

Petitioner,

vs.

NO: 13 WC 2498

17IWCC0643

KANKAKEE NURSERY,

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, prospective medical care, and temporary total disability, and being advised of the facts and law, reverses 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).

This case was consolidated at hearing with 14 WC 39062. Petitioner sustained two accidents resulting in lumbar injuries while working for Respondent. The first one occurred on August 17, 2012 (13 WC 2498). The second was on April 28, 2014 (14 WC 39062).

The Commission finds that Petitioner had reached maximum medical improvement (MMI) from his first injury as of the September 17, 2013 visit with Dr. Harvey. Dr. Harvey noted that Petitioner denied having any weakness, numbness, or tingling, and that Petitioner had been working without restrictions for more than two months, including lifting 75 pounds. He wrote that, clinically, Petitioner was doing very well but he had dull pain, once or twice a week at the end of a day. Dr. Harvey stated that Petitioner had reached MMI at that time.

Following the second accident, on April 28, 2014, Petitioner returned to Riverside Corporate Health on April 29th. Those records indicate a history of Petitioner stepping over a water boom pipe after entering a greenhouse and when he stood up straight he felt a pain and tightness to his lower back. The pain had increased over the last 24 hours and was described as intense pain to the lower lumbar area with tingling down both his legs posteriorly to the mid calf. Petitioner was unable to

17IWCC0643

bend forward. This record notes Petitioner's prior treatment for the L5-S1 herniated disc but indicates that Petitioner reported that "he did fine until yesterday and had no further reoccurrence of the back pain and paresthesia until now."

Although surgery had been recommended after the first accident, Petitioner did not want to pursue it at that time and, following conservative treatment, his symptoms resolved to the point of being able to return to work full duty. It wasn't until the second accident that his symptoms recurred. We find the opinion of the §12 examining physician, Dr. Goldberg, to be persuasive that Petitioner aggravated his prior disc herniation at L5-S1 secondary to the accident of April 28, 2014, and that the need for surgery was due to that accident.

Therefore, we reverse the Arbitrator on the issue of causation and find that Petitioner's need for surgery is related to the second accident on April 28, 2014. The award for prospective surgery related to the August 17, 2012 accident is hereby vacated.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $319.00 per week for a period of 28-3/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award for prospective surgery is hereby vacated as it relates to this case.

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 $2,500.00. 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: OCT 13 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/30/17
49

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

ZARATE, RAMON
Employee/Petitioner

Case# **13WC002498**

14WC039062

KANKAKEE NURSERY COMPANY
Employer/Respondent

17IWCC0643

On 3/28/2016, 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 0.44% 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:

0000 SPIROS LAW PC
SAMDRA LOEB
1230 W COURT ST
KANKAKEE, IL 60901

0507 RUSIN & MACIOROWSKI LTD
DAVID L KALIMUTHU
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

17IWCC0643

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ramon Zarate
Employee/Petitioner
v.
Kankakee Nursery
Employer/Respondent

Case # **13** WC **2498**

Consolidated cases: **14 WC 39062 under separate Decision**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Kankakee**, on **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 17, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,800.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$7,543.26** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $.

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

ORDER

This Arbitrator finds Petitioner's current condition of ill-being is related to the August 17, 2012 accident. This Arbitrator further opines that Petitioner's prescribed surgery is causally related to the August 17, 2012 accident and therefore liability for that surgery remains with the Respondent with respect to case number 13 WC 2498.

Respondent shall pay Petitioner TTD for the stipulated period of 28-3/7 weeks commencing 11/10/12 through 5/27/13 at the minimum rate of $319.00. Respondent shall receive credit for amounts paid.

Respondent shall authorize and pay for the recommended surgery as prescribed by Dr. Harvey along with the attendant care pursuant to Sections 8 and 8.2 of the Act.

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

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

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

Carolyn M. Doherty

Signature of Arbitrator

3/24/16
Date

ICArbDec19(b)

MAR 28 2016

FINDINGS OF FACT

Petitioner alleges 2 accidents in these consolidated matters. Each Decision is rendered under separate cover. In case 13 wc 2498, Petitioner alleges he was injured at work on 8/17/12. Respondent does not dispute accident or notice in 13 wc 2498. In the consolidated matter on 14 wc 39062, Petitioner alleges he was injured at work on 4/28/14. Respondent disputes accident in case 14 wc 39062. Although the Respondent in both matters is Kankakee Nursery Company, Respondent was insured by two different carriers on the alleged dates of accident. Thus, Respondent was represented by separate counsel in the two consolidated matters at trial.

Petitioner, a 26 year old nursery worker, testified that he began working for Respondent in August 2005. His duties include picking tree orders and preparing the orders for planting and shipping. His duties required him to lift weights on occasion in excess of 75 pounds and frequently up to 75 pounds. Some trees weighed up to 150 pounds and he was required to lift up to 80 pounds alone.

Petitioner testified that prior to 8/17/12, he had no problems with his back. Petitioner testified that on 8/17/12, he was in a pole barn when he stepped on floor debris in the barn and fell landing on his side and back. Petitioner testified that he noticed immediate pain in his back and reported the accident. Again, accident and notice are not at issue in connection with 8/17/12.

Due to continued low back pain petitioner sought medical treatment on October 3, 2012 at Riverside Corporate Health Services. (Pet. Ex 3) Petitioner was directed by his employer to this medical facility. At the time of the October 3, 2012 visit petitioner provided a consistent history of the slip and fall accident while working for respondent. Petitioner stated that he was experiencing low back pain with radiation down the right leg with intermittent numbness and tingling. (Pet. Ex 3) X-rays at that time revealed no acute findings. (Pet. Ex 2) A diagnosis of lumbar radiculopathy was provided. Petitioner was prescribed pain medication, physical therapy and work restrictions. Petitioner's work restrictions consisted of no lifting greater than 15lbs along with avoidance of bending, squatting and kneeling. (Pet. Ex 3)

Petitioner returned to Riverside Corporate Health on October 26, 2012. Petitioner indicated his pain had improved, but he requested alternate medication based on the lack of reduction of pain from the Relafen. Additional therapy was prescribed and work restrictions were continued. (Pet. Ex 3)

On November 8, 2012 petitioner returned with a history of insignificant improvement of his low back pain. He indicated he experienced minor relief with 6 PT sessions but no sustained improvement. Petitioner rated his pain at 6 out of 10 with radiation down his right leg to his calf. Petitioner was concerned his radiating pain was worsening. It was recommended undergo a lumbar MRI and work restrictions were continued. (Pet. Ex 3) Due to a seasonal lay off petitioner stopped working on November 10, 2012 and respondent began paying temporary total disability. ARB EX 1.

Petitioner underwent a lumbar MRI on November 26, 2012. This exam revealed a moderate to large diffuse disc herniation resulting in high grade compromise of the anteroposterior diameter of the spinal canal at the second to last lumbar type intervertebral disc space, presumably L5-S1. (Pet. Ex 4)

On November 28, 2012, petitioner returned to Riverside Corp Health to review his MRI results. At that time petitioner had continued low back pain with radiation, numbness and tingling down his right leg. Petitioner

stated he had pain with heavy work and prolonged standing. He was diagnosed with a lumbar herniation. He was referred to neurosurgery for further evaluation. (Pet. Ex 5)

Petitioner was seen by Dr. Charles Harvey, a neurosurgeon, on December 28, 2012. Petitioner provided a consistent history of the work accident. At that time petitioner had complaints of intermittent sharp low back pain with radiation down both thighs stopping just below the knees. His present pain was 5 out of 10 with the worst being 8/9 out of 10. Dr. Harvey performed a physical exam and reviewed the lumbar MRI. Dr. Harvey's diagnosis was displacement of the lumbar intervertebral disc without myelopathy. Dr. Harvey indicated the large herniation impinged on the nerve roots and thecal sac producing severe spinal stenosis of about ninety percent. Based on the MRI finding, Dr. Harvey recommended surgery in the form of a lumbar laminectomy and discectomy with medial facetectomy and foraminotomoy L5-S1 right. (Pet. Ex 6)

Petitioner testified that he was afraid of undergoing surgery and wanted to explore non-surgical treatment options. (Tran 17) Based on petitioner's fear of surgery Dr. Harvey prescribed physical therapy. On 1/29/13, Dr. Harvey noted Petitioner reported that his back pain had improved since the last visit stating it was more of a discomfort at that point and that he wanted to discuss non-surgical options. Petitioner reported "intermittent dull to sharp low back achiness without any further radiation down his thighs, however discomfort still radiates midway up his spine at times. His pain at present is 1/10 worst 4/10 .... He continues with mild intermittent numbness and tingling to the right posterior thigh. ... Ramon no longer needs to support himself with a cart when shopping and is able to walk upright when shopping." PX 6. Under Assessment, Dr. Harvey noted "he deferred surgery last month and feels his pain has improved with less activity. He is interested in trying to avoid surgery if possible. I will send him back to outpatient PT and see if he can make progress towards returning to work. If not, we will reconsider surgery. I will see him again in 6 weeks or as needed." PX 6.

At the request of the respondent petitioner was examined pursuant to Section 12 of the Act by Dr. Ramis Ghaly. Dr. Ghaly obtained a history from the petitioner including the details of the August 17, 2012 accident. He reviewed the MRI and agreed a large disc herniation with severe stenosis was present at L5-S1. Dr. Ghaly agreed that surgery was an "attractive option" given the size of the herniation and the severe stenosis and agreed with the type of recommended surgery. He was of the opinion that the accident on August 17, 2012 caused the need for surgery as prescribed by Dr. Harvey and specifically stated "there is too much to risk by continuing to watch even if the symptoms decrease since his duty is physical." (Resp2 Ex 1)

On March 7, 2013 petitioner returned to see Dr. Harvey. Petitioner stated he had completed twelve sessions of physical therapy and noticed fifty percent improvement. Petitioner complained of continued intermittent dull to sharp ache in the lower back without radiation to the right leg. His pain was present at 2-4/10. Petitioner also reported one instance of right leg numbness following an intense therapy session the week prior from lateral right thigh down to mid calf lasting ½ hour. His medication was only providing minimal relief. Petitioner again desired to put off surgery and requested 3 additional weeks of PT as recommended by the physical therapist. Petitioner was to follow up in 3 weeks. (Pet. Ex 6)

On March 15 2013 petitioner underwent another lumbar MRI. This exam revealed a disc herniation at L5-S1 high grade compromise of the spinal canal. (Resp2 Ex 2)

Petitioner returned to Dr. Harvey on March 19, 2013, with continued intermittent dull to sharp low back ache. His back pain ranged from 1-4/10. Dr. Harvey reviewed the recent MRI and found no change in the large disc

herniation. Dr. Harvey opined based on the lack of change in the large disc herniation that petitioner would benefit from surgical intervention as previously prescribed. (Pet. Ex 6). However, he continued PT.

On April 9, 2013, petitioner returned to Dr. Harvey after completing 9 additional PT sessions. Petitioner advised that his "pain is better under control since therapy" and that his therapist would like to start work conditioning. Petitioner reported continued dull to sharp low back ache 2-4/10. Dr. Harvey again noted the lack of change in MRI results, the size of the herniation and his continued recommendation for surgery. He also noted Dr. Ghaly's agreement on the need for surgery. However, based on Petitioner's reported improvement with PT and his continued disinterest in surgery, Dr. Harvey agreed Petitioner could go to work hardening and that he should return in 4 to 6 weeks or as needed. PX 6.

On May 21, 2013, Petitioner returned to Dr. Harvey and stated he had completed work conditioning and achieved an eighty percent benefit with continued complaints of intermittent dull ache to his mid to low back. Pain was at 1-2/10. Dr. Harvey wrote, "he again has no desire to proceed with back surgery being as his pain is controlled." Petitioner's work conditioning results indicated he was capable of performing his regular work duties including lifting up to 75lbs. Thus, Dr. Harvey allowed the petitioner to return to work in a full duty capacity with a six week follow up for further evaluation noting "if his pain significantly worsens, then surgery will be recommended." (Pet. Ex 6)

Petitioner returned to Dr. Harvey on July 2, 2013. At that time he indicated he had returned to work in a full duty capacity on 5/28/13 and that he was doing well. Petitioner reported intermittent dull ache to his mid to low back "which has neither improved or worsened since RTW." Pain was at 1-4/10. Petitioner reported pain control through his TENS unit. Dr. Harvey noted that Petitioner did "very well" with PT and work conditioning, allowed Petitioner to continue full duty and told Petitioner to follow up in six to eight weeks for further evaluation. (Pet. Ex 6)

On September 17, 2013 petitioner returned to Dr. Harvey. Dr. Harvey noted that Petitioner was in for further evaluation of a large disk herniation at L5-S1 that has responded to conservative therapy well. He continues with an intermittent dull ache to his mid to low back. Pain currently 1/10 and 4/10 at worst. Aggravating factor is sitting for prolonged periods, while staying active and using his TENS unit helps." In his assessment, Dr. Harvey wrote "Mr. Zarate has been working without restrictions for more than 2 months, including lifting 75 lbs. Clinically, he is doing very well. He has dull pain, once or twice a week at the end of a day. I encourage him to continue HEP and weight loss program. Patient has reached MMI at this time. ... follow up will be as needed. We will defer his medication management to his primary." PX 6. (Pet. Ex 6)

Petitioner testified that he did not seek any further medical treatment and continued to work full duty through November 25, 2013 when he was laid off due to the seasonal nature of his work. Petitioner returned to work for the respondent on March 20, 2014. From November 25, 2013 through March 20, 2014, while off work, petitioner testified he still experienced on and off pain. (Tran 52) He testified he continued to use his TENS unit when needed and his pain level reached 3-4/10 at times. Petitioner went on to testify that when he returned to work in March of 2014 he was still experiencing pain both at work and at home. (Tran 53-54)

With regard to the second accident, Petitioner testified that approximately 6 weeks after returning from seasonal lay off, on 4/28/14, he was at work walking into a greenhouse with an awkward entrance, Specifically, Petitioner testified that in order to enter the greenhouse he had to step over a small wall and a water boom in the entryway. He testified that he was bent at the waist while entering the building causing him to enter

awkwardly. Petitioner testified that he was not carrying anything while walking in the doorway and was in a bent position for 5 to 6 seconds while maneuvering the entrance. He testified that the doorway was small at a height of 5 feet and that he is 5'11" tall requiring him to bend in the entry. Petitioner testified that when he crossed over the water boom and stood straight up he felt a pain in his lower back. He testified that the pain took his breath away due to the severity. The incident was immediately reported and the respondent directed the petitioner to seek care at Riverside Corporate Health.

On April 29, 2014 the petitioner was examined by a nurse practitioner, Barbara Sauvage at Riverside Corporate Health. Petitioner provided a history of experiencing back pain the day before when entering the green house, stepping over the water boom and feeling severe low back pain and tightness when he stood up. Petitioner reported that the back pain had increased over the prior 24 hours. He described the pain as intense pain to eh lower lumbar area with tingling down both his legs posteriorly to the mid calf. He was unable to bend forward. Petitioner reported the history of treatment for the herniated disc in 2012 at L5-S1 and that he declined the recommended surgery. Petitioner reported that he "did fine until yesterday and had no further reoccurrence of the back pain and paresthesis until now." Petitioner requested a PT trial "instead of a referral back to neurosurgery. PX 7. He was also provided work restrictions of no lifting greater than 5 pounds and ordered to obtain an updated MRI of the lumbar Spine. (Pet. Ex 7) Respondent accommodated the restrictions.

Beginning on May 7, 2014 petitioner began physical therapy. PX 11. On May 30, 2014, Petitioner returned to Riverside and nurse practitioner Sauvage. She noted "This is a recheck of a lumbar strain with radiculopathy. The patient has a history of disc herniation L5-S1 previously obtained while employed by same company. He has up until this time opted to try physical therapy prior to having an MRI and following up with Neurosurgery. He reports some significant improvement in his symptoms, however he does have lower back pain that radiates to his buttocks. He has pain at night while trying to sleep as well as pain with extended sitting. He has been reticent to lift anymore than 35 pounds. The pain from the lumbar area also radiates to the right groin. He rates the pain at 3/10. It increases with standing for long periods of time as well as lying on hard surfaces. His pain medication is not entirely relieving the pain as it had previously. He is continuing with physical therapy. He has been following his work restrictions. At this time, he states that he is willing to proceed with having an MRI and referral to Neurosurgery if the MRI warrants it." PX 7. An MRI was ordered and work restrictions were continued. Follow up was set for 6/20/14.

The MRI of June 5, 2014 showed a diffuse disc herniation at L5-S1 reducing the canal diameter significantly. PX 8. On 6/10/14, nurse Sauvage noted continued low back pain with radiating pain and that Petitioner reported feeling 60% improved with PT. Petitioner was referred to Dr. Harvey. PX 9.

Petitioner participated in physical therapy through June 19, 2014, a total of eighteen visits. At the time of discharge petitioner had a pain rating of zero out of ten, no pain in the lower extremities, and felt he could perform his normal work routine. (Pet. Ex 11). At that time, Petitioner was working restricted duty but advised "I think I can do it" referring to his normal full duty job.

After completing physical therapy petitioner returned to see Dr. Harvey on July 15, 2014. Petitioner provided a history of experiencing pain while stepping into the greenhouse. Dr. Harvey noted, "He has recurrent back and right buttock pain that started about three months ago when he was working in a greenhouse that required some bending and stepping into and out of the greenhouse. He has some physical therapy during that time to help with condition, which did help some, but still continues to have radiating low back pain that is aggravated with

walking, and states that after walking about ten or fifteen minutes he has to walk like an old man. ... He continues with intermittent dull ache to his lower back and right buttock that occasionally radiates into his right thigh. He denies any pain today, but at worst his pain is 7/10 severity. ... he has continued with work during the past few months, and has completed PT that was completed on 6/19/14 at Axcess and reports benefit from that." PX 10.

Dr. Harvey concluded, "Mr. Zarate has a large disc herniation at L5-S1 sustained at work which has failed prolonged conservative management. He initially did very well with physical therapy and work conditioning and was able to return to work including lifting 75 lbs at a time at work without restrictions. About three months ago he suddenly felt increased pain while at work inside a greenhouse and since that time has continue to have low back pain that radiates into his left leg. A course of physical therapy during that time helped to improve his condition somewhat, but he still suffers from continued sciatic pain that he considers intolerable. He was counseled about a right L5-S1 laminectomy and diskectomy. ... The patient can no longer live with the current pain." Dr. Harvey again recommended a lumbar laminectomy and discectomy L5-S1 right with medical facetectomy and foraminotomy. (Pet. Ex 10)

Petitioner further testified that when he told Dr. Harvey during the July 15, 2014 visit that he could no longer live with the pain, he meant the pain he had been experiencing over the past two years since the initial accident in 2012. (Tran 72) Petitioner further testified that Dr. Harvey does not accept Medicaid and Petitioner is waiting for surgical authorization. Petitioner testified that he wants to proceed with the surgery recommended by Dr. Harvey most recently in July 2014 because his symptoms never really went away. (Tran 28)

Respondent accommodated Petitioner's work restrictions following the second accident starting 4/29/14 through the time of seasonal lay off in November 2014. After lay off, Petitioner returned to work for Respondent on restricted duty on March 9, 2015. T. 24. Petitioner worked restricted duty continuing to lift 75 pounds with occasional help. T. 25. In August 2015, Petitioner was promoted to a supervisory position with Respondent as a crew driver. This position requires Petitioner to lift over 75 pounds but Petitioner testified that he does not lift over 75 pounds. As a crew driver, Petitioner pulls orders and prunes trees. Petitioner testified he lifted less in this position, but that was due to the nature of the position, not due any physical limitations. (Tran 64) Petitioner was again placed on seasonal lay off starting 12/18/15 through the time of trial. Petitioner was set to return to the crew driver position in March 2016.

At the request of Respondent petition was examined by Dr. Edward Goldberg on February 27, 2015 pursuant to section 12 of the Act. Dr. Goldberg performed a physical exam of the petitioner as well as taking a history of the August 17, 2012 accident as well as the April 28, 2014 accident. Dr. Goldberg was of the opinion that the August 17, 2012 accident caused petitioner's disc herniation at L5-S1, but he was unable to comment upon the issue of causation and petitioner's need for surgery without reviewing the MRI films personally. Nevertheless, Dr. Goldberg opined petitioner needed surgery and work restrictions. (Pet. Ex. 1)

Dr. Goldberg drafted an addendum report dated May 27, 2015. (Pet. Ex 1) In conjunction with drafting this report Dr. Goldberg reviewed petitioner's lumbar MRI films dated November 26, 2012, March 15, 2013, and June 4, 2014. Dr. Goldberg opined he did not see any acute differences in the MRI films. (Pet. Ex 1 pg 26) Dr. Goldberg went on to opine that the April 28, 2014 accident aggravated the initial herniation. (Pet. Ex 1 pg 33) Thus petitioner's need for surgery was caused by the April 28, 2014 accident. Dr. Goldberg support this opinion based on his understanding that petitioner returned to work in a full duty capacity after the August 17, 2012 but did not return to full duty after the April 28, 2014 accident. (Pet. Ex 1)

On December 9, 2015, Dr. Goldberg presented for an evidence deposition. He testified that the August 17, 2012 accident caused petitioner's herniation. PX 1, p. 10-12. After reviewing the MRI films, Dr. Harvey opined that the accident of April 28, 2014 aggravated the pre-existing condition. PX 1, p. 12. He then testified that he was "unable to say with any medical and surgical certainty" which accident caused the need for surgery. PX 1, p. 13. He notes that Petitioner was a surgical candidate after the first accident, appeared to improve, returned to work full duty without surgery, and is again a surgical candidate after the second accident. Dr. Goldberg agrees with the surgical recommendation. PX 1, p. 13. Dr. Goldberg testified that both accidents contributed to the need for surgery. PX 1, p. 13.

On cross exam, Dr. Goldberg testified that he understood Petitioner returned to full duty work from May 2013 through the date of the second accident in April 2014. PX 1, p. 15. He also understood that Petitioner received no medical treatment from September 2013 until April 2014. PX 1, p. 15. When asked if the need for surgery is related to the April 2014 accident, Dr. Goldberg responded, "Well, I will say that, again, he had the herniation from the original accident, and he reported a subjective exacerbation of symptoms so I felt it was the second accident where he was – if he couldn't live with the pain, he would be a candidate for the surgery, yes." PX 1, p. 16. He was again asked if the current need for surgery was related to the April 2014 accident and he responded, "yes." PX 1, p. 16.

On further cross exam for the Respondent in connection with the second accident, Dr. Goldberg testified that Petitioner was not pain free when he returned to work in May 2013 but that his pain was functionally tolerable. PX 1, p. 21. Dr. Goldberg agreed that Petitioner still had pain complaints to his doctor in July and September 2013 and that Dr. Harvey placed Petitioner at MMI in September 2013 "if he did not want to undergo surgery." PX 1, p. 22. Upon his review of all MRI films, the disk herniation size had not increased. PX 1, p. 23. Petitioner started to treat again in April 2014 pursuant to a pain increase after bending at work. PX 1, p. 24. Once again, Dr. Harvey recommended surgery. PX 1, p. 24. Upon reviewing all MRI films, Dr. Goldberg did not find any acute changes when comparing MRI before and after the April 2014 accident. PX 1, p. 26. He testified that the only change prior to the 2014 accident and after is an increase in subjective complaints. PX 1, p. 29. He further agreed that based on the size of the herniation resulting from the 2012 accident everyday activities could have caused the need for surgery thereafter. PX 1, p. 32. He further agreed that without the 2012 accident Petitioner likely would not need any surgery. PX 1, p. 32. He further agreed that it would be fair to say that the initial need for surgery is a result of the initial herniation. PX 1, p. 33. Dr. Goldberg further stated the consistent administration of medication between MMI in September 2013 and the accident of April 2014 may be considered treatment which could change his opinion, which was primarily based on Petitioner's full duty return to work in May 2013. PX 1, p. 38.

Petitioner testified that he currently notices back aches, stiffness and occasional radiation of the pain which are all symptoms he experienced before the April 2014 accident. He testified that he is not able to play with his children. Petitioner has not sought medical attention since July 2014 because he is waiting for surgical approval. Petitioner testified that Dr. Harvey is recommending the same surgery now as he did in 2012. He also agreed that his back pain has never completely gone away since the 2012 accident and that he has always had intermittent pain even when not at work. T. 62. Dr. Harvey did not recommend work restrictions for Petitioner in July 2014 and that he returned to full duty lifting 75 lbs occasionally with help through August 2015 when he became a crew leader. T. 64-65. At the time of trial, Petitioner was again on seasonal lay off and was set to return to his position as a crew driver in March 2016.

CONCLUSIONS OF LAW

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

In connection with case **13 WC 2498 DOA 8/17/12** the Arbitrator makes the following conclusions. Conclusions in consolidated case 14 WC 39062 are rendered under separate Decision.

F. Is Petitioner's current condition of ill-being causally related to the injury? K. Is Petitioner entitled to any prospective medical care?

At trial, the parties stipulated that Petitioner sustained accidental injuries at work on August 17. 2012. ARB EX 1. The evidence is undisputed that Petitioner suffered a large disc herniation at L5-S1 as a result of that accident and that the surgery proposed by Dr. Harvey is a reasonable option to treat that condition. Respondent disputes causal connection for Petitioner's condition of ill-being after Petitioner's return to work full duty after September 2013 and thus disputes causal connection for the recommended surgery and further TTD thereafter. Respondent for the DOA of 8/17/12 further disputes causal connection based on the fact that Petitioner sustained a second accident on 4/28/14 and takes the position that Petitioner's current condition of ill-being and the need for surgery are the result solely of the 4/28/14 accident. Respondent for the DOA of 4/28/14 disputes causal connection and responsibility for the recommended surgery asserting that Petitioner's DOA of 4/28/14 only temporarily aggravated Petitioner's pre existing condition, that Petitioner returned to baseline as of June 2014 and that the surgical recommendation remained the same as it did in September 2013.

In the matter of 13 WC 2498 with DOA of 8/17/12, the Arbitrator finds that Petitioner's current condition of ill-being in his low back and the need for the recommended surgery is causally related to the accident of 8/17/12. In so finding, Petitioner's full duty return to work in May 2013 through his seasonal lay off in November 2013 is not lost on the Arbitrator. However, based on the current record, the Arbitrator is not persuaded to find that the full duty return to work equates to Petitioner's symptoms having resolved. Rather, the Arbitrator is persuaded by the fact that Dr. Harvey recommended lumbar surgery up through his "release" of Petitioner in September 2013 and relented in his recommendation based solely on Petitioner's desire not to undergo surgery and his reports of improvement with conservative care. Thereafter, Petitioner testified that he returned to work until his seasonal lay off in November 2013 but continued to have intermittent back pain and symptoms controlled with a TENS unit and assistance lifting at work after his return. Petitioner further testified that he had continued symptoms even during the time of seasonal lay off between November 2013 and March 2014. Petitioner further testified that he continued to have intermittent symptoms controlled with the TENS unit after his return in March 2014 for the six weeks prior to the accident of April 2014. Accordingly, the Arbitrator finds that Petitioner had reached a baseline after the 8/17/12 accident sufficient for him to work for a short period of time, approximately 6 months before the lay off and 6 weeks after the layoff, but not full resolution of his symptoms so as to make the return to work the defining factor based on the record in its entirety.

The Arbitrator further notes that there is no evidence that the event of April 28, 2014 changed the nature of Petitioner's injury, other than to temporarily aggravate the pre-existing large disk herniation sustained in the undisputed work accident of 8/17/12. The Arbitrator notes there was no change in the size or pathology of the large disc herniation between Petitioner's MRI studies taken before and after the April 28, 2014 accident. The need for the surgery prescribed by Dr. Harvey became well apparent prior to the April 28, 2014 accident, but was deferred due to solely to Petitioner's clear desire to avoid surgery. Although the event of April 24, 2014 may have caused an increase in Petitioner's symptoms, the Arbitrator finds that the increase in subjective

symptoms was temporary and that Petitioner's symptom level returned to his post 8/17/12 accident baseline as of June 19, 2014 when he completed physical therapy and returned to full duty work.

Finally, the Arbitrator notes that on the one visit Petitioner had with Dr. Harvey in July 2014, Dr. Harvey concluded, "Mr. Zarate has a large disc herniation at L5-S1 sustained at work which has failed prolonged conservative management. He initially did very well with physical therapy and work conditioning and was able to return to work including lifting 75 lbs at a time at work without restrictions. About three months ago he suddenly felt increased pain while at work inside a greenhouse and since that time has continue to have low back pain that radiates into his left leg. A course of physical therapy during that time helped to improve his condition somewhat, but he still suffers from continued sciatic pain that he considers intolerable. He was counseled about a right L5-S1 laminectomy and diskectomy. ... The patient can no longer live with the current pain." Dr. Harvey again recommended a lumbar laminectomy and discectomy L5-S1 right with medical facetectomy and foraminotomy. (Pet. Ex 10) At trial, Petitioner testified that when he told Dr. Harvey during the July 15, 2014 visit that he could no longer live with the pain, he meant the pain he had been experiencing over the past two years since the initial accident in 2012. (Tran 72) Petitioner further testified that Dr. Harvey does not accept Medicaid and Petitioner is waiting for surgical authorization. Petitioner testified that he wants to proceed with the surgery recommended by Dr. Harvey most recently in July 2014 because his symptoms never really went away. (Tran 28)

Based on the above, and on the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being and the need for surgery is causally related to the accident of August 17, 2012 in case 13 WC 2498. As a result, the Arbitrator further finds that Respondent shall authorize and pay for the surgery and the attendant care recommended by Dr. Harvey pursuant to Sections 8 and 8.2 of the Act.

L. What temporary benefits are in dispute? TTD

The parties stipulated to the undisputed TTD period between November 10, 2012 and May 27, 2013 which total 28-3/7 weeks. ARB EX 1. The parties also stipulated that Petitioner's average weekly wage was $400.00 at the time of his injury and that he was single with 3 dependents at the time of his injury. Petitioner shall be paid TTD at the minimum rate of $319.00. Respondent shall pay Petitioner TTD for the stipulated period of 28-3/7 weeks commencing 11/10/12 through 5/27/13. Respondent shall receive credit for amounts paid.

Based on the finding of causal connection, the Arbitrator further considered the TTD periods requested by Petitioner in case 14 WC 39062 which occurred after the April 28, 2014 accident. Petitioner requests TTD for the periods of seasonal lay off commencing 11/22/14 to 3/8/15 and again 12/18/15 to 2/10/16. The Arbitrator finds that Petitioner failed to prove entitlement to TTD during these two periods of seasonal lay off. The evidence supports a finding that Petitioner was working full duty lifting 75 pounds occasionally prior to both of these lay off periods and was thus not under any active work restrictions prior to the layoffs that would justify an award of TTD during the seasonal lay off.

M. Should penalties or fess be imposed upon Respondent?

In case 13 WC 2498 DOA 8/17/12, the Arbitrator denies Petitioner's request for penalties and fees under the Act. In so doing, the Arbitrator finds that Respondent's conduct was neither so unreasonable nor vexatious so as to impose the imposition of penalties and/or fees under the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAMON ZARATE,

Petitioner,

vs.

NO: 14 WC 39062

KANKAKEE NURSERY,

17IWCC0644

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection and prospective medical care, and being advised of the facts and law, reverses 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).

This case was consolidated at hearing with 13 WC 2498. Petitioner sustained two accidents resulting in lumbar injuries while working for Respondent. The first one occurred on August 17, 2012 (13 WC 2498). The second was on April 28, 2014 (14 WC 39062).

The Commission finds that Petitioner had reached maximum medical improvement (MMI) from his first injury as of the September 17, 2013 visit with Dr. Harvey. Dr. Harvey noted that Petitioner denied having any weakness, numbness, or tingling, and that Petitioner had been working without restrictions for more than two months, including lifting 75 pounds. He wrote that, clinically, Petitioner was doing very well but he had dull pain, once or twice a week at the end of a day. Dr. Harvey stated that Petitioner had reached MMI at that time.

Following the second accident, on April 28, 2014, Petitioner returned to Riverside Corporate Health on April 29th. Those records indicate a history of Petitioner stepping over a water boom pipe after entering a greenhouse and when he stood up straight he felt a pain and tightness to his lower back. The pain had increased over the last 24 hours and was described as intense pain to the lower lumbar area with tingling down both his legs posteriorly to the mid calf. Petitioner was unable to

17IWCC0644

bend forward. This record notes Petitioner's prior treatment for the L5-S1 herniated disc but indicates that Petitioner reported that "he did fine until yesterday and had no further reoccurrence of the back pain and paresthesia until now."

Although surgery had been recommended after the first accident, Petitioner did not want to pursue it at that time and, following conservative treatment, his symptoms resolved to the point of being able to return to work full duty. It wasn't until the second accident that his symptoms recurred. We find the opinion of the §12 examining physician, Dr. Goldberg, to be persuasive that Petitioner aggravated his prior disc herniation at L5-S1 secondary to the accident of April 28, 2014, and that the need for surgery was due to that accident.

Therefore, we reverse the Arbitrator on the issue of causation and find that Petitioner's need for surgery is related to the second accident on April 28, 2014. The prospective surgery by Dr. Harvey is hereby awarded in the instant case (14 WC 39062). We have vacated the award for surgery in 13 WC 2498 in a separate decision.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the recommended surgery as prescribed by Dr. Harvey along with the attendant care 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 $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 13 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/30/17
49

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

ZARATE, RAMON
Employee/Petitioner

Case# **14WC039062**

13WC002498

KANKAKEE NURSERY COMPANY
Employer/Respondent

17IWCC0644

On 3/28/2016, 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 0.44% 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:

0000 SPIROS LAW PC
SANDRA LOEB
1230 W COURT ST
KANKAKEE, IL 60901

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

17 IWCC0644

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ramon Zarate
Employee/Petitioner

v.

Kankakee Nursery
Employer/Respondent

Case # **14** WC **39062**

Consolidated cases: **13 WC 2498 under separate Decision**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Kankakee**, on **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0644

FINDINGS

On the date of accident, **April 28, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$24,480.00**; the average weekly wage was **$420.00**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **3** dependent children.

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

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

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

ORDER

Based on the Arbitrator's finding of no causal connection between Petitioner's current condition of ill-being and the accident of April 28, 2014, no benefits are owed Petitioner.

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

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

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

Carolyn M. Wheeler

Signature of Arbitrator

3/24/16

Date

ICArbDec19(b)

MAR 28 2016

FINDINGS OF FACT

Petitioner alleges 2 accidents in these consolidated matters. Each Decision is rendered under separate cover. In case 13 wc 2498, Petitioner alleges he was injured at work on 8/17/12. Respondent does not dispute accident or notice in 13 wc 2498. In the consolidated matter on 14 wc 39062, Petitioner alleges he was injured at work on 4/28/14. Respondent disputes accident in case 14 wc 39062. Although the Respondent in both matters is Kankakee Nursery Company, Respondent was insured by two different carriers on the alleged dates of accident. Thus, Respondent was represented by separate counsel in the two consolidated matters at trial.

Petitioner, a 26 year old nursery worker, testified that he began working for Respondent in August 2005. His duties include picking tree orders and preparing the orders for planting and shipping. His duties required him to lift weights on occasion in excess of 75 pounds and frequently up to 75 pounds. Some trees weighed up to 150 pounds and he was required to lift up to 80 pounds alone.

Petitioner testified that prior to 8/17/12, he had no problems with his back. Petitioner testified that on 8/17/12, he was in a pole barn when he stepped on floor debris in the barn and fell landing on his side and back. Petitioner testified that he noticed immediate pain in his back and reported the accident. Again, accident and notice are not at issue in connection with 8/17/12.

Due to continued low back pain petitioner sought medical treatment on October 3, 2012 at Riverside Corporate Health Services. (Pet. Ex 3) Petitioner was directed by his employer to this medical facility. At the time of the October 3, 2012 visit petitioner provided a consistent history of the slip and fall accident while working for respondent. Petitioner stated that he was experiencing low back pain with radiation down the right leg with intermittent numbness and tingling. (Pet. Ex 3) X-rays at that time revealed no acute findings. (Pet. Ex 2) A diagnosis of lumbar radiculopathy was provided. Petitioner was prescribed pain medication, physical therapy and work restrictions. Petitioner's work restrictions consisted of no lifting greater than 15lbs along with avoidance of bending, squatting and kneeling. (Pet. Ex 3)

Petitioner returned to Riverside Corporate Health on October 26, 2012. Petitioner indicated his pain had improved, but he requested alternate medication based on the lack of reduction of pain from the Relafen. Additional therapy was prescribed and work restrictions were continued. (Pet. Ex 3)

On November 8, 2012 petitioner returned with a history of insignificant improvement of his low back pain. He indicated he experienced minor relief with 6 PT sessions but no sustained improvement. Petitioner rated his pain at 6 out of 10 with radiation down his right leg to his calf. Petitioner was concerned his radiating pain was worsening. It was recommended undergo a lumbar MRI and work restrictions were continued. (Pet. Ex 3) Due to a seasonal lay off petitioner stopped working on November 10, 2012 and respondent began paying temporary total disability. ARB EX 1.

Petitioner underwent a lumbar MRI on November 26, 2012. This exam revealed a moderate to large diffuse disc herniation resulting in high grade compromise of the anteroposterior diameter of the spinal canal at the second to last lumbar type intervertebral disc space, presumably L5-S1. (Pet. Ex 4)

On November 28, 2012, petitioner returned to Riverside Corp Health to review his MRI results. At that time petitioner had continued low back pain with radiation, numbness and tingling down his right leg. Petitioner stated he had pain with heavy work and prolonged standing. He was diagnosed with a lumbar herniation. He was referred to neurosurgery for further evaluation. (Pet. Ex 5)

Petitioner was seen by Dr. Charles Harvey, a neurosurgeon, on December 28, 2012. Petitioner provided a consistent history of the work accident. At that time petitioner had complaints of intermittent sharp low back pain with radiation down both thighs stopping just below the knees. His present pain was 5 out of 10 with the worst being 8/9 out of 10. Dr. Harvey performed a physical exam and reviewed the lumbar MRI. Dr. Harvey's diagnosis was displacement of the lumbar intervertebral disc without myelopathy. Dr. Harvey indicated the large herniation impinged on the nerve roots and thecal sac producing severe spinal stenosis of about ninety percent. Based on the MRI finding, Dr. Harvey recommended surgery in the form of a lumbar laminectomy and discectomy with medial facetectomy and foraminotomoy L5-S1 right. (Pet. Ex 6)

Petitioner testified that he was afraid of undergoing surgery and wanted to explore non-surgical treatment options. (Tran 17) Based on petitioner's fear of surgery Dr. Harvey prescribed physical therapy. On 1/29/13, Dr. Harvey noted Petitioner reported that his back pain had improved since the last visit stating it was more of a discomfort at that point and that he wanted to discuss non-surgical options. Petitioner reported "intermittent dull to sharp low back achiness without any further radiation down his thighs, however discomfort still radiates midway up his spine at times. His pain at present is 1/10 worst 4/10 .... He continues with mild intermittent numbness and tingling to the right posterior thigh. ... Ramon no longer needs to support himself with a cart when shopping and is able to walk upright when shopping." PX 6. Under Assessment, Dr. Harvey noted "he deferred surgery last month and feels his pain has improved with less activity. He is interested in trying to avoid surgery if possible. I will send him back to outpatient PT and see if he can make progress towards returning to work. If not, we will reconsider surgery. I will see him again in 6 weeks or as needed." PX 6.

At the request of the respondent petitioner was examined pursuant to Section 12 of the Act by Dr. Ramis Ghaly. Dr. Ghaly obtained a history from the petitioner including the details of the August 17, 2012 accident. He reviewed the MRI and agreed a large disc herniation with severe stenosis was present at L5-S1. Dr. Ghaly agreed that surgery was an "attractive option" given the size of the herniation and the severe stenosis and agreed with the type of recommended surgery. He was of the opinion that the accident on August 17, 2012 caused the need for surgery as prescribed by Dr. Harvey and specifically stated "there is too much to risk by continuing to watch even if the symptoms decrease since his duty is physical." (Resp2 Ex 1)

On March 7, 2013 petitioner returned to see Dr. Harvey. Petitioner stated he had completed twelve sessions of physical therapy and noticed fifty percent improvement. Petitioner complained of continued intermittent dull to sharp ache in the lower back without radiation to the right leg. His pain was present at 2-4/10. Petitioner also reported one instance of right leg numbness following an intense therapy session the week prior from lateral right thigh down to mid calf lasting ½ hour. His medication was only providing minimal relief. Petitioner again desired to put off surgery and requested 3 additional weeks of PT as recommended by the physical therapist. Petitioner was to follow up in 3 weeks. (Pet. Ex 6)

On March 15 2013 petitioner underwent another lumbar MRI. This exam revealed a disc herniation at L5-S1 high grade compromise of the spinal canal. (Resp2 Ex 2)

Petitioner returned to Dr. Harvey on March 19, 2013, with continued intermittent dull to sharp low back ache. His back pain ranged from 1-4/10. Dr. Harvey reviewed the recent MRI and found no change in the large disc herniation. Dr. Harvey opined based on the lack of change in the large disc herniation that petitioner would benefit from surgical intervention as previously prescribed. (Pet. Ex 6). However, he continued PT.

On April 9, 2013, petitioner returned to Dr. Harvey after completing 9 additional PT sessions. Petitioner advised that his "pain is better under control since therapy" and that his therapist would like to start work conditioning. Petitioner reported continued dull to sharp low back ache 2-4/10. Dr. Harvey again noted the lack of change in MRI results, the size of the herniation and his continued recommendation for surgery. He also noted Dr. Ghaly's agreement on the need for surgery. However, based on Petitioner's reported improvement with PT and his continued disinterest in surgery, Dr. Harvey agreed Petitioner could go to work hardening and that he should return in 4 to 6 weeks or as needed. PX 6.

On May 21, 2013, Petitioner returned to Dr. Harvey and stated he had completed work conditioning and achieved an eighty percent benefit with continued complaints of intermittent dull ache to his mid to low back. Pain was at 1-2/10. Dr. Harvey wrote, "he again has no desire to proceed with back surgery being as his pain is controlled." Petitioner's work conditioning results indicated he was capable of performing his regular work duties including lifting up to 75lbs. Thus, Dr. Harvey allowed the petitioner to return to work in a full duty capacity with a six week follow up for further evaluation noting "if his pain significantly worsens, then surgery will be recommended." (Pet. Ex 6)

Petitioner returned to Dr. Harvey on July 2, 2013. At that time he indicated he had returned to work in a full duty capacity on 5/28/13 and that he was doing well. Petitioner reported intermittent dull ache to his mid to low back "which has neither improved or worsened since RTW." Pain was at 1-4/10. Petitioner reported pain control through his TENS unit. Dr. Harvey noted that Petitioner did "very well" with PT and work conditioning, allowed Petitioner to continue full duty and told Petitioner to follow up in six to eight weeks for further evaluation. (Pet. Ex 6)

On September 17, 2013 petitioner returned to Dr. Harvey. Dr. Harvey noted that Petitioner was in for further evaluation of a large disk herniation at L5-S1 that has responded to conservative therapy well. He continues with an intermittent dull ache to his mid to low back. Pain currently 1/10 and 4/10 at worst. Aggravating factor is sitting for prolonged periods, while staying active and using his TENS unit helps." In his assessment, Dr. Harvey wrote "Mr. Zarate has been working without restrictions for more than 2 months, including lifting 75 lbs. Clinically, he is doing very well. He has dull pain, once or twice a week at the end of a day. I encourage him to continue HEP and weight loss program. Patient has reached MMI at this time. ... follow up will be as needed. We will defer his medication management to his primary." PX 6. (Pet. Ex 6)

Petitioner testified that he did not seek any further medical treatment and continued to work full duty through November 25, 2013 when he was laid off due to the seasonal nature of his work. Petitioner returned to work for the respondent on March 20, 2014. From November 25, 2013 through March 20, 2014, while off work, petitioner testified he still experienced on and off pain. (Tran 52) He testified he continued to use his TENS unit when needed and his pain level reached 3-4/10 at times. Petitioner went on to testify that when he returned to work in March of 2014 he was still experiencing pain both at work and at home. (Tran 53-54)

With regard to the second accident, Petitioner testified that approximately 6 weeks after returning from seasonal lay off, on 4/28/14, he was at work walking into a greenhouse with an awkward entrance, Specifically, Petitioner testified that in order to enter the greenhouse he had to step over a small wall and a water boom in the entryway. He testified that he was bent at the waist while entering the building causing him to enter awkwardly. Petitioner testified that he was not carrying anything while walking in the doorway and was in a bent position for 5 to 6 seconds while maneuvering the entrance. He testified that the doorway was small at a

height of 5 feet and that he is 5'11" tall requiring him to bend in the entry. Petitioner testified that when he crossed over the water boom and stood straight up he felt a pain in his lower back. He testified that the pain took his breath away due to the severity. The incident was immediately reported and the respondent directed the petitioner to seek care at Riverside Corporate Health.

On April 29, 2014 the petitioner was examined by a nurse practitioner, Barbara Sauvage at Riverside Corporate Health. Petitioner provided a history of experiencing back pain the day before when entering the green house, stepping over the water boom and feeling severe low back pain and tightness when he stood up. Petitioner reported that the back pain had increased over the prior 24 hours. He described the pain as intense pain to eh lower lumbar area with tingling down both his legs posteriorly to the mid calf. He was unable to bend forward. Petitioner reported the history of treatment for the herniated disc in 2012 at L5-S1 and that he declined the recommended surgery. Petitioner reported that he "did fine until yesterday and had no further reoccurrence of the back pain and paresthesis until now." Petitioner requested a PT trial "instead of a referral back to neurosurgery. PX 7. He was also provided work restrictions of no lifting greater than 5 pounds and ordered to obtain an updated MRI of the lumbar Spine. (Pet. Ex 7) Respondent accommodated the restrictions.

Beginning on May 7, 2014 petitioner began physical therapy. PX 11. On May 30, 2014, Petitioner returned to Riverside and nurse practitioner Sauvage. She noted "This is a recheck of a lumbar strain with radiculopathy. The patient has a history of disc herniation L5-S1 previously obtained while employed by same company. He has up until this time opted to try physical therapy prior to having an MRI and following up with Neurosurgery. He reports some significant improvement in his symptoms, however he does have lower back pain that radiates to his buttocks. He has pain at night while trying to sleep as well as pain with extended sitting. He has been reticent to lift anymore than 35 pounds. The pain from the lumbar area also radiates to the right groin. He rates the pain at 3/10. It increases with standing for long periods of time as well as lying on hard surfaces. His pain medication is not entirely relieving the pain as it had previously. He is continuing with physical therapy. He has been following his work restrictions. At this time, he states that he is willing to proceed with having an MRI and referral to Neurosurgery if the MRI warrants it." PX 7. An MRI was ordered and work restrictions were continued. Follow up was set for 6/20/14.

The MRI of June 5, 2014 showed a diffuse disc herniation at L5-S1 reducing the canal diameter significantly. PX 8. On 6/10/14, nurse Sauvage noted continued low back pain with radiating pain and that Petitioner reported feeling 60% improved with PT. Petitioner was referred to Dr. Harvey. PX 9.

Petitioner participated in physical therapy through June 19, 2014, a total of eighteen visits. At the time of discharge petitioner had a pain rating of zero out of ten, no pain in the lower extremities, and felt he could perform his normal work routine. (Pet. Ex 11). At that time, Petitioner was working restricted duty but advised "I think I can do it" referring to his normal full duty job.

After completing physical therapy petitioner returned to see Dr. Harvey on July 15, 2014. Petitioner provided a history of experiencing pain while stepping into the greenhouse. Dr. Harvey noted, "He has recurrent back and right buttock pain that started about three months ago when he was working in a greenhouse that required some bending and stepping into and out of the greenhouse. He has some physical therapy during that time to help with condition, which did help some, but still continues to have radiating low back pain that is aggravated with walking, and states that after walking about ten or fifteen minutes he has to walk like an old man. ... He continues with intermittent dull ache to his lower back and right buttock that occasionally radiates into his right thigh. He denies any pain today, but at worst his pain is 7/10 severity. ... he has continued with work during

the past few months, and has completed PT that was completed on 6/19/14 at Axcess and reports benefit from that." PX 10.

Dr. Harvey concluded, "Mr. Zarate has a large disc herniation at L5-S1 sustained at work which has failed prolonged conservative management. He initially did very well with physical therapy and work conditioning and was able to return to work including lifting 75 lbs at a time at work without restrictions. About three months ago he suddenly felt increased pain while at work inside a greenhouse and since that time has continue to have low back pain that radiates into his left leg. A course of physical therapy during that time helped to improve his condition somewhat, but he still suffers from continued sciatic pain that he considers intolerable. He was counseled about a right L5-S1 laminectomy and diskectomy. ... The patient can no longer live with the current pain." Dr. Harvey again recommended a lumbar laminectomy and discectomy L5-S1 right with medical facetectomy and foraminotomy. (Pet. Ex 10)

Petitioner further testified that when he told Dr. Harvey during the July 15, 2014 visit that he could no longer live with the pain, he meant the pain he had been experiencing over the past two years since the initial accident in 2012. (Tran 72) Petitioner further testified that Dr. Harvey does not accept Medicaid and Petitioner is waiting for surgical authorization. Petitioner testified that he wants to proceed with the surgery recommended by Dr. Harvey most recently in July 2014 because his symptoms never really went away. (Tran 28)

Respondent accommodated Petitioner's work restrictions following the second accident starting 4/29/14 through the time of seasonal lay off in November 2014. After lay off, Petitioner returned to work for Respondent on restricted duty on March 9, 2015. T. 24. Petitioner worked restricted duty continuing to lift 75 pounds with occasional help. T. 25. In August 2015, Petitioner was promoted to a supervisory position with Respondent as a crew driver. This position requires Petitioner to lift over 75 pounds but Petitioner testified that he does not lift over 75 pounds. As a crew driver, Petitioner pulls orders and prunes trees. Petitioner testified he lifted less in this position, but that was due to the nature of the position, not due any physical limitations. (Tran 64) Petitioner was again placed on seasonal lay off starting 12/18/15 through the time of trial. Petitioner was set to return to the crew driver position in March 2016.

At the request of Respondent petition was examined by Dr. Edward Goldberg on February 27, 2015 pursuant to section 12 of the Act. Dr. Goldberg performed a physical exam of the petitioner as well as taking a history of the August 17, 2012 accident as well as the April 28, 2014 accident. Dr. Goldberg was of the opinion that the August 17, 2012 accident caused petitioner's disc herniation at L5-S1, but he was unable to comment upon the issue of causation and petitioner's need for surgery without reviewing the MRI films personally. Nevertheless, Dr. Goldberg opined petitioner needed surgery and work restrictions. (Pet. Ex. 1)

Dr. Goldberg drafted an addendum report dated May 27, 2015. (Pet. Ex 1) In conjunction with drafting this report Dr. Goldberg reviewed petitioner's lumbar MRI films dated November 26, 2012, March 15, 2013, and June 4, 2014. Dr. Goldberg opined he did not see any acute differences in the MRI films. (Pet. Ex 1 pg 26) Dr. Goldberg went on to opine that the April 28, 2014 accident aggravated the initial herniation. (Pet. Ex 1 pg 33) Thus petitioner's need for surgery was caused by the April 28, 2014 accident. Dr. Goldberg support this opinion based on his understanding that petitioner returned to work in a full duty capacity after the August 17, 2012 but did not return to full duty after the April 28, 2014 accident. (Pet. Ex 1)

On December 9, 2015, Dr. Goldberg presented for an evidence deposition. He testified that the August 17, 2012 accident caused petitioner's herniation. PX 1, p. 10-12. After reviewing the MRI films, Dr. Harvey opined that the accident of April 28, 2014 aggravated the pre-existing condition. PX 1, p. 12. He then testified that he was

"unable to say with any medical and surgical certainty" which accident caused the need for surgery. PX 1, p. 13. He notes that Petitioner was a surgical candidate after the first accident, appeared to improve, returned to work full duty without surgery, and is again a surgical candidate after the second accident. Dr. Goldberg agrees with the surgical recommendation. PX 1, p. 13. Dr. Goldberg testified that both accidents contributed to the need for surgery. PX 1, p. 13.

On cross exam, Dr. Goldberg testified that he understood Petitioner returned to full duty work from May 2013 through the date of the second accident in April 2014. PX 1, p. 15. He also understood that Petitioner received no medical treatment from September 2013 until April 2014. PX 1, p. 15. When asked if the need for surgery is related to the April 2014 accident, Dr. Goldberg responded, "Well, I will say that, again, he had the herniation from the original accident, and he reported a subjective exacerbation of symptoms so I felt it was the second accident where he was – if he couldn't live with the pain, he would be a candidate for the surgery, yes." PX 1, p. 16. He was again asked if the current need for surgery was related to the April 2014 accident and he responded, "yes." PX 1, p. 16.

On further cross exam for the Respondent in connection with the second accident, Dr. Goldberg testified that Petitioner was not pain free when he returned to work in May 2013 but that his pain was functionally tolerable. PX 1, p. 21. Dr. Goldberg agreed that Petitioner still had pain complaints to his doctor in July and September 2013 and that Dr. Harvey placed Petitioner at MMI in September 2013 "if he did not want to undergo surgery." PX 1, p. 22. Upon his review of all MRI films, the disk herniation size had not increased. PX 1, p. 23. Petitioner started to treat again in April 2014 pursuant to a pain increase after bending at work. PX 1, p. 24. Once again, Dr. Harvey recommended surgery. PX 1, p. 24. Upon reviewing all MRI films, Dr. Goldberg did not find any acute changes when comparing MRI before and after the April 2014 accident. PX 1, p. 26. He testified that the only change prior to the 2014 accident and after is an increase in subjective complaints. PX 1, p. 29. He further agreed that based on the size of the herniation resulting from the 2012 accident everyday activities could have caused the need for surgery thereafter. PX 1, p. 32. He further agreed that without the 2012 accident Petitioner likely would not need any surgery. PX 1, p. 32. He further agreed that it would be fair to say that the initial need for surgery is a result of the initial herniation. PX 1, p. 33. Dr. Goldberg further stated the consistent administration of medication between MMI in September 2013 and the accident of April 2014 may be considered treatment which could change his opinion, which was primarily based on Petitioner's full duty return to work in May 2013. PX 1, p. 38.

Petitioner testified that he currently notices back aches, stiffness and occasional radiation of the pain which are all symptoms he experienced before the April 2014 accident. He testified that he is not able to play with his children. Petitioner has not sought medical attention since July 2014 because he is waiting for surgical approval. Petitioner testified that Dr. Harvey is recommending the same surgery now as he did in 2012. He also agreed that his back pain has never completely gone away since the 2012 accident and that he has always had intermittent pain even when not at work. T. 62. Dr. Harvey did not recommend work restrictions for Petitioner in July 2014 and that he returned to full duty lifting 75 lbs occasionally with help through August 2015 when he became a crew leader. T. 64-65. At the time of trial, Petitioner was again on seasonal lay off and was set to return to his position as a crew driver in March 2016.

CONCLUSIONS OF LAW

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

In connection with case **14 WC 39062 DOA 4/28/14** the Arbitrator makes the following conclusions. Conclusions in consolidated case 13 **WC 2498 DOA 8/17/12** are rendered under separate Decision.

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

Based on the record, the Arbitrator finds that Petitioner sustained an accident at work on 4/28/14 when he stepped awkwardly into the greenhouse causing a temporary aggravation of his pre-existing low back condition causally related to the work accident of 8/17/12.

F. Is Petitioner's current condition of ill-being causally related to the injury? K. Is Petitioner entitled to any prospective medical care?

At trial, the parties stipulated that Petitioner sustained accidental injuries at work on August 17, 2012. ARB EX 1. The evidence is undisputed that Petitioner suffered a large disc herniation at L5-S1 as a result of that accident and that the surgery proposed by Dr. Harvey is a reasonable option to treat that condition. Respondent disputes causal connection for Petitioner's condition of ill-being after Petitioner's return to work full duty after September 2013 and thus disputes causal connection for the recommended surgery and further TTD thereafter. Respondent for the DOA of 8/17/12 further disputes causal connection based on the fact that Petitioner sustained a second accident on 4/28/14 and takes the position that Petitioner's current condition of ill-being and the need for surgery are the result solely of the 4/28/14 accident. Respondent for the DOA of 4/28/14 disputes causal connection and responsibility for the recommended surgery asserting that Petitioner's DOA of 4/28/14 only temporarily aggravated Petitioner's pre existing condition, that Petitioner returned to baseline as of June 2014 and that the surgical recommendation remained the same as it did in September 2013.

In the matter of 13 WC 2498 with DOA of 8/17/12, under separate Decision, the Arbitrator finds that Petitioner's current condition of ill-being in his low back and the need for the recommended surgery is causally related to the accident of 8/17/12. As a result, in the current matter of 14 WC 39062 with a DOA of 4/28/14, the Arbitrator finds no causal connection for Petitioner's current condition of ill-being or the recommended surgery. In so finding, Petitioner's full duty return to work in May 2013 through his seasonal lay off in November 2013 is not lost on the Arbitrator. However, based on the current record, the Arbitrator is not persuaded to find that the full duty return to work equates to Petitioner's symptoms having resolved. Rather, the Arbitrator is persuaded by the fact that Dr. Harvey recommended lumbar surgery up through his "release" of Petitioner in September 2013 and relented in his recommendation based solely on Petitioner's desire not to undergo surgery and his reports of improvement with conservative care. Thereafter, Petitioner testified that he returned to work until his seasonal lay off in November 2013 but continued to have intermittent back pain and symptoms controlled with a TENS unit and assistance lifting at work after his return. Petitioner further testified that he had continued symptoms even during the time of seasonal lay off between November 2013 and March 2014. Petitioner further testified that he continued to have intermittent symptoms controlled with the TENS unit after his return in March 2014 for the six weeks prior to the accident of April 2014. Accordingly, the Arbitrator finds that Petitioner had reached a baseline after the 8/17/12 accident sufficient for him to work for a short period of time, approximately 6 months before the lay off and 6 weeks after the layoff, but not full resolution of his symptoms so as to make the return to work the defining factor on the issue of causal connection based on the record in its entirety.

The Arbitrator further notes that there is no evidence that the event of April 28, 2014 changed the nature of Petitioner's injury, other than to temporarily aggravate the pre-existing large disk herniation sustained in the

undisputed work accident of 8/17/12. The Arbitrator notes there was no change in the size or pathology of the large disc herniation between Petitioner's MRI studies taken before and after the April 28, 2014 accident. The need for the surgery prescribed by Dr. Harvey became well apparent prior to the April 28, 2014 accident, but was deferred due to solely to Petitioner's clear desire to avoid surgery. Although the event of April 24, 2014 may have caused an increase in Petitioner's symptoms, the Arbitrator finds that the increase in subjective symptoms was temporary and that Petitioner's symptom level returned to his post 8/17/12 accident baseline as of June 19, 2014 when he completed physical therapy and returned to full duty work.

Finally, the Arbitrator notes that on the one visit Petitioner had with Dr. Harvey in July 2014, Dr. Harvey concluded, "Mr. Zarate has a large disc herniation at L5-S1 sustained at work which has failed prolonged conservative management. He initially did very well with physical therapy and work conditioning and was able to return to work including lifting 75 lbs at a time at work without restrictions. About three months ago he suddenly felt increased pain while at work inside a greenhouse and since that time has continue to have low back pain that radiates into his left leg. A course of physical therapy during that time helped to improve his condition somewhat, but he still suffers from continued sciatic pain that he considers intolerable. He was counseled about a right L5-S1 laminectomy and diskectomy. ... The patient can no longer live with the current pain." Dr. Harvey again recommended a lumbar laminectomy and discectomy L5-S1 right with medical facetectomy and foraminotomy. (Pet. Ex 10) At trial, Petitioner testified that when he told Dr. Harvey during the July 15, 2014 visit that he could no longer live with the pain, he meant the pain he had been experiencing over the past two years since the initial accident in 2012. (Tran 72) Petitioner further testified that Dr. Harvey does not accept Medicaid and Petitioner is waiting for surgical authorization. Petitioner testified that he wants to proceed with the surgery recommended by Dr. Harvey most recently in July 2014 because his symptoms never really went away. (Tran 28)

Based on the above, and on the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being and the need for surgery is causally related to the accident of August 17, 2012 in case 13 WC 2498. As a result, the Arbitrator finds no causal connection between Petitioner's accident of 4/28/14 and his current condition of ill-being or need for surgery. The Arbitrator has awarded Petitioner's surgery and medical expenses to be paid by Respondent in connection with case 13 WC 2498 and the accident of August 17, 2012.

L. What temporary benefits are in dispute? TTD

Based on the finding of causal connection in this matter and 13 WC 2498, the Arbitrator considered the TTD periods requested by Petitioner in this case 14 WC 39062 which occurred after the April 28, 2014 accident, in connection with case 13 WC 2498. The Arbitrator makes reference to the Decision in 13 WC 2498 on the issue of TTD and notes that no further TTD benefits were awarded.

M. Should penalties or fess be imposed upon Respondent?

In case 14 WC 39062 DOA 4/28/14, the Arbitrator denies Petitioner's request for penalties and fees under the Act. In so doing, the Arbitrator finds that Respondent's conduct was neither so unreasonable nor vexatious so as to impose the imposition of penalties and/or fees under the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAURIE ROHDE,

Petitioner,

vs.

NO: 12 WC 17794

CHICAGO PUBLIC SCHOOLS,

Respondent.

17IWCC0645

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. On August 13, 2014, a Section 19(b) hearing was held before an arbitrator and a decision was issued on September 29, 2014. On November 24, 2015, the Commission issued a Decision and Opinion on Review, which reversed the arbitrator on the issue of accident and found that Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment. The Circuit Court's Opinion and Order dated October 21, 2016 found that the Commission's determination that Petitioner failed to prove accident and causation was against the manifest weight of the evidence and clearly erroneous. This case was remanded to the Commission "for determination of benefits in accordance with this Opinion and Order." (Cir.Ct. Order at 23).

The benefits at issue in this case are medical expenses and temporary total disability. In accordance with the court's instructions, we find that Petitioner is entitled to 139-2/7 weeks of temporary total disability benefits under Section 8(b) of the Act from December 13, 2011 through August 13, 2014, which is supported by the work restrictions given by Dr. Bresch and which Respondent did not accommodate. We further find that Petitioner is entitled, under Section 8(a) of the Act, to the reasonable and necessary medical bills related to the treatment of her medial meniscal tear, subject to the fee schedule in Section 8.2 of the Act. Respondent shall receive credit for amounts paid, including credit under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services or insurers for which Respondent is receiving this credit.

The Commission notes that we are obligated to issue this decision pursuant to *Noonan v. IWCC*, (2016 IL App (1st) 152300WC; 65 N.E.3d 530; 2016 Ill. App. LEXIS 724; 408 Ill. Dec.

17IWCC0645

308). However, we respectfully maintain our position that Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment. In our opinion, this is a specific injury case in search of a repetitive trauma cause, which has not been proven.

Petitioner testified that she started performing the lunch and recess duties on August 25, 2011, and after the first few days she noticed her right knee was sore from the extra walking, which got progressively worse day by day. T.24-25. She testified that she elevated it, iced it and took ibuprofen when she got home. T.26. However, none of this information was given to Dr. Bresch when Petitioner saw him on October 13, 2011. This record indicates, "She states that she has had an onset of right knee pain for the past 3 weeks and has had pain when getting out of a chair and *states that originally 3 weeks ago her right knee 'gave out'*." Px3 (emphasis added).

It is clear from this record that Petitioner was relating her current pain and symptoms to a specific incident of her right knee giving out. This is when her "onset of pain" started. There is no evidence in the records to support Petitioner's claim that she began having problems within a few days after starting her new job nor at any point thereafter until the chair incident. This is further supported by Dr. Bresch's testimony that Petitioner reported to him that "she had *new pain after trying to get out of a chair when the knee gave out.*" Px5 at 35 (emphasis added). Dr. Bresch testified that Petitioner did not report to him that she had an injury while excessively walking. *Id.*

Petitioner did not testify that she told anybody at Respondent that she was having any pain or symptoms from walking until after the incident on September 27, 2011. Petitioner testified that, after the incident, she told the assistant principal, Manda Lukic, that her "knee gave out because of all the extra walking that I'm not used to." T.28. We find this testimony to be self-serving and not supported by any medical opinion.

Although Dr. Bresch testified that the activity of walking was a contributing factor in her meniscal tear and treatment (Px5 at 20, 44), we note that he never testified that walking was a cause or contributing factor of her right knee giving out while getting out of the chair on September 27th. This is the date that Petitioner had "new pain" according to Dr. Bresch's testimony. This "new pain" required Petitioner to take the next day off work, per her testimony. This was a specific injury that occurred on that date.

Dr. Bresch also testified that "all walking counts" whether work-related or not (Px5 at 40) and that "what occurs is that the meniscus undergoes this maceration and changes, that just one little event like getting out of the chair as she reports, that unfortunately, causes that abnormal tissue to displace, and then once it's displaced, then we have this downward spiral that we have witnessed." *Id.* at 39. This again supports the inference that Dr. Bresch was relating Petitioner's condition of ill-being to the chair incident. Given the clear evidence of a specific incident, we do not find Dr. Bresch's repetitive trauma opinion about excessive walking, uncontradicted or not, to be persuasive.

Dr. Bresch further testified that the restrictions he gave Petitioner of no increased running, walking, standing, kneeling, squatting, and excusing her from lunch and recess duties, "had nothing to do necessarily with the etiology of her problem. Those restrictions are in place because that's what's aggravating the current condition regardless of what that diagnosis is. And that's not unusual for pretty much any condition of the knee." Px5 at 43-44. We find that the specific chair incident caused the need for her restrictions and treatment; not excessive walking.

As for the opinion of Dr. Cole, it is true that he did not render an opinion regarding "excessive walking." However, we find that this is because Petitioner was not truthful with him at the time of the examination. Or, at least, Petitioner did not give him the same story that she

17IWCC0645

gave to Dr. Bresch. Dr. Cole's June 27, 2013 report indicates, "She adamantly denies any previous problem with the affected right knee prior to the alleged date of injury of September 27, 2011. No discrete injury occurred that day, and she really describes that she was simply walking up stairs when she began to have pain thereafter. She describes that she 'may have been sitting too long, or standing' when she first noticed the pain as well.'"

We make three observations about this history. First, Petitioner's denial of any problems prior to September 27, 2011 is inconsistent with her testimony that she began having soreness within a few days after starting the school year on August 25th, which required her to elevate it, ice it and take ibuprofen when she got home. Second, Petitioner's description to Dr. Cole that "she was simply walking up stairs when she began to have pain thereafter" is inconsistent with her testimony that her knee gave out while getting out of a chair on September 27th and her report to Dr. Bresch on October 13th that her knee gave out three weeks prior. Third, Petitioner apparently did not mention anything about "excessive walking" for any length of time or that her job description had changed. Instead, she stated that it "'may have been sitting too long, or standing' when she first noticed the pain as well." It is not surprising that an examining physician would not address an issue, such as excessive walking, when the claimant is not truthful about when and how her pain began. Just because Petitioner, later in the examination, admitted to him that she actually had undergone a lateral unicompartmental knee replacement in 2002 does not change the fact that she initially tried to convey to Dr. Cole that she had no problems prior to September 27, 2011.

The bottom line is that we did not find Petitioner's testimony credible, nor supported by the evidence, that she was having pain with walking or performing her job duties prior to her specific incident getting out of the chair. And, she failed to prove that her "excessive walking" caused her knee to give out. The records are clear that it was the specific incident of getting out of the chair on September 27, 2011 that caused "new pain" for Petitioner, which required her to seek medical treatment.

We next turn to the issue of whether Petitioner getting up from a chair resulted in an accident that arose out of and in the course of her employment. While *Noonan* directs us to issue this decision in compliance with the circuit court's order, it is also instructive on the issue of accident. In *Noonan*, the claimant, while sitting in a chair, reached down to pick up a pen from the floor and the chair "went out" from underneath him, causing a right wrist injury. *Noonan* at 533. The Appellate Court wrote:

> We decline to find claimant's risk of injury in the present case was distinctly associated with his work for the employer. Instead, we find the risk of falling from a chair while reaching to the floor is one which claimant would have been equally exposed to apart from his work for the employer. Thus, it presents a neutral risk and is compensable only when claimant establishes he was quantitatively or qualitatively exposed to the risk to a greater degree than the general public. On appeal, claimant argues he was qualitatively subjected to a greater risk than that of the general public because he was injured while attempting to pick up a writing instrument that was essential to the completion of his job duties. Again, we disagree. *Id.* at 537.

We previously found that Petitioner's right knee giving out was a personal risk due to her prior knee condition. Even under a neutral-risk analysis, Petitioner engaged in an activity (rising

17IWCC0645

from a chair) to which the general public is equally exposed. There was no evidence that Petitioner engaged in that activity more frequently or that there was anything about this particular chair or workstation that exposed her to a greater risk. Whether rising from the chair was a personal risk or a neutral risk, we would find that Petitioner failed to prove that her injury arose out of and in the course of her employment.

We respectfully submit that our previous decision was not against the manifest weight of the evidence nor clearly erroneous, but, rather, based on a thoughtful determination of the facts and the reasonable inferences therefrom.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $666.67 per week for a period of 139-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses related to her medial meniscus tear under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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: OCT 13 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/30/17
49

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

NAHEED IQBAL,

Petitioner,

vs.

NO: 15 WC 28758

COMPASS GROUP,

17IWCC0646

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and 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, with the additions noted below.

Petitioner's own orthopedic surgeon, Dr. Templin, found no herniations on the MRIs and on March 21, 2016, wrote, "I see no structural abnormality that can be explained by this injury that would require surgical intervention." This is consistent with the December 17, 2015 opinion of Respondent's §12 examiner, Dr. Mather, that the MRIs showed no herniations or nerve root compression.

Although Petitioner went through months of treatment including physical therapy, MRIs, EMGs, medications, and injections, Dr. Mather opined that Petitioner's studies were normal, including the lower extremity EMG on September 30, 2015. He found Petitioner's mechanism of injury to be "suspect" and that she had no objective findings on examination or the studies. He did find "many, many positive nonorganic pain findings" and opined that she did not even have a valid medical diagnosis because she has "subjective complaints that are wildly out of proportion to her physical examination, objective findings, and her MRI findings." We find Dr. Mather's opinion to be persuasive.

17IWCC0646

We find that Petitioner failed to prove that any of the unpaid medical bills were reasonable and necessary based on our finding that Petitioner's subjective complaints were vastly out of proportion to her objective findings and considering the suspect nature of her mechanism of injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 2, 2016, is hereby affirmed and adopted with the additions noted above.

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: OCT 13 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 10/3/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

IQBAL, NAHEED
Employee/Petitioner

Case# **15WC028758**

COMPASS GROUP
Employer/Respondent

17IWCC0646

On 8/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0210 GANAN & SHAPIRO PC
JULIE M SCHUM
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0646

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

Naheed Iqbal
Employee/Petitioner

v.

Compass Group
Employer/Respondent

Case # **15** WC **28758**

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 **July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0646

FINDINGS

On **August 29, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,304.00**; the average weekly wage was **$352.00**.

On the date of accident, Petitioner was **54** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of **$1879.42** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$n/a**.

ORDER

THE ARBITRATOR FINDS THE OPINION OF DR. MATHER MORE CREDIBLE AND CONCLUDES THAT PETITIONER SUFFERED FROM A LUMBAR AND CERVICAL CONTUSION.

PETITIONER IS ENTITLED TO TTD BENEFITS FROM OCTOBER 24, 2015 THROUGH DECEMBER 17, 2015 – OR 7 6/7 WEEKS AT $286.00.

THE ARBITRATOR FINDS THAT PETITIONER SUSTAINED PERMANENT PARTIAL DISABILITY TO THE EXTENT OF 3% LOSS OF USE OF PERSON AS A WHOLE PURSUANT TO §8 OF THE ACT, OR 15 WEEKS AT $286.00 PER WEEK.

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

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

David A. Kane
Signature of Arbitrator

August 2, 2016
Date

AUG 2 – 2016

EFNaheed Iqbal v. Compass Group

15 WC 028758

Statement of Facts

Naheed Iqbal (hereinafter "Petitioner") was employed by Compass Group (hereinafter "Respondent") on August 29, 2015. Her duties at that time involved delivering food to customers and patients. On that date, she was standing near the dish room when Michael Koval came through the door and the door made contact with her. Petitioner testified that the door struck her entire spine, from her neck to her bottom. She further testified that she was pushed forward and had to grab onto a pillar for support.

Mr. Koval, who was also employed by Compass Group at that time and was arriving for work, testified that the door did bump Petitioner. He further testified that while it was a heavy door, it was early in the morning and he was not moving fast nor was he pushing the door with any significant force. Though he was not looking when he initially opened the door, he saw the door make contact to the back of Petitioner's shoulder. He testified that Petitioner did not stagger or have to grab on to anything in support. He asked if she was fine and testified that she told him she was ok.

Subsequent to the incident, after her shift ended, Petitioner went to the Alexian Brothers Occupation Health. She complained of pain in the back of her right shoulder. The pain diagram from this visit is consistent with that. She also noted some right flank pain. XRays were performed of her right shoulder which were negative and she was diagnosed with a

contusion to her shoulder. Medication and light duty restrictions were provided.

On August 31, 2015, Petitioner was seen by the family nurse practitioner, Elaine Shapiro, at Skypoint Medical Center on referral from her attorney. Petitioner complained of pain in her neck and back, reporting that her entire back was hit by the door. She was diagnosed with lumbago and cervicalgia for which MRI's and medication were recommended. No work restrictions were given in those records.

MRI's of the lumbar and cervical spine were performed on September 2, 2015. They were interpreted to show disc protrusion throughout the cervical spine with a 1-2 mm disc protrusion at C3-4 and C5-6 with effacement of the thecal sac. No spinal canal or neural foramina encroachment was noted at any level. The lumbar spine showed desiccation at L4-5 and 1-2mm disc protrusion at T12-L1 and 2-3mm protrusion at L4-5. Renal cysts were also noted.

On September 3, 2015, Petitioner was seen at Skypoint again. The medical record notes the encounter was performed and documented by Ariel Gabor, who is not licensed in any healthcare capacity in Illinois. The encounter was signed off on by Elaine Shapiro, the nurse practitioner, but does not indicate that Ms. Shapiro at any point examined Petitioner, saw her, or otherwise participated in this visit. It should also be noted that the Skypoint records area for current complaints indicate Petitioner is 74 years old and are identical in every word to her first visit. At that point, Petitioner was diagnosed with protrusions at T12-L1, L4-5, C3-4 and C5-6 as well as lumbago, cervicalgia, and renal cysts. Medication and pain management were prescribed. Again, no work restrictions are provided.

An EMG of the lower extremities was performed on September 30, 2015. It was interpreted to show right S1 lumbar spine radiculopathy. An EMG of the left upper extremity was performed on October 14, 2015. It was interpreted to be normal.

Petitioner was again seen by Ms. Shapiro at Skypoint on October 19, 2015, for continued complaints of pain. Her diagnosis at that point was only lower back pain with no complaints of radiation. She was referred for physical therapy at that time. No work status is noted in the records at this time.

Dr. Naseeruddin, who specializes in internal medicine, saw Petitioner on October 24, 2015. At that point, though her pain had been at 5/10 on the 19th, he notes her pain at 9/10. She complained only of back pain at that time. He diagnosed Petitioner with disorder of the lumbar disc and lower back pain for which he recommended pain management, physical therapy and orthopedic evaluation. At that time, he took Petitioner off of work.

Dr. Assan evaluated Petitioner on referral from the nurse practitioner on November 6, 2015. Petitioner reported pain in her neck radiating down to her hand and pain in her lower back sometimes radiating to her knees. He recommended a cervical ESI at that time.

On December 1, 2015, Petitioner underwent a lumbar steroid injection to L4-5. Based upon her testimony, the injection actually increased Petitioner's pain and provided no relief. A second lumbar steroid injection was performed on February 4, 2016. Petitioner reported improvement at her March follow up. Petitioner remained off work per Dr. Naseeruddin at that time. Petitioner has not returned to Skypoint Medical since April 2016.

On March 21, 2016, Petitioner was evaluated by Dr. Templin. There is no referral in the records at that point. Petitioner reported being hit in the back with a door and complained of pain in her neck that occasionally extended to her back. She complained of pain at 9/10 and indicated that neither therapy nor injections had provided relief. Dr. Templin reviewed the MRI's and opined that Petitioner had no significant stenosis in either her neck or back though he noted a transitional segment at S1-2 and desiccation at L5-S1. He opined specifically that there was no structural abnormality in her spine that could be explained by her injury that would require surgical intervention. He diagnosed degenerative disc disease in the lumbar spine with cervical spondylosis without myelopathy and cervical and lumbar sprain.

Though Petitioner stated that she had been to the emergency room relative to this incident in 2016, no records pertaining to that were submitted into evidence.

On December 17, 2015, Petitioner was evaluated by Dr. Mather, a board certified orthopedic surgeon specializing in the spine, for an IME. Petitioner reported that she was bent over at approximately 30-35 degrees when a coworker entered and she was hit in the back with the door. She asserted that it contacted her "entire spine." When asked how this could occur, Petitioner reportedly could not explain it. Petitioner told Dr. Mather that she previously ran a daycare in her home but closed it in 2010. Notably, during testimony, Petitioner testified that she ran that daycare only for a year from 2007-2008.

On examination, Petitioner reported no numbness in her right leg but did complain of leg pain. He noted she complained of pain with even very

light palpation. He described her as complaining of pain with "less pressure than I would need even to blanch a fingernail." Petitioner also "nearly collapses" because of complaints of pain but is able to perform those rotations when she reached down to grab something out of her purse. She also complained of pain throughout her entire spine with light axial compression to the top of her head. Dr. Mather reviewed the MRI's and opined that they showed age appropriate changes with no nerve root compression or any signs of disc herniation or nerve root impingement. He diagnosed Petitioner with a spinal contusion to the cervical and lumbar spines with psychogenic pain/functional overlay. He concluded her symptoms did not correlate with the physical exam and MRI findings. He listed 7 specific non organic pain findings and opined that her complaints were "wildly" out of proportion to her physical exam. He concluded she was at MMI from the contusions and could return to work without restrictions.

Conclusions of Law

The foregoing statement of facts is hereby incorporated into every section of the Conclusions of law.

With regards to "F", is Petitioner's current condition related to the injury, the Arbitrator finds as follows:

The Arbitrator finds the opinion of Dr. Mather to be persuasive. Based upon that opinion, the Arbitrator concludes that Petitioner suffered from a lumbar and cervical spine contusion for which she had reached MMI by December 17, 2015.

In making this finding, the Arbitrator notes that numerous inconsistencies in Petitioner's testimony and the medical records. Petitioner testified that she was struck so hard by the door in the spine that she stumbled and had to grab onto a pillar. Michael Koval saw the door contact the back of her shoulder and testified that he did not see Petitioner stumble or have to grab onto anything. His testimony that it struck the back of her shoulder is also consistent with the first medical record which both in the narrative and the diagram reflect that the door made contact with the back of her shoulder.

The Arbitrator finds Mr. Koval's testimony relative to the incident itself to be more credible than Petitioner's. The Arbitrator notes that the medical records support Mr. Koval's version of events and Petitioner's testimony contain several inconsistencies – such as the fact that she testified to having a daycare business in her home for a year ending in 2008 but told Dr. Mather she sustained that business through 2010 as well as the fact that Petitioner testified that she has been to the emergency room subsequent to the initial date of accident but presented no supporting medical records for that fact. During her IME with Dr. Mather, he noted 7 different substantial non organic complaints and specifically noted her complaints were "wildly" out of proportion to her physical findings and diagnostic testing.

The Arbitrator also notes that Petitioner's reports of pain, both in degree and location, vary throughout her medical reports. There are no complaints of radiculopathic pain when she is seen by the nurse practitioner or the internal medicine physician – those complaints only appear when she goes for an EMG and when she is seen for an injection.

The Arbitrator also notes that the medical records do not reflect an actual order for an EMG and the EMG of the left upper extremity was performed even though the records to that point do not reflect any complaints of left upper extremity pain or radiation from the neck.

The Arbitrator also notes that the opinion of Dr. Mather is consistent with the opinion of Dr. Templin, the spinal surgeon Petitioner chose to be evaluated by. Dr. Templin concluded that Petitioner suffered from a sprain and opined she had no structural abnormalities in her spine. This is also consistent with the diagnostic testing including the EMG of the left upper extremity which was normal and the EMG of the lower extremity which showed radiculopathy at a level which was not indicated on the MRI.

Given all of the above, the Arbitrator finds the opinion of Dr. Mather – that Petitioner suffered from a lumbar and cervical contusion – to be the most credible. Petitioner reached MMI as of December 17, 2015 and her current condition is not causally related to the work incident.

With regards to "j", were the medical services provided to Petitioner reasonable or necessary, the Arbitrator finds as follows:

As noted with regards to causal connection, the Arbitrator finds the opinion of Dr. Mather persuasive and concludes that Petitioner suffered from a contusion to her cervical and lumbar spines for which she was at MMI at the December 17, 2015 visit. Given this, all medical rendered subsequent to that date is not causal related to Petitioner's work incident.

Relative to the medical treatment rendered prior to that date, the Arbitrator notes that Petitioner herself testified that the physical therapy did

not improve her condition. In fact, her complaints significantly increased to the point where her pain had returned to a reported 9/10 when she was seen by Dr. Templin. Under the Illinois Workers' Compensation Act, the employer is only liable for treatment which is required to "cure or relieve" Petitioner's condition. The physical therapy rendered by Skypoint Medical did neither by Petitioner's own testimony and therefore was not required to cure or relieve Petitioner's condition.

The Arbitrator also notes that at least one visit at Skypoint, from September 3, 2015, according to their own records, was not conducted by a medical professional of any kind. Nor is there any medical record providing an order for the two EMG's which were performed in September of 2015. Given this, the Arbitrator concludes that visit and the two EMG's were not reasonable or necessary for the treatment of Petitioner's condition.

With regards to "K", is Petitioner entitled to any additional TTD, the Arbitrator concludes as follows:

Based upon the medical records submitted into evidence, on the date of accident, Petitioner was placed on light duty work. She testified that returned to work even though she felt it was painful. When she began treatment at Skypoint, no medical restrictions were noted in their records until October 24, 2015, at which point Petitioner was taken off work.

Based upon that and the opinions of the Arbitrator as noted above with regards to causal connection and medical care, the Arbitrator

concludes that Petitioner was entitled to TTD benefits from October 24, 2015 through December 17, 2015.

With regards to "L", what is the nature and extent of the injury, the Arbitrator concludes as follows:

Given Petitioner's date of accident, she is entitled to have the Arbitrator consider the five factors as noted in Section 8.1b(b) of the Act. With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator concludes that Petitioner suffered from a lumbar and cervical contusion as noted by Dr. Mather. There is evidence in the records that Petitioner significantly exaggerated her complaints of pain. Dr. Mather concluded that Petitioner was at MMI and capable of working at full duty. Given this, the Arbitrator therefore gives no weight to Petitioner's evidence of continuing disability.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a minimum wage, unskilled, food service worker at the time of the accident and that she is able to return to work in her prior capacity pursuant to the opinion of Dr. Mather.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 54 years old at the time of the accident. With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that pursuant to the opinion of Dr. Mather, Petitioner is

capable of returning to work at a full duty capacity. Petitioner testified that she has not sought to return to any work since the IME. Petitioner presented no other evidence that Petitioner's future earnings capacity is in any way impaired.

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 3% loss of use of person as a whole pursuant to §8.1(b) of the Act.

WITH REGARDS TO "N", IS RESPONDENT DUE ANY CREDIT, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Based upon the payment screens submitted by Respondent, the Arbitrator concludes that Respondent is entitled to a credit of $1879.42.

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

William Dearing,
Petitioner,
vs. NO: 14WC 10773

Mason County,
Respondent.

17IWCC0647

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 30, 2016, is hereby affirmed and adopted.

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

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

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

DATED: OCT 16 2017
MJB/bm
o-10/3/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEARING, WILLIAM
Employee/Petitioner

Case# **14WC010773**

MASON COUNTY
Employer/Respondent

17IWCC0647

On 11/30/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0834 KANOSKI BRESNEY
CHARLES EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0000 INMAN & FITZGIBBONS LTD
FRANK G JOHNSON ESQ
301 N NEIL ST SUITE 350
CHAMPAIGN, IL 61820

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIAM DEARING,
Employee/Petitioner

v.

MASON COUNTY,
Employer/Respondent

Case # 14 WC 10773

Consolidated cases:

17IWCC0647

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **11/10/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0647

FINDINGS

On **1/24/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,426.40**; the average weekly wage was **$815.89**.

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

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services for petitioner's left forearm from 1/24/13 through 4/23/13, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $489.53/week for 18.975 weeks, because the injuries sustained caused the 7.5% loss of the left arm, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

11/28/16
Date

NOV 30 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 45 year old highway maintenance work, sustained an accidental injury to his left forearm that arose out of and in the course of his employment by respondent on 1/24/13. Petitioner testified that on 1/24/13 he and a coworker were lifting a 200 pound poly tank filled with some water. When petitioner lifted up his corner of the tank, a coworker lifted his corner and 25-50 gallons of water rushed to the corner petitioner was holding. Petitioner felt a pop in his left forearm just below the elbow. He testified that he experienced a sharp knife like pain in his left forearm. Petitioner continued working that day with a chainsaw. Petitioner denied any prior problems with, or treatment for, his left forearm.

After work petitioner sought treatment for his injury at the emergency room at Mason District Hospital. Petitioner gave a history of a 50 pound barrel falling onto his left forearm. He complained of sharp pain in his left forearm. He rated his pain at a 10/10. No bruising or deformity was noted. X-rays were taken that showed no definite fracture involving the radius or ulna. Petitioner was diagnosed with a contusion of the upper extremity. He was also given a sling and referred to his primary care physician.

On 1/28/13 petitioner presented to Dr. Markley for follow-up of a muscle strain of the left forearm. Petitioner was not wearing his sling. He stated that it hurt worse wearing the sling. He also stated that he had not been icing the area. He complained of pain in the anterior forearm up towards the elbow with twisting his hand back and forth. He stated that this seemed to increase the pain. He denied any elbow or bicep pain. Dr. Markley examined petitioner and assessed a strain/sprain, most likely supinator. He noted that the biceps was normal. He restricted petitioner to lifting no more than 5 pounds with the left arm. On 2/5/13 petitioner reported that he gained a little bit better range of motion. He still reported a lot of pain with pronation. Petitioner's supination improved, but his grip strength was lacking secondary to pain. Dr. Markley noted that petitioner was slowly improving but his restrictions should continue for the next 2 weeks. On 2/21/13 petitioner reported that he had not had much improvement holding things. Dr. Markley ordered a course of physical therapy. His assessment remained strain/sprain of the left pronator muscle. He continued petitioner's restrictions.

Petitioner began a course of physical therapy at Rehabilitation Services beginning on 3/4/13 for a sprain/strain of his left forearm. On 3/26/13 petitioner followed-up with Dr. Markley. Petitioner reported some improvement with therapy. He reported that he still had significant pain with arm flexion with weight, but was improving. Dr. Markley continued petitioner on light duty. On 4/5/13 the therapist noted that the petitioner was making slow progress per his reported pain levels.

On 4/23/13 petitioner returned to Dr. Markley. He reported that he had some significant improvement and was doing a lot better with range of motion and weight and felt that he was ready to return to full duty work without restrictions. Dr. Markley noted that petitioner still had some mild pain with extreme supination but had improved strength and range of motion. Dr. Markley noted that petitioner was improved. He released him to full duty. He instructed petitioner to be mindful on lifting techniques. At trial, petitioner testified that he requested this full duty release at the request of his employer.

On 7/26/13 petitioner presented to Dr. Markley for a sore throat. He also reported some snoring and sleeping issues. Petitioner made no complaints of any left forearm problems. Dr. Markely ordered a polysomnography.

On 8/16/13 petitioner underwent an overnight polysomnography for his sleep apnea. As part of this process he completed a Questionnaire. On that questionnaire, #6 asked petitioner to check the box for any parts of the body where he was having physical complaints at that time. The only boxes he marked were neck pain and back pain. He did not check the box for arm pain. At trial, petitioner testified that he did not mark the arm box because it was not related to his sleep.

From 4/23/13 through 8/16/13 petitioner worked his regular duty job for respondent without any issue or further treatment.

Petitioner quit working for respondent on 8/16/13. He testified he quit working for respondent because he thought he had a job in Texas working for the highway department. Petitioner testified that when he got down to Texas there was no job, and he eventually returned to Illinois in October of 2013. Petitioner testified that he did not work in Texas.

After petitioner returned to Illinois, he got a job with Fornoff Fertilizer on 11/15/13. Petitioner drives a spray applicator truck. Petitioner drives a truck that applies fertilizer to the fields. Petitioner testified that this job requires a lot of turning of the steering wheel with his left arm. He testified that he does this all day. He testified that he can start as early as 5:00 am and work into the night.

On 12/19/13 petitioner returned to Dr. Markley for a DOT physical. He reported that he was employed by Fornoff Fertilizer. Petitioner denied any acute concerns or complaints. Petitioner denied any joint pain, joint swelling, muscle pain, limitation of motion, or muscular weakness. On the Medical Examination Report for Commercial Driver Fitness Determination, completed by petitioner on 10/19/13, petitioner indicated that he did not have any missing or impaired hand, arm , foot, leg, finger, or toe.

On 3/11/14 petitioner returned to Dr. Markley to discuss continued pain in the left forearm. He reported pain more in the upper forearm in the supinator muscle area. Petitioner reported pain with supination and biceps flexion with his palm up. Dr. Markley noted that petitioner was seen a year ago and was doing great with physical therapy and was released back to full duty at work. Petitioner reported that since then he had actually quit his job, moved to Texas for awhile and then moved back. Petitioner reported that he now has another job and with that job he does some lifting and he was having a hard time lifting anything above15 pounds in that type of curling motion. He denied any pain in the biceps area or even the biceps tendon area. He reported that the pain seemed to be in the proximal forearm in the anterior region. He denied any decreased range of motion or any other traumas or injuries. Dr. Markley referred petitioner for an orthopedic evaluation.

On 3/19/14 petitioner underwent some x-rays of the left elbow. Petitioner reported left elbow pain anteriorly for several months, unable to lift more than 15 pounds. The impression was no osseous abnormality, and round focus of increased opacity within the anterior aspect of the left elbow joint space.

On 3/24/14 petitioner presented to Dr. Drake White for a chief complaint of left proximal volar forearm pain. He gave a history of an injury to his left forearm in January of 2013 when he and 2 others were holding a 100 gallon polyethylene brine tank that was partially full of liquid. He stated that when one of the others lifted his end of the tank, all the fluid drained rapidly toward his end of the tank. He reported some improvement with physical therapy, but said he has had ongoing pain since then. He was able to curl 15 pounds at the end of physical therapy. He also reported intermittent tingling in his fingers since the injury. He stated that he lacks strength in his left arm. Dr. White reviewed x-rays and examined petitioner. His impression was left forearm pain one year after injury. An MRI of the left forearm and elbow was ordered, as well as an EMG.

On 5/8/14 petitioner underwent an MRI of the left elbow. The impression was no acute findings in the elbow; slight ulnar nerve prominence and edema. It was noted that there should be correlation for symptoms of mild carpal tunnel. An EMG revealed moderate to severe left median neuropathy at the left carpal tunnel and moderate to severe left ulnar neuropathy at the cubital tunnel. Dr. White recommended a left carpal tunnel release and anterior transposition of the left ulna nerve at the cubital tunnel. Petitioner underwent these surgeries on 6/27/14 by Dr. White, followed by occupational therapy. He was release to full duty work on 9/15/14. (Petitioner is not alleging left carpal tunnel or left cubital tunnel conditions are related to injury on 1/24/13).

On 2/16/15 petitioner last followed-up with Dr. White. Petitioner reported pain in his volar proximal forearm which was unchanged over the last two years. He reported numbness in his hand after a 14 hour drive to and from Texas. He also reported some pain in the medial aspect of his left elbow. Dr. White was of the

opinion that petitioner had reached maximum medical improvement. He noted that petitioner will probably always have pain in the volar forearm, but the cause of that pain is unknown given his negative MRI. Dr. White instructed petitioner to continue his current activity including working without restrictions. He released petitioner from his care.

On 8/14/15 petitioner presented to Dr. Tad Vetter. Petitioner complained of ongoing pain in left forearm since injury on 1/23/13. Petitioner complained of pain when driving a truck or doing any lifting. Dr. Vetter made no recommendations with respect to petitioner's left arm. He did make recommendations regarding petitioner's unrelated problems.

On 8/24/15 petitioner presented to Dr. Ashkon Razavi for an initial evaluation of his elbow problem. Petitioner reported pain and an inability to hold weight. He complained of numbness in the upper extremity. Dr. Razavi examined petitioner and reviewed x-rays and MRI of the left elbow. He assessed left elbow pain, partial distal biceps avulsion, likely compression of the ulnar nerve at the right elbow, and likely compression of the median nerve at the level of the right carpal tunnel.

On 8/26/15 petitioner underwent an EMG for his left forearm pain and intermittent tingling in both hands. The tests were within normal limits.

On 9/4/15 petitioner returned to Dr. Ashkon Razavi complaining of a gradual onset of constant episodes of moderate bilateral elbow problem. Dr. Razavi noted that petitioner's symptoms are caused by no known event. He believed petitioner's pain was attributable to the partial biceps tear. He recommended physical therapy.

Petitioner underwent a physical therapy evaluation on 9/14/15. On 10/19/15 petitioner followed-up with Dr. Razavi. Petitioner reported that physical therapy had been helping. Dr. Razavi assessed elbow pain, and partial tear of the left distal biceps tendon with much improvement symptomatically after therapy. He released petitioner on an as needed basis.

Petitioner was discharged from physical therapy on 11/20/15. Petitioner reported that his arm had been good. He reported that could now hold his 16 pound bowling ball without any discomfort. He reported that he is "a hell of a lot better".

On 2/22/16 petitioner returned to Dr. Razavi for what he believed was a partial tear of the left distal biceps tendon. Petitioner had tenderness to palpation along the distal potion of the biceps tendon. Dr. Razavi's assessment was elbow pain, and likely partial tear or avulsion of the distal left biceps tendon, versus biceps tendon tendinitis. Dr. Razavi ordered a left elbow MRI. He told petitioner to avoid activities that cause or worsen pain.

On 3/1/16 petitioner underwent an MRI of the left elbow. The impression was postsurgical changes compatible with cubital tunnel release surgery, intact appearing tendons and ligaments, and no acute findings in the elbow.

On 3/11/16 petitioner last followed-up with Dr. Razavi. Petitioner complained of a gradual onset of intermittent episodes of moderate elbow problems. He stated that his symptoms were worsening. He complained of decreased range of motion, painful pronation or supination and tenderness, but no elbow bruising, no difficulty extending the elbow, and no difficulty flexing the elbow. Dr. Razavi assessed left elbow pain and proximal forearm pain of unknown etiology. Dr. Razavi released petitioner on an as needed basis.

Petitioner testified that currently his left forearm hurts every day. He testified that it hurts most when he is driving the truck at work. He stated that when he is operating equipment at Fornoff Fertilizer he has constant pain in his left forearm. He stated that the left to right motion of steering the wheel is what aggravates his condition. Petitioner testified that he cannot lift heavy objects or tighten bolts with left arm. Petitioner is right hand dominant. Petitioner no longer golfs, plays softball or bow hunts. He stated that when he does this he has sharp pain in his forearm.

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

Petitioner claims his current condition of ill-being as it relates to his left forearm is causally related to his injury on 1/23/13. Respondent claims that petitioner's current condition of ill-being as it relates to his left forearm is not causally related to the injury on 1/23/13. The respondent claims petitioner's current condition of ill-being as it relates to his left forearm is only causally related to the injury on 1/24/13 through 4/23/13.

Following the injury on 1/23/13 petitioner received treatment for his left forearm at the emergency room of Mason District Hospital on 1/23/13. He was diagnosed with a contusion of the upper extremity. On 1/28/13 he presented to Dr. Markley, who diagnosed a strain/sprain, most likely supinator. Petitioner denied any elbow or biceps pain. Dr. Markley noted that petitioner's biceps was normal. On 2/21/13 Dr. Markley diagnosed a strain/sprain of the left pronator muscle. Petitioner reported improved supination, but reported his grip strength was lacking secondary to pain.

Petitioner underwent a course of physical therapy for his complaints, and on 4/23/13 he returned to Dr. Markley and reported that he had some significant improvement and was doing a lot better with range of motion and weight and felt that he was ready to return to full duty work. He noted that petitioner still had some mild pain with extreme supination, but had improved strength and range of motion. At trial, petitioner testified that

his request to return to full duty work was because he employer asked him to get that. However, the arbitrator finds the petitioner offered no credible evidence to support this claim.

After 4/23/13 petitioner returned to work for respondent and worked without incident or any further treatment for his left forearm through 8/16/13, the date he quit working for respondent, in order to go to Texas for a job with the highway department. During this period petitioner presented to Dr. Markley on 7/26/13 for a sore throat and made no mention of any left forearm problems. Petitioner completed a questionnaire for a sleep study on 8/16/13 and did not identify and current complaints related to his left arm, even though he did identify back and neck issues.

After petitioner quit working for respondent he went to Texas for the highway job, but there was none. In October of 2013 he returned to Illinois. On 11/15/13 he began working as a driver of a spray applicator truck for Fornoff Fertilizers. Petitioner testified that this job required a lot of turning of the steering wheel with his left arm all day. He testified that some days he starts as early as 5:30am and works into the night. Petitioner stated that his arm hurt most when he drives the truck for Fornoff Fertilizer. He stated that the left to right motion of the steering wheel aggravates his condition.

Despite these complaints, when petition underwent a DOT physical on 12/19/13 for the job at Fornoff Fertilizer, he denied any joint pain, joint swelling, muscle pain, limitation of motion, or muscular weakness. He also denied any missing or impaired hand, arm, foot, leg, finger, or toe.

Petitioner sought no further treatment until 3/11/14. He reported more pain in the upper forearm in the supinator muscle area. He also reported pain with supination and biceps flexion. At that time, Dr. Markley noted that petitioner was seen a year ago and was doing great. Petitioner again denied any pain in the biceps area or even the biceps tendon area.

Dr. Markley referred petitioner to Dr. White. Petitioner told Dr. White on 3/19/14 that the onset of his pain was several months ago. Dr. White ordered an EMG and MRI. The EMG revealed moderate to severe left carpal tunnel and cubital tunnel, for which petitioner underwent surgical repair on 6/27/14. Petitioner was released to full duty work on 9/15/14. Petitioner claims these conditions are not related to the injury petitioner sustained on 1/24/13.

Petitioner continued working for Fornoff Fertilizer and did not seek any further treatment until 8/14/15. He saw Dr. Vetter that day, but Dr. Vetter made no recommendations. On 8/24/15 he began treating with Dr. Razavi for a left elbow problem. Dr. Razavi assessed left elbow pain, partial distal biceps avulsion, likely compression of the ulnar nerve at the right elbow and likely compression of the median nerve at the level of the

right carpal tunnel. On 9/4/15 petitioner returned to Dr. Razavi and complained of a gradual onset of constant episodes of moderate bilateral elbow problem. Dr. Razavi noted that petitioner's symptoms were not caused by a known event. On 11/20/15, after a course of physical therapy, petitioner reported that his arm was good and he could hold his 16 pound bowling ball without any discomfort.

The arbitrator finds it significant that even though Dr. Razavi diagnosed a likely partial tear or avulsion of the distal left biceps tendon, an MRI performed 3/1/16 showed intact appearing tendons and ligaments. The arbitrator also finds it significant that both Dr. White and Dr. Razavi were of the opinion that petitioner's forearm pain was of an unknown etiology. Additionally, the arbitrator finds it significant that when petitioner treated with Dr. Razavi on 9/4/15 he gave a history of a "gradual" onset of constant episodes of moderate bilateral elbow pain, which is inconsistent with petitioner's original history of a sudden onset of left forearm pain following a lifting injury on 1/24/13. Additionally, when petitioner presented to Dr. White on 3/19/14 he gave a history of pain in his forearm for only several months, which would coincide with the time he started working for Fornoff Fertilizer.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his left arm is causally related to the injury he sustained on 1/24/13. The arbitrator finds the petitioner's current condition of ill-being as it relates to his left forearm is causally related to the injury on 1/24/13 only through 4/23/13. The arbitrator finds that after reaching maximum medical improvement on 4/23/13, petitioner denied any problems with his left arm, and sought no treatment for his left arm until almost a year later on 3/11/14, after he had been working for Fornoff Fertilizer for at least 3 months and complained of several month history of forearm pain, and that the driving of the truck for Fornoff Fertilizer since November of 2013 is what caused him the most pain. It was also after 4/23/13 that petitioner underwent unrelated left carpal tunnel release and left cubital tunnel release, and continued to have residual problems. For these problems petitioner resumed treatment in February of 2015, and then again in August of 2015. At that time petitioner's chief complaints were with respect to his left elbow, not his forearm.

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 his left forearm is causally related to the injury on 1/24/13 only through 4/23/13, the arbitrator finds that only the medical services provided to petitioner through 4/23/13 were reasonable and necessary to cure or relieve petitioner from the effects of his

injury on 1/24/13. The arbitrator finds all medical treatment petitioner received after 4/23/13 was not reasonable and necessary to cure or relieve petitioner from the effects of his injury on 1/24/13.

Respondent shall pay reasonable and necessary medical services for petitioner's left arm from 1/24/13 through 4/23/13, as provided in Sections 8(a) and 8.2 of the Act. Respondent is not responsible for any medical services after 4/23/13. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act

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

As a result of the injury on 1/24/13 petitioner sustained a strain/sprain of the left pronator muscle.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, petitioner was a highway maintenance worker for respondent. On 4/23/13 petitioner was released to full duty without restrictions, and returned to full duty work for respondent. Petitioner continued to work for respondent without incident or any further treatment for his left forearm through 8/16/13, the day he quit working for respondent in order to go to Texas for another highway department job. Petitioner did not get that job and eventually returned to IL, and began working full duty for Fornoff Fertilizer on 11/15/13. Based on these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Since the accident petitioner has been released to full duty work without restrictions, returned to full duty work for respondent until quitting for another job on 8/16/13. Although the other job fell through, petitioner began working full duty for Fornoff Fertilizer on 11/15/13 and continues to work in that capacity. Based on these findings, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that petitioner offered no evidence that his future earnings have been diminished. In fact, he did not even offer any evidence with respect to his future earnings capacity. Because of this the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator adopts the findings and opinions of Dr. Markley on 4/23/13. At that time petitioner

reported that he had significant improvement and was doing a lot better with range of motion. Dr. Markely returned petitioner to full duty work without restrictions and petitioner worked in that capacity without any further treatment until he quit working for respondent on 8/16/13. Additionally, petitioner sought no further treatment for his left arm until after he had been driving a spray fertilizer truck for Fornoff Fertilizer all day for months. Petitioner even testified that his left forearm hurts most when he is steering the wheel of the fertilizer spray truck for Fornoff Fertilizer. When Dr. Markely saw petitioner on 4/23/13 he noted that petitioner still had some mild pain with extreme supination, but had improved strength and range of motion. Dr. Markley's diagnosis was a strain/sprain of the left pronator muscle. Even additional testing years later showed no tear of any muscles or tendons.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of 7.5% loss of use of his left arm, pursuant to §8(e) 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

Stephen Hann,
Petitioner,
vs.

NO: 15WC 19122

Walgreens,
Respondent.

17IWCC0648

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent, herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitioner permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 16 2017
MJB/bm
o-10/3/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANN, STEPHEN
Employee/Petitioner

Case# **15WC019122**

WALGREENS
Employer/Respondent

17IWCC0648

On 3/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0180 EVANS & DIXON LLC
MICHAEL A KARR
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102-2727

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
NATURE AND EXTENT ONLY

STEPHEN HANN
Employee/Petitioner

v.

WALGREENS
Employer/Respondent

Case # 15 WC 19122

Consolidated cases: _____

17IWCC0648

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **February 2, 2017**. By stipulation, the parties agree:

On the date of accident, **January 28, 2015**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$38,435.51**, and the average weekly wage was **$739.14**.

At the time of injury, Petitioner was **65** 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 **$5,561.15** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,561.15**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$443.48 per week** for 125 weeks, because the injuries sustained caused permanent disability to the extent of **25% of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **November 9, 2016** through **February 2, 2017**, 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

March 17, 2017
Date

ICArbDecN&E p.2

MAR 24 2017

STATEMENT OF FACTS

Petitioner, 65 years old, worked for Respondent as a 15 year split case stocker at their distribution center. The parties have stipulated that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 1/28/15. On that date, he was lifting a 30 to 40 pound tray of dog food to a higher shelf and developed neck pain that went into his left arm and hand. Petitioner testified that he had no cervical treatment, testing or workers compensation claims prior to 1/28/15.

The split case stocker job involves opening boxes on a conveyor, and then stocking the shelves so the pickers can take the items. The Petitioner is right handed.

After initially being evaluated at Respondent's Work Injury Solutions clinic, he visited his primary care physician, Dr. Amorado, on 2/6/15. He reported an immediate burning sensation in his neck and radiating down

the left arm to the fingers at the time of the 1/28/15 accident, extending into his small finger. (Px3). Dr. Amorado referred Petitioner for an orthopedic evaluation, and he saw Dr. Smith on 2/26/15. Dr. Smith noted that Petitioner reported a sudden onset of worsening, constant pain in the left neck and upper left shoulder at the time of the accident, with numbness and tingling in the left medial forearm, dorsal forearm as well as his left ring and little fingers. Examination indicated decreased cervical flexion/extension, tenderness to palpation of the left cervical facets/paraspinals and trapezius, and significant weakness of the left hand intrinsic muscle with early signs of claw hand and decreased sensation to touch over the left forearm and fingers of the hand. X-rays showed degenerative disc disease from C4 through C7 as well as multilevel degenerative facet joint disease. MRI, EMG, medication and physical therapy were prescribed. Petitioner was allowed to continue to work regular duty based on his indication that he was able to do so. (Px4).

The 3/5/15 cervical MRI showed multilevel degenerative cystic changes of the cervical spine with long segment canal stenosis, most prominent at C4-5 and C5-6. At C2/3, there was moderate to severe left neuroforaminal narrowing with probable encroachment on the left C3 nerve root and advanced left facet arthrosis. At C3/4, there was moderate to severe left neuroforaminal stenosis with probable encroachment on the left nerve root. At C5/6, there was severe bilateral neuroforaminal narrowing with encroachment on the C6 nerve roots. At C6/7, there was no specific additional findings. At C7/T1, there was a disc bulge contacting the ventral cord, and a left foraminal disc extrusion causing severe left neuroforaminal stenosis and encroachment on the left C8 nerve root. (Px4)

EMG/NCV was performed by Dr. Chow on 3/5/15. Petitioner reported continued neck and left extremity pain as well as weakness in the left hand and fingers. He noted intermittent numbness and tingling in his hands for years, but sudden onset of left neck and arm pain and numbness after the work accident. The testing suggested possible subacute left C8 radiculopathy superimposed with old left C7 radiculopathy, mild bilateral carpal tunnel syndrome without denervation in the thenar muscles, and no evidence of ulnar neuropathy bilaterally. (Px4).

At a 3/13/15 follow up, Petitioner reiterated that he had left neck pain but that weakness of the left hand was his primary concern, and that this was a new onset with the accident, otherwise noting only transient and brief numbness and tingling in the hands over the prior several years. Dr. Smith reviewed the MRI and opined that Petitioner may have subacute left C8 radiculopathy due to left C7-T1 foraminal disc herniation superimposed with old left C7 radiculopathy, since Petitioner had MRI evidence of left C6-7 posterior lateral disc herniation. Petitioner was referred to Dr. Kovalsky for a surgical consultation. Dr. Smith also recommended occupational therapy to strengthen the left hand and left arm, as well as a series of two cervical epidurals. Petitioner was allowed to return to work at regular duty. (Px4).

Cervical epidural was performed by Dr. Smith at C7/T1 on 4/1/15. (Px4).

Petitioner saw orthopedic surgeon Dr. Kovalsky on 4/4/15. Petitioner indicated continued complaints of left sided neck pain with radiation to the left arm and numbness and tingling in the left arm and hand. Neurologic exam noted decreased sensation and grip strength in the left hand, and no indication of peripheral nerve compression. X-rays and MRI were reviewed. Dr. Kovalsky noted an acute left sided herniation at C7/T1 which was clearly causing compression of the C8 nerve root, and a herniation / osteophyte complex at C6-7. Dr. Kovalsky recommended a two-level anterior cervical discectomy and inter-body fusion at C6/7 and C7/T1. He noted weakness in the C8/T1 ennervated muscle groups, and that surgery should resolve his pain and weakness, though the weakness would take months to improve. He was allowed to continue full duty work pending surgery. (Px4 & 5).

Dr. Kovalsky performed surgery on 6/22/15. This involved anterior cervical discectomy, epidural decompression, bilateral foraminotomies at C6/7 and C7/T1, interbody fusions from C6/7 to T1, and local bone grafting and plating. The report notes that disc material was found in the left foramen at both disc levels, as well as a defect in the left posterior longitudinal ligament. The spurring at C6/7 was noted to be mild, and less uncovertable hypertrophy degeneration was noted at C7/T1 than at C6/7. The pre- and post-operative diagnoses were a left-sided herniated disc at C6/7 with radiculopathy and left-sided herniated disc at C7/T1 on the left with radiculopathy and grip weakness. (Px5).

Following surgery, Petitioner's neck and arm pain and numbness improved, but he had persistent complaints of weakness in the fourth and fifth digits of his left hand with a claw deformity which caused him to frequently drop things. (Px4) When Dr. Kovalsky released Petitioner at maximum medical improvement on 11/9/16, he noted that post-operative therapy improved some of Petitioner's symptoms, but that he still continued to have cramping in his left hand with activity, along with an occasional stabbing pain in the left side of his neck. On 9/2/15 a TENS unit was prescribed, and Petitioner was released to regular duty as of 9/9/16. On 11/6/15 he developed some numbness and tingling in the right 4th and 5th fingers with weakness, which Dr. Kovalsky noted could be some C8 radiculopathy. X-rays at that time noted the fusion was healing. (Px4) Physical examination demonstrated chronic decreased left triceps reflex. Petitioner was released to return to work full duty as a split case picker. Dr. Kovalsky noted on 8/5/15 that whatever function the Petitioner had a year after surgery was likely to be permanent.

On 1/8/16, Dr. Kovalsky indicated Petitioner's neck and radicular pain had resolved, but there was still weakness in the 4th and 5th, which was related to the C7 to T1 radiculopathy. He was recommended to be fitted for a night splint, as well as a TENS unit to be able to stop formal therapy after 3 more weeks. (Px4). The last therapy note of 2/1/16 noted ongoing clawhand deformity and instruction regarding a home exercise program. (Px6).

Petitioner was examined by orthopedic surgeon Dr. Rende on 3/21/16 at the request of the Respondent. Petitioner denied any arm or back pain. He noted some weakness in the left hand, about 3/5 in severity. Dr. Rende diagnosed a C6-7 and C7-T1 disc herniation attributable to the 1/28/15 accident, and he opined that the Petitioner had reached MMI and was in need of no further treatment. Dr. Rende provided an impairment rating of 15% loss of use of the body as a whole based on the 6th Edition AMA guide. This was based on an intervertebral disc herniation with documented residual radiculopathy at a single level, C8, which placed Petitioner in class 3. Dr. Rende also added a grade modification for functional history and physical exam of no pain and minimal symptoms with normal activities. (Rx1, RDepx3).

On 4/7/16, Dr. Kovalsky indicated he believed Petitioner had a neurapraxia of the C7/8 enervated muscle groups in the left arm due to delayed surgery. Petitioner had been working full time and using the TENS unit. He reported occasionally using over-the-counter anti-inflammatories, but had stopped using Neurontin and muscle relaxers as he did not feel he needed them. His left hand weakness was improving, and the fusion was healing. (Px4). On 7/7/16 Petitioner followed-up with Dr. Kovalsky, who noted his left hand strength continued to improve. Petitioner was to continue to work full duty. On 11/9/16, Dr. Kovalsky released the Petitioner from care at maximum medical improvement. He noted that it had taken that long for all the strength and sensation to return to normal in Petitioner's left hand. The only problem the Petitioner reported was some left hand cramping if he overdoes it at work or home. X-rays showed a solid fusion. He believed that the cervical spondylosis above C6/7 was likely causing any ongoing neck pain. Strength and sensation was back to normal, with no significant atrophy, but did have mild chronic decrease in the left tricep reflex.

17IWCC0648

Dr. Rende's evidence deposition was obtained by the parties on 10/18/16. Dr. Rende confirmed his opinions from this 3/11/16 evaluation. He testified that he was confident Petitioner's condition would only continue to improve, but that the impairment rating he determined would not change even if the Petitioner continued to improve. Dr. Rende testified that, given the length of Petitioner's arm, it could take 24 months for improvement of left hand symptoms to be complete. He agreed that he had not reviewed Dr. Kovalsky's 4/7/16 and 7/7/16 reports until at the time of the deposition, but that they did not change his opinions in any way. (Rx1).

On cross-examination, Dr. Rende testified that the cervical level of an injury would not impact a determination of cervical impairment. He acknowledged that Petitioner had a claw hand because of persistent radiculopathy in his C8 root despite his surgery, likely due to permanent nerve damage. He also noted a measured a 1.5 cm triceps atrophy which he attributed to the surgical procedure, but no bicep atrophy. He acknowledged that Petitioner's reported pain level and range of motion had no bearing on the impairment rating, as the 6th edition of the AMA impairment guide focuses on functional history. (Rx1).

Petitioner testified that surgery did help, and that post-surgical physical therapy helped "somewhat". He testified that he continues to have some symptoms, including arm pain that comes on with activity. After about 3 hours his forearm and hand wants to start to cramping up. His left 3rd, 4th and 5th fingertips are always numb, which impacts his dexterity/fine manipulation. He can no longer play guitar, which he has done since he was a child and was continuing to do 3 to 4 times per week. His left hand and arm remain weak. His symptoms depend on his level of activity. For relief, he rubs it, stretches it and takes aspirin if needed. As to his neck, he testified that he gets a twinge if he turns the wrong way, but nothing like he had before. He can rotate his neck pretty well, but can't turn to the left as much. He no longer uses a hand / wrist brace.

On cross examination, Petitioner agreed that he continues to work as a split case stocker, but that he now works with lighter products. He also testified that he has to hold the boxes against his body due to his ongoing left hand symptoms. He continues to work 10 hour shifts, and he has not suffered any diminution of his earnings. He was given no specific permanent restrictions. He initially used a brace for about 5 months to stop his hand cramping and curling. He continues to use a TENS unit approximately 2 to 3 times a week, when he starts having more severe symptoms. He also continues to perform a daily home exercise program. The surgery did improve the constant tingling he had in the arm – some numbness is gone, but the three fingers are still numb. Cold weather bothers him a lot. He testified that he has reported this to Dr. Kovalsky.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

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

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

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

(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains a rating of 15% of the whole person impairment as determined by orthopedic surgeon Dr. Rende pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Rx1). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a split case stocker at the time of the accident and that he has been able to return to work in his prior capacity as a result of said injury. He did testify that he was not lifting products as heavy as he had been before. The Arbitrator notes that the Petitioner's left hand appears to be used significantly in his job, and thus that this injury impacts his job more than it might impact others, but acknowledges that the Petitioner is right hand dominant.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 65 years old at the time of the accident. Neither party has submitted evidence which indicates how the Petitioner's age may impact his permanent disability in this case.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner testified he has returned to his regular job, and that he has not suffered a diminution in earnings. He testified that the only raise he has had since his return to work has possibly been a cost of living increase. He did not testify that his accident and injury have impacted his earning capacity, or whether the injury had any impact on whether he received a raise or not.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the records are generally consistent with the Petitioner's testimony. However, there is some discrepancy between the Petitioner's testimony and the 11/9/16 last report of Dr. Kovalsky. The report indicates that the Petitioner's sensation and strength had fully returned in his left hand, while the Petitioner notes more significant ongoing symptoms in his testimony. That said, the Arbitrator did find the Petitioner's testimony to be credible with regard to having ongoing left hand symptoms.

The Arbitrator notes that, while the Petitioner clearly has a significant amount of preexisting cervical spine degeneration, the osteophytes noted at C6/7 during surgery were mild, and Dr. Kovalsky noted the degeneration was even less at C7/T1. It is also clear from his surgical report that there was herniation material in the foramen at both levels on the left, with significant disc material at C7/T1. The Petitioner testified in credible fashion that he had no prior similar problems in his neck, left arm or hand. Section 12 examining physician also opined that the Petitioner's post-accident symptoms were related to the accident. Based on this evidence, the Arbitrator concludes that the accident appears to have done significantly more than simply aggravate the Petitioner's preexisting condition, and in fact caused herniated discs that caused the Petitioner's acute left arm symptoms.

17IWCC0648

Overall, the Arbitrator gives weight to factors (i), (ii) and (v), while factors (iii) and (iv) do not really impact the permanency determination in any significant way. The Arbitrator also acknowledges that weight was given to both the impairment rating of Dr. Rende, as well as prior precedent of the Commission in terms of awards for similar injuries, surgery and results. Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the person as a whole pursuant to §8(d)(2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Throop,

Petitioner,

vs.

NO: 10WC 46889

SOI/Pinckeyville Correctional Center,

17IWCC0649

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 18, 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.

DATED: OCT 16 2017
MJB/bm
o-10/3/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THROOP, THOMAS
Employee/Petitioner

Case# **10WC046889**

SOI/PINCKEYVILLE CORRECTIONAL CENTER
Employer/Respondent

17IWCC0649

On 4/18/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
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

APR 18 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

THOMAS THROOP
Employee/Petitioner

v.

STATE OF ILLINOIS/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

Case # **10** WC **46889**

Consolidated cases: _____

17IWCC0649

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **October 13, 2016**. By stipulation, the parties agree:

On the date of accident, **December 1, 2010**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$56,381.00**, and the average weekly wage was **$1,084.25**.

At the time of injury, Petitioner was **49** 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 **$all paid** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$all paid**.

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

ORDER

Respondent shall pay Petitioner the sum of **$650.55**/week for a further period of **91.6** weeks, as provided in Section **8** of the Act, because the injuries sustained caused **10% loss of use of the right arm (25.3 weeks), 10% loss of use of the left arm (25.3 weeks), 10% loss of use of the right hand (20.5 weeks), and 10% loss of use of the left hand (20.5 weeks).**

Respondent shall pay Petitioner compensation that has accrued from **August 22, 2016,** through **October 13, 2016**, 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

April 11, 2017
Date

ICArbDecN&E p.2

APR 18 2017

STATE OF ILLINOIS)
) ss
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

THOMAS THROOP
Employee/Petitioner

17IWCC0649

v.

Case #: **10 WC 46889**

STATE OF ILLINOIS/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Procedural History

This case was previously tried before a different Arbitrator on December 12, 2014, pursuant to Section 19(b) of the Act on several issues, including accident, causation, and liability for medical benefits. Findings were in favor of Petitioner and the Commission affirmed and adopted the Arbitration Decision. PX7, RX6, RX7. The Arbitrator hereby acknowledges and incorporates herein the prior Arbitration Decision and the Commission Decision and Opinion on Review.

Issues in Dispute

The parties stipulated that the only issue currently in dispute is the nature and extent of Petitioner's permanent partial disability.

On December 1, 2010, the date of accident, Petitioner was 49 years old, married, with no dependent children. He was a Correctional Officer at Respondent's Pinckneyville Correctional Center, and had been so employed since 1998. By way of background only, Petitioner sustained repetitive trauma to both hands and both arms as a result of his work-related duties. He was diagnosed with bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome.

Subsequent to the prior hearing of December 12, 2014, Petitioner returned to his treating physician, Dr. David Brown, on March 14, 2016. He reported he had been awarded treatment by the Commission, that he continued to work the same job as a Correctional Officer, and that the numbness and tingling in both hands had worsened. Examination showed positive Tinel's over the ulnar nerve at the right and left cubital tunnels, positive direct compression test/elbow flexion

test bilaterally, positive Tinel's over the right and left carpal tunnels, and positive Phalen's/direct compression test on the left. Dr. Brown noted it had been more than five years since Petitioner had undergone electrodiagnostic studies and he recommended repeat studies. PX3.

On April 11, 2016, Petitioner underwent EMG/NCS by Dr. Daniel Phillips at Neurological Electrodiagnostic Institute. Dr. Phillips noted the following impressions. (1) There was moderate, predominantly demyelinative ulnar motor neuropathy across the left elbow. Although the absolute values fell within the range of normal, there had been a decrement in the ulnar sensory response voltages. (2) There was mild demyelinative ulnar motor neuropathy across the (right) elbow. Right ulnar sensory response voltage fell at the lower limit of normal and similar to what it had been in 2010. (3) The left median nerve study had deteriorated since the prior study and there was significant moderate sensory motor median neuropathy across the left carpal tunnel. (4) The right median nerve study had also deteriorated and there was mild demyelinative sensory motor median neuropathy across the right carpal tunnel. PX4.

Petitioner returned to Dr. Brown on April 11, 2016, who reviewed his EMG/NCS results. He noted the studies confirmed the diagnoses of bilateral carpal tunnel and cubital tunnel syndrome and he recommended surgery to address both. PX3.

On May 13, 2016, Petitioner underwent a left carpal tunnel release and decompression of the left ulnar nerve and left cubital tunnel. On June 3, 2016, he underwent the same procedures on the right side. He was referred to physical therapy following each surgery. PX5.

On June 27, 2016, Petitioner followed up with Dr. Brown. He reported he had no numbness in his right hand and that the numbness in his left hand had improved, although there was still some in the ring and middle finger. Examination showed he had good active range of motion bilaterally. He was instructed to continue physical therapy. At that time he was released to full use of his left upper extremity and restricted to less than five pounds lifting with his right upper extremity. On July 18, 2016, he was released to full duty with no restrictions. PX3.

Petitioner underwent physical therapy at Sparta Physical Therapy and Sports Medicine following both surgeries, from May 17, 2016, through July 8, 2016. Throughout the records it was noted that Petitioner felt good and that his sensation was improving. At his final therapy session of July 8, 2016, he reported he had numbness in his left hand between the ring finger and long finger only, but had no other symptoms. It was noted that all his therapy goals had been met and he was discharged at that time. PX6.

On August 22, 2016, Petitioner returned to Dr. Brown. He reported he had no numbness or tingling in his right hand and had improved numbness and tingling in his left hand. On examination, he had good active range of motion of both upper extremities. Dr. Brown noted Petitioner had done well and he had no further recommendations. Petitioner was released to full duty with no restrictions and was released from care at that time. PX3. The Arbitrator notes this is the last treatment record.

Petitioner testified he continues to be a Correctional Officer at the Pinckneyville facility, with the same job duties. He is right hand dominant. He testified that the left arm seemed better

after surgery and the right arm was a little more painful, and he felt his left arm healed better than his right arm. The incision sites at his wrists are tender when pressure is put on them. He does not believe his wrists extend backward as far as they used to and believes that his grip strength is weaker than it once was. He has some pain when his incision sites come into contact with door handles. He experiences numbness and tingling in his arms if they are kept in a certain position for an extended period of time, though it is better since the surgeries. Petitioner testified he has a farm and does a lot of gardening, and he feels his hands tire more quickly now with those activities. He has increased pain after an extended period of activity involving his hands, and takes Tylenol to help with the symptoms.

On cross-examination, Petitioner confirmed he is currently working full duty with no restrictions. He is not currently seeing a doctor for his wrists and/or elbows, nor is he participating in physical therapy. He does not take any prescription medication and is not required to wear any kind of protective device or brace. He is able to perform his job satisfactorily and has not had any complaints from his supervisors regarding his job performance since his return to work. He testified he continues to garden on his "hobby farm" and continues to ride his motorcycle. He agreed that when he last saw Dr. Brown on August 22, 2016, he denied any numbness or tingling in his right hand and reported that the numbness and tingling in his left hand was much improved. He acknowledged that Dr. Brown told him at that time that he could continue to improve with time.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Facts, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated that the only issue currently in dispute is the nature and extent of Petitioner's permanent partial disability. The Arbitrator notes that Petitioner's injuries occurred prior to September 1, 2011, and thus Section 8.1b of the Act does not apply.

As a result of his job duties, Petitioner developed bilateral carpal tunnel and bilateral cubital tunnel syndrome and underwent surgical repair of each. Following treatment, he returned to his former position as a Correctional Officer and continues to perform all of his duties without restrictions. He testified he continues to experience pain and tenderness with pressure at the incision sites and continues to have loss of hand strength and reduced backward extension of his hands. He feels pain when he pushes the steel doors at work and the door comes in contact with the incision sites on his hands. He still feels some numbness and tingling in his arms if they are kept in a certain position for an extended period of time. He testified his hobbies of gardening and working around his farm have been adversely affected and his pain increases after an extended period of activity. The Arbitrator notes Petitioner is still able to ride his motorcycle.

After review of the evidence and due deliberations, the Arbitrator finds that Petitioner sustained injuries that resulted in 10% loss of use of the right arm (25.3 weeks), 10% loss of use of the left arm (25.3 weeks), 10% loss of use of the right hand (20.5 weeks), and 10% loss of use of the left hand (20.5 weeks), pursuant to Section 8(e) of the Act. The parties stipulated that Petitioner's average weekly wage was $1,084.25. The Arbitrator finds his permanent partial disability rate is $650.55.

STATE OF ILLINOIS)
) SS.
COUNTY OF Sangamon)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Nihiser Jr.,
Petitioner,

vs. NO: 13WC 26651

ATI Services of Illinois, LLC,
Respondent.

17IWCC0650

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

OCT 16 2017

DATED:
MJB/bm
o-10/3/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NIHISER JR, GARY
Employee/Petitioner

Case# **13WC026651**

ATI SERVICES OF ILLINOIS LLC
Employer/Respondent

17IWCC0650

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1539 DRUMMOND LAW OFFICE
PETER C DRUMMOND
703 W UNION SUITE 3 PO BOX 130
LITCHFIELD, IL 62056

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gary Nihiser Jr.
Employee/Petitioner

v.

ATI Services of Illinois, LLC
Employer/Respondent

Case # 13 WC 26651

Consolidated cases: _____

17IWCC0650

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield, IL**, on **September 28, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/03/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$49,686.48**; the average weekly wage was **$958.89** .

On the date of accident, Petitioner was **37** years of age, ***married*** with **3** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$19,086.46** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$19,086.46**.

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

ORDER

TTD is awarded for the period of 7/4/13 through 12/9/14, or 74 6/7 weeks at a rate of $639.26. Respondent is entitled to a credit of $19,086.46 for TTD paid.

Respondent shall pay reasonable and necessary medical services incurred through December 9, 2014, pursuant to the fee scheduled as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any medical benefits paid.

Respondent shall pay Petitioner permanent partial disability of $575.33/week for 125 weeks because the injuries sustained caused the 25% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Edward Lee
Signature of Arbitrator

1/3/17
Date

ICArbDec p

JAN 6 - 2017

STATEMENT OF FACTS

Petitioner testified he worked for Respondent as a mechanic and was employed during two different periods. Petitioner testified that his second period of employment began in October of 2012. Petitioner testified that while employed with Respondent his job duties included performing mechanical work on power company boom trucks, semi trucks, big box vans, and company vehicles.

Petitioner testified that on July 3, 2013 he was using a sledge hammer to remove ball joints from an older Chevy truck when he began experiencing pain in his upper back between his shoulder blades. Petitioner testified it took approximately two and a half hours to replace the ball joints because they were corroded. Petitioner testified that while using the sledge hammer to remove the old ball joints the truck was on a lift with the brakes about chest high.

Petitioner testified that by the time he finished the job his back pain had worsened, so he went into his boss' office to ask if he could leave early. Petitioner testified that after leaving work he went home and lay on the couch. The next day, July 4th, Petitioner testified that he went out with his family to Springfield to eat and then to the fireworks, but by that night was unable to sleep.

Petitioner testified that the next morning he called his boss and told him he intended to seek medial treatment as his pain had gotten worse. Petitioner testified he then presented to the emergency room at Decatur Memorial Hospital.

Medical records from Decatur Memorial Hospital confirm that Petitioner presented to the emergency room on July 5, 2013 with complaints of back pain ongoing for 14 years with constant and more intense pain over the last three to four days. While Petitioner testified he reported his work accident while at the ER, the records confirm Petitioner denied any injury or trauma related to his pain. Petitioner ultimately refused x-rays and was diagnosed with a thoracic strain and given a prescription for Tylenol with Codeine. Petitioner was also instructed to follow up with his primary care physician. Petitioner did not report complaints of neck pain. (Pet. Ex. #4)

Petitioner followed up at SIU Healthcare Decatur Family Physicians on July 15, 2013. It is noted that Petitioner was seen at that time as a new patient. Petitioner reported upper back pain at T7, present for 15 years, but with acute on chronic pain beginning July 3, 2013 after using a hammer at work. Petitioner was prescribed Naproxen and Flexeril and instructed to limit his activity to comfort and follow up in two weeks.

Petitioner again presented to the ER on July 20, 2013. A MRI of Petitioner's thoracic spine revealed a mild T8-9 disc herniation; however, Petitioner was again diagnosed with a thoracic strain. (Pet. Ex. #4)

Petitioner followed up again at SIU Healthcare Decatur Family Physicians on July 24, 2013 and was referred for a MRI of his cervical spine to rule out cervical pathology as the cause of his symptoms. Petitioner was also placed on restrictions for the first time of no lifting more than five pounds, no twisting, and allowance for sitting break every 10 minutes. Respondent was unable to accommodate Petitioner's restrictions. (Pet. Ex. #5)

Petitioner's cervical MRI was completed on July 31, 2013 and revealed a posterior disk bulge with broad-based herniation, mildly impinging upon the thecal sac at the origin of the left-sided nerve root sleeve on the left at C5-6; foraminal encroachment at some cervical levels, most prominent on the right at C3-4, bilaterally at C4-5, on the left at C5-6 and on the left at C6-7; and degenerative disc disease. (Pet. Ex #4)

Based on the results of Petitioner's MRI he has referred for a neurosurgical consult with Dr. Per Freitag. Petitioner first presented to Dr. Freitag on September 4, 2013. After reviewing Petitioner's MRIs Dr. Freitag diagnosed him with an ineterspinous ligament sprain and administered a Lidocaine and Depomedrol injection to the location of pain. (Pet. Ex #6)

Before returning to Dr. Freitag Petitioner returned to SIU Healthcare Decatur Family Physicians on September 24, 2013. Petitioner's light duty restrictions were continued pending his follow up with Dr. Freitag. (Pet. Ex, #4)

On October 30, 2013 Dr. Freitag ordered a CT of Petitioner's chest to rule out a possible disc in the thoracic area as the source of his pain. Pending the results of Petitioner's CT, Dr. Freitag relcased Petitioner to return to work with restrictions of no lifting more than five pounds and no twisting or turning and rest breaks for sitting every 10 minutes. (Pet. Ex. #6)

Petitioner's CT scan was completed on November 4, 2013. Petitioner returned to Dr. Freitag on November 13, 2013 and was referred for physical therapy. (Pet. Ex. #6)

Petitioner began physical therapy at Decatur Memorial Hospital Rehabilitation on November 25, 2013. Petitioner continued in physical therapy until December 6, 2013. Upon completion of his physical therapy Petitioner reported worsening back pain. (Pet. Ex. 8)

Petitioner was scheduled for an independent medical examination at Respondent's request with Dr. Timothy VanFleet on January 17, 2014. Dr. VanFleet testified that after examining Petitioner and reviewing his medical records, CT scan and MRI, he diagnosed Petitioner with a thoracic strain. Dr. VanFleet testified that Petitioner's MRI showed some evidence of long-standing degenerative changes in both the thoracic and cervical spines, but no acute findings to explain his ongoing symptoms. Dr. VanFleet testified that as it related to Petitioner's work accident he was at maximum medical improvement and could return to work full duty.

Petitioner returned to Dr. Freitag on January 29, 2014. After confirming that Petitioner's MRI and CT scan showed no explanation for the cause of Petitioner's pain, Dr. Freitag referred Petitioner to Dr. Pineda for a second opinion. (Pet. Ex. #6)

Petitioner saw Dr. Pineda on March 10, 2014 and recommended pain management treatment to manage Petitioner's symptoms.

Petitioner presented to Decatur Memorial Hospital Millennium Pain Center for an initial pain management evaluation with Dr. Atiq Rehman on March 20, 2014. Dr. Rehman recommended an EMG of Petitioner's bilateral upper extremities. (Pet. Ex. #8) Petitioner's EMG was completed on April 7, 2014 and was normal. (Pet. Ex. #4)

After the EMG was confirmed to be normal, Petitioner presented to Decatur Memorial Hospital Corporate Health Services and was referred for a surgical consultation with Dr. Robert Kraus. (Pet. Ex. 4). Petitioner first saw Dr. Kraus on April 29, 2014. Dr. Kraus ordered an updated MRI of Petitioner's cervical spine. (Pet. Ex. 7)

While awaiting the results of the updated MRI, Petitioner returned to Dr. Rehman who recommended cervical facet medial branch blocks to rule out facet mediated pain. (Pet. Ex. #8)

Petitioner's MRI was completed on May 7, 2014 and revealed a small herniation posteriolaterally on the left at C5-6 indenting upon the thecal sac at the origin of the left-sided nerve root sleeve. (Pet. Ex #7)

Before returning to Dr. Kraus, Petitioner underwent a facet block with Dr. Rehman on May 13, 2014. Petitioner reported only 10 to 15 minutes of relief with the injection. (Pet. Ex #8)

On May 28, 2014 Petitioner returned to Dr. Kraus for review of his updated MRI. Dr. Kraus noted that when compared to Petitioner's prior MRI of July 31, 2013 it revealed a worsening left C5-6 disc bulge with a small degree of herniation. Dr. Kraus diagnosed Petitioner with left-sided cervical pain, left intersacpular pain, and a left C5-6 disc herniation and recommended a diagnostic epidural steroid injection. Petitioner's injection was administered on June 9, 2014. (Pet. Ex. #7)

After returning to Dr. Kraus on June 25, 2014 with reports of no improvement with the epidural steroid injection, Dr. Kraus recommend surgery to include an anterior cervical discectomy and fusion at C5-6. Petitioner's surgery took place on July 14, 2014. (Pet. Ex. #7)

Dr. Kraus testified that post-operatively Petitioner did well and reported mild neck stiffness with no arm symptoms and was placed on light duty restrictions of no lifting more than 10 pounds as of July 22, 2014. Dr. Kraus testified Petitioner's restrictions were increased to 20 pounds on August 13, 2014 and to 30 to 40 pounds on September 23, 2014. Dr. Kraus also testified that as of September

23rd Petitioner was referred for physical therapy and given a TENs until for treatment of his muscle pain. (Res. Ex. #2)

Dr. Kraus testified Petitioner returned on October 28, 2014 with a new report of arm symptoms. Dr. Kraus testified that based on Petitioner's complaint he referred him for an updated MRI of his thoracic spine. Dr. Kraus testified he reviewed the results of Petitioner's MRI on December 9, 2014 which was unremarkable. Based on the results of Petitioner's MRI, Dr. Kraus testified he released Petitioner at MMI related to his cervical and thoracic spine conditions and to full duty. Dr. Kraus testified that even though Petitioner continued to complain of scapular discomfort and thoracic pain, his complaints were muscular in nature and not uncommon after surgery. Dr. Kraus testified he referred Petitioner back to Dr. Rehman for possible trigger point injections related to his muscle pain. (Res. Ex. #2)

After being released by Dr. Kraus Petitioner testified he did not attempt to return to work for Respondent. Petitioner returned to SIU Decatur Family Medicine instead and was seen by Dr. Charles Ellington. Dr. Ellington testified he is a family medicine doctor. Dr. Ellington testified he first saw Petitioner on April 24, 2015 and May 28, 2015 related to his complaints of ongoing thoracic back pain. Dr. Ellington testified that while he agrees that Petitioner is at maximum medical improvement for his conditions he requires permanent restrictions no heavy lifting and avoiding repetitive bending, twisting, and pulling. Dr. Ellington testified that in his opinion Petitioner's condition was either caused or significantly contributed to by his work accident. (Pet. Ex. #2, exhibit 2 therein, letter dated July 24, 2015 from Dr. Ellington).

At Respondent's request, Dr. VanFleet reviewed updated medical records for Petitioner in March of 2015. Dr. VanFleet testified that he reviewed both Dr. Freitag and Dr. Pineda's records that both supported his position that Petitioner was not a surgical candidate and had no imagining findings to support his complaints. (Pet. Ex. 1)

Petitioner testified that based on Dr. Ellington's recommendation he continues to undergo pain management treatment with Dr. Rehman, but is primarily seen by Dr. Rehman's nurse practitioner, Katherine Naron. Petitioner testified his pain is being managed primarily with medication.

Petitioner testified that continues to experiencing a burning pain between his shoulder blades. Petitioner testified that he spends 80% to 90% of his time on the couch. Petitioner testified he is unable to do chores around the house (inside and outside), including dishes, vacuuming and mowing. Petitioner testified he does drive, but not for extended periods of time. Petitioner testified that he collects hot wheels cars and remote control cars as a hobby but is unable to work on them for more

than 25 minutes to a half an hour due to his inability to hold his arms out in front of him. Petitioner also testified he can no longer fish and has not fished in a year to a year and a half.

However, Petitioner's Facebook posts submitted into evidence by Respondent show that Petitioner is active. Not only is Petitioner shown fishing as recently as August 19, 2016 and out with his family on several occasions, but he is also running a small business known as HotWheelsToys.net. (Res. Ex. #6)

At Petitioner's request a vocational evaluation was conducted by Robert Hammond. Mr. Hammond testified that he met with Petitioner and reviewed his medical records. Mr. Hammond testified that based on the medical information he was provided he would classify Petitioner as less than sedentary, which would give him no access to the general labor market. (Pet. Ex. #9)

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally related to the work injury on July 3, 2013?

The Arbitrator finds there is a causal connection of Petitioner's condition to the injury. This is based on the history of the accident, on set of symptoms, subsequent treatment and doctors opinions.

The Petitioner testified he hurt himself swinging a sledge hammer on July 3, 2013 and this is reflecteded in many of the medical records and accident report (PE 10). Moreover, Petitioner experienced upper back and/or neck pain coupled with radicular symptoms immediately or shortly after the accident. This is also reflected in the extensive medical treatment records.

Dr. Ellington, one of the Petitioner's treating physicians opined that the accident or contributed to Petitioner's condition, PE 2, pp. 16).

Dr. Kraus, the Petitioner's surgeon was reluctant to render an opinion on causation because he felt he couldn't verify the accident, in spite of being asked to assume. There was abundant evidence of the accident from the Petitioner and the medical records. The Arbitrator finds the doctor's refusal to give an opinion on the issue of causal connection will not undermine it.

For the above reasons the Arbitrator concludes the Petitioner's condition is related to his injury.

J. Were the medical services provided to Petitioner reasonable and necessary?

The Arbitrator finds that the medical care Petitioner received up to the time he was released by Dr. Kraus on December 9, 2014 were reasonable and necessary. On that date the doctor released Petitioner at MMI full duty without restrictions. Respondent is liable for Petitioner's medical

treatment incurred through December 9, 2014 subject to the fee schedule. Respondent shall receive a credit for any bills paid.

K. What TTD benefits are due Petitioner?

The Arbitrator finds Petitioner to have been temporarily totally disabled from July 4, 2013 through December 9, 2014. This is based on the Petitioner's testimony, the treating records, the Respondents inability to accommodate his restrictions, and finally the surgeon, Dr. Kraus' release of Petitioner to full duty on December 9, 2014.

Respondent paid Petitioner $19,086.46 in TTD benefits and is entitled to a credit in that amount.

L. What is the nature and extent of Petitioner's injury?

Petitioner argues that he is permanently totally disabled based on the permanent restrictions imposed by Dr. Ellington and the vocational opinion provided by Mr. Hammond. However, the Arbitrator the Arbitrator finds the evidence of Petitioner's restrictions, disability, and employability are not sufficient to warrant PTD.

Dr. Kraus and Dr. Van Fleet opined that Petitioner could return to work full duty and Dr. Ellington in his letter of July 24, 2015, infra, stated Petitioner is limited by his pain from doing heavy lifting. Mr. Hammond testified he relied on out-of-date medical information, including the temporary restrictions imposed by Dr. Freitag in 2013, in assessing Petitioner's vocational capacity and was not aware that Dr. Kraus had released Petitioner to full duty. Therefore his testimony was not credible. As a result, The Arbitrator finds Petitioner is not permanently totally disabled and is entitled to permanent partial disability benefits.

Pursuant to Section 8.1b of the Act, the level of permanent partial disability shall be determined based on: (1) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (2) the occupation of the injured employee; (3) the age of the employee at the time of the injury; (4) the employee's future earning capacity; and (5) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability.

(1) No impairment ratings have been completed in this case. Therefore no weight will be given to this factor.

(2) Occupation: As a mechanic Petitioner's work was at a heavy level and disability would have a significant impact on a heavy level occupation. Accordingly, the Arbitrator gives significant weight to this factor.

(3) Age: The Petitioner was 37 at the time of the injury. There was evidence on how age may affect the Petition disability. In time he may get better or worse the. The Arbitrator will not speculate. Accordingly, this factor is given little weight.

(4) Future earning capacity: Inasmuch, as the it appears the Petitioner will be unable to do as heavy work as before the accident, the Arbitrator concludes Petitioner's earning capacity is reduced. The Arbitrator gives moderate weight to this factor.

(5) Evidence of disability corroborated by the treating medical records: The medical records via MRIs and CT scans showed cervical and thoracic pathology worse at the cervical level. Dr Kraus diagnosed left C5-C6 disk herniation and performed a cervical discectomy with interbody fusion and plating. The medical records also indicated Petitioner underwent extensive treatment consisting of injections, physical therapy, medication and pain management. His most recent treatment is for thoracic pain. The recent medical records show the Petitioner complaints of pain and on going medication for pain.

This factor is important because it discloses the serious surgery and extensive treatment. However, it does not help determine the source of pain. Accordingly, the Arbitrator gives moderate weight to this factor.

. From REx 6 the Arbitrator finds the Petitioner to be more active and in less pain that he testified to at trial.

Taking into account the foregoing factors, a finding is made that Petitioner sustained permanent partial disability of $575.33/week for 125 weeks because the injuries sustained caused the 25% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

N. Is Respondent entitled to a credit?

Respondent shall be given a credit for all TTD and medical paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Therese Whitham,
Petitioner,

vs. NO: 13 WC 22134

17IWCC0651

State of Illinois,
Department of Healthcare & Family Services,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the sole issue of nature and extent of Petitoner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The parties stipulated that the claimant was owed 136 -6/7 weeks of TTD benefits incurred from 5/29/2013 through 1/14/2016, and that the respondent would be credited $48,131.44 in TTD benefits previously paid (see Arbitrator's Exhibit 1). The Arbitrator acknowledged such at the hearing, and included the credit for TTD benefits in the "Findings" section of the decision, but did not overtly specify the TTD award in the "Order" section, so the Commission adds the following language to the "Order" section of the Arbitrator's Decision:

Pursuant to the parties' stipulations, the respondent shall pay the petitioner temporary total disability benefits of $426.97/week for 136-6/7 weeks, as provided in Section 8(b) of the Act. Against this amount, the respondent shall have credit for all disability benefits paid to date.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as noted above, the Decision of the Arbitrator filed May 5, 2017 is affirmed and adopted. The Respondent shall pay to Petitioner the sum of $384.27 per week for a period of 112.5 weeks, as provided in §8(d)2 of the Act, as the injuries sustained caused the 22.5% loss of use of the Petitioner's whole person.

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: OCT 16 2017

o-10/11/17
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHITHAM, THERESE
Employee/Petitioner

Case# **13WC022134**

13WC024263

STATE OF IL DEPARTMENT OF HFS
Employer/Respondent

17IWCC0651

On 5/9/2017, 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:

5559 CROWLEY BURGER & PRILL
EDWARD J PRILL
3012 DIVISION ST
BURLINGTON, IA 52601

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

MAY 9 - 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Therese Whitham
Employee/Petitioner

v.

State of IL Department of HFS
Employer/Respondent

Case # **13** WC **22134**

Consolidated cases: **13 WC 24263**

17IWCC0651

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **3/28/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 5/16/13 & 5/29/13, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

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

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

In the year preceding the first injury, Petitioner earned $30,771.00; the average weekly wage was $640.45.

On the first date of accident, Petitioner was 47 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 $48,131.44 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $48,131.44.

Respondent is entitled to a credit of for all reasonably related group medical under Section 8(j).

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, Respondent shall pay Petitioner permanent partial disability benefits of $384.27 per week for 112.5 weeks because the injuries sustained caused a 22.5% loss of use of the person as a whole.

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

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

Edward Lee

Edward Lee, Arbitrator

5/6/17

Date

MAY 9 - 2017

FINDINGS OF FACT

Petitioner Therese Whitham is an office clerk with Respondent State of Illinois, Department of Healthcare & Family Services. She alleges that on 5/16/13, she suffered a work-related injury to her neck by lifting heavy boxes at work. She further alleges that on 5/29/13, she suffered a work-related injury to her neck by lifting boxes at work in a repetitive manner. Petitioner filed Applications for Adjustment of Claim for both dates of accident, and then consolidated them. PX2.

Petitioner had suffered a prior work accident on 11/8/05. RX2. She testified that she had a cervical fusion at C4-5 in May 2010, and cervical hardware replacement in August 2011, performed by Dr. Richard Kube. She said she felt "100 percent. I had no side effects…I recovered completely." She received a settlement of 30 percent man as a whole. RX2.

After the 5/29 accident, Petitioner presented at Memorial Medical Center's emergency room with complaints of intermittent dizziness for the past 10 days, headache, pressure in her neck, left arm pain, and anxiety. PX3. A CT of her head was normal. Id. A cervical x-ray showed significant foraminal compromise at C4-5 and C5-6. PX4. On 6/10, a cervical MRI found increased size of the central disc protrusion at C6-7, and that a myelogram would be useful to further evaluate this area. PX6. Petitioner returned to Dr. Kube, who recommended physical therapy and an EMG. PX5, 9. The EMG showed left C7 radiculopathy. PX7. Dr. Kube recommended a C6-7 decompression and disc replacement. PX9.

On 1/2/2014, Petitioner presented to Dr. Patrick O'Leary for an IME. PX16. He opined that her neck and left arm pain are due to her 5/16 work accident, but that her dizziness and anxiety are not. Id. He agreed with Dr. Kube's surgical recommendation. Id. On 4/21, Petitioner underwent the recommended surgery, but woke up in the recovery room with persistent left shoulder and arm pain going to the elbow. PX9. On 8/11, a cervical MRI showed moderate right foraminal disc protrusion at C4-5 impinging on the exiting right C5 nerve root, a prior ACDF at C5-6, and Chiari 1 malformation. PX6. On 8/24, an EMG showed left C5 radiculopathy, but no C7 radiculopathy. PX8.

On 4/21/2015, a cervical CT myelogram showed bony fusion at C4-5 with uncovertebral spurring resulting in mild left and moderate right foraminal stenosis. PX6. On 6/1, Petitioner

underwent a left C4-5 hemilaminectomy with partial facetectomy and foraminotomy for decompression of the exiting C5 root. PX12.

On 1/16/2016, Petitioner returned to work. RX4. On 2/6, Dr. Kube releases her at MMI, but schedules a one-year follow-up. PX9.

On 1/24/2017, Petitioner presented for her one-year follow-up. PX9. Dr. Kube records Petitioner's complaint of occasional left arm and right arm flare-ups, but that "she is doing still excellent." Id. She said at trial that she did not have any pain flare-ups after she reached MMI following her 2011 surgery, but Dr. Kube recorded "she has occasional aches and pains with her neck which would be expected and normal." RX1.

Dr. Kube was deposed on 2/2/2017. PX15. Dr. Kube called the 2014 surgery a success. Id. Regarding the cause of her post-surgical symptoms, Dr. Kube said the 2014 surgery is "really about the only thing I can put a point to…I don't really have another explanation for that." Id. He said "the actual work event didn't cause the C5 radiculopathy." Id.

Dr. Kube explained some of the ways he objectively measures a patient's functional capacity and pain. Id. He said the neck disability index is used to measure surgical outcomes, that a lower number is better, and that Petitioner has an NDI of 2. Id. He said "from the clinical standpoint at this point indicating pain levels that are…similar in success where she was back in 2011. And her…neck disability index for the functional impairment likewise shows success." Id. At her last office visit with Dr. Kube following the 2011 surgery, he recorded an NDI of 12. RX1.

Petitioner testified that her job has changed "drastically" between 2013 and now. She said that her office has become mostly paperless and computerized, and that her job is less physically demanding now. She said she maintains her pre-injury title of office clerk. She said she currently makes $1828 every two weeks.

CONCLUSIONS OF LAW

In regards to issue (L), pursuant to Section 8.1b of the Act, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Regarding these factors, the Arbitrator notes the following evidence:

(i). 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. Sec. 8.1b. Inasmuch as neither party submitted an impairment report, the Abitrator is unable to to give weight to this factor.

(ii). The Petitioner is able to work her pre-injury job. The Arbitrator gives this factor moderate weight.

(iii). Petitioner was 47 years old at the time of the accident. The Arbitrator gives this factor minimal weight as there is no evidence how this affects her disability either positively or negatively.

(iv). Petitioner makes more money now than she did pre-injury. Her pre-injury AWW is $640.45, and she testified that she now makes $1828 every two weeks, resulting in a weekly wage of $914. The Arbitrator gives this factor moderate weight.

(v). The most recent objective evidence of disability is from Dr. Kube's 1/24/17 office note where he says, "She is doing still excellent. At this point, she is doing quite well. She is proceeding well with her outcome. She occasionally gets some right arm flare-up, left arm flare-up, but otherwise, she is really doing quite well. I am happy with the result." The Arbitrator gives this factor substantial weight.

Based on the factors listed above, Petitioner has suffered a 22.5% loss of use of her person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TENA STUDER,

Petitioner,

17IWCC0652

vs.

NO: 14 WC 02350

ROCKWELL AUTOMATION, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, occupational disease, 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.

Findings of Fact and Conclusions of Law

Petitioner testified she was 47 years old at the time of the arbitration hearing. The Commission notes the Application for Adjustment of Claim confirms Petitioner was born on October 15, 1968 and finds that she was 45 years of age at the time of the injury.

Petitioner and her co-worker Kristi Clark were friends since childhood and testified they worked together from roughly 2007 until their termination in October 2013. Clark testified her desk was directly below the air conditioner. Petitioner sat approximately four feet from Clark's desk in their office. Petitioner and Clark testified that the environment in which they worked was dirty so they had to clean the filter in the air conditioner quite a bit. Petitioner testified she would see black dust when she would beat the filter against the trash can. Petitioner testified over the years she started having chronic respiratory conditions; "around 2009, 2010" it started getting worse. (T, p. 58, 59)

17IWCC0652

The Commission finds that Petitioner and Kristi Clark were credible witnesses. The Petitioner was in a stable condition of good health, with a history of occasional and intermittent exercise-induced asthma before working for Respondent, when she began having increased respiratory problems after working in the Continental Tire office after only a few years.

The Commission is entitled to draw reasonable inferences from the evidence. *Twice Over Clean v. Industrial Comm'n*, 214 Ill.2d 403; 827 N.E.2d 409, 292 Ill.Dec 880 (2005) quoting *City of Des Plaines v. Industrial Comm'n*, 95, Ill.2d 83, 90, 447 N.E.2d 307, 69 Ill.Dec. 90 (1983).

The Commission notes prior to August 2013 Petitioner and Clark managed the air conditioner's leak, requiring Petitioner to sop up black water daily in the summer of 2013, and the air conditioner's filter had black dust when Petitioner cleaned it. It was not until the file holder fell and exposed black mold that required remediation by people in "hazmet" suits, that it became obvious there was extensive black mold growth in the wall and insulation by the summer of 2013.

In support of the Arbitrator's finding that Petitioner's last date worked is deemed to be the last date of her exposure, the Commission notes the testimony of Kristi Clark regarding Petitioner's and Clark's return to their office after the mold remediation. Clark testified the air conditioner was moved to another wall during the remediation process and remained there after the two women returned to work in their office at Continental Tire, until they were terminated, a period of approximately 2-1/2 months. (T, p. 40)

Dr. Istanbouly also credibly testified that he did not know the date Petitioner was last exposed to the black mold prior to December 26, 2013 but if the exposure was within the past couple of years, "it won't matter because we are not talking about the infection itself. We are talking about allergic reaction to aspergillus. So, it's a combination of the infection and the allergic reaction to that infection. You may have mold in your lungs for years, but you may not react. You may not show allergic reaction until now." (Px2, pp. 27-29) Dr. Istanbouly opined consolidation, like the one on Petitioner's December 2013 CT scan, for fungal pneumonia would take "weeks or months" to form. (Px2, p. 25) Based on Dr. Istanbouly's testimony regarding the latency period, the Commission finds the black mold growing in her lungs in December 2013 was from her exposure in the summer of 2013 through October 18, 2013, the date of Petitioner's termination.

Therefore, the Commission finds that October 18, 2013 was the Petitioner's last date of exposure and the Arbitrator properly concluded October 18, 2013 is Petitioner's accident date.

The Commission also finds the Petitioner's respiratory condition permanently worsened in December 2013, when she went to the emergency room due to shortness of breath and was hospitalized. Dr. Istanbouly testified "what looked like a panic attack was acute bronchospasm and shortness of breath related to an asthma attack triggered by her pulmonary fungal infection. (Px2, pp. 24-26) During her hospital stay, the mold growing in her lungs was verified from the tissue sample collected by Dr. Istanbouly. Dr. Istanbouly credibly testified that Petitioner's tests including the bronchoscopy, the cultures tissue sample from the mass-like-density in the left lobe, was consistent with invasive bronchopulmonary aspergillus which is fungal infection. Fungal infection is a condition that that can occur from exposure to black mold. Black mold had been deposited in her lungs. (Px2, pp. 14-15) It was after the identification of the black mold growing

17IWCC0652

in her lungs that a causal connection between the conditions at Petitioner's work and the occupational disease was readily apparent. Dr. Istanbouly opined that Petitioner's asthma condition was aggravated following that exposure and infection. (Px2, p. 16)

Dr. Istanbouly testified on cross-examination that Petitioner had mentioned in his initial evaluation that she was diagnosed with asthma before. Although he had not reviewed Petitioner's prior medical records, Dr. Istanbouly was aware of her pre-existing diagnosis of asthma. Besides asthma that was aggravated following exposure and infection, Petitioner has bronchiectasis which is like the end outcome of the severe infection, the severe inflammation in her lungs. It (bronchiectasis) is a form of fibrosis and scarring of the lungs where small airways lose their structure, become dilated and unable to clear the secretions which will predispose the Petitioner to develop frequent infections in the future. Dr. Istanbouly testified although the 2013 ABPA infection was treated and cleared, the worsened clinical asthma symptoms remained. (Px2, pp. 15-16) Dr. Von Essen also opined Petitioner had remaining bronchiectasis on CT testing in October 2014. (Rx1)

Despite the fact that Dr. Istanbouly did not have the CT scan dated six years prior to compare the extent of bronchiectasis from Petitioner's prior bout of pneumonia, he testified credibly that although the ABPA condition had resolved on Petitioner's CT scan findings, her clinical condition did not resolve. Clinically she was still sick and that is why he decided to upgrade the management of her asthma. (Px2, p. 17) It was his opinion that clinically she was still sick because of the exposure to the black mold as opposed to the preexisting asthma that she suffered from. (Px2, pp. 39-40)

Dr. Istanbouly explained once she is exposed to the black mold and it gets into her lungs, the acute allergic reaction can generate new and more significant scar tissue in the lungs. That scar tissue from the acute infection can lead to permanent impairment to make her ongoing asthma worse at least as far as symptoms. (Px2, p. 49)

Dr. Istanbouly also testified "...It is a good possibility the black mold is the reason that she needs ongoing care." (Px2, pp. 48-50) Dr. Istanbouly also testified the sequence of events indicates that the exposure she had at the workplace led to this infection and led to the remarkable worsening of her asthma symptoms. (Px2, p. 52)

Respondent's expert Dr. von Essen essentially agreed with Petitioner's treatment and in her letter opined: "It is possible that she developed ABPA from heavy exposure to mold in her workplace. Her underlying asthma was no doubt also a predisposing factor for developing this problem as is described in the medical literature. She had been asthmatic for some time but the development of ABPA coincided with working in a mold contaminated office.... It is quite possible, though impossible to prove at this point in time, that the exposure to mold in the workplace is casually related to the conditions for which Dr. Istanbouly is treating her." (Rx1)

The Commission finds the ABPA condition was at minimum a contributing cause to the Petitioner's bronchiectasis condition of scarring and fibrosis in her lungs based upon Dr. Istanbouly's and based upon Petitioner's testimony that her asthma worsened, her stamina and lung capacity had decreased and her respiratory condition had deteriorated.

17IWCC0652

The Commission further finds the Petitioner's baseline condition before the ABPA infection is starkly different than her condition at the time of the hearing based upon Petitioner's and Clark's testimony and based upon the evidence Petitioner requires additional and ongoing medications and medical treatment and her activities are severely limited since the exposure. The Commission finds Petitioner's exposure to black mold at the Continental Tire office led to her ABPA infection and permanently worsened her pre-existing asthma and respiratory condition.

Therefore, the Commission finds the Respondent has further liability for ongoing treatment because Petitioner's respiratory condition is compromised because she had the ABPA infection.

Petitioner testified she had not treated with any doctor for her asthma except her PCP, Dr. Latta, until she was hospitalized in December 2013, after the black mold exposure and resulting infection. At that time, Dr. Istanbouly was called as a consult because of the density or consolidation on the abnormal CT scan. Thereafter, Dr. Istanbouly became her pulmonary doctor. Thus, the Arbitrator properly awarded the Herrin Hospital bill, the associated charges at Cape Radiology, SI medical Services ER Medicine and Dr. Latta's bill for $119.00 and properly found that Petitioner's ongoing condition remains causally related, at least in part, to the October 18, 2013 accident and exposure.

The Commission also concurs with the Arbitrator's award of $650.00 bill to Dr. Nicholas and finds the Petitioner's anxiety and panic attacks increased as a result of her deteriorating respiratory condition. Dr. Istanbouly testified that there is a "correlation between shortness of breath and anxiety." At the time of her December 26, 2013 hospitalization, he noted "what looked like a panic attack I would say it was acute bronchospasm and shortness of breath related to asthma attack triggered by her pulmonary fungal infection." (Px2, p.26)

The Commission finds the Petitioner is entitled to all reasonable and necessary medical treatment related to Petitioner's respiratory condition for the remainder of her life including, but not limited to, physiotherapy to exercise her lungs as needed.

The Commission strikes the last sentence in paragraph one on page 10 of the Arbitrator's Decision under the conclusions of law, Issue (J). The Commission agrees with the Arbitrator that there is no indication that any of the charges, or the services related to said charges, are unreasonable or unnecessary. The Commission does not agree with the Arbitrator's exclusion of the liver function bill or the amount of the liver function bill the Arbitrator referenced. The liver function lab test bill was $184.00, one of three services ordered by Dr. Istanbouly on May 28, 2014 along with venipuncture and a chest x-ray. Dr. Istanbouly testified they were hospital charges and that the liver function test was part of an initial evaluation. After that, if baseline was not normal, they may do follow-up. (Px2, pp. 21, Pet'sDepx2) Therefore, the Commission awards all of Herrin Hospital charges with no exclusions.

The Commission also adds the following paragraph to the Arbitrator's conclusions of law, under Issue (J) on page 10: Respondent is liable under the medical fee schedule for reasonable and necessary respiratory medications including but not limited to an inhaled long acting beta agonist and corticosteroid combination inhaler, Montelukast, albuterol, short courses of

17IWCC0652

prednisone and antibiotics as necessary from October 18, 2013 for the remainder of her life.

With respect to the Arbitrator's conclusions of law, Issue (L), the Commission strikes the third sentence in the third paragraph on page 11, under subsection (ii) of §8.1b(b), the occupation of the employee, and replaces it with the following two sentences: The Petitioner testified she is able to sit at her current job. She may not always have that option and she may have occasional infections.

With regard to subsection (v) of §8.lb(b), evidence of disability corroborated by the treating medical records, the Commission adds the following paragraph after the Arbitrator's three sentences and prior to the last paragraph on page 11: The Petitioner's spirometry in September 2015 was 49% of predicted with normal being 80%. (Px2, p. 20) Dr. von Essen opined in place of Xolair, Petitioner may use an inhaled corticosteroid on a daily basis and albuterol for rescue. She may occasionally need a short course of prednisone and possibly treatment with an antibiotic from time to time. Dr. von Essen expected that Petitioner will continue to need treatment for these conditions with the medications she discussed in her report. While Petitioner was being treated with Xolair at the time of the arbitration hearing, Dr. Istanbouly and Dr. von Essen agreed that after the Xolair was discontinued, Petitioner would need ongoing treatment which Dr. Istanbouly thought might include an inhaled corticosteroid and Montelukast on a daily basis and physiotherapy to exercise her lungs to help her clear the secretions including simple ways like flutter valve or aggressive ways like an oscillation vest to help her break the phlegm loose and cough it up.

Given Dr. Istanbouly's testimony regarding the correlation between shortness of breath and anxiety, the Commission also strikes the fourth and fifth sentences of the last paragraph on page 11 of the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 27, 2017 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $399.00 to Cape Radiology, $26,108.68 to Herrin Hospital, $19,076.00 to Dr. Suhail Istanbouly, $119.00 to Dr. Ralph Latta, $650.00 to Michael Nicholas, Ph.D., and $265.00 to SI Medical Services ER Medicine, and Respondent shall pay future reasonable medical services related to Petitioner's pulmonary condition for the remainder of Petitioner's life, as provided in Sections 8(a) and 8.2 of the Act except the Respondent is not liable for Xolair injections as of 8/11/17, one year from the hearing date.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for all reasonable medications necessary to treat Petitioner's pulmonary condition beginning October 18, 2013 for the remainder of Petitioner's life pursuant to Sections 8(a) and 8.2 of the Act.

17IWCC0652

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $533.71 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 10% loss of use of the person as a whole.

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 S8(j) of the Act, if applicable.

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 $73,403.00. 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.

OCT 16 2017

DATED:
KWL/bsd
O-8/15/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STUDER, TENA
Employee/Petitioner

Case# **14WC002350**

17IWCC0652

ROCKWELL AUTOMATION INC
Employer/Respondent

On 2/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0250 HOWERTON DORRIS STONE & ET AL
DOUGLAS N DORRIS
300 W MAIN ST
MARION, IL 62959

2337 INMAN & FITZGIBBONS LTD
JACK M SHANAHAN
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17 IWCC0652

TENA STUDER
Employee/Petitioner

v.

ROCKWELL AUTOMATION, INC.
Employer/Respondent

Case # **14** WC **02350**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **August 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 18, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,254.52**; the average weekly wage was **$889.51**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **3** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner's current and ongoing condition, in part, remains causally related to the October 28, 2013 accident. The Petitioner had a preexisting respiratory condition, and the Arbitrator finds that a level of worsening was caused by the black mold exposure, and thus that her ongoing condition, in part, remains causally related.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $399.00 to Cape Radiology, $26,108.68 to Herrin Hospital, $19,076.00 to Dr. Suhail Istanbouly, $119.00 to Dr. Ralph Latta, $650.00 to Michael Nicholas, Ph.D., and $265.00 to SI Medical Services ER Medicine, as provided in Sections 8(a) and 8.2 of the Act. However, the Respondent is not liable for the liver function lab test bill of $546 from Herrin Hospital performed on 5/28/2014, which is contained in Px1. The Respondent is also not liable for Xolair injections as of 8/11/17, one year from the hearing date.

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

Respondent shall pay Petitioner permanent partial disability benefits of **$533.71 per week** for **50 weeks**, because the injuries sustained caused the **10% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **October 23, 2014** through **August 11, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

January 27, 2017
Date

FEB 27 2017

STATEMENT OF FACTS

The initial testimony in this case was given by Kristi Clark, a Respondent employee since 2003/2004. She and the Petitioner have been social friends since 1979, and they still see each other a couple times per week. In 2006, she recruited the Petitioner to work for the Respondent, initially as a temp and then a full time employee. The Respondent manufactures industrial controls and automation products. She and the Petitioner were both assigned to work in an office at their customer Continental Tire's Mt. Vernon plant to manage their repairable electronic assets/parts. The office was about 8 x 12 square feet, paneled and had a concrete floor. There was one desk and a counter. They would work in close proximity to each other from late 2006 until they were both terminated on 10/18/13 and told their positions were eliminated. Ms. Clark testified that those positions were subsequently filled.

Ms. Clark testified that there was an air conditioning (AC) unit in their office in close proximity to where they sat. On a daily basis it would drip water down the wall and puddle on the floor. They reported it to the HVAC team at Continental, who brought towels to clean the water, which they would use to clean the puddles. The environment there is very dirty, so they didn't initially notice anything but the water. While construction was being performed on the other side of the wall that contained the AC unit in approximately July or August of 2013, a file holder that was attached to the wall fell, and Ms. Clark noticed what appeared to be black mold where it had been. This is visibly depicted in the photograph (Px3) taken by Ms. Clark, right above the post-it note on the wall.

Ms. Clark reported this to the Continental stock room manager and environmental contact, as well as her supervisor. There was no real response, so she resent the emails and escalated it to the Respondent's environmental person, who in turn contacted Continental. Approximately a week or two after she and the Petitioner discovered the mold, Continental sent a contractor, and they were asked to leave and go to work at another office at Kirby Risk Electrical Supply while repairs were being performed. They would return to Continental occasionally for meetings and such, and Ms. Clark testified that she could see through the office

window that the insulation behind the paneling on the wall was that removed contained what appeared to be black mold.

About a week after the work was completed, which was about two to two and a half months prior to their 10/18/13 termination, she and the Petitioner went back to work in their regular office at Continental Tire. Ms. Clark testified that she noticed the Petitioner had constant trouble with coughing and congestion, as well as a general malaise while working at Continental. They rode to and from work together often. Ms. Clark agreed that Petitioner did have preexisting asthma, but only had problems in the past with heavy exertion, such as gym class, where she would use an inhaler. After returning to the office, the Petitioner would cough up a lot of mucus and material, sometimes so badly that she would vomit. She began to use an inhaler while just walking. Ms. Clark also testified that Petitioner seemed to be worse while in the office at Continental than while away from the office.

After Petitioner left the job at Continental, Ms. Clark testified that there was "absolutely" a change, with more limits on Petitioner's physical exertion. They used to walk several miles together to exercise, and the Petitioner now has difficulty walking just a few blocks. She noted the Petitioner also had a lot of anxiety, and it became hard to get her out of the house to do things, which has continued to the present time.

On cross examination, Ms. Clark testified that all of the repairs had been performed within a week or two. When she and Petitioner returned to the Continental office, the AC unit remained but had been put on another wall, and the prior wall with mold had been repaired. Ms. Clark agreed that when the Petitioner went on vacation for two weeks in July, which was prior to the mold incident, she told Clark that she didn't cough as much when she left the office, and that it then increased when she returned.

Ms. Clark agreed that the Petitioner developed pneumonia after she initially started working at Continental Tire, and had recurrent respiratory infections. She testified that she first noticed the Petitioner having difficulty walking to the office at Continental the last couple of years they worked at that location. The AC unit had started leaking about a month or two before the file folder fell off the wall.

Don Sondermann was their supervisor with Respondent. She testified her email to him stating, "This can be construed as bad timing" was said because an agreement was being negotiated with Continental and things were volatile. Two months later she and the Petitioner were terminated with severance.

The Petitioner testified consistently with Ms. Clark with regard to how she obtained the job with Respondent and that they worked at their customer Continental Tire's facility. She recalled that the AC unit in their office, from approximately June to August 2013, had a constant leak, and they would have to clean up a pool of water every morning with large paper towels. They noticed a water line down the wall, and the water was black. She worked in that room throughout her employment with the Respondent. She testified that Continental personnel would clean the AC filter, but that she and Clark have also done it, noting they were told to beat it against a trash can. She has seen black dust come out of it.

The Petitioner was present during the construction outside of the office when something banged on the wall, causing the file holder to fall, which exposed the black mold depicted in Px3. This was in mid-August 2013. Petitioner believed it took a couple of weeks after they reported the problem for Continental's contractor (Danny) to come and look at it, and he told them they needed to get their belongings and leave the office. She also testified that they still had to come to Continental to an area right next to their office for work, and she could see through the window that the AC unit and paneling had been removed. The insulation and back of the paneling was black and fuzzy, and the wall insulation was black.

The Petitioner testified that it was sometime around 2009/2010 that her respiratory situation worsened and became chronic. She started coughing productively, sometimes to the point that she had to vomit. Nothing like this had occurred previously. Her stamina also was impacted. She testified that she was an avid walker, liked to dance, and played the flute, but she began to have problems just walking to the office, and she was physically exhausted all the time. The Petitioner also testified that her condition was worsening from 2011 to 2013, including anxiety, but she continued to work until she was terminated on 10/18/13. About three weeks after that, she was offered a desk job as HR Manager at Freedom Transport. She was able to work there part time, noting she indicated to them that she couldn't work more hours due to her anxiety and stamina condition. The coughing episodes and chronic vomiting slowed down in 2013 after she lost her job with Respondent, but she continued to feel fatigued.

The Petitioner has had asthma her whole life, as well as allergies. If she was ever short of breath, an inhaler would take care of it. The only doctor she had seen for this since age 25 is Dr. Latta, her primary care provider, and she had never been sent to a respiratory specialist prior to seeing Dr. Istanbouly in 2013. Her allergies were treated in the past by over the counter medications. On average, her Ventolin inhaler prescriptions from Dr. Latta would last for 6 months to a year before needing a new one. Petitioner did have a bout of pneumonia in 12/07 or 1/08, but was not hospitalized, and she returned to work for the Respondent thereafter.

On 12/26/13, the Petitioner testified that she went to Herrin Hospital because her heart was racing, she was having trouble breathing and had chest tightness, and thought she was having a panic attack. The emergency room doctors admitted Petitioner to Herrin Hospital. Petitioner reported a panic attack, noting a prior history of same and anxiety, and she also noted a chronic cough for about 3 to 4 months with an increase in productivity in the last month or two. She was given a battery of tests, including x-rays and a CT scan. She testified that at one point during these tests she was told she might have lung cancer, which was ultimately not accurate. She initially saw respiratory specialist, pulmonologist Dr. Istanbouly, for consult on 12/27/13. The discharge diagnoses were listed as left lung mass of possible infectious etiology (fungal), anxiety with panic attack, sinus tachycardia, newly diagnosed hypertension and a history of asthma. (Px1, Red Tab 2).

Dr. Istanbouly testified via deposition on 10/28/15. He is board certified in pulmonology and critical care, and has practiced in the Herrin, Illinois area since 2003. The Petitioner reported shortness of breath and tachycardia, and he was contacted due to an abnormal x-ray and/or CT scan indicating a density in the lower lobe of the left lung that was suspicious for a mass. Dr. Istanbouly performed a bronchoscopy of the Petitioner's lungs, which included a saline wash, diagnostic brushing and biopsy of the interior of her lungs to determine if the density was infection or a tumor. Based on his testing, Dr. Istanbouly diagnosed fungal pneumonia induced by aspergillus, also called pulmonary aspergillosis. He testified that aspergillus is a certain type of mold. The Petitioner did improve with the medication protocol he instituted. (Px2).

On 1/3/14, Dr. Istanbouly reported that the bronchial "wash" material from Petitioner's lungs grew mold, which he testified indicated that mold had been deposited into her lungs. Dr. Istanbouly's 1/29/14 diagnosis was: "Severe asthma with bronchiectatic changes and a mass like density in the left lower lobe with peripheral eosinophilia and moderate eosinophilia in the endobronchial biopsy associate with BAL culture showing aspergillosis flavis, in addition to severe elevation of IGE including the aspergillosis specific IGE, these findings are consistent with allergic broncho-pulmonary aspergillosis (ABPA)." He testified that all of this is consistent with invasive pulmonary aspergillosis, i.e. fungal infection. He also testified that this fungal infection can occur with exposure to black mold. (Px1, Px2, p. 14).

Dr. Istanbouly opined that Petitioner's preexisting asthma was aggravated by the fungal infection, namely aspergillosis, which turned into allergic bronchopulmonary aspergillosis, or "ABPA". He noted the Petitioner on 1/3/14 (see Px1) reported that she had been exposed to black mold at work in the two years before she quit her job, and testified that "it is a good possibility" that the Petitioner's respiratory condition was aggravated or caused by the mold exposure. While he did testify that this mold exists in the air generally, the specific work exposure and the sequence of events leading to her hospital visit supports a causal connection. (Px2).

Dr. Istanbouly explained that Petitioner had a history of a preexisting asthmatic condition, and that her exposure to mold and the aspergillus infection aggravated the asthma. While the infection did resolve under his care, the severe inflammation in the lungs left her with permanent bronchiectasis, or fibrosis / scarring, which causes the small airways to lose structure and become unable to clear secretions, which predisposes the Petitioner to asthma attacks and frequent infections in the future. Treatment for this entails chest physiotherapy and optimizing of asthma management. Dr. Istanbouly further explained that the Petitioner's asthma got worse remarkably even after the infection was treated. As a result, he had to step-up her maintenance treatment for asthma, which included a regimen of biweekly Xolair injections with his nurse. (Px2)

With regard to a 9/4/15 visit where Petitioner reported a recent history of becoming very short of breath with strenuous exercise, he testified this was part of her overall picture, including asthma, seasonal allergies in September and the underlying bronchiectasis. He testified that spirometry testing reflected she was at only 49% of the predicted amount, with 80% being expected for a woman her age and condition. (Px1 & 2). Dr. Istanbouly testified that his treatment and the treatment he was involved with at Herrin Hospital was reasonable and necessary, including a liver enzyme test that he indicated was part of the initial ER evaluation. (Px2).

During cross-examination of Dr. Istanbouly, he testified that he had not reviewed any of the Petitioner's prior medical records. He was aware that she had preexisting asthma, but that she saw him because her symptoms were remarkably worse, and that the finding of the density, i.e. infection, in her lung was acute. He could tell this by how it looked during the bronchoscopy: "So what happened, she got sick; she ended up in the hospital; there was something abnormal on the x-ray; we scoped her; we came up with the diagnosis; we treated her accordingly and the x-ray did get remarkably better after that. So everything indicates an acute event which means a new onset." (Px2, p. 24). He testified that the fungal pneumonia density/infection could have taken weeks to months to develop after exposure. Petitioner had given him a history of suffering an upper respiratory infection several weeks before her admission to the hospital, and that this infection had gotten much worse shortly before her 12/26/2013 admission to Herrin Hospital. (Px2)

Dr. Istanbouly also said that the bronchospasm and anxiety that brought the Petitioner to the ER on 12/26/13 might have appeared to be a panic attack, but actually was the result of an acute asthma attack triggered by her pulmonary fungal infection, i.e. aspergillosis. Dr. Istanbouly testified that the Petitioner gave a history in the two year period of frequent exposure on a daily basis at work. He did not know her last date of exposure. He testified that her last date of exposure did not matter unless it was years prior, noting that the bronchospasm she had was not the infection itself, but rather the allergic reaction to it: "So you may have mold in your lungs for years, but you may not react. You may not show allergic reaction until now." (Px2, pp. 28-29).

Dr. Istanbouly testified that the bronchiectasis, i.e. scarring, seen on CT scan in the medial right upper lobe could be due to the fungal infection or, because it is permanent, could be due to the Petitioner's prior 2007 bout with pneumonia. However, he believed the scarring in the lower left lobe was due to the fungal infection: "because here we do have confirmation about the acute infection induced by aspergillus" based on the bronchoscopy" (Px2). His statements in and after August 2014 indicating asthma under control is based on the institution of medication treatments. On 10/23/14 he noted that repeat CT scanning indicated the density

previously seen had resolved, but the permanent bilateral bronchiectasis remained. He agreed his 3/6/15 report indicated Petitioner hadn't treated for an asthma attack in more than a year. With regard to future treatment, Dr. Istanbouly testified that while Petitioner was improved, Xolair treatments would likely need to continue for at least another year, though they aren't meant to be used forever. In his opinion, the mold exposure is a significant factor in the need for this ongoing treatment. He agreed that the asthma aggravation the Petitioner had with mold exposure subsided, but, based on Petitioner's report of pre and post exposure symptoms, she did not return to her pre-exposure baseline. (Px2).

Respondent introduced the report of its Section 12 record reviewer, pulmonologist Dr. Von Essen of Nebraska's Health Science Center in Omaha. She did not examine the Petitioner, but Dr. Von Essen reviewed the deposition transcript of Dr. Istanbouly along with his medical records and the bronchoscopy report. She was also advised of the evidence of Petitioner's exposure to black mold in the workplace in the summer of 2013. Dr. Von Essen stated that the main reason for the emergency room visit in 2013 appears to be a panic attack, but after various tests the findings were most consistent with ABPA. Her 3/27/2016 report noted her agreement that it is quite possible that Petitioner's exposure to black mold at work could have led to bronchopulmonary aspergillosis (ABPA), which led to a condition of mild bronchiectasis. She also agreed that this exposure to mold in the work place could have caused the need for the medical treatment that Petitioner received. She noted, however, that the chest CT scan done in October, 2014 showed complete resolution of the ABPA condition. She further noted that by 9/4/15, per the records, Petitioner was not using her rescue inhaler routinely for asthma, suggesting that her asthma was under good control. She stated that if the ABPA had come back or was still present, her asthma would likely be poorly controlled. Dr. Von Essen agreed with Dr. Istanbouly's recommended on-going conventional asthma inhaler medication treatment, with occasional need for antibiotics and/or prednisone, but testified that the Petitioner should not continue Xolair injections indefinitely. She testified that this would not be supported by current medical literature, and because there are no long term use studies of the drug at the present time. She also noted that it is only FDA-approved for allergic asthma that is not controlled, and since the Petitioner's asthma was in good control, as evidenced by the medical records in 2015, "there is no indication for her to receive Xolair for the rest of her life." (Rx1).

Petitioner also saw neuropsychologist Dr. Nicholas in Paducah, Kentucky a few times for her anxiety between 9/3 and 11/3/14. She testified he did help her by talking through things and giving her various coping mechanisms. By the last visit, Dr. Nicholas indicated she reported continued improvement, and felt she could be placed on a return as needed basis. The diagnoses were generalized anxiety disorder and post traumatic stress disorder, with Dr. Nicholas noting the conditions were adequately controlled. (Px1, Red tab #6).

Petitioner continues to see Dr. Istanbuli every 6 months, and gets Xolair injections bilaterally in her arms every two weeks. When she went about a month and a half without these due to insurance issues, she started getting drainage and felt her respiratory problems were worsening. She noted that Dr. Istanbouly has also taken over her asthma care, and changed her regimen so she started to use the Ventolin inhaler every other day for a while, and she has a Symbicort preventative inhaler, which she didn't recall taking prior to starting with Respondent.

Currently, the Petitioner testified that she has started to try to take walks again, but still has to stop and catch her breath even on shorter walks. She used to be an avid flute player, active in the Southern Illinois Concert Band, but no longer has the lung capacity, so she is now an instructor. She does still play with her church because other players can cover her if she needs to stop playing. She feels limited in day to day activities. She is able to work at her current desk job with ManTraCon Corporation as a grant coordinator seven hours per day. She doesn't get the chronic respiratory infections anymore since she has been getting the injections. She feels her condition has essentially plateaued since 2015 or so. She testified that she was on steroids for about 4 months, as well as antifungal, and has gained 40 plus pounds, noting she can't exercise as much to lose weight.

On cross examination, the Petitioner testified that she began working at the Continental Tire site in November, 2006. She first started noticing an increase in her respiratory symptoms in about 2011, when the production and vomiting started. Her ability to walk distances gradually worsened. She was still sick, but wasn't vomiting the week she was off. She testified that during the week she was off on vacation in July 2013 she was still sick, but she didn't vomit. When she left her employment with the Respondent she was still "spitting things up", but the vomiting decreased.

The Petitioner agreed that she had initially been prescribed Ativan by Dr. Latta for anxiety in approximately December 2012, but testified that she left that medication untouched in her cabinet for over a year. Prior to December 2012, Petitioner agreed she had seen a doctor for "general anxiety", but had not had any major panic attacks.

Also on cross exam, Petitioner testified that she used a Ventolin inhaler about once a month before she started working at the Continental Tire location, and that her use increased after a few months of starting work there in November 2006. Since 2012, her use of it has remained about the same – about every two or three days. She uses it when her lungs feel tight or she's had any type of exertion. She cut back on flute playing probably back in 2011.

CONCLUSIONS OF LAW

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

The Arbitrator initially notes that the Respondent does not dispute that the Petitioner was, in fact, exposed to black mold at her office within Continental Tire. The Arbitrator also specifically finds that, regardless of that lack of dispute, the Petitioner has shown by a preponderance of the evidence an exposure to black mold in that office via the evidence presented. This is clearly supported by multiple pieces of evidence, including the photograph that was submitted into evidence, the testimony of the Petitioner and Ms. Clark, and the remedial measures taken by Continental Tire.

Pursuant to Section 1(d) of the Occupational Diseases Act:

"In the Act the term "Occupational Disease" means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public. A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence."

Based on the above statute and the evidence of exposure presented in this case, the Petitioner has proven an accident/exposure which arose out of and in the course of the Petitioner's employment with the Respondent.

It is the Arbitrator's understanding that the OD Act indicates that the date of last exposure to the noted risk constitutes the "accident date" in an occupational disease claim. Here, the Petitioner has claimed an accident date of 10/18/13. This is based on the Petitioner's last date of work with Respondent at the Continental Tire facility, the date she was terminated. While the Respondent performed remedial measures to remove the mold in the wall, the Arbitrator believes that it remains reasonable to conclude that the Petitioner had a continuing exposure to mold in the office at Continental Tire through her 10/18/13 termination date. It is true that the Respondent performed remedial procedures to get rid of the obvious mold that was in the wall of the Petitioner's office where the air condition had been located. That said, there also is no clear proof that all mold in that office was remediated. The Arbitrator believes it is a fair inference to determine that 10/18/13 was the last date of exposure.

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

It is clear in this case that the Petitioner had preexisting asthma and some level of breathing issues going back to childhood. However, the fact remains that Dr. Istanbouly credibly testified that testing of lung tissue indicated the presence of a black mold. He testified that the Petitioner's preexisting condition was aggravated by aspergillosis, which turned into ABPA. While he agreed that the infection from the mold did ultimately clear the lungs, it left a level of permanent scar tissue in part of the lung, and that this would predispose the Petitioner to asthma attacks and infections in the future.

Dr. Von Essen agreed that the Petitioner's exposure to mold could have led to the ABPA condition, and the need for subsequent treatment. Her main disagreement with Dr. Istanbouly involved the ingoing Xolair injection treatment. She also believed that the Petitioner's initial hospital visit was likely due to a panic attack.

The Arbitrator finds that the Petitioner has shown that her preexisting asthma / respiratory condition was aggravated by the work exposure to mold. The question of whether a claimant's condition was caused or aggravated by an exposure at work is a question of fact. *General Cooperage Co. v. Industrial Comm'n*, 284 Ill.App.3d 936, 672 N.E.2d 910, 220 Ill.Dec. 93 (1996).

While it is true that the Petitioner did not seek treatment until the 12/16/13 hospital visit, Dr. Istanbouly testified that the Petitioner reported to him that she had been suffering a respiratory infection several weeks before this hospital visit. Dr. Istanbouly opined that it could take weeks or months to develop ABPA following exposure, and that it was clear to him based on his investigation that there had been a relatively new and acute onset. He further opined that while the 12/16/13 visit may have appeared to be a panic attack, it actually was the result of an acute asthma attack triggered by ABPA. The need for the hospital visit was the infection, and he noted that the mold may have existed in her lungs for a long time before there was an allergic reaction to it.

The Arbitrator further finds that at least part of the Petitioner's ongoing respiratory problems are due to the mold exposure at work and resulting ABPA. While it is clear that the ABPA infection has resolved, as noted above, Dr. Istanbouly pointed to objective evidence on film which showed resultant scar tissue or fibrosis in the lung, and testified that this was a permanent condition. That said, it is equally clear that a portion of the scar tissue/fibrosis seen in the lungs was due to her preexisting condition. Based on the testimony of Dr. Istanbouly, this preexisting scarring would also be considered permanent.

Unfortunately, it appears that there is no way to know how long black mold had been in the wall of the Petitioner's office at Continental Tire. It was discovered when the file holder fell from the wall, but no evidence

was presented which would estimate how long that mold may have existed prior to the discovery. Thus, while there was evidence indicating that the Petitioner's symptoms and various respiratory complaints became worse starting in approximately 2010 or 2011, there is no way to separate out, based on the evidence, how much of the Petitioner's ongoing problems are due to the mold exposure versus worsening of her preexisting condition.

The Arbitrator finds that the Petitioner's preexisting respiratory condition was aggravated by the mold exposure in this case, and that her ongoing condition remains causally related, in part, to the 10/18/13 accident.

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

Based on the Arbitrator's findings regarding accident/exposure and causation, the Arbitrator further finds that the Petitioner is entitled to the requested medical expenses submitted into evidence. There is no indication that any of the charges or the services related to said charges are unreasonable or unnecessary. Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $399.00 to Cape Radiology, $26,108.68 to Herrin Hospital, $19,076.00 to Dr. Suhail Istanbouly, $119.00 to Dr. Ralph Latta, $650.00 to Michael Nicholas, Ph.D., and $265.00 to SI Medical Services ER Medicine, as provided in Sections 8(a) and 8.2 of the Act. However, the Respondent is not liable for the liver function lab test bill of $546 from Herrin Hospital performed on 5/28/2014, which is contained in Px1.

The Arbitrator further finds that the Xolair injections that Dr. Istanbouly is providing to the Petitioner on an ongoing basis are considered reasonable and necessary for an additional year. Dr. Von Essen's testimony supports that these injections are not supposed to continue indefinitely according to current medical literature, and that it has only been approved to date for allergic asthma. As the Petitioner's asthma in 2015 was noted to be under good control per Dr. Von Essen, the Arbitrator finds that these injections should not continue indefinitely. Dr. Istanbouly himself agreed with this, and indicated that injections would continue for another year. The Respondent is not liable for further Xolair injections after one year from the hearing date.

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

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

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence by either party. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a clerical or office worker at the time of the accident and that the claimed incident did not require medical treatment during her employment with Respondent. Further, Petitioner has been able to continue in the full performance of her duties as an office worker with subsequent employers with no claim of lost time since the occurrence. Petitioner initially performed only part-time work, but there is no medical restriction basis for this that is related to the work accident. The Arbitrator gives reasonable weight to this factor, as the Petitioner is essentially prohibited from working in an environment with mold that could trigger another infection.

With regard to subsection (iii) of §8.1b(b), the Arbitrator finds that Petitioner was 47 years old at the time of the accident. Neither party has submitted evidence which indicates the impact of the Petitioner's age on her permanent disability. The Arbitrator notes that the Petitioner will have to live with what appears to be a greater predisposition to infection and/or asthma attack as a result of the mold exposure and resultant lung fibrosis. Therefore, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator finds that Petitioner lost no time from work following the occurrence in August, 2013, and that despite the treatment she has undergone, including twice monthly Xolair injections, she has continued working in her chosen professions as of the hearing date. There is no evidence in the record that would indicate that the Petitioner's future earning capacity has been adversely impacted by this accident and resulting injuries. The Arbitrator gives reasonable weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds that petitioner had well documented asthma and respiratory problems prior to her employment with respondent in 2007, and developed complications from that underlying condition as early as 2010 according to the testimony. This is three years prior to the discovery of mold in her workplace. However, as noted above, there is no way to know how long any exposure to black mold lasted prior to the discovery.

The Arbitrator believes, based on a review of all of the evidence in this case, that the Petitioner clearly had a preexisting asthma condition which required treatment on an ongoing basis, minimally via inhalers to be used as needed. Her testimony reflects her subjective complaints that her preexisting condition was significantly worsened as a result of the mold exposure. The Arbitrator believes that this exposure did, in fact, worsen the Petitioner's preexisting condition and has likely led to a greater propensity to develop infections in the lungs and/or asthma attacks as the result of additional fibrosis and Dr. Istanbouly's testimony regarding a greater predisposition. At the same time, the Arbitrator believes that the evidence presented via Dr. Nicholas indicates a certain level of anxiety in the Petitioner, and that this appears to also be a contributor to her ongoing subjective complaints. He indicated solid improvement in her ability to handle her condition via coping mechanisms. Petitioner testified that she was offered full-time work by the initial employer she worked for subsequent to

Respondent, but she did not feel she could work full-time due to her anxiety issues, which, as noted, pre-existed her mold exposure. The Arbitrator notes that Dr. Istanbouly confirmed in his testimony that at no time did he authorize petitioner off of work or limit her work activities to part-time only.

Overall, the Arbitrator finds that a portion of the Petitioner's ongoing problems are due to the mold exposure, but that much of her ongoing condition remains due to her preexisting condition. Based on all of the above noted factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a 10% loss under section 8(d)2 as a result of the 10/18/13 work injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Kalis,

Petitioner,

vs. NO: 13WC 02822

Safeway Services,

17IWCC0653

Respondent,

DECISION AND OPINION ON REVIEW

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

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

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

17IWCC0653

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 17 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

o101117
CJD/rlc
049

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

KALIS, ROBERT
Employee/Petitioner

Case# **13WC002822**

SAFEWAY SERVICES
Employer/Respondent

17IWCC0653

On 6/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% 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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
LINDSEY BEUKEMA
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
19(b)/8(a)

Robert Kalis
Employee/Petitioner
v.
Safeway Services
Employer/Respondent

Case # 13 WC 02822

17IWCC0653

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

DISPUTED ISSUES

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

17IWCC0653

FINDINGS

On the date of accident, **January 8, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$126,360.00**; the average weekly wage was **$2,430.00**.

On the date of accident, Petitioner was **46** 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 **$32,005.51** for TTD, **$9,610.81** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$41,616.32**. The Parties agreed that Petitioner was entitled to TTD benefits of $1,243.00/week from June 15, 2011 through August 28, 2011 and from December 7, 2012 through March 17, 2012 and TPD benefits of $686.49/week from March 18, 2013 through May 4, 2013 and that all said benefits have been paid.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $4,535.93, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be entitled to a credit for all claimed bills that it has paid.

Respondent shall authorize and pay for the requested left total knee replacement and all related services, pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

June 7, 2016
Date

ICArbDec19(b)

JUN 7 - 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

FINDINGS OF FACT:

Petitioner, ROBERT KALIS was a 46 year old carpenter employed by Respondent, SAFWAY SERVICES. He worked for Respondent for 28 years, he started working for the Respondent on April 4, 1985 as a laborer and in 1991 he began working for them as a carpenter and later was promoted to the position of superintendent. His job duties involved both the manual labor of a carpenter and the managerial work of a site superintendent, with his work day apportioned approximately one third, two thirds, respectively. He would run crews of anywhere between four and thirty men, his duties included bidding, selling and scheduling work, payroll, assisting sales reps, as well as the physical duties of a carpenter, including lifting and climbing up and down swing stage modular scaffold, lifting 55 pound counter weights and individually lifting I-beams that weighed as much as 120 pounds. The requirements of his trade demanded that he be able to lift objects upwards of 160 pounds.

Petitioner's past medical history includes a March 14, 2007 left knee arthroscopy, as a result of a basketball injury, with several subsequent knee injections through 2010. He was diagnosed with moderate arthritis in August of 2007. Dr. Bartucci took Petitioner off work following the 2007 arthroscopy, however once he recovered, he was able to resume working at full duty effective June 5, 2007. Petitioner did return to Dr. Bartucci and received injections on several occasions up until August 16, 2010. He lost no time from work due to his knee, from the time he returned to work after the 2007 arthroscopy, until he was subsequently injured in the automobile accident of January 8, 2011. (PX8)

On January 8, 2011, Petitioner was delivering materials to a job site, pulling a bobcat on a trailer. As he approached a red light on Congress and depressed the brake, the trailer on the twelve foot truck he was driving failed to properly brake. The trailer locked up and swung into the left lane. Petitioner maneuvered his vehicle away from traffic and it went directly into a "dead man's wall," colliding with it at approximately 40 miles per hour. From the site of the accident, Petitioner called Respondent's branch manager and the project superintendent and notified them of the accident. The disabled truck was towed away from the crash site. Petitioner injured his left knee, shoulder and neck in the accident but did not seek treatment initially due to his heavy work load with Respondent. Upon the advice of his branch manager, McCarthy, Petitioner went to Advanced Occupational Medicine Specialists on January 26, 2011 and was seen by Dr. Rajeev Khanna, M.D. Petitioner stated that he hit his head, left shoulder, and left knee against the side of the car, he had current complaints of neck, left shoulder and left knee pain. Following the accident, he initially suffered from occasional headaches and dizziness, which had resolved. He was diagnosed with a head contusion, a cervical neck sprain, neck pain, left shoulder contusion and pain, and a left knee contusion and pain. Dr. Khanna recommended icing the affected areas three times per day, Ibuprofen, and to follow up on January 31, 2011. Petitioner remained able to work, full duty. (PX6)

Petitioner attended the follow up appointment with Dr. Khanna on January 31, 2011. He continued to complain of some neck and shoulder discomfort, as well as significant left knee discomfort. He reported that he continued to do his regular work, however it was causing a lot of discomfort. Dr. Khanna diagnosed Petitioner with a possible left glenoid labrum tear, possible cervical disc syndrome and a left knee contusion. Dr. Khanna ordered a follow up on February 7, 2011 and recommended an MRI of his left shoulder and neck if his symptoms persisted. Petitioner was advised to stop the Ibuprofen, continue to ice the affected areas and to being taking MDP and Cyclobenzaprine. At the February 7, 2011 appointment, Dr. Khanna noted that Petitioner presented with an antalgic gain. Upon examination of the left shoulder, Dr. Khanna noted a positive O'Brien test and a test positive for mild impingement of the supraspinatus. In Dr. Khanna's examination of Petitioner's left knee, he noted positive tests for the medial joint line, lateral joint line, quads was active, patellar apprehension, squat test, and one leg squat. Petitioner was diagnosed as status post blunt head trauma, cervical strain/pain, left shoulder contusion and possible labral tear, and left knee contusion and possible meniscus tear. Dr. Khanna recommended an MRI of both the left knee and left shoulder, he recommended the continued use of ice, to resume taking Ibuprofen and to continue with the Cyclobenzaprine. Petitioner could continue with regular work and was ordered to follow up after th MRIs. (PX6)

The February 10, 2011 MRI of the left shoulder revealed supraspinatus tendinosis, superior labrum anterior posterior (SLAP) tear and acromioclavicular arthritis. The left knee MRI revealed an abnormal appearance of the posterior horn and body of the medial meniscus, compatible with an acute tear, moderate to high grade chondromalacia of the patellofemoral compartment, chondromalacia of the medial and lateral femorotibial compartment, intraligamentous cyst/mucoid

degeneration of the anterior cruciate ligament, joint effusion and tissue edema. When Petitioner returned to Dr. Khanna on February 14, 2011, he was diagnosed with a left shoulder labral tear, left shoulder pain, a left knee medial meniscal tear, left knee pain and neck pain. He was referred to Dr. Christos Giannoulias for treatment of the left shoulder and knee. (PX8)

Petitioner presented to Dr. Giannoulias on February 15, 2011 for consultation regarding his shoulder and knee injuries. Dr. Giannoulias reviewed the shoulder and knee MRIs and noted Petitioner's medical history as significant for left knee arthroscopy. In his physical examination of Petitioner's left shoulder, Dr. Giannoulias noted tenderness over the tuberosity, a positive O'Brien's test, pain over the AC joint, elevation to 150 degrees, external rotation to 80 degrees, internal rotation to upper spine and strength was 4+/5. On exam of Petitioner's left knee, Dr. Giannoulias noted some crepitation in the medial compartment, some tenderness with circumduction and range of motion from 0 to 120 degrees. The X-rays of the shoulder were negative and the X-rays of the knee revealed arthrosis in the medial compartment. Dr. Giannoulias diagnosed a left shoulder labral tear, AC joint arthrosis and left knee arthrosis. He was prescribed four weeks of physical therapy, three times per week and to follow up in four weeks. If the symptoms persisted, the doctor opined that he would be a good candidate for evaluation and repair of his labrum and AC joint. Dr. Giannoulias noted that Petitioner's knee symptoms were more related to the arthritic aspect of his condition and that arthroscopy would more than likely not help with pain secondarily to the fact that he has very severe arthritis in the medial compartment. Petitioner attended physical therapy at Advanced Occupational Medicine Specialists with therapist Emalyn Agoncillo. In her examination, she noted positive VMO atrophy of the left thigh, positive locking of terminal knee extension, positive antalgic gait with decreased weight bearing on the left, difficulty ascending and descending stairs, left knee pain reported at five to six out of ten, difficulty with partial squat and single leg heel raises on the left whereas he was able to perform ten times on the right without pain. Range of motion was measured as 130/135 both knees for flexion, right extension was zero degrees and left was negative twenty. Petitioner tested positive for pain on Apley's compression, McMurray's IR/varus test and Ober's test on the left side. It was noted by his therapist that Petitioner should attend physical therapy three times a week for four weeks. (PX3; PX6)

On March 15, 2011, Petitioner attended his follow up appointment with Dr. Giannoulias. Dr. Giannoulias noted that his shoulder was improving with therapy, but that his knee pain comes and goes, particularly with climbing and going up and down stairs. Dr. Giannoulias noted Petitioner's diagnoses of left shoulder impingement, AC joint degeneration, SLAP tear, left knee medial meniscus tear and medial compartment arthrosis. Petitioner was given injections to both the subacromial space of his left shoulder and his left knee joint and surgery was discussed as an option should his symptoms persist. Petitioner continued his course of physical therapy and was re-evaluated by Dr. Giannoulias on April 26, 2011. He continued to have pain in his left shoulder and knee, noting good days and bad days. It was noted that Petitioner wanted to wait on the option for surgery. He was given an intraarticular knee injection of 2 cc Depo-Medrol and 6 cc of lidocaine, continued on his physical therapy and was scheduled to follow up three weeks later. Petitioner's next appointment with Dr. Giannoulias occurred on May 17, 2011. He continues to have good days and bad, he continues to have trouble going up and down the stairs and he has trouble with overhead activity. The left knee examination revealed tenderness over the left medial joint line and pain with circumduction and compression. The left shoulder exam revealed pain over the AC joint, positive impingement signs and pain with an O'Brien maneuver. Dr. Giannoulias noted his diagnoses of Petitioner as consisting of a superior labral tear, AC joint arthrosis, left knee arthrosis and a meniscus tear. He noted that Petitioner had failed conservative therapy and that he recommended surgical intervention. He recommended an arthroscopic procedure to the knee to address the medial meniscus tear. Petitioner saw Dr. Khanna for pre-operative clearance. (PX3; PX6)

Dr. Giannoulias performed surgery on Petitioner's left knee on June 14, 2011. He performed a left knee partial medial meniscectomy, an extensive two compartment synovectomy, and a patellofemoral chondroplasty. Dr. Giannoulias noted Petitioner's post-operative diagnoses to include a left knee medial meniscus tear, left knee grade II patellar and trochlear chondromalacia, grade III medial femoral and tibial plateau chondromalacia, grade II lateral condyle and lateral plateau chondromalacia and extensive multiple compartment synovitis. Petitioner was taken off work. Petitioner followed up with Dr. Giannoulias on June 21, 2011 for suture removal. It was noted that he developed some swelling after surgery and examination revealed well healed incisions, a large effusion and range of motion from 10 to 80 degrees. He was diagnosed with a medial meniscus tear and degenerative joint disease. It was noted that Petitioner was taking Ibuprofen and that he was instructed to use ice, to resume a supervised course of physical therapy and to follow up in two to three weeks. He was to remain off work. Petitioner resumed his course of physical therapy and was seen by Dr. Giannoulias on July 19, 2011 for follow up appointment. Petitioner continued to report having good days and bad days and he reported having improvement with physical therapy. The examination of his left knee revealed well healed incisions, range of motion from 0

to 120 degrees, significant quadriceps atrophy, and weakness with knee extension and hip flexion. Dr. Giannoulias recommended that Petitioner continue with physical therapy three times a week for four weeks and to work on his strengthening for his recovery. Dr. Giannoulias restricted him to sedentary office work only, no squatting, bending, climbing, pushing or pulling, he was restricted to one to three hours driving, one to three hours standing or walking and overhead work was restricted to five to eight hours. (PX3; PX6)

Petitioner continued with physical therapy until July 26, 2011, when Dr. Giannoulias operated on his left shoulder, performing a left shoulder subacromial decompression, distal clavicle excision and a glenohumeral extensive debridement. Dr. Giannoulias noted postoperative diagnoses of left shoulder subacromial impingement, distal clavicle arthrosis, left shoulder synovitis, hemarthrosis, grade II and III changes of the inferior glenoid and degenerative fraying of the anterior, superior and posterior labrum. Petitioner followed up with Dr. Giannoulias on August 2, 2011. His sutures were removed and it was noted upon examination that there was ecchymosis anteriorly, that he had full range of motion with the elbow and wrist, that passive elevation is to about 80 degrees and that external rotation is 30 degrees. Dr. Giannoulias noted the AC joint arthrosis and impingement and wanted Petitioner to participate in a supervised course of physical therapy. He was taken off of work and was instructed to follow up in three weeks. Petitioner followed up with Dr. Giannoulias on August 23, 2011. It was noted that he was progressing fairly well with his left shoulder and that his main problem was pain in his left knee with prolonged walking. The examination of the left shoulder revealed well healed incisions, elevation to 160 degrees, external rotation to 50 degrees and internal rotation to the lower lumbar spine. He has 4-/5 strength in elevation and external rotation. The examination of the left knee revealed slight effusion, range of motion from about 3 to 120 degrees, quadriceps atrophy and tenderness over the medial and lateral joint line. Dr. Giannoulias noted left shoulder impingement, AC joint arthrosis, left knee meniscus tear and degenerative joint disease. He injected Petitioner's left knee with 2 cc of Depo-Medrol and 6 cc of lidocaine. Petitioner was instructed to continue his exercises and therapy for both his left knee and shoulder, and to follow up in three to four weeks. He was restricted to maximum lifting and carrying of five pounds, walking, standing, bending, pushing, pulling and driving for one to three hours and sitting for five to eight hours. He was also restricted from any overhead work, climbing or squatting. He continued his physical therapy. (PX3; PX6)

Petitioner followed up with Dr. Giannoulias on October 11, 2011. Dr. Giannoulias noted that Petitioner is doing great, as it pertains to his shoulder, however the knee is still bothering him. He was given another injection into his knee consisting of 2 cc of Depo-Medrol and 6 cc of lidocaine. Dr. Giannoulias discussed with Petitioner how he was going to have good and bad days with his knee as a result of the arthritic changes. He was released to return to work but was restricted from kneeling, squatting, and climbing. Petitioner followed up with Dr. Giannoulias on November 1, 2011. He was given another injection and it was recommended that he begin receiving viscosupplementation injections. It was noted that his shoulder was doing great. Petitioner made a follow up appointment on November 8, 2011 to begin a course of Hyalgan injections. Dr. Giannoulias noted the diagnosis of left knee Osteoarthritis and injected Petitioner's knee with 1 unit of Hyalgan. He was prescribed Voltaren gel and Norco. Petitioner followed up with Dr. Giannoulias four more times until he received his fifth Hyalgan injection on December 27, 2011. At this time, Dr. Giannoulias discussed with Petitioner the possibility that if his symptoms persisted despite the conservative care, he would be a candidate for knee replacement. Petitioner returned to Dr. Giannoulias on January 17, 2012. He presented with a flair-up with pain, aggravated by the weather. He was given a cortisone injection and Dr. Giannoulias explained that he could give him three to four more injections if needed, however that this is a permanent condition and that he will have good and bad days. He discussed the possibility that he would need a total knee replacement secondary to his symptoms. His next appointment occurred on February 16, 2012. At that time, Dr. Giannoulias noted another bad flair-up and that Petitioner's requested another injection. He administered the injection and directed him to follow up in a few weeks. The following appointment occurred on February 28, 2012. It was noted that Petitioner was experiencing daily pain and the previous cortisone injection only provided temporary relief. Dr. Giannoulias referred Petitioner to Dr. Stewart for a plasma platelet injection, they again discussed the potential need for a knee replacement and he noted Petitioner's desire to avoid such a surgery if possible. Dr. Giannoulias administered another cortisone injection. (PX3; PX6)

After the plasma platelet therapy was denied by Respondent, Petitioner desired to get a second opinion from another orthopedic surgeon. Petitioner then saw Dr. Bernard Bach, at Midwest Orthopedics at Rush, on June 27, 2012. Dr. Bach agreed that Petitioner had medial compartment arthritis but noted that he did not review any comparison imaging studies in conjunction with the radiographic images he did review. Dr. Bach believed that Petitioner's loss of range of motion was due to scar tissue on the medial side of this knee and that this scar tissue was caused either by the blunt trauma or the previous

surgeries. Dr. Bach recommended another arthroscopic surgery for the lysis of adhesions, followed by another six to twelve weeks of physical therapy. (PX4; RX2)

On December 7, 2012, Dr. Bach performed left knee surgery: arthroscopic extensive lysis of adhesions and debridement of distal patellar osteophyte. Thereafter, Petitioner began his course of physical therapy at Industrial Rehab Allies, beginning on December 12, 2012. On December 18, 2012, John Comerouski, PT noted in his examination of Petitioner that he had an extremely antalgic gain, obvious left calf atrophy and swelling throughout the knee joint region. Weakness was also apparent with Petitioner unable to straight leg raise without at least an additional five to ten degrees of active lag. Petitioner was seen again by Dr. Bach on December 19, 2012. Dr. Bach noted the use of extension boards in his physical therapy and that this is causing shooting pains from his back. Petitioner was prescribed Celebrex for ten days followed by Medrol Dosepak, he was also given a prescription for an extension board and directed to follow up in six weeks. He was restricted to desk type work only, with no more than 10 pounds lifting, pushing or pulling. In his subsequent physical therapy sessions, it was noted by the therapist that Petitioner was concerned with ongoing pain throughout the left lower extremity, including his groin and ankle regions. Petitioner followed up with Dr. Bach on January 23, 2013. Dr. Bach noted that while supine, Petitioner appeared to have a two to three degree flexion contracture (PX2; PX4; RX2)

Petitioner scheduled a follow up appointment with Dr. Fardon on February 7, 2013. Dr. Fardon noted that possible causes for the Petitioner's left calf atrophy were due to neuromuscular dysfunction or from disuse, but that in his experience, it was odd to have the level of atrophy present in Petitioner's left leg with the rather limited disuse that he has had, that the atrophy was out of proportion with the amount of disuse he had in his legs secondary to his knee problems. Dr. Fardon ordered an MRI of Petitioner's lumbar spine as well as electrodiagnostic studies of his leg. Dr. April Fetzer D.O. performed the left lower extremity EMG. She noted an abnormal examination with diagnostic evidence of aggravation of the left superficial peroneal nerve and fibular head. Petitioner was seen by Dr. Fardon on March 5, 2013 to discuss the EMG results. Based on Petitioner's physical therapy history which included activities which stretched the peroneal nerve after experiencing a flexion contracture, the therapist's attempt to stretch his leg out made his neurological conditions worse, which is consistent with the finding of slowed peroneal nerve conduction across the knee. Dr. Fardon explained that the peroneal nerve may have been somewhat sensitized by proximal compression due to stenosis in Petitioner's lower back, creating a situation where he was at higher risk for double crush phenomena, the trauma that he suffered to his knee provoked his symptoms in the peroneal branch of the sciatic nerve which derived from the fifth lumbar nerve root primarily. It was Dr. Fardon's opinion that the problems that he has had with his knee have aggravated his vulnerability to his peroneal nerve to create the symptoms. On March 11, 2014 Dr. Fetzer performed an L4-5 transforaminal epidural steroid injection to treat left L5 radiculitis, as ordered by Dr. Fardon. (RX4)

On March 14, 2013, Petitioner underwent a functional capacity evaluation at Industrial Rehab Allies, with therapist Steve Adamkiewicz, upon the order of Dr. Bach. Mr. Adamkiewicz found the examination to be valid and reported that Petitioner demonstrated a protected work tolerance at the medium physical demand level. As the full performance of Petitioner's job requires activity at the medium-heavy physical demand level, Dr. Bach recommended work hardening. On April 24, 2013, Dr. Bach opined that Petitioner was at MMI, but would need a knee replacement. He reiterated Petitioner's physical restrictions as maximum lifting of 10 pounds, occasional lifting and carrying articles such as dockets, ledgers and small tools. Petitioner later returned to Dr. Bach on June 20, 2013. Although Dr. Bach had previously recommended the permanent restrictions stated above, upon request of Petitioner, Dr. Bach gave him a full duty release to commence on June 24, 2013. (RX2; PX4)

Petitioner returned to Dr. Giannoulias on March 31, 2015 for complaints of significant left knee pain and swelling, Dr. Giannoulias noted the left knee arthrosis and in the examination of the left knee, Dr. Giannoulias noted range of motion from 5 to 120 degrees, lacking degrees of flexion and extension with crepitation throughout range of motion. He noted that patellofemoral disease and significant medial compartment loss was visualized in X-rays taken during this visit. 3 cc's of blood was aspirated from his left knee and he was injected with 2 cc of Depo-Medrol and 6 cc of lidocaine, total knee replacement was again discussed. Petitioner last followed up with Dr. Giannoulias on November 3, 2015. Another knee injection was provided and it was noted that Petitioner is now waiting to get his knee replaced. Dr. Giannoulias stated that this is the best way to get him back to his pre-injury status. (PX3)

Petitioner testified that he treated with Dr. Bartucci prior to the January 8, 2011 accident. He underwent knee surgery in year 2007. He had returned to work at full duty prior to the January 8, 2011 accident. Petitioner's knee did not

interfere with his ability to do his job prior to 2011. He was never prescribed or recommended to have a total knee replacement surgery by Dr. Bartucci or any other doctor prior to the accident that is the subject matter of this case.

After the accident, Petitioner chose to delay immediate treatment because he was concerned with performing his job duties. Thereafter, he did go to the doctor because he was instructed to do so by his branch manager, McCarthy. He later began treating with Dr. Giannoulias, on a referral from Respondent's Occ. Med. Clinic, for the left shoulder and knee injuries suffered in the accident. He had arthroscopic shoulder and knee surgery. He had ongoing and constant knee pain, originating with the January 8, 2011 injury. Dr. Giannoulias advised Petitioner that he was a candidate for total knee replacement surgery. Petitioner sought a second opinion with Dr. Bach. Dr. Bach prescribed a different procedure which ultimately did not provide him with any pain relief (increased range of motion was noted), moreover, he developed nerve pain running through his shin to his groin.

Petitioner denied subsequent injuries to his left knee or left shoulder.

Respondent stopped paying lost time benefits in May of 2013. Petitioner understood that this occurred as a result of Dr. Bach noting his belief that his need for TKA surgery was unrelated to the January 8, 2011 accident. At this time, he had a 10 pound lifting restriction. As he was now running out of his savings and needed money to pay bills, Petitioner asked Dr. Bach to release him to full duty. Dr. Bach wrote a full duty release on June 24, 2013. (RX 2)

Petitioner wants to undergo the proposed total knee replacement and requested that this surgery be authorized.

When he returned to work at Respondent, he was given his previous job title of construction manager. However, as that position was already held by someone else on the job site, he was assigned the duties of a foreman. Petitioner attempted to perform the duties of his job, but experienced brutal and chronic pain in his left knee going down to his shin. Petitioner worked for about 6 months. He was fired when his employer accused him of stealing gas. Petitioner believes he was blackballed from the carpentry. He has had trouble finding work. Ultimately, Petitioner was able to work for a friend who owned a scaffold company. He works there on a limited basis, working about three days on a good week and about eight to ten days per month. Petitioner describes his abilities in doing this job as very limited. When he is required to climb, he has to create a crutch out of his arms, moving his legs with his arms step by step, he cannot move normally on the scaffold, and his co-workers have to give him extensive help to complete the duties of his job. He has left groin and knee pain every day, he takes Ibuprofen, wraps, various ointments and neoprene knee braces. None of these modalities really helps. He has had to adapt to the job site, leaning on his co-workers to do the tasks he is unable to perform himself, such as going up a scaffold. He walks with a limp. He never had a limp prior to his 2011 injury. His knee swells up every day; he has to use ice and heat on his knee daily. He has trouble sleeping. He has to lie on his left side to help with the knee pain, however when he does this, his left shoulder hurts. His left shoulder is not as bad as his knee, however he has pain when he does overhead work. He is required to do overhead work every day. Petitioner describes his knee pain as brutal, the type of thing you wouldn't wish on anybody.

The Arbitrator observed that Petitioner walked with a limp. He favored his left knee. His left calf was smaller than the right calf and that there was a lump on the lateral aspect of the left leg above the ankle. His left knee was swollen. Petitioner testified that his left calf was not smaller than the right calf prior to his 2011 injuries.

The Testimony of Dr. Christos Giannoulias, Petitioner's Orthopedic Surgeon (PX 10)

Dr. Giannoulias testified by way of evidence deposition on April 13, 2015. Dr. Giannoulias is an orthopedic surgeon and is board certified in both orthopedic surgery and orthopedic surgery sports medicine. (PX10 p. 4-5) He graduated from the Chicago Medical School, did a five year residency program in orthopedic surgery at Loyola University Medical Center and completed a one year fellowship in sports medicine the New England Medical Center. (PX10 p. 5) He performs about 150 shoulder and 150 knee operations per year. (PX10 p. 5)

Dr. Giannoulias testified that any type of force across a joint can cause damage and the faster an object is moving, the more force will be generated across a body part that is struck in this manner (PX10 p. 7) Surgery is a traumatic event that can cause an acceleration, aggravation, or exacerbation of previously existing arthritis (PX10 p.7) When performing a meniscectomy, an increase in the load or force is applied across the knee joint space and this can cause a pre-existing arthritic condition to accelerate (PX10 p. 7) The removal of 50 percent of someone's meniscus, by itself, is going to accelerate an arthritic condition because it is going to increase the load of the two pieces of cartilage touching each other (PX10 p. 18) The main reason to do an arthroscopy for a patient with knee pain and arthritis is to correct mechanical symptoms or meniscus pathology. If the patient is only suffering from arthritis, then such a procedure rarely helps,

therefore he tries to avoid it except as a last resort (PX10 p. 11) Chondromalacia has four grades; grade one chondromalacia is a mild softening of the cartilage, grade two is where the top layer of the cartilage is starting to wear away, it is considered grade three when more than 50 percent of the cartilage is wearing away, and grade four is when the bone is exposed (PX10 p. 13)

Dr. Giannoulias testified that he first treated the Petitioner on February 15, 2011 (PX10 p.7-8) Petitioner gave Dr. Giannoulias a history; he described being involved in a motor vehicle collision in which he injured his left knee and left shoulder which was causing him left shoulder and knee pain (PX10 p.8) Petitioner described a prior knee condition which required an arthroscopy in 2007 and subsequent injections through 2010, during which time he was working as a heavy laborer (PX10 p. 8) Petitioner brought with him copies of the X-rays and MRI's of both his left knee and his shoulder (PX10 p. 9) Upon review of the shoulder MRI, Dr. Giannoulias diagnosed a labral tear and rotator cuff tendonitis. The left shoulder X-Ray was negative (PX10 p. 9) He determined from the left knee X-Ray that Petitioner had arthritis in the medial compartment. The left knee MRI revealed a blunting of the meniscus, as well as medial compartment fragments (PX10 p.10) Based on both the shoulder and knee diagnoses and considering Petitioner's age group, Dr. Giannoulias recommended conservative care. He started him with a course of physical therapy, noting that if the symptoms did not go away, they would discuss doing injections (PX10 p.10)

Petitioner did not respond well to conservative care. Ultimately Dr. Giannoulias performed injections in both his left shoulder and knee. (PX10 p.10) It was determined that Petitioner would benefit from an arthroscopic procedure on his shoulder, which was performed and from which Petitioner recovered from very well. (PX10 p. 10) They wanted to avoid knee surgery, as Petitioner already had arthritic changes in his knee. As the course of physical therapy and multiple rounds of cortisone injections failed, they collectively decided to proceed with the knee arthroscopy. (PX10 p. 11, 27)

Dr. Giannoulias performed an arthroscopy on Petitioner's left knee on June 14, 2011 comprised of a partial medial meniscectomy, wherein 50 percent of the meniscus was removed; a synovectomy, wherein he removed inflamed tissue lining the synovium join; and a chondroplasty, in which the he shaved away cartilage underneath the kneecap. (PX10 p. 12) The postoperative diagnosis was: medial meniscus tear, grade two patellar and trochlear chondromalacia, grade three medial, femoral and tibial plateau chondromalacia, and grade two lateral condyle and lateral plateau chondromalacia and synovitis. (PX10 p. 13) Dr. Giannoulias examined Petitioner post-operatively, and placed him in physical therapy. Petitioner continued to have symptoms in the knee. (PX10 p. 14) Dr. Giannoulias then decided to proceed with a Hyalgan injection, for the arthritis, as Petitioner was not doing great after surgery. (PX10 p.14) He later examined Petitioner on December 27, 2011, this was after the Hyalgan treatment and his fifth injection. (PX10 p. 14) Given the fact that Petitioner was continuing to have pain and was not doing well after this course of treatment, Dr. Giannoulias believed that he may be a candidate for knee replacement. (PX10 p. 14)

Dr. Giannoulias was aware that Dr. Bach performed a synovectomy and capsular release on Petitioner in December of 2012, by review of the operative report, and that Dr. Bach observed the chondromalacia in Petitioner's medial compartment to be at grade four. (PX10 p. 15) He noted that as of June, 2011, Petitioner had grade two to three chondromalacia, but by December 2012, it had progressed to grade four. (PX10 p. 15)

This was the last date that Petitioner treated with Dr. Giannoulias prior to 2015. He did not place any restrictions on the Petitioner and noted that he was working his regular job. (PX10 p. 30) The next time that he would examine Petitioner would be on March 31, 2015. (PX10 p. 14)

In relation to the mechanism of injury, Dr. Giannoulias opined that although it would not cause arthritis, a blow to the knee can cause synovitis as well as a meniscus tear, and because the symptoms were significant after the accident, Dr. Giannoulias explained that it was more than likely that the meniscus tear and the synovitis were directly related to the accident. (PX10 p. 12)

In his February 28, 2015 narrative repot, Dr. Giannoulias opined that if it were not for the January 2011 accident, the need for knee replacement would more than likely have been delayed and the two surgeries after the January 8, 2011 accident more likely than not would not have occurred. He further opined that repeated surgeries can certainly accelerate arthritic conditions and the subsequent two surgeries more than likely accelerated the preexisting osteoarthritis. (PX10 Dep. Ex. 2)

Dr. Giannoulias explained at pages 17 and 18 of his deposition:

6 Q. Doctor, in that record Dr. Bach opined that it

was his opinion that this degree of arthritis was longstanding and was not worsened by his injury. Do you agree or disagreement with that statement?

A. Well, I disagree with that statement in the sense that there's a lot of gray involved with arthritis.

So I agree that he had pre-existing arthritis. That's obvious from reviewing the medical records, even looking at his X-rays before I did surgery on him.

The difference, and the reason that I disagree, is that Dr. Bach opines that there is zero aggravation, there's no change in this gentleman's arthritis after his incident.

And so my disagreement is based on the fact that from 2007 until 2011, he was dealing with the symptoms that he had in his knee. He had arthritis. It was mild to moderate.

18

Occasionally he would go in and get injections, and he was working as a laborer. He has this injury in 2011, which necessitates additional treatment, and conservative care was obtained. We did significant conservative treatment, but he just didn't get better, so we proceeded with arthroscopy. With that arthroscopy he had significant risks. We removed 50 percent of his meniscus.

So just in and off of itself, removing 50 percent of someone's meniscus is going to change the physical forces on the knee. It's going to increase the load of the two pieces of cartilage touching together. So that alone is going to accelerate an arthritic condition.

And on top of that, looking at his operative report from June of 2011, to the operative report of December 2012, he had a change from grade two and three chondromalacia to grade four chondromalacia. So there was certainly a worsening of his chondromalacia.

So I don't agree with Dr. Bach saying his accident and then the surgery after the accident did not cause any acceleration or aggravation. I disagree with that.

(PX10 p. 17-18)

Dr. Giannoulias also reviewed the Section 12 report produced by Dr. Bare and disagrees with his conclusion that the Petitioner's arthritic condition was likely just the result of the natural progression of arthritis. He explained, "Mr. Kalis had 50 percent of his meniscus excised in June of 2011, and that is probably the biggest factor for me to opine that that in and of itself will cause an acceleration or an aggravation to someone's condition, arthritic condition in and of itself, regardless of this flexion contracture that Dr. Bare is opining". (PX10 p. 20) He further opined that Petitioner's need for

the knee replacement is not the result of the natural progression of the arthritis in his knee, as he would have probably needed a knee replacement but it would have occurred much later in time, if he did not have the motor vehicle accident in 2011. (PX 10 p. 21-22)

Dr. Giannoulias testified that, to a reasonable degree of medical and surgical certainty, the medical treatment provided to Petitioner for his left shoulder and knee was reasonable and necessary to treat the injuries that he suffered in accident of January 8, 2011. (PX10 p. 21)

On cross examination, Dr. Giannoulias agreed that Petitioner had very severe arthritis and that on the MRI the meniscus looked smaller, probably from the previous meniscectomy, however it did not specifically look like a meniscal tear. This was one of the reasons he preferred starting with conservative treatment. (PX10 p. 23-24) Dr. Giannoulias did not initially want to do an arthroscopy because he did not think it was going to do much for Petitioner at that time. He agreed that the standard of care for treating arthritic changes in a knee does not call for an arthroscopy unless the patient has exhausted conservative care or if there is a finding consistent with a meniscus injury. (PX10 p. 25, 26) In the February 28, 2012 examination, Dr. Giannoulias noted no loss of range of motion, no contracture, however he did refer the Petitioner for plasma platelet injections. Dr. Giannoulias did not know whether that treatment was administered (PX10 p. 30) He agreed that the arthritis was a pre-existing condition and the joint narrowing and loss of cartilage was not caused by the accident. (PX10 P. 25)

In order to eliminate Petitioner's symptoms of knee pain, a total knee replacement would be needed. (PX10 p.28) He does not believe that the 2011 surgery caused a flexion contracture in Petitioner's knee and that if a patient develops flexion contracture due to surgery you should see it within six months of the date of surgery. (PX10 p. 30, 31) He agreed that it is possible to suffer from degenerative meniscal pathology, that this is differentiated from acute tears because it appears fibrillated, rather than thecleaves and tears found in acute tears. Petitioner's meniscus did not appear to be degenerative because it presented with a tear. (PX10 p. 33)

The Testimony of Dr. Aaron Bare, Respondent's §12 Examining Physician (RX 1)

Dr. Aaron Bare testified by way of evidence deposition on November 12, 2014. Dr. Bare is a board certified orthopedic surgeon. (RX1 p. 4-5) He did most of his training at Northwestern University and completed a fellowship in Los Angeles, specializing in shoulder and knee injuries (RX1 p. 5) Dr. Bare currently works at Northwestern Cadence Health and specializes in shoulder and knee problems. (RX1 p. 5) The majority of his practice involves the treatment of arthritic conditions and he performs arthroscopies and knee replacement surgeries. (RX1 p. 5-6) He performs about two independent medical examinations per week, which amounts to less than two percent of his practice. (RX1 p. 6)

According to Dr. Bare, arthritis, by definition, is a degenerative condition and everyone with degenerative osteoarthritis will have, to a certain extent, loss of range of motion. (RX1 p. 16, 45) The advancement of arthritis is very difficult to predict, it's variable, so as a degenerative condition progresses, as it often does, you often-time see a corresponding loss of range of motion. (RX1 p.16) Obesity is a negative prognostic indicator for the ability to live with and manage osteoarthritic conditions in the hip and knee and individuals that are overweight have a higher likelihood of progressing. (RX1 p.22, 46) A person could have arthritis in a joint and continue normally with their lives for years, even though an X-ray is positive for arthritis. (RX1 p.26) A positive McMurray's sign suggests pathology of the inside part of the knee and can be indicative of both arthritis and a meniscal tear. (RX1 p. 29-30) Surgery is not typically recommended for individuals with osteoarthritis because it does not work. (RX1 p. 31)

Dr. Bare testified that he did not have an independent recollection of his July 9, 2014 examination at the time he gave his testimony. (RX1 p. 8) Per his report, Petitioner sustained an injury January 8, 2011 during a motor vehicle accident, after which he had some pain in his shoulder and head, soon thereafter he developed some knee pain and then sought treatment. (RX1 p. 9) Dr. Bare agreed that Petitioner reported to his doctors that this accident occurred when he struck an embankment at 40 miles per hour. (RX1 p.26)

Petitioner gave the history of his 2007 arthroscopic knee surgery; he was diagnosed with a moderate amount of arthritis and reported that he had no issues with his knee after the procedure. (RX1 p.10) Dr. Bare found that the medical records prior to 2011 indicated a substantial amount of degenerative osteoarthritis in Petitioner's knee. (RX1 p.11) The MRI from 2008 documented a moderate amount of medial compartmental osteoarthritis with full thickness cartilage loss and also a fair amount of degenerative wear underneath the kneecap. (RX1 p. 11) The 2007 post–arthroscopy medical records documented continuing pain at a time which Petitioner should have had full resolution of said pain. He was

walking with a limp and that he underwent an MRI and was given a number of injections over the next year or so. (RX1 p.11-12) He noted that Dr. Giannoulias documented Petitioner's osteoarthritis in his February 15, 2011 office note and that range of motion was examined to be 0 to 120 degrees, which Dr. Bare considered to be at the lower end for flexion, but considered reasonably normal. (RX1 p.13)

Dr. Bare examined Petitioner on July 9, 2014. (RX1 p.7) Dr. Bare reviewed medical records from G & T Orthopedics, Dr. Bach and an independent medical evaluation performed by Dr. James Cohen. (RX1 p. 7) Dr. Bare did not review the medical records pertaining to Petitioner's other injuries, such has his shoulder surgery. (RX1 p. 29) He also reviewed prior medical records from Dr. Bartucci, relating to a 2007 basketball injury. (RX1 p. 8, 11) He measured Petitioner's range of motion to be from 2 to 115 degrees, which he felt was normal given the arthritis. (RX1 p.18) Dr. Bare measured Petitioner to be 6'2'' and 255 pounds. (RX1 p.21) Petitioner reported that neither post-accident knee surgery helped. (RX1 p. 32)

Dr. Bare disagrees with Dr. Bach's opinion that Petitioner's loss of flexion as of June 27, 2012, is to the degree that it is not consistent with his medial compartment arthritis. (RX1 p.17) Dr. Bare believes that an individual with a moderate amount of degenerative osteoarthritis will have loss of motion and that it is expected that Petitioner will have a loss of motion. (RX1 p.17) Petitioner has degenerative osteoarthritis of the left knee and a knee replacement is a reasonable treatment option. (RX1 p.19) Petitioner's need for a knee replacement is not related to the January 8, 2011 accident. The need for the surgery is based upon degenerative osteoarthritis. (RX1 p. 19) The loss of motion that Petitioner suffered subsequent to the June 2011 surgery did not cause or accelerate the need for the proposed knee replacement. (RX1 p. 19) The June 2011 surgery did not cause or accelerate the loss of motion that was documented by Dr. Bach in June of 2012. (RX1 p. 20) As it relates to the January 8, 2011 accident, Petitioner does not require any additional treatment and, as of the July 9, 2014 examination, Petitioner was at maximum medical improvement. (RX1 p. 20-21) Dr. Bare considers Petitioner to be overweight and this gives his left knee arthritis a higher likelihood of progressing. (RX1 p. 22) The arthritis existing in Petitioner's knee prior to the January 2011 accident did not disable him from construction work activity. (RX1 p. 25) A positive X-ray is not the only criteria for determining whether a person needs a knee replacement. Radiographs must be correlated with the clinical findings and the complaints of the patient. (RX1 p.25)

On cross examination, upon review of Dr. Bartucci's records, Dr. Bare concluded that Petitioner was not restricted from performing the full duties of a carpenter after the 2007 arthroscopy and Petitioner performed the duties of a carpenter even though he had some arthritis in his knee. (RX1 p. 24-25) Dr. Bare agreed that there was no pending prescription in Dr. Bartucci's chart for any type of knee surgery for the Petitioner prior to January 8, 2011 and that there was no prescription for knee replacement prior to 2011. (RX1 p.28, 40) Prior to the injury of January, 2011, Petitioner was working full duty in his profession as a carpenter. Dr. Bare agreed that Petitioner had a positive McMurray sign, per the records. (RX1 p. 29) Petitioner's medical records document that his left knee became more painful after the accident of January 8, 2011. (RX1 p. 30) He agreed with Dr. Giannoulias's recommendation that a knee replacement may be appropriate and that this need for a replacement is part of a sequence of events following the trauma of January 8, 2011. (RX1 p. 35) After the January 8, 2011 injury, none of Petitioner's doctors ever found him to have returned to his pre-2011 condition. (RX1 p.39)

Dr. Bare agreed that Petitioner suffered an injury to his left knee on January 8, 2011; that he complained of pain following the accident; that striking an embankment while going 40 miles per hour is sufficient force to cause trauma to a joint; that Petitioner's injuries were caused when the his truck struck an embankment going 40 miles per hour and that this trauma led to his subsequent medical treatment. (RX1 p.26-27, 40) He agreed that the purpose of the June 14, 2011 surgery was to improve the condition of the knee, however he did not think that it would be successful. (RX1 p.31) He agreed that the two post-accident surgeries were related, at least in some part, to the January 8, 2011 trauma and that this traumatic event led to the surgeries. He stated the accident of January 8, 2011 lead to the surgery of June 14, 2011 and one of the diagnoses contained in the operative report was that Petitioner suffered a meniscus tear. (RX1 p. 29, 32, 48) Although Dr. Bare opined in his report that Petitioner was suffering from a temporary aggravation of his arthritis condition, he agreed that the June 14, 2011 surgery was done within the window of this temporary aggravation and he did not know when the temporary aggravation ended. (RX1 p. 32-33) He agreed that there was an objective basis for Petitioner's subjective complaints of knee pain and that he could not point to a single date between the accident and the June 14, 2011 surgery where Petitioner was not in pain. (RX1 p.33) The January 8, 2011 accident caused a trauma to the knee joint and trauma across an arthritic joint can cause pain. (RX1 p. 34) For a person like Petitioner, who has moderate arthritis in 2007 and 2008 that is symptomatic, you would expect his condition to be aggravated in a car accident and that is an

aggravation of a pre-existing problem. (RX1 p.37) Dr. Bare does not believe that this aggravation was the cause for the need for the knee replacement, however he does believe that the January 8, 2011 accident was a factor that set in motion a series of events that led to the prescription in December 2011 for a knee replacement. (RX1 p. 38-39) He believes that the accident could have caused a temporary aggravation of a pre-existing condition, though he cannot point to any point in time where the temporary aggravation ended. He does not believe that the injury caused, accelerated or permanently aggravated Petitioner's problem. (RX1 p. 47, 49) That being said, Dr. Bare agrees that, but for the January 8, 2011 injury, Petitioner may not have needed a knee replacement for five to ten years down the line. It is possible that arthritis would have gotten worse enough to need treatment, but there is no way to know and he may have been able to work for years working as a carpenter if this trauma had not occurred. (RX1 p. 39)

The Testimony of Dr. James Cohen, Petitioner's Examining Physician (PX 9)

Dr. James Cohen testified by way of evidence deposition on October 29, 2014. He was retained by Petitioner's attorney to examine Petitioner. Dr. Cohen is an orthopedic surgeon who has been in practice since 1986. (PX9 p. 5-6) He specializes in the knee and performs most procedures related to it, including arthroscopy, meniscectomy, ACL reconstruction, fractures, total knee replacement and total knee revisions. (PX9 p. 5) He also performs medical legal examinations, such as independent medical examinations, about three to six times per week, and does about well over 90 percent of them for insurance companies. (PX9 p. 6)

A flexion contracture of the knee is condition wherein the knee is bent and will not fully straighten out. (PX9 p. 12) When a patient is not able to straighten his leg all the way out, the peroneal nerve does not remain under tension and becomes relaxed, which can cause it to become somewhat contracted. (PX9 p. 10) A normal range limit for people to flex their knee is to 125 degrees. (PX9 p.12) The chondroplasty procedure can make the patient better, make the condition worse, or not change the condition at all. (PX9 p. 17-18)

Dr. Cohen understood that prior to the accident Petitioner was working as a carpenter, in construction, and that as part of the job, he would traverse up and down scaffolds. (PX9 p.16) Petitioner was involved in an auto accident on January 8, 2011. (PX9 p. 6) Petitioner had some arthritic changes in his knee prior to the accident. (PX9 p. 8) The accident occurred when Petitioner was driving a truck with a trailer and he hit a barricade, which caused him to injure his left knee and shoulder, resulting in a significant increase in pain in the knee. (PX9 p. 8) Prior to the accident, Petitioner was working full duty, but after the accident, with the resultant painful symptoms, Petitioner required arthroscopic surgery. (PX9 p. 8) He had a poor result from the first surgery. He had a downhill course with continued pain and decreased motion, ultimately leading to the recommendation for a second surgery. (PX9 p.8, 15) The second surgery was done to try and correct the ongoing issues, and there was some improvement in the contracture that had developed between the first and second arthroscopies, however he developed nerve damage and increased pain and then knee replacement was recommended. (PX9 p. 8-9)

After the first surgery, Dr. Giannoulias had recommended a total knee replacement for Petitioner, but when he went for a second opinion, Dr. Bach believed that he could help him by performing another arthroscopy. (PX9 p.9) Dr. Bach believed that he could help with Petitioner's loss of range of motion by clearing scar tissue he believed to be the cause. After the surgery, Petitioner still had a contracture and Dr. Bach began to use bracing to try and straighten Petitioner's leg. (PX9 p.9) Although the surgery did provide some increased range of motion, it also caused Petitioner to develop neurological symptoms, possibly related to trying to force the knee to stretch back to obtain greater range of motion. (PX9 p. 10) Dr. Cohen believed that Petitioner developed symptoms from stretching the peroneal nerve while trying to straighten out his knee. (PX9 p. 10) As of January 26, 2011, prior to the surgeries but after the car accident, Petitioner had 120 degrees range of motion in flexion. (PX9 p. 12) Dr. Giannoulias recommended a total knee replacement after the first surgery, but Dr. Bach did not make this recommendation until after the second surgery, subsequent to his recommendation that Petitioner be evaluated by one of his partners who performs total knee replacement surgery. (PX9 p. 13) Neither of the arthroscopic surgeries successfully repaired the knee. (PX9 p. 13)

When he examined Petitioner on November 12, 2013, he noted a 0 to 90 degree range of motion in the left leg, in contrast to the zero to 120 range of motion reported on January 8, 2011. (PX9 p. 12, 19) This was the result of soft tissue and arthritic conditions. (PX9 p. 19)

There is a relationship between the accident and Petitioner's current need for a total knee replacement. (PX9 p. 7, 14, 21, 32, 33) Petitioner had pre-existing arthritis however, prior to the 2011 injury, Petitioner was working at a full duty

status. (PX9 p. 14) Petitioner suffered a significant injury when he hit the barricade and he never recovered to the status he was at prior to this injury; he underwent treatment to address the knee, however it progressively became worse; the first surgery resulted in a loss of range of motion and the second surgery may have improved the range of motion slightly but the pain persisted. (PX9 p. 14) The June 14, 2011 surgery yielded a poor result. (PX9 p. 18) The accident of January 8, 2011 caused an aggravation of the pre-existing osteoarthritis condition. Even though Petitioner did recover some range of motion after the second surgery, it did not return to where it was prior to the accident and his pain persisted. (PX9 p. 15, 32) Petitioner's loss of range of motion was an aggravation of the internal knee condition and the arthritis. (PX9 p.16, 32)

The accident of January 8, 2011 accelerated Petitioner's pre-existing condition because the knee replacement is now a reasonable treatment for the Petitioner as it stands today and there was no such recommendation based on the degree of his symptoms prior to the accident. (PX9 p. 15) But for the accident, Petitioner may not have needed a knee replacement for five or ten years, maybe not ever at all. (PX9 p. 32) Petitioner is not able to normally perform the duties of his job, such as traversing up and down scaffolding and generally working as a carpenter or in construction, based upon his condition after the work accident. (PX9 p. 16) To a reasonable degree of medical and surgical certainty, the loss of motion is related to both the January 8, 2011 accident and the surgery of June 14, 2011. (PX9 p. 20) The chondroplasty was probably the most likely part of the procedure that would have caused the postoperative flexion contracture. (PX9 p.24) On cross examination, Dr. Cohen stated that he was unsure if the chondroplasty led to the postoperative flexion contracture but that the lack of normal motion was an aggravating factor to Petitioner's pre-existing arthritis. (PX9 p. 24) Dr. Cohen disagreed with Dr. Bach's June, 2013 causation opinion relative to the osteoarthritis because there was a significant traumatic event, the surgery itself can be a form of trauma, Petitioner clearly has a decreased range of motion that he did not have before, there where increased signs of trauma subjectively, and he never got back to the condition that he was in prior to the accident. (PX9 p. 17, 21-22) Petitioner's lack of motion aggravated or accelerated his arthritic condition such that he will need a knee replacement. The reason he had the chondroplasty was because he was having increased symptoms and pain. (PX9 p. 25) When someone tries to increase the range of motion of an arthritic joint with therapy, it's like beating a dead horse, you are not going to help it and you will probably aggravate it; the reason why it was done in this instance was due to the sudden decrease in the range of motion, therefore it was appropriate for Dr. Bach to attempt it in this situation, however it still puts force on the cartilage of the knee joint. (PX9 p. 26)

Unpaid Medical Bills

The following unpaid medical bills were admitted in evidence (PX11):

Provider	Service Date(s)	Amount
Advanced Occupational Medicine Specialists	1/26/2011 to 9/16/2011	$2,384.48
Elmhurst Memorial Healthcare	3/31/2011	$467.00
Elmhurst Radiologists	3/31/2011	$27.00
G & T Sports Orthopaedics	11/3/2015	$615.00
Midwest Orthopedics at Rush	6/27/2012 to 2/7/2013	$1,042.45
TOTAL MEDICAL CLAIMED:		$4,535.93

CONCLUSIONS OF LAW:

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

With reference to "F" (causal connection) and "K" (Prospective medical treatment), the Arbitrator finds:

The Arbitrator finds the current condition of ill-being regarding Petitioner's left leg/knee (status post MVA with meniscus tear and 2 arthroscopic surgeries following prior meniscectomy with preexisting osteoarthritis, yielding end stage OA with pain and disability as shown above, along with the recommendation for a TKA procedure and a resultant injury to the peroneal nerve) is causally related to the accident of January 8, 2011 based upon the credible testimony of Petitioner, the medical records and the credible and persuasive testimony of Dr. Giannoulis and Dr. Cohen.

Having found a causal connection between the injury sustained and Petitioner's current condition of ill-being regarding his left knee, the Arbitrator finds that the surgery prescribed by all of the doctors, a left total knee replacement, is reasonable and necessary to cure or relieve the effects of the injuries sustained by Petitioner on January 8, 2011.

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 preexisting disease such that the employee's current condition of ill being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process. 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. 207 Ill.2d 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 is persuaded that there was an acceleration of a preexisting condition as a result of this accident. The condition that was accelerated was the need for a left total knee replacement which is due to the advanced osteoarthritis in Petitioner's left knee. Prior to the accident, no doctor had prescribed a left total knee replacement, even though he had osteoarthritis in the left knee. Less than one year post injury, in December of 2011, Dr. Giannoulias was recommending a total knee replacement. All testifying physicians, Drs. Cohen, Giannoulias and Bare agreed the need for surgery was accelerated as a result of this accident. Each doctor agreed the need for the surgery may not have occurred for five to ten years. In this case, after the accident, the need for the surgery emerged in less than one year. Dr. Bach gave no opinion on acceleration. The evidence supports acceleration. The accident accelerated the need for the left total knee replacement by many years according to all the doctors who gave an opinion on it.

The Arbitrator also is persuaded that the preexisting osteoarthritis in Petitioner's left knee was aggravated by the accident and the subsequent two knee surgeries, thereby being a cause of the need for a total knee replacement. This conclusion is based upon the opinions of Dr. Giannoulias, Dr. Cohen and Respondent's Section 12 examiner, Dr. Bare, who admitted to parts of causation. Drs. Giannoulias and Cohen opined that the January 8, 2011 work accident aggravated the pre-existing arthritis in Petitioner's left knee. Dr. Bare stated that the injury only temporarily aggravated the pre-existing condition, but he could not state when the "temporary" aggravation ceased. Dr. Bare's opinion is not persuasive. Dr. Bare does concede that the accident set off a chain of events, leading to the 2 arthroscopic surgeries on an arthritic joint, leading to the recommendation for a TKA. Dr. Bach disagrees that the work injury aggravated the pre-existing OA condition but he did not do a full record review and consider all the evidence. The only doctors to review the complete medical records and provide medical – legal opinions are Drs. Giannoulias, Cohen and Bare. Dr. Bach, a treating physician with a solid reputation, did state that the knee replacement need is not work related, but there is no evidence he considered Petitioner's medical history, medical records, the accident, the first surgery, compared diagnostic studies, or did a thorough medical – legal analysis of the case. (RX 2) Dr. Bach did not testify and the opinion in his chart note is given less weight.

Petitioner clearly had significant arthritis in his left knee joint before the accident. Subsequent to 2007 knee surgery, he had several steroid injections of the knee joint. The last injection before the accident was in August of 2010. Obviously, given the condition of Petitioner's knee as shown in Dr. Bartucci's records, Petitioner's habitus and activity level, he was likely to eventually be offered a TKA procedure. Nevertheless, Petitioner lost no time from work due to his left knee after June of 2007, he was able to perform heavy labor as a carpenter and no physician had recommended or offered a TKA. Subsequent to the January 8, 2011 accident, Petitioner's left knee became painful, a possible torn meniscus was diagnosed and surgery took place to try to remedy Petitioner's complaints of pain and the meniscal pathology. Thereafter, further

surgery on the arthritic joint took place to try to increase range of motion. After the second surgery, an injury to the peroneal nerve developed, either from the surgery or therapy. The knee joint remains painful and Petitioner is limited in his activities because of the pain and loss of range of motion. The injury of January 8, 2011 accelerated or aggravated the OA condition in Petitioner's left knee, leading to the end stage condition that has lead to the recommendation for a total knee arthroplasty.

The Arbitrator also finds that Petitioner's current condition of ill-being regarding his left shoulder (status post MVA with resultant RTC tear/SLAP lesion and subsequent surgical repair) is causally related to the injury of January 8, 2011, based upon Petitioner's testimony and the medical records.

With reference to "J" (was prior treatment reasonable and necessary, has Respondent paid all bills incurred for reasonable and necessary medical treatment), the Arbitrator finds:

The Arbitrator finds that the following medical, surgical and hospital bills contained in Petitioner's Group Exhibit No. 10 were reasonable, necessary and causally related to Petitioner's work injuries, the said bills are awarded pursuant to Section 8(a) and 8.2. Accordingly, the Arbitrator finds that Respondent is liable for and shall pay the following amounts to Petitioner, subject to the statutory medical fee schedule in effect on the dates of treatment, if applicable:

Provider	Service Date(s)	Amount
Advanced Occupational Medicine Specialists	1/26/2011 to 9/16/2011	$2,384.48
Elmhurst Memorial Healthcare	3/31/2011	$467.00
Elmhurst Radiologists	3/31/2011	$27.00
G & T Sports Orthopaedics	11/3/2015	$615.00
Midwest Orthopedics at Rush	6/27/2012 to 2/7/2013	$1,042.45
TOTAL MEDICAL AWARD:		$4,535.93

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

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIE C. BLANKENSHIP,

Petitioner,

17IWCC0654

vs.

NO: 15 WC 04464

M. CANNON ROOFING COMPANY, LLC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability and medical expenses 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 Petitioner was born September 10, 1966. Therefore, Petitioner was 48 years of age on the date of accident, January 28, 2015. The Commission, after considering the entire record, otherwise affirms and adopts the §19(b) Decision of the Arbitrator, finding that Petitioner failed to prove his current condition of ill-being is causally related to his January 28, 2015 work-related injury. As a result of the Commission's findings herein, 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 Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the §19(b) Decision of the Arbitrator filed on June 20, 2016 is hereby modified for the reasons stated herein, and is otherwise affirmed and adopted and 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.

17IWCC0654

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not liable for medical bills incurred after November 16, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not liable for temporary total disability benefits after November 16, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is not entitled to prospective medical treatment under Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

Based upon the denial of compensation herein, no bond is set by the Commission. *820 ILCS 305/19(f)(2).* 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: OCT 17 2017
KWL/bsd
O-8/22/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0654

BLANKENSHIP, WILLIE C
Employee/Petitioner

Case# **15WC004464**

M CANNON ROOFING COMPANY LLC
Employer/Respondent

On 6/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WISEMAN & CAIRO LTD
JOEL J BLOCK
ONE E WACKER DR SUITE 3900
CHICAGO, IL 60601

2337 INMAN & FITZGIBBONS LTD
JACK M SHANAHAN
33 N DEARBORN ST SUITE 1825
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

17IWCC0654

Willie C. Blankenship
Employee/Petitioner

v.

M. Cannon Roofing Co., LLC
Employer/Respondent

Case # **15** WC **4464**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **April 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. 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. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. x Other **prospective treatment**

17IWCC0654

FINDINGS

On **1/28/15**, 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 $**55,397.16**; the average weekly wage was $**1,065.33**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$24,346.34** 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

Pursuant to the attached Findings of Fact and Conclusions of Law, the Arbitrator finds as follows:

- As to causation, the Petitioner's alleged condition of ill-being after November 16, 2015 is not causally related to the January 28, 2015 work accident.
-
- Respondent is not liable for any medical bills or TTD incurred after November 16, 2015.
-
- Petitioner is not entitled to prospective medical treatment under section 8A 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

June 17, 2016
Date

JUN 20 2016

FINDINGS OF FACT

-- Testimony

Petitioner testified that on January 28, 2015, he was employed with the respondent as a roofer involved in a commercial industrial project. He was working on a flat roof when his supervisor asked him to move TPO rolls. Petitioner testified that these weigh over 250 pounds, and the method was to pick up one end and roll it or kick it to start unrolling it. As he reached down to pick up the end of the roll, he testified that his legs went out from under him and he fell backwards onto his buttocks. There is a small variance in the testimony and the medical record history. Respondent does not dispute that petitioner had an incident involving him falling while working on a roof on January 28, 2015.

Petitioner felt a complete burning sensation across his entire low back and shooting pain up to his shoulders. He called his supervisor and the owner of the company, who told him to go home for the rest of the day and he would receive a full day's pay. He took the following day off and was expecting to work on January 30, but still was in pain. His supervisor referred him to the company's Concentra clinic on January 30.

Petitioner testified that he treated at that facility, but shortly thereafter on his own went to Suburban Orthopedics and came under the care of Dr. McNally. He complained of low back and left leg pain, and was eventually referred to Dr. Novosoletsky. He was administered epidural steroid injections by Dr. Novosoletsky and was put back on physical therapy. He reported that his symptoms did not improve, and that Dr. McNally then referred him to Dr. Kelly for pain management issues.

Dr. Kelly continued the epidural steroid injections and then, per petitioner's testimony, referred him back to Dr. McNally for consideration of surgery. Petitioner testified that Dr. McNally has recommended surgery at L5 – S1.

Petitioner testified that he was authorized off of work for approximately six months, and then returned to light duty work on July 23, 2015. He continued in that capacity until September 28, 2015, when the job he was on was nearing completion. He was then authorized off of work completely by Dr. Kelly on September 29, 2015, and has not returned to work since then.

In addition to the above, petitioner testified that he was sent to Dr. Alexander Ghanayem at Loyola for a Respondent section 12 examination June and again in November, 2015. Petitioner testified that he was paid TTD for all of his time off of work until shortly after the second evaluation by Dr. Ghanayem.

According to the trial stipulations, petitioner was paid TTD from January 29 through July 21, 2015, and again from September 29 through December 6, 2015. (Arb. Ex. 1). Petitioner has not returned to work through the trial date. Morever, respondent has denied the surgery proposed by Dr. McNall, the last office visit being April 5, 2016.

On cross-examination, petitioner acknowledged that in May, 2015, he was admitted to Silver Cross Hospital for cardiac-related problems with no workers compensation claim being made for that medical issue.

-- Trial Exhibits

The records from Occupational Health Centers (Concentra) (PX 1) confirm that Petitioner was seen there on January 30, 2015 with a complaint of 10/10 back pain, left leg numbness and bilateral shoulder pain following a fall. He stated that he fell while lifting a heavy object on a roof, and complained of bilateral low back pain radiating to the "right" SI region and "right" side. X-rays were taken and were negative for fracture. The initial assessment was lumbar radiculopathy and lumbar contusion. He was prescribed pain medications and hot packs, and referred to physical therapy. He was allowed to work the following day with a 5-pound lifting restriction. (PX 1).

According to Petitioner's Exhibit 5, petitioner went to the emergency room at Silver Cross Hospital on January 31, 2015. From reviewing the records of this admission, petitioner complained of ongoing pain despite the visit to the company clinic on the prior day. Petitioner rated his pain as 10/10. The arbitrator notes, however, a psychosocial assessment which states, "appears in no distress able to ambulate fine and sit down in a chair and get up without difficulty." (PX 5).

Following examination and evaluation, he was diagnosed with a lumbar strain and provided a home exercise program. The arbitrator deems this visit as petitioner's first choice of physicians. (PX 5).

Petitioner then underwent therapy for the next few days at Concentra. Following a February 4, 2015 examination, he was prescribed/ llowed to lift 5 pounds constantly and his push/pull weight restriction was increased to 10 pounds. (PX 1).

On a referral from a friend, petitioner sought out the care of Dr. McNally at Suburban Orthopedics (PX 2). The arbitrator deems Dr. McNally as petitioner's second choice of physicians. He was first seen on February 5, 2015, stating that he had been injured at work the previous week after being told to move a 12-foot membrane roll that weighed 250 to 350 pounds. Petitioner stated that as he went to lift one end of the roll, his feet slipped and he landed flat on his back. He immediately felt a burning pain in his low back, but continued to work until telling his boss that he was unable to perform the job. (PX 2). He reported that there was no work on the following day due to weather, but his pain increased.

He complained of pain across his lower back with shooting pains into the shoulders and neck area. He had a difficult time sitting or standing, and complained of pain radiating to the left leg and foot. He made no complaints of pain on the right side. He also reported that he had had a motor vehicle collision "a few years ago," resulting in a neck/shoulder muscle strain that resolved with a few weeks of therapy. Otherwise, he denied any prior injuries.

Dr. McNally diagnosed a lumbar strain and radiculopathy, and ordered an MRI of the lumbar spine. He also ordered a CT scan to evaluate transitional bony anatomy, and authorized petitioner off of work while these studies were undertaken. (PX 2).

Petitioner underwent a CT scan of the lumbar spine without contrast on February 18, 2015. The impression showed suspected degenerative changes at L3 – L4, mild diffuse disc bulges without significant stenosis, no significant neural foraminal stenosis visualized and sacralization of the L5 vertebra. (PX 2)

Petitioner followed up at Concentra on February 25, 2015, and was allowed to return to work on March 4 with a 20-pound lifting restriction and a 20-pound push/pull restriction. The doctor allowed occasional bending, standing and walking. (PX 1). Conversely, petitioner was seen by Dr. McNally on March 6, and authorized off of work, with a referral to Dr. Novosoletsky for pain management (PX 2).

Petitioner underwent an epidural steroid injection in the lumbar spine by Dr. Novosoletsky on May 13, 2015. He returned on May 18, "sooner than usual" according to Dr. Novosoletsky's note, due to complaints of severe pain following the procedure. He was provided additional pain medications and was offered a bilateral sacroiliac joint injection. Petitioner refused it, indicating he wanted to explore surgical options. He was referred back to Dr. McNally for these purposes. (PX 3).

At respondent's request, Petitioner underwent a section 12 exam Dr. Ghanayem on June 15, 2015. Dr. Ghanayem reviewed the medical records and diagnostic studies done to date except for the CT scan of the lumbar spine. With that limitation, Dr. Ghanayem diagnosed an aggravation of underlying lumbar stenosis related to the reported work accident. He noted that the EMG petitioner had undergone was "not very helpful," but that the treatment to date appeared to have been reasonable relative to the work injury. Dr. Ghanayem felt petitioner could work light duty with a 20 pound lifting restriction, but asked to see the CT scan before concluding his opinions. (RX 1).

In a follow-up note on June 29, 2015, Dr. Ghanayem stated that the CT scan showed subtle changes consistent with lumbar stenosis. He therefore concurred in the epidural steroid injections that had begun. (RX 1).

Although Dr. McNally had already referred petitioner to Dr. Novosoletsky for pain treatment, he then referred him to Dr. Wayne Kelly on June 18, 2015 "for workup of non-diabetes related moderate sensorimotor polyneuropathy." (PX 3).

From reviewing Dr. Kelly's records, however, (PX 7), the arbitrator notes that Dr. Kelly simply continued the epidural steroid injections begun by Dr. Novosoletsky, and administered pain management treatment as Dr. Novosoletsky had been. Petitioner last saw Dr. Novosoletsky on August 20, 2015. (PX 3)

On August 25, 2015, Dr. McNally recommended that Petitioner continue with Dr. Kelly for continued non-interventional pain management, and to plan for a "left-sided" L3-4, L4-5, and L5-S1 decompression and L3-4 fusion. (PX 3).

On October 5, 2015, Dr. Kelly performed a lumbar epidural injection at the L3-4 vertebral level. On October 15, 2015, he performed another epidural injection, this one at the L4-5 vertebral level. The Petitioner reported no improvements from these injections. He was still experiencing pain, numbness, and tingling, and his pain level was at 6-7 out of 10 with medication, and 9-10 out of 10 without medication. Dr. Kelly recommended the Petitioner continue his leave of absence from work, and maintained his hopes of allowing him to return to work with restrictions if he responded well to the injections. (PX 7).

Petitioner was then sent back to Dr. Ghanayem for a November 16, 2015 re-examination. Dr. Ghanayem noted the epidural injections and the therapy that petitioner had undergone, without relief of symptoms. Petitioner noted he felt worse than he did previously.

On examination, Dr. Ghanayem noted tenderness from petitioner's mid-thoracic spine all the way down to the lumbosacral junction, including tenderness to light palpation. He also complained of low back pain with compression of the head. He demonstrated only 10° of extension and 40° of flexion, but the neurologic motor exam revealed no deficits. Petitioner also voiced decreased sensation in every dermatome from L1 to S1, according to the report.

Dr. Ghanayem noted that petitioner's CT myelogram performed in August, 2015 showed very mild narrowing without any significant neurological compression. He felt petitioner's subjective complaints were in excess of the objective diagnostic testing, and that petitioner exhibited multiple and nonorganic physical examination findings consistent with symptom magnification. (RX 2).

Doctor noted that he previously felt that epidural injections with therapy would be appropriate due to his review of the initial plain CT scan. With the more advanced CT myelogram study, Dr. Ghanayem found no compression of any significance in the lumbar spine, and stated that petitioner's symptoms in his legs could not be substantiated. He felt that petitioner was at maximum medical improvement from the work injury, and the current diagnosis was nonorganic pain behaviors. He felt petitioner could resume his normal occupation. (RX 2). The Arbitrator adopts this opinion as a finding of fact in case at bar.

Thereafter, petitioner continued to see Dr. McNally every few months and Dr. Kelly more frequently through the end of 2015 and into 2016 (PX 3, 7). By February 9, 2016,

Dr. McNally was recommending a left L5 – S1 laminotomy, and to hold off on laminotomies at the higher levels. He also continued to authorize pain management treatment with Dr. Kelley. (PX 4). Dr. Kelley last saw petitioner on March 17, 2016, by which time he concurred in the surgery recommendation of Dr. McNally, and disagreed with the conclusions of Dr. Ghanayem. (PX 7). Pursuant to the opinions of Dr. Ghanayem, however, respondent has not authorized the requested treatment.

CONCLUSIONS OF LAW

With regard to Issue F, is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

There is no dispute that the petitioner sustained an accident on January 28, 2015 when he fell down while working on a flat roof for the respondent. Both the physicians at the company clinic and respondent's IME physician agreed that petitioner had underlying degenerative changes in his lumbar spine and sustained at least a strain from that occurrence. The aggravation of an underlying degenerative condition was also the conclusion reached by petitioner's chosen treating physicians, starting with Dr. McNally.

Petitioner then underwent a course of treatment consisting of therapy and the commencement of epidural injections, and Dr. Ghanayem on respondent's behalf initially endorsed the appropriateness of the proposed treatment in light of the diagnostic studies, and petitioner's complaints. Petitioner was authorized off work and paid benefits, and also returned to available work for a few months during the summer of 2015.

Petitioner's pain complaints continued, however, and the treatment recommendations largely remained the same despite the lack of any evidence of subjective improvement in petitioner's condition. Petitioner underwent at least four injections in his lumbar spine between Dr. Novosoletsky and Dr. Kelly, yet experienced, at best, only brief and minimal improvement following each one. Not only did petitioner continue to complain of pain throughout the course of his 15 months of treatment through the trial date, the arbitrator notes that petitioner persistently described the level of pain at up to 10/10 without medication, and no better than 6/10 or 7/10 when on medication.

Due to the persistence of petitioner's treatment and the long-term intensity of his pain complaints, petitioner was sent for reevaluation by Dr. Ghanayem at respondent's request in November, 2015. Dr. Ghanayem detailed petitioner's subjective responses to his examination, noting tenderness to even light palpation from the mid-thoracic spine down to the lumbosacral junction, and ranges of motion in the lumbar spine that would make it difficult for petitioner to dress , if accurate. The neurologic examination of the lower extremities revealed no motor deficits, yet petitioner claimed a decreased sensation in every dermatome from L1 through S1.

Dr. Ghanayem also reviewed a CT myelogram study obtained in August 2015 which minimized even further the diagnostic findings on the plain film CT, which had failed to show evidence of any neural compression, or even significant stenosis. (RX 2).

Contrasted with that, Dr. McNally and Dr. Kelly continued to treat petitioner for more than a year with orthopedic and pain management treatment modalities that provided petitioner with no relief by petitioner's own description of his complaints and pain level at every visit.

Dr. McNally even had redundant treatment by two pain management physicians in Dr. Novosoletsky and Dr. Kelly for a couple of months in 2015 with no discernible distinction as to the reason for the referrals. Yet, other than proposing surgery as early as August 2015, the lack of success in treating petitioner's complaints and the persistence and severity of his complaints have not resulted in any reconsideration of the treatment modalities.

Based on the totality of the evidence, including the medical records as well as petitioner's presentation before the arbitrator at the hearing and his testimony, the arbitrator finds that petitioner failed to prove by a preponderance of the credible evidence that the condition which he currently complained of at the time of trial, and for which he has sought treatment since November 16, 2015 is causally related to the injuries sustained in the work accident of January 28, 2015.

In reaching this decision, the arbitrator adopts and relies on the opinions of Dr. Ghanayem over those of petitioner's chosen treating physicians. In addition, the arbitrator notes that the petitioner's self-reporting of his pain level to his providers and his limitations, along with his presentation at trial, find no support in the objective medical evidence, particularly the diagnostic testing that petitioner has undergone, consisting of x-rays, a CT scan, a CT myelogram and an EMG/NCV. The CT myelogram is a key piece of evidence herein.

The arbitrator acknowledges that there is evidence of some spinal canal narrowing of the lumbar spine, but both Dr. McNally and Dr. Ghanayem agree that there was no evidence of spinal cord compression or significant stenosis, and that the evidence of any disc bulging in the lumbar spine was mild at best. Further, Dr. McNally's suggestion of which level he would even perform his operation on petitioner's lumbar spine changes throughout the course of his treatment. (PX 2-4).

Further, in his rebuttal to Dr. Ghanayem's opinion, Dr. Kelly engages in a silent oration in print, to the extent it can be understood in light of numerous typographical or dictation errors. This doctor suggests that there essentially may be a number of things that *could be* accounting for petitioner's symptoms, even though the diagnostic studies tend to confirm that there is no active pathology.

Representative of this conclusion is Dr. Kelley's statement that, "his CT myelogram absolutely demonstrates an abnormality at the L5 – S1 level that could well be involving his nerve roots *even though overt compression is not noted*.... He also has abnormalities *though not dramatic* noted on the CT myelogram at the L3 – 4 level.... The patient *may well have some periodic symptom magnification* as well complicating things given the emotional nature of what occurs with Workmen's Comp. and work related injury without recognition of the legitimate numbness of patient's and [sic] then their frustration and resentment of what occurs." (PX 7), 12/14/2015 note, page 2).

The following page literally contains the following sentence, "the patient did His boss on-the-job on Saturday, January 31 a Which she showed me on his own registered to that date." This page of his report, in particular, shows an advocacy on behalf of the patient that defies rational and objective medical evaluation.

In reaching this conclusion, the arbitrator also considers the petitioner's overall persuasiveness. While respondent did not dispute the occurrence, the arbitrator notes that the weight of the TPO rolls that petitioner was asked to move varies by as much as 200 pounds in his histories to the various physicians. In addition, after being sent to the company clinic on January 30 and being diagnosed with a sprain, the petitioner went to the emergency room at Silver Cross Hospital, allegedly with complaints of pain at 10/10.

The results of the examination and the ultimate diagnoses were the same as his visit to Concentra on the previous day, and there was no evidence of acuteness to his condition that would have warranted a trip to the emergency room or complaints of pain on a 10/10 level. In addition, as noted in the recitation of facts, petitioner was noted to ambulate well and sit down and get up without any difficulty during this admission.(PX 2).

The fact that petitioner would continue to complain of pain on a 10/10 basis absent pain medication for the duration of time that he has done so also raises questions of credibility.

Based on the totality of the evidence, the arbitrator finds that the petitioner sustained an aggravation of underlying degenerative changes in his lumbar spine from the work accident of January 28, 2015, for which he required the treatment he underwent through his initial return to light-duty work on July 23, 2015. Petitioner successfully worked a light-duty job for just over two months before the project was almost completed, and petitioner was then authorized off of work again.

The arbitrator adopts and finds Dr. Ghanayem's subsequent conclusion on November 16, 2015 that petitioner could not substantiate his subjective complaints with the objective diagnostic evidence or his inconsistent examination findings to be more credible than the petitioner's subjective complaints and the ongoing treatment that was being administered despite the lack of improvement in petitioner's subjective condition.

The arbitrator therefore finds that petitioner had fully recovered from his lumbar sprain and aggravation of underlying degenerative disc disease initiated by the January 28, 2015 accident by no later than November 16, 2015. Compensation for medical treatment and lost time after that date is hereby denied.

With regard to Issue J, were the medical services provided reasonable and necessary, the Arbitrator finds the following:

The Arbitrator incorporates by reference as though fully set forth herein his findings on the issue of causal connection. Petitioner sustained a compensable occurrence on January 28, 2015 which reasonably led to a course of treatment that, through June 15, 2015, was endorsed by the respondent's IME physician as well.

At that time of that initial examination on June 15, 2015, petitioner had undergone one epidural steroid injection, and Dr. Ghanayem incurred with additional such injections following his review of the CT scan. (RX 1). After five more months with petitioner not demonstrating any change in his subjective complaints, nor his treating physicians demonstrating any change in the proposed treatment other than to suggest surgery of differing levels, Dr. Ghanayem had another opportunity to review petitioner's records and examine him on November 16, 2015.

At that time, he felt that petitioner was at maximum medical improvement and was exhibiting only nonorganic pain behaviors.

The arbitrator therefore finds as a matter of law and conclusion of fact that petitioner failed to prove by a preponderance of credible evidence that he is entitled to payment by respondent of any treatment he received after November 16, 2015. Respondent is liable for any unpaid bills of treatment, at the fee schedule rate, for treatment prior to this date.

With regard to Issue K, what temporary benefits are in dispute, the Arbitrator finds the following:

The Arbitrator incorporates by reference as though fully set forth herein his findings on the issue of causal connection. Specifically, the parties agree that petitioner was temporarily totally disabled and received benefits from January 29 through July 21, 2015, and that he worked light duty from July 22 through September 28, 2015. Petitioner was again authorized off work as of September 29 and was paid TTD through November 16, 2015, when Dr. Ghanayem opined that petitioner was at maximum medical improvement and could return to work without restrictions.

As respondent paid TTD benefits through December 6, 2015 (Arb. Ex 1) respondent is entitled to credit on any future PPD award that may be entered for all TTD payments after November 16, 2015. Petitioner failed to prove entitlement to additional TTD as of November 17, 2015 and through the trial date.

With regard to Issue O, petitioner's entitlement to prospective treatment, the Arbitrator finds the following:

The Arbitrator incorporates by reference as though fully set forth herein his findings on the issue of causal connection. Petitioner failed to prove by a preponderance of the credible medical evidence that the treatment he received after November 16, 2015 was medically necessary to cure or relieve the effects of the injury he sustained and/or causally related to that injury.

The arbitrator finds Dr. Ghanayem's opinions on this issue to be more persuasive credible than those of petitioners treating physicians, for the reasons previously expressed.

All compensation after November 16, 2015, other than for an eventual determination of petitioner's entitlement to permanent partial disability, if any, from this occurrence is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALAN SALATA,

Petitioner,

17IWCC0655

vs.

NO: 10 WC 16668

WIRTZ BEVERAGE,

Respondent.

DECISION AND OPINION ON REVIEW UNDER SECTIONS 19(h) and 8(a)

Timely Petition for Review under Section 19(h) and 8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the evidence and being advised of the facts and law, finds Petitioner failed to prove that his disability has worsened since July 27, 2010, the date of his arbitration hearing before Arbitrator Carlson.

On April 14, 2016, a hearing pursuant to Petitioner's Petition for Review under Section 19(h) and 8(a) was presided over by Commissioner Kevin Lamborn with both parties represented by counsel. Petitioner testified before Commissioner Lamborn and tendered medical records that documented his treatment at Marianjoy Hospital from August 9, 2010, through May 12, 2014, as well as the evidence deposition testimony of Dr. Jeffery Oken taken on July 24, 2014. Respondent tendered the transcript made from Petitioner's July 27, 2010, arbitration hearing before Arbitration Carlson. In addition to Petitioner, the transcript included testimony from Shannon Wildenradt, Joe Siler, and Gina Nix and exhibits detailing Petitioner's medical treatment from October 2, 2009, through June 24, 2010. The testimony of Petitioner before Commissioner Lamborn on April 14, 2016, and the testimony of Dr. Oken on July 24, 2014, and the totality of the medical records provides the Commission a clear picture of Petitioner's health after July 27, 2010.

The Commission places the greatest weight on Petitioner's testimony before Commissioner Lamborn on April 14, 2016. Before Commissioner Lamborn on that date as he

17IWCC0655

did before Arbitrator Carlson, he testified to his generalized pain being present 24-hours a day. His testimony did not indicate that his more current pain was more severe in 2016 or conversely less severe in 2010, only that it was present 24-hours a day. He also testified to having headaches in 2010 and in 2013 and indicating that, in one form or another, that his pain has been the same pain since the date of the accident.

Dr. Oken's testimony is most notable in that it states Petitioner's condition has improved since 2010. He noted Petitioner's pain complaints at that time he entered Marianjoy Hospital's Pain Management Program ranged in severity from 6/10 to 9/10 but, as of the date Dr. Oken's testimony, ranged from 5/10 to 7/10. The Commission places significant weight on Dr. Oken's testimony concerning the diminishing severity of Petitioner's pain complaint.

Dr. Oken's testimony is also notable in that he provided only an equivocal opinion as to whether Petitioner's complaints of and his treating Petitioner for myofascial pain, chronic pain syndrome, secondary adjustment disorder related to Petitioner's chronic pain, insomnia related to Petitioner's chronic pain, chronic headaches, and low back pain were causally related to Petitioner's workplace accident. He indicated that Petitioner's complained-of conditions could have been caused or aggravated by Petitioner's September 8, 2009, accident but did so without differentiating which of Petitioner's conditions were caused by and which were aggravated by said accident. Without a more definitive opinion as to which, if any, of these conditions are either directly or indirectly attributable to the September 8, 2009, accident, the Commission places little weight on Dr. Oken's tentative causation opinion, particularly considering his concluding that Petitioner's pain complaints had diminished since 2010.

The Commission finds Petitioner not only failed to demonstrate that his symptoms directly attributable to his September 8, 2009, accident have worsened since his arbitration hearing on July 27, 2010, but convincingly established, through his own testimony, that his condition has remained stable. The Commission also finds those symptoms of Petitioner that manifested themselves after the July 27, 2010, arbitration hearing were not convincingly shown to be relatable back to Petitioner's September 8, 2009, accident. For these reasons, the Commission cannot adopt Petitioner's claim that his physical condition, relatable to his September 8, 2009, accident merits additional benefits under the Act.

The Commission, in deciding the Petitioner's Petition for Review under Section 19(h) and 8(a), takes pause to acknowledge Respondent's Motion to Dismiss Petitioner's Petition for Review on the parallel arguments that the Petition both violates the Law of the Case doctrine and is barred by the principle of *res judicata*. The Commission finds neither are applicable as the Petitioner is seeking a Commission finding as to whether his condition has worsened since his arbitration hearing and decision and not to revisit the arbitration decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review under Section 19(h) and 8(a) is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that that Respondent's Motion to Dismiss Petitioner's Petition for Review is denied.

17IWCC0655

As there was no award 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: OCT 17 2017
KWL/mav
O: 08/23/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

Yolonda Cruz,
Petitioner,

vs. No: 06 WC 30172

Chicago Cylinder Corp.,
Respondent.

17IWCC0656

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 casual connection, medical expenses, temporary disability, and permanent partial disability, and being advised of the facts and law, generally affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. In doing so, however, the Commission clarifies one statement of the Arbitrator, and corrects one finding of the Arbitrator.

First, regarding the clarification, the Arbitrator's decision correctly notes the claimant treated briefly following the February 28, 2005 date of loss, receiving some physical therapy and an MRI, and being released from treatment and allowed to work without restrictions no later than April 15, 2005. Thereafter, she did not seek treatment for more than a year, until July 2006.

However, later in his decision, in support of his conclusion that there was no causal relationship to the ongoing medical care in 2006 and thereafter, the Arbitrator wrote that the claimant "did not seek medical care and treatment for sixteen months subsequent to the date of accident." We clarify this to note that the sixteen-month treatment gap actually took place after the claimant's initial brief six-week treatment course, rather than immediately following the date of loss. While perhaps imprecisely stated, the Arbitrator's conclusion that this extended treatment gap strongly suggests the absence of a causal connection between the later extended treatment and the original accident was and remains well supported by the facts, and the Commission adopts that position and reasoning.

17IWCC0656

With regards to the correction of the Arbitrator's findings, the Commission affirms and adopts all the Arbitrator's findings save one. The Arbitrator issued a specific finding that the Petitioner was not personally liable for the medical expenses incurred at Los Quiropracticos, LLC, the Spine Centers Institute, and Pain Net Medical. We concur with the Arbitrator and we specifically find that the medical treatment incurred at those facilities was, first, not causally related to the case at bar; second, was not medically reasonable or necessary; and, third, was not well substantiated by the facilities in question. However, the specific discharging of the claimant's personal liability is beyond our authority as inconsistent with Section 8.2(e-20) of the Act. That language is therefore deleted.

All other findings of the Arbitrator are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as noted above, the Decision of the Arbitrator filed May 18, 2016, is hereby affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION 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 $2,000.00. 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: OCT 17 2017

Joshua D. Luskin

Charles J. DeVriendt

Elizabeth Coppoletti

o-10/11/17
jdl-ac
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRUZ, YOLANDA
Employee/Petitioner

Case# 06WC030172

CHICAGO CYLINDER CORP
Employer/Respondent

17IWCC0656

On 5/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0800 BARRY E BLUMENFELD
3424 W 26TH ST
SUITE 200
CHICAGO, IL 60623

0159 FRANCIS J DISCIPIO LAW OFFICE
1200 HARGER RD
SUITE 500
OAK BROOK, IL 60521

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

Yolanda Cruz
Employee/Petitioner

v.

Chicago Cylinder Corp
Employer/Respondent

Case # 06 WC 30172

Consolidated cases: _____

17IWCC0656

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **January 28, 2016 and March 18, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0656

FINDINGS

On **February 28, 2005**, 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 $; the average weekly wage was $.

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

Petitioner has been provided by Respondent and has received all reasonable and necessary medical services.

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

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

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

ORDER

The Arbitrator finds upon the totality of the evidence that she sustained an accident in the scope and course of her employment with the Respondent at bar on February 28, 2005.
The Arbitrator finds that the Petitioner's condition of ill being, if any, asserted in the case at bar is not causally connected to the accident in the case at bar.

Respondent shall pay reasonable and necessary medical charges of $1,556.00 to Excel Occupational Health Center, as provided in Section 8(a) of the Act for services rendered in the case at bar.
Based upon the evidence and representations of counsel, the medical practices of Los Quiropracticos LLC plus Spine Centers Institute and Pain Net Medical were given appropriate /testify as to causation plus the necessity and reasonableness of their services and charges. The Arbitrator specifically makes a finding of fact that those providers failed to avail themselves of the opportunity to testify on all issues relating to their care and treatment and charges before the proper judicial body at said trial date certain. The Petitioner as a matter of law is not individually liable for payment of any unpaid charges or interest from said providers.

Respondent is not liable for any permanent partial disability benefits in the case at bar.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 16, 2016
Date

MAY 18 2016

Statement of Facts: 06 WC 30172

Yolanda Cruz was employed at Chicago Cylinder Corp. as a machine operator. She was injured on February 28, 2005 when a piece of hollow aluminum measuring 4-5 feet long fell from a machine, bounced off the floor and struck her hips and buttocks. Ms. Cruz received treatment at Excel Occupational immediately after the injury and was diagnosed with contusions and abrasions. She had an MRI which revealed no significant findings. Ms. Cruz received physical therapy and was eventually released to return to work without restrictions on April 15, 2005.

Ms. Cruz did not seek additional treatment until July of 2006, about fifteen months later at Los Quiropracticos under the care of Dr. Gavin. There was no documented causal connection given between her back condition and the accident of February 28, 2005. She then received treatment at Pain Net Medical Group and Spine Centers Institute. She began to complain of low back pain and radiating pain into the thigh. She received injections into nerve roots and underwent a discogram on October 19, 2006.

Ms. Cruz was examined by Dr. Steven Delheimer at the request of the respondent on December 15, 2006. Ms. Cruz indicated an accident date of May 5, 2005 to Dr. Delheimer. His impression was that petitioner suffers from degenerative disc disease and that at most, Ms. Cruz had suffered a soft tissue injury. He further opined that the degenerative disc disease was not related to any work related incident and the petitioner did not need any further treatment. Dr. Delheimer also states that she was capable of returning to work without restriction as of the date of the examination, December 15, 2006.

In addition, the records of Los Quiropracticos Pain Net Medical Group and Spine Centers Institute were reviewed by Dr. Lawrence Rugg (Soma Heathcare) at the request of the Respondent. Dr. Rugg indicated that there was no direct cause for the care and treatment rendered and that medical bills incurred and treatment was not necessary, nor related to the alleged injury of February 28, 2005.

The Arbitrator finds based on the testimony of the Petitioner that she sustained injuries while in the scope and course of her employment on February 28, 2005. The Respondent's assertion that an injury occurred on or about May 5, 2005 is unfounded nor substantiated by any testimony. In light of the foregoing the Arbitrator finds that the Petitioner sustained her burden of proving that an accident occurred on February 28, 2005 while in the scope and course of her employment for the Respondent Chicago Cylinder Corporation.

Although the Petitioner sustained her burden of proving that an injury arose out of the scope and course of her employment on February 28, 2005, the Petitioner has failed to prove that her ongoing condition of ill-being if any, is directly and causally connected to the injuries of February 28, 2005. It is clear from the evidence presented that the Petitioner did not seek medical care and treatment for sixteen months subsequent to the date of accident. Once the Petitioner did receive medical care and treatment there was no indication contained in the records of any initial evaluation or subsequent re-evaluations relative to any alleged low back complaints. As indicated above, Petitioner sought sick treatment sixteen months post injury however there was no direct diagnosis or rationale for any treatment that the Petitioner may have been receiving by or through Los Quiropracticos, LLC and/or Spine Centers Institute and lastly, no direct indication of any direct medical care and treatment rendered from Pain Net Medical Group, P.C.

The Petitioner has failed to sustain her burden of proving that her condition of ill-being is related to a claimed injury of February 28, 2005.

In addition to the foregoing the Arbitrator relies on the section 12 examination of Dr. Steven Delheimer dated December 15, 2006. Dr. Delheimer clearly indicates that there is no indication of permanent partial disability relating to the injuries in the case at bar.. Dr. Delheimer finds that the Petitioner complained date of accident of February 5, 2005 and not February 28, 2005; however the Arbitrator finds the discrepancy inconsequential regarding the lack of ongoing findings as they could or might relate to an alleged injury of February 28, 2005.

Based upon the totality of the evidence, the Arbitrator finds that the Petitioner failed to prove as a matter of fact and as a conclusion of law that her alleged , current condition of is related to an alleged injury of February 28, 2005.

Given Petitioner failed to prove her ongoing condition of ill-being is related to the alleged injuries of February 28, 2005, the Arbitrator finds that any permanent partial disability claimed in the case at bar is denied..

The Arbitrator finds that the Petitioner originally sought treatment at Excel Occupational Health Center at the request of the Respondent herein. While at the Excel Occupational Health Center the petitioner incurred a medical bill in the amount of $1,556.00. The Arbitrator finds based on the totality of evidence, Respondent is liable for the medical bill in the amount of $1,556.00.

However, based upon the totality of the evidence the Arbitrator finds as a matter of fact and conclusion of law the medical bills of Los Quiropracticos , LLC in the amount of $29,670.85 are not related to the care and treatment of an injury that occurred on February 28, 2005.

In addition to the foregoing the Arbitrator finds based upon the totality of the evidence that the care and treatment of Spine Center Institute also rendered treatment to the Petitioner totaling $55,386.96..

Lastly, the Arbitrator finds that the Petitioner was treated at Pain Net Medical Group incurring medical bills totaling $481.77. the Arbitrator finds based upon the totality of the evidence that the respondent is not liable for said treatment or bills. The treatment is not related to the case at bar.

The Arbitrator finds Respondent's Exhibit #2 to be highly persuasive regarding the issue of medical bills and their alleged relationship to the injuries of February 28, 2005. The Arbitrator adopts the opinion of the doctor in the case at bar as determinative of all matters addressed therein regarding the case at bar.

Dr. Lawrence Rugg indicated in his report not only that there was no causation for the care and treatment that was being rendered but there was never a diagnosis that was attached to the care and treatment that was being rendered. Dr. Rugg opined the medical bills incurred were not reasonable, not necessary, nor related to the alleged injuries of February 28, 2005. Dr. Rugg was clear the treatments were duplicative in nature and not substantiated by normal medical practices.

Based upon the totality of the evidence, the Arbitrator finds that the Respondent has liability for the Excel Occupational Health bill in the amount of $1,556.00 regarding the care and treatment rendered to the Petitioner at the request of the Respondent at a clinic that the Respondent had recommended.

Morever, in further denial of the medical expenses, the Arbitrator places great weight on the medical facilities unwillingness or inability to come to open Court to substantiate the care and treatment that was rendered to the Petitioner and the subsequent bills that ensued from that care and treatment. Based upon this, the Petitioner is not personally liable for said bills.

Based on the foregoing the only liability the Respondent shall have is clearly identified the Excel Occupational Health bill in the amount of $1,556.00.

Given the totality of the evidence including the findings supra, the Respondent is not liable for any future medical care.

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

Misty Henderson,
Petitioner,

vs. NO: 11 WC 34010

Caterpillar, Inc,,
Respondent.

17IWCC0657

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2016 is hereby affirmed and adopted.

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

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: OCT 17 2017

Joshua D. Luskin

Charles J. DeVriendt

Kevin W. Lamborn

o-10/11-17
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENDERSON, MISTY
Employee/Petitioner

Case# **11WC034010**
11WC016693

CATERPILLAR INC
Employer/Respondent

17IWCC0657

On 1/5/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
JON WALKER
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Misty Henderson
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # 11 WC 34010

Consolidated cases: 11 WC 11693

17IWCC0657

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 19, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0657

FINDINGS

On October 20, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $10,656.40; the average weekly wage was $666.03.

On the date of accident, Petitioner was 28 years of age, single with 3 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $9,776.31 for other benefits, for a total credit of $9,776.31.

Respondent is entitled to a credit of $41,228.84 paid under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's 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

January 4, 2016
Date

JAN 5 - 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case number 11 WC 34010, the Application alleged that Petitioner sustained repetitive trauma to the left leg and body and that the date of accident (manifestation) was October 20, 2010. In case number 11 WC 16693, the Application alleged that on October 27, 2010, Petitioner was struck in the face with a wrench and sustained injuries to the face/he and woman as a whole (Arbitrator's Exhibits 3 and 4).

In case number 11 WC 34010, Respondent disputed liability on the basis of accident and causal relationship. In case number 11 WC 16693, Respondent stipulated that Petitioner sustained a work-related accident on October 27, 2010; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner worked for Respondent as an assembler from June, 2007, through April, 2009. At that time Petitioner was laid off; however, she returned to work for Respondent as an assembler in December, 2010.

At trial, Petitioner testified that she worked on three different types of trucks. Petitioner spent approximately 70% of her time working underneath the trucks and she connected various lines, hoses and tubes, installed pans, tightened bolts, etc. The truck Petitioner worked on was usually two to three feet off of the ground and Petitioner had to perform her job duties would in a minimal amount of space.

Petitioner estimated that she was in a squatting position while performing her job duties for approximately 30% of the time. She estimated that she spent another 30% of her work day sitting on a stool and that she would have to stand up or sit down 100 or more times per day. Petitioner stated that she would spend another 30% of her work day performing tasks on the side of the truck which required her to go up/down a ladder 25 or more times per day. When seated on the stool, Petitioner stated that she may have hit her left knee against the stool or other objects a few times per week.

On October 20, 2010 (the date of manifestation alleged in the Application), Petitioner prepared an Employee Incident Report in which she stated that she had complaints of pain in her left knee when moving in and out from under the truck for about two days. Petitioner stated that her left knee was swollen but she did not recall striking it on anything (Petitioner's Exhibit 1).

Petitioner initially sought medical treatment from Dr. Thomas Bilyeu, her family physician, on January 26, 2011. At that time, Petitioner informed Dr. Bilyeu that her left knee had been sore for the preceding five months. She stated that it started hurting at work and that she did a lot of stepping up/down off of a stool; however, she did not recall any acute injury. Dr. Bilyeu ordered an MRI (Petitioner's Exhibit 5).

The MRI was performed on January 31, 2011, and it revealed findings consistent with a bone bruise, edema and chronic injury to the medial patellar retinaculum. The radiologist also noted in

his report that "If the patient did not have any specific injury, this could be due to repetitive injury perhaps related to the patient's occupation." (Petitioner's Exhibit 1).

Dr. Bilyeu referred Petitioner to Dr. Kenneth Tuan, an orthopedic surgeon, who initially evaluated Petitioner on February 11, 2011. In his record of that date, Dr. Tuan noted that Petitioner's work required a lot of up and down motions, but that she did not recall any specific injury. Dr. Tuan reviewed the MRI and opined that Petitioner had sustained a stress injury to her left patella. Dr. Tuan opined that the injury was a result of Petitioner reinstituting a heavy workload after not having worked for over a year. He recommended Petitioner do some stretching exercises (Petitioner's Exhibit 2).

Petitioner was periodically seen by Dr. Bilyeu in March and May, 2011, and Dr. Bilyeu injected the left knee when he saw her on May 13, 2011. On July 6, 2011, Dr. Bilyeu sent Dr. Tuan a letter in which he stated that Petitioner's job "...involves climbing up and down ladders, working on vehicles at Caterpillar, and I think this has aggravated her knee." (Petitioner's Exhibit 5).

Dr. Tuan continued to treat Petitioner conservatively; however, he eventually performed arthroscopic surgery on Petitioner's left knee on September 1, 2011. The surgical procedure consisted of a lateral retinacular release (Petitioner's Exhibit 2).

Following surgery, Petitioner continued to be treated by Dr. Tuan from October 2011, through September 2012. During that period of time, Petitioner was also seen by Zac Sowa, Dr. Tuan's Physician's Assist (Petitioner's Exhibit 2).

At the direction of her attorney, Petitioner was examined by Dr. Jeffrey Coe, an occupational medicine specialist, on September 19, 2012. Dr. Coe examined Petitioner in regard to both of her workers' compensation cases. In connection with his examination, Dr. Coe reviewed medical records provided to him by Petitioner's counsel. Dr. Coe opined that Petitioner sustained repetitive strain injuries to her left knee because of her work as an assembler. He opined that Petitioner still required orthopedic treatment for the injury (Petitioner's Exhibit 4; Deposition Exhibit 2).

On October 23, 2012, Petitioner was evaluated by Dr. Daniel Adair, an orthopedic surgeon. Dr. Adair's record of that date noted that Petitioner had left knee pain since October 2010, and that she worked in assembly, had to climb on and underneath trucks, up and down ladders, and other repetitive motions. Dr. Adair's impression was probable patella subluxation and he ordered physical therapy and that Petitioner be on light duty (Petitioner's Exhibit 3).

Dr. Adair subsequently saw Petitioner on December 11, 2012 and on April 16, 2013. At the time of the April 16th evaluation, Petitioner's condition had improved and Dr. Adair opined that she could work with mild limitations which he stated were frequent stair climbing, going up ladders or carrying heavy objects (Petitioner's Exhibit 3).

Dr. Coe's deposition was taken on December 13, 2013, and his deposition testimony was received into evidence at trial. Dr. Coe's testimony on direct examination was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Coe specifically opined that

Petitioner's work activities of having her left knee in awkward positions, kneeling, squatting, climbing ladders and periodic bumping of her knee caused Petitioner's patella femoral syndrome (Petitioner's Exhibit 4; pp 29-30).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on January 30, 2014. In connection with his examination of Petitioner, Dr. Lehman reviewed medical reports/records provided to him by Respondent as well as a description of Petitioner's job. Dr. Lehman opined that Petitioner's left knee symptoms were due to a pre-existing Q-angle and lateral tilting of the patella which he opined was due to a congenital malalignment. He stated that this condition was not related to Petitioner's work activities (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Lehman's deposition was taken on June 17, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Lehman's testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner's left knee condition was not related to her work activities. Dr. Lehman opined that Petitioner had a pre-existing accentuated Q-angle and lateral tilting of the patella which he also described as a malaligned patella. He opined that this condition can lead to premature breakdown of the joint and bone bruising; however, he opined that this condition was not related to Petitioner's job activities (Respondent's Exhibit 2; pp 11-15).

When cross-examined regarding the statements in the records of Dr. Bilyeu and Dr. Tuan regarding the etiology of Petitioner's left knee condition, Dr. Lehman noted that neither of them described an acute injury at work but that Petitioner's knee started hurting while she was at work. Further, Dr. Lehman also questioned how the radiologist could opine as to the cause of the condition based solely on a review of an MRI. Dr. Lehman did agree that work activities could aggravate this condition; however, he opined that "...something has to happen," in the manner of a specific trauma (Respondent's Exhibit 2; pp 28-32).

At trial, Petitioner testified that she earned $17.59 per hour when she sustained the injury on October 20, 2010, and that when she returned to work on December 27, 2011, she earned $15.30 per hour. She stated that she was paid the lower hourly rate because of a change in her job duties that was mandated because of work restrictions. Respondent introduced Petitioner's payroll records into evidence and they indicated that Petitioner earned $16.30 per hour at the time of the accident which was subsequently increased to $16.99 per hour shortly before she underwent surgery. The records also indicated that when Petitioner returned to work, she earned $15.45 per hour which was subsequently increased to $15.93 per hour. Petitioner's employment with Respondent was terminated sometime in October, 2013, for reasons that had nothing to do with her workers' compensation cases.

At trial, Petitioner testified that she had no prior injuries or symptoms in her left knee. Petitioner stated that her knee condition had improved; however, it was not 100%. Petitioner was able to use a stair climber, but can no longer roller skate. She has not, as yet, returned to any type of gainful employment.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury to her left knee that manifested itself on October 20, 2010, and that her current condition of ill-being is not related to her work activities.

In support of this conclusion the Arbitrator notes the following:

While Petitioner testified that she would periodically hit her left knee against the stool and other objects while at work, this history was not given to any of her treating physicians. Petitioner informed both Dr. Bilyeu and Dr. Tuan that she had not sustained a specific injury.

Dr. Lehman examined Petitioner and opined that she had a congenital condition in her left knee that was not caused by her work activities. While he agreed that a traumatic specific event could aggravate this condition, Petitioner did not sustain such an accident.

The Arbitrator is not persuaded by the statements contained in the records of Dr. Bilyeu and Dr. Tuan that purport to relate Petitioner's left knee condition to either repetitive activity or a heavy workload.

The Arbitrator is also not persuaded by the opinion of the radiologist who, as noted by Dr. Lehman, purported to opine as to the etiology of the condition after only reviewing an MRI.

The Arbitrator is also not persuaded by the opinion of Dr. Coe, an occupational medicine specialist, not an orthopedic surgeon.

Based on the preceding, the Arbitrator finds the opinion of Dr. Lehman to be more persuasive.

In regard to disputed issues (J), (K) and (L) 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)		☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.		☒ Affirm with changes ☐ Reverse	☐ Rate Adjustment Fund (§8(g)) ☐ Second Injury Fund (§8(e)18)
COUNTY OF COOK)		☐ Modify	☐ PTD/Fatal denied ☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Avalos,
Petitioner,

vs. NO: 12 WC 21007

Caldwell Letter Service, Inc.,
Respondent.

17IWCC0658

DECISION AND OPINION ON REVIEW

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

In so affirming, the Commission specifically finds Petitioner's testimony is more credible than that of Mr. Perry or Mr. Hogan in that Petitioner testified he was attacked without provocation from behind by Mr. Perry. T.50. Certainly, cases exist which indicate wholly unexplained attacks by co-workers are not compensable. See, *e.g. Thurber v. The Industrial Commission*, 49 Ill.2d 561, 564 (1971) ("The hazard of being suddenly attacked by a fellow employee for no known reason was neither incidental nor peculiar to defendant in error's employment, but was, instead, a risk incidental to the general public."); see also *Math Igler's Casino, Inc. v. The Industrial Commission*, 394 Ill. 330, 338 (1946) ("Manifestly, an award of compensation cannot rest upon sheer speculation that an injury inflicted by a fellow employee was connected with the work in which they were engaged."). It is questionable whether such cases are still controlling given the Supreme Court's ultimate ruling in *Rodriquez v. The Industrial Commission*, as well as its explanation of its holding in *Health & Hospitals Governing Com. v. The Industrial Commission*, 62 Ill.2d 28, 33 (1975)- "this court indicated that a 'neutral' assault of the general type is compensable without any further showing of a specific causal link between the employment and the assault." 95 Ill.2d 166, 174 (1983).

17IWCC0658

Notwithstanding the above, the matter of *Hurt v. The Industrial Commission*, 191 Ill.App.3d 733 (1989), is on point. In *Hurt*, the claimant was assaulted by a co-employee who was combative and emotionally unstable. The court reasoned the claimant proved the reason for the assault: specifically, the co-employee's combativeness and hostility. As the claimant was required to work in such an environment, "the risk of assault was one peculiar to his employment and not one shared by the world at large." *Id.* at 742.

In the present matter, Petitioner testified he witnessed Mr. Perry engage in several fights at work as well as arguments and screaming at others. T.52. Mr. Perry confirmed his propensity to engage in arguments and altercations. T.122. Mr. Perry's hostility and emotional instability lead to an unprovoked attack on Petitioner who was required to work in such an environment. Such attack arose out of and in the course of Petitioner's employment.

Considering the above, all other findings and awards of the Arbitrator are affirmed in their entirety.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 1, 2016 is hereby affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION 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 $39,000.00. 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: OCT 17 2017

Joshua D. Luskin

L. Elizabeth Coppoletti

Charles J. DeVriendt

o-10/11/17
jdl/mcp
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AVALOS, JOSE A
Employee/Petitioner

Case# **12WC021007**

17IWCC0658

CALDWELL LETTER SERVICE INC
Employer/Respondent

On 3/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

1922 SALK, STEVEN B & ASSOC LTD
PIRADA MOLINA ESQ
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

1596 MEACHUM STARCK BOYLE ETAL
JANNISCH, JAMES
W WASHINGTON ST SUITE 500
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

Jose A. Avalos
Employee/Petitioner

v.

Caldwell Letter Service, Inc.
Employer/Respondent

Case # 12 WC 21007

Consolidated cases: _____

17IWCC0658

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 4, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,049.40**; the average weekly wage was **$500.95**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

The Respondent shall pay the Petitioner compensation for **5%** loss of use of the person as a whole, or **25** weeks at a weekly PPD rate of **$300.57 / per week.**

Respondent shall pay Petitioner temporary total disability benefits of $333.97/week for 23 & 3/7th weeks, commencing 6/5/2012-11/15/2012, for a total of **$7,824.44** as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$22,546.83**, pursuant to the fee schedule or by prior agreement, whichever is less, as provided in Section 8(a) of the Act.

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

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

Deborah L. Simpson

Signature of Arbitrator

February 28, 2016
Date

MAR 1 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Avalos ,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 21007**
	)	
Caldwell Letter Service, Inc.,	)	**17IWCC0658**
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on June 4, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. On that date the Petitioner gave the Respondent notice of the accident that is the subject matter of this case within the time limits stated in the Act. They further agree that in the year preceding the injury the Petitioner earned $26,049.40 and the Petitioner's average weekly wage was $500.95.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services that were provided to the Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) Is the Petitioner entitled to TTD; (5) What is the nature and extent of the injury; and (6) Should penalties or fees be imposed upon the Respondent.

STATEMENT OF FACTS

Petitioner worked for Respondent as a machine operator for approximately ten (10) years. (T40). On average, he worked five (5) days a week, eight (8) hours a day, from 7:00 AM to 3:00 PM. (T44). As a machine operator, he was responsible for setting up and programming a machine that created various paper products, including letters, envelopes, cards, and magazines. (T41). Petitioner testified that he was required to use rulers and tape measures to measure the length of the various paper materials he used to complete his projects. (T41-43; T71-72). His co-worker, and Respondent's plant manager and chief operating officer of business operations on 6/4/2012, Aaron Perry, confirmed that machine operators for Respondent used tape measures to perform their duties. (T22; T115).

Petitioner explained that after obtaining the measurements, he would input the information into the computer that ran the machine. (T43). Petitioner was also responsible for

gathering the materials he needed for each project. The materials would be located in nearby areas within Respondent's facility and Petitioner would collect what he needed, bring it to his work station, and set up the machine. (T43).

On June 4, 2012, Petitioner was in his usual state of good health and was not under any care or treatment for his neck, right arm, right shoulder, or back. Prior to June 4, 2012, Petitioner never missed work due to illness or injury. (T46; T53). He had never been diagnosed with cervical herniation or suffered from cervical radiculopathy before that day either. (T46).

At approximately 2:30 PM on June 4,2012, Petitioner had programmed the machine at his work station to begin its self-cleaning process. (T47). This process took about forty-five (45) minutes to an hour to complete. (T47). While the machine went through its cleaning process, Petitioner testified that he wanted to take measurements and prepare for a project he had the next day. He went to Mr. Perry's office to borrow a tape measure as was his custom. (T48-49; T75). Petitioner explained at trial that whenever he needed to use a tape measure, he would borrow one from his boss Will Perry, his son Aaron Perry or from Juvenal Escamilla, a supervisor. (T76).

At trial, Petitioner and Aaron Perry gave different descriptions of the layout of Aaron Perry's office that day as well as the sequence of events that occurred resulting in Petitioner being injured. Petitioner stated that as he entered Aaron Perry's office, he entered through the "dock side" door. (T142). The desk containing the tape measure was located on the right side, next to the door. (T86; T142-143). Mr. Perry's description was; that when you entered the dock side door, his desk was to the right with the cabinet of tools to the right of his desk. Mr. Perry testified that to the left side of the office, there was a conference table where Respondent's driver, Mike Hogan, was seated. (T123). Mr. Perry explained that there was also another desk with wheels next to his regular desk. (T124).

According to Petitioner, Mr. Perry was seated behind his desk that was facing the doorway. (T86-87). The drawer with the tape measure was about six to seven feet from Mr. Perry's desk. (T150). Mr. Perry was behind his desk and "[h]is computer is on the right side, facing in the room on the right side, and then against to the left wall they have a couple of chairs in there and that's about it and it's the door going for the production place." (T142).

Petitioner stated that when he went in to retrieve the tape measure, Mr. Perry was alone in his office and that he had Mr. Perry's permission to use the tape measure. (T48). Conversely, Mr. Perry on direct examination by Respondent's attorney stated that he was not alone in his office when Petitioner came in to borrow the tape measure. (T113). He stated that Mr. Hogan was with him. (T113). Petitioner testified that Mr. Hogan was not in the office "because he always takes the mail to the main office . . . downtown around 1:30." (T77-78). Petitioner testified further that he knew this, " Because he delivered mail all the time at the same time." (T135). According to Petitioner, Mr. Hogan would leave anytime from noon to one o'clock to drop off mail at the post office downtown. (T145). Mr. Hogan testified at the hearing that he went to the main post office downtown every day. (T135). Petitioner testified that Mr. Hogan was not in the building when the accident happened because he had finished a particular project around 2:30 PM for pick-up by Mr. Hogan and it had not yet been picked up. (T147).

Upon returning to Mr. Perry's office to put the tape measure back, Petitioner noticed that Mr. Perry was taking pictures of him with his cell phone. (T49-50). Mr. Perry was alone in his office. (T50). Mr. Perry did not respond when Petitioner asked why he was taking pictures with his cell phone. (T50).

On June 4, 2012, Petitioner stated he was five-feet, nine-inches (5'9") tall and weighed approximately one-hundred fifty (150) pounds. (T58). Mr. Perry testified that on the date of accident, he was five-feet, ten inches (5'10") and weighed approximately two-hundred forty (240) pounds. (T30). Mr. Perry admitted that he had a physical advantage over Petitioner. (T30).

After Petitioner put the tape measure back into the drawer, he walked back out of the office, with his back to Mr. Perry when, without warning, Petitioner was pushed face forward by Mr. Perry into a forklift directly in front of him, about ten (10) feet from the office door, striking his right arm. (T50-51; T89, T90). Petitioner testified that "he just come from behind me and attacked me and pushed me." (T50). According to Petitioner, Mr. Perry had not said anything to him and there had been no argument between them at the time he was attacked. (T51). Petitioner stated that Mr. Perry then grabbed his neck, pulled him to the ground, and began choking him. (T51). The altercation ended when another co-worker named Angelica helped pull Mr. Perry off Petitioner. (T87; T108).

The Petitioner called Aaron Perry as an adverse witness in Petitioner's case-in-chief. Mr. Perry testified to his version of events leading up to the confrontation. He stated that Petitioner wanted to borrow a tool to fix his motorcycle, which was on the Respondent's premises with Respondent's permission. (T23-24). At first, Mr. Perry testified that he did not remember the type of tool that Petitioner had requested. (T23). Mr. Perry did remember that Petitioner proceeded into Mr. Perry's office and grabbed the tool out of a drawer. He testified further that Petitioner pushed the rolling desk up and into his person making contact with his knee. At that point he got up and told the Petitioner to give the tool back, he grabbed the tool and a brief struggle ensued over the tool. Momentum carried them towards the office door and both fell down outside the door. (T24).

Mr. Perry testified that the rolling desk was next to his desk, the desk is on wheels and it came forward and hit me on the knee. According to Mr. Perry he then stood up, and told him again, you cannot borrow the tape measure ... "That's when I grabbed the tape measure. That's when the struggle ensued." (T116).

This was the first altercation between the two men in the ten (10) years that Petitioner worked for Respondent. There was no prior history of arguments or other problems between Petitioner and Mr. Perry. (T27; T52). According to Petitioner whenever he spoke with Mr. Perry it was about work and nothing personal. (T52). He also stated that he never spent time with Mr. Perry outside of work. (T53). Petitioner said that in the ten (10) years he worked for Respondent, he had never been disciplined or received any warning or suspension. (T44). According to Petitioner, Mr. Perry had a history of conflict, outbursts at work, and having a quick temper. (T52). Petitioner stated that he had witnessed a couple of fights and arguments involving Mr. Perry and other people at work, including Aaron Perry's own father, Will Perry. (T52).

Aaron Perry agreed that he had "several dozen" arguments or altercations with his father at the work place that involved yelling. (T122).

After the fight, Petitioner notified his boss Will Perry about the altercation. The Petitioner testified that Mr. Will Perry confronted his son Aaron about the situation. (T55; T58). Petitioner stated that he stayed for another five to ten minutes until his machine finished, then he went to shut down the machine and left. (T58)

When he was struck by Aaron Perry, Petitioner maintains that he did not have the tape measure anymore. (T91). He further denied that they had been struggling over the tape measure. (T91).

Mr. Perry stated that some of the personal tools that were normally kept in his office for use in Respondent's printing and direct mail business included a hammer, a couple of screw drivers, a wrench, and a tape measure. (T24-25).

Petitioner denied that he was working on or repairing his motorcycle on the date of the accident. (T79). He also stated that there was no need to use a tape measure to fix a motorcycle. (T54).

Mr. Perry testified that after the altercation, he was not hurt and did not seek any medical treatment. (T30). Mr. Perry testified that he appeared in criminal court in connection with the events of June 4, 2012. Mr. Hogan and Petitioner testified at that proceeding and after the testimony the case was dismissed. (T 118)

Mike Hogan testified that he worked for Respondent as a truck driver before finding alternate employment in September 2013. (T 127,128) Mr. Hogan knows Mr. Aaron Perry from his employment with Respondent. He is also familiar with Petitioner from his employment with Respondent. (T 129) Mr. Hogan's relationship with Petitioner was only professional. He never had any issues or disputes with Petitioner. (T 129)

On June 4, 2012, Mr. Hogan observed the Petitioner enter Mr. Perry's office and attempt to obtain Mr. Perry's tape measure around 3 p.m. (T 131) Mr. Hogan testified that Petitioner and Mr. Perry struggled for control of the tape measure with the Petitioner falling to the ground. (T 132) Mr. Hogan also confirmed he was summoned to a criminal court proceeding. He testified under oath during that proceeding. The case was dismissed following the proceeding in which he testified. (T 97,133)

Petitioner stated that his pain level immediately after the accident was an 8/10. (T92). That same day, his pain worsened after work, and he sought emergency treatment at Saint Anthony Hospital with complaints of pain in his neck, right forearm, right shoulder, and back. (PX1, T93). The emergency room records document the following history:

> [S]tates he was beaten by his boss's son at about 3 pm, states he was pushed against a wall and he hit his right forearm against the metal part of a forklift, states he was grabbed by the neck and pushed to the ground, states he was kicked in the back. (PX1).

Abrasions to the right shoulder, swelling and bruising to the right arm, as well as a laceration to the left leg were noted by the emergency room physician. (PX1). Range of motion of his right hand, wrist, and shoulder were noted to be painful. (PX1). The Chicago Police Department was called to the hospital so that Petitioner could complete a report. Petitioner told the police officer that he had been attacked by Mr. Perry over a tape measure. (T62).

Petitioner next sought treatment at Marque Medicos on June 6, 2012. On that date, Mr. Avalos complained of pain in his right forearm, right shoulder, neck, mid back, and right-sided lower rib cage area. The history noted on that date by Dr. Fernando Perez was consistent with the description given at the emergency room.

During his first visit with Dr. Perez, Petitioner stated that when he was in a comfortable position, his pain level was at 6/10; it rose to a 10/10 level at its worst. (PX2). Petitioner reported having pain performing any type of movements involving his injured body parts, he had trouble sitting and standing, and he also had difficulty sleeping due to his injuries. (PX2,) Dr. Perez noted tenderness to palpation throughout Mr. Avalos' right forearm, right shoulder. There was also tenderness to his cervical and thoracic spine, right-sided lower rib cage area, right arm, right elbow, and lumbar spine. Active range of motion was decreased in the cervical spine, right wrist, right elbow, right shoulder, and lumbar spine. The straight leg raise test, supraspinatus' press test, and Drawbar's tests were all positive on the right. Cervical compression test and rib compression test were also positive. (PX2)

Dr. Perez noted that Petitioner's present condition was directly related to his work injury of June 4, 2012. He then referred Petitioner to physical therapy three (3) times per week which included active therapeutic exercises and passive physical medicine modalities. He also referred him to Dr. Andrew Engel for pain management. Petitioner was taken off work at that time. (PX2)

On June 7,2012, Petitioner returned to Dr. Perez, at this time he was wearing an arm sling on his right arm. Dr. Perez noted that Petitioner continued to experience persistent pain and that his worse pain was concentrated in his right forearm, extending from his right wrist to his right elbow. (PX2). Dr. Perez ordered physical therapy for the right forearm, which Petitioner attended on June 8 and 12 of 2012.

Petitioner saw Dr. Engel for the first time on 6/12/2012, complaining of pain on both sides of his neck, right shoulder pain, right forearm pain, and numbness that radiated down his arm to his fourth and fifth fingers. (PX3). Petitioner noted that his pain level was a 6/10. Dr. Engel prescribed physical therapy and prescription medication – specifically Mobic, omeprazole, and Soma. He ordered Petitioner to remain off work until the pain substantially decreased. (PX3).

Petitioner commenced physical therapy for his right shoulder at Marque Medicos on June 15, 2012. His pain level for the right shoulder was 7/10. He also reported feeling numb in the shoulder region and tingling in his right fingers. The therapist noted, among other things,

limitation of motion in the right shoulder, decreased muscle strength, tenderness to pressure, and positive O'Brien and empty can tests. (PX2).

Dr. Engle referred Petitioner for an MRI of his cervical spine due to developing weakness in his right hand. (PX3). The MRI was completed on July 9, 2012 at Archer Open MRI. Dr. Engel agreed with the radiologist's findings that Petitioner had a right-sided C5-6 disc herniation causing neural foraminal stenosis. There was also a contained disc herniation at C6-7. (PX3). Dr. Engel diagnosed Petitioner with a cervical herniated disc, right shoulder pain, thoracic spine pain, and low back pain syndrome. He ordered additional physical therapy for the right shoulder and an EMG study. (PX3). Dr. Perez also agreed that an EMG was necessary to assess Petitioner's complaints of persistent weakness in his right hand and radiating pain extending from his neck into his right upper extremity. (PX2).

On July 10, 2012, Petitioner reported increased movement in his right shoulder and a pain level of 4/10. He also did not require the use of an arm sling anymore. (PX2).

Petitioner reported improvements in his condition on July 20, 2012. However, he continued to have complaints of weakness in his right hand and pain extending from his neck to his right upper extremity. Dr. Perez noted that Petitioner continued "to experience neck pain that is greater on the right side . . . right-sided mid back and low back pain." (PX2).

The EMG study completed on August 3, 2012 revealed evidence of a lesion on the median nerve of the wrist "resulting in decreased conduction velocities of the sensory fibers." (PX2, 8/3/2012 EMG Report).

On August 16, 2012, Dr. Engel noted that Petitioner had "essentially no right shoulder pain." (PX3). His right-sided neck pain and low back pain were 3/10 on the visual analog scale and his finger numbness had resolved. Dr. Engel stated in his progress report that Petitioner had improved dramatically in physical therapy for his right shoulder. Dr. Engel stopped physical therapy for the right shoulder as of August 20, 2012, and ordered that Petitioner begin therapy for his neck. (PX3). Petitioner underwent physical therapy for his cervical spine from August 21, 2012 through September 20, 2012. (PX2).

Petitioner was also allowed to return to work on August 17, 2012 with restrictions of no lifting greater than ten (10) pounds and to limit activities which caused him pain. (PX3). When he was finally released to return to light duty work, he testified that he attempted to return to work with Respondent, but that Respondent had fired him as of June 2012 and gave Petitioner his final paychecks. (T67). He was unable to find work within his restrictions and testified that he did not receive any temporary total disability benefits from June 5, 2012 to the date he was released full duty on November 15, 2012. (T67-68). Petitioner had no other source of income and he had a hard time paying bills. (T67).

On September 10, 2012, Dr. Perez noted that Petitioner continued to experience persistent pain in his neck area, greater on the right side, rating the pain at a 6/10 level. He also continued to experience pain in his low back, mid back, and right shoulder areas. (PX2).

On September 20, 2012, Dr. Engel noted that Mr. Avalos had no shoulder pain, and had minimal mid back, and low back pain. (PX3). His neck pain persisted and Petitioner reported that moving his head from side to side made the pain worse. During his examination, Dr. Engel noted pain to palpation in Petitioner's bilateral trapezius and splenius cervices musculature. At this point, Dr. Engel ordered an FCE to see if Petitioner would benefit from a work conditioning program as he had plateaued in his physical therapy exercises for his cervical spine. (PX3). He was also prescribed Dendracin cream.

On October 2, 2012, Petitioner underwent a functional capacity evaluation at Elite Physical Therapy. (PX4). The FCE, which was considered valid, stated that Petitioner, "demonstrated the physical capabilities to function at the Light Physical Demand Level, as defined by the U.S. Department of Labor, which is indicative of an occasional 2-hand lift/carry of 20 [pounds] from floor to chest level." (PX4). Following the FCE, Dr. Engel referred him to a work conditioning program at Elite Physical Therapy. (PX3). He also stopped the Dendracin prescription and switched Petitioner to over-the-counter medication. Petitioner's work restrictions were changed per the FCE to no lifting greater than 20 pounds and to limit activities which caused him pain. (PX3).

Petitioner was released full duty by Dr. Engel on November 15, 2012. (PX3). On that date, Dr. Engel noted that Petitioner had right-sided neck pain on occasion and that the physical therapy had greatly decreased his pain.

Petitioner testified that on occasion, he has pain in his right shoulder. With certain movements, he has pain up to 5/10. (T69). He also stated that due to his injury, he is unable to exercise because of pain. (T69).

The Respondent did not submit any utilization review (UR) report or independent medical evaluation (IME) report into evidence.

CONCLUSIONS OF LAW

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

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to 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; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v.*

Industrial Commission, 153 Ill. App. 3d 238, 242 (1987). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

Whether Petitioner sustained an injury that arose out of and in the course of his employment?

The Arbitrator finds that Petitioner did sustain an accidental injury that arose out of and in the course of employment. This determination is based upon the credible testimony of the Petitioner, which is supported by the medical records. The burden of proof in this case is a preponderance of the evidence, a lesser burden than that of the criminal courts which is beyond a reasonable doubt.

An injury is accidental within the meaning of the Workers' Compensation Act when it is traceable to a definite time, place, and cause and occurs in the course of employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v. Indus. Bd.*, 284 Ill. 378 (1918).

In *Rodriguez v. Indus. Comm'n*, 95 Ill. 2d 166 (1982), our Supreme Court held that injuries as a result of an assault "in the workplace during work hours are compensable in Illinois if the assault arose in the course of a dispute involving the conduct of the work, provided that the claimant is not the aggressor." In rendering its decision, the Supreme Court relied on *Pekin Cooperage Co. v. Indus. Comm'n,* 285 Ill. 31 (1918). In *Pekin*, the Court explained that compensation awarded under the Act did not cover *all* accidental injuries which may be sustained by an employee while at work. *Id.*

> There must be some causal relation between the employment and the injury. It is not necessary that the injury be one which ought to have been foreseen or expected, but it must be one which after the event may be seen to have had its origin in the nature of the employment. *Id.*

The Court further stated in *Rodriguez* that "such injuries are not compensable as to either the aggressor or the victim where the dispute was purely personal between the two employees." *Rodriguez v. Indus. Comm'n*, 95 Ill. 2d 166 (1982).

The facts in the instant case show that the accident did not result from a personal dispute. Petitioner testified that this was the first altercation between he and Mr. Perry in the ten (10) years that Petitioner worked for Respondent. There was no prior history of arguments or other problems between them. (T27; T52). Petitioner testified that whenever he spoke with Mr. Perry

it was about work and nothing personal. (T52). He also stated that he never spent time with Mr. Perry outside of work. (T53).

Mr. Perry was known to have a quick temper and would argue with other people at work, including his own father, Will Perry. (T52). Aaron Perry admitted at the hearing that he had "several dozen" arguments or altercations with his father at the work place that involved yelling. (T122).

Next, no matter the different descriptions of the accident provided by Petitioner, Mr. Hogan and Mr. Perry, the assault occurred after Petitioner borrowed a tape measure from Mr. Perry. Both parties testified that tape measures were used by machine operators, including Petitioner, and were required in the performance of their duties. (T22; T41-43; T71-72; T115). Petitioner testified that he was attacked from behind and forced to the ground, the description of the injuries noted in the emergency room support the Petitioner's description of the events. The Arbitrator finds that Petitioner was not the aggressor in this altercation.

Respondent maintains that the Petitioner was off the clock, working on his motorcycle, his own personal business and not that of Respondent and therefore the injury was not in the course of his employment. Petitioner denied that he was off the clock or working on his motorcycle. He testified that he wanted to take measurements and prepare for a project he had the next day. He went to Mr. Perry's office to borrow a tape measure as was his custom. (T48-49; T75). No payroll records or time sheets were offered by the Respondent to support Respondent's theory and contradict or rebut the testimony of the Petitioner. Those records would certainly be in the custody and control of the Respondent.

The Arbitrator finds that Petitioner sustained a work accident on June 4, 2012 that arose out of and in the course of employment.

Whether Petitioner's current condition of ill-being is causally related to the injury?

The Arbitrator finds that Petitioner's current condition of ill-being, as diagnosed by his treating physicians, is causally related to the injury that occurred on June 4, 2012. The Arbitrator relies on the uncontradicted opinions and treating records of Dr. Fernando Perez and Dr. Andrew Engel in finding causal connection. There were no Utilization Review or Section 12 examination reports offered by the Respondent. The causation opinions of the treating doctors were admitted into evidence unchallenged. While Respondent did not agree with or adopt the opinions offered in those records, they did not offer any alternative opinions to consider.

It is well established law that proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. *Navistar Int'l Transp. Corp.*, 315 Ill. App. 3d 1197, 1206 (2000). Prior to the attack on June 4, 2012, Petitioner was not under any care or treatment for his neck, right arm, right shoulder, or back. (T46; T53). He had also testified that prior to that date, he had never been diagnosed with cervical herniation or suffered from cervical radiculopathy. (T46).

Petitioner's testimony at trial as to the chain of events and the mechanism of injury correlate with the body parts injured. The mechanism of injury as well as the complaints of pain

were not only documented within the medical records, but were consistent with Petitioner's testimony at trial.

Petitioner testified that Mr. Perry pushed him forcefully from behind and that the front of his body fell forward towards a forklift directly in front of him and he struck his right arm. (T50-51; T89, T90). Petitioner stated that Mr. Perry then grabbed his neck, pulled him to the ground, and began choking him. (T51). Abrasions to the right shoulder, swelling and bruising to the right arm, as well as a laceration to the left leg were noted by the emergency room physician. Two days after the injury, Petitioner sought treatment and complained of pain in his right forearm, right shoulder, neck, mid back, and right-sided lower rib cage area. Following his examination, Dr. Perez stated that Petitioner's present condition was directly related to his work injury of June 4, 2012.

Petitioner denied any other accidents or injuries to the same body parts after June 4, 2012 as well. Thus, taking into account the lack of prior history, the immediacy of his complaints, and Respondent's lack of defense as to causal connection, the Arbitrator finds that Petitioner's current condition of ill-being, as diagnosed by his treating physicians, is causally related to the injury that occurred on June 4, 2012. For the aforementioned reasons, the Arbitrator finds Petitioner satisfied his burden of proof and established causal connection.

Were the medical services that were provided to Petitioner reasonable and necessary?

The Arbitrator finds that medical services that were provided to Petitioner were reasonable, necessary, and causally related. Petitioner offered into evidence the outstanding medical bills of Petitioner as Exhibits 5-13 on September 10, 2015. (PX5-13). No evidence was offered indicating that the treatments were not reasonable or necessary, nor was any evidence produced indicating that the fees were not reasonable. Based on the record as a whole, the Arbitrator finds that Petitioner sustained his burden of proof that medical bills PX5 through PX 13 are reasonable and necessary medical care causally related to the accident of June 4, 2012. The Arbitrator orders Respondent to pay said outstanding charges in accordance with the fee schedule or by prior agreement whichever is less pursuant to Act.

The Arbitrator notes that Respondent failed to rely upon a utilization review to deny the reasonableness and necessity of the treatment rendered. Pursuant to Section 8.7(i)(3) of the Act, "An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section." 820 ILCS 305 8.7(i)(3). This section of the Act is applicable to all treatment rendered on or after 9/1/2011. Once a Petitioner meets his or her burden of proof and establishes causal connection, if Respondent fails to offer a utilization review opinion into evidence denying treatment, then all treatment is therefore deemed reasonable and necessary.

Through the date of Arbitration, the following balances remained outstanding pursuant to the fee schedule:

1.	Saint Anthony Hospital	6/4/2012	$785.76

2.	Saint Anthony Hospital Physicians	6/4/2012	$180.58
3.	Chicago Imaging Associates	6/4/2012	$66.64
4.	Marque Medicos	6/6/12-9/20/12	$13,318.23
5.	Medicos Pain & Surgical Assoc.	6/12/12-11/15/12	$530.20
6.	Industrial Pharmacy	6/12/12-9/20/12	$1,647.36
7.	Specialized Radiology	7/9/12	$185.28
8.	Archer Open MRI	7/9/12	$1,147.44
9.	Elite Physical Therapy	10/2/12-11/6/12	$4,685.34
		Total	**$22,546.83**

The Arbitrator found accident and causal connection. The Arbitrator notes the absence of UR denying the necessity of treatment rendered and adopts the credible opinions of Petitioner's medical providers. Accordingly, for the reasons noted, the Arbitrator finds all medical treatment rendered through the date of arbitration to be reasonable, necessary, and causally related to the injury Petitioner sustained on June 4, 2012.

Is Petitioner is entitled to TTD?

Having established accident and causal connection, the Arbitrator finds Petitioner satisfied his burden of proof and is entitled to TTD benefits from 6/5/2012 through 11/15/2012 for a total of 23 3/7 weeks. Aside from denial of accident, Respondent offered no defense to negate Petitioner's claim to TTD.

During the time in question, Petitioner was either completely off work or capable of returning to work with restrictions. Petitioner testified that when he was finally released to return to light duty work, Respondent never provided light duty work. (T67). Petitioner was unable to find work within his restrictions and testified that from the date of accident of 6/4/2012 to the date he was released full duty on 11/15/2012, he received no TTD benefits, had no other source of income. (T67-68).

Taking into account an AWW of $500.95 and a TTD of rate of $333.97, Petitioner should have been paid $7,824.44 in TTD benefits during the relevant time period.

What is the nature and extent of the injury?

The Arbitrator adopts by reference all prior findings and conclusions into this Section without restating them herein. This claim arose after September 1, 2011, therefore the 5 factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2) Occupation of the injured employee; 3) Age of the employee at the time of the injury; 4) Employee's future earning capacity; and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: Neither Petitioner nor Respondent presented an AMA Impairment Rating. Based on the failure to submit an AMA Impairment Rating the Arbitrator cannot consider this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a machine operator for ten years. He was released to return to full duty work in November of 2012, about five months after the injury, although he was not taken back by the Respondent, as he had been fired before he was released to return. The Arbitrator gives some weight to this factor.

3. ***Age of the employee at the time of the injury***: Petitioner was 35 at the time of his accident. There is no evidence that Petitioner's age impacted his injury or created any permanent disability. No weight is given to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that he when he had the restrictions on him before his release to full duty in November, he was unable to find work with the restrictions. No evidence was provided by Petitioner that his ability to earn an income or to work full time has been impacted by the injury since his full duty release. Petitioner did not testify to any diminution of his earnings since this accident. There is no evidence of disability due to this factor the Arbitrator gives some weight to this factor as well.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained an injury to his right shoulder, neck, thoracic spine and low back, including a herniated disk at C5-6 with cervical radiculopathy. The medical records document these injuries. Although Petitioner has reached MMI, and was released to return to work full duty in November of 2012, he testified that he continued to have pain in his neck and right shoulder. The Arbitrator gives significant weight to this factor.

Given the nature of the injury the Petitioner suffered to his right shoulder, his neck, his cervical and thoracic spine and his low back following the June 4, 2012, incident, he is entitled to have and receive from the Respondent compensation for **5%** loss of use of the person as a whole, or **25** weeks at a weekly PPD rate of **$300.57 / per week.**

Should penalties and attorneys' fees be awarded?

Section 19(l) penalties are appropriate if the Respondent fails, neglects, refuses, or unreasonably delays payment of benefits due. An employer withholding benefits has the burden of proving that its delay was reasonable. *Jacobo v. Illinois Workers' Comp. Comm'n*, 355 Ill. Dec. 358 (2011). In *McMahan v. Indus. Comm'n*, the Supreme Court held Section 19(l) penalties are "**mandatory** if the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." 183 Ill. 2d 499 at 515 (1998). When the Respondent fails to meet its burden, the Petitioner is to be awarded thirty dollars ($30) per day, with a maximum award of ten thousand dollars ($10,000.00).

Under a more stringent standard, penalties under Section 19(k) and Section 16 are appropriate if the Respondent is guilty of delay or unfairness towards the employee in the payment of benefits, is unreasonable or vexatious in delaying payment of benefits, or engages in

frivolous defenses which do not present real controversy. Unlike Section 19(l) penalties, these penaltics arc not mandatory, they are discretionary and "intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose." Mech. Devices v. Indus. Comm'n, 344 Ill. App. 3d 752.

In the case at bar, the Respondent denied benefits under a theory that the injury did not arise out of or in the course of the Petitioner's employment with Respondent. The Respondent claimed that the Petitioner had completed his work for the day and was off the clock, doing personal work on his motorcycle, which apparently they permitted him to do occasionally. There was also the matter of the criminal case, which apparently went to trial before a judge and was dismissed. The burden of proof in a criminal case is higher than that of a civil case, including cases before the IWCC which has a preponderance of the evidence standard rather than beyond a reasonable doubt. The criminal decision is not binding on the IWCC and has no effect on a decision on the merits at the commission. Respondent's reliance on these factors, although misguided does not amount to being vexatious or unreasonable.

Penalties and attorney's fees are denied.

ORDER OF THE ARBITRATOR

Given the nature of the injury the Petitioner suffered to his right shoulder, his neck, his cervical and thoracic spine and his low back following the June 4, 2012, incident, he is entitled to have and receive from the Respondent compensation for **5%** loss of use of the person as a whole, or **25** weeks at a weekly PPD rate of **$300.57 / per week.**

Respondent shall pay Petitioner temporary total disability benefits of $333.97/week for 23 & 3/7th weeks, commencing 6/5/2012-11/15/2012, for a total of **$7,824.44** as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$22,546.83**, as provided in Section 8(a) of the Act.

Penalties and attorney's fees are denied.

Deborah L. Simpson

Signature of Arbitrator

February 28, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dolores "Dee" Wisneski (widow of Thomas "Buck" Wisneski, deceased),
Petitioner,

v.

NO: 10 WC 27928

Enterprise Transportation Company,
Respondent.

17IWCC0659

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability/maintenance 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.

Temporary Total Disability/Maintenance

Petitioner alleged Mr. Wisneski was temporarily and totally disabled from June 22, 2010 through September 14, 2015. The Commission finds the evidence clearly establishes Mr. Wisneski reached maximum medical improvement on December 20, 2011, consequently his entitlement to TTD benefits ended as of that date. See *Matuszczak v. Illinois Workers' Compensation Commission*, 2014 IL App (2d) 130532WC, ¶14 (once an injured employee's condition stabilizes, *i.e.*, once the employee reaches MMI, he is no longer eligible for TTD benefits (although he may be entitled to PPD benefits)). The Commission affirms the Arbitrator's award of temporary total disability benefits from June 22, 2010 through December 20, 2011.

Finding Mr. Wisneski had permanent restrictions which Respondent could not accommodate, the Arbitrator awarded maintenance benefits from December 21, 2011 through

17IWCC0659

December 9, 2014, the date Mr. Wisneski "refused to participate in vocational rehabilitation." The Commission initially notes there is no evidence vocational rehabilitation was offered on December 9, 2014, nor any evidence it was refused; in fact, there is nothing in the record to suggest December 9, 2014 has any significance whatsoever. More importantly, though, there is no evidence Mr. Wisneski was entitled to any maintenance benefits. By its own terms, the Act grants maintenance benefits only while a claimant is engaged in a vocational rehabilitation program; if the claimant is not engaged in some type of "rehabilitation" such as physical rehabilitation, formal job training, or a self-directed job search, there is no obligation to provide maintenance. See *e.g. Greaney v. Industrial Commission*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331 (2005); see also, *W.B. Olson v. Illinois Workers' Compensation Commission*, 2012 IL App (1st) 113129WC, ¶39, 981 N.E.2d 25 (An employer is obligated to pay maintenance benefits only "while a claimant is engaged in" a vocational rehabilitation program.) The record demonstrates Mr. Wisneski never engaged in a rehabilitation program; as such, he is not entitled to the maintenance benefits associated therewith. The Commission vacates the award of maintenance benefits and finds Mr. Wisneski's permanent disability began on December 21, 2011.

Permanent Disability

Section 19(e) requires the Commission to review "all questions of law or fact" which appear from the transcript of evidence. *820 ILCS 305/19(e)*. At arbitration, Mr. Wisneski maintained his injuries rendered him entitled to "odd-lot" permanent total disability benefits.

Under the Act, an employee is entitled to benefits for "complete disability, which renders [him] wholly and permanently incapable of work." *820 ILCS 305/8(f)*. However, entitlement to permanent total disability ("PTD") benefits does not require "complete physical incapacity." *Lenhart v. Illinois Workers' Compensation Commission*, 2015 IL App (3d) 130743WC, ¶32, 29 N.E.3d 648. Instead, a PTD award is proper "when the employee can make no contribution to industry sufficient to earn a wage." *Id.* This "odd-lot" theory of compensation permits an award of PTD benefits to one who, though not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market.

The Appellate Court has repeatedly held odd-lot status can be established in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Industrial Commission*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342 (2007); *Professional Transportation, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (3d) 100783WC, ¶34, 966 N.E.2d 40. Mr. Wisneski pursued odd-lot status based on the latter method, relying on the opinions of Susan Entenberg, Petitioner's vocational expert.

Ms. Entenberg was deposed in this matter on two occasions. The first deposition occurred on September 12, 2013. PX7. Ms. Entenberg is a vocational rehabilitation counselor and has worked with the industrially injured in Illinois since 1977. PX7, p. 4-5. She conducted a vocational

17IWCC0659

assessment of Mr. Wisneski on December 22, 2011. PX7, p. 6. She testified Mr. Wisneski's restrictions prohibit him from returning to his past work as a truck driver. PX7, p. 15-16. In light of his age, education, and prior training, Ms. Entenberg opined Mr. Wisneski was not trainable:

> Well, he's now 61 years old. Has been a truck driver his entire life for over 40 years. He has very severe restrictions to essentially using the left arm for any functioning activity. And the left arm is his non-dominant arm, so that's very important.
> He doesn't have any clerical or computer skills. He has no transferrable skills. So he has a lot of negative factors relating to an ability to work and to work at a different, a new job considering his inability to use his dominant arm for really any type of activity. He has problems even writing for any period of time.
> His age is a factor. At that age it's difficult to start looking at new employment. He doesn't have any skills that are going to be transferrable or utilized. I think - - Because of all of that, I think prognosis for any type of placement would be very difficult and very poor. PX7, p. 17-18.

She concluded vocational rehabilitation was not recommended for Mr. Wisneski:

> I don't think it would be cost effective because of all the significant amount of negative vocational factors that he has. He's considered to be an older individual from a vocational point of view. He has done one type of job his entire life. And he has very severe limitations to his dominant arm, and that's really important. If it was the non-dominant arm, there may be some other things he could do, but not with - - not with the dominant are being affected. PX7, p. 19-20.

For the same reasons, she did not feel a stable labor market existed for Mr. Wisneski. PX7, p. 20. Ms. Entenberg then reiterated she did not recommend any form of vocational rehabilitation as she did not believe it would be successful. PX7, p. 20. She also opined any job search would be similarly unsuccessful. PX7, p. 21. She reviewed an August 9, 2013 labor market survey conducted by Coventry and opined the jobs identified therein were not appropriate as they were either beyond Mr. Wisneski's physical restrictions or required skills he does not possess. PX7, p. 21-23. The Commission notes this labor market survey was not offered into evidence. Ms. Entenberg then explained her opinion regarding Mr. Wisneski's re-trainability was not tied to an intellectual deficit but was rather a consequence of his age, skills, training, and work history:

> But it's more of you have a 61-year-old man who has extremely limited use of the dominant arm, which is what would you utilize for doing these types of skills, and to start attempting to train him - - and he's been a truck driver his entire life and basically said he has problems figuring out his cell phone or using it. So to start trying now and developing skills that potentially - - and I'm not even sure what skills those would be - - to try to make him marketable, I don't think there's a cost benefit to it. PX7, p. 31.

17IWCC0659

In response to Ms. Entenberg's conclusions, Respondent offered the opinions of Jacqueline Bethell, whose evidence deposition was admitted as Respondent's Exhibit 2. Ms. Bethell began her employment at MedVoc doing strictly job placement and working under the direction and supervision of Julie Bose. RX2, p. 16. She sat for the CRC exam in October of 2012 and learned she passed in January of 2013. RX2, p. 16-17. Ms. Bethell prepared a report dated April 17, 2014. RX2, p. 5. She did not interview Mr. Wisneski prior to preparing her report. RX2, p. 8. Ms. Bethell testified she reviewed two labor market surveys prepared by Coventry, one in Chicago and one in Pahrump, Nevada, which targeted appointment setter, cashier, and surveillance security positions; these reports demonstrated there was no stable labor market for those positions in Pahrump, but there existed vocational opportunities for those positions in the Chicagoland area. RX2, p. 10. The Commission again notes neither of these labor market surveys was placed into evidence. Ms. Bethell testified Mr. Wisneski's work history is considered Medium in exertional level with a Specific Vocational Preparation of 4, making it a semi-skilled position. RX2, p. 11. Ms. Bethell concluded Mr. Wisneski was employable:

> Basically, based on his work history, based on the fact that he did hold a semi - - previously semi-skilled position, he's capable of performing entry level positions such as information clerk, greeter, and courier - - light courier positions that involve the medical field: specimen pickup, drop-off, stuff like that. These positions are typically unskilled, learning in 30 - - 30 days to maybe 3 months. Typically 30 days and may extend - - it will be employer specific - - to 3 months.
> They're retirement-type of positions. Given Mr. Wisneski's age - - I know he is 62, but the retirement age - - I mean, the trend shows it keeps increasing. So I do believe that, yes, he would be able to do those types of positions given work history, physical capabilities. Some of these positions are considered light, but that's just due to the walking tolerances and the standing tolerances. There's not much lifting involved in these positions at all. RX2, p. 12-13.

Ms. Bethell then explained she utilized the Bureau of Labor Statistics SkillTRAN program to determine an average hourly wage: for information clerk and greeter positions in Chicago, the hourly mean wage is $13.45; for courier positions in Chicagoland, the hourly mean wage is $14.24. RX2, p. 14-15. Ms. Bethell stated the Bureau of Labor Statistics ("BLS") indicates approximately 5,580 positions for information clerk and greeter. RX2, p. 18. She testified she relied on the BLS data to show positions are available; Ms. Bethell then agreed the BLS data does not establish the existence of a stable labor market for an individual but identifies jobs which exist in a certain community. RX2, p. 20. The deposition concluded with the following colloquy regarding the distinction between jobs existing and a stable labor market for Mr. Wisneski:

> Q. So either way, we don't know, as we're sitting here today, or you don't know whether there's a stable labor market for an individual like Mr. Wisneski in the city of Pahrump or the area of Pahrump, Nevada, for either of these jobs? Is that a fair statement?

17IWCC0659

A. I would say that there are positions - - that there are positions available in - - The positions I named, there are positions available in that - - in Pahrump, Nevada.
Q. Your research hasn't indicated there's any jobs available as of the date of your report; is that correct? It just shows they exist. It doesn't mean they're open and available, right?
A. That is correct, yes.
Q. So we don't know - - As of the time you wrote your report, you don't know what's available?
A. That is correct. Yes. They're out there, but, yeah, I don't know what employers are hiring or what - -
Q. Right.
A. - - aren't.
Q. So we don't know specifically for an individual like Mr. Wisneski, his background, his age, his education, his disability? We don't know what extent he would be employable, right?
A. No, I'm not saying that. I don't think - - I think that based on that he - - and based on all of those - - the concrete - - the objective findings in regards to age, work history, and based on my experience, he would be employable. I just - - do we know - - He is employable. Do we know that employers are hiring? No, I can't say that I do because I have not contacted them.
Q. But when you say he's employable, you don't know of any stable labor market for him in Pahrump, Nevada; is that accurate?
A. I - - I - - and I guess you - - explain - - I'm having - - I'm having a difficulty - - or a difficult time with saying - - with, I guess, saying in regards to stable labor market.
Q. Uh-huh.
A. The positions exist. Do I know what positions that - - that - - or what employers are hiring? Like I said, no, I do not.
Q. What's a stable labor market?
A. I would say - - I mean, I guess the - - Yes, what employers, what we're looking at, or what employers are currently hiring and what aren't. So without further research, no, I don't - - I couldn't say that. RX2, p. 25-27.

Susan Entenberg was deposed for a second time on March 23, 2015. PX8. Since her prior testimony, Ms. Entenberg had authored a letter dated October 1, 2014 and conducted a labor market survey. PX8, p. 5. She also reviewed Ms. Bethell's report and deposition. PX8, p. 5. Ms. Entenberg testified she utilized the 2011 restrictions imposed by Dr. Marra and reviewed Dr. Cole's restrictions of lifting of 10 to 15 pounds and no overhead. PX8, p. 6. Ms. Entenberg testified she conducted a labor market survey for Pahrump, Nevada to determine the availability of the three positions Ms. Bethell identified as appropriate: information clerk, greeter, and courier. PX8, p. 7.

Ms. Entenberg explained her search yielded no jobs:

> There were no information clerk, greeter, or courier jobs available in Pahrump. The only job opening that was available that was somewhat appropriate was a Pizza Hut delivery driver. There were jobs in Las Vegas, Nevada, which was the closest area. That's 45 miles from Pahrump going through the desert. But those jobs required experience and skills beyond what Mr. Wisneski holds. So there were no positions for - - Information clerk and greeter were essentially - - and as Ms. Bethell basically states - - the same job and there were no - - there were no positions. There were no courier positions. PX8, p. 8.

She identified Deposition Exhibit 2 as printouts from her research including her online search for a greeter position on the Wal-Mart website, where zero jobs were available nationally, as well as the classified ads from the Pahrump Valley Times which included no opportunities within Mr. Wisneski's skills and abilities. PX8, p. 8-9. Ms. Entenberg then detailed why the data utilized by Ms. Bethell is not relevant for determining whether a stable labor market exists: "It just gives the jobs, the [standard and occupational classification] codes, and those numbers of jobs within the region…but it doesn't tell you what the – if there's openings in those jobs, if they are still available, that sort of thing." PX8, p. 11. She then testified it remains her opinion there is no stable labor market for Mr. Wisneski. PX8, p. 12.

The Commission finds the credible vocational evidence proves no stable labor market existed for Mr. Wisneski. In making this finding, the Commission relies on Petitioner's expert Ms. Entenberg, whose conclusions are consistent with the facts and therefore most persuasive. Ms. Entenberg highlighted Mr. Wisneski was 61 years old at the time of her vocational assessment, had very severe restrictions for his dominant arm, no transferable skills, could not use a computer, and struggled with a cell phone. Analyzing the facts under the *National Tea* guidelines, Ms. Entenberg concluded vocational rehabilitation would not be worthwhile or cost-effective, and no stable labor market existed for Mr. Wisneski. Therefore, pursuant to Ms. Entenberg's opinion, Mr. Wisneski fell within the odd-lot category. At that point, the burden shifted to Respondent to show "some kind of suitable work is regularly and continuously available to the claimant." *Valley Mould & Iron Co. v. Industrial Commission*, 84 Ill. 2d 538, 546, 419 N.E.2d 1159 (1981).

In an attempt to meet that burden, Respondent presented the opinions of Jacqueline Bethell. Ms. Bethell opined, without having met Mr. Wisneski, he was employable and could pursue positions as an information clerk, greeter, or light courier. She further concluded the Bureau of Labor Statistics established the existence of these jobs in both Chicago and Pahrump, Nevada. The Commission finds Ms. Bethell's opinions are unpersuasive. Aside from her difficulty articulating the definition of a stable labor market, the Commission emphasizes Ms. Bethell failed to appreciate the significant difference between simply showing jobs exist and demonstrating an actual availability of those jobs for someone in Mr. Wisneski's circumstances. For example, Ms. Bethell highlights 900 people work as couriers in Pahrump, Nevada, but this is irrelevant if none of the employers are hiring. As explained by Ms. Entenberg, the data Ms. Bethell relied on does not prove

what she claims it does: "It just gives the jobs, the [standard and occupational classification] codes, and those numbers of jobs within the region…but it doesn't tell you what the – if there's openings in those jobs, if they are still available, that sort of thing." PX8, p. 11. This is borne out by the fact Ms. Entenberg performed a labor market survey targeting the positions identified by Ms. Bethell, and there were no openings. PX8, p. 8. The Commission finds Ms. Bethell's opinion Mr. Wisneski is employable is incompatible with the facts. See, *e.g.*, *Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

The Commission has considered whether Mr. Wisneski "retired" to Nevada and therefore removed himself from the labor market, but notes that argument presupposes the existence of a stable labor market from which to retire. While Ms. Bethell opined there were a greater number of information clerk, greeter, and courier positions in the Chicagoland area, the Commission emphasizes the same flaw exists in her analysis as she did not perform a labor market survey to demonstrate if companies were actually hiring and thus jobs were "regularly and continuously available" to Mr. Wisneski.

The Commission finds Mr. Wisneski established odd-lot permanent total disability under Section 8(f) of the Act. The Commission awards permanent total disability benefits commencing December 21, 2011, the day after Mr. Wisneski reached maximum medical improvement, through the date of his death, October 15, 2015.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $588.35 per week for a period of 78 1/7 weeks, representing June 22, 2010 through December 20, 2011, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of maintenance benefits from December 21, 2011 through December 9, 2014 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all maintenance payments made to be applied toward the permanent total disability benefits awarded.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent and total disability benefits of $588.35 per week, commencing December 21, 2011 and continuing through Decedent's death on October 15, 2015 as provided in §8(f) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $5,352.74 for medical expenses, as provided in §§8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits paid and shall hold Petitioner harmless from any claims by any

17IWCC0659

providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,200.00.

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

DATED: OCT 18 2017

L. Elizabeth Coppoletti

LEC/mck

O: 8/30/17

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WISNESKI, THOMAS BUCK
Employee/Petitioner

Case# **10WC027982**

ENTERPRISES TRANSPORTATION CO
Employer/Respondent

17IWCC0659

On 10/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOCIATES
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
WILLIAM F O'BRIEN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

17IWCC0659

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

THOMAS BUCK WISNESKI
Employee/Petitioner

v.

ENTERPRISE TRANSPORTATION CO.
Employer/Respondent

Case # 10 WC 27928

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 **Gerald Granda**, Arbitrator of the Commission, in the city of **Kankakee, IL**, on **September 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0659

FINDINGS

On **June 21, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$882.53**; the average weekly wage was **$45.891.56**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$61,188.40** for TTD, **$0.00** for TPD, **$75,739.05** for maintenance, and **$6,066.15** for other benefits, for a total credit of **$143,067.65**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $5,352.74, as provided in Sections 8(a) and 8.2 of the Act, and subject to the Fee Schedule. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $588.35/week for 78-1/7 weeks, commencing June 22, 2010 through December 20, 2011, as provided in Section 8(b) of the Act. Respondent shall receive a credit for any TTD it has already paid.

Respondent shall pay Petitioner maintenance benefits of $588.35/week for 155 weeks, commencing December 21, 2011 through December 9, 2014, as provided in Section 8(a) of the Act. Respondent shall receive a credit for any maintenance it has already paid.

Respondent shall pay Petitioner permanent partial disability benefits, commencing December 10, 2014, of $321.69/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Petition for Penalties and Attorneys' Fees is denied.

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

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

Signature of Arbitrator

9/30/15
Date

OCT 2 - 2015

17IWCC0659

FINDINGS OF FACT

This claim involves a Petitioner who was involved in an undisputed accident on June 21, 2010. The issues in dispute are as follows: 1) medical expenses; 2) TTD/maintenance; 3) penalties and attorney fees; and 4) nature and extent. With regard to the issue of nature and extent, the Petitioner is claiming he is entitled to a permanent and total disability award.

Petitioner was employed as a truck driver for the Respondent on June 21, 2010. At that time he was involved in a head-on collision with another driver and suffered injuries to his right shoulder.

The Petitioner attended formal schooling through high school. He graduated from high school in 1970. From 1970 until his accident in June 2010, he as employed driving trucks and heavy equipment. The Petitioner completed no other special schooling.

The Petitioner explained that, during his career as a commercial truck driver, he drove concrete mixers, chemical tanker's and low boys. Throughout his 40-year career he would drive either local routes or cross-country. During his time with Respondent he primarily drove cross-country routes.

When Petitioner worked for Respondent, he drove hazardous chemical trailers across the country using a tractor-trailer. He testified that he was required to climb on top of the hazardous chemical tankers and check the top of the tank, the caps, and the dome for leaks. The Petitioner was required to do a "three-point" stance in order to climb to the top of these tankers. This involved having three points of contact—such as the left foot, left hand, and right hand—in contact with the truck at all times. The Petitioner testified that he was able to climb safely before his June 2010 accident. He further testified that his job required him to unload hazardous chemicals using hoses. When clean, these hoses weighed approximately 30-40 pounds. When dirty, the hoses would weigh an increased 5-10 pounds.

The Petitioner had treated for right shoulder injuries before his June 2010 workplace accident., The Petitioner testified that he had a right shoulder replacement on February 28, 2007. This injury was causally connected to a work-related injury on August 24, 2006. The Petitioner returned to full-duty work as a truck driver on June 25, 2007. He continued to work full-duty as a truck driver until his June 2010 accident. Prior to the June 2010 accident he had difficulty performing certain aspects of his job due to his right shoulder, (operating stick shift) but found ways to compensate and complete his job duties as a truck driver.

INJURY AND TREATMENT

Petitioner presented to Advocate Good Samaritan Hospital on June 21, 2010 complaining of right shoulder pain after a motor vehicle accident. (PX 1). He reported that he was thrown forward during the collision and hit his right shoulder against the steering wheel. Id. He was diagnosed with acute right shoulder pain and right A.C. separation. Id.

The Petitioner presented to Dr. Paul Perona on June 24, 2010. (PX 4). Dr. Perona performed the Petitioner's prior right shoulder surgery in 2007. Dr. Perona noted that the Petitioner's right shoulder was tender over the AC joint and diagnosed right shoulder pain and trauma. Id. He prescribed a round of physical therapy and ordered the Petitioner off of work for six weeks. Id. The Petitioner returned to Dr. Perona on July 15, 2010 and reported that the physical therapy did not help. Id. Dr. Perona ordered another attempt at physical therapy which, also, did not elicit any relief. Id. On August 10, 2010, Dr. Persona diagnosed adhesive capsulitis and rotator cuff tendon tear and referred the Petitioner to Dr. Guido Marra. Id.

The Petitioner saw Dr. Marra on September 21, 2010. (PX 2). At that time, Dr. Marra diagnosed a massive cuff tear associated with a total shoulder replacement. Id. He recommended that the Petitioner undergo an ultrasound examination of his right shoulder. Id. That ultrasound revealed a very large retracted rotator cuff tear. Id. Dr. Marra recommended surgical intervention. Id.

Dr. Marra performed surgery on the Petitioner on February 23, 2011. Id. This procedure included the removal of the Petitioner's prior right total shoulder arthroplasty, irrigation and debridement of the humeral osteomyelitis, and debridement of the glenoid, and insertion of a hemiarthroplasty. Id. The Petitioner also received treatment for a right shoulder infection at this time. Id. Dr. Marra continued to monitor the Petitioner's progress post-surgery and noted some improvement with his pain. Id. On May 24, 2011, Dr. Marra opined that the Petitioner required further surgery to convert his PROSTALAC to a total shoulder arthroplasty. Id. The Petitioner underwent this procedure on June 29, 2011. Id.

Dr. Marra declared the Petitioner at MMI on December 20, 2011. (PX 1). At that time he issued the following permanent restrictions: No lifting more than 0-5 pounds. No overhead work. No climbing. No push/pull. Id.

The Petitioner testified that he continues to experience pain and difficulty with his right shoulder. When asked whether he believed he

17IWCC0659

could return to his prior employment as a truck driver, the Petitioner testified that he could not return to that line of work. Specifically, he testified that he needs two good arms in order to climb in and out of the trucks. He further testified that he could not operate the manual transmission in the commercial trucks because his right arm and shoulder hurt when he attempted to stretch out and manipulate the stick shift. The Arbitrator notes that the Petitioner was able to drive from Nevada for the hearing but that the Petitioner was driving a personal vehicle, not a commercial truck.

The Petitioner further testified that he has not reinjured his right shoulder since his June 2010 accident. He explained that his right shoulder hurts all of the time, especially when he tries to lift or do anything with his right arm. He stated that he now does more with his left arm. He testified that he has a hard time when dressing, especially when tucking in a shirt because he cannot reach his right arm all the way around his back. He also stated that he now must eat primarily using his left arm.

The Petitioner testified that he cannot hold his head straight without causing pain. The Arbitrator observed the Petitioner sitting in a chair. He sits slightly leaning to the right, with his head leaning to the right. When asked about it, he did straightened his head, or brought his head and neck to a neutral position. This caused visible pain, as he grimaced during the hearing. The Petitioner also appeared to protect the right arm, moving it a limited amount during the hearing.

When asked about driving, the Petitioner stated that he can drive but is sore if he has to drive great distances. The Petitioner testified that he drove to the hearing from Nevada but was sore during and after the drive. He rests his right arm exclusively on his center console. He uses his left arm to drive.

The Petitioner testified that he can no longer get good sleep after this injury. He stated that he can lay down for a few hours but cannot lay on his side without causing pain. When he lays down he "feels like his arm is coming out of his socket." The Petitioner usually sleeps sitting in an armchair.

The Petitioner answered questions regarding whether he is able to write. He stated that he cannot comfortable rest his arm on a desk in order to write. He must put a book or pad on his leg in order to sign or write at a lower level. Ultimately, the Petitioner stated that it "takes me ten times longer to do anything." By way of example, he said that he can no longer reach overhead with his right arm without pain so that a simple task, such as changing a light bulb, is much harder. He testified that "if it took me a half hour it now takes me one and a half to two hours."

Regarding his employment, the Petitioner testified that he would still be employed with the Respondent if he had not been injured. He believed that he would make at least the same wage he earned at the time of his injury. He did ask for light duty work from respondent, but none was offered.

On December 22, 2011 the Petitioner interviewed with vocational rehabilitation counselor Susan Entenberg. He testified that she did not recommend he look for a job.

The Petitioner moved to Pahrump, Nevada in February 2012. He testified that he moved there because he feels that there are better living conditions. He stated that the hot climate makes his shoulder feel better; in Chicago, the damp weather made him hurt. It's less expensive. He also stated that he moved to be closer with his son and grandchildren.

In Pahrump, the Petitioner participates in "swap meets." He sells items that he buys on TV, such as knives and hats, for a small profit. He called the activity a "hobby," rather than a steady type of work, and earns between $5.00 and $30 per day. The Petitioner no longer attends the swap meets because the location was sold. When he participated he would go once-a-week on the weekends.

On Cross-Examination, the Petitioner testified that he has not looked for a job since moving to Nevada. He did not use the internet to apply for jobs because he cannot use computers. He answered questions regarding the "swap meets" that he used to attend on weekends. He testified that he usually attends one day on the weekend for 3-6 hours. On both cross-examination and direct-examination the Petitioner testified that he viewed the "swap meet" as a hobby where he earns some extra money selling items, such as knives and hats. He testified that attending these swap meets did not affect his decision not to look for work

The Respondent asked if the Petitioner retired in Nevada. The Petitioner answered that, for all intents and purposes, he retired in Nevada but he did not want to retire and that he would have liked to have a full time job if not for his injuries.

§ 12 EXAMINATION

The Petitioner attended a § 12 Examination with Dr. Brian Cole on December 13, 2010. (RX 1). At that time, Dr. Cole diagnosed a

17IWCC0659

right shoulder total shoulder replacement with subsequent rotator cuff deficiency and clinical findings consistent with rotator cuff arthropathy status post motor vehicle accident 6/21/2010. Id. Dr. Cole further noted that "the claimant has a well-resolved total shoulder replacement with what appears to be an uncomplicated recovery and a full-duty return with unrestricted work for more than two years prior to the 6/21/2010 head-on collision motor vehicle accident that was work related. He has failed to thrive since then and demonstrated rotator cuff deficiency, and resultant findings of rotator cuff arthopathy that warrant definitive management." Id. Dr. Cole opined that the Petitioner would benefit from surgery, specifically a reverse total shoulder arthroplasty. Id.

Dr. Cole issued an addendum § 12 report on May 28, 2013. Id. He reviewed further medical records as well as significant surveillance footage over the dates of March 9, 2012, March 10, 2012, January 11, 2013, January 12, 2013, and January 18, 2013. Id. This is the same footage offered by the Respondent into evidence as Respondent's Exhibit 3. Id. After reviewing the additional records, Dr. Cole maintained his previous opinion regarding the causal relationship between the Petitioner's motor vehicle accident and his injuries and need for treatment. Id. Dr. Cole agreed with Dr. Marra's MMI release in December 2011, but disagreed as to the Petitioner's Permanent restrictions. Id. Specifically, Dr. Cole stated:

> I believe a 5-pound lifting limit is a bit extreme. I cannot assess nor delineate exact lifting specifications; however, I can state that the claimant is likely capable of more than he was restricted to. Something in the range of 10-15 pounds with the right upper extremity, but nothing lifted overhead seems reasonable. If work capacity is needed to be delineated with any more granularity, then a job-specific functional capacity evaluation would be warranted. Id.

VOCATIONAL REHABILITATION DEPOSITIONS

The Arbitrator considered the evidence deposition testimony of Susan Entenberg and Jacqueline Bethell regarding the Petitioner's vocational rehabilitation. (PX 7; PX 8; RX 2).

Susan Entenberg testified on September 12, 2013. (PX 7). She interviewed petitioner December 22, 2011. Ms. Entenberg is a certified vocational rehabilitation counselor. Id. at 4. She testified that she based her opinions, in part, off of the restrictions imposed by Dr. Marra in December 2010. Id. at 10. Ms. Entenberg noted the Petitioner's history as a high school graduate with no military experience and a commercial driver's license since 1970. Id at 8. Ms. Entenberg stated that the Petitioner does not cook, has no computer skills, and has a hard time both using and holding a cell phone. Id. at 12. She further noted that the Petitioner could not write on a desk without pain and difficulty. Id. The Petitioner's vocational history was significant for only working as a truck driver. Id. at 14. Ms. Entenberg stated that the Petitioner's prior job as a truck driver was a medium-level job according to the Department of Labor. Id. at 15. A medium-level job requires the ability to lift up to 50 pounds occasionally, 25 pounds frequently, and using both arms consistently. Id. She opined that the Petitioner could not return to his past work because it involves lifting more than 0-5 pounds, overhead lifting, climbing in and out of a truck, pulling himself into a truck, pushing and pulling, using hands above waist level, steering, and using a stick shift. Id. at 15-16. Ms. Entenberg opined that, because of the Petitioner's injury, he has experienced a reduction and earning power and a loss of job security. Id.at 16-17. He has no transferrable skills and is not trainable based on his age, education, and prior occupational training. Id at 17-18. The Petitioner has had no prior vocational rehabilitation and training. Id. at 17. Ms. Entenberg did not recommend the Petitioner undergo vocational rehabilitation and opined that no stable labor market exists for the Petitioner. Id. at 19-20.

Ms. Entenberg reviewed the results of a labor market survey conducted by Coventry. Id. at 21-22. The labor market survey identified jobs as a cashier and in the surveillance industry. Id. Ms. Entenberg opined that these jobs were not appropriate for the Petitioner. Id. The Petitioner cannot work as a cashier because it would require using his dominant hand to use computers, handle money, make change, open a cash register, issue receipts, and make photocopies. Id. at 22. The Petitioner also cannot work in the surveillance industry because those jobs required 1-2 years of experience in the surveillance field, a thorough knowledge of Microsoft Office, and excellent written communications skills. Id. Ms. Entenberg noted that the Petitioner had no experience in the surveillance field, had no computer skills, and has difficulty and pain when writing. Id.

The Respondent cross examined Ms. Entenberg. First, Ms. Entenberg stated that she had not reviewed medical records after the Petitioner reached MMI. Id. at 25-26. Ms. Entenberg further stated that the Petitioner had no intellectual issues preventing him from learning computer skills, but, given his work history and problems even using his cell phone, she felt that there was no good cost benefit. Id. at 31. She further testified that a labor market survey was not appropriate because you must have jobs that the Petitioner is capable of performing in order to go and look at those jobs. Id. at 32. Finally, she testified that the Petitioner's home in Nevada has a worse labor market than Chicago. Id.

The Arbitrator also considered the evidence deposition of Ms. Jacqueline Bethell. Ms. Bethell testified on August 11, 2014. (RX 2 at 4). Ms. Bethell is a certified rehabilitation counselor retained by the Respondent. Id. at 5. She reviewed two labor market surveys

17IWCC0659

conducted by Coventry—one for Chicago, Illinois and one for Pahrump, Nevada—the §12 Examination report from Dr. Cole, the vocational rehabilitation report from Susan Entenberg, and the restrictions issued by Dr. Marra. Id. at 6. She also reviewed the Petitioner's education and work history but did not interview the Petitioner. Id. at 7-8. Ms. Bethell opined that a review of the Pahrump, Nevada labor market survey revealed no stable labor market for the Petitioner in Nevada. Id. at 9-10. The Chicago, Illinois labor market survey did reveal vocational opportunities for the Petitioner. Id. at 10. Ms. Bethell opined that the Petitioner is capable of performing entry level positions, such as information clerk, greeter, or courier. Id. She opined that these are "retirement-type" positions. Id. at 13. She stated that an information clerk or a greeter would make between $13 and $15 per hour in the Chicago area. Id. at 14. A courier in Chicago would earn between $14 and $16 per hour. Id. at 15. She opined that the Petitoiner is not permanently and totally disabled. Id Ms. Bethell stated that the labor market survey does not show any stable labor market for the Petitioner in Pahrump Nevada. Id. at 19. She further stated that she relied upon the Bureau of Labor Statistics to show that jobs may exist in a certain community. Id at 19-20. Ms. Bethell clarified that the Bureau does not establish whether a stable labor market exists for an individual. Id. at 20. Ms. Bethell testified as to whether a position exists for the Petitioner as an information clerk and greeter. Id. at 21. She stated that an information clerk would work in a public setting and provide information to individuals. Id. She did not believe that the Petitioner's lack of computer and typing skills would be a barrier to the type of job because the Petitioner may receive training on the job. Id. Ms. Bethell stated that the Petitioner's history as a truck driver since 1970 did not qualify him to interact and deal with the public. Id. at 22-23. Ms. Bethell then testified regarding a position as a courier. She referred to a company, Quest Diagnostics, as an example of such a position. Id at 23. Ms. Bethell did not know whether a job with Quest Diagnostics exists in Nevada, only that such positions exist in the Chicago area. Id. at 23-24. She did not believe that the Petitioner's difficulty using a cell phone would affect his ability to get a job as a courier. Id. at 24. On cross-examination, Ms. Bethell stated that her research into available jobs did not verify that any jobs were open and available for the Petitioner; it only showed that jobs exist. Id. at 24-25.

SURVEILLANCE

The Respondent submitted more than eight hours of video surveillance of the Petitioner into evidence. RX 3. This surveillance was taken on January 11, 2013; January 12, 2013; March 9 2012; and March 10, 2012. Id. The Arbitrator has reviewed this footage. These videos all follow the Petitioner as he attends a flea market, or "swap meet." At various points in the surveillance, the Petitioner is seen selling knives, hats, and other goods to patrons at the swap meet. Id. At times, the Petitioner is seen moving boxes, a table, a coat rack, bags, and an umbrella.

The Petitioner testified regarding the surveillance footage. He stated that the footage shows him attending a swap meet in order to make some extra money. The Petitioner testified that this is a hobby to keep him busy on the weekends. He would attend once or twice a week for 3-6 hours each day.

The Petitioner testified regarding four points on the January 11, 2013 footage. At the 10:03 mark the Petitioner is observed dragging a plastic tub with his left, non-injured arm. He testified that he was dragging a box of knives, hats, and other small objects. The Petitioner stated that this box weighed approximately 6-8lbs. On the same date, at the 23:30 mark, the Petitioner is seen lifting a plastic tub into the back of a truck using both arms. The Petitioner testified that this tub contained a few hats, a couple knives, and other junk. He stated that the tub weighed approximately 5lbs. At the 31:30 mark, the Petitioner is observed moving a wooden coat-rack into the back of a truck. The Arbitrator observed the Petitioner using his left hand to push the coat-rack and using his right, injured hand to balance and guide the coat-rack. The Petitioner testified that this weighed 3-4lbs. Finally, at the 33:39 point, the Petitioner is observed carrying a box with his left arm and then throwing the box into a dumpster. The Petitioner primarily uses his left arm to throw the box. The Petitioner testified that he was throwing away papers and that the box weighed 3-4lbs.

On January 12, 2013 at the 5:18 mark, the Petitioner is observed carrying beach bags using both arms. The Petitioner testified that these bags contained sandwiches and bottles of water. He stated that the bags weighed 3-4lbs.

On March 10, 2012 at the 4:38:45 mark, the Petitioner is observed putting away a table and umbrealla using both hands. He testified that the table weighed approximately 10lbs. The Arbitrator notes that the Petitioner uses both hands, but appears to use his left arm to push the table and the right arm to balance the table. At approximately the same time the Petitioner puts away an umbrella and several boxes into the back of his trunk and shuts the door. After shutting the door he remains hunched over for several seconds. The Petitioner testified that the boxes and umbrella weighed between 4-6lbs. He further testified that he remained hunched over the door because his right arm felt sore and painful.

Dr. Cole reviewed this surveillance footage after his second § 12 Examination. RX1. This is discussed in more detail above. The Petitioner testified that he disagrees with Dr. Cole's restrictions. He stated that he can lift between 5-8lbs with his right arm and not 10-15lbs are Dr. Cole opines. Id. The Petitioner testified that he primarily uses his right arm to balance objects and does most lifting with his left arm.

17IWCC0659

CONCLUSIONS OF LAW

1. With regard to the issue of medical expenses, the Arbitrator finds that the care and treatment provided to the Petitioner for his left arm condition was reasonable, necessary, and related to the accident of June 21, 2010. Therefore, the Arbitrator orders Respondent to pay the Petitioner, pursuant to §8(a) and subject to § 8.2 of the Act, the following outstanding balance for such care and treatment: medical bills for Dr. Perona at Family Orthopedic Center, Dr. Arturo D. Tomas, Laboratory & Pathology Diagnostics, and Ottawa Regional Hospital totalling $5,352.74. The Respondent offered no contrary medical opinion to dispute the reasonableness or necessity of the treatment rendered to Petitioner.

2. Regarding the issue of TTD/maintenance, the Arbitrator finds that the Petitioner was temporarily and totally disabled from June 22, 2010 through December 20, 2011 for a total of 78 and 1/7 weeks. On December 20, 2011 Dr. Marra declared that the Petitioner had reached MMI. PX 1. He gave the following work restrictions: No lifting more than 0-5 pounds. No overhead work, No climbing, no push/pull. PX 1. Respondent could not accommodate the Petitioner's restrictions. Thereafter, Petitioner was entitled to maintenance pay from December 21, 2011 through December 9, 2014 for a total of 155 weeks. As of December 9, 2014, Petitioner refused to participate in vocational rehabilitation, as evidenced by his own testimony that he retired in Nevada. Respondent shall receive a credit for any TTD or maintenance it has paid to date.

3. With regard to the issue of nature and extent, the Arbitrator finds that the Petitioner has not proven that he is entitled to a permanent and total disability award. This is supported by the evidence showing that the Petitioner had some restrictions and instead of going through the vocational rehabilitation process to look for any work within those restrictions, chose to retire in Nevada. The Arbitrator notes that Dr. Marra gave Petitioner permanent restrictions on December 20, 2011. Forty-eight hours later, Petitioner was interviewed by vocational rehabilitation counselor Susan Entenberg at the request of Petitioner's counsel. At that time Petitioner told Ms. Entenberg that he was moving to Nevada "as soon as possible." Petitioner further testified that they moved there to be with his son and grandchildren. Petitioner moved to Nevada in February 2012. He had to fly back to the Chicagoland area in order to obtain an MMI opinion in June 2012. Since then Petitioner has demonstrated that he can drive from Nevada to Illinois and he can perform various activities as shown in the surveillance video. These facts clearly go against Petitioner's claim that he would have liked to find work, but for the condition of his injured arm.

While the Arbitrator does not find that the Petitioner is permanently and totally disabled, the facts presented at the hearing show the Petitioner did sustain a significant injury that ended his career as a truck driver and has resulted in a loss of earning. As such, the Petitioner in this case is entitled to a wage differential award pursuant to Section 8(d)(1) of the Act. The Arbitrator finds persuasive the testimony and evidence presented by Ms. Jacqueline Bethell on this issue. Based on her testimony and supporting evidence, the Chicago Labor Market Survey listed seven potential employers with an average potential wage of $10.00 per hour, or $400.00 per week. Using Petitioner's average weekly wage at the time of the accident, $882.53, Petitioner's weekly differential would be $321.69 (2/3 of the difference between $882.53 and $400.00). Accordingly, the Arbitrator finds that Petitioner is entitled to a wage differential award of $321.69 per week beginning on December 10, 2014 for the duration of his disability.

4. The Petition for penalties and attorneys fees is denied. This finding is based on the various issues in dispute, upon which the Respondent's decision to delay or withhold benefits was neither vexatious or unreasonable.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Gilmartin (Janet Gilmartin, widow),
Petitioner,

v.

NO: 09 WC 16579

17IWCC0660

Kipin Industries, Inc., and the State Treasurer as *ex-officio* custodian of Illinois Injured Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to Petitioner's timely Petition for Review of Arbitrator Kane's November 2, 2016 decision. Therein the Arbitrator found Decedent did not sustain an accidental injury arising out of and in the course of his employment and denied all benefits. On review, Petitioner requests the Commission find Decedent sustained a compensable accident and award benefits accordingly. However, as the alleged injury occurred in West Virginia, a jurisdictional determination is necessary before the merits of Petitioner's claim can be reached.

Findings of Fact

The evidence deposition of William Gilmartin (hereinafter referred to as "Decedent") was taken on two dates. Direct examination was completed on September 19, 2014 (admitted as Petitioner's Exhibit 2); the deposition resumed, starting with cross-examination, on November 7, 2014 (Petitioner's Exhibit 3).

Decedent suffers from type 2 diabetes, high cholesterol, high blood pressure, coronary artery disease and peripheral vascular disease, smoked a pack-and-a-half per day from 1972 until he had his first heart attack in 1995, and has undergone multiple angioplasties with placement of heart stents. PX3, p. 28-30. In 2000, he underwent a right iliac artery angioplasty. PX3, p. 30.

17IWCC0660

Decedent testified he began working as a project manager for Kipin Industries in 1998. PX2, p. 34, 8. Kipin performs environmental services in coke plants as well as environmental demolitions, soil excavating, tank removal, and plant closures; the company is headquartered in Pennsylvania and handles projects in multiple states. PX3, p. 6-7. As project manager, Decedent's job duties included operating heavy equipment, paperwork, and supervising crews. PX2, p. 34-35. The first four years of his employment with Kipin, Decedent worked a project in Chicago. PX2, p. 9. Thereafter, he worked at out-of-state job sites. PX2, p. 9.

In October or November of 2008, Decedent was assigned to a project in West Virginia. PX3, p. 8. His job title remained project manager but as John Sigler oversaw this site, Decedent operated the heavy equipment. PX3, p. 8, 18.

Decedent alleged an accidental injury while working at the West Virginia job site on December 16, 2008. He described his activities that morning: "I was operating a Track hoe excavator, loading a hopper, which would separate soil and heavy debris would stay into the hopper. And once the hopper was full, no more material would come out, [the supervisor] would have me go in there and clean it out by hand, concrete blocks, bricks, steel plates, rail ties, any kind of debris." PX2, p. 13-14. Decedent stated the weights of the debris ranged from five to 50 pounds, with one piece feeling like it was 100 pounds. PX2, p. 14. He testified he "[w]asn't feeling good and I talked to my immediate supervisor for that job site, told him I wanted to go to the doctor." PX2, p. 11-12.

On further questioning, Decedent stated he informed Mr. Sigler he was not feeling well in the early morning. PX3, p. 9. Decedent denied having a traumatic accident or injury to his right leg or groin then testified he had experienced similar symptoms/pain "a couple days prior." PX3, p. 10. Decedent was next asked to confirm the sequence of events, and he explained he first told Mr. Sigler he was not feeling well on December 15, 2008 then he again mentioned not feeling well after working two to three hours on December 16, 2008. PX3, p. 13-15. As to his specific activities that day: he started working at 7:00 a.m. performing the required routine check of the excavator to make sure it was in working order; he then began processing material, moving it into the hopper; he estimated the first time he climbed into the hopper to clean it out was 8:30 or 9:00 a.m., and it was between 9:00 and 10:00 a.m. that Decedent advised Mr. Sigler he was not feeling well. PX3, p. 38-41. Decedent estimated he was cleaning the hopper for 30 to 45 minutes of the two to three hours he worked that morning. PX3, p. 16.

Decedent testified he left the job site and went to a clinic next to the motel where he was staying. When he saw the doctor, "I told him I wasn't feeling good, my groin was hurting, lower back, he checked it out and stated that I had an aneurysm in the right side of my groin." PX2, p. 15. Decedent testified the doctor advised him he "needed to go home ASAP and see my own doctors because if I was his patient I'd be in the hospital right then and there prepping for surgery." PX2, p. 16.

The records from Wedgewood Family Practice in Morgantown, West Virginia reflect Decedent was evaluated by Dr. William Mitchell on December 16, 2008. Dr. Mitchell documented

17IWCC0660

Decedent's complaints as increased frequency of urination the last few days, a little bit of pain in his groin, as well as low back discomfort. His past medical history was notable for noninsulin-dependent diabetes, hypercholesterolemia, peripheral vascular disease, and coronary artery disease with stenting in 2002. On examination, Dr. Mitchell observed the "inguinal area had no hernias present...No inguinal hernias." PX6, p. 159. The doctor's assessment was possible early prostatitis. Noting the symptoms of increased frequency of urination at night and pain especially in the groin area, Dr. Mitchell recommended a seven-day trial of Levaquin; if Decedent did not improve, he was to return for further evaluation and treatment. PX6, p. 159.

Decedent testified he phoned his supervisor and reported the doctor had directed he go home immediately to address an aneurysm. PX2, p. 17-18. When he returned from West Virginia, Decedent was evaluated by Dr. Savio Manatt, who has been his physician for 22 years. PX3, p. 21. Decedent testified he advised Dr. Manatt of what the West Virginia physician had stated and showed him his groin; Dr. Manatt reportedly discussed the matter with another physician then directed Decedent to the hospital for an ultrasound. PX2, p. 19-20. Decedent testified the ultrasound was completed that day, and he was informed surgery would be scheduled once the necessary pre-operative tests were completed. PX2, p. 20-21.

On December 30, 2008, Dr. Manatt conducted a pre-operative history and physical. Dr. Manatt recorded Decedent was to be admitted for repair of the aortofemoral bypass and noted Decedent "came to my office complaining that he had a lump on his right inguinal area. The patient was referred to Dr. Lamba and workup showed that the patient had a pseudoaneurysm." PX8, p. 234. Significantly, Dr. Manatt's examination findings include "a lump on the right inguinal area." PX8, p. 234.

On January 2, 2009, Decedent presented to his treating cardiologist, Dr. Narayan Mulamalla, to obtain cardiac clearance. PX2, p. 26. Dr. Mulamalla noted Decedent was scheduled for a resection of the right iliac artery aneurysm by Dr. Aswath Subram. PX4, p. 69. Decedent's "Problem List" included coronary artery disease major vessels; status post stenting of the right coronary artery and left anterior descending artery; status post aortobifemoral bypass graft; large right iliac artery aneurysm; severe peripheral vascular disease of both lower extremities without symptoms of claudication; old inferolateral wall myocardial infarction in 1995; hyperlipidemia; hypertension; and diabetes mellitus. PX4, p. 69. On examination, Dr. Mulamalla noted a four-by-four centimeter pulsatile mass directly above the right inguinal area. PX4, p. 70. Dr. Mulamalla's impression was severe coronary artery disease, stable; severe peripheral vascular disease, stable; and right iliac artery aneurysm; he directed Decedent to continue beta blockers for the perioperative period and cleared him for surgery. PX4, p. 70.

On January 5, 2009, Decedent was admitted to St. James Hospital for repair of his pseudoaneurysm on the aortofemoral bypass graft. Prior to the anticipated surgery, Decedent was diagnosed with bilateral hydronephrosis and underwent cystoscopy, bilateral ureteral catheterization, and bilateral retrograde pyelogram. PX8, p. 247. On January 8, 2009 Dr. Subram performed the pseudoaneurysm surgery: repair of pseudoaneurysm right limb aortofemoral bypass with new right iliac limb of the right to profunda femoris bypass graft and second graft to

17IWCC0660

superficial femoral artery. PX8, p. 245-246. Decedent was discharged on January 13, 2009. The final diagnoses were pseudoaneurysm of the aortofemoral bypass; iliofemoral obstruction; bilateral ureteral constriction; coronary artery disease; hypertension; hypercholesterolemia; noninsulin dependent diabetes mellitus; history of smoking. PX8, p. 233.

Conclusions of Law

The threshold issue a petitioner must establish is the Illinois Workers' Compensation Commission possesses jurisdiction over the claim. The Act confers Illinois jurisdiction over "persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois, persons whose employment results in fatal or non-fatal injuries within the State of Illinois where the contract of hire is made outside of the State of Illinois, and persons whose employment is principally localized within the State of Illinois, regardless of the place of the accident or the place where the contract of hire was made...." *820 ILCS 305/1(b)2.* Kipin Industries, Inc. is a Pennsylvania corporation, and Decedent, who was assigned to job sites in various states over his tenure with Kipin, alleges an accidental injury while working in West Virginia. As such, for the Commission to possess jurisdiction over this claim, the contract of hire must have been made in Illinois. See *Mahoney v. Industrial Commission*, 218 Ill. 2d 358, 374, 843 N.E.2d 317 (2006) ("the place of the contract of hire is the sole determining factor for the existence of jurisdiction over employment injuries occurring outside this state"). A contract of hire is made where the last act necessary for the formation of the contract occurs. *Cowger v. Industrial Commission*, 313 Ill. App. 3d 364, 370, 728 N.E.2d 789 (2000).

The Commission emphasizes there is no evidence in the record regarding the situs of Decedent's contract of hire with Kipin. The totality of the evidence on Decedent's start of employment with Kipin is as follows:

Q. And best you can recall did you begin working for that company around 1998?

A. Yes.

Q. Where did you first work for that company?

A. Acme Steel Coke Plant in Chicago. PX2, p. 8.

Decedent testified he worked for Kipin in Chicago for three or four years then began working at projects out-of-state. PX2, p. 9.

Certainly, a subsequent transfer to an out-of-state job site does not defeat jurisdiction so long as the original contract of hire remains in force (*Mahoney*); here though, there is nothing in the record to establish the situs of the original contract of hire. The Commission notes Decedent was deposed on two occasions. Despite the need to establish Illinois jurisdiction over an injury occurring in West Virginia, there was absolutely no testimony elicited, by either party, as to the hiring process, *i.e.*, where Decedent applied or interviewed, what steps were involved, or how he

17IWCC0660

was informed he was hired. In other words, there is no evidence as to what the "last act necessary to the formation of the contract" was or where that event occurred, and therefore, no direct evidence regarding the situs of the contract of hire. As such, to find jurisdiction rests in Illinois, the Commission would have to infer the contract of hire was made in Illinois based solely on the fact Decedent's initial assignment was in Chicago. While the Commission has the authority to make reasonable inferences from the evidence, "[w]here the evidence allows for the inference of the nonexistence of a fact to be just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot be reasonably drawn. [citations omitted]." *First Cash Financial Services v. Industrial Commission*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799 (2006). Even assuming *arguendo* such inference is reasonable, we are unwilling to rely on an inference to find Illinois jurisdiction over an extraterritorial injury.

The Commission must find its jurisdiction over this claim within the provisions of Illinois Workers' Compensation Act, and it cannot be found in this record without resorting to speculation or conjecture. The Commission finds the claim should be dismissed for lack of jurisdiction.

The Commission further notes, assuming *arguendo* Illinois jurisdiction exists, it would find Decedent failed to prove he sustained an accidental injury arising out of and in the course of his employment on December 16, 2008 and similarly failed to prove his condition of ill-being was causally related to the alleged accident. The Commission finds Petitioner's arguments on the issues unavailing and emphasizes the following facts.

Contrary to Petitioner's assertion in brief, Decedent did not testify he "worked 'several hours' on this date constantly lifting objects weighing up to 100 pounds." Decedent in fact testified he worked for only two to three hours on December 16, 2008, and of that time, he estimated he was cleaning the hopper for 30 to 45 minutes. PX3, p. 16. He reiterated this timeline later in his testimony when he provided a more detailed description of his activities that morning: he started work at 7:00 a.m.; he first performed the daily maintenance check, then he climbed into the excavator and began moving material into the hopper; Decedent estimated the first time he climbed into the hopper to clean it out was 8:30 or 9:00 a.m. PX3, p. 38-39. It was between 9:00 and 10:00 a.m. that he told Mr. Sigler he was not feeling well. PX3, p. 41. The claim that Decedent was constantly lifting heavy objects for several hours is simply not supported by the record.

The Commission additionally notes Decedent started feeling ill days before his alleged accident. The December 16, 2008 record from the West Virginia clinic documents Decedent reported symptoms "the last few days." PX6, p. 159. This is consistent with Decedent's testimony he first felt symptoms "a couple days prior" (PX3, p. 10) and told Mr. Sigler he was not feeling well on December 15, 2008. PX3, p. 13. The Commission also finds it significant the December 16, 2008 physical examination revealed "inguinal area had no hernias" (PX6, p. 159), yet Decedent described his aneurysm as a lump the size of a golf ball. PX2, p. 21.

The Commission further finds Dr. Mulamalla's opinions to be unpersuasive. Dr. Mulamalla specifically denied knowing what either medical causation or legal causation is, then agreed he would not be able to offer a causation opinion because "I don't know exactly what

17IWCC0660

happened to him that whole period, I have no idea." PX5, p. 35. Moreover, Dr. Mulamalla was not involved in diagnosing or treating Decedent's aneurysm: "He didn't come to me with the aneurysm. Basically he came to me whether he will be able to go through the surgery. That was issue for us, what is the heart status, can he go through the surgery. So obviously somebody else already has done that testing and confirmation." PX5, p. 36. The "somebod[ies] else" were Dr. Manatt and Dr. Subram, the physicians who treated the aneurysm, yet neither doctor provided a causation opinion.

The evidence shows Decedent had a long-standing history of severe cardiovascular problems, including coronary artery disease, history of aortobifemoral bypass graft, severe peripheral vascular disease of both lower extremities, history of myocardial infarction, hyperlipidemia, hypertension, and diabetes mellitus. He did not suffer a traumatic aneurysm on December 16, 2008. Rather, the evidence established it was pre-existing and growing naturally because of the atherosclerosis of the artery. PX5, p.48. While Dr. Mulamalla testified stress such as lifting "can" increase blood pressure and thereby increase the risk of more enlargement, the Commission finds this is insufficient to meet the burden of proof in light of Decedent's complaints of symptoms in the days before as well as the lack of objective examination findings on December 16, 2008.

IT IS THEREFORE ORDERED BY THE COMMISSION that the claim is dismissed for lack of jurisdiction.

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: OCT 18 2017

LEC/mck

O: 8/30/17

43

/s/ Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GILMARTIN, WILLIAM
Employee/Petitioner

Case# **09WC016579**

17IWCC0660

KIPIN INDUSTRIES INC AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 11/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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.

2243 LAW OFFICE OF MITCHELL A KLINE
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

0000 KIPIN INDUSTRIES INC
4194 GREEN GARDEN RD
ALIQUIPPA, PA 15001

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0660

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

William Gilmartin,
Employee/Petitioner

Case # **09** WC **16579**

v.

Kipin Industries, Inc., and the 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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **August 25, 2016, September 28, 2016 and October 26, 2016.**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **6/20/08**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$50,000.00**; the average weekly wage was **$961.54**.

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 did not sustain an accident that arose out of and in the course of his employment. Petitioner's request for benefits is denied.

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 the Respondent-Employer to pay the benefits due and owing the Petitioner, the Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of the Respondent-Employer 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.

David A. Kane
Signature of Arbitrator

November 2, 2016
Date

NOV 2 - 2016

STATE OF ILLINOIS)
)
COUNTY OF COOK)

17IWCC0660

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William Gilmartin,
Employee/Petitioner,

Case # **09** WC **16579**

v.

Kipin Industries, Inc.,
and the State Treasurer, as *ex-officio* Custodian
of the Injured Workers' Benefit Fund,
Employers/Respondents.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act by the Petitioner and sought relief from the Respondent Employer-Kipin Industries, and Respondent Injured Workers' Benefit Fund (the "IWBF").

On December 16, 2008, the alleged date of the Petitioner's work-related accident, Kipin Industries, Inc. did not maintain workers' compensation insurance. [Pet. Ex. 1b]

On August 25, 2016, a hearing was held before Arbitrator David Kane in Chicago, Illinois. The Petitioner gave notice of the hearing to Kipin Industries by U.S. certified mail. [Pet. Ex. 1a] Kipin Industries was not represented by an attorney and did not appear at the arbitration proceedings.

The Illinois Attorney General previously filed an appearance on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the IWBF, and participated in the arbitration proceedings.

Petitioner testified he began working for Kipin Industries in 1998. On the date of accident he was working as a project manager making $50,000 per year.

Petitioner testified that in the middle of December 2008 he informed his supervisor, John Sigler, that he wasn't feeling well. Mr. Sigler told him to go to the nearby clinic. He was in West Virginia.

Petitioner presented to the clinic and was diagnosed with an aneurysm in the right side of the groin area.

Petitioner recalled telling Mr. Sigler that he needed to take care of the aneurysm.

On January 5, 2009, Petitioner underwent surgery consisting of cystoscopy, bilateral ureteral catheterization, and bilateral retrograde pyelogram.

Petitioner was released to work full duty on March 14, 2009.

Petitioner testified he was let go from Kipin after his injury because they did not have any work for him. Petitioner, with the help of his wife, began applying for jobs after being released to full duty work.

The parties took the evidence deposition of Dr. Mulamalla. He is a cardiologist and only performed the screening to make sure Petitioner was healthy enough to undergo surgery. Dr. Mulamalla does not treat groin pseudoaneurysms as part of his practice. Dr. Mulmalla did not evaluate Petitioner's pseudoaneurysm in this case. He did no testing to confirm the diagnosis. Dr. Mulmalla was not able to draw a causal connection between

Petitioner's work activities and the injury. Dr. Mulmalla testified that he did not evaluate the injury and could not say whether it was trauma induced.

CONCLUSIONS OF LAW

With regard to issue "A", was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds as follows:

The Arbitrator finds that Respondent-Employer was operating under and subject to the Illinois Workers' Compensation Act.

With regard to issue "B", was there an employee-employer relationship, the Arbitrator finds as follows:

The Arbitrator finds that the evidence establishes that there was an employee-employer relationship.

With regard to issue "C", whether Petitioner's accident arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of his employment. Petitioner was diagnosed with a pseudoaneurysm of the right groin. There was no traumatic accident that led to his injury. Dr. Mulmalla could not say that this type of work could lead to this injury. Petitioner failed to present any evidence proving that he sustained an accident that arose out of and in the course of his employment.

With regard to issue "D" what was the date of the accident, the Arbitrator finds as follows:

The Arbitrator finds that the evidence establishes that the date of the injury was December 16, 2008.

With regard to issue "E" was timely notice of the accident given to Respondent, the Arbitrator finds as follows:

The Arbitrator finds that timely notice was not given to Respondent-Employer. The Act requires notice to the employer within 45 days. Here, Petitioner told his supervisor that he was not feeling well and needed to go to the doctor. Petitioner did not tell his employer within 45 days that he was alleging this injury was a work-related accident.

With regard to issue "F", whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner is currently deceased due to reasons not related to his alleged accident. Petitioner failed to present any evidence proving that his current condition of ill-being was causally related to his injury. The evidence establishes that Petitioner's current condition of ill-being is not causally related to this injury.

With regard to issue "G", what were Petitioner's earnings, the Arbitrator finds as follows:

The Arbitrator finds that the evidence establishes that Petitioner's earnings during the year preceding the injury were $50,000.00 and his average weekly wage was $961.54.

With regard to issue "H", what was Petitioner's age at the time of the accident, the Arbitrator finds as follows:

The Arbitrator finds that the evidence establishes that the Petitioner was 54 years old at the time of the injury.

With regard to issue "I", what was Petitioner's marital status at the time of the accident, the Arbitrator finds as follows:

The Arbitrator finds that the evidence establishes that the Petitioner was married at the time of the accident.

With regard to issue "J", 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 services, the Arbitrator finds as follows:

Given the Arbitrator's finding that Petitioner did not sustain a compensable accident, the issue of whether the medical services provided were reasonable and necessary is moot.

With regard to issue "K", what temporary benefits are in dispute, the Arbitrator finds as follows:

Given the Arbitrator's finding that Petitioner did not sustain a compensable accident, temporary total disability is not awarded.

With regard to issue "L", what is the nature and extent of the injury, the Arbitrator finds as follows:

Given the Arbitrator's finding that Petitioner did not sustain a compensable accident, permanent partial disability is not awarded.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GEORGIA MCLAREN,

Petitioner,

vs.

NO: 11 WC 47746

C-U REGIONAL REHAB,

Respondent.

17IWCC0661

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of temporary total disability, permanent partial disability, and prospective medical treatment and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below but attaches the Decision of the Arbitrator for the Findings of Fact, which is made a part hereof with the modifications noted.

The Commission finds that Petitioner had reached maximum medical improvement (MMI) from her injury as of March 27, 2012. Although Petitioner's treating physician, Dr. Gurtler, noted that conservative treatment did not work to reduce Petitioner's pain, his treating notes all state that Petitioner was not ready for a total knee replacement and that she would potentially need it at some point in the future. Petitioner did not seek additional medical treatment between March 27, 2012, and February 6, 2014. Therefore, we vacate the Arbitrator on the issue of causation and find that Petitioner's need for total knee replacement is speculative at this point. The award for prospective total knee replacement surgery related to the June 23, 2010 accident, is hereby vacated.

As to temporary total disability, accident and causation were not disputed. Petitioner reached MMI as of March 27, 2012. Respondent paid TTD through that date. Petitioner worked as a unit secretary, and was able to return to work as of March 28, 2012. Petitioner did not offer evidence sufficient to show she would be entitled to TTD or maintenance after she had reached MMI.

The Commission finds that as a result of injuries to her right knee, Petitioner underwent

17IWCC0661

injections and physical therapy, but was not a candidate for surgery. Although the possibility of a total knee replacement was discussed, all of the medical records noted that it would be sometime in the future and that Petitioner was not ready for the surgery presently. In reducing the Arbitrator's Award, we note that Petitioner did not seek medical attention between March 27, 2012 and February 6, 2014, Petitioner was stable and retired, and could have obtained a sedentary job. Based on the above, we find that the Arbitrator's award of PPD should be reduced to 22.5% of the right leg.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 12 6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $297.00 per week for a period of 48.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 22.5% loss of use of the right leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 18 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O:10/3/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McLAREN, GEORGIA
Employee/Petitioner

Case# 11WC047746

C-U REGIONAL REHAB
Employer/Respondent

17IWCC0661

On 5/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0874 FREDERICK HAGLE FRANK & WALSH
KEVIN MARKES
129 W MAIN ST
URBANA, IL 61801

2965 KEEFE CAMPBELL BIERY & ASSOC
ARIK D HETUE
118 N CLINTON ST SUITE 399
CHICAGO, IL 60661

17IWCC0661

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

Georgia McLaren
Employee/Petitioner

v.

C-U Regional Rehab
Employer/Respondent

Case # 11 WC 47746

Consolidated cases: None

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **March 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

17IWCC0661

On **June 23, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,740.00**; the average weekly wage was **$495.00**.

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

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

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

Petitioner was temporarily totally disabled from **June 24, 2010** through **July 14, 2010, January 19, 2012** through **March 27, 2012,** and **March 27, 2012** through **February 6, 2014,** a total period of **110 2/7 weeks.**

Respondent shall be given a credit of **$9,726.86** for TTD, **$0** for TPD, **$0** for maintenance, and **$23,944.00** for other benefits (an advancement), for a total credit of **$33,670.86.**

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$330.00**/week for **110 2/7** weeks, commencing **June 24, 2010** through **July 14, 2010,** a period of 3 weeks, from **January 19, 2012** through **March 27, 2012,** a period of 9 6/7 weeks, and from **March 27, 2012** through **February 6, 2014,** a period of 97 3/7 weeks, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$297.00**/week for **96.75** weeks, because the injuries sustained caused the **45%** loss of use of the **right leg,** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **June 23, 2010** through **February 6, 2014** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Nancy Lindsay
Signature of Arbitrator

May 9, 2016
Date

MAY 11 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

The parties stipulated that on June 23, 2010 Petitioner sustained an accident that arose out of and in the course of her employment with Respondent.

Petitioner presented to the Department of Occupational Medicine (Occ Med) at Carle Physician Group on June 24, 2010 complaining of right knee pain sustained after injuring herself the day before while getting in an elevator. According to the office note, the elevator did not stop at the exact height of the floor and Petitioner, upon walking into the elevator, stumbled forward and fell striking her right lower extremity hard on the ground. The floor of the elevator was estimated to be about 8 inches below the threshold. Petitioner did not recall striking her knee directly but noticed swelling in her knee over the evening and ongoing pain with weight bearing. On physical examination, there was no sign of swelling or evidence of any direct trauma. Petitioner did have discomfort with palpation along the lateral joint line posteriorly. It was felt that she had sustained a right knee strain and x-rays were ordered. Petitioner was given sedentary duty restrictions, a cane, and told to follow-up in a week. (PX 2)

X-rays taken on June 24, 2010 showed a small suprapatellar effusion, and bony irregularity involving the posterior margin of the tibial plateau from which a subtle fracture might be considered in the proper clinical setting. Mild medial compartment joint space narrowing was also seen. Additional imaging or a CT was recommended in ten days. (PX 2)

Petitioner returned to the Occupational Medicine Department on June 30, 2010. The history of her accident was again reviewed with Petitioner noting that she stepped onto the elevator without knowing about the height discrepancy and twisted her knee during the fall. While a "large amount of swelling" was not initially noted, posterior tenderness was. She had been given a cane to help with ambulation. Petitioner reported "significant problems" even with her sitting job as she would experience significant knee pain when pushing back in her chair, turning, or twisting. Petitioner was also reporting problems with sleep due to knee pain and a feeling of instability when walking. Petitioner appeared uncomfortable and a small effusion in the right knee and edema of the lower extremity was noted. The primary point of tenderness was posterolaterally. The earlier right knee x-ray was felt to reflect cortical irregularity of the posterior tibial condyle. Her diagnosis remained unchanged but she was sent for an MRI and given a stabilizing knee brace to use along with her cane. (PX 2)

Petitioner underwent an MRI of her right knee on July 6, 2010 which indicated a medial collateral ligament tear, joint effusion, and evidence of a horizontal, oblique nondisplaced fracture of the posterior aspect of the proximal tibia underlining the posterior tibial spine. There were soft tissue signal abnormalities posterior to the knee joint and proximal tibia and the radiologist was suspicious for a ruptured Baker's cyst. An additional possibility was a muscle strain/partial tear containing blood components. An MCL tear was noted. (PX 2, p. 6)

Petitioner presented to Dr. Sutter at Occ Med on July 9, 2010 with continuing complaints. Dr. Sutter noted that Petitioner had a history of a ligamentous injury 25 years earlier from a softball injury. He felt the medial collateral ligament tear on the MRI was "likely" a chronic tear. The MRI had shown a large effusion and it was read as also showing an oblique nondisplaced fracture in the posterior aspect of the proximal tibia including the posterior tibial spine. Petitioner was still showing joint effusion with increased swelling of the leg and foot. No

"significant" calf tenderness was noted. Petitioner was partially weight bearing although she required the use of a cane. She had an antalgic gait with the cane. Tenderness at the proximal tibia was noted. The doctor also noted that Petitioner opened up medially with valgus stress but she was not tender in the region of the MCL. Petitioner was not working and she was describing increased swelling in the right lower extremity. Dr. Sutter recommended a CT scan of the knee, pain medications, off work, and a follow up in a week. Dr. Sutter diagnosed Petitioner with a nondisplaced fracture of the poster aspect of the tibial plateau including the tibial spine. Petitioner was referred to Dr. Gurtler, in Orthopedics, and was to remain off work. She was also to remain non-weight bearing on the right lower extremity. Petitioner was instructed in the use of her crutches which she indicated she did not feel stable using. She mentioned having a walker at home which she preferred to use. (PX 2, p. 7)

Petitioner underwent a CT scan of her right knee on July 14, 2010 which confirmed a proximal tibial fracture extending through the tibial spines and medially to involve the medial tibial plateau. The femur was intact. Joint effusion was present. (PX 2, p.9)

Petitioner presented to Dr. Gurtler, in the Orthopedics Department at Carle, for the first time on July 15, 2010. He noted that Petitioner had fallen on the front of her right knee about three weeks earlier and it was a "pretty big injury." Petitioner reported getting better but that "it" was still awfully swollen. Dr. Gurtler noted she had effusion and swelling all the way down her leg to her foot, along with bruising. Dr. Gurtler reviewed the X-rays and the CT scan and the MRI, and opined Petitioner had avulsed the attachment of the posterior cruciate ligament (PCL), which was now mildly displaced. He opined this would heal and should not be a "major problem" although it set her up for osteoarthritis down the road. He noted Petitioner's age of 61 and felt by 70 the arthritis should be an issue "from this injury" but he felt she needed to let the avulsion heal and go on with her life. She could work but he felt she needed to be kept "mostly seated." He didn't want to start any physical therapy just then, preferring to let the avulsion heal on its own. Petitioner was cautioned to be "very, very careful" not to fall on her knee again because she could totally avulse the PCL if she did. (PX 2, p. 10)

Petitioner returned to work on July 15, 2010 per Dr. Gurtler's restrictions. (PX 2, AX 1)

Petitioner returned to Dr. Gurtler on August 5, 2010 and was reportedly "actually doing well" with decreased swelling and improved pain. She was to continue sedentary work and use of her cane to reduce the amount of walking. Petitioner was told to return in a month. (PX 2, p. 11)

A repeat x-ray was taken on August 5, 2010 and showed moderate joint effusion perhaps increased from that of June 24, 2010. (PX 2, p. 12)

Petitioner returned to P.A. McFarlin (Dr. Gurler's office) on August 26, 2010. Petitioner reported ongoing right knee discomfort and some anterior knee pain. A small amount of effusion was still present. Flexion and extension was somewhat uncomfortable, especially with flexion. Petitioner was kept on light duty with "No stairs, stand, sit alternating every 30 minutes." Petitioner needed to sit or stand to either rest or actively move the leg. She was to use ice and Ibuprofen/Tylenol as needed for pain. Petitioner was to return in four weeks. (PX 2, p. 13)

Petitioner again presented to P.A. McFarlin, on September 23, 2010 with complaints of increased pain. Petitioner was wearing a brace but it was wearing out and she had been going without it and noting a significant increase in her pain. Again, she reported a feeling of instability in her knee. P.A. McFarlin spoke with Dr. Gurtler and they decided she needed to obtain a brace for her instability and that she would "someday" require a

knee replacement. Mr. McFarlin noted that there was little to offer surgically and Petitioner agreed as she was not interested in surgery. She was to continue light duty, and return for a follow-up in 6 weeks. (PX 2, p. 15)

Petitioner did not return to see P.A. McFarlin until February 10, 2011, at which time she reported ongoing generalized pain in the right knee. McFarlin and Dr. Gurtler reviewed Petitioner's earlier MRI and CT scan noting there was a large bone abnormality involving the tibia that was thought to be a "bone infarct." While Petitioner's knee showed no significant swelling or overlying tissue erythema, Petitioner was continuing to report pain on palpation of her knee, both anteriorly as well as posteriorly. Swelling in the back of her knee was also noted. Petitioner was diagnosed with a tibial plateau avulsion fracture involving the attachment side of the posterior cruciate ligament and a tibial bone lesion. Dr. Gurtler recommended a bone scan to assess the lesion. She was advised to continue wearing her brace and to take Ibuprofen/Tylenol as needed. Petitioner was reportedly working full duty and she was allowed to continue doing so. (PX 2, p. 16)

Petitioner underwent the bone scan on February 21, 2011, the results indicating no significant pathology in the knee, suggestive of the knee area being dormant as far as any new bone growth. (PX 2, pp. 17-18)

An x-ray taken on February 22, 2011 showed chronic posterior tibial plateau deformity dating back to August of 2010 and unchanged. (PX 2, p. 19)

Petitioner presented to Dr. Gurtler on February 22, 2011. He reviewed the bone scan, and performed a physical examination. According to Dr. Gurtler, Petitioner's tibia defect had a fluid level suggesting a healing infarct. The avulsion fracture also showed a healed fragment. Additionally, he noted her right knee had a very positive (almost 3+) signal on the posterior drawer, which was why her knee hurt – it was very loose. He noted this would cause premature osteoarthritis because of the laxity and "the laxity was caused by the fall." He felt there was little that could be done as she would end up needing a knee replacement. Trying to repair the PCL "would be folly." He recommended an occasional Cortisone shot, as needed. He again noted in his office note that the need for the knee replacement would be the fall which caused the laxity in Petitioner's PCL. (PX 2, p. 18)

On October 20, 2011, Petitioner presented to Dr. Lawrence Li for an independent medical examination. (RX 1, Dep. Ex. 2) His report, addressed to Patriot Risk Services, followed. According to his report, he reviewed records of Dr. Gurtler and the Carle Occupational Medicine Center as well as various x-ray, CT, and MRI reports. Petitioner was noted to weigh 180 lbs. On examination she showed no effusion and Lachman's was stable. He noted Petitioner had no pain to palpation anywhere. Significant quadriceps atrophy on the right as compared to the left was noted. In response to specific questions from Respondent's insurance carrier, Dr. Li described Petitioner's diagnosis as "Status post tibial plateau fracture right side with what appears to be satisfactory healing, but significant loss of function secondary to the fact she did not receive any physical therapy and was not instructed to do any home exercises." He felt her current diagnosis of "heel fracture" [sic] and residual weakness was related to her work accident. He recommended she undergo physical therapy two times a week for six weeks and then progress to home exercises. He anticipated she would reach maximum medical improvement in three to four months and that she could return to full duty work as a "unit clerk" although she should be limited to walking one hour at a time and for no more than four hours a day. He did not think she needed a knee replacement or injections; rather, she needed to strengthen her quads. (Id.)

Petitioner signed her Application for Adjustment of Claim herein on December 13, 2011. (PX 3)

On January 19, 2012 Dr. Gurtler examined new x-rays and indicated Petitioner's condition was not worsening. (RX 3)

There is a work status note dated January 19, 2012, indicating Petitioner could return to work with the sole restriction of "very limited standing." The doctor also noted "Future TKR." (PX 1, Dep. Ex. 3)

According to a February 1, 2012 phone record of Dr. Gurtler, Petitioner was advised that her knee was likely not ready for a total knee replacement (TKR) but that therapy might be of some value. Therefore, Petitioner was to begin therapy. (PX 2, p. 20) The order report from this visit indicates no restrictions were given. (PX 2, p. 47)

Petitioner presented to physical therapy for an initial evaluation on February 14, 2012. Petitioner reported "missing a step" and landing on her right knee. Her pain had slowly worsened but had been about the same for the past couple of months. Her pain was noted in the medial side of her knee and worse with walking, stairs, and carrying groceries. She described her pain at night as "terrible." Petitioner was noted to be unemployed and not working due to her injury. Petitioner completed a Lower Extremity Functional Scale reporting quite a bit of difficulty with work, housework, squatting, putting on shoes and socks, performing heavy activities, and hopping. She also reported "extreme difficulty" with walking two blocks, walking a mile, going up and down a flight of stairs, standing for one hour, running or making sharp turns while running. (PX 2, p. 57)Petitioner was to be seen two times a week for six to eight weeks. (PX 2, pp. 26-28, 56)

Petitioner underwent therapy on February 21, 2012 and was advised to stop her exercises at home if painful. Petitioner also noted having access to a neighbor's stationary bike if needed. She was advised to initially start with 5 minutes and then slowly increase her time. (PX 2, p. 25)

Petitioner presented for physical therapy at Carle Therapy Services on February 28th, March 1st, 6th, 8th and 15th of 2012, a total of seven sessions. (PX 2, pp. 25-43)

On March 27, 2012, Petitioner presented to Dr. Gurtler complaining of continued right knee pain. Dr. Gurtler noted that cortisone shots had not helped. Physical therapy was a complete failure and she was miserable. Petitioner was having difficulty even walking around. Dr. Gurtler noted Petitioner's posterior cruciate instability was profound. "Because she is youngish, 63, we tried every conservative measure possible and her knee has not responded. She cannot do anything, practically walking across the street it is so painful she does not want to do it a lot of her pain, I think is patellofemoral" Dr. Gurtler discussed options less than a TKR if Petitioner were thirty years younger but such was not the case. He described her PCL instability as "grade 4" and worse that day than any time in the past. He wrote, "I think she is deteriorating significantly" noting her only option was the knee replacement. (PX 2, pp. 21-22)[1]

A work status note dated March 27, 2012, indicated Petitioner should remain off work completely pending the total knee replacement surgery Dr. Gurtler was recommending as of that date. (PX 1, dep. ex. 4)

Deposition of Dr. Li

Dr. Li was deposed on September 24, 2012. (RX 1) Dr. Li testified that he examined Petitioner at the request of Respondent on October 20, 2011. It was Dr. Li's understanding that Petitioner injured her right knee when entering an elevator and falling into and landing on her right leg. She had been treated at Occupational Medicine Clinic and undergone an MRI that showed a medial collateral ligament tear and evidence of a horizontal oblique nondisplaced fracture in the posterior aspect of the tibia and a ruptured Baker's cyst. Thereafter, she was seen by Dr. Gurtler who felt Petitioner might have avulsed a small portion of the posterior cruciate ligament. A subsequent bone scan showed a healing fracture. As of the date of the exam (Oct. 26, 2010) Petitioner was

[1] The correction noted on PX 2, p. 22 was not done by the Arbitrator.

walking without any brace and reportedly experiencing pain after standing on her leg for about thirty minutes. She had been offered Cortisone shots and a knee replacement and refused. Dr. Li reviewed Petitioner's medical records and diagnostic reports. He did not see the actual films. (RX 1, pp. 1-9, 18)

Dr. Li testified as to his physical exam noting no positive findings. He felt Petitioner had a healed tibial plateau fracture with a significant loss of function secondary to the fact she had not received any physical therapy or training in home exercises. He felt her condition was due to her work injury but that she needed about six weeks of therapy followed by a home exercise program. Until then, Petitioner was not at maximum medical improvement. (RX 1, pp. 9—10, 21, 26) He estimated MMI in about three to four months after therapy and home exercises. Dr. Li was also of the opinion that Petitioner could perform full duty work as a unit clerk although she should only work for one hour at a time or four hours a day. She did not, in his opinion, need injections or a knee replacement. Rather, she needed to strengthen her quads. (RX 1, pp. 10-11)

Dr. Li did not feel Petitioner had any evidence of ligamentous instability or "any sort of significant arthritis, which would be the indication for a knee replacement." (RX 1, pp. 11-12)

On cross-examination Dr. Li clarified that Petitioner had a "healed" fracture and not a "heel" fracture. (RX 1, p. 13) He did not think the ruptured Baker's Cyst was of any clinical significance. (RX 1, p. 18) When asked if the occurrence ruptured the cyst, he replied that he only reviewed the report and couldn't tell by it. However, assuming it was related, it was of no clinical significance and would not affect whether Petitioner needed surgery. (RX 1, p. 19)

Dr. Li did not know if Petitioner had been back to see Dr. Gutler since February of 2011. He reiterated that Petitioner was not at MMI. (RX 1, p. 20) He did not know if she ever pursued physical therapy. He had no opinions beyond the time of his October 20, 2011 IME. (RX 1, p. 21)

Regarding Petitioner's ability to work, it was Dr. Li's understanding that Petitioner, as a unit clerk, answered the phone and performed clerical work. (RX 1, p. 22) He further testified that if she went through physical therapy and was reportedly still in the same condition as that of October 20, 2011 he would re-examine her before making any further recommendations. He acknowledged that the bone scan reported a "healing" fracture. (RX 1, p. 24) He felt it was a healed fracture based upon the August 26, 2010 x-ray. He did not feel a bone scan would be as sensitive as an x-ray for a fracture. (RX 1, p. 24)

Dr. Li testified that he was familiar with utilization review. He further testified that his opinions were based upon the clinical data available to him. If there was clinical data that pre-dated his exam of Petitioner that he was unaware of, it would certainly affect his opinion. If there was clinical data that occurred after his examination it wouldn't affect his opinion when given because new clinical data could result in a new diagnosis and/or treatment. (RX 1, pp. 27-28) When shown the utilization report dated June 25, 2012 Dr. Li noted it showed a diagnosis of posterior cruciate ligament instability and not a tibial plateau fracture which would be a different diagnosis than the one he arrived at. (RX 1, p. 30)

Dr. Li did not recall if Petitioner described her job duties to him. (RX 1, p. 37) Dr. Li did not note any instability within her ligaments at the time of his exam. Furthermore, he did not believe the MRI revealed any either. (RX 1, p. 38)

On re-cross-examination Dr. Li acknowledged there have been times when an individual had arthritis followed by an acute trauma and it resulted in the need for a TKR. (RX 1, p. 40)

Deposition of Dr. Gurtler

The parties took the deposition of Dr. Robert Gurtler on February 5th 2013. (PX 1) Dr. Gurtler testified to the content of the records summarized above.

Dr. Gurtler testified that when he first examined Petitioner he diagnosed her with a posterior cruciate ligament (PCL) avulsion through fracture of the posterior tibia. The diagnosis was confirmed by the CT scan and MRI. He told Petitioner she needed time to heal and that she would get better but would have osteoarthritis in the future. (PX 1, p. 7)

Dr. Gurtler also testified that his physician's assistant is Mr. McFarland and he would rely on Mr. McFarland's records regarding the care and treatment of Petitioner. (PX 1, p.9) As of August 29, 2010 Petitioner was on light duty due to restrictions. (PX 1, p. 9) When he re-examined Petitioner on September 23, 2010 he noted significant posterior laxity (a/k/a instability) which, in lay terms, meant Petitioner's knee was loose and when one would push on the front of her tibia it would "shuck/sublux" backwards. (PX 1, p. 10) She was prescribed a brace designed for the PCL instability but the doctor didn't know if she ever received it. (PX 1, pp. 10-11) Dr. Gurtler further testified that it was at this visit he first mentioned she would need a total knee replacement (TKR) at some point. (PX 1, p. 11)

Dr. Gurtler testified that when he next saw her on February 21, 2011 Petitioner was not doing well and he recommended a bone scan to further investigate a bone lesion in the tibia. She was told to continue wearing her brace which seemed to be helping "some." Petitioner was also noted to be working her regular job but not without difficulty. (PX 1, p. 12)

Dr. Gurtler further testified that the bone scan was performed and it showed active healing; however, at that point in time, he did not yet believe she was at maximum medical improvement (MMI). (PX 1, pp. 12-13) He also testified that while the x-ray showed a healed fracture, the MRI showed ongoing healing. His concern was that Petitioner was developing increasing instability which he described as "3+." (a change from when he initially saw her and it was "1 to 2+)." Dr. Gurtler felt the instability/laxity was going to cause Petitioner to get premature arthritis. Due to her age Dr. Gurtler did not feel a PCL repair was warranted and her treatment options were a total knee replacement or cortisone shots and living with the condition. (PX 1, p. 14)

Dr. Gurtler testified that he and Petitioner had a telephone discussion on January 19, 2012 which indicated the doctor didn't feel her knee was ready for a TKR but that therapy could be of some value, especially with the PCL issue. He also had an additional note indicating "Petitioner had a work-related injury. It is slowly destroying her knee, but we got new x-rays today and it really doesn't look enough worse at this point [for a TKR.]" (PX 1, p. 16)

Dr. Gurtler testified that he re-examined Petitioner on March 27, 2012 and she wasn't doing very well. She had undergone the physical therapy but had continued to experience significant pain. Coritsone shots had been attempted but did not help. Therapy was a complete failure and Petitioner was miserable. Dr. Gurtler felt they had exhausted conservative treatment and he felt Petitioner required a total knee replacement as her condition was getting worse with PCL instability rising to a grade 4. (PX 1, pp. 17-19) As of the date of his deposition the doctor still felt Petitioner needed the TKR. (PX 1, p. 19)

Dr. Gurtler opined that Petitioner's fall injury was consistent with the objective findings and physical examination. (PX 1, p.p. 20-21) He opined that her condition in her right knee was causally related to the injuries she sustained in her work accident. He explained that Petitioner had experienced an unusual progression

of instability after a PCL injury. He also felt she came across as a reliable person. He testified, "In [Petitioner's] case she relentlessly in front of our eyes got worse and worse. (PX 1, pp. 21-22) He further attributed her grade 4 instability to her work injury. (PX 1, pp. 22, 43, 52) He also was of the opinion that her need for a TKR was due to her work injury. (PX 1, pp. 22-23)

Dr. Gurtler recalled that Petitioner went back to regular duty work in her brace but wasn't doing well. (PX 1, p. 23) He further testified that Petitioner probably had an arthritic condition in her right knee before her work accident but it had been asymptomatic. (PX 1, p. 23) He was of the opinion that her fall aggravated the arthritic condition. The doctor explained, "…, a posterior cruciate ligament instability of this magnitude basically guarantees you arthritis in the future. The only question is how long does it take for that arthritis to develop, and she was continuing to develop arthritis since the injury, and the instability, but even more alarming was her dramatic deterioration of stability. Her knee became profoundly unstable right in front of our eyes, which is unusual….." (PX 1, p. 24) He could not recall ever seeing anyone with that much instability adding ",but remember, posterior cruciate ligament tear is an injury of youth and she's not youthful." (PX 1, p. 24) He felt her progression had been "alarming." (PX 1, p. 25)

Dr. Gurtler was asked some general questions about TKR procedures. He indicated it would require a three month recovery and she would be off work for three months at least. One could expect MMI within 12 weeks and some degree of permanent restriction. He would anticipate that she will have to reduce certain activities post-surgery simply to make the knee replacement last the rest of her life. (PX 1, p. 26)

Dr. Gurtler was also asked some questions about a utilization review document marked as Exhibit 2. He testified that he wasn't really familiar with utilization review. (PX 1, p. 29) Exhibit 2 references a "right total knee replacement, posterior cruciate ligament substituting type" being approved from June 25, 2012 through August 27, 2012. That's the same procedure Dr. Gurtler has recommended. (PX 1, pp. 30-31) As of March 27, 2012 Petitioner was not at MMI and the doctor felt she would not be at MMI until after she had the TKR. (PX 1, p. 31)

On cross-examination Dr. Gurtler was asked about any restrictions he might have imposed when he last examined Petitioner on March 27, 2012. He was under the impression Petitioner was working without restrictions but, "I'm a little uncomfortable with that, to be frank with you, but I believe that's the category; she was working in her brace without restrictions as I understand it, but I don't a clear recollection of that." (PX 1, pp. 32-33) In the end, he really wasn't sure they even addressed her work status at that time. (PX 1, p. 33)

Dr. Gurtler first noticed laxity at the time of their first examination. He felt it unusual for posterior cruciate instability to become looser and looser but that was what was happening in Petitioner's case. (PX 1, p. 34) As for the mechanism of injury it was his understanding she fell on the front of her right knee. (PX 1, p. 36) He explained that the classic PCL injury is a fall on the front of a knee on ice followed by a car accident where the front of the knee hits the dashboard. Swelling might follow but not necessarily. The damage to Petitioner was in the back of her knee. He felt she fell on the front of her knee and it damaged the ligaments in the back of the knee. (PX 1, p. 37)

Dr. Gurtler was unaware of a prior softball injury to Petitioner's knee. (PX 1, pp. 38-39) He disagreed that the laxity in Petitioner's posterior area would happen overnight 25 years after an accident. He explained that most PCL tears do not worsen overtime; rather, they become lax at a level and stay that way. He added that while the injuries develop arthritis over time it is unusual for the laxity/instability to worsen. (PX 1, p. 39)

Dr. Gurtler did not believe any injections were ordered at the time of the February 22, 2011 office visit. He believed at that time she was to return as needed. When asked if her condition had plateaued at that time, Dr. Gurtler responded, "It turns out the answer is no." (PX 1, p. 41)

Dr. Gurtler further testified that the initial laxity in Petitioner's knee would have been immediate and noted by a skilled examiner. When asked if Dr. Chen or Dr. Sutter would be considered skilled examiners, Dr. Gurtler replied, "Not of posterior cruciate ligament tears." (PX 1, p. 44) He also testified that laxity is noted on exam with a posterior drawer test and with MRI and CT scan. (PX 1, p. 45)

Dr. Gurtler could not recall Petitioner's employment/work status as of March 27, 2012. (PX 1, p. 45)

Dr. Gurtler did not know where Petitioner underwent her physical therapy. He thought she had undergone one cortisone injection. (PX 1, p. 46) He further testified that the TKR is designed to substitute for the function of the PCL. While he agreed that arthritis can develop over the course of one's life and that a TKR will address arthritis, the predominant reason for the TKR he is recommending is Petitioner's PCL. (PX 1, pp. 47-48)

Dr. Gurtler also testified that once a person has a ligamentous injury she is at higher risk for developing arthritis. He further testified that one can determine which of two separate accidents caused the arthritis to progress. In Petitioner's case, he did not dispute her prior arthritis but he believed that her injury and subsequent instability definitely made that prior arthritic condition and symptoms worse. (PX 1, pp. 48-49) He did not feel posterior laxity would develop without trauma. (PX 1, p. 51)

On additional redirect examination Dr. Gurtler identified a January 19, 2012 office note/work restriction that stated "Released to modified work." Also noted were "Very limited standing and future total knee replacement." (PX 1, p. 53) Dr. Gurtler described that as a sedentary work restriction. (PX 1, p. 53) As of March 27, 2012 the doctor noted she was not released to any form of work as she needed to undergo a right total knee replacement. (PX 1, p. 54) The doctor further added that Petitioner has been temporarily totally disabled since March 27, 2012 pending a TKR. (PX 1, p. 54)

On further cross-examination the doctor was asked about his practice concerning work ability and people not employed. He explained that he isn't always aware of the patient's employment status and fills out the restrictions anyway. Petitioner, as of March 27, 2012, had "dramatic and alarming instability." He testified that it was "nauseating to move her knee backwards it was so unstable and I felt she was unsafe." (PX 1, pp. 55-56) According to the doctor, Petitioner had a very dramatic injury and she is 63 and her tissues aren't as strong as a 25 year old's. Consequently, when one takes the nature of her injury combined with the findings on CT and MRI, it explains why she has continued to deteriorate, although it is unusual. (PX 1, p. 56) He added that the overall tissues in the back of Petitioner's knee were so damaged they simply weren't stiff enough to resist further displacement. He clearly indicated the MRI findings were acute. She had obvious evidence of acute injury to the soft tissues in the posterior aspect of the tibia. One doesn't find blood components and a fracture in a chronic injury. There was a horizontal oblique nondisplaced fracture of the posterior aspect of the proximal tibia underlying the posterior tibial spine which is where the PCL attaches, indicative of "an acute injury." (PX 1, pp. 58, 59, 60) Dr. Gutler would disagree with Dr. Sutter if he felt she had a chronic injury. (PX 1, p. 58)

Additional Medical

Petitioner returned to see Dr. Gurtler on February 6, 2014 having last been seen on March 27, 2012. Petitioner stated it had been a about a year and a half since she was last examined by a doctor; however, her knee was still

bothering her and she could not walk for long distances. Petitioner described walking with a cane on a daily basis for the past three years. Petitioner reported she had retired as a medical secretary. She had someone doing the household cleaning for her and she could no longer garden. She denied being able to be on uneven ground. Petitioner also reported feeling like she would fall and being unsafe. He wrote, "Her x-rays show osteoarthritis. Certainly, in my opinion, not bad enough for a total knee yet, but it is worse in that she has osteopenia, particularly in the patella on that right knee, almost as if she had some element of reflex dystrophy associated with this, although I have seen this before with patellofemoral syndromes. Petitioner was also noted to have some burning down the back of her left leg which the doctor felt might be related to something else as her MRI showed lumbar stenosis. Her knee and skin looked "blotchy" consistent with constant inflammation. Her motion was limited. She still displayed a posterior drawer which was visible. Dr. Gurtler doubted Petitioner would ever go back to work where she needed to be on her feet, and he recommended proceeding with the total knee replacement in a few years. He reiterated that Petitioner's pain began with her work accident. (PX 2, pp. 23-24)

Dr. Li conducted a second IME on May 21, 2015. In his written report issued post-examination he noted Petitioner's history of her accident and subsequent care. He noted that the MRI showed no abnormality of the posterior cruciate ligament and that Dr. Gurtler believed she had avulsed that ligament. He had recommended a TKR that Petitioner declined at the time. At the present, Petitioner was complaining of pain and swelling in her knee and tingling in her foot. She denied the ability to stand on her foot for a prolonged period of time. Petitioner occasionally took Tylenol and sometimes wore a brace on her knee. Due to increased symptoms she wished to revisit getting a TKR. Petitioner had stopped working around May of 2011 having been terminated. She was spending her days watching TV and riding a three wheeler bike. (RX 2, dep. ex. 2)

Dr. Li noted that Petitioner had gained fifteen pounds since their earlier visit. The posterior drawer exam on the right had a firm endpoint and it was slightly increased compared to the left but the endpoint was definitely firm leading the doctor to feel the PCL was stable. She had pain with palpation along the medial joint line. (RX 2, dep. ex. 2)

Dr. Li further noted that Petitioner's current complaints of pain kept her from walking and standing for a prolonged period of time. She reported using a walker to help ambulate. She denied employment since May of 2011 and denied any other medical care and treatment since the first IME except for seeing Dr. Gurtler in 2014. Dr. Li felt the weight gain of 15 pounds would definitely cause increased stress across Petitioner's knees. (RX 2, dep. ex. 2)

Dr. Li had not reviewed the actual x-rays but noted Dr. Gurtler had documented osteoarthritis but not bad enough for a TKR. Therefore, Dr. Li felt Petitioner had some underlying arthritis that would support her complaints. He found no evidence of symptom magnification. (RX 2, dep. ex. 2)

Dr. Li's diagnosis remained unchanged noting the diagnosis of some arthritis but that was based solely on Dr. Gurtler's note as the doctor had no x-rays to support it. If she did have osteoarthritis it would be degenerative in nature as Petitioner was now 66 years old and" morbidly obese" having gained 15 pounds over the last four years. Any further treatment would be directed to her osteoarthritis which was unrelated to her 2010 accident. He still felt she could be working as a "unit secretary." He did not believe a TKR would be related to her accident. He felt she needed no further treatment for her "healed" tibial plateau fracture but might require anti-inflammatory medication and cortisone for her osteoarthritis. He felt she was at MMI one year after her accident. (RX 2, dep. ex. 2) Based upon the Sixth Edition of the AMA guidelines, Petitioner's impairment rating was found to be 0%. Dr. Li noted Petitioner's fracture was nondisplaced and there were no "objective findings to indicate that the fracture is causing any problems." (RX 2, dep. ex. 2)

Second Deposition of Dr. Li

The parties deposed Dr. Li again on August 20, 2015. (RX 2)

Dr. Li testified his opinion was unchanged, that Petitioner's injury resulted in a non-displaced tibial plateau fracture, that she did not suffer a PCL ligament injury, and she did not require a total knee replacement surgery. Id. at 15-16 He testified he did not believe the fracture caused a loss of function as she required no significant treatment for that issue to resolve on its own. (RX 2, p. 19)

Dr. Li testified Petitioner did not have any arthritis in her knee when he last examined her in October 2011 and that it could not have developed because of the work accident because the non-displaced fracture she suffered had healed on its own and this fracture would not cause traumatic arthritis to develop. He felt the arthritis found in Petitioner's knee now was degenerative in nature. (RX 2, pp.14-15) Dr. Li also testified the 15 lbs. Petitioner had gained in the past four years put extra stress on her joints. (RX 2, p. 13)

Dr. Li testified there was no evidence of Petitioner having suffered a PCL injury during the work accident as a PCL injury would be extremely easy to identify on an MRI and there was no reason to suppose that such evidence would be missed by anyone interpreting the MRI scans. (RX 2, p. 15) Furthermore, Dr. Li also testified he personally found no evidence of PCL instability as was being claimed by Dr. Gurtler during his physical examination. (RX 2, p. 15)

Dr. Li testified, based on Petitioner's complaints of pain and her morbid obesity, he would recommend relatively sedentary work. (RX 2, p. 21) He confirmed this was not related to her work injury, just her general deconditioned state. (RX 2, p. 26)

Dr. Li testified he did not believe Petitioner required a total knee replacement, and if she did at a future date, it would not be related to the tibial fracture injury. (RX 2, p. 16)

Dr. Li opined Petitioner would have been at MMI following the therapy recommended during his initial IME, and agreed that date should have been around January or February 2012. (RX 2, p. 25)

Dr. Li noted that MMI does not mean a patient is asymptomatic and if Petitioner had symptoms after the MMI date had been reached, he would still not have recommended an FCE because Petitioner was working in an administrative job and he did not feel an FCE would be warranted in light of her light duty position. (RX 2)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 10, 2016. At the time of the hearing Respondent was being represented by the Illinois Guaranty Fund. The parties stipulated that Petitioner was working as a medical secretary for Respondent, C-U Regional Rehab, on June 23, 2010 when she sustained an accident while entering into an elevator at work. Disputed issues included causal connection, temporary total disability and/or maintenance benefits after March 27, 2012, liability for medical bills after March 27, 2012, nature and extent, and prospective medical care (a total knee replacement). Petitioner was the sole witness.

Petitioner testified her work as a medical secretary involved liaison work between caregivers, patients, and families. Petitioner explained that her job required her to check on patients, going from patient room to patient room, and reporting back to the nurses. According to Petitioner, whatever the nurses usually needed they needed "stat." She was responsible for getting things the nurses needed like IV poles, suctions, and things that might be

located on a different floor. If it was an emergency she had to get it quickly so she was the "runner" for that. Petitioner also did a lot of filing, and retrieving of supplies and materials from Central Supply. Petitioner testified she would visit 35 separate rooms per day, walking to each room, and that each room usually had two patients. With respect to the medical supplies, Petitioner testified she worked on the north side of the second floor and Central Supply was on the south side of the first floor, she testified the hallway she had to walk to get there was roughly 50-60 feet long. Petitioner usually used the elevator to go back and forth to Central Supply. Petitioner testified about 60% of her normal 8 hour shift was spent on her feet. Petitioner usually worked 7:00 a.m. to 3:00 p.m.

Petitioner testified that she suffered a right knee injury while carrying a box of paperwork when she tripped at the threshold of an elevator that had not come to a level resting position. Petitioner had stayed late as it was the end of a billing cycle and she had to transport medical records. She didn't have a cart so she was carrying a box full of medical charts that had to go to medical records. Petitioner testified that when she stepped onto the elevator she didn't know it hadn't come up even with the floor. She put her foot in and then "crunched her knee somehow behind her" and heard a pop. Petitioner testified that she was able to get up and get herself together and then hobbled to medical records, went home, and iced her knee. According to Petitioner, she landed "really funny."

Petitioner testified that the next day her knee was swollen and she could hardly walk on it. Petitioner reported the injury the next day and the nurses in charge directed, and assisted her, to Occupational Medicine.

Petitioner testified she was off work for three weeks, after which she returned to work but not in her pre-accident capacity. Petitioner testified she was offered help with some of her job duties so that her work was easier.

Petitioner testified her work for C-U Regional Rehab ended April 25th, 2011. Petitioner later testified she sought no employment between this date and March 27, 2012.

Petitioner testified that she was ultimately referred by Occupational Medicine to Dr. Gurtler. She underwent physical therapy in February or March of 2012. Petitioner testified that the therapy provided no relief or improvement.

Petitioner testified Dr. Gurtler recommended a total knee replacement surgery in March of 2012. Petitioner testified she refused the surgery at that time because she wanted to keep her job. When reminded she had been "terminated" in April of 2011, Petitioner apologized as it had been six years earlier and her mind wasn't as fresh as it once was. Petitioner explained that she wanted to hold off on a knee replacement for as long as possible because she didn't wish to be debilitated or stop working anywhere.

Petitioner acknowledged that she hasn't worked since March 27, 2012. She also acknowledged that she didn't receive any treatment between March 27, 2012 and February 6, 2014. She further testified that she hasn't had access to all the medical care that she wanted as a result of the injury explaining that care was denied several years ago when "they" told her the "work comp issue" had been closed and she would no longer be able to get medical care unless she paid up front for it at Carle.

Petitioner testified that she believed Dr. Gurtler took her off work completely as of March 27, 2012. She followed up with him again on February 6, 2014 and didn't believe her restrictions had changed at any time. At the time of the 2014 visit Petitioner was still "begging off" on a total knee replacement but the doctor told her she was eventually going to have to get it done if she wanted to have full use of her knee. At that time he told

her she couldn't stand for longer than 30 minutes or so and he didn't see how she could go back to work. Petitioner would be unable to return to work as a medical secretary with that restriction.

Petitioner testified that she applied for a couple of receptionist positions. She applied for general jobs but they included duties of lifting, pushing, and pulling that she wasn't sure she could complete. In the end she applied at Walmart to be a greeter but the store was downsizing and it wasn't hiring. She never heard back thereafter. Petitioner explained that she can't rely on her knee to withstand whatever lifting or walking she might be asked to do and didn't want to take on a job unless she was capable of it. As such, she didn't feel her knee was strong enough.

Petitioner was asked questions about her activities of daily living. She explained that she cannot do stairs without a lot of help. She's doing better now and if there is a handle she can ambulate the stairs; however, she can't walk on uneven ground at all. She is back to walking "good" and she tries to exercise a little bit with the therapy exercises she was given in an effort to strengthen her leg. She doesn't do much around the house and doesn't go out very much.

Petitioner further testified that her husband does much of the driving because she is worried she wouldn't be able to use her knee in an emergency situation if she had to "stop and start." He has been doing most of the driving for the last six years although she had to drive herself to the hearing site for trial.

Petitioner testified that she wants to undergo the total knee replacement when things get too painful but she dreads it even though everything about it sounds positive.

Petitioner acknowledged some unrelated health issues between March 2012 and February 2014. During that time Petitioner suffered from an inflamed gallbladder and end stage liver disease and was hospitalized. Petitioner testified she is now in remission, but there was about a year and a half where she couldn't even function.

When asked if she would describe her job as a medical secretary for Respondent as "mostly sedentary," Petitioner replied "No, not at all."

On cross-examination Petitioner was asked about her work history prior to working for Respondent. Petitioner was a licensed practical nurse "for years" having graduated from LPN school in 1970. She moved to California and got into the computer software industry (customer support) and when they returned to Illinois she had to "re-up" her nursing license. She also got into plumbing work and didn't actually resume nursing until after her late husband passed away. Petitioner then wanted to get back into the medical field and got into clinical work and medical work. Petitioner acknowledged being pretty savvy with the internet at home and that she uses it for personal correspondence with friends.

Petitioner testified she suffered a torn ligament to the same knee in the early 1980's due to a softball injury, for which she never underwent surgery.

Petitioner also testified that she returned to work around the middle of July of 2010. She then continued treating with doctors and, when asked if she continued performing her regular job during that time, she replied that she didn't know/remember. Petitioner explained that everyone was very conscious of her injury and "automatically helped" her. She denied that she was doing her full job as she didn't go from room to room like she had been doing, at least not more than once a day. At first she tried it morning and afternoon but then she had to only do it mid-day. She acknowledged that neither her shift nor her hours were reduced and she kept very busy.

When asked if Dr. Gurtler released her without restrictions in February of 2011 after undergoing a bone scan, Petitioner did not remember. She believed that she always had restrictions and that she was working between February and April of 2011 just as she had described.

Petitioner acknowledged that after May of 2011 she didn't seek any additional medical care and that Respondent had her examined by Dr. Li. Thereafter she returned to Dr. Gurtler and underwent physical therapy. The therapy was stopped because "they" indicated it wasn't progressing and she agreed as she wasn't able to do any activities she could before her accident. She could not recall if Dr. Gurlter took her off work in March of 2012. She did recall not looking for work until after the therapy in 2012.

Petitioner acknowledged that she was miserable while dealing with her gallbladder and liver conditions. Whether she felt her inability to function during that time was due to those conditions or her knee, she wouldn't know as she was simply miserable and wasn't moving much whatsoever. She recalled getting use to the pain and limitations of her knee.

Petitioner looked for the jobs on-line and did so in just the past year. She was looking for something close to home so she wouldn't have to depend on her husband to take her long distances. Petitioner further testified she is able to drive short distances of ten miles or so, although she does not feel comfortable driving long distances. Petitioner testified no doctor has given her a driving restriction. There are no businesses within a ten mile range of her home and there is no public transportation. When asked if she felt "comfortable" looking for some kind of work, Petitioner replied that she was "desperate" to try and get herself up. She denied any public transportation available. Petitioner acknowledged it was a forty mile drive to the hearing site and she didn't feel comfortable while driving.

Petitioner testified that she thought Dr. Gurtler had told her she shouldn't lift over ten pounds. She knows her limitations and stops if something isn't going to work. She felt she could work in a sedentary position.

Petitioner testified she retired from the medical secretary position some time before February 6, 2014. Petitioner explained that she felt she was "forced into it." She further testified she began collecting social security at age 62.

On redirect examination Petitioner was asked about her decision to stop working. She explained that she thought she would work for Respondent until she died because she loved that job. She retired because she was "giving up." When asked if she could visit 35 rooms a day, she replied "Maybe." When asked if she could be on her feet sixty percent of the day, she replied "No." Petitioner testified that she attempted to return to full duty work after February of 2011 and was then gone within two months. She feels she left because of her inability to perform her job.

Petitioner further testified that while treating for her unrelated medical problems her knee was about the same.

Petitioner testified that the lifting restriction is the only one she is aware of.

Petitioner further testified that her husband didn't drive her to the hearing site because he is 79 years old and "feeling it." He had been very sick in the last couple of weeks and she felt the trip would be really hard on him.

On further cross-examination Petitioner was asked about her ability to walk. She testified that she was walking better now than she was during the time period when she felt there was no change in her condition. When she

returned to work in February of 2011 she wasn't on her feet sixty percent of her day. She also reiterated that she believed her injury or her restrictions were partially what led to her employment ending. The actual reason given was that she failed to call/show up one day. However, she disputes that. She acknowledged unsuccessfully seeking unemployment compensation thereafter. On redirect examination she testified that she didn't submit any evidence at the time of the unemployment hearing and that it affected the decision.

The Arbitrator concludes:

PETITIONER'S CREDIBILITY.

Petitioner was a very credible witness. While she had trouble clearly recollecting some matters, the Arbitrator attributes this to the passage of time rather than anything affecting her believability or honesty. She came across as a very hard working individual who loved her job and wished to continue working as long as possible. She did not embellish her testimony or present herself in any way except truthful.

WITH REGARD TO ISSUE (F), WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE JUNE 23, 2010 INJURY:

Petitioner's current condition of ill-being in her right knee is causally related to the June 23, 2010 accident. In support thereof, the Arbitrator relies upon Petitioner's credible testimony, the medical treatment records, a chain of events, and the more persuasive opinions and testimony of Dr. Gurtler over those of Dr. Li, Respondent's examining physician.

In the case herein, accident was undisputed. Petitioner credibly testified that she suffered a right knee injury on June 23, 2010. Petitioner testified she tripped while entering an uneven elevator while holding a box of filing, and directly struck her right knee. There is no question she suffered a tibial plateau fracture which healed on its own and she had several weeks of light duty before being released to unrestricted work. However, she remained symptomatic in her right knee.

The central issue in this case is whether Petitioner's present condition of ill-being, primarily a diagnosis of a PCL instability and arthritis, is related to her June 23, 2010 accident. Petitioner testified she suffered a prior softball ligament tear in the same knee; however, she denied any ongoing problems. She testified, without rebuttal, that she was asymptomatic prior to her accident herein. While Dr. Li took issue with the diagnosis of PCL instability he relied solely on the MRI report and never actually reviewed that film or any others. Dr. Gurtler credibly and persuasively explained how he came to diagnose the PCL instability. (See, for ex., PX 2, p. 10.) In this instance, given Dr. Gurtler's diagnosis was based upon a more through consideration and review of all pertinent medical information and tests, his opinions are found more persuasive.

Dr. Gurtler is not only Petitioner's primary treating physician in this case but also an agent of Respondent as all of Petitioner's care in this case was directed by Respondent. Petitioner's supervising nurses directed her, and accompanied her, to Occupational Medicine. In turn, Occupational Medicine referred Petitioner to Dr. Gurtler.

From the time of the occurrence, and throughout the course of her medical treatment, Petitioner's pain complaints have remained. Her condition actually worsened as her right knee became increasingly unstable. Her knee was described as grade three plus instability, and Dr. Gurtler testified that this is a very severe level of instability. While Petitioner testified at arbitration that she was feeling better than she had in 2012 and 2014 and

while her instability in 2014 was reduced from that of 2012, neither negates a finding of ongoing causation for the underlying knee condition and she has never returned to her pre-accident condition.

Throughout the course of Petitioner's treatment, Dr. Gurtler noted that Petitioner was an accurate historian, and he never had any reason to doubt her subjective complaints. Furthermore, Petitioner's subjective complaints were confirmed by numerous imaging studies. Dr. Gurtler testified that Petitioner's injuries caused her knee to continue to worsen to the point that she was in a state of misery. The doctor also explained through his testimony that Petitioner's osteoarthritis is a component of her need for a total knee replacement. He also explained that any arthritis present at the time of her June 23, 2010, injury was asymptomatic. That work injury, at a minimum, aggravated any underlying arthritis, and caused it to become symptomatic.

Dr. Li, Respondent's examining doctor, acknowledged on a number of occasions a lack of information or was uncertain in his opinions. At his second deposition he did not know whether Petitioner had undergone the therapy he had earlier recommended, and if she had what the results were. Dr. Li's opinions with respect to MMI dates, as well as Petitioner's work capabilities, were not persuasive. He testified to two completely different dates as to when Petitioner reached MMI. In one instance, he stated it was in June of 2011, while in another he indicated spring of 2012. He had an incorrect and incomplete understanding of Petitioner's job duties and incomplete information regarding her care and treatment. Dr. Li also tried to link Petitioner's weight gain between examination dates as a reason for Petitioner's arthritic knee. That weight gain can reasonably be connected to Petitioner's lack of activity resulting from her work accident and Dr. Li did not consider that possibility.

In reliance on the opinions of Dr. Gurtler, the Arbitrator finds that Petitioner suffered a tibial plateau fracture, posterior cruciate ligament instability, and aggravation of her pre-existing osteoarthritis as a result of the June 23, 2010 accident.

WITH REGARD TO ISSUE (J) WHETHER THE MEDICAL TREATMENT RENDERED TO PETITIONER WAS REASONABLE AND NECESSARY?:

Consistent with her causation determination set forth above, the Arbitrator finds Respondent liable for medical expenses incurred by Petitioner subsequent to March 27, 2012 and through the last office visit with Dr. Gurtler in February of 2014. The parties stipulated to medical through March 27, 2012. (AX 1) The troubling issue is that no medical bills were submitted into the record and, therefore, the Arbitrator cannot award the payment of any specific medical bills for treatment after March 27, 2012. Therefore, no medical bills are awarded.

WITH REGARD TO ISSUE (O), WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE TOTAL KNEE REPLACEMENT SURGERY?:

Prospective medical care is denied. This is not a 19(b) proceeding. Petitioner's rights under Section 8(a) of the Act remain open and she may elect to pursue an award of prospective medical care at a later date. The Arbitrator does find, however, that, based upon this record, the accident herein is a cause of Petitioner's eventual need for a total knee replacement. In support thereof, she replied upon her causation analysis set forth above.

WITH REGARD TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, AND FOR MAINTENANCE?:

The parties stipulated that Petitioner was entitled to TTD benefits from June 24, 2010 through July 14, 2010 and January 19, 2012 through March 27, 2012, a period of 12 4/7 weeks. Petitioner was terminated by Respondent in May of 2011. At that time, she had been back to work for less than two full months. While she was not given

any restrictions at that time her testimony that she was not working full duty and was being assisted by co-workers was unrebutted. Petitioner was then given a restriction of very limited standing as of January 19, 2012 and she was completely taken off work as of March 27, 2012 pending a total knee replacement.

As of March 27, 2012, Petitioner had just completed the physical therapy recommended by Respondent's examining physician, Dr. Li. When re-examined by Dr. Gurtler on March 27, 2012, Petitioner was taken off work pending a total knee replacement procedure. Nothing in the doctor's note of that date indicates Petitioner did not wish to go forward with the procedure at that time. Dr. Li was then deposed in September of 2012. He had not re-examined Petitioner prior to that deposition and his opinion regarding her MMI status remained no different than the one expressed in his initial report – ie., Petitioner was not yet at MMI. Dr. Gurtler was deposed on February 5, 2013. He was still of the opinion that Petitioner was not at MMI pending a total knee replacement. As of February 5, 2013 he still felt Petitioner needed the procedure. Nothing in his deposition suggests Petitioner was not electing to proceed with the deposition as of that date.

Petitioner underwent no medical treatment for her knee between March 27, 2012 and February 6, 2014. Some of that may have been attributable to other health problems. Additionally, as Petitioner alluded to, there appears to have been some problems with coverage/authorization for treatment[2]. On February 6, 2014 Dr. Gurtler advised Petitioner that, in light of her complaints and examination findings that date, she would still need a total knee replacement but it was no longer as emergent and he recommended she put it off a few years. Petitioner also reported that she wasn't working and had retired as a medical history. Her examination findings were somewhat improved, in some ways, from her 2012 visit.

Given the foregoing, the Arbitrator finds that Petitioner's condition in her right knee was stabilized/ plateaued as of February 6, 2014. Dr. Gurtler no longer felt surgery was needed right away. Petitioner's knee was somewhat better although clearly still symptomatic and troublesome. However, it appears to have plateaued or stabilized at that point with the doctor offering no other treatment options at that time. Accordingly the Arbitrator awards Petitioner temporary total disability benefits from March 27, 2012 through February 6, 2014, a period of 97 3/7 weeks.

Respondent shall receive credit for all payments previously made, totaling $33,670.86. (See AX 1)

The Arbitrator declines to award maintenance benefits. As of February 6, 2014, no other treatment options were available to her as she declined surgery. Dr. Gurtler doubled Petitioner would ever be able to work where she needed to be on her feet. However, it also appears that Petitioner was no longer really trying to work as she had "retired." She testified to minimal efforts at a job search. As such, the Arbitrator declines to award Petitioner any maintenance benefits.

WITH REGARD TO ISSUE (N), WHAT IS THE NATURE AND EXTENT OF THE INJURY?:

Petitioner had a significant injury to her right leg as a result of her undisputed accident. The Arbitrator believes that Petitioner's inability to continue in working in 2011 was due, in part, to her knee. Even though Petitioner was working "full duty" her testimony as to how her job was being accommodated was unrebutted.

Petitioner testified to significant restrictions resulting from this injury and Dr. Gurtler's records corroborate as much. Any surgery, except a total knee replacement, has been ruled out given Petitioner's age. There has never been a request for a vocational assessment nor was there evidence presented showing efforts at substantive job seeking. Therefore, the Arbitrator finds no basis to award Petitioner permanency associated with a demonstrable

[2] The Arbitrator notes that Respondent's insurance carrier was not listed as the respondent's insurance carrier or service company at the time of arbitration. The Guaranty Fund had taken over the case.

loss of trade. Petitioner also testified that she believed she could do her prior work, as modified following her July 2010 return to work.

Petitioner's treating doctor, Robert Gurtler, has described Petitioner as being "miserable" due to her pain. The doctor stated that her knee is gradually being destroyed, and the medical records and deposition testimony confirm this. Petitioner's instability in the right knee continued to worsen. Petitioner's arthritis, even assuming it was present prior to the June 23, 2010 accident, has worsened and, at a minimum, has gone from asymptomatic to symptomatic. Petitioner testified that her knee has never been the same since her accident. She testified that upon returning to work, she found her job duties difficult due to the need to walk around the building and check on patients. Petitioner also testified regarding her inability to walk, stand, or drive for prolonged periods of time. She replies upon her husband for significant help in getting by in daily life. Petitioner struggles with stairs and any uneven surfaces. She must rely upon a handle or a cane in such situations. Dr. Gurtler, when last examining Petitioner, doubted she could ever resume a job where she would need to stand on her feet.

Based upon the foregoing, as well as Petitioner's credible testimony and the medical records of Dr. Gurtler, the Arbitrator finds that Petitioner has suffered a tibial plateau fracture, posterior cruciate ligament instability, and an aggravation of her pre-existing osteoarthritis in her right knee. As a result of these injuries, she has significant limitations and will ultimately need a total knee replacement. The Arbitrator concludes that Petitioner has sustained the 45% loss of use of her right leg.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Espino,

Petitioner,

vs.

NO: 09WC 48261

MLV Construction, and Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

17IWCC0662

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent IWBF herein and notice given to all parties, the Commission, after considering the issues of accident, employment relationship, temporary disability, benefit rates, wage calculations, permanent disability, and proof of no insurance, 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 Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

17IWCC0662

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: OCT 20 2017
SJM/sj
o-8/31/2017
44

Stephen J. Mathis

David L. Gore

DISSENT

I respectfully dissent from the opinion of the majority. I would vacate the Arbitrator's award against the Injured Workers' Benefit Fund. I am not persuaded that Respondent MLV Construction was not covered by workers' compensation insurance at the time of the alleged accident. Petitioner failed to submit certification from the National Council on Compensation Insurance ("NCCI"). Instead, Petitioner submitted exhibit #24 as evidence of MLV's lack of insurance. However, this document is hearsay and of no probative value, and it reflects an incorrect date of accident. Furthermore, the medical records of several providers reference Liberty Mutual as the insurance carrier and include a workers' compensation claim number. There are also Liberty Mutual documents in the medical records indicating that charges are pending further investigation of the claim; these forms include a workers' compensation claim number and the date of accident. There is no credible evidence proving that a Liberty Mutual policy, or any other carrier's policy, was not in effect at the time of the alleged accident. I do not believe that sufficient evidence has been presented to hold the Injured Workers' Benefit Fund responsible for any monetary award in this case and therefore I dissent from the majority opinion affirming and adopting the Decision of the Arbitrator.

I would also modify the Arbitrator's award of permanent partial disability with respect to the left leg because I do not believe the evidence supports a finding that Petitioner sustained 30% loss of use. Petitioner complained of left knee pain that increased in the weeks after he underwent right knee surgery. Dr. Silver suspected "compensatory stress," and believed Petitioner had a torn medial meniscus. On arthroscopic examination, however, no tears were found and there was no bursitis in the left knee. Dr. Silver debrided loose bodies and cartilage fragments, and the records show no significant residual complaints. I would modify the Arbitrator's permanent partial disability award down to 15% of the left leg.

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ESPINO, JUAN
Employee/Petitioner

Case# **09WC048261**

17IWCC0662

MLV CONSTRUCTION LLC AND INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4595 WHITESIDE & GOLDBERG LTD.
BRENT R EAMES
155 N MICHIGAN AVE SUITE 540
CHICAGO, IL 60601

0000 MLV CONSTRUCTION A/K/A
AND D/B/A DOMO GROUP LLC
20 DANADA SQ WEST SUITE 290
WHEATON, IL 60187

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK

17IWCC0662

☒ 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

JUAN ESPINO
Employee/Petitioner

v.

MLV CONSTRUCTION, L.L.C., and
INJURED WORKERS' BENEFIT FUND
Employer/Respondent

Case # **09** WC **48261**

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 **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **OCTOBER 26, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the ten (10) months preceding the injury, Petitioner earned **$12,500.00**; the average weekly wage was **$562.50**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **3** dependent children.

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

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

ORDER

The Respondent shall pay the Petitioner temporary total disability benefits of **$375.00**/week for **67** weeks, for the period from **10/31/2009** through **2/11/2011**, as provided in Section 8(b) of the Act.

The Respondent shall pay the Petitioner reasonable and necessary medical services of **$162,398.35**, pursuant to the Medical Fee Schedule, as provided in Section 8(a) of the Act.

The Respondent shall pay the Petitioner PPD benefits of **$337.50** per week for **129** weeks as provided in Section 8(e) of the Act, because the injuries sustained caused a **30% loss of use of the right leg** and a **30% loss of use of the left leg.**

Goldstein, Bender & Romanoff, the fee petitioning law firm, is entitled to 15% of the total attorney's fees applicable for this award.

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'S OFFICE. AWARD IS HEREBY ENTERED AGAINST THE FUND TO THE EXTENT PERMITTED AND ALLOWED UNDER SECTION 4(D) OF THE ACT. IN THE EVENT OF THE FAILURE OF THE RESPONDENT-EMPLOYER TO PAY THE BENEFITS DUE AND OWING THE PETITIONER, THE RESPONDENT-EMPLOYER SHALL REIMBURSE THE INJURED WORKERS' BENEFIT FUND FOR ANY COMPENSATION OBLIGATIONS OF THE RESPONDENT-EMPLOYER 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

FEBRUARY 14, 2017
Date

FEB 14 2017

17IWCC0662

JUAN ESPINO V. MLV CONSTRUCTION, L.L.C, and INJURED WORKERS' BENEFIT FUND

09 WC 48261

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson in Chicago on December 2, 2016. All issues were in dispute. Additionally, the parties agreed to receipt of this Arbitration Decision and any subsequent Decision and Opinion on Review via e-mail. (*Arbitrator's Exhibit* 1).

FINDINGS OF FACT

The Petitioner, Juan Espino, was the only witness to deliver live testimony. The Respondent employer, MLV Construction (hereinafter, "MLV"), received proper notice of said hearing via certified mail on or after November 14, 2016. (*Petitioner's Exhibit* 25). No representative of MLV was present for the December 2, 2016 hearing. (*Transcript* at 41-42). Furthermore, MLV did not have workers' compensation insurance on the date of accident, October 25, 2009. (*Petitioner's Exhibit* (hereinafter, *PX*) 24). The Illinois Attorney General's office appeared on behalf of the Illinois State Treasurer, the ex officio custodian of the Injured Workers' Benefit Fund.

The Petitioner testified that on and before October 26, 2009, he was employed by MLV. (*Transcript* (hereinafter, *T.*) at 11). The Petitioner began working for MLV in mid-May of 2009 after contacting the owner of the company, Lucian Micu, in response to an online employment advertisement. (*T.* at 11-12). He interviewed with Mr. Micu directly and discussed the work he would be expected to perform, how much he would be paid, and what his expected work hours would be. (*T.* at 12).

The Petitioner testified that Mr. Micu would call the Petitioner every morning between 6:30 a.m. and 7:00 a.m. and direct the Petitioner to the location of the work to be performed that day. (*T.* at 13). Mr. Micu required the Petitioner to start work at 8:00 a.m. every day, provided the tools with which the Petitioner performed his work, and supplied the materials for the work to be performed. (*T.* at 14-15). MLV also supplied a uniform for the Petitioner to wear and required the Petitioner to wear the uniform while working. (*T.* at 15). The uniform consisted of a blue shirt with the name, "MLV Construction", as well as a badge. (*T.* at 15). The

Petitioner also was required to call Mr. Micu at the conclusion of every workday to report on his progress and any remaining work tasks at the job site. (*Id.*).

The Petitioner was compensated by MLV via a weekly check singed by Mr. Micu from the account of MLV Construction. (*T.* at 16 and *PX* 19). No taxes were withheld from these checks by MLV and the Petitioner testified he did not receive any tax documentation from MLV. (*T.* at 17). He further stated he declared his wages from MLV as Form 1099 income on the advice of his accountant and the Internal Revenue Service as he had not received a W-2 form from MLV. (*T.* at 19 and *PX* 20).

Initially, the Petitioner performed carpentry work for MLV that included wall construction and replacing plywood. (*T.* at 13). However, an MLV tile project was behind schedule and, after bringing his tile experience to the attention of MLV, his job duties changed to exclusively laying tile. (*T.* at 13). The Petitioner stated this type of work required him to work on his knees and placed all of his weight and a lot of pressure on his knees. (*T.* at 21). Prior to his accident date, the Petitioner was laying approximately 15 to 18 cases of tile every day. (*T.* at 22). In the weeks and months leading up to October 26, 2009, the Petitioner appreciated a worsening of pain and swelling in his knees, but he continued working his normal job and hours. (*T.* at 22).

On October 26, 2009, the Petitioner, while at a MLV jobsite, was working on a tile project when he heard "a big lock" in his knees. (T. at 22-23). He continued to work on the tile project but appreciated increasing pain and swelling in his knees. (T. at 23). He contacted Mr. Micu later that morning, advised him of his knee injury, and requested that he be allowed to go home. (T. at 23). However, the Petitioner testified Mr. Micu denied his request as the jobsite was behind schedule. (*Id.*). As such, the Petitioner continued with his work and finished his normal work hours for that date. (*Id.*).

The Petitioner sought medical care from Los Quiropracticos on October 27, 2009, and reported pain in his right knee as a result of working on his knees. (*PX* 2 at 8). At the end of that medical visit, he was diagnosed with a right knee ligament injury, issued a knee brace, and placed on modified work status that began with three days of being completely off of work. (*PX* 2 at 10, 20, and 39). The Petitioner testified he advised Mr. Micu on that day of his work restrictions and tendered a written copy of the same to Mr. Micu. (*T.* at 24). The Petitioner then returned to work on October 30, 2009 after his three days of off work status. (*T.* at 25). He testified that Mr. Micu informed him at the end of the work day that he was being terminated from MLV due to his work injury episode. (*T.* at 25).

After treating with Los Quiropracticos for approximately one month, the Petitioner then sought further medical care on November 25, 2009 from the Chicago Pain Center. (*T.* at 27 and *PX* 3 at 86). The Petitioner provided a history of increasing right knee pain as a result of laying tile at work. (*PX* 3 at 86). He was instructed to undergo a physical therapy regime for "4-6 consecutive weeks". (*PX* 3 at 88). After that therapy program did not reduce his knee pain, the Petitioner was referred to Dr. Leon Huddleston on December 4, 2009. (*PX* 3 at 95). The Petitioner advised Dr. Huddleston of his history of knee pain while laying tile at work. (*PX* 3 at 95). Dr. Huddleston examined the Petitioner, opined the Petitioner's right knee pain was "related to his work as a construction worker", and recommended he undergo a right knee MRI study "to evaluate for any internal derangement." (*Id.*). The December 7, 2009 MRI study indicted "pre-tibial bursitis with prominent prepatellar edema." (*PX* 7). After reviewing the MRI study on December 18, Dr. Huddleston recommended the Petitioner continue his therapy program and utilize a Medrol Dosepak for pain (*PX* 3 at 102). However, the Petitioner's knee pain symptoms continued and, after a series of injections failed to relieve his knee pain, Dr. Huddleston referred the Petitioner to Dr. John O'Keefe to explore an orthopedic surgery option. (*PX* 3 at 112).

During his January 26, 2010 appointment with the Petitioner, Dr. O'Keefe took the Petitioner's accident and medical history, conducted a physical examination, and reviewed the Petitioner's MRI study. (*PX* 8). Dr. O'Keefe opined the Petitioner's knee difficulties were causally related to his work for the Respondent, directed him to utilize a cane for ambulation, revised his medication program, and took him off of work. (*PX* 8). On February 22, 2010, the Petitioner returned to Dr. O'Keefe and received a diagnosis of right knee internal derangement and prepatellar bursitis. Dr. O'Keefe continued the Petitioner's off work status and further revised his prescribed medications. (*Id.*). During a subsequent visit on March 10, 2010, Dr. O'Keefe recommended a right knee buresctomny to address the Petitioner's ongoing knee complaints and continued his physical therapy and work restrictions. (*Id.*).

The Petitioner then met with Dr. Ronald Silver for a consultation regarding his right knee pain. (*T.* at 29). After taking the Petitioner's work and medical history, conducting a physical examination, and reviewing the Petitioner's diagnostic studies, Dr. Silver opined the Petitioner to be suffering from chronic prepatellar bursitis with possible cartilage damage. (*PX* 9). Dr. Silver recommended and, on May 4, 2010, performed a right knee prepatellar bursectomy, arthroscopic debridement, and removal of a loose body. (*PX* 9). During the surgery, Dr. Silver noted the Petitioner suffered an articular cartilage fracture and fragmentation and prepatellar bursitis. (*Id.*).

After this surgery, Dr. Silver restricted the Petitioner from returning to any work and implemented a post-surgical therapy program. (*PX* 9). During a July 14, 2010, follow up

appointment, Dr. Silver found the Petitioner had both "significant quadriceps atrophy" and increasing pain in his left knee "due to the compensatory stress he has placed on it." (PX 9). Subsequently, Dr. Silver noted improvement in the Petitioner's right knee while also finding further difficulties in his left knee. (*Id.*). An August 19, 2010 MRI study found a small tear in the medial meniscus and mild joint effusion that Dr. Silver then addressed via a second arthroscopic procedure on October 8, 2010, when he performed an arthroscopic debridement and removal of loose bodies in the joint. (*Id.*). Dr. Silver again recommended post-surgical therapy and continued to keep the Petitioner off of work. (*Id.*).

Due to ongoing difficulties with his right knee, the Petitioner sought a second opinion referral from Dr. Kreuger and, subsequently, was directed to Dr. Blair Rhode. (*PX* 3 at 220). He met with Dr. Rhode on January 5, 2011 and reported his work injury history of right knee pain due to repetitive tiling. (*PX* 15). Dr. Rhode opined the Petitioner to be suffering from right knee prepatellar bursitis due to repetitive kneeling at work. (*PX* 15). He kept the Petitioner off of work, performed a right knee injection, and asked the Petitioner to return for a follow-up visit in two weeks. (*Id.*). Due to improvements in his right knee after the injection, Dr. Rhode urged the Petitioner to attempt a return to work after a February 11 appointment. (*Id.*). Subsequently, the Petitioner returned to Dr. Rhode on May 9, 2011, with lingering right knee pain. (*Id.*). Dr. Rhode noted the Petitioner had tolerated full duty work but also provided a second right knee injection for the Petitioner's "aggravated" pain complaints. (*Id.*).

Thereafter, the Petitioner returned to Dr. Kreuger on May 12, 2011 and was directed to complete a functional capacity evaluation. (PX 3 at 231). On May 24, 2011, the FCE indicated the Petitioner capable of medium duty work with a 45 pound lifting restriction and a 25 pound carrying restriction. (*PX* 16).

The Petitioner testified he returned to carpentry work for a different construction company approximately one month after the FCE. (*T.* at 34). He indicated he is able to work within his restrictions by avoiding lifting tasks as well as kneeling work. (*T.* at 35). He also noted difficulty with certain daily living tasks and had not suffered any prior injuries to either his right or left knee. (*T.* at 35-26 and 22).

The Petitioner provided notice of the December 2, 2016 trial date to Respondent MLV Construction. (PX 25). Counsel for the Petitioner also unsuccessfully sought out a representative from MLV Construction outside the hearing room at the Commission. (T. at 41-42).

17IWCC0662

CONCLUSIONS OF LAW

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

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

The Arbitrator finds that the Respondent-employer was operating under and subject to the Illinois Workers' Compensation Act. The Petitioner's un-rebutted and credible testimony establishes that MLV Construction was operating a construction and carpentry business in the State of Illinois. As such, the Respondent-employer was operating as an employer under the Act which applies automatic coverage to: "[a]ny business or enterprise in which goods, wares or merchandise are sold or in which services are rendered to the public at large..." 820 ILCS 305/3(17(a)).

Issue B: *Was there an employee-employer relationship?*

The Arbitrator finds that there was an employee-employer relationship between Petitioner and MLV Construction. The Petitioner credibly testified the Respondent-employer hired him to perform carpentry and tile work as a part of MLV Construction's remodeling and carpentry business. The Petitioner also demonstrated MLV Construction exerted significant control over the Petitioner's work. This included the Respondent-employer mandating a specific start time, directing the Petitioner to particular job sites, issuing a uniform to be worn while working, and requiring and end-of-day debrief session to ascertain both accomplished tasks and remaining work to be done at the job site. Furthermore, the Petitioner's unrebutted testimony detailed how MLV Construction supplied both the construction materials and tools utilized by the Petitioner when performing his carpentry and tile jobs. Finally, the Arbitrator notes the Petitioner was paid by the Respondent-employer for his work and that MLV Construction further confirmed the employee-employer relationship by terminating the Petitioner shortly after his October 26 work accident. As such, the preponderance of the evidence in this case establishes the existence of a bona-fide employer-employee relationship between the Petitioner and MLV Construction.

Issues C & D: *Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? What was the date of the accident?*

The Arbitrator finds that an accident did occur on October 26, 2009 that arose out and in the course of the Petitioner's employment by the Respondent employer. The Petitioner provided credible and detailed testimony as to the mechanism of injury and how it occurred

while he was laying tile. Further, the medical records support a work-related accident as described by Petitioner. (*PX* 2 and *PX* 3).

For a claim based upon repetitive trauma, defining a so-called manifestation date is a fact determination for the trier of fact. *Palos Electric Co. V. Industrial Commission*, 314 Ill.App.3d 920, 930 (1st Dist. 2000). That means, *inter alia*, an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Williams v. Industrial Commission*, 244 Ill.App.3d 204, 209 (1st Dist. 1993).

In the instant claim, the Petitioner testified in detail regarding the repetitive nature of his work activities and the corresponding impact on his bilateral knees. This testimony was unrebutted, and it was corroborated by the medical records as the Petitioner reported to each and every treating medical provider that his knee pain began as a result of working for the Respondent, MLV Construction. The Petitioner's testimony that he reported to his employer that he hurt his knees at work and also that he provided an off-work slip from his medical provider to his employer also is unrebutted. As a result, the Arbitrator finds the Petitioner sustained an accident which arose out of and occurred in the course of his employment with the Respondent, MLV Construction, on October 26, 2009.

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

The Arbitrator finds that timely notice was given to the Respondent employer MLV Construction. The Petitioner credibly testified he informed Mr. Micu of his knee difficulties on October 26, 2009 when he sought permission to leave work early due his pain complaints. (*T.* at 23). His testimony regarding this notice went unrebutted and, as such, the preponderance of the evidence in this case establishes that timely notice of the accident was given to MLV Construction.

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

To establish causation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injury. *Land & Lakes Co. v. Industrial Commission*, 359 Ill.App.3d 582, 592 (2d Dist. 2005). It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Republic Steel Corp. v. Industrial Commission*, 26 Ill. 2d 32, 45 (1962).

In the instant claim, the Petitioner provided a consistent history of injury to all of his medical providers that his work activities for the Respondent caused his pain and problems. The Petitioner also introduced the opinions contained in the medical records of orthopedic

surgeons Dr. John J. O'Keefe, Dr. Ronald Silver and Dr. Blair Rhode concerning his bilateral knee conditions. Dr. O'Keefe, Dr. Silver and Dr. Rhode all opined that the Petitioner's right knee condition of ill-bring is casually connected to the subject work accident, and Dr. Silver opined that the Petitioner's condition of ill-being in his left knee is casually connected to the subject work accident. As such, the Arbitrator finds that the Petitioner's present condition of ill-being is causally related to the October 26, 2009 injury.

Issue G: *What were Petitioner's earnings?*

The Petitioner introduced his 2009 tax return into evidence, which shows $12,500.00 in gross wages earned from MLV Construction over the course of the year. (*PX* 20). Given the Petitioner's testimony that his employment with Respondent commenced in mid-May 2009 and he was terminated on October 30, 2009, the Arbitrator finds, based upon the greater weight of the evidence, the Petitioner's average weekly wage pursuant to Section 10 of the Act is $562.50.[1]

Issues H & I: *What was Petitioner's age at the time of the accident? Marital Status? Dependent children?*

The Arbitrator finds on the date of accident, the Petitioner was 32 years of age, married, and had three (3) dependent children.

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?*

Section 8(a) of the Illinois Workers' Compensation Act mandates that employers shall provide and pay for all the necessary surgical services which are reasonably required to cure or relieve the employee from the effects of the accidental injury. 820 ILCS 305/8(a). Medical care under Section 8(a) is continuous as long as such care is required to relieve the effects of the injury. *Freeman United Coal Mining Co. v. Industrial Commission*, 81 Ill.2d 335 (1980). The necessity of medical care is not dependent upon a finding of temporary total disability. *Zarlev v. Industrial Commission*, 84 Ill.2d 380 (1981). Instead, the question of whether medical care should be awarded is whether said care is reasonable and necessary to cure or relieve from the effects of the accidental injury. *Plantation Mfg. Co. v. Industrial Commission*, 294 Ill.App.3d 705 (2d Dist. 1997).

[1] The following calculation was used to arrive at the AWW: $12,500.00 in claimed income divided by 22.22 weeks worked = $562.50.

Based upon the greater weight of the medical evidence, including the opinions of the various treating providers and orthopedic surgeons, and based upon the Arbitrator's finding that Petitioner's current condition of ill-being is causally related to the October 26, 2009 work accident, the Petitioner has established that he is entitled to satisfaction of his past medical expenses. The Arbitrator hereby awards Petitioner past medical expenses in the amount of $162,398.35 to be satisfied by Respondent pursuant to the fee schedule of the Workers' Compensation Act. (*PX* 1).

Issue K: *What temporary benefits are in dispute?*

The medical records and evidence indicate that the last date the Petitioner worked for Respondent was October 30, 2011 and he was restricted from working from October 27, 2009 through the date he was allowed a return to a trial of full duty work by Dr. Rhode on February 11, 2011. (*PX* 15). The Arbitrator finds that the Petitioner is entitled to TTD benefits in the lump sum of $25,125.00, totaling 67 weeks of temporary disability from October 31, 2009 through the date he reached maximum medical improvement on February 11, 2011.

Issue L: *What is the nature and extent of the injury?*

The Petitioner was released with permanent medium level restrictions pertaining to his bilateral knees. (*PX* 16). Although the Petitioner was able to return to work as a carpenter for another employer, he testified that his employment is challenging given his permanent lifting restrictions, and he is forced to avoid lifting in favor of other lighter tasks, including supervising and deliveries. (*T.* at 35). The Petitioner also testified that working on his knees causes him considerable pain and problems and he is forced to limit work on his knees to approximately 30 minutes to an hour maximum. Additionally, the Petitioner continues to struggle with many activities of daily living, such as riding a bike, walking and playing with his children.

In light of the Petitioner's testimony and the medical evidence, the Arbitrator finds that the Petitioner sustained injuries to the extent of a 30% loss of use of the right leg and a 30% loss of use of the left leg under Section 8(e) of the Act.

Issue O: *Attorney's Fees by Former Attorney.*

The law firm of Goldstein, Bender & Romanoff filed a fee petition for work performed on this claim that was entered and continued to disposition by Arbitrator Robert Lammie on May 12, 2010. (*T.* at 44-45). At hearing, counsel of record for the Petitioner from Whiteside & Goldberg, admitted to having failed to notify Goldstein, Bender & Romanoff of the December 2,

2016 hearing date. (*T.* at 45). Accordingly, the Arbitrator finds Goldstein, Bender & Romanoff entitled to 15% of any earned attorney's fees arising out of this Arbitration Decision.

Signature of Arbitrator

February 14, 2017
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

Michelle Ewing,

Petitioner,

vs.

NO: 08 WC 54162

Road Link Transportation,

17IWCC0663

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of statute of limitations, exposure, occupational disease, causal connection, medical expenses, prospective medical care, permanent disability, evidentiary rulings and 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.

As a preliminary matter, the Commission considers Petitioner's "Motion to Order Penalties Under Section 19(k) For Respondent Failure to Provide Respondent's OSHA Logs/Summaries And Petitioner's Exposure Records," which was filed during the pendency of this matter on review. In addition to penalties, Petitioner asks the Commission to "issue an order directing the Respondent by through their attorneys and insurance carrier to promptly produce a copy of Respondent's OSHA Logs, all environmental testing studies reports with results and related exposure information to Petitioner's accident that the Respondent is required to maintain." On April 26, 2017, Commissioner Joshua Luskin heard arguments on the motion and took the matter under advisement, noting Respondent's valid objection to reopening proofs and re-arbitrating the case. The Commission finds that Petitioner's motion is improper, as it is not within the purview of section 19(k), and section 19(e) of the Act prohibits the introduction of new evidence on review.

17IWCC0663

Turning to the issues on review, having carefully considered the entire record the Commission finds the Decision of the Arbitrator should be affirmed in its entirety.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's "Motion to Order Penalties Under Section 19(k) For Respondent Failure to Provide Respondent's OSHA Logs/Summaries And Petitioner's Exposure Records" is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 29, 2015, is hereby affirmed and adopted.

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

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

DATED: OCT 20 2017
o-09/21/2017
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EWING, MICHELLE
Employee/Petitioner

Case# **08WC054162**

ROADLINK
Employer/Respondent

17IWCC0663

On 9/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 EWING, MICHELLE
9326 S CORNELL AVE
CHICAGO, IL 60617

1872 SPIEGEL & CAHILL PC
PHILLIP JOHNSON
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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

MICHELLE EWING
Employee/Petitioner

v.

ROADLINK
Employer/Respondent

Case # **08** WC **54162**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **9/25/14; 5/15/15; and 6/26/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0663

FINDINGS

On **7/9/08**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,640.41**; the average weekly wage was **$1,122.00**.

On the date of accident, Petitioner was **39** years of age, *single* with **1** child under 18.

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

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

Respondent shall be given a credit of **$18,969.94** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $0.00 for other benefits, for a total credit of $18,969.94.

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

ORDER

The Petitioner has not proven, by a preponderance of the evidence that her current condition of ill-being is causally related to the accident which arose out of and in the course of her employment by Respondent therefore, no benefits are awarded, pursuant to the Act.

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

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

FINDINGS OF FACTS

The petitioner represented herself in this matter and the disputed issues are: 1) accident; 2) causal connection; 3) medical bills and 4) the nature and extent of her injuries. *See,* AX1.

Petitioner's Testimony

Ms. Ewing, (the "petitioner") testified at trial, that she was employed by Roadlink (the "respondent") on February 9, 2008. While so employed, she worked in an office setting, as a human resources ("HR") professional. The petitioner testified and alleges that, while so employed, she was exposed to mold from a leaking pipe and as a result of the exposure to mold, she developed certain breathing and respiratory difficulties, including but not limited to a chronic cough, shortness of breath, allergic rhinitis hoarseness, vocal cord dysfunction and asthma. She also alleges that as a result of the mold exposure, she developed a pancreatic tumor, heart problems and lung scarring. The petitioner testified that she was off work and was paid weekly compensation benefits from October 27, 2008 through April 7, 2009, when her employment was terminated.

At hearing, the petitioner testified that she was experiencing difficulty breathing; and was required to use a nebulizer twice a day. Also, petitioner testified that she continues to take Symbicort twice a day and carries a rescue inhaler, in cases of emergency. She has a burning sensation in her chest and testified that she has difficulty walking extended periods of time; and that winter weather and summer heat make it more difficult for her to breathe.

The petitioner testified that at the time she was separated from employment in April 2009, she spent the following year seeking employment. Petitioner worked through Office Team, which is a staffing agency. Petitioner further testified that she looked for work in and out of the Chicago metropolitan area and in most suburbs. Petitioner testified that she had excellent HR and clerical skills and had an administrative assistant's background. After seeking a position through the agency, the petitioner was able to find employment as an HR assistant and the job duties were similar to but not identical to the work done for the respondent.

Petitioner testified that in the early part of 2011, she would work in different functions at different sites. She would get long-term jobs which would run between six months to a year and one particular position lasted approximately two years. Petitioner performed her usual and customary work between 2011 until 2012. While working in this assignment, she was required to commute by public transportation. Petitioner testified that her hours would vary to approximately 7 1/2 hours per day. During the time she was working between 2010 and 2012, she alleged she was having breathing problems and therefore, would limit any other activities. Petitioner further testified that she lives in her home with her son and pet dog; and that her air system in her home is cleaned on a regular basis.

Petitioner testified that, while being seen for breathing difficulty at the University of Illinois Hospital from September 2009 through 2014; she also presented for other unrelated issues. Prior to going to the University of Illinois, she treated with various physicians whenever she experienced breathing difficulties, including emergency room physicians. She utilizes inhalers, on occasion and that since she left the respondent's employ in 2009, to the best of her knowledge she is no longer exposed to mold however, she still has shortness of breath and also experiences triggering mechanisms from dust in the environment.

Petitioner testified that the only medical management she is currently receiving is the use of inhalers, prescribed by Drs. Dudek and Dr. Turner. Petitioner testified that she is a full-time employee and that the medical bills she incurred, subsequent to leaving the respondent's employment, were submitted to Blue Cross Blue Shield.

Medical Treatment

The petitioner has placed into evidence a plethora of medical records, of which only some are relevant. On January 30, 2008, Petitioner presented to Dr. Arnold Turner, complaining of right frontal headaches, speech changes and vocal weaknesses, a cough and sore throat. Upon evaluation, petitioner presented with benign hypertension and headaches, with an acute respiratory infection of unspecified nature.

Exhibit 9 is the medical records from Trinity Advocate Medical Center. The petitioner was admitted to Trinity Hospital emergency room on July 9, 2008, for constant and reproducible chest pain, non-radiating, with shortness of breath. It was indicated that Petitioner had no known allergies. Due to the emergency nature of the visit, the petitioner was given a complete evaluation and examination of respiratory functions. The indications were "breath sounds normal, no respiratory distress, and some tenderness present anteriorly in the left chest moderate in intensity with palpation of the chest producing symptoms." Advocate Trinity Hospital completed an EKG with interpretations. Radiological evaluations were completed and interpreted on July 10, 2008 as: chest x-ray was negative, no infiltrates, no pneumothorax, no hemothorax, no masses, and no cardiomyopathy. Petitioner's final diagnosis was that of chest pain, non-specific and she was discharged.

The petitioner returned to Dr. Turner on July 20, 2008, with the chief complaint being hypertension. Petitioner gave a history of having been seen at Trinity Hospital emergency room for chest pains and elevated blood pressure. An examination was conducted by the Dr. Turner on July 28, 2008. Petitioner was to return in two months. She was diagnosed with essential hypertension with blood pressure having improved, esophageal reflux and with TCE's disease.

Petitioner returned to Dr. Turner on August 8, 2008, the visit was made secondary to an emergency room visit. Petitioner was indicating that the emergency room visit was secondary to chest pain due to costochondritis. PX7.

On or about August 18, 2008, the records of Dr. Turner indicate that a telephone call was received from the petitioner telling him that she had mold in her office. On August 20, 2008, petitioner called the doctor indicating that she had a cough and sore throat. Dr. Turner's records indicate that on August 21, 2008, he received a report of x-ray from Mercy Hospital indicating that Petitioner's heart was normal in size and shape; the lung fields were clear and pulmonary vascularity was normal. Further, on August 21, 2008, Dr. Turner's records indicate that the petitioner was complaining of a cough, which she alleged had developed when she returned to work; and that she subsequently had chest pains with hoarseness. Petitioner's diagnosis as of August 21, 2008 remained hypertension benign; and acute bronchitis, with an assessment of a possible allergy.

On August 21, 2008, Petitioner returned to Mercy Hospital, at the request of Dr. Turner. The chest x-rays were complete and the clinical indication was a "potential exposure to mold according to the petitioner" in her history. The chest examination indicated that the cart was in normal size, the lung fields were clear, the pulmonary vascularity was normal; no abnormalities were seen and the study was reported as normal.

On August 26, 2008, Dr. Turner's records indicate that the petitioner called, requesting a statement for work. The memo in Dr. Turner's records indicates "pt needs a doctor statement for work she has been off starting today August 26, 2008 and states that you told her that you were not releasing her to work until she got better and therefore she needs a note stating that she will be off work until she is better than that she is under your care. The patient does not want to see Dr. Gruber anymore he is trying to say that her condition is psychological she mentioned she wants to see an infectious control doctor". PX7.

Dr. Turner's records further indicate that he received a report from Chicago Otolaryngology Associates, dated August 26, 2008. The otolaryngologist report indicated "voice quality fluctuates throughout the visit; normal larynx no nodules no tumors." The diagnosis was a conversion reaction and a second opinion was recommended.

On August 29, 2008, Petitioner returned to Dr. Turner who, at the request of the petitioner, prepared a statement indicating that she was being treated for laryngitis and that she had hoarseness, which limited her speech. She was further being evaluated for a possible hypersensitivity reaction to an environmental allergen; and she was to seek a follow-up appointment on September 4, 2008.

Dr. Beard's physical examination showed the petitioner in no acute distress, that her airway examination was remarkable for nasal congestion and erythema of the posterior larynx. The petitioner was experiencing frequent throat clearing. Examinations were conducted of the chest, lung, skin, abdominal area and all extremities; along with a neurological evaluation. All were unremarkable. Dr. Beard reviewed the chest x-ray completed on October 26, 2008 and found the results to be normal.

On October 31, 2008, Dr. Turner prepared a letter indicating that the petitioner was under his care for allergic rhinitis with a reactive airway disease which "may have resulted from exposure to mold at work." She was released to work half days but her symptoms returned along with some wheezing and possible change in a chest x-ray. She was sent to Dr. Glenn Beard, a pulmonary medicine specialist at Mercy Hospital; and Dr. Beard suggested that she work half-day schedules, effective November 17, 2008. Petitioner returned to Dr. Turner on November 6, 2008, continuing to complain of shortness of breath; additional diagnostic studies were recommended.

The petitioner has placed into evidence Exhibit 8, which contains the medical records and reports from Dr. Glenn Beard, one of the petitioner's treating physicians. Dr. Beard's records also contain certain records from Advocate Trinity Hospital. Dr. Beard's records indicate that diagnostic studies of the petitioner's lungs were completed on October 26, 2008. The petitioner had been examined on that day complaining of chest pain and shortness of breath. On August 29, 2008, Dr. Beard's records contain a statement from a Dr. Alan F. Turner indicating that the petitioner, Ms. Ewing, was under his care for severe laryngitis and dysphonia. As of August 29, 2008, petitioner was experiencing hoarseness and Dr. Turner indicated that "the petitioner was also being evaluated for a possible hypersensitivity reaction to an environmental allergen." Dr. Turner's notes state that the petitioner was to be seen again September 4, 2008.

Petitioner returned to Dr. Turner on September 9, 2008, September 24, 2008 and October 8, 2008. On October 21, 2008, Dr. Turner's records indicate that the petitioner called stating that she had returned to work on October 13, 2008; and her symptoms had returned therefore, she was asking for a referral to a new physician.

On October 26, 2008, Petitioner was readmitted to Trinity Hospital, again complaining of non-radiating chest pain, worse on palpation. The emergency records indicate that Petitioner was under the care of an ENT for vocal hoarseness for several months. Due to the emergency nature of the admission, Petitioner was again given a complete examination, which included respiratory and cardiovascular evaluations. Examination of the petitioner indicated that she had complaints of pain in her chest and a nonproductive cough. After completion of the examination, the petitioner's final diagnosis was bronchitis or possible pneumonia; or a reactive airway disease. Additionally, petitioner was diagnosed as having chest pain and a cough. The discharge diagnosis on October 26, 2008 was that of acute bronchitis, nonspecific chest pain, chest wall pain with a cough; and petitioner was advised to see her family physician for follow-up.

On October 31, 2008, the petitioner returned to Mercy Hospital for a further respiratory evaluation known as a spirometry, which was read as normal. The examination indicated that gas transfer had decreased, reflecting a loss of pulmonary capillary surface areas, which is seen in emphysema, interstitial lung disease, pulmonary vascular disease including pulmonary emboli and pulmonary

hypertension. The interpretation suggested that if asthma was clinically suspected, additional tests would be needed. PX10.

On November 7, 2008, Dr. Turner received a letter from Dr. Beard which indicates that Petitioner had a cough, hoarseness, dyspnea and vocal cord dysfunction. Dr. Beard recommended to Dr. Turner that the petitioner should have pulmonary function tests and speech therapy. Dr. Turner's records indicate that on November 11, 2008, a copy of the CT angiogram of the chest with and without contrast was received by his office.

On November 7, 2008 Dr. Beard's records indicate "in summary, Ms. Ewing has a cough, hoarseness in dyspnea (nonpersistent) she is felt to have a vocal cord dysfunction by ENT examination." Dr. Beard recommended pulmonary function studies and suggested potential speech therapy. In a second letter to Dr. Turner, he stated that the petitioner had returned for management of cough, hoarseness and chest pains. The petitioner reported that the cough had improved but her hoarseness was only slightly better. She was also complaining of dyspnea after walking approximately a half a block and she had had indications of wheezing, over the previous weekend. Dr. suggested that the petitioner have a spiral CT angiogram; pulmonary function studies revealed normal spirometry. He further indicated the petitioner had evidence of nasal polyps.

On November 8, 2008, the petitioner completed the CT angiogram of the chest, which was negative for PE within the central or segmental branches; and showed no radiographic evidence of interstitial lung disease. There was a mild cardiomegaly and borderline evidence of possible pulmonary hypertension, which needed clinical correlation. On November 19, 2008, Dr. Beard interpreted the spirometry tests and opined that they suggested mild, obstructive airway disease. Dr. Beard goes on to state "this represents an equal vocal response to methacholi, it could represent some degree of a bronchial hypersensitive hyper activity but clinical correlation was advised."

The petitioner returned to Mercy Hospital on November 11, 2008 and an examination was conducted regarding complaints of shortness of breath. The petitioner completed a CT angiogram of the chest with and without contrast. The results of the test indicated that there was no evidence of interceptal wall thickening, no honeycombing or interstitial fibrosis. The chest was examined and demonstrated no filling defects within the central or segmental branches of the pulmonary artery, to suggest a presence of pulmonary artery disease. The CT angiogram was negative for PE, within the central or segmental branches of the pulmonary artery, there was no radiographic evidence of anti-interstitial lung disease, there was a mild cardiomegaly and there were borderline evidence of pulmonary artery disease, which indicated a possible pulmonary hypertension, which needed to be clinically correlated.

On December 4, 2008, the petitioner returned to Dr. Turner, who noted that the cough had decreased significantly, and her voice is better. Dr. Turner further noted the petitioner denied any wheezing but has an occasional nocturnal cough. Respiratory evaluation demonstrated that the lungs were clear.

Cardiovascular examination was normal and petitioner's assessment indicated that her hypertension with blood pressure had improved. Petitioner was diagnosed with an acute laryngitis and allergic rhinitis, which the cause was unspecified. Petitioner was further diagnosed with a chronic cough and abdominal pain in the right upper quadrant, with a suspicion of gallstones.

On December 15, 2008, the petitioner presented at Mercy Hospital at the request of Drs. Beard and Turner, for the purpose of a cardiac Echo Doppler study. The provisional diagnosis was hypertension, a cough, and pulmonary hypertension. The cardiac Echo Doppler test was completed and reported normal.
On December 26, 2008, the petitioner again presented to Dr. Beard, complaining of cough and hoarseness. Dr. Beard notes that the petitioner was diagnosed with "vocal cord dysfunction." In summary, Dr. Beard stated that the petitioner had a cough with bronchial hyperactivity and vocal cord dysfunction: she was directed to a speech therapist.

On January 12, 2009, the petitioner returned to Mercy Hospital for a vocal cord evaluation secondary to vocal cord dysfunction. The examination of the petitioner, secondary to the admission for vocal cord dysfunction, also included a respiratory evaluation wherein the lungs were reported clear and the examination of the HEENT indicated no nasal congestion or arrhythmia. Petitioner was advised to continue with her vocal hygiene strategies; she was to continue monitoring any vocal cord abuses, she was advised to avoid environmental irritants; and she was discharged from further care regarding her speech therapy and vocal cord dysfunctions. PX8.

On January 30, 2009, the petitioner returned to Dr. Beard for bronchial hyperactivity and vocal cord dysfunction. Dr. Beard indicates that the petitioner's hoarseness was relative to the vocal cord dysfunction and that, since she took speech therapy classes, the voice had returned to normal and that the cough had decreased. Dr. Beard suggested the petitioner's cough had much improved, her medication for the cough had been reduced, and if further problems developed, she was to return to the doctor in approximately four weeks.

On March 6, 2009, the petitioner returned to Dr. Beard for management of a bronchial hyperactivity, cough, and vocal cord dysfunction. The petitioner was reporting occasional coughing at night and that her problems with her voice had resolved and she stated that she had shortness of breath on exertion. Dr. Beard opined that the petitioner had no acute distress. The HEENT examination was remarkable only for nasal congestion, the lymph nodes were normal, skin examination was normal, cardiovascular system, respiratory system, abdominal, and musculoskeletal examinations along with neuropsychiatric examinations were reported as normal.

On March 30, 2009, Dr. Turner authored a report indicating that the petitioner had been seen on March 18, 2009 for a follow-up evaluation and she was found to be much improved. Her voice was normal was physical examination was remarkable for normal breath sounds without wheezing, during

the course of the examination. Dr. Turner also noted that petitioner did not cough during examination with a final diagnosis; he determined that the petitioner was able to return to work in a full duty capacity, effective April 8, 2009.

On April 29, 2009, Petitioner returned to Dr. Turner, indicating that she had been released from her job and that she had experienced wheezing in the morning and nocturnal coughing. Examination was conducted, respiratory system was described as clear and normal; there was no wheezing with forced expiration. Her cardiovascular examination was normal, lymphatic system was normal, final diagnosis was essential hypertension benign extrinsic asthma, unspecified.

Dr. Turner's records further contain a report of May 9, 2009 for Dr. Beard. Dr. Beard's opinion was that Ms. Ewing had bronchial hyperactivity with a history of exposure to mold and dust. Since being removed from the setting, the symptoms had improved with medication. It was recommended that the petitioner maintain her current medication. "For the allergic rhinitis she should continue with over-the-counter Claritin." The vocal cord dysfunction had improved and it was recommended that petitioner should follow-up with Dr. Beard in approximately two months.

On May 9, 2009, the petitioner returned to Dr. Beard, complaining of shortness of breath after walking approximately five blocks. Patient also recorded that she had experienced some cardiovascular difficulties. She completed a stress electrocardiogram on May 6, 2009. Examination by Dr. Beard on May 9, 2009 was unremarkable. Dr. Beard suggested the petitioner had bronchial hyperactivity, he stated that the petitioner had given him and a history of being exposed to mold and dust, in that after being removed from the environment, those symptoms had improved. Dr. Beard states "possibly the mold triggered and irritated of response without any antibody productions." Dr. Beard further states that the vocal cord dysfunction had improved and suggested the petitioner should return in approximately eight weeks.

On May 9, 2009, the petitioner returned to the emergency room of Mercy Hospital and was admitted complaining of chest pain. Petitioner was evaluated for potential myocardial ischemia and to evaluate and assess cardiac rhythm and arrhythmia and to assess cardiac rhythm in response to exercise. An examination of the cardio system indicated that the echocardiographic studies were normal and petitioner was discharged for the alleged cardiac issues and returned to her treating physician.

On June 3, 2009, petitioner returned to Dr. Beard, who evaluated her complaints of coughing, which had resumed approximately three weeks previously. She also complained of wheezing. Petitioner indicated she had nocturnal coughs with hoarseness. Petitioner's assessment by Dr. Turner was essentially unchanged. i.e., essential hypertension, benign extrinsic asthma, unspecified voice disturbance mildly exacerbated, with shortness of breath. Dr. Turner noted the stress test, which was conducted, was normal and cardiac ideology was therefore, ruled out.

On July 13, 2009, the petitioner again presented to Mercy Hospital indicating that she was having difficulty breathing. Petitioner was evaluated for all systems due to the emergency nature of the visit. Petitioner was again provided with written and oral instructions regarding conditions of bronchitis and asthma.

On July 22, 2009, the petitioner returned to Dr. Turner complaining of shortness of breath and coughing, which was producing white sputum. Petitioner indicated that she was using her medication. An examination was conducted which findings were essentially unchanged. Petitioner was diagnosed again with essential hypertension, benign extrinsic asthma, unspecified.

On August 5, 2009, Petitioner returned to Dr. Turner for an evaluation of hypertension and asthma. Petitioner stated that she had an increase in coughing, which was worse during the day but at night she had wheezing. An examination was completed with a diagnosis of essential hypertension, benign extrinsic asthma, unspecified; and a cough which was secondary to airway inflammation, for which petitioner received a prescription for medication.

The medical records from the University of Illinois Medical Center indicate that the petitioner's first visit to the facility was on September 9, 2009. Petitioner was complaining of a cough, with occasional wheezing and that the cough developed when she had gone into "some buildings." Evaluations were completed: the lungs were described as clear, there was no wheezing, or forced expiration. Cardiovascular examination was normal and the diagnosis was asthma.

On October 21, 2009, the petitioner returned with the same complaints and the diagnosis was possible reactive airway disease. PX11.

On November 2, 2009 petitioner returned to the clinic stating that "she was exposed to some mold at work which she feels caused her to feel some along pain and pressure." Petitioner was complaining of shortness of breath and chest tightness. The doctor's impression upon discharge, was that the petitioner was exhibiting moderate to severe asthma.

On November 10, 2009, the petitioner returned to Mercy Hospital with what was described as asthma, which was being controlled with medication. On page 2 of 10 of the admission of November 10, 2009, following an allergy sensitivity evaluation, it is noted as follows: "her mold IGES and IGS were all negative her HSP panel was negative with the exception of pigeon droppings which tend to be a false positive in a city population skin testing done with good controls were all negative -2 Al Turner a LTE."
On December 23, 2009, the petitioner returned to Mercy Hospital for additional radiological studies. Petitioner was admitted for right upper quadrant rib pain, which the petitioner thought was due to coughing and had recently been aggravated by certain allergies. X-ray evaluations were conducted;

the rib films were described as normal. There was no evidence of any rib fractures or deformity, but there was evidence of a surgical clip in the right upper quadrant of the lung.

On January 25 of 2010, the petitioner again returned to Trinity Hospital, stating that she was having difficulty breathing with a burning sensation in the left side of the chest. Petitioner alleged that her condition was caused by a mold exposure at work, approximately one year previous. Examination of the petitioner indicated that her respiratory rate was normal, she was comfortable and she was alert, all vital signs were reviewed and found to be normal. Respiratory evaluation was completed the chest was described as non-tender, breath sounds were normal, there was no respiratory distress, and the patient was described as "moving air well." Cardiovascular examinations were reported as normal; the discharge diagnosis was that the petitioner was suffering from an acute asthma exacerbation.

On February 2, 2010, the petitioner was admitted to Mercy Hospital for additional studies. On page 2 of 8 in the admission of February 2, 2010, again is indicated that the mold studies for sensitivity were normal, the HSP panel was negative with the exception of pigeon droppings which was considered previously to be a false positive.

Petitioner returned on February 3, 2010, with complaints of a cough. Petitioner indicated that she had seen an allergist who started her on prednisone and that she had gone to Trinity Hospital for emergency visit, due to shortness of breath.

On March 1, 2010, Petitioner returned complaining of a recurrent cough. Examination was conducted and medications were evaluated. Petitioner's health status was checked and allergic reactions were indicated as no known allergy. Petitioner's medications were continued and she returned on March 15, 2010 complaining of a cough of "sudden onset."

On April 16, 2010, Petitioner was diagnosed as having a cough, asthma, unspecified; benign essential hypertension; nonspecific abnormal findings on radiological examinations. Petitioner then returned to the clinic on June 16, 2010 and on July 19, 2010. On July 19, 2010, petitioner's history was that of a 41-year-old woman with history of cough and asthma, with a previous follow-up at a pulmonary clinic by Dr. Hong. Petitioner reports that since March 2010 the cough was much better. Her exercise tolerance had improved; she was able to walk approximately eight blocks before developing shortness of breath. Petitioner indicated that her symptoms became somewhat increased over the past few weeks, when the weather became hot and humid. Petitioner indicated that she had one nocturnal event of coughing in the past month and petitioner indicated that overall she felt well at the present time. Petitioner was given a thorough evaluation on July 19, 2010. The final impression was that of a chronic cough, asthma, and chronic rhinitis or sinusitis.

When Petitioner returned on October 25, 2010, she reported she had been doing well but had had certain symptoms after running out of her medication. Petitioner complained of burning in her chest

and a nonproductive cough. She indicated that she experienced shortness of breath after walking approximately one-half block. Provisional and final diagnosis was asthma. Petitioner returned on October 28, 2010, with essentially the same complaints and findings.

On November 23, 2010, Petitioner returned to the clinic, complaining of low back pain, radiating into the left lower extremity; and indicating she had been rear-ended in a motor vehicle accident. An examination was conducted and her lungs were described as clear, breath sounds were described as equal. Petitioner was described as having some tenderness in the lumbar spine and a cough. She indicated she saw an allergist who was performing tests to determine if she in fact, had asthma.

On January 31, 2011, petitioner returned with complaints of "coughing asthma." Petitioner indicated that she had an intermittent cough, shortness of breath and burning in her chest because of the cold weather. Petitioner indicated that her voice was occasionally hoarse and the symptoms were controlled with medications. Upon examination, the petitioner was described as in no apparent distress. HEENT examinations demonstrated no sinus tenderness or nasal congestion. The cardiovascular examination was normal, pulmonary examination showed no wheezing and no forced expiration. She was again diagnosis as having chronic cough, asthma; and a chronic rhinitis or sinusitis.

On February 17, 2011, petitioner called the clinic to report to Dr. Dudek that she was having breathing difficulties. On February 18, 2011, the petitioner returned complaining of coughing, tightness in her chest and wheezing and shortness of breath for seven days. Examination was essentially normal, except for Petitioner's subjective complaints; the diagnosis remained the same. Petitioner returned on March 14, 2011 with the history of a cough and asthma would be finally seen on January 31, 2011. On the March 14, 2011, Dr. Dudek states "of note she reportedly was not wheezing on examination at the time of the visit." Medications for the asthma were maintained as the laboratory studies for the office visit of March 14, 2011 confirmed that the petitioner tested positive for asthma. Petitioner was to continue her medication; and a secondary diagnosis was chronic rhinitis and sinusitis for which she was given an over-the-counter medication.

Dr. Dudek went on to perform a complete evaluation of the petitioner as he had done previously. The diagnosis was asthma, chronic cough, and chronic rhinitis and sinusitis. Under social history, Dr. Dudek said that the petitioner alleges that she was exposed to mold in 2008, while working and believes that all the problems began after the exposure. Examination was conducted and the pulmonary valuation showed no wheezing, clear lungs, and there was no coughing noted during the entire visit. Dr. Dudek performed a record review of the pulmonary valuation, which also suggested that the petitioner suffered from some sort of allergic rhinitis cough and hoarseness, bronchial hyperactivity; and vocal cord dysfunction.

On June 6, 2011, petitioner was seen for swelling in her ankles secondary to blood pressure issues. Petitioner was also seen for her coughing, which she alleged worsened with exertion.
On July 2, 2011, Dr. Dudek describes the petitioner as returning with relatively stable symptoms; she has coughing spells throughout the day without triggering the cough, which is now associated with a sharp, left-sided chest pain, accompanied by chest tightness and shortness of breath. The petitioner was complaining that the current therapy was insufficient to control her symptoms and that her cough had not been adequately determined or explained to her.

In his evaluation dated July 18, 2011 Dr. Dudek says that the petitioner's cough remains a primary clinical complaint. Dr. Dudek goes on to state:

> The etiology of the cough may be multi-factorial, with possibilities including airway hyperactivity/asthma abnormal vocal cord function, upper airway cough syndrome, or GERD. It is notable that she is not wheezing on examination today or on recent visit and that are past (methylcloreline) challenge test was equivocal for hyperactivity.

It was recommended that the petitioner complete a full PFT evaluation chest CT scan. Dr. Dudek noted that past imaging studies including the recent CX test, did not suggest any abnormalities.

Dr. Dudek suggested that the petitioner would then be referred to an allergist for further evaluation of possible triggers. Dr. Dudek goes on to state at page 7 of 8 on the July 2011 evaluation that "the symptoms could be consistent with asthma. However the review of her prior outside records demonstrates equivocal testing for obstruction and methylcloreline sensitivity."

Dr. Dudek goes on to state that:

> the patient has asked me in the past to make assessments about the cause of her symptoms, specifically whether or not they have been caused by her occupational exposure in 2008. It is well documented that brief, intense exposures to airway irritants can result in a prolonged sometimes lifelong airway hyperactivity in some patients known as reactive airway syndrome (RADS) or an irritant induced asthma. However, it is not possible, in this case, for me to determine if the patient's persistent symptoms (described above) are definitely related to her past occupational exposure. Since mold is suspected as a possible trigger she will be referred for an additional evaluation by an allergist to address the issue. For now we will continue her medications.

Dr. Dudek goes on to note, in the July 2011 appointment, that the petitioner has a chronic rhinitis and sinusitis, which are well-controlled.

On July 26, 2011 petitioner completed the CT study of the chest, which was read as negative except for findings regarding the pancreas.

On August 1, 2011 the petitioner completed additional diagnostic studies which were reported as normal. On August 4, 2011 the petitioner completed an MRI of the abdomen for issues regarding the pancreas. On August 9, 2011 petitioner returned to the clinic and was seen by two pulmonologists. She had with CT scans of the chest and PFT studies, without improvement. "She does not have any triggers for her cough. She wakes up twice nightly, to use her inhaler she has very little wheezing." The August 9, 2011 report goes on to state "not working in the same place and not exposed to mold anymore."
Petitioner returned to the clinic on September 7, and September 21, 2011. On September 21, 2011, she came in for follow-up for chronic cough and rhinitis which she alleges started when she was exposed to mold at work. It is noted that petitioner had a "chronic cough and possible cough variant asthma; possible rhinitis, GERD may be a factor as suggested VCD needs to be ruled out. As she is not exposed to mold any more, exposure to the mole in 2008 will not be a trigger at this time. I will do an arrow allergen intradermal skin test next week. She is already on anti-inflammatory medications and will continue with her present medications. She will not use the antihistamines for one week prior to the skin test and I will see her after the test is done."

On October 28, 2011, the petitioner presented to the emergency room at Advocate Hospital, giving a history of an onset of coughing approximately seven days previously. An examination of the petitioner was completed showing the neurological, cardiovascular and musculoskeletal evaluations as normal. The diagnosis was "bronchitis, upper respiratory infection, asthma, or pneumonia." Petitioner's medications were reviewed and she was directed to return to her family doctor for further follow-up care.

The medical records from the University of Illinois Hospital and Health System contain an entry of June 12, 2014, where petitioner had completed a CT of the chest without contrast. The CT was compared to a study of May 24, 2013. The impression was petitioner had a stable, right lobe scarring, unchanged and no evidence of new consolidation effusion or pulmonary mass. PX12.

On June 18, 2013, Dr. Dudek reviewed the petitioner's study and concluded that the petitioner was a 44-year-old female with a history of recalcitrant chronic cough, HTN and possible asthma, who came in for a bronchoscopy. Following review of the study, Dr. Dudek concludes that the petitioner's preliminary diagnosis was asthma, chronic cough, HTN, chronic rhinitis.

Examination and report from Dr. Orris

On page 228 of the 1233 pages of material, there is a report from the University of Illinois Hospital of a consultation by Dr. Peter Orris, who is a professor of occupational and environmental medicine. Dr.

He took a history from the petitioner as well as reviewed all medical records and data which were available. Dr. Orris' report is dated April 26, 2013 and he concludes that Petitioner was in no acute distress although her voice was found to be raspy and hoarse. Examination of her lungs was clear with bilateral vesicular breath sounds, no wheezing and good air movement. She was observed to have a severe dry cough when walking from the waiting room to the examining room, but after sitting down her cough resolved. Cardiovascular examination was normal. PX12.

Dr. Orris goes on to state that he had reviewed the reports from the studies conducted at the site of the petitioner's employment. Dr. Orris concluded that the petitioner was 44-year-old woman with no history of any allergies or asthma and develops shortness of breath, bronchial spasm symptoms after exposure in her office to air-conditioning condensation and mold. He states that the symptoms persisted since she was terminated from her job and have continued to worsen. Dr. Orris states the petitioner had been tested for mold allergy in skin tests and all were found to be negative. The report from the industrial hygienist to assess the building indicates that mold in the air in her office at significantly higher levels than other areas. In addition, significant overgrowth of mold, secondary to water damage was noted above the false ceiling in the office area.

Dr. Orris goes on to say that the petitioner's presentation was not fully consistent with any single diagnosis. Specifically, the hyper-expanded lung, with prominence of the pulmonary vascular and small bilateral pleural effusion; as well as mild scarring on the right lobe, is not fully explained solely by disease due to an allergic or irritant mechanism. There were a number of specific diagnoses perhaps in combination that could account for this picture and that the specific diagnosis may become obvious if a more invasive diagnostic test was performed.

As a separate issue, Dr. Orris opined that the contribution of Petitioner's workplace to her current condition could be answered to a reasonable degree of medical certainty based upon her history and clinical presentation. It is likely that her exposure to high levels of fungus in the workplace contributed to an obstructive bronchospasm disease. He further opined that more information was needed to say whether or not this effect is stable or progressive and specifically to understand the continuing cough that Petitioner suffers. He concluded that if the clinical picture justified it and the treating physician believed, it is needed, he would suggest a laryngoscope, a vocal cord study and a transfer bronchial biopsy, in addition to testing which would help further define the contribution of the workplace to her condition. There was no evidence admitted showing that these diagnostic tests were performed. PX12.

Petitioner introduced Exhibit 4(b), part of which was admitted into evidence, i.e. a search by the Chicago Department of Environment (CDOE), pursuant to the Freedom of Information Act, of the building in which she worked during her exposure to mold. The petitioner testified that she worked for Respondent from February 9, 2000 to approximately April 9, 2009. The Arbitrator finds that in the reports relevant to this time period, i.e., 11/7/2008, the inspector "did not notice anything unusual

during today (sic) inspection". The Arbitrator further notes that these records are for a company titled Superior Graphite Company and there was no testimony regarding how this company is related to the Respondent, Roadlink Transportation.

Petitioner also admitted into evidence reports from two different vendors that performed inspections at her work place regarding the mold issues, i.e., Hygieneering Inc. ("Hygieneering") and Mold Solutions. A report was generated dated September 12, 2008. Mold had been discovered in Petitioner's office, apparently resulting from a leaking air conditioner. The leak had been repaired, the office was cleaned with a HEPA vacuum, tiles had been cleaned with bleach however, had not been replaced. "According to the Mold Solution's report dated July 30, 2008, they conducted particle count measurements in Ms. Ewing's' office and surrounding areas. Particle counts of 0.3 um particles ranged between approximately 70K-100K in the office areas tested. Tests were also performed above the ceiling where particle count of 0.3 um particles ranged between approximately 140K-150K. They presume that the higher level in 0.3 um particles above the ceiling may be due to mold growth on the ceiling site. No specific tests for airborne mold spores were taken to verify their assumption. In their report they also state that Apex Research verified the presence of mold, however, no additional details about the sampling location including approximate area of mold growth, chain of custody, or lab data is included in their report. Hygieneering was engaged to assist in assessing the current conditions in Mrs. Ewing's office."

The results of the air sampling were read to show that "the airborne mold spores sampling data collected does not indicate an elevated level of airborne mold spores in Mrs. Ewing's office compared to the outside sample, based on the limited sampling conducted." "The total count indoors ranged between 39 to 750 spores per cubic meter of air....significantly lower than the outside levels of 13,000. Additionally, there was no significant difference in the biodiversity of the indoor samples compared to the outdoor sample." This company concluded that "there were no water/moisture affected building materials identified in Mrs. Ewing's office by visual inspection, thermal imagining camera and moisture meter measurements"; and that no further work needed to be performed in the petitioner office. PX8, pp. 1-4.

CONCLUSIONS OF LAW

B. Did an accident occur that arose out of or in the course of Petitioner's employment by Respondent?

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require

that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

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

The petitioner brings this action pursuant to 820 ILCS 310, the Occupational Disease Section of the Illinois Workers' Compensation Act (the "Act"). The Arbitrator finds that this matter should be brought pursuant to 820 ILCS 305, under the Illinois Workers' Compensation Act. The Arbitrator notes that the petitioner's theory of recovery is that, while in her workplace environment, she was exposed to mold, resulting in the development of chronic, respiratory illness; including but not limited to asthma. It is her theory that the mold exposure was the single causative factor in the development of current respiratory conditions, as well as other medical difficulties. The Arbitrator notes that there was a physical finding of mold in her office, which she was obviously exposed to. The petitioner's testimony and reports from the two environmental companies prove that she was exposed to mold spores. Therefore the Arbitrator concludes that the petitioner has proven, by a preponderance of the evidence, that an accident occurred, which arose out of and in the course of her employment by Respondent.

F. Is Petitioner's current condition of ill-being causally related to the injury?
A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim.

Illinois Institute of Technology v. Industrial Commission, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The Arbitrator references the report of Dr. Orris in petitioner's exhibit 12 starting at page 228. Dr. Orris states that he had reviewed the environmental studies of the area in which the petitioner was working, and he felt that the level of mold may have been a causative factor in the petitioner's breathing difficulties, which she experienced at that time. In addition, further more invasive testing would have to be performed to determine if the mold exposure was the proximate cause of petitioner current respiratory conditions. This testing was not done. Dr. Orris also states that he has reviewed the petitioner's test results which were administered to determine whether or not the she had an allergy to mold. Dr. Orris states that the petitioner's test results were negative. Additionally, the petitioner has been diagnosed with sinusitis, coughing, rhinitis and asthma. No medical evidence has been produced to support that any of these conditions were related to the work environment.

The petitioner's medical records demonstrate a continuous complaint and diagnosis by all treating physicians that the petitioner does have a form of an allergic sinusitis and rhinitis, however, no doctor has expressed an opinion as to what the petitioner is allergic to and what the triggering mechanism is. As stated previously in this decision, the petitioner has tested negative for mold allergies. Additionally, and significantly, the petitioner has not worked in her original workplace since April 2009, and between April 2009 and the present, she has consistently and regularly reported to her doctors, coughing spells and breathing difficulties related to the rhinitis and sinusitis. The petitioner testified that cold and hot weather and dusty environments are irritants since she left the respondent's place of employment.

The petitioner has tested for asthma and positively diagnosed. However, there is no medical evidence to indicate that this condition was either caused or aggravated by the petitioner's employment environment. Again, the Arbitrator calls attention to the report of Dr. Orris, who suggested that the workplace environment might have been a causative factor in the initial onset of symptomatology, and yet, the petitioner subsequently tested negative for sensitivity to mold.

The Arbitrator, therefore, finds that the petitioner has failed to prove any causal relationship between the exposure to mold and the present condition of ill-being as the petitioner testified before the arbitrator. Between 2009 and 2014 the petitioner has repeatedly been seen by experts who have failed to produce a medical report which definitively states that petitioner's current condition of ill-being of having asthma, rhinitis, sinusitis, vocal cord dysfunction or shortness of breath, is the result of the initial exposure to mold spores, on July 9, 2008.

The Arbitrator turns to petitioner's Exhibit 11 and 12, which are the reports from Dr. Dudek and the University of Illinois Hospital. On July 2, 2012, Dr. Dudek, in petitioner's Exhibit 11, authors a very detailed report regarding the petitioner's diagnosis and then current condition of ill-being. In the conclusion, Dr. Dudek states that the petitioner's cough remains the primary clinical complaint and he goes on to state "the etiology of the cough may be ..... airway hyperactivity, asthma, abnormal vocal cord functions, upper airway cough syndrome or GERD. It is notable that she is not wheezing on examination today or on any recent visits and has passed the methylchloroline challenge test which was equally vocal for hyper activity." Dr. Dudek goes on to state the petitioner "has asked me in the past to make assessments about her cause of symptoms, specifically, whether or not they have been caused by her occupational exposure into 2008. It is well documented that brief intense exposures to airway irritants can result in a prolonged sometimes lifelong airway hyperactivity in some patients known as reactive airway syndrome (RADS) or an irritant induced asthma. However, it is not possible in this case for me to determine if the patient's persistent symptoms described above are definitely related to her past occupational exposure since mold is suspected as a possible trigger she will be referred to an additional evaluation by an allergist to address the issue for and for now we will continue her medications." Following this evaluation, Dr. Dudek performed test to determine if Petitioner's condition was related to the exposure to mold. She completed mold allergy evaluations; and they were negative for sensitivity to mold.

Accordingly, the petitioner has failed to prove, by a preponderance of the evidence, that her current condition of ill-being is causally related to the accident, therefore an award of benefits is denied, pursuant to the Act. As causal connection has not been proven, the remaining issues are moot and will not be addressed.

17IWCC0663

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
08WC54162
SIGNATURE PAGE

Signature of Arbitrator

September 29, 2015
Date of Decision

SEP 29 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL S. HABERMAN,

Petitioner,

vs.

NO: 15 WC 01279

MIDSTATES CORP.,

17IWCC0664

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 accident, causal connection, medical expenses, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies in part and affirms in part the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission hereby modifies the Arbitrator's Decision relative only to the nature and extent of Petitioner's right shoulder condition. The Commission finds the Petitioner to be permanently partially disabled to the extent of 7.5% loss of use of the body as a whole, and otherwise affirms and adopts the remainder of the Arbitrator's Decision.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings, and arguments submitted by the parties.

The Arbitrator considered the factors in Section 8.1(b) of the Act to determine the nature and extent of Petitioner's condition, and the Commission relies upon same. The Commission, however, disagrees with the weight the Arbitrator placed on the evidence of Petitioner's disability, and believes that additional PPD is required.

The Arbitrator awarded Petitioner 5% loss of use of the body as a whole pursuant to Section 8(d)2 of the Act. The Arbitrator noted that the nature of Petitioner's injury was a Grade 2 AC separation with impingement.

In consideration of the five factors listed under Section 8.1(b) of the Act, the Commission finds:

(i) Impairment Rating: No weight should be given to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: Petitioner testified that on the date of accident, he worked as an operating engineer for Respondent. (T.9). Petitioner's duties involved operating heavy equipment. (T.11). The Arbitrator indicated that Petitioner "was able to return to work full duty," but there is no such indication in the record. While Petitioner did return to work, he had been released to work with restrictions.

(iii) Petitioner's Age: Petitioner was 45 years old on the accident date. The Arbitrator noted that Petitioner's relatively young age favored his position.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, no weight should be given to this factor.

(v) Evidence of Disability: Petitioner underwent arthroscopic subacromial decompression with partial resection of the distal clavicle on April 2, 2015. (PX1, pg. 15; PX2). When Dr. Michael Watson released Petitioner to work on August 26, 2015, he noted that Petitioner had a normal exam despite having mild discomfort with overhead lifting and crepitation. (T.25-26; PX1, pgs. 17-18; PX2). At arbitration, Petitioner testified consistent to what he reported to Dr. Watson, and also stated he had a loss of strength, and could not sleep on his right side. Petitioner stated he is able to work but is achy. His right arm is his dominant arm. (T.35-36).

Based on the totality of the evidence, the Commission finds an award of 7.5% loss of use of the body as a whole more appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed November 18, 2016, is hereby modified as stated above, and otherwise affirmed and adopted.

17IWCC0664

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 3, and as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $909.33 per week for 33 1/7 weeks, commencing January 7, 2015 through August 26, 2015, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $735.37 per week for a period of 37.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 7.5% loss of use of the body as a whole. Respondent shall be given credit for the sum of $2,442.92 which was previously paid to Petitioner as PPD advancement.

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 $55,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 20 2017

MJB/pm
O: 9-18-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HABERMAN, MICHAEL S
Employee/Petitioner

Case# **15WC001279**

17IWCC0664

MODSTATES CORP
Employer/Respondent

On 11/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5757 MARTIN J HAXEL PC
310 E ADAMS ST
SPRINGFIELD, IL 62701

0265 HEYL ROYSTER
DANIEL SIMMONS
PO BOX 9678
SPRINGFIELD, IL 62791-9678

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael S. Haberman
Employee/Petitioner

v.

Midstates Corp.
Employer/Respondent

Case # **15** WC **1279**

Consolidated cases: _____

17IWCC0664

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **10/27/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/1/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70928.00**; the average weekly wage was $**1364.00**.

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

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

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $**2442.92** for other benefits, for a total credit of $**2442.92**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, as identified in Petitioner's Exhibit 3, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

Respondent shall pay petitioner temporary total disability benefits of $909.33 per week for 33 1/7 weeks commencing January 7, 2015, through August 26, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $735.37 per week for 25 weeks because the injury sustained caused the 5% loss of use of the body as a whole as provided in Section 8(d)2 of the Act. Respondent shall be given credit for the sum of $2442.92 which was previously paid to Petitioner as a PPD advancement.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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. Dyas McCarty

Signature of Arbitrator

11-11-2016
Date

NOV 18 2016

ACCIDENT

With regard to L, did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner testified that on December 1, 2014 he was employed by the Respondent as a heavy equipment operator working in Blue Mound, Illinois where a new school was being constructed. He needed to put oil into the backhoe he had been operating. He walked into a tool trailer and found the floor of this trailer covered with tools, buckets, supplies and other items that had been thrown onto the floor. Petitioner described having to walk carefully the entire length of this trailer that was approximately 12-14 feet long. The 5-gallon bucket of oil was located up against the front wall of the trailer. Petitioner further testified that he could not put his feet onto the floor of the trailer near this bucket of oil and his feet were spread apart because of all of the objects thrown onto the floor. Petitioner leaned forward and grabbed the bucket of oil with his right hand. Petitioner estimated this bucket of oil weighed approximately 45-50 pounds. Then, with his left arm, he pushed off the front wall of the trailer and at the same time he lifted the bucket of oil with his right hand and tried to straighten up when the top of his right shoulder struck a shelf on the sidewall of the trailer. Petitioner felt a sharp pain in his right shoulder and dropped the bucket of oil. After a few minutes, he carried the oil out of the trailer with his left arm and put oil into the backhoe, also using his left arm.

None of the other workers were around when this happened because they were all working on concrete that was being poured. Petitioner's immediate supervisor was someone named Oscar who was not there at the time of the accident but had told the Petitioner earlier that day that it might be another week or two before they would come back to finish that particular job.

Petitioner worked through the end of the day and at the end of that day another foreman gave him a check and said that it was the end of that job. Petitioner still thought he would be called back in another week or two consistent with what Oscar had told him earlier that day.

The parties stipulated that Petitioner gave notice of his injury in compliance with the provisions of the Act but notice was not provided until more than a month later, after Petitioner saw Dr. Watson. Petitioner explained that he did not provide notice sooner for a number of reasons. First, the pain did subside somewhat as the day wore on and Petitioner hoped it was something that would eventually go away. Also, the notes from Dr. Watson's initial exam of January 7, 2015 show an individual with pain but not a disabling condition. He had diagnostic testing results consistent with an AC joint injury but he still had normal strength and a full range of motion. He did not have evidence of a full tear of the rotator cuff which, if it were present, would have more likely caused him to seek treatment earlier. Dr. Watson said that not seeking immediate treatment was unusual with the type of injury the Petitioner had, but something he had seen before in his practice. (PX 1 at 27) Secondly, Petitioner had just returned to work a few months earlier after undergoing surgery on his other shoulder and really did not want to go

through all of that again. And, Oscar, Petitioner's immediate supervisor, was not there on the date of the accident and Petitioner thought he would see Oscar again in another week or two.

Petitioner's testimony concerning the accident itself is corroborated by several exhibits admitted into evidence. RX2 and PX4 are the same hand-written note Petitioner prepared on January 7, 2015 describing the accident. Petitioner first sought medical treatment from Dr. Watson and the history of the accident Petitioner gave to the doctor is consistent with this testimony (see first page of PX2). When Petitioner was sent to Dr. Johnson for a Section 12 examination the description of the accident Petitioner gave to Dr. Johnson is consistent with this testimony (RX5, pages 8 and 9). At trial Petitioner looked at the photographs of wooden shelves containcd in RX1. He did not know if these photographs were of the same trailer in which he injured himself but he did say that the wooden shelves looked similar. PX 5 consist of Dr. Watson's records for his treatment of Petitioners' left (opposite) shoulder surgery which occurred on April 17, 2014 and resulted in Petitioner's return to work on July 22, 2014. PX 6 consists of the IME reports for Petitioner's left (opposite) shoulder where the doctor opined that Petitioner's work injury did injure his left shoulder and the physical examination was consistent with the mechanism of the injury.

Respondent argues that there was an inconsistency between the Petitioner's description of the accident at trial and what he told his providers. The medical histories contain a reference to the Petitioner falling forward after picking up the oil can, and then pushing himself back up with his left arm before striking his right shoulder on the shelf. At trial, the Petitioner said that he pushed back off the wall with his left arm and struck his right shoulder. The Arbitrator finds this variance insignificant. Petitioner testified that when he lifted the oil can he was leaning forward. On cross exam, he said he was standing on his toes before pushing away with his left arm. The fact is that he was initially leaning forward to lift a heavy can of oil before pushing back and striking his shoulder, and none of his histories are inconsistent with that mechanism.

Respondent also argues the Petitioner was not credible because of the examination findings notes by Dr. Johnson during his Section 12 exam on February 18, 2015. Dr. Johnson said that the Petitioner's pain responses during the exam were inconsistent and exaggerated. He said that the Petitioner also displayed pain behaviors inconsistent with his injury. While that all certainly could have been true, the Arbitrator is more persuaded by the consistent objective findings of an AC joint injury seen by Dr. Watson during his examinations done around the same time as Dr. Johnson's. The MRI of January 22 showed a partial joint separation and tendinopathy of the rotator cuff consistent with a partial tear. Dr. Watson found positive Hawkins and crossover signs indicative of an AC injury present on all of his examinations between January 7 and March 18. Finally, Dr. Watson testified that his surgical findings were consistent with an impingement syndrome. (PX 1 at 18)

Petitioner's testimony is credible and corroborated by much of the other evidence presented at trial. The description of the accident is consistent from the very beginning through trial. The Arbitrator concludes that Petitioner did sustain an accidental injury arising out of and in the course of his employment with the Respondent on December 1, 2014.

CAUSAL CONNECTION

With regard to F, is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner testified that he really did nothing after injuring his shoulder. Petitioner denied re-injuring the shoulder at any time after the date of the accident. After waiting a few weeks and still having pain in the shoulder he made an appointment to see Dr. Watson who saw Petitioner on January 7, 2015 (PX2). Dr. Watson testified for Petitioner and opined that, in the absence of any prior problems with the right shoulder, there is a causal connection between the work injury and the medical treatment received including the surgery. Dr. Watson further testified that his physical findings pertaining to Petitioner's right shoulder are consistent with the injury described by the Petitioner who has always been truthful with the doctor in the past. Dr. Watson also testified that he has no reason to think Petitioner had not been truthful and the doctor did not detect any signs of symptom magnification (PX1, pages 19-22). Dr. Watson's operative report states that Petitioner's post-operative diagnosis was chronic impingement syndrome with osteoarthritis of the AC joint (PX 2).

The Respondent relies upon the opinion of its Section 12 examiner, Dr. Johnson, to dispute causal connection. Dr. Johnson examined petitioner on February 18, 2015. Dr. Johnson opined that Petitioner's physical examination was inconsistent, indicated symptom magnification and that the mechanism of the accident was insufficient to cause a Grade II shoulder separation which was the diagnosis arrived at by Dr. Watson on January 7, 2015 (RX5, pages 13-16; PX 2, office visit of January 7, 2015).

On cross-examination Dr. Johnson admitted that his examination of the Petitioner revealed a mildly positive O'Brien's test which could be an indication of AC joint problems. Dr. Johnson also testified that Petitioner has a Type II acromion which means that Petitioner has an increased chance of developing impingement syndrome (RX5, pages 19-21). Dr. Johnson also admitted that Petitioner had degenerative changes in the AC joint and also in his distal clavicle which could also be consistent with impingement syndrome (RX 5, page 25). Dr. Johnson also testified that the existence of an osteophyte on the under surface of the clavicle could contribute to impingement syndrome (RX5, p. 24).

Dr. Watson's operative report indicated the existence of a large osteophyte on the undersurface of the Petitioner's distal clavicle which was removed during surgery (PX 2).

Butch Cooper testified for the Petitioner. He is an acquaintance of the Petitioner who was hired to pour concrete for a house that Petitioner was going to build. Cooper testified that he began this job in late January 2015 and finished up some time in February 2015. He was able to pour concrete because the weather was unusually warm. Cooper estimated that he was at the job site on 10 different days. Cooper testified that the Petitioner told him he had hurt his shoulder and would not be able to help. Cooper never saw Petitioner do any work, lift anything or do

anything physically strenuous when he was at the job site on those approximately 10 different days.

The Arbitrator concludes that Petitioner's current condition of ill-being is causally connected to the work accident. First of all, there is no evidence to refute causal connection other than the testimony of Dr. Johnson who had to admit that his examination of the petitioner revealed AC joint tenderness, a positive O'Brien's test and degenerative changes of the AC joint and of the distal clavicle, all of which would be consistent with impingement syndrome, Petitioner's final diagnosis after surgery was performed. Dr. Johnson also admitted that petitioner had a Type II acromion which made him more susceptible to suffer from impingement syndrome.

The Arbitrator also notes that there was the presence of an ostcophyte underneath Petitioner's clavicle which was removed during surgery, something else Dr. Johnson admitted could be associated with impingement syndrome.

There is no evidence that Petitioner's right shoulder was painful or symptomatic prior to the work accident. Dr. Watson's treatment was reasonable especially the decision to undergo surgery since Petitioner had undergone the same surgery on the opposite shoulder in 2014. Dr. Watson's opinions are more persuasive, supported by the great weight of the evidence and those opinions are adopted by the Arbitrator.

MEDICAL TREATMENT

With regard to J, were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following findings of fact and conclusions of law:

Please see the Arbitrator's findings of fact and conclusions of law with regard to causal connection, above.

PX 3 consists of Petitioner's medical bills. Petitioner identified these bills at trial and indicated that all of them were related to the medical treatment received for his right shoulder injury. A review of the bills shows that they are, in fact all related to medical treatment for Petitioner's right shoulder with the first date of treatment being January 7, 2015 which is the first time petitioner sought any medical treatment at all and is the date he first saw Dr. Watson.

One document in PX 3 is not actually a bill but an explanation of benefits from the Operating Engineers # 965 Health Benefit Plan. It shows that the Plan paid nothing for the administration of anesthesia on April 2, 2015 which is the date of Petitioner's shoulder surgery. This particular charge in this amount is not found on the other bill, from St. John's Hospital, where the surgery took place. In the absence of a bill from an anesthesiologist, the Arbitrator infers that the explanation of benefits is for the charge incurred for the administration of anesthesia by the anesthesiologist.

The Arbitrator concludes that all of the medical treatment provided to the Petitioner was reasonable and necessary and causally related to the work accident. The Respondent is responsible for the payment of the medical bills contained in PX 3 as provided in Sections 8 (a) and 8.2 of the Act, subject to the fee schedule.

TTD

With regard to K, what temporary benefits are in dispute, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner first received medical treatment for the injury in question on January 7, 2015 when he saw Dr. Watson. On that date the doctor restricted his activities by advising Petitioner not to do any lifting, pushing or pulling with his right arm. These restrictions continued until the next office visit on January 21, 2015 at which time the doctor took Petitioner off work completely. Petitioner was released to return to work with restrictions beginning on August 27, 2015 (PX 2). Petitioner testified that after being injured he really did nothing afterwards and did nothing to re-injure his shoulder. He further testified that in the event he is not injured, it is possible he could have worked in January or February if the weather was warm enough. The Arbitrator notes the testimony of Butch Cooper who testified that it was warm enough for him to pour concrete in January and February. Petitioner also testified that he was called by the union hall sometime after seeing Dr. Watson for the purpose of sending him out on another job. However, Petitioner advised the union hall that he had injured his shoulder and could not work.

One could hardly conclude that Petitioner was capable of working as a heavy equipment operator under the restrictions imposed by Dr. Watson on January 7, 2015. There was no evidence presented at trial that light duty was available. Petitioner has proven that he could not work due to a work-related injury and the Petitioner is entitled to temporary total disability benefits beginning on January 7, 2015 up through and including August 26, 2015 which totals 33 1/7 weeks.

NATURE AND EXTENT

With regard to L, what is the nature and extent of the injury, the Arbitrator makes the following findings of fact and conclusions of law:

In order to determine the nature and extent of the injury it is necessary to examine the five factors contained in section 8.1b (b) of the Act and the evidence presented on each of these factors.

(i) An AMA impairment rating. No evidence of any impairment rating was presented.

(ii) Petitioner's occupation. The evidence at trial indicated that Petitioner's occupation is that of a heavy equipment operator. The evidence further indicated Petitioner was able to return to work full duty. This factor weighs for the Respondent.

(iii) The age of the Petitioner at the time of the injury. At the time of the accident in question Petitioner was 45 years old. The relatively young age of the Petitioner favors his position.

(iv) The Petitioner's future earning capacity. No evidence was presented with regard to Petitioner's future earning capacity.

(v) Evidence of disability corroborated by treating medical records. Petitioner testified that his right arm feels pretty good but he has lost strength in that arm. Petitioner testified he has difficulty with overhead activities and that the pain in his right arm does affect his ability to sleep because he cannot lay on it due to the pain.

Dr. Watson's last office visit note of August 26, 2015 showed an essentially normal examination. The Petitioner complained of occasional crepitus and mild discomfort when lifting overhead. Dr. Watson did impose some ongoing restrictions, but he also told the Petitioner to return in one month and the Petitioner failed to attend that appointment. The Petitioner said that he was now performing his normal job.

Given the nature of the injury, which was not a full thickness rotator tear but instead a Grade 2 AC separation with impingement, the Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 5% of a man as a whole. Consistent with the stipulation of the parties, the Respondent is entitled to a credit in the amount of $2442.92 for the payment of an advancement of permanent partial disability.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH DUNLEVY,

Petitioner,

17IWCC0665

vs. NO: 15 WC 38988

ARCH COAL,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator awarded Petitioner benefits under Section 8(e) to compensate him for injuries sustained on August 28, 2014, when a large rock fell onto his left leg and resulting in spiral fractures to both his tibia and fibula, the former requiring surgery and the implantation of hardware to repair the fracture. In addition to the fractures of the tibia and fibular, it was discovered that Petitioner was experiencing problems with the great toe of his left foot, specifically an inability to extend the toe. This development was attributed to Petitioner's August 28, 2014, accident as either the toe being injured at the time of the accident or the toe being affected by the hardware implanted to repair the fractured tibia and was addressed surgically on March 9, 2015. Petitioner, with respect to his left great toe, was released to return to work on May 12, 2015, and, with respect to remaining complaints involving Petitioner's left lower extremity, Petitioner was released to return to work at full duty without restrictions on August

17IWCC0665

17, 2015, by Dr. Wollen, his treating physician. Dr. Wollen subsequently found Petitioner to have achieved maximum medical improvement and released Petitioner from his care on October 9, 2015.

The Commission, having reviewed the record before it, finds the Decision of the Arbitrator thoroughly and accurately reflects both the medical treatment records as well as Petitioner's testimony, and adopts both the Findings of Fact and Conclusions of Law as written in the Decision of the Arbitrator. The Commission, however, arrives at a somewhat different conclusion than did the Arbitrator concerning the extent of the injury to Petitioner's left great toe.

As noted above, the dysfunction involving Petitioner's left great toe was addressed on March 9, 2015, with a left extensor halluces longus release that was performed by a Dr. Benjamin Stevens. Petitioner was seen and his left great toe examined approximately three weeks later by one of Dr. Stevens' assistants. At that time, the examination found no extensor lag and resulted an assessment of a stable postoperative course. Petitioner returned to Dr. Stevens' office on May 12, 2015, and was recorded telling Dr. Stevens that, overall, he was doing well but noticed a "little different feeling" with motion. Dr. Stevens also recorded that Petitioner has minimal, if any, pain. Dr. Stevens, on that day and with respect to Petitioner's left foot, released Petitioner to work as tolerated. Petitioner's subsequent treatment addressed his left knee with his left great toe only being mentioned in a historical context.

The Commission finds some difficulty reconciling the condition of Petitioner's left great toe at the time he was released from Dr. Stevens' care with Petitioner's testimony as to the current condition of the same toe. Before the Arbitrator, Petitioner testified to the toe sticking "straight out," to being unable to move the toe, and to the toe cramping up to three to four times a week. These testified-to complaints were, per the treatment records of both Dr. Stevens and Dr. Wolcott, were not present at the time Petitioner was released from their care. Absent from Petitioner's testimony was any claim that he sought to address these complaints any thereafter. Accordingly, the Commission concludes Petitioner embellished the extent of the injury to his left great toe when testifying before the Arbitrator on August 25, 2016, and, as a result, finds the injury to Petitioner's left great toe resulted in the 50% loss of use of that toe.

In modifying the Decision of the Arbitrator to reflect the modified compensation for the injury to Petitioner's left great toe, the Commission is compelled under Section 8.1b of the Act to establish how it came to its decision:

(1) Level of Impairment based Impairment Rating: Neither party obtained an impairment rating. No weight is given to this factor.

(2) Occupation of the Injured Employee: Petitioner was employed as a production roof bolter at the time accident and returned to the same position after being released to full duty work without restrictions by both Dr. Stevens and Dr. Wolcott. The testimony of Petitioner and Petitioner's father as to Petitioner's current condition exacerbated by his work activities are uncorroborated my contemporaneous medical

17IWCC0665

treatment records. Great weight is placed on Petitioner's return to his usual and customary job activities. Less weight is placed on the testimony of Petitioner and his father.

(3) Age at the Time of Injury: Petitioner was 25-years old at the time of injury and is expected to work for many years into the foreseeable future. Great weight is placed on this factor.

(4) Future Earning Capacity: No evidence of the effect of Petitioner's future income was presented. No weight is given this factor.

(5) Evidence of Disability as Corroborated by Treating Medical Records: The treating medical records indicate Petitioner sustained fractures of the tibia and the fibula as well as left extensor halluces longus dysfunction. His tibia and left extensor halluces longus required surgical intervention to repair. He was subsequently released to return to his usual and customary job duty without restrictions. He indicated to Dr. Wolters that he can run, walk, and squat without difficulty and had worked 70-hour work weeks without discomfort. Petitioner's testified-to continuing complaints are less than consistent with his medical records. Great weight is placed on the medical records.

Other than the modifications as addressed above, the Commission affirms and adopts all other aspects of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $542.75 per week for a period of 96.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 45% loss of use of Petitioner's left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $542.75 per week for a period of 19 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 50% loss of use of Petitioner's left great toe.

IT IS FURTHER ORDERED BY THE COMMISSION that no compensation is awarded to Petitioner under §8(c) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner compensation that has accrued between August 28, 2014, and August 25, 2015, and shall pay the remainder of the award, if any, in weekly installments.

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 $63,000.00. 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: OCT 2 0 2017
KWL/mav
O: 09/18/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0665

DUNLEVY, JOSEPH M
Employee/Petitioner

Case# **15WC038988**

ARCH COAL INC
Employer/Respondent

On 10/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1909 ACKERMAN LAW OFFICE PC
JAMES W ACKERMAN
1201 S 6TH ST
SPRINGFIELD, IL 62703

1454 THOMAS & PORTELA
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 17IWCC0665

Joseph M. Dunlevy
Employee/Petitioner

v.

Arch Coal, Inc.
Employer/Respondent

Case # 15 WC 38988

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **August 25, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0665

FINDINGS

On **8/28/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$40,038.68**; the average weekly wage was **$904.59.**

On the date of accident, Petitioner was **25**[1] years of age, ***single*** with **0** dependent children.

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

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

Petitioner was temporarily totally disabled from **8/29/14** through **8/16/15**, a period of **50 3/7 weeks**.

Respondent shall be given a credit of **$28,602.27** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$28,602.27**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability of **$542.75/week** for a total of **130.95 weeks,** because the injuries sustained caused the **45% loss of use of Petitioner's left leg (96.75 weeks) and the 90% loss of use of Petitioner's left great toe (34.2 weeks)**, as provided in Section 8 (e) of the Act.

The Arbitrator declines to award disfigurement for the scar to Petitioner's right arm.

Respondent shall pay Petitioner compensation that has accrued between **August 28, 2014** and **August 25, 2016** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Nancy Lindsay
Signature of Arbitrator

October 23, 2016
Date

OCT 2 7 2016

[1] The parties stipulated that Petitioner was 28 years old on the date of accident but that doesn't match up with his date of birth. Petitioner was 25 years old.

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was injured in an undisputed accident on August 28, 2014 at work when a big rock (a piece of shale), estimated to be between 400 and 600 pounds, fell on his left leg. He reported to Memorial Medical Center unable to bear weight. X-rays were taken, revealing a displaced spiral fracture of Petitioner's distal tibia and a possible fibula fracture. A CT scan showed a comminuted displaced obliquely oriented fracture of the proximal fibula. The major fracture, of the tibia, had 5 mm. of displacement. The CT also showed a non-displaced malleolus fracture. Petitioner was referred to Dr. Stevens who had previously treated him for a left metatarsal fracture in 2013. Until seen by Dr. Stevens, Petitioner was placed in a long leg splint and told to remain non-weight bearing. (PX 1, 2, 3)

On September 1, 2014 Petitioner's father placed a phone call to Dr. Stevens' office regarding his son's unrelenting pain and vomiting. Petitioner's father was advised to take his son to the emergency room. Dr. Pineda was paged. (PX 3)

On September 1, 2014, Dr. Pineda performed surgery on Petitioner's lower extremity. First, he repaired the left posterior malleolus which involved placing a guide wire across the malleolus fracture, drilling the cortex, placing a screw, and then placing more wire around the fracture. (PX 2, PX 3) Next, Dr. Pineda reduced and nailed the left tibia. (This was an intra-medullary nailing.) He then opened the proximal part of Petitioner's tibia with an awl to guide down the shaft of the tibia. He then put the nail all the way down the tibia. Petitioner, when he testified, described the nail as going from his knee to his ankle. An x-ray following surgery showed placement of the screw within the proximal aspect of the fifth metatarsal bone. The x-ray report notes that the screw appeared fractured. The x-ray showed rodding of the tibia at the bottom (distal) and proximal part of the tibia going to the top (proximal) part of the tibia. (PX 2, PX 3)

Petitioner remained in the hospital from September 1, 2014 through September 4, 2014. While there he underwent physical therapy. (PX 2)

On September 13, 2014, Petitioner went to Memorial Hospital Express Care due to left groin pain. He was having difficulty breathing and felt that he might pass out. He had a chest x-ray to rule out deep venous thrombosis. A left lower extremity Doppler ultrasound was also performed. (PX 2)

Dr. Pineda saw Petitioner on September 15, of 2014. Petitioner was lacking 10° of knee extension and his ankle was stiff. He could minimally dorsiflex and plantarflex his ankle. (PX 3)

On September 23, 2014 Petitioner was examined by his primary care physician, Dr. Lanzotti, for panic attacks. The doctor noted that Petitioner had a history of them but they were described as having been relatively mild. A low threshold for anxiety was noted. (PX 3)

On October 14, 2014, Dr. Pineda re-examined Petitioner noting that he could not extend his big toe. He wrote that it was unclear why he was having difficulty with the toe and not sure if he could move it when he performed surgery. Dr. Pineda thought the tendon might be bound by the terminal screw and it might have ruptured. Dr. Pineda ordered Petitioner to remain off work in light of his many problems, including panic attacks. (PX 3)

Petitioner was seen at Memorial Medical Center's emergency room on October 15, 2014 due to a panic attack the night before followed by neck and left arm pain. Records note that medical personnel discussed with Petitioner the potential effects of anxiety in light of his traumatic mining accident. He was evaluated and discharged with instructions to follow up with Dr. Lanzotti who had previously been treating him for some anxiety. (PX 2)

Petitioner saw Dr. Stephens on October 23, 2014 for further evaluation of his toe drop. Dr. Stephens ordered an MRI as he noted that Petitioner's toe was unable to flex and he suspected a possible EHL rupture. (PX 3)

Petitioner returned to Memorial Medical Center's emergency room on October 24, 2014 due to shortness of breath and pressure on his chest which seemed to be aggravated by lying on his back. He was diagnosed with acute anxiety and dyspnea. (PX 2)

Petitioner saw Dr. Pineda again on November 11, 2014. Dr. Pineda noted that the Petitioner's leg was weak. Petitioner was still using a walker and could only walk short distances. Petitioner could flex his left knee to approximately 120 degrees and fully extend his knee. His great toe motion was minimal. Dr. Pineda noted that Petitioner could do sit down work with limited walking. Otherwise, he wanted Petitioner off work. Dr. Pineda also ordered physical therapy. (PX 3)

An MRI dated November 14, 2014 showed a non-united oblique fracture of the proximal shaft of the left fibula with mild edema in the deep aspect of the extensor muscles in the left lower leg. Petitioner also appeared to have a healing fracture of the distal shaft of his tibia. (PX 3)

On November 18, 2014, Dr. Stephens noted numbness on Petitioner's proximal tibia in the medial aspect of his foot along with the inability to extend his great toe. He believed Petitioner had nerve damage and ordered an EMG/NCV. (PX 3)

Dr. Lanzotti saw Petitioner on November 18, 2014 for his chronic anxiety which pre-dated his work accident and for which he was noted to be doing well with medication. Gastrointestinal issues were also discussed. (PX 3)

Petitioner began physical therapy on November 21, 2014. The therapist noted that Petitioner's toe prevented him from walking well. His sensation was impaired and he was numb in the fibular nerve and the peroneal nerve distribution. The physical therapist wrote that Petitioner's sensation was impaired, objectively. Petitioner underwent physical therapy numerous times between November 21, 2014 and February 11, 2015. The therapist noted pain when Petitioner was walking (12/10/14), pain with rainy weather (12/17/15), toe cramping (12/17/15), Petitioner's toe catching on things and his knee stiffening after twenty minutes of sitting (1/28/15), and weakness and shakiness (2/2/15), among other things. (PX 3)

Dr. Becker performed an EMG/NCV on December 2, 2014 which demonstrated a left deep peroneal neuropathy and left saphenous mononeuropathy. (PX 3)

A December 5, 2014 physical therapy note indicated cowboy boots provided added support for Petitioner. (PX 3)

When attending therapy on December 10, 2014 the therapist noted Petitioner's left knee was bothering him. (PX 3)

On December 23, 2014 Petitioner returned to see Dr. Pineda who felt Petitioner could now do work or activity as tolerated as his tibia was healing. Petitioner was noted to still be treating with Dr. Stevens who might recommend surgery. Petitioner was cleared for weight bearing as tolerated and normal activity. (PX 3)

On December 30, 2014 Petitioner was discharged from formal therapy and advised to continue with his home exercise program. (PX 3)

On January 8, 2015, Dr. Stephens decided that Petitioner's nerve injury accounted for the deficit in his leg, but he was not sure it accounted for the toe (EHL) deficiency. He noted no improvement in flexion of Petitioner's great toe and diminished sensation about the medial aspect of Petitioner's left leg. His diagnosis was a left saphenous and deep peroneal nerve injury. Dr. Stephens recommended that Petitioner remain on light duty and see if the nerve healed. (PX 3)

Petitioner attended physical therapy on January 15, 2015 at which time the therapist noted Petitioner still had the inability to extend his left great toe, pain in his knee/ankle, and weakness in his leg. Petitioner reported being able to ambulate without pain and holding onto the railing when negotiating steps as he needed support. Petitioner was unable to walk barefoot at home as he would get the left toe caught on the floor. Dr. Stevens was being consulted in regard to possible surgery for Petitioner's toe. While Petitioner had been released to light duty the therapist noted it was unavailable at the coal mine which involved a lot of physical work. (PX 3)

On February 10, 2015, Petitioner was re-examined by Dr. Pineda who noted that Petitioner had limited flexion. Dr. Pineda recommended Petitioner return to work without restrictions concerning the leg, but referred Petitioner to Dr. Stephens concerning the toe. Dr. Pineda felt light duty for the toe was reasonable as Petitioner couldn't move his foot normally. (PX 3) Petitioner was discharged from formal therapy for his leg as of February 11, 2015. He was to continue with his home exercises. Petitioner was still complaining of the inability to move his big toe in extension. (PX 3)0

Petitioner presented to Dr. Stevens on February 19, 2015. Petitioner reported a great deal of difficulty lifting his great toe. He wished to proceed with surgery if it would help him lift his great toe. On physical exam, Petitioner had minimal, if any, IP joint extension and no MTP joint extension. Plantarflexion was present but limited at the hallux. Petitioner's diagnosis was noted as left leg injury with hallux extensor lag. They discussed surgery in the form of a tenodesis of the EHL. Petitioner was to remain on light duty until after surgery. (PX 3)

In a pre-op visit dated March 5, 2015, Dr. Esslinger examined Petitioner. Dr. Esslinger noted that the injury to Petitioner's toe stemmed from his leg being crushed at the mine where he worked. Petitioner was going to undergo a tendon release in his left great toe as it kept flexing and made it difficult for Petitioner to walk. Petitioner reported having no feeling in his leg from the knee down. Dr. Esslinger noted that Petitioner needs to walk and that his gait was smooth and steady with his boot on but without his shoes he trips and falls. Dr. Esslinger also noted that Petitioner had gained thirty-five pounds since the injury. (PX 3)

Dr. Stephens performed a left tenodesis of the EHL on Petitioner's toe on March 9, 2015, in which he sewed Petitioner's tendon to the bone. Petitioner was noted to be having trouble walking because he was dragging his toe. (PX 3)

On March 31, 2015, a physician's assistant (Reuter) kept Petitioner off work if sit down work was unavailable. (PX 3)

Petitioner presented to Memorial Medical Center's emergency room on April 15, 2015 complaining of left calf pain that had begun earlier that day. No swelling or redness was noted. X-rays of Petitioner's left leg revealed healing fractures of the left tibia and fibula. He was discharged with left leg pain of uncertain etiology and told to follow up with Dr. Lanzotti. (PX 2) On May 12, 2015, Dr. Stephens noted that Petitioner still had lots of knee pain with swelling. He recommended light duty in the form of sit down work with no prolonged sitting or standing. Overall, Petitioner was noted to be doing well with minimal pain but a "different feeling" in terms of overall motion. With regard to Petitioner's leg and foot,

Petitioner felt able to return to work. The doctor noted Petitioner felt pain and swelling in his knee for which he was being referred to Dr. Wolters.

Petitioner was still having problems with his knee on May 26, 2015, when he saw Dr. Brett Wolters. Dr. Wolters diagnosed a possible meniscal tear or painful hardware. He ordered an MRI, which was performed May 30, 2015. The MRI showed a partial tear of the patellar tendon. (PX 3)

On June 3, 2015, Petitioner returned to see Dr. Wolters complaining that he could not do his job because of the knee pain. Dr. Wolters recommended removing the hardware that was in Petitioner's knee as the knee itself looked good. (PX 3)

Petitioner returned to see Dr. Pineda on June 22, 2015. (PX 3)

Petitioner returned to see Dr. Pineda on June 29, 2015. (PX 3)

Dr. Wolters performed surgery on July 6, 2015 to remove the hardware and described this as a work-related injury. (PX 3)

On July 15, 2015, Petitioner attended physical therapy reporting that he was having a lot of pain following his most recent surgery, but it was getting better. Mr. Johnson noted that he still had an antalgic gait and significant objective impairments. Petitioner had significant swelling and increased tissue density. He did say he was having minimal pain because he had not been doing much. However, the Petitioner told Mr. Johnson that when he was on his feet for a while his entire knee would hurt. Petitioner reported increased pain and significant instability with any turning or pivoting of his left leg. On exam, Mr. Johnson noted "significant swelling." On the same day, Dr. Wolters felt Petitioner should have physical therapy and he took Petitioner off work. (PX 3)

Petitioner underwent more physical therapy from July 20, 2015 through August 14, 2015. As of July 20, 2015 Petitioner reported that he had no complaints of pain but felt like he walked differently and leaned to the right. Attention was to be given to Petitioner's gait deviation. Petitioner then returned one week later on July 27, 2015 reporting his knee was feeling fairly well until his truck was hit from behind. Since then his knee felt like it needed to pop and his ankle had swelled. By July 31, 2015, Petitioner was feeling pretty good. The therapist noted some instability and proprioceptive deficit, which the therapist

hoped would improve with weight-bearing and exercise. On August 07, 2015, Petitioner reported his knee felt the best it had since accident with no real pain, just some pressure. The therapist noted Petitioner had no feeling in the ball of the foot, aggravating his poor proprioception. On August 10, 2015, the therapist noted he had decreased balance with activities but, otherwise, his knee and ankle felt pretty good. (PX 3)

Petitioner saw Dr. Wolters again on August 11, 2015. Petitioner felt like he was doing much better and wanted to return to work full duty. The doctor gave him a release to return to work as of August 17, 2015. Dr. Wolters noted that he was not having swelling, locking or catching. Petitioner had no difficulty walking, running, or squatting. Petitioner had full range of motion of his left knee. He lacked any tenderness along the patella tendon. Dr. Wolters recommended controlled physical therapy and conservative management anticipating Petitioner would be at maximum medial improvement in two months. (PX 3)

On August 14, 2015, Petitioner reported to physical therapy. Petitioner denied pain, but said he had instances of his nerves "trying to fire" through his legs. He was excited to return to work on Monday and would be undergoing a physical examination test prior to returning to work. Petitioner was discharged from further therapy. (PX 3)

On October 9, 2015, Dr. Wolters met with Petitioner and he noted Petitioner was doing quite well. He advised Petitioner to continue his exercises at home. Dr. Wolters stated Petitioner was at maximum medical improvement and noted he had been working seventy hours a week without discomfort or swelling although Petitioner reported he would get a little sore on occasion. Petitioner was not taking any pain medication. Dr. Wolters noted that Petitioner's alignment was in "slight valgus" but the doctor didn't believe it should cause any "significant issues" with arthritis in the future. Dr. Wolters felt the risk of continued patellar tendon pain and anterior knee pain was small. Petitioner was released as being at maximum medical improvement. (PX 3; RX 1)

Petitioner's case proceeded to arbitration on August 25, 2016. Petitioner and his father, Kenneth Dunlevy, were the sole witnesses testifying at the hearing. The disputed issues were causal connection and nature and extent. (AX 1)

Petitioner testified that he was 27 years old at the time of trial. He further testified that he graduated from Williamsville High School and attended some classes at Lincoln Land Community College, but he doesn't have a college degree. Petitioner has worked for the coal mine ever since he went to Lincoln Land Community College, about eight years.

Petitioner is a production roof bolter for Respondent at its coal mine. He puts roof bolts in the roof of the mine with steel rebar to protect workers. He is required to stand on his feet for eight hours in this position with no sitting.

Petitioner testified that he occasionally has to clean and shovel the belts. In this capacity, he shovels the belts to get the coal off of them. On the average night, they lift 350 eight foot roof bolts. They are each about ten pounds that have to be lifted about eight feet tall, so you have to bend the piece of metal and then shove it up on the top and straighten it out with your arms. Petitioner does a lot of lifting of relatively small weights. Occasionally, he has to lift heavier weights. The maximum lifting he has to do is ninety pounds in certain circumstances.

Petitioner also testified that he has worked in a ram car while on light duty. According to Petitioner, this job requires that the miner load a ram car full of coal and then take it to a belt. The ram car then dumps it on a belt. Petitioner described it as being like a dump truck underground. It is a sit down job.

Petitioner testified that he never had any problems with his right arm, left leg, left ankle, or big toe prior to his accident.

Petitioner testified that, as a result of the accident, a drill landed on his right arm and caused a burn (see photos). Petitioner testified that he doesn't have any pain in his arm, only a very small scar which the Arbitrator viewed and noted was not even the size of a dime.

Petitioner testified that his left ankle still gets pretty and it pops a lot. Petitioner spends a lot of time working it back and forth making sure it does not stiffen up. He does an exercise which is similar to a brake pedal/gas pedal type of thing where he does flexion extension. This gets it loosened up. Petitioner testified that he does this every day when he gets up in the morning. He tries to get up three to four hours

before he goes to work to get his leg functioning so that he can use it correctly. He does the exercises for an hour. He does a rolling motion which helps a lot. When he does the rolling motion with his ankle, he has a popping sound like one hears when popping a knuckle. Petitioner explained that if he doesn't do this, he has a bad limp in his ankle.

Petitioner also testified that his ankle bothers him when it rains and his ankle will swell about one and a half times the normal size and is very tight. Sometimes he feels a loss of range of motion. Petitioner testified that his ankle is always swollen when he wakes up in the morning and if he can keep working it, keep it elevated and put ice on it, it will bring the swelling down. Petitioner testified to a lack of feeling in the front part of his shin. According to Petitioner, it goes, basically, from the top of his knee to right above his ankle, and it goes all around the front part of his shin. Petitioner is concerned he will start having significant pain in it if he ever gets the feeling back.

With regard to his left leg, Petitioner testified that he normally gets in the hot tub, depending on the weather, and he sits in it for an hour and a half while he tries to move his leg back and forth. The warm water helps it if he can get it hot enough. He likes to have the massaging jets on it when he is in the hot tub in the morning. Petitioner also testified that he gets up and walks around to limber his leg up. If he does not limber it up as described, he feels weak and he will lose a lot of range of motion. Petitioner explained that in his job, he has to be able to turn and cut very often and very quickly to get out of the way of things that are happening in the mine. His job also requires him to do a lot of turning and twisting when performing the roof bolting, so he needs significant range of motion. If he is not able to plant and turn, his knee will buckle. If he does not use his leg to get it moving, he feels shaky in his leg. Petitioner testified that his leg will not hold up the way that he needs for it to hold up.

Petitioner testified that he is able to walk about a quarter mile above ground. He can do that when he is out on the weekends. As long as he has a place to sit down, he can stand the whole day and walk around if there is a festival or something. However, he has to be able to sit every thirty minutes or so, because he has swelling and he starts limping badly.

When asked why he went back to work, Petitioner explained that he saw a lot of people take extended time off for injuries that were not hurt very badly. He considered it as a "pride thing." Petitioner stated he saw a lot of people work the system with minimal injuries and he did not want to do that.

Petitioner further testified that he had difficulty working in the ram car because one is not allowed to have one's body out of the piece of equipment, so he has to sit down the whole time, which causes his leg to cramp. Petitioner testified that his leg is always swelling and causes a lot of pain. Petitioner also testified that when he is inside the small cabin, he is unable to work his leg and get it moving, so it started getting worse and worse. Petitioner testified that he "begged and pleaded" with his employer, so it finally let him rake and shovel belts. He further testified that when he started doing that, it started feeling a little better. Petitioner testified that he is currently back to roof bolting.

When asked what he would do if he could no longer do his job, Petitioner testified that he did not know. He indicated that he has been doing the roof bolting job since he was twenty and he is now twenty-seven years old.

Petitioner testified that his range of motion in his knee is reduced.

Petitioner also testified that when he gets home from work, he gets cleaned up and goes into the hot tub or the tub. He explained that by that point in the day, it is usually swollen. In the car ride home, it freezes up and swells once he gets off of it. He usually spends two and a half or three hours in the tub trying to get it to stop throbbing or just loosen it up enough so that he can go to sleep without it bothering him.

Petitioner testified that elevation helps his leg so he spends a lot of time in his recliner with his leg elevated. If he stays off of his leg too long, it stiffens up.

Petitioner testified that his big toe has no range of motion in it. When he went to Dr. Wottowa[1] after the injury, Dr. Wottowa noticed that the nerve test showed there was no nerve function in the big toe. Dr. Wottowa decided that he would pin the big toe so that it would not bend down, which would cause it to catch on things. Petitioner testified that he would catch his big toe on things and could not

[1] While Petitioner testified to seeing Dr. Wottowa for his toe, the Arbitrator believes he meant Dr. Wolters.

figure out why it was catching. He was using a walker at the time and keeping his foot up. However, he could feel it dragging every once in a while. Petitioner testified that he has no range of motion in his big toe because it is surgically pinned. It just sticks straight out and he cannot move it. It cramps if he has a shoe on. He is concerned that his muscle will pull the big toe and then break the tendon. He acknowledges that is probably far-fetched, but he worries about it. Petitioner testified that his toe cramps about three to four times a week.

Petitioner testified that on a good day he does his ritual, goes to work, comes home, has minor swelling, and not a lot of pain. He describes it achy more than anything. On a bad day, his leg swells up badly as soon as he gets home and he has to get off of it. Some days his leg swells so badly it makes him sick to his stomach. Petitioner testified that he walks with a bad limp on bad days but, on a good day, it's not too bad.

Petitioner testified that he takes Tylenol for pain which he described as an achy and dull pain "24/7."

When asked to describe how his injury affects his job, Petitioner testified that his pace is reduced because of the leg injury. Normally, he is required to work at a fast pace and push himself hard and he can only leave so many places swinging unsupported for the next shift, so he is supposed to hurry and be quick; however, he finds it hard to keep up with everyone else because of his leg.

Petitioner acknowledged that he was released on August 17, 2015 to light duty. He has worked for Arch Coal since then. When he was initially released, he went back to driving the ram car, which he did for a couple of weeks. Then he began shoveling for about a month or two. He was back to roof bolting in October 2015.

Petitioner testified that he went back to the doctor on August 4, 2016[2] for a check-up on his knee. No additional surgery has been prescribed.

Kenneth Dunlevy, Petitioner's father, testified Petitioner lives with him and they see each other every day. Mr. Dunlevy takes Petitioner to work sometimes, depending on the shift. Mr. Dunlevy

[2] There is no office note for this visit in the record.

describes that Petitioner is in pain all the time now as noted by his facial expressions and the fact that he will moan when he is walking. Petitioner is constantly in the bath tub before work, and after work. Mr. Dunlevy described it as "a ritual". Mr. Dunlevy testified that his son is no longer the same person. He is totally different from the way he was prior to the injury. According to Mr. Dunlevy, Petitioner limps and it looks like his leg will kick out from him from time to time. When he picks his son up from work, Mr. Dunlevy watches him walk from his work for about thirty to forty yards, noticing that he limps the whole way to the truck. He further testified that Petitioner limps on the way to work, but not as badly.

Mr. Dunlevy testified that Petitioner's moods have changed and he now has horrible moods. He is always mad. If you try to help him out, he will "bite at you." Mr. Dunlevy testified that he used to have a great relationship with his son and his mother did too. Mr. Dunlevy feels that his son's change in mood is related to his pain. Mr. Dunlevy stated that you can physically see him in pain.

Mr. Dunlevy testified they have two living rooms in the house. In the front living room, they set up a specific recliner so that if Petitioner is not at work or in the bathtub, he can sit in the recliner, because he likes to elevate his leg.Mr. Dunlevy testified that Petitioner sits in the tub for an hour to three hours at a time.

The Arbitrator concludes:

Issue (F) Causal Connection

Petitioner's current condition of ill-being in his left leg, left knee, left ankle and left great toe are causally connected to his undisputed accident. This is based upon Petitioner's very credible testimony, the opinions of Petitioner's treating physicians, the medical records, and a chain of events. Petitioner never had any problems before the accident. While he had previously treated with Dr. Stevens for a left ankle injury, no evidence was introduced that Petitioner was having any problems with his left ankle prior to his accident herein. He was working full duty for Respondent. The accident he sustained on August 29, 2014 was a significant one as an extremely heavy piece of rock/shale fell on him, fracturing his malleolus, tibia and fibula. Petitioner's doctor felt his toe injury was related. No evidence to the contrary was presented.

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

Section 8.1b of the Act provides:

"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."

With regard to the five factors and the instant case, the Arbitrator notes the following:

1. The reported level of impairment.

   Neither party submitted an impairment rating in this case. Therefore, the Arbitrator assigns no weight to this factor.

2. The Occupation of the Injured Employee.

Petitioner works in a coal mine as a production roof bolter. He has to stand on his feet for eight hours without sitting. He has to clean and shovel belts so the coal can be passed along on the belt. He does a lot of lifting small amounts of weight. Petitioner must lift about 350 eight foot rails per shift, each at ten pounds. Occasionally, he must lift up to 90 pounds. He must be able to turn and twist his leg quickly to place the metal pieces up on the ceiling and move out of the way. Petitioner's job is a physically demanding one. He is working up to seventy hours per week. While Petitioner was released to return to work with no restrictions, he was still on doctor prescribed pain medication at that time. Petitioner has resumed working as a roof bolter and he very credibly testified to how the injury has affected his ability to perform his job. To his credit, he sounds determined to try and continue working for

Respondent has fully as he is able and pushes through his pain to get his day's work done. He has difficulty standing, turning, and working as quickly as he should. He credibly testified to the ritual he follows to deal with the effects of his returning to work on a full duty basis. Respondent presented no evidence to rebut Petitioner's credible testimony. The Arbitrator gives great weight to this factor.

3. Petitioner's Age at the Time of the Injury.

Petitioner was twenty-five years old on the date of accident. Thus, he is of younger age and can reasonably be expected to work for many, many more years. Consequently, he will have to live and work with the effects of his injury for a long period of time. The Arbitrator gives great weight to this factor.

4. Future Earning Capacity

No evidence was presented as to how Petitioner's future earning capacity has been affected by his injury. Therefore, the Arbitrator gives no weight to this factor.

5. Evidence of Disability As Corroborated by Treating Medical Records

Petitioner's accident was significant and his fracture, serious, as it was a spiral fracture. Further, the November 14, 2014 MRI demonstrated that the fracture did not unite. He had neuropathy, both peroneal and saphenous. Petitioner also had a partial tear at the patellar tendon and has a toe that will not straighten at all. He has undergone multiple surgeries to his left lower extremity.

Petitioner's treating doctors have released him to return to work full duty. Except for a visit with his knee doctor approximately three weeks before the hearing herein, Petitioner has not returned to see his doctors about any problems. Nevertheless, the Arbitrator found Petitioner to be very credible regarding his injuries and the manner in which he is dealing with the effects of the injuries so that he may move forward with his life in a positive manner. Petitioner came across as a very believable young man intent upon keeping his job with Respondent and trying to make the best of his physical situation. Given the nature of his injury and surgeries, Petitioner's testimony regarding his ongoing symptoms and limitations are corroborated by his medical records, including the therapy notes. Respondent did not have Petitioner undergo an IME.

Based upon the foregoing, the Arbitrator concludes that Petitioner is permanently partially disabled to the extent of 45% loss of the use of his left leg and 90% loss of use of his left great toe. The Arbitrator declines to award disfigurement to Petitioner's right arm.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RITA HERNANDEZ,

Petitioner,

17IWCC0666

vs.

NO: 14 WC 19901

ARAMARK,

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

The Commission agrees with the Arbitrator that Petitioner proved she had an accident arising out of and in the course of employment on February 7, 2013. The Commission's view of the Petitioner's testimony and the medical evidence diverges from the Arbitrator's findings and conclusions of law, however. The Commission finds Petitioner's current condition of ill-being is more significant than a sprain/strain and Petitioner has not yet reached maximum medical improvement (MMI).

17IWCC0666

The Commission arrives at a different conclusion than the Arbitrator based, in part, upon the Petitioner's testimony that her right shoulder problem started with her initial accident on February 7, 2013 and as evidenced by the medical treatment, that her right shoulder problems continued until the time of the arbitration hearing.

Procedurally, the subject case was consolidated with two subsequent filings. All three cases allege Petitioner sustained injury to her right shoulder. The two consolidated cases, 14 WC 37711 and 14 WC 32037 are addressed in separate Commission decisions. The Arbitrator's statement of facts illustrates Petitioner's medical treatment from her first consult after the February 7, 2013 date of accident through the date of the arbitration hearing. The Commission finds the Petitioner's lost time and outstanding medical bills are causally related to the initial accident of February 7, 2013.

Based upon a review of the record, the Commission finds that Petitioner did not reach MMI at the time of the arbitration hearing. Therefore, the Commission strikes page 20 of the Arbitrator's Decision, under Conclusions of Law, beginning after the heading "F: Is Petitioner's current condition of ill-being causally related to the injury" and substitutes the following:

Petitioner testified through a translator that she worked for almost 14 years for Respondent as a custodian keeping bathrooms, hallways, entrances and terraces clean using a yellow bucket with a very heavy mop and a vacuum. Petitioner testified she was cleaning the ladies room on February 7, 2013 and when she tried to wring the mop, something "cracked" in her right shoulder. Petitioner testified the pain was very strong. The Commission acknowledges Petitioner was not a detailed historian in some respects, however, the Commission also finds the Petitioner's language barrier contributed to minor inconsistencies in the accident histories and her testimony. The Commission finds Petitioner's medical histories are consistent with her testimony regarding the onset of right shoulder pain and her persistent right arm pain was well documented thereafter.

When Petitioner first saw her primary care physician, Dr. Narula, (PCP) on February 11, 2013, she had a positive Hawkin's impingement sign and the Hawkin's impingement sign remained positive on February 18, 2013 when she was referred to orthopedics in the same practice at Union Health. On February 26, 2013 Petitioner saw Dr. Ira Kornblatt, an orthopedic doctor within the practice. Petitioner reported she was still taking ibuprofen and hydrocodone which provided relief. Dr. Kornblatt recommended ice and physical therapy. At the next visit, March 19, 2013, Petitioner reported she was much better, would like to finish therapy and return to work. The therapy notes document on March 22, 2013, that Petitioner had attended 10 therapy sessions, canceled zero and had zero scheduled appointments. At that time, Petitioner reported her shoulder symptoms improved by 75-80%.

An Accelerated therapy note dated May 9, 2013 documents that the Petitioner was discharged from therapy due to not getting any more approval and notes her last day in therapy was on March 22, 2013. Accelerated therapy notes on May 16, 2013 document she returned to therapy and reported she still struggles to reach behind her back, lift heavy items, and put away

17IWCC0666

dishes over shoulder height. On May 29, 2013, Petitioner's PCP noted the pain in her shoulder was improving with physical therapy and she was to complete therapy. (Px2)

The Commission finds Petitioner was not at MMI on March 28, 2013 because Petitioner was attempting to finish physical therapy treatment. No additional therapy was authorized however as evidenced by the Accelerated May 9, 2013 discharge summary.

A claimant reaches MMI when he is as far recovered or rested as the permanent character of his injury will permit. *Nascote Industries v. Industrial Comm'n*, 353 Ill. App. 3d 1067, 1072, 820 N.E.2d 570, 289 Ill. Dec. 794 (citing *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118, 561 N.E.2d 623, 149 Ill. Dec. 253 (1990)). "In determining whether the claimant has reached MMI, a court may consider such factors as a release to return to work, and medical testimony or evidence concerning the claimant's injury, the extent thereof, and most importantly, whether the injury has stabilized." *Nascote Industries v. Industrial Comm'n*, 353 Ill. App. 3d 1067, 1072, 820 N.E.2d 570, 289 Ill. Dec. 794 In this case, the right shoulder condition clearly had not stabilized.

On October 18, 2013, the Union Health records confirm that Petitioner was complaining of right shoulder pain and she saw Dr. Alex Buder. She reported she had a work injury 9 (sic) months prior. The notes state Petitioner was told she may need a steroid shot, she was to follow-up with the orthopedic doctor and she was to remain off-work until then.

When Petitioner returned to Dr. Kornblatt on October 28, 2013, he noted that he had treated her in the spring, and that her right shoulder had painful range of motion. Petitioner agreed to a steroid injection. Dr. Kornblatt kept her off work. Petitioner returned to Dr. Kornblatt the following week and his impression was recurrent right shoulder pain with possible rotator cuff tear, thus clearly Petitioner's shoulder condition had not stabilized. Dr. Kornblatt recommended a MRI which was reviewed at the next office visit. Dr. Kornblatt noted that the MRI revealed only minimal tendinosis of the supraspinatus tendon. Petitioner reported feeling better, however, she was off-work. Dr. Kornblatt recommended she remain off work and undergo another round of physical therapy. (Px2)

When Petitioner returned to Dr. Kornblatt on December 23, 2013, she felt better but reported intermittent pain. She was to return to work on January 2, 2013 (sic) and continue an independent exercise program. When she saw Dr. Kornblatt the next visit, he documented she had rotator cuff syndrome that was resolving, however, she was short of full range of motion. She was working and Dr. Kornblatt recommended Petitioner carry out an independent exercise program.

Petitioner returned to Union Health and saw her PCP on March 24, 2014, approximately two months later, and reported she had right arm pain for one week. Petitioner told her PCP it was "painful to work as a janitress." She reported "she can't even open a bottle of water" and "workman's comp doesn't want to pay for additional PT." Petitioner rated her pain as "8" on a

17IWCC0666

scale of 1-10. She requested a prescription and for her doctor to complete a form. Petitioner was prescribed Vicodin and Ibuprofen and referred to Dr. Kornblatt. (Px2)

At the next visit, April 1, 2014, Dr. Kornblatt noted that Petitioner had therapy, injections, and pain. He also wrote she has ongoing disability and as such arthroscopic surgery is indicated. Dr. Kornblatt documented "this is a workman compensation case and she needs to go through worker comp." The next office visit, April 29, 2014, confirmed Petitioner would like to have surgery done. (Px2)

Petitioner testified she stopped working in March 2014 but she did not recall the exact date. She reported increased problems with her shoulder on March 22, 2014. March 23, 2014 was her last day at work. She noticed very strong pain. (T, pp. 49-53) On cross-examination, Petitioner testified the problem with her right shoulder started with her first accident with the mop. From then on, she had been having the same problem up to the day of the arbitration hearing. (T, pp. 53, 54) The Petitioner testified she noticed the pain increasing when mopping. (T, pp. 54-56)

The Commission finds Dr. Robertson's interview of Petitioner resulted in a thorough Section 12 evaluation because he testified he speaks Spanish fluently. Further, when Dr. Robertson examined Petitioner, he found positive rotator cuff impingement signs. Petitioner was unable to touch the small of her back and there was no forward or lateral elevation. After she got past 90° of abduction, the pain was so severe that she could not elevate her arm past that. Dr. Robertson thought Petitioner had a rotator cuff impingement syndrome and a labral tear that failed to respond to conservative treatment. The Commission finds Dr. Robertson's recommendation for a right shoulder arthroscopy for a subacromial decompression comports with Dr. Kornblatt's treatment plan for Petitioner.

The Commission also diverges from the Arbitrator's opinion regarding the credibility of the §12 experts. The Commission finds Dr. Robertson more credible than Dr. Lieber. Dr. Lieber did not have a translator for the §12 evaluation he conducted on July 15, 2015. He testified Petitioner's current condition was not associated with any acute injury but was a degenerative condition, however, admitted that there was a discrepancy between his May 19, 2014 records review report and his July 15, 2015 report where he performed an interview and actual physical examination of Petitioner. In the May 19, 2014 records review Section 12 opinion report, Dr. Lieber noted Petitioner felt a cracking and pain in her right shoulder, however, he did not indicate she had an acute injury in his later report.

The Commission was further persuaded by Dr. Robertson's causal opinion regarding the mechanism of accident. He opined the forward pushing/pulling on the handle of the bucket, emptying the bucket and mopping all increased the pressure on the tendon of the rotator cuff and those activities produced the impingement syndrome with tendon and bursa swelling. Dr. Robertson opined an anterior labral tear was probably produced by pulling on the handle of the bucket which pushes the humeral head forward and that could tear the labrum. He further testified

17IWCC0666

she had no symptoms until she pushed on that handle and if she kept repeating that motion, it was going to aggravate it. (Px4)

Therefore, the Commission finds the Petitioner's current condition of ill-being is causally related to the injury. The Illinois Supreme Court has stated that "the determinative inquiry for deciding entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized." *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 111. 2d 132, 149 (2010). "If the injured employee is able to show that he [*17] continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits..." *Id.*

The Commission therefore finds that in addition to the period of TTD that was paid by Respondent and to which the parties stipulated, February 26, 2013 through March 27, 2013, representing 4-2/7 weeks, Petitioner is also entitled to temporary total disability for the period October 18, 2013 through January 1, 2014, representing 10-6/7 weeks lost time, plus March 24, 2014 through the date of the arbitration hearing on February 25, 2016 representing 100-4/7 weeks lost time since her condition has not yet stabilized.

The Commission strikes the words "an overpayment in" on page two in the second paragraph of the Arbitrator's Order, preceding the words "temporary total disability benefits."

Based on these findings, the Commission also strikes the first paragraph on page 21 under the heading "K: Is Petitioner entitled to prospective medical care?" and substitutes "The Commission finds Petitioner is entitled to prospective medical care for her right shoulder in the form of a right shoulder arthroscopic surgery and related measure necessary to cure Petitioner's right shoulder condition of ill-being."

The Commission further strikes the first paragraph in the Arbitrator's Order and substitutes "Respondent shall provide and pay for reasonable prospective medical treatment in the form of a right shoulder arthroscopic surgery and related measures necessary to cure Petitioner's right shoulder condition of ill-being pursuant to the provisions of Sections 8(a) and 8.2 of the Act."

Finally, in the first paragraph on page one, the Arbitration Decision states that the matter was heard before an Arbitrator of the Commission, in the city of Chicago, on February 7, 2013. The Commission finds the referenced Arbitration date is a scrivener's error and substitutes the correct date the matter was heard, "February 25, 2016."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 23, 2016 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $293.09 per week for a period of 115-5/7 weeks, for the period February 26, 2013 through March 27, 2013, and the period October 18, 2013 through January 1, 2014 plus the period March 24, 2014 through February 25, 2016, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,498.34 for medical expenses under §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 23 2017
KWL/bsd
O-8/22/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0666

HERNANDEZ, RITA
Employee/Petitioner

Case# **14WC019901**

14WC037711
14WC032027

ARAMARK
Employer/Respondent

On 8/23/2016, 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 o.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:

4129 WOLFE LAW PC
KENNETH WOLFE JR
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
MARK CARTER
33 N DEARBORN ST SUITE 1825
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)

17IWCC0666

RITA HERNANDEZ
Employee/Petitioner

Case # **14 WC 19901**

v.

Consolidated cases: **14 WC 37711; 14 WC 32037**

ARAMARK
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Steven Fruth, Arbitrator of the Commission, in the city of Chicago, on 2/7/2013. After reviewing all 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, 2/7/2013, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Petitioner sustained a sprain/strain to her right shoulder which resolved with conservative care and for which she reached MMI on March 28, 2013.

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 $22,861.40; the average weekly wage was $439.64.

On the date of accident, Petitioner was **38** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$535.33** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$535.33**.

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

ORDER

Petitioner failed to prove that her current claimed condition of ill-being is causally related to her February 7, 2013 date of accident, therefore Petitioner's request for prospective medical benefits is denied.

Respondent shall be given a credit of **$535.33** for an overpayment in temporary total disability benefits that were paid during the time period of February 26, 2013 through March 27, 2013.

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.

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)

17IWCC0666

RITA HERNANDEZ
Employee/Petitioner

v.

ARAMARK
Employer/Respondent

Case # 14 WC 37711

Consolidated cases: 14 WC 19901; 14 WC 32037

An *Application for Adjustment 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 2/25/2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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?

17IWCC0666

August 22, 2016

Signature of Arbitrator

AUG 23 2016

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

17IWCC0666

HERNANDEZ, RITA
Employee/Petitioner

Case# **14WC037711**

14WC019901
14WC032037

ARAMARK
Employer/Respondent

On 8/23/2016, 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 o.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:

4129 WOLFE LAW PC
KENNETH WOLFE JR
200 W ADAMS ST SUITE 200
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
MARK CARTER
33 N DARBORN ST SUITE 1825
CHICAGO, IL 60602

17IWCC0666

N. ☐ Is Respondent due any credit?

O. ☐ Other ____

FINDINGS

On the date of accident, **10/13/2013**, 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 **$22,861.40**; the average weekly wage was **$439.64**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$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

Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment on October 13, 2013 and failed to prove to prove that her current claimed condition of ill-being is causally related to her October 13 , 2013 date of claimed accident, therefore Petitioner's request for benefits is denied.

Because the Petitioner's current condition of ill-being is not causally related to her October 13, 2013 date of claimed accident, outstanding medical bills and prospective medical benefits 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.

17IWCC0666

Signature of Arbitrator

August 22, 2016
Date

AUG 23 2016

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)

RITA HERNANDEZ
Employee/Petitioner

Case # 14 WC 32037

v.

Consolidated cases: 14 WC 19901; 14 WC 37711

ARAMARK
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Steven Fruth, Arbitrator of the Commission, in the city of Chicago, on 2/25/2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

C. ☐ 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?

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

17IWCC0666

HERNANDEZ, RITA
Employee/Petitioner

Case# **14WC032037**

14WC019901
14WC037711

ARAMARK
Employer/Respondent

On 8/23/2016, 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 o.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:

4129 WOLFE LAW PC
KENNETH WOLFE JR
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
MARK CARTER
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

O. ☐ Other ____

FINDINGS

On the date of accident, **3/23/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$22,861.40**; the average weekly wage was **$439.64**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$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

Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment on March 23, 2014 and failed to prove to prove that her current claimed condition of ill-being is causally related to her March 23 , 2014 date of claimed accident, therefore Petitioner's request for benefits is denied.

Because the Petitioner's current condition of ill-being is not causally related to her March 23, 2014 date of claimed accident, outstanding medical bills and prospective medical benefits 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.

17IWCC0666

Signature of Arbitrator

August 22, 2016
Date

AUG 23 2016

RITA HERNANDEZ v. ARAMARK

INTRODUCTION

Disputed issues included:

14 WC 19901 (DOI 2/7/2013): ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***K:*** Is Petitioner entitled to prospective medical care?

14 WC 37711 (DOI 10/13/2013): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD

14 WC 32037 (DOI 3/17/2014): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD

Petitioner testified at trial with a Spanish translator.

STATEMENT OF FACTS

Petitioner Rita Hernandez was employed by Respondent Aramark as a custodian for approximately 14 years. Her job duties included cleaning bathrooms classrooms hallways, and terraces, utilizing a vacuum sweeper and a heavy mop with bucket.

On February 7, 2013 Petitioner testified she was mopping in the women's restroom when she tried to wring out her mop. She felt a "crack" in her right shoulder. She stated that her arm felt hot and painful. She continued to clean the women's restroom and then moved on to the men's restroom. However she could no longer wring out the mop due to pain in her shoulder. She reported her injury to her supervisor who sent her to the emergency room.

Petitioner presented to the emergency department at Evanston Hospital (PX #1) on February 7, 2013. She complained of pain in the right arm from the shoulder down to the hand. She gave a history of feeling pain and a "crack" in her shoulder while she was pressing water out of her mop. Petitioner had a full range of motion with the right

shoulder but with pain. The shoulder was tender to palpation. X-rays of the shoulder were normal. It was noted that Petitioner was an inconsistent historian.

Petitioner was diagnosed with musculoskeletal pain. Petitioner was advised to take 2 days off work. She was discharged with a prescription of 600 mg of ibuprofen, minimize use of the shoulder, and to apply ice for 24 to 48 hours.

Petitioner was seen by Dr. Sapna Narula, her primary care physician, at Union Health Service (PX #2) on February 11, 2013. She complained of 7/10 right shoulder pain. She reported that she had been mopping normally as she had been doing for 12 years. She had an acute onset of right shoulder pain. She was diagnosed with a strain at Evanston Hospital emergency room. On examination right shoulder range of motion was reduced. Petitioner had a positive Hawkin's impingement sign with mild pain. Petitioner returned on February 18. Her pain was reduced and range of motion was improved but still limited. Dr. Narula diagnosed shoulder pain and gave Petitioner instructions for exercises and an orthopedic referral. Petitioner was released for work with restrictions.

Petitioner returned to Dr. Narula, on February 18, 2013. Dr. Narula noted his consideration of impingement versus strain. Petitioner was taking 600 mg ibuprofen, which reduced her pain to 5–6/10. She was reporting her pain was worse with work activities and mixing sugar in coffee. Petitioner had for 160° of abduction but complained of pain at 120°. She had a positive Hawkins impingement sign but a normal liftoff test.

Dr. Narula referred petitioner to an orthopedist. He gave 10 pound work restrictions, no overhead activities and no pulling or pushing. He also prescribed Vicodin

Petitioner saw Dr. Kornblatt on February 26 2013 (PX #2). She gave a history of her injury when she was putting a mop into a bucket and developed acute shoulder pain. On examination Petitioner's right shoulder had minor limitation of motion at the extremes due to pain. Strength appeared to be satisfactory. Dr. Kornblatt noted the X-ray of the right shoulder was within normal limits. He diagnosed a sprain/strain of the acromioclavicular joint. He prescribed hydrocodone and ibuprofen for pain relief. He took Petitioner off work and prescribed physical therapy.

Another X-ray of the right shoulder, March 1, 2013 (PX #2), was read as normal.

Petitioner had 12 sessions of physical therapy from March 1 through May 28, 2013 at Accelerated Rehabilitation Centers (PX #3).

Petitioner returned to Dr. Kornblatt on March 19, 2013 (PX #2). She had attended approximately 15 physical therapy sessions at Accelerated Rehab (PX #2). She told Dr. Kornblatt she was doing much better. His final diagnosis was sprain/strain acromioclavicular joint. He recommended that she complete physical therapy and return to work on March 28. She was advised to return p.r.n. (as needed).

Petitioner testified that she returned to work on March 28, 2013. She was assigned to work in the laundry room. She was supposed to fold laundry but ended up

also loading and unloading washers and dryers. She testified that this aggravated her shoulder pain. Petitioner testified that she continued to work full duty full duty during the summer and fall of 2013. She worked in the laundry room as well as his performing mopping. Over the course of the summer and the fall her shoulder pain became worse and worse.

Petitioner returned to Dr. Narula on May 29, 2013. She reported that she was still receiving physical therapy. She complained of fatigue but reported that she slept 6 to 7 hours per night. Petitioner also reported that her three year history of sternal lesions, but also reported that her right shoulder pain and range of motion were improved. Dr. Narula advised Petitioner to complete her physical therapy physical therapy for her shoulder.

In the Application for Adjustment of Claim for 14 WC 37711, Petitioner claimed an October 13, 2013 accident that resulted in injuries to her right shoulder and whole body.

Petitioner continued to work until October 13, 2013. She testified that her shoulder pain never went away. She testified that on October 13 she complained to her supervisor Greg about her pain. Petitioner returned to Union Health on October 18, 2013. She was then seen by Dr. Alex Buder. She complained of right shoulder and arm pain for the previous 5 days. Her work injury from 9 months before was noted. There was no documentation that Petitioner had injured or aggravated her right shoulder in any recent accident or event. On examination on October 18 Petitioner had pain on range of motion. No instability of the shoulder joint was noted. She is referred for follow up with an orthopedist. She was advised to stay off work.

Petitioner saw Dr. Kornblatt again on October 28, 2013. He noted his prior treatment of the right shoulder. Petitioner reported she had recurrent pain over the past 2 weeks. There was no documentation of a specific trauma or incident which triggered the recurrent pain or aggravated the prior shoulder problem. Petitioner reported that she was taking Vicoprofen for pain relief. On examination Dr. Kornblatt noted pain with range of motion and an equivocal impingement sign. He administered a steroid injection and advised Petitioner to stay off work. Petitioner returned November 4 with right shoulder pain. Again she had painful range of motion. Dr. Kornblatt thought there was a possible rotator cuff tear. He ordered an MRI and kept Petitioner off work.

Petitioner testified that she went in to work on October 28, 2013 to fill out paperwork for the Family Medical Leave Act. In a December 2, 2013 FMLA notice from Jason Braun (HR Manager) to Petitioner, it was indicated that on October 18, 2013 Petitioner informed Respondent that she needed leave beginning on October 18, 2013 for her "own serious health condition" and that she was eligible for FMLA leave (PX #6). The specific health condition for which Petitioner sought leave under FMLA was not noted.

Petitioner had the right shoulder MRI on November 8, 2013 (PX #2) The scan was as showing minimal hyperintensity of supraspinatus tendon, suspicious for tendinopathy and a questionable abnormal signal involving the anterior labral fibrocartilage with tiny joint effusion but no other significant finding.

Petitioner saw Dr. Kornblatt on November 18, 2013 for review of the MRI. The MRI revealed minimal tendinitis of the supraspinatus without other significant findings. Range of motion was still limited by pain. There was weakness on abduction. Dr. Kornblatt ordered 4 weeks of physical therapy and that Petitioner remain off work.

Petitioner began physical therapy at Accelerated Rehabilitation Centers on November 26, 2013 (PX #3). She had 8 sessions through December 18, 2013. The December 18, 2013 note indicated Petitioner's shoulder was feeling much better and that she should continue to perform her home exercise program.

Petitioner returned to Dr. Kornblatt on December 23, 2013 (PX #2). She testified that her shoulder pain continued and was not intermittent but was constant. Dr. Kornblatt's December 23 note indicated that Petitioner had completed physical therapy and was "feeling significantly better, although she still has intermittent pain". Dr. Kornblatt noted that she had full range of motion and satisfactory strength. He recommended that she return to work on January 2, continue her home exercise program, and follow up in two months.

Petitioner returned to Dr. Kornblatt on February 17, 2014 (PX #2). She testified that she told him that her shoulder pain was increasing and was getting worse. Dr. Kornblatt's February 17 note documented that Petitioner reported she "is feeling significantly better". On examination Petitioner had "just short" of full range of motion and excellent strength. She is working. Dr. Kornblatt diagnosed "rotator cuff syndrome – resolving" and recommended that she carry out an independent exercise program and return on a p.r.n. (as needed) basis.

Petitioner testified that after her February 17, 2014 Dr. Kornblatt visit her pain was aggravated by her work duties of mopping and vacuuming.

In her Application for Adjustment of Claim on 14 WC 32037 Petitioner claimed a March 17, 2014 accident while working that involved her right shoulder and whole body. On oral motion at trial Petitioner amended that Application for Adjustment of Claim, changing the date of accident to March 23, 2014.

Petitioner testified at trial that her pain was aggravated on March 17, 2014 when she had to vacuum away all the salt that had been brought in by the snow. The pain was aggravated and would never go away. The Petitioner testified that she reported the situation to her supervisor, Greg, but she didn't remember the exact date. In the Request for Hearing, the Petitioner stated that she reported her alleged March 17, 2014 accident to her manager, Greg, on March 17, 2014 (Arbitrator's Exhibit #3). Petitioner later testified that she reported her claimed aggravation on March 22, 2014 and that her last day of work was March 23.

Petitioner returned to Dr. Narula at Union Health on March 24, 2014 (PX #2). She reported to RN Barbara Skrzypcznski that she had right shoulder pain for one week. Her history of a work-related injury on February 7, 2013 from wringing out mop was noted. She reported seeing Dr. Kornblatt over the last year. She was diagnosed with right rotator cuff tendonitis and had physical therapy. Petitioner reported that she had returned to work on January 2, 2014 but that it was painful for her to do her job. There was no documentation that the current complaints had been triggered or aggravated by a recent accident or event. She was then complaining that she can't open a bottle of water. She noted her pain was 8/10. On examination Dr. Narula noted almost complete abduction of the right arm but weakness with the empty-can sign. Petitioner was unable to perform the subscapularis liftoff test. Dr. Narula took Petitioner off work and referred her to Dr. Kornblatt.

Petitioner testified that she started missing time from work again on March 24, 2014 and that she followed up with Dr. Kornblatt on April 1, 2014. Petitioner saw Dr. Kornblatt on April 1, 2014. He noted her report of increased pain in her right shoulder. It was noted she would like to proceed with surgical treatment. On exam Petitioner was noted to be well-maintained but had painful range of motion in the right shoulder. The impingement shoulder sign was "equivocal". Dr. Kornblatt noted the MRI was consistent with rotator cuff tendinopathy with partial anterior labral tear.

Dr. Kornblatt noted Petitioner's history of therapy, injections, and pain medication. He noted she had an ongoing disability and that arthroscopic surgery was indicated.

Petitioner had one last follow-up with Dr. Kornblatt on April 29, 2014. She was still symptomatic and wanted to have surgery. She was to return when Workers' compensation clearance was obtained.

On May 30, 2014 Petitioner saw Dr. Narula for allergies and a Theraflu rash (PX #2). Her current illness symptoms included "shoulder pain, vitamin D deficiency, heart murmur and hypertriglyceridemia". Dr. Narula noted her history of a work-related injury on February 7, 2013. It was noted that she was seeing Dr. Kornblatt over the last year and had been diagnosed with right rotator cuff tendinitis and a partial anterior labral tear. She had physical therapy, a steroid injection and had a current surgery recommendation. Dr. Narula noted that Petitioner needed an FMLA form completed that day.

Petitioner testified that she has not had any medical treatment since May 30, 2014. She had applied for Social Security disability, but was denied. Petitioner testified that she has not worked anywhere since March 24, 2014 and that she had been laid off by the Respondent. Petitioner testified that currently takes Ibuprofen, that she does no work around the house and that she has difficulties with daily activities. Petitioner testified that she did not have right shoulder problems prior to February 7, 2013 and that she had not re-injured her shoulder since she last worked for the Respondent.

On cross-examination Petitioner acknowledged that she saw Dr. Narula for medical issues other than her shoulder. She acknowledged that her time cards, Respondent's Exhibits, showed her last day of work was March 23, 2014. It was noted that Respondent's Exhibit #3, time sheet for March 13 through March 19, 2014, was signed by Petitioner but dated March 12, 2012. It is noted that RX #3 shows petitioner did not work on March 17, 2014, that date of accident on her initial Application for Adjustment on 14 WC 32037.

On redirect-examination Petitioner acknowledged that she has problems remembering dates. She testified that she had no explanation on why her signed timesheets were inaccurate. She reaffirmed that that she last worked on March 23, 2014 because of very strong pain at that time.

On recross-examination Petitioner stated that she originally injured her right shoulder in 2013 and that her problems started with the first accident of wringing out the mop.

EVIDENCE DEPOSITIONS

Dr. Lawrence Lieber

Orthopedic surgeon Dr. Lawrence Lieber gave his deposition on July 16, 2015 (RX #1). At the request of Respondent Dr. Lieber conducted a records review on May 9, 2014. He reviewed the records of Dr. Narula, Dr. Kornblatt, Evanston Hospital, and Accelerated Rehabilitation. He also reviewed a job analysis of a custodian. Dr. Lieber conducted a §12 IME of Petitioner on April 15, 2015. He testified from his reports of the records review and that IME.

Dr. Lieber testified that, based upon the records that he reviewed, there was no evidence of significant trauma. He attributed Petitioner's present condition to the natural progression of the underlying degenerative changes in the right upper extremity. Dr. Lieber reviewed the November 2013 right shoulder MRI scan, which he felt showed evidence of some AC joint arthritis, and rotator cuff tendinitis. He testified that he did not appreciate an anterior labrum tear on the MRI. Dr. Lieber also reviewed a video job analysis of housekeeping work activities.

Dr. Lieber testified that he agreed with Petitioner's treating physician, Dr. Kornblatt, in that as of March 28, 2013 Petitioner did not require any further medical treatment. Dr. Lieber opined in his May 9, 2014 report that the Petitioner did not require any additional medical treatment and there was no evidence of any need for surgical intervention with respect to the work accident. Dr. Lieber further opined that the Petitioner was capable of working full duty with no restrictions, as there was no objective evidence of any abnormalities in the right shoulder that could be related to the alleged work accident. Dr. Lieber further opined in his May 9, 2014 report that the Petitioner had reached MMI in regard to her February 7, 2013 event by Dr. Kornblatt's

March 28, 2013 release for work. Dr. Lieber also opined that any treatment after March 28, 2013 was not caused by, related to, or associated with the February 2013 work accident.

Dr. Lieber noted that Petitioner described a mechanism of injury for the February 7, 2013 accident of "pain in the right shoulder area associated with mopping: utilizing the mop and squeezing out the mop in a bucket below waist level". Petitioner did not describe a specific injury for the alleged October 13, 2013 and March 17, 2014 accidents. She only described increased shoulder pain in relation to the two latter dates.

Dr. Lieber did not have a translator for the §12 exam. He testified that he repeated questions or directions if Petitioner did not seem to understand. On physical examination Dr. Lieber found that Petitioner's right shoulder range of motion was decreased due to pain. He noted positive AC tenderness, impingement, apprehension, greater Tuberosity, Speed's, O'Brien, and Reverse O'Brien signs. Dr. Lieber opined that he found no evidence of any abnormality in Petitioner's right shoulder that could be associated with any of her three reported dates of injury. He added that her current condition was not associated with any acute injury, but was a degenerative condition. Dr. Lieber further testified neither his clinical examination nor the MRI showed any acute abnormalities that could have been caused or aggravated by the February event. He opined that Petitioner's condition on April 15, 2015 was degenerative AC joint arthritis and degenerative rotator cuff syndrome. Dr. Lieber confirmed that Petitioner did not require any further medical treatment associated with any of her three alleged work accidents and had reached MMI and could work full duty.

On cross-examination, Dr. Lieber testified that 98% of the forensic review he does is for the defense. He acknowledged that there was a discrepancy between his May 19, 2014 records review report and his July 15, 2015 exam report. In the May 19 review he reported that records indicated Petitioner felt a cracking and pain in her right shoulder but that he did not indicate an acute injury in his later report.

On further cross-examination Dr. Lieber acknowledged that there may have been a language barrier resulting in a lack of full communication and/or understanding. He noted that MRI's are not 100% diagnostically reliable and that there was a possibility of a torn labrum. He felt that Petitioner's pain complaints were out of proportion to his objective findings, he agreed that different people have different responses to the same stimuli and a patient's pain cannot be measured objectively. Finally, Dr. Lieber agreed that due to the fact that the MRI of Petitioner's shoulder was 9 months post-accident, her symptoms (i.e. swelling) could have subsided over time and that an MRI immediately after the incident would have been helpful.

Dr. David Robertson

Dr. Robertson performed an IME of Petitioner on October 28, 2014 at the request of Petitioner's counsel. He also reviewed Petitioner's medical records. He gave his deposition on December 3, 2015 (PX #4). He testified from his IME report.

Dr. Robertson is still a board certified orthopedic surgeon, his original certification exempted him from re-certification, although he has not performed surgery since 2012.

Dr. Robertson stated he is fluent in Spanish and conducted the history and exam in Spanish. Petitioner gave a consistent history of the accident beginning with feeling a sharp pain in her right shoulder that radiated down the arm while mopping on February 7, 2013. He noted that Petitioner was a good historian. He further noted Pettioner's care with Dr. Kornblatt, including physical therapy and steroid injection.

On examination Dr. Robertson found full passive motion of the right shoulder. Active motion was limited by pain. He also found a positive rotator cuff impingement. Petitioner was unable to touch the small of her back. Dr. Robertson diagnosed rotator cuff impingement and a labral tear. He opined that Petitioner's history of pushing/pulling a handle of a bucket could have increased the pressure on the tendon of the rotator cuff and produced the rotator cuff impingement syndrome with tendon and bursa swelling and partial labral tear. Dr. Robertson opined that since Petitioner failed to respond to conservative treatment he recommended a right shoulder arthroscopy for a subacromial decompression. Petitioner would also need post-operative physical therapy. He further opined that the need for surgery could or might have related to her injuries of February 7, 2013, October 13, 2013, and March 17, 2014.

On cross-examination Dr. Robertson testified his only history of the Petitioner's alleged accidents and complaints was taken from Petitioner at his one visit. He did not review a job description or job analysis of the Petitioner's job. Dr. Robertson also indicated that he did not know the amount of time that the Petitioner spent mopping as part of her job duties and did know how many times Petitioner squeezed out a mop or pushed the handle of a bucket with her right arm on the February 7, 2013 date of accident. He did not inquire whether Petitioner mopped at home, whether she performed any activities around her house or outside of work that involved right shoulder pushing/pulling.

On further cross-examination Dr. Robertson acknowledged that two reasonable physicians could disagree interpreting an MRI. He then testified that he did not actually review actual the right shoulder MRI imaging but only reviewed the radiologist's report.

On redirect-examination Dr. Robertson opined that the described activities on October 13, 2013 and March 17, 2014 could or might have aggravated Petitioner's condition that was established on February 7, 2013. Dr. Robertson did not testify to what specific activities Petitioner was doing on October 13, 2013 and March 17, 2014. Dr. Robertson further testified that he did not know whether Petitioner was working on October 13, 2013 or March 17, 2014. Dr. Robertson opined that Petitioner further aggravated her rotator cuff impingement syndrome due to repetitive motion.

CONCLUSIONS OF LAW

14 WC 19901 (DOI 2/7/2013):

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

Petitioner proved that she sustained a right shoulder sprain/strain as a result of her work activities on February 7, 2013. However, Petitioner failed to prove that her current claimed condition of ill-being is causally related to that accident.

Petitioner treated conservatively for her February 2013 shoulder injury at Evanston Hospital and at Union Health Services with Drs. Narula and Kornblatt. Her conservative care included physical therapy and one steroid injection administered by Dr. Kornblatt. Dr. Kornblatt released Petitioner to work without noted restrictions effective March 28, 2013. She was advised to return p.r.n. at that time. He obviously believed Petitioner had reached MMI then.

Petitioner was not a credible witness. She has over the course of this matter alleged three different dates of accident in March of 2014. She had filed an Application for Adjustment of Claim alleging a date of accident when, as evidence showed, she was not working. She also changed the date on which she gave notice of one of her later claimed injuries. These elements, on top of her admitted poor memory, make for a witness who is not credible or reliable.

In addition, the Arbitrator notes the conflicting opinions of the IME physicians, Drs. Lieber and Robertson. Each was retained as an expert by one of the parties. Both physicians reviewed Petitioner's medical records from her treating physicians and then examined her. The Arbitrator finds Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being was not caused by an accident in March 2014 more persuasive than the opinion of Dr. Robertson that there was causation.

The Arbitrator notes that Dr. Lieber's examination and records review was more thorough than Dr. Robertson's. In particular, Dr. Robertson reviewed only the report of the right shoulder MRI, no the actual imaging. Further, although Dr. Robertson is still board certified, his original certification exempted him from re-certification, he has not performed surgery since 2012. Dr. Lieber is a currently practicing orthopedic surgeon. Also, Dr. Robertson's opinions are in large part based on the accuracy of Petitioner's history. Petitioner was not credible, particularly when changing the date of her alleged third accident. An opinion based on an unreliable or inaccurate patient history is itself unreliable. For these reasons the Arbitrator adopts Dr. Lieber's opinion that Petitioner is at MMI and that Petitioner's current claimed condition of ill-being is not related to a claimed accident on February 7, 2013.

K: Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's finding that Petitioner was at MMI as of March 28, 2013 and that Petitioner failed to prove that her current claimed condition of ill-being is causally related to her accident on February 7, 2013, this issue is moot.

14 WC 37711 (DOI 10/13/2013):

C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F: Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator addresses these issues jointly in that they are intertwined.

The Arbitrator finds that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent. The Arbitrator further finds that Petitioner's also failed to prove that her current claimed condition of ill-being is causally related to the claimed accident.

The Arbitrator noted Petitioner's admitted poor memory. That detracted from her credibility. She filed an Application for Adjustment of Claim stating that she was injured on March 17, 2014 and only amended the Application when it was proven she did not work that day. Petitioner was not a credible witness. More importantly was the evidence contained within Petitioner's own evidence.

Petitioner was seen at Union Health on October 18, 2013 (PX #2), 5 days after her claimed work injury on October 13. There was documentation in the clinical notes of that visit that Petitioner reported a work injury, much less than one on October 13. In addition, despite objective evidence to the contrary in RX #3, Petitioner reported to IME physician Dr. Robertson that she had an aggravation of her right shoulder problem at work on October 17, 2014.

Petitioner returned to Dr. Kornblatt on October 28, 2013. She complained of recurrent shoulder pain over the previous two weeks. She did not report an accident or incident that triggered that complaint or that had aggravated her prior shoulder condition. She testified that Dr. Kornblatt examined her and gave her an injection in her shoulder. He also took her off work. Petitioner followed up with Dr. Kornblatt on October 28, 2013. Again, there was no note that Petitioner reported a work injury, much less one on October 13.

Further, at trial Petitioner did not describe a specific event or work-related activity that approximated an accident on October 13, 2013.

In addition, the Arbitrator notes the conflicting opinions of the IME physicians, Drs. Lieber and Robertson. Each was retained as an expert by one of the parties. Both physician reviewed Petitioner's medical records from her treating physicians and then examined her. The Arbitrator finds Dr. Lieber's opinion that Petitioner's current

claimed condition of ill-being was not caused by an accident on October 13, 2013 more persuasive than the opinion of Dr. Robertson that there was causation.

The Arbitrator notes that Dr. Lieber's examination and records review was more thorough than Dr. Robertson's. In particular, Dr. Robertson reviewed only the report of the right shoulder MRI, no the actual imaging. Further, although Dr. Robertson is still board certified, his original certification exempted him from re-certification, he has not performed surgery since 2012. Dr. Lieber is a currently practicing orthopedic surgeon. Also, Dr. Robertson's opinions are in large part based on the accuracy of Petitioner's history. Petitioner was not credible, particularly when changing the date of her alleged third accident. An opinion based on an unreliable or inaccurate patient history is itself unreliable. For these reasons, the Arbitrator adopts Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being is not related to a claimed accident on October 13, 2013.

Finally, Petitioner's treating orthopedist, Dr. Kornblatt, did not document an opinion of causal connection to Petitioner's complaints in October 2013. Mere recitation of her history does not amount to an opinion of causal connection after the passage of 7 months, Dr. Narula's May 29 note notwithstanding. It is noted that Dr. Narula never documented a causation opinion. Dr. Kornblatt had released Petitioner to work without noted restrictions effective March 28, 2013. She was advised to return p.r.n. at that time. He obviously believed Petitioner had reached MMI then.

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

Petitioner's testimony that she gave timely noticed was unrebutted. The Arbitrator finds that Petitioner gave timely notice of her claimed injury.

However, in light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue 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?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

K: Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

L: What temporary benefits are in dispute? TTD

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

14 WC 32037 (DOI 3/17/2014):

C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F: Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator addresses these issues jointly in that they are intertwined.

The Arbitrator finds that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent. The Arbitrator further finds that Petitioner's also failed to prove that her current claimed condition of ill-being is causally related to the claimed accident.

At trial Petitioner did not describe a specific event or work-related activity that approximated an accident on March 17 or March 22 or March 23, 2014. She has over the course of this matter alleged three different dates of accident in March of 2014. More importantly, Respondent's timesheet exhibits, along with Petitioner's admitted poor memory, demonstrate that Petitioner is not a credible witness.

When Petitioner returned to Union Health on March 24, 2014 she gave a history of right shoulder pain for one week. She did not report an accident or incident that triggered that complaint or that had aggravated her prior shoulder condition.

Further, at trial Petitioner did not describe a specific event or work-related activity that approximated an accident in March 2014.

In addition, the Arbitrator notes the conflicting opinions of the IME physicians, Drs. Lieber and Robertson. Each was retained as an expert by one of the parties. Both physician reviewed Petitioner's medical records from her treating physicians and then examined her. The Arbitrator finds Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being was not caused by an accident in March 2014 more persuasive than the opinion of Dr. Robertson that there was causation.

The Arbitrator notes that Dr. Lieber's examination and records review was more thorough than Dr. Robertson's. In particular, Dr. Robertson reviewed only the report of the right shoulder MRI, no the actual imaging. Further, although Dr. Robertson is still board certified, his original certification exempted him from re-certification, he has not performed surgery since 2012. Dr. Lieber is a currently practicing orthopedic surgeon. Also, Dr. Robertson's opinions are in large part based on the accuracy of Petitioner's history. Petitioner was not credible, particularly when changing the date of her alleged third accident. An opinion based on an unreliable or inaccurate patient history is itself unreliable. For these reasons the Arbitrator adopts Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being is not related to a claimed accident in March 2014.

Finally, Petitioner's treating orthopedist, Dr. Kornblatt, did not document an opinion of causal connection to Pettioner's complaints in March 2014. Although Dr. Kornblatt recommended arthroscopic surgery he did not note that the surgery was necessary to treat an accidental injury that occurred in February 2013 or October 2013 or March 2014.

Dr. Kornblatt had released Petitioner to work without noted restrictions effective March 28, 2013. She was advised to return p.r.n. at that time. He obviously believed Petitioner had reached MMI then.

It is noted that Dr. Narula never documented a causation opinion.

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

Petitioner's testimony that she gave timely noticed was unrebutted. The Arbitrator finds that Petitioner gave timely notice of her claimed injury.

However, in light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue 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?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

K: Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that

she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

L: What temporary benefits are in dispute? TTD

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

Steven J. Fruth, Arbitrator

August 22, 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rita Hernandez,
Petitioner,

17IWCC0667

vs.

NO: 14 WC 32037
14 WC 37711

ARAMARK,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 23, 2016 is hereby affirmed and adopted.

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

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

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: OCT 23 2017
KWL/vf
O-8/22/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0667

HERNANDEZ, RITA
Employee/Petitioner

Case# **14WC037711**

14WC019901
14WC032037

ARAMARK
Employer/Respondent

On 8/23/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4129 WOLFE LAW PC
KENNETH WOLFE JR
200 W ADAMS ST SUITE 200
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
MARK CARTER
33 N DARBORN ST SUITE 1825
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)

17IWCC0667

RITA HERNANDEZ
Employee/Petitioner

v.

ARAMARK
Employer/Respondent

Case # 14 WC 37711

Consolidated cases: 14 WC 19901; 14 WC 32037

An *Application for Adjustment 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 2/25/2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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?

17IWCC0667

August 22, 2016

Signature of Arbitrator

AUG 23 2016

N. ☐ Is Respondent due any credit?

O. ☐ Other ____

FINDINGS

On the date of accident, **10/13/2013**, 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 **$22,861.40**; the average weekly wage was **$439.64**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$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

Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment on October 13, 2013 and failed to prove to prove that her current claimed condition of ill-being is causally related to her October 13 , 2013 date of claimed accident, therefore Petitioner's request for benefits is denied.

Because the Petitioner's current condition of ill-being is not causally related to her October 13, 2013 date of claimed accident, outstanding medical bills and prospective medical benefits 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.

17IWCC0667

Signature of Arbitrator

August 22, 2016
Date

AUG 23 2016

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)

17IWCC0667

Case # 14 WC 32037

RITA HERNANDEZ
Employee/Petitioner

v.

Consolidated cases: **14 WC 19901; 14 WC 37711**

ARAMARK
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Steven Fruth, Arbitrator of the Commission, in the city of Chicago, on 2/25/2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

C. ☐ 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?

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

17IWCC0667

HERNANDEZ, RITA
Employee/Petitioner

Case# **14WC032037**

14WC019901
14WC037711

ARAMARK
Employer/Respondent

On 8/23/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4129 WOLFE LAW PC
KENNETH WOLFE JR
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
MARK CARTER
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

O. ☐ Other _____

FINDINGS

On the date of accident, **3/23/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$22,861.40**; the average weekly wage was **$439.64**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$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

Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment on March 23, 2014 and failed to prove to prove that her current claimed condition of ill-being is causally related to her March 23 , 2014 date of claimed accident, therefore Petitioner's request for benefits is denied.

Because the Petitioner's current condition of ill-being is not causally related to her March 23, 2014 date of claimed accident, outstanding medical bills and prospective medical benefits 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.

17IWCC0667

Signature of Arbitrator

August 22, 2016
Date

AUG 23 2016

RITA HERNANDEZ v. ARAMARK

INTRODUCTION

Disputed issues included:

14 WC 19901 (DOI 2/7/2013): ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***K:*** Is Petitioner entitled to prospective medical care?

14 WC 37711 (DOI 10/13/2013): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD

14 WC 32037 (DOI 3/17/2014): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD

Petitioner testified at trial with a Spanish translator.

STATEMENT OF FACTS

Petitioner Rita Hernandez was employed by Respondent Aramark as a custodian for approximately 14 years. Her job duties included cleaning bathrooms classrooms hallways, and terraces, utilizing a vacuum sweeper and a heavy mop with bucket.

On February 7, 2013 Petitioner testified she was mopping in the women's restroom when she tried to wring out her mop. She felt a "crack" in her right shoulder. She stated that her arm felt hot and painful. She continued to clean the women's restroom and then moved on to the men's restroom. However she could no longer wring out the mop due to pain in her shoulder. She reported her injury to her supervisor who sent her to the emergency room.

Petitioner presented to the emergency department at Evanston Hospital (PX #1) on February 7, 2013. She complained of pain in the right arm from the shoulder down to the hand. She gave a history of feeling pain and a "crack" in her shoulder while she was pressing water out of her mop. Petitioner had a full range of motion with the right

shoulder but with pain. The shoulder was tender to palpation. X-rays of the shoulder were normal. It was noted that Petitioner was an inconsistent historian.

Petitioner was diagnosed with musculoskeletal pain. Petitioner was advised to take 2 days off work. She was discharged with a prescription of 600 mg of ibuprofen, minimize use of the shoulder, and to apply ice for 24 to 48 hours.

Petitioner was seen by Dr. Sapna Narula, her primary care physician, at Union Health Service (PX #2) on February 11, 2013. She complained of 7/10 right shoulder pain. She reported that she had been mopping normally as she had been doing for 12 years. She had an acute onset of right shoulder pain. She was diagnosed with a strain at Evanston Hospital emergency room. On examination right shoulder range of motion was reduced. Petitioner had a positive Hawkin's impingement sign with mild pain. Petitioner returned on February 18. Her pain was reduced and range of motion was improved but still limited. Dr. Narula diagnosed shoulder pain and gave Petitioner instructions for exercises and an orthopedic referral. Petitioner was released for work with restrictions.

Petitioner returned to Dr. Narula, on February 18, 2013. Dr. Narula noted his consideration of impingement versus strain. Petitioner was taking 600 mg ibuprofen, which reduced her pain to 5–6/10. She was reporting her pain was worse with work activities and mixing sugar in coffee. Petitioner had for 160° of abduction but complained of pain at 120°. She had a positive Hawkins impingement sign but a normal liftoff test.

Dr. Narula referred petitioner to an orthopedist. He gave 10 pound work restrictions, no overhead activities and no pulling or pushing. He also prescribed Vicodin

Petitioner saw Dr. Kornblatt on February 26 2013 (PX #2). She gave a history of her injury when she was putting a mop into a bucket and developed acute shoulder pain. On examination Petitioner's right shoulder had minor limitation of motion at the extremes due to pain. Strength appeared to be satisfactory. Dr. Kornblatt noted the X-ray of the right shoulder was within normal limits. He diagnosed a sprain/strain of the acromioclavicular joint. He prescribed hydrocodone and ibuprofen for pain relief. He took Petitioner off work and prescribed physical therapy.

Another X-ray of the right shoulder, March 1, 2013 (PX #2), was read as normal.

Petitioner had 12 sessions of physical therapy from March 1 through May 28, 2013 at Accelerated Rehabilitation Centers (PX #3).

Petitioner returned to Dr. Kornblatt on March 19, 2013 (PX #2). She had attended approximately 15 physical therapy sessions at Accelerated Rehab (PX #2). She told Dr. Kornblatt she was doing much better. His final diagnosis was sprain/strain acromioclavicular joint. He recommended that she complete physical therapy and return to work on March 28. She was advised to return p.r.n. (as needed).

Petitioner testified that she returned to work on March 28, 2013. She was assigned to work in the laundry room. She was supposed to fold laundry but ended up

also loading and unloading washers and dryers. She testified that this aggravated her shoulder pain. Petitioner testified that she continued to work full duty full duty during the summer and fall of 2013. She worked in the laundry room as well as his performing mopping. Over the course of the summer and the fall her shoulder pain became worse and worse.

Petitioner returned to Dr. Narula on May 29, 2013. She reported that she was still receiving physical therapy. She complained of fatigue but reported that she slept 6 to 7 hours per night. Petitioner also reported that her three year history of sternal lesions, but also reported that her right shoulder pain and range of motion were improved. Dr. Narula advised Petitioner to complete her physical therapy physical therapy for her shoulder.

In the Application for Adjustment of Claim for 14 WC 37711, Petitioner claimed an October 13, 2013 accident that resulted in injuries to her right shoulder and whole body.

Petitioner continued to work until October 13, 2013. She testified that her shoulder pain never went away. She testified that on October 13 she complained to her supervisor Greg about her pain. Petitioner returned to Union Health on October 18, 2013. She was then seen by Dr. Alex Buder. She complained of right shoulder and arm pain for the previous 5 days. Her work injury from 9 months before was noted. There was no documentation that Petitioner had injured or aggravated her right shoulder in any recent accident or event. On examination on October 18 Petitioner had pain on range of motion. No instability of the shoulder joint was noted. She is referred for follow up with an orthopedist. She was advised to stay off work.

Petitioner saw Dr. Kornblatt again on October 28, 2013. He noted his prior treatment of the right shoulder. Petitioner reported she had recurrent pain over the past 2 weeks. There was no documentation of a specific trauma or incident which triggered the recurrent pain or aggravated the prior shoulder problem. Petitioner reported that she was taking Vicoprofen for pain relief. On examination Dr. Kornblatt noted pain with range of motion and an equivocal impingement sign. He administered a steroid injection and advised Petitioner to stay off work. Petitioner returned November 4 with right shoulder pain. Again she had painful range of motion. Dr. Kornblatt thought there was a possible rotator cuff tear. He ordered an MRI and kept Petitioner off work.

Petitioner testified that she went in to work on October 28, 2013 to fill out paperwork for the Family Medical Leave Act. In a December 2, 2013 FMLA notice from Jason Braun (HR Manager) to Petitioner, it was indicated that on October 18, 2013 Petitioner informed Respondent that she needed leave beginning on October 18, 2013 for her "own serious health condition" and that she was eligible for FMLA leave (PX #6). The specific health condition for which Petitioner sought leave under FMLA was not noted.

Petitioner had the right shoulder MRI on November 8, 2013 (PX #2) The scan was as showing minimal hyperintensity of supraspinatus tendon, suspicious for tendinopathy and a questionable abnormal signal involving the anterior labral fibrocartilage with tiny joint effusion but no other significant finding.

Petitioner saw Dr. Kornblatt on November 18, 2013 for review of the MRI. The MRI revealed minimal tendinitis of the supraspinatus without other significant findings. Range of motion was still limited by pain. There was weakness on abduction. Dr. Kornblatt ordered 4 weeks of physical therapy and that Petitioner remain off work.

Petitioner began physical therapy at Accelerated Rehabilitation Centers on November 26, 2013 (PX #3). She had 8 sessions through December 18, 2013. The December 18, 2013 note indicated Petitioner's shoulder was feeling much better and that she should continue to perform her home exercise program.

Petitioner returned to Dr. Kornblatt on December 23, 2013 (PX #2). She testified that her shoulder pain continued and was not intermittent but was constant. Dr. Kornblatt's December 23 note indicated that Petitioner had completed physical therapy and was "feeling significantly better, although she still has intermittent pain". Dr. Kornblatt noted that she had full range of motion and satisfactory strength. He recommended that she return to work on January 2, continue her home exercise program, and follow up in two months.

Petitioner returned to Dr. Kornblatt on February 17, 2014 (PX #2). She testified that she told him that her shoulder pain was increasing and was getting worse. Dr. Kornblatt's February 17 note documented that Petitioner reported she "is feeling significantly better". On examination Petitioner had "just short" of full range of motion and excellent strength. She is working. Dr. Kornblatt diagnosed "rotator cuff syndrome – resolving" and recommended that she carry out an independent exercise program and return on a p.r.n. (as needed) basis.

Petitioner testified that after her February 17, 2014 Dr. Kornblatt visit her pain was aggravated by her work duties of mopping and vacuuming.

In her Application for Adjustment of Claim on 14 WC 32037 Petitioner claimed a March 17, 2014 accident while working that involved her right shoulder and whole body. On oral motion at trial Petitioner amended that Application for Adjustment of Claim, changing the date of accident to March 23, 2014.

Petitioner testified at trial that her pain was aggravated on March 17, 2014 when she had to vacuum away all the salt that had been brought in by the snow. The pain was aggravated and would never go away. The Petitioner testified that she reported the situation to her supervisor, Greg, but she didn't remember the exact date. In the Request for Hearing, the Petitioner stated that she reported her alleged March 17, 2014 accident to her manager, Greg, on March 17, 2014 (Arbitrator's Exhibit #3). Petitioner later testified that she reported her claimed aggravation on March 22, 2014 and that her last day of work was March 23.

Petitioner returned to Dr. Narula at Union Health on March 24, 2014 (PX #2). She reported to RN Barbara Skrzypcznski that she had right shoulder pain for one week. Her history of a work-related injury on February 7, 2013 from wringing out mop was noted. She reported seeing Dr. Kornblatt over the last year. She was diagnosed with right rotator cuff tendonitis and had physical therapy. Petitioner reported that she had returned to work on January 2, 2014 but that it was painful for her to do her job. There was no documentation that the current complaints had been triggered or aggravated by a recent accident or event. She was then complaining that she can't open a bottle of water. She noted her pain was 8/10. On examination Dr. Narula noted almost complete abduction of the right arm but weakness with the empty-can sign. Petitioner was unable to perform the subscapularis liftoff test. Dr. Narula took Petitioner off work and referred her to Dr. Kornblatt.

Petitioner testified that she started missing time from work again on March 24, 2014 and that she followed up with Dr. Kornblatt on April 1, 2014. Petitioner saw Dr. Kornblatt on April 1, 2014. He noted her report of increased pain in her right shoulder. It was noted she would like to proceed with surgical treatment. On exam Petitioner was noted to be well-maintained but had painful range of motion in the right shoulder. The impingement shoulder sign was "equivocal". Dr. Kornblatt noted the MRI was consistent with rotator cuff tendinopathy with partial anterior labral tear.

Dr. Kornblatt noted Petitioner's history of therapy, injections, and pain medication. He noted she had an ongoing disability and that arthroscopic surgery was indicated.

Petitioner had one last follow-up with Dr. Kornblatt on April 29, 2014. She was still symptomatic and wanted to have surgery. She was to return when Workers' compensation clearance was obtained.

On May 30, 2014 Petitioner saw Dr. Narula for allergies and a Theraflu rash (PX #2). Her current illness symptoms included "shoulder pain, vitamin D deficiency, heart murmur and hypertriglyceridemia". Dr. Narula noted her history of a work-related injury on February 7, 2013. It was noted that she was seeing Dr. Kornblatt over the last year and had been diagnosed with right rotator cuff tendinitis and a partial anterior labral tear. She had physical therapy, a steroid injection and had a current surgery recommendation. Dr. Narula noted that Petitioner needed an FMLA form completed that day.

Petitioner testified that she has not had any medical treatment since May 30, 2014. She had applied for Social Security disability, but was denied. Petitioner testified that she has not worked anywhere since March 24, 2014 and that she had been laid off by the Respondent. Petitioner testified that currently takes Ibuprofen, that she does no work around the house and that she has difficulties with daily activities. Petitioner testified that she did not have right shoulder problems prior to February 7, 2013 and that she had not re-injured her shoulder since she last worked for the Respondent.

On cross-examination Petitioner acknowledged that she saw Dr. Narula for medical issues other than her shoulder. She acknowledged that her time cards, Respondent's Exhibits, showed her last day of work was March 23, 2014. It was noted that Respondent's Exhibit #3, time sheet for March 13 through March 19, 2014, was signed by Petitioner but dated March 12, 2012. It is noted that RX #3 shows petitioner did not work on March 17, 2014, that date of accident on her initial Application for Adjustment on 14 WC 32037.

On redirect-examination Petitioner acknowledged that she has problems remembering dates. She testified that she had no explanation on why her signed timesheets were inaccurate. She reaffirmed that that she last worked on March 23, 2014 because of very strong pain at that time.

On recross-examination Petitioner stated that she originally injured her right shoulder in 2013 and that her problems started with the first accident of wringing out the mop.

EVIDENCE DEPOSITIONS

Dr. Lawrence Lieber

Orthopedic surgeon Dr. Lawrence Lieber gave his deposition on July 16, 2015 (RX #1). At the request of Respondent Dr. Lieber conducted a records review on May 9, 2014. He reviewed the records of Dr. Narula, Dr. Kornblatt, Evanston Hospital, and Accelerated Rehabilitation. He also reviewed a job analysis of a custodian. Dr. Lieber conducted a §12 IME of Petitioner on April 15, 2015. He testified from his reports of the records review and that IME.

Dr. Lieber testified that, based upon the records that he reviewed, there was no evidence of significant trauma. He attributed Petitioner's present condition to the natural progression of the underlying degenerative changes in the right upper extremity. Dr. Lieber reviewed the November 2013 right shoulder MRI scan, which he felt showed evidence of some AC joint arthritis, and rotator cuff tendinitis. He testified that he did not appreciate an anterior labrum tear on the MRI. Dr. Lieber also reviewed a video job analysis of housekeeping work activities.

Dr. Lieber testified that he agreed with Petitioner's treating physician, Dr. Kornblatt, in that as of March 28, 2013 Petitioner did not require any further medical treatment. Dr. Lieber opined in his May 9, 2014 report that the Petitioner did not require any additional medical treatment and there was no evidence of any need for surgical intervention with respect to the work accident. Dr. Lieber further opined that the Petitioner was capable of working full duty with no restrictions, as there was no objective evidence of any abnormalities in the right shoulder that could be related to the alleged work accident. Dr. Lieber further opined in his May 9, 2014 report that the Petitioner had reached MMI in regard to her February 7, 2013 event by Dr. Kornblatt's

March 28, 2013 release for work. Dr. Lieber also opined that any treatment after March 28, 2013 was not caused by, related to, or associated with the February 2013 work accident.

Dr. Lieber noted that Petitioner described a mechanism of injury for the February 7, 2013 accident of "pain in the right shoulder area associated with mopping: utilizing the mop and squeezing out the mop in a bucket below waist level". Petitioner did not describe a specific injury for the alleged October 13, 2013 and March 17, 2014 accidents. She only described increased shoulder pain in relation to the two latter dates.

Dr. Lieber did not have a translator for the §12 exam. He testified that he repeated questions or directions if Petitioner did not seem to understand. On physical examination Dr. Lieber found that Petitioner's right shoulder range of motion was decreased due to pain. He noted positive AC tenderness, impingement, apprehension, greater Tuberosity, Speed's, O'Brien, and Reverse O'Brien signs. Dr. Lieber opined that he found no evidence of any abnormality in Petitioner's right shoulder that could be associated with any of her three reported dates of injury. He added that her current condition was not associated with any acute injury, but was a degenerative condition. Dr. Lieber further testified neither his clinical examination nor the MRI showed any acute abnormalities that could have been caused or aggravated by the February event. He opined that Petitioner's condition on April 15, 2015 was degenerative AC joint arthritis and degenerative rotator cuff syndrome. Dr. Lieber confirmed that Petitioner did not require any further medical treatment associated with any of her three alleged work accidents and had reached MMI and could work full duty.

On cross-examination, Dr. Lieber testified that 98% of the forensic review he does is for the defense. He acknowledged that there was a discrepancy between his May 19, 2014 records review report and his July 15, 2015 exam report. In the May 19 review he reported that records indicated Petitioner felt a cracking and pain in her right shoulder but that he did not indicate an acute injury in his later report.

On further cross-examination Dr. Lieber acknowledged that there may have been a language barrier resulting in a lack of full communication and/or understanding. He noted that MRI's are not 100% diagnostically reliable and that there was a possibility of a torn labrum. He felt that Petitioner's pain complaints were out of proportion to his objective findings, he agreed that different people have different responses to the same stimuli and a patient's pain cannot be measured objectively. Finally, Dr. Lieber agreed that due to the fact that the MRI of Petitioner's shoulder was 9 months post-accident, her symptoms (i.e. swelling) could have subsided over time and that an MRI immediately after the incident would have been helpful.

Dr. David Robertson

Dr. Robertson performed an IME of Petitioner on October 28, 2014 at the request of Petitioner's counsel. He also reviewed Petitioner's medical records. He gave his deposition on December 3, 2015 (PX #4). He testified from his IME report.

Dr. Robertson is still a board certified orthopedic surgeon, his original certification exempted him from re-certification, although he has not performed surgery since 2012.

Dr. Robertson stated he is fluent in Spanish and conducted the history and exam in Spanish. Petitioner gave a consistent history of the accident beginning with feeling a sharp pain in her right shoulder that radiated down the arm while mopping on February 7, 2013. He noted that Petitioner was a good historian. He further noted Pettioner's care with Dr. Kornblatt, including physical therapy and steroid injection.

On examination Dr. Robertson found full passive motion of the right shoulder. Active motion was limited by pain. He also found a positive rotator cuff impingement. Petitioner was unable to touch the small of her back. Dr. Robertson diagnosed rotator cuff impingement and a labral tear. He opined that Petitioner's history of pushing/pulling a handle of a bucket could have increased the pressure on the tendon of the rotator cuff and produced the rotator cuff impingement syndrome with tendon and bursa swelling and partial labral tear. Dr. Robertson opined that since Petitioner failed to respond to conservative treatment he recommended a right shoulder arthroscopy for a subacromial decompression. Petitioner would also need post-operative physical therapy. He further opined that the need for surgery could or might have related to her injuries of February 7, 2013, October 13, 2013, and March 17, 2014.

On cross-examination Dr. Robertson testified his only history of the Petitioner's alleged accidents and complaints was taken from Petitioner at his one visit. He did not review a job description or job analysis of the Petitioner's job. Dr. Robertson also indicated that he did not know the amount of time that the Petitioner spent mopping as part of her job duties and did know how many times Petitioner squeezed out a mop or pushed the handle of a bucket with her right arm on the February 7, 2013 date of accident. He did not inquire whether Petitioner mopped at home, whether she performed any activities around her house or outside of work that involved right shoulder pushing/pulling.

On further cross-examination Dr. Robertson acknowledged that two reasonable physicians could disagree interpreting an MRI. He then testified that he did not actually review actual the right shoulder MRI imaging but only reviewed the radiologist's report.

On redirect-examination Dr. Robertson opined that the described activities on October 13, 2013 and March 17, 2014 could or might have aggravated Petitioner's condition that was established on February 7, 2013. Dr. Robertson did not testify to what specific activities Petitioner was doing on October 13, 2013 and March 17, 2014. Dr. Robertson further testified that he did not know whether Petitioner was working on October 13, 2013 or March 17, 2014. Dr. Robertson opined that Petitioner further aggravated her rotator cuff impingement syndrome due to repetitive motion.

CONCLUSIONS OF LAW

14 WC 19901 (DOI 2/7/2013):

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

Petitioner proved that she sustained a right shoulder sprain/strain as a result of her work activities on February 7, 2013. However, Petitioner failed to prove that her current claimed condition of ill-being is causally related to that accident.

Petitioner treated conservatively for her February 2013 shoulder injury at Evanston Hospital and at Union Health Services with Drs. Narula and Kornblatt. Her conservative care included physical therapy and one steroid injection administered by Dr. Kornblatt. Dr. Kornblatt released Petitioner to work without noted restrictions effective March 28, 2013. She was advised to return p.r.n. at that time. He obviously believed Petitioner had reached MMI then.

Petitioner was not a credible witness. She has over the course of this matter alleged three different dates of accident in March of 2014. She had filed an Application for Adjustment of Claim alleging a date of accident when, as evidence showed, she was not working. She also changed the date on which she gave notice of one of her later claimed injuries. These elements, on top of her admitted poor memory, make for a witness who is not credible or reliable.

In addition, the Arbitrator notes the conflicting opinions of the IME physicians, Drs. Lieber and Robertson. Each was retained as an expert by one of the parties. Both physicians reviewed Petitioner's medical records from her treating physicians and then examined her. The Arbitrator finds Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being was not caused by an accident in March 2014 more persuasive than the opinion of Dr. Robertson that there was causation.

The Arbitrator notes that Dr. Lieber's examination and records review was more thorough than Dr. Robertson's. In particular, Dr. Robertson reviewed only the report of the right shoulder MRI, no the actual imaging. Further, although Dr. Robertson is still board certified, his original certification exempted him from re-certification, he has not performed surgery since 2012. Dr. Lieber is a currently practicing orthopedic surgeon. Also, Dr. Robertson's opinions are in large part based on the accuracy of Petitioner's history. Petitioner was not credible, particularly when changing the date of her alleged third accident. An opinion based on an unreliable or inaccurate patient history is itself unreliable. For these reasons the Arbitrator adopts Dr. Lieber's opinion that Petitioner is at MMI and that Petitioner's current claimed condition of ill-being is not related to a claimed accident on February 7, 2013.

K: Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's finding that Petitioner was at MMI as of March 28, 2013 and that Petitioner failed to prove that her current claimed condition of ill-being is causally related to her accident on February 7, 2013, this issue is moot.

14 WC 37711 (DOI 10/13/2013):

C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F: Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator addresses these issues jointly in that they are intertwined.

The Arbitrator finds that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent. The Arbitrator further finds that Petitioner's also failed to prove that her current claimed condition of ill-being is causally related to the claimed accident.

The Arbitrator noted Petitioner's admitted poor memory. That detracted from her credibility. She filed an Application for Adjustment of Claim stating that she was injured on March 17, 2014 and only amended the Application when it was proven she did not work that day. Petitioner was not a credible witness. More importantly was the evidence contained within Petitioner's own evidence.

Petitioner was seen at Union Health on October 18, 2013 (PX #2), 5 days after her claimed work injury on October 13. There was documentation in the clinical notes of that visit that Petitioner reported a work injury, much less than one on October 13. In addition, despite objective evidence to the contrary in RX #3, Petitioner reported to IME physician Dr. Robertson that she had an aggravation of her right shoulder problem at work on October 17, 2014.

Petitioner returned to Dr. Kornblatt on October 28, 2013. She complained of recurrent shoulder pain over the previous two weeks. She did not report an accident or incident that triggered that complaint or that had aggravated her prior shoulder condition. She testified that Dr. Kornblatt examined her and gave her an injection in her shoulder. He also took her off work. Petitioner followed up with Dr. Kornblatt on October 28, 2013. Again, there was no note that Petitioner reported a work injury, much less one on October 13.

Further, at trial Petitioner did not describe a specific event or work-related activity that approximated an accident on October 13, 2013.

In addition, the Arbitrator notes the conflicting opinions of the IME physicians, Drs. Lieber and Robertson. Each was retained as an expert by one of the parties. Both physician reviewed Petitioner's medical records from her treating physicians and then examined her. The Arbitrator finds Dr. Lieber's opinion that Petitioner's current

claimed condition of ill-being was not caused by an accident on October 13, 2013 more persuasive than the opinion of Dr. Robertson that there was causation.

The Arbitrator notes that Dr. Lieber's examination and records review was more thorough than Dr. Robertson's. In particular, Dr. Robertson reviewed only the report of the right shoulder MRI, no the actual imaging. Further, although Dr. Robertson is still board certified, his original certification exempted him from re-certification, he has not performed surgery since 2012. Dr. Lieber is a currently practicing orthopedic surgeon. Also, Dr. Robertson's opinions are in large part based on the accuracy of Petitioner's history. Petitioner was not credible, particularly when changing the date of her alleged third accident. An opinion based on an unreliable or inaccurate patient history is itself unreliable. For these reasons, the Arbitrator adopts Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being is not related to a claimed accident on October 13, 2013.

Finally, Petitioner's treating orthopedist, Dr. Kornblatt, did not document an opinion of causal connection to Petitioner's complaints in October 2013. Mere recitation of her history does not amount to an opinion of causal connection after the passage of 7 months, Dr. Narula's May 29 note notwithstanding. It is noted that Dr. Narula never documented a causation opinion. Dr. Kornblatt had released Petitioner to work without noted restrictions effective March 28, 2013. She was advised to return p.r.n. at that time. He obviously believed Petitioner had reached MMI then.

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

Petitioner's testimony that she gave timely noticed was unrebutted. The Arbitrator finds that Petitioner gave timely notice of her claimed injury.

However, in light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue 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?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

K: Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

L: What temporary benefits are in dispute? TTD

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

14 WC 32037 (DOI 3/17/2014):

C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F: Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator addresses these issues jointly in that they are intertwined.

The Arbitrator finds that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent. The Arbitrator further finds that Petitioner's also failed to prove that her current claimed condition of ill-being is causally related to the claimed accident.

At trial Petitioner did not describe a specific event or work-related activity that approximated an accident on March 17 or March 22 or March 23, 2014. She has over the course of this matter alleged three different dates of accident in March of 2014. More importantly, Respondent's timesheet exhibits, along with Petitioner's admitted poor memory, demonstrate that Petitioner is not a credible witness.

When Petitioner returned to Union Health on March 24, 2014 she gave a history of right shoulder pain for one week. She did not report an accident or incident that triggered that complaint or that had aggravated her prior shoulder condition.

Further, at trial Petitioner did not describe a specific event or work-related activity that approximated an accident in March 2014.

In addition, the Arbitrator notes the conflicting opinions of the IME physicians, Drs. Lieber and Robertson. Each was retained as an expert by one of the parties. Both physician reviewed Petitioner's medical records from her treating physicians and then examined her. The Arbitrator finds Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being was not caused by an accident in March 2014 more persuasive than the opinion of Dr. Robertson that there was causation.

The Arbitrator notes that Dr. Lieber's examination and records review was more thorough than Dr. Robertson's. In particular, Dr. Robertson reviewed only the report of the right shoulder MRI, no the actual imaging. Further, although Dr. Robertson is still board certified, his original certification exempted him from re-certification, he has not performed surgery since 2012. Dr. Lieber is a currently practicing orthopedic surgeon. Also, Dr. Robertson's opinions are in large part based on the accuracy of Petitioner's history. Petitioner was not credible, particularly when changing the date of her alleged third accident. An opinion based on an unreliable or inaccurate patient history is itself unreliable. For these reasons the Arbitrator adopts Dr. Lieber's opinion that Petitioner's current claimed condition of ill-being is not related to a claimed accident in March 2014.

Finally, Petitioner's treating orthopedist, Dr. Kornblatt, did not document an opinion of causal connection to Pettioner's complaints in March 2014. Although Dr. Kornblatt recommended arthroscopic surgery he did not note that the surgery was necessary to treat an accidental injury that occurred in February 2013 or October 2013 or March 2014.

Dr. Kornblatt had released Petitioner to work without noted restrictions effective March 28, 2013. She was advised to return p.r.n. at that time. He obviously believed Petitioner had reached MMI then.

It is noted that Dr. Narula never documented a causation opinion.

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

Petitioner's testimony that she gave timely noticed was unrebutted. The Arbitrator finds that Petitioner gave timely notice of her claimed injury.

However, in light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue 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?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

K: Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that

she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

L: What temporary benefits are in dispute? TTD

In light of the Arbitrator's findings that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment and that she failed to prove that her current claimed condition of ill-being is causally related to a claimed accident, this issue is moot.

Steven J. Fruth, Arbitrator

August 22, 2016

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

Diego Carrillo,
Petitioner,

vs.

NO: 15 WC 06739

Chicago Transit Authority,
Respondent,

17IWCC0668

DECISION AND OPINION ON REVIEW

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

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

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

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

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

DATED: OCT 24 2017

Charles J. DeVriendt

Joshua D. Luskin

d100417
CJD/rlc
049

17IWCC0668

DISSENT

To obtain benefits under the Act, an employee must prove his injury arose out of and occurred during the course of his employment. "In the course of" speaks to time, place, and circumstances of the injury. Petitioner was in the course of his employment when his injury occurred. "Arising out of" speaks to risk- is the risk encountered by the employee a risk incidental to the employment as not all injures suffered while at work are compensable. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements expressed by the legislature in the Act"). Petitioner confronted a neutral risk -alighting from the step of a bus- and the evidence failed to support a finding that such neutral risk was either qualitatively or quantitatively increased due to the nature of Petitioner's employment. Accordingly, I respectfully dissent.

"There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. [citations omitted]." *Adcock v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130884WC, ¶ 31. Further, an injury which results from a neutral risk requires the employee to show he was exposed to the risk to a greater degree than the general public. *Springfield Urban League v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 120219WC, ¶ 27. Such showing of an increased risk may be proved by "either qualitative (i.e., when some aspect of the employment contributes to the risk) or quantitative (such as when the employee is exposed to the risk more frequently than the members of the general public by virtue of his employment). [citation omitted]." *Adcock*, 2015 IL App (2d) 130884WC, ¶ 32.

In the present matter, Petitioner testified he was employed as a bus mechanic which required him to service and repair buses. T. 13. Petitioner further testified as part of his job duties, he was required to travel into the field to obtain malfunctioning buses two to five times in a seven-day period. T. 14-15. Petitioner testified on February 12, 2017 he stepped from the bus and felt pain in his back. T. 16. Petitioner testified the height of bus step was approximately 17 to 26 inches. T. 17. Petitioner testified later that same evening, he again felt the same pain when he stepped off the bus. T. 25. Petitioner testified on direct examination he stepped onto ice but provided no testimony of sipping due to the ice, just experiencing the same pain. *Id.* Only on cross-examination did he testify as to slipping. T. 34.

Three reports of injury and/or accident investigation were offered into evidence as Petitioner's Exhibit 1 and Respondent's Exhibits 2 & 3. Each of these reports memorializes Petitioner felt a sharp pain or injury to his back while stepping down or off a bus. PX1; RX1; RX2. There is no mention of slipping on snow or ice. These accident reports are consistent with Petitioner's testimony on direct examination that he felt pain in his back when stepping off the bus.

The majority in adopting the opinion of the Arbitrator ignores Petitioner's testimony as well as the accident reports -that his pain occurred while stepping from the bus. Instead the majority finds Petitioner slipped and fell to the ground due to ice. Such finding is not supported by the record. Petitioner did not testify to falling to the ground. At most, he testified to slipping and only on cross-examination. Further such testimony simply is not supported by any of the three accident reports which memorialize back pain occurring when Petitioner stepped from the bus.

17IWCC0668

In stepping off the bus, Petitioner confronted a neutral risk. The evidence does not support that such risk was qualitatively or quantitatively increased due to his employment duties as a mechanic. Qualitatively, Petitioner testified the rise of the step was approximately 17 to 26 inches but further conceded a bus passenger could also alight from this same distance. More importantly, there exists no testimony that stepping from this height caused the pain. There is no credible testimony that such height caused him to trip; caused him to land awkwardly; or caused him difficulty in any way. Certainly, the Commission is free to draw an inference but such inference must be reasonable. "Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot be reasonably drawn. [citations omitted]." *First Cash Financial Services v. The Industrial Commission*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799 (2006). To draw such an inference with these facts, I believe would not be reasonable.

Quantitatively, Petitioner testified within a seven-day period he would be required to collect malfunctioning buses two to five times. At best this would equate to an average CTA passenger traveling during her work week, and at least significantly less. Further, Petitioner testified on the day in question, he was required to repair a New Flyer 40-footer. There is no testimony as to how often this type of bus versus other models require repair. Certainly, the Respondent owns and operates a multitude of buses of all makes and models. There is no testimony as to the rise on these types of bus's steps, or how often Petitioner is required to repair the same.

For the reasons set forth above, I conclude Petitioner failed to prove he sustained an accident which arose out of his employment. As such, I would reverse the decision of the Arbitrator. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARRILLO, DIEGO F
Employee/Petitioner

Case# **15WC006739**

17IWCC0668

CTA
Employer/Respondent

On 3/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

1377 PARENTE & NOREM
DAVID A IAMMARTINO
221 N LASALLE ST 27TH FL
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
MICHELE D MORRIS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

17IWCC0668

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

Diego F. Carrillo
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **15** WC **6739**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **August 6, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0668

FINDINGS

On **February 12, 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 $**48547.20**; the average weekly wage was $**933.60**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**1911.64** for other benefits, for a total credit of $**1911.64**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2500.00 to Hispanic Regional, $9681.96 to ATI, and $1872.78 to Metro Anesthesia $5582.98 ION $5900.00 MRI Lincoln, and $1256.13 exactly to IWP for prescription charges as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $622.40/week for 13 5/7 weeks, commencing 2/13/15 through 5/19/15, as provided in Section 8(a) of the Act.

Petitioner failed to prove that he suffered any permanent injury as result of the accident therefore no award for permanency is ordered.

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

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

Deborah L. Simpson

Signature of Arbitrator

March 2,2016
Date

MAR 2 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Diego F. Carrillo,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 15 WC 6739**
	)	
CTA,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on February 12, 2015, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident that is the subject matter of this dispute within the time limits stated in the Act. They further agree that in the year preceding the injury the Petitioner earned $48,547.20 and his average weekly wage was $933.60.

At issue in this hearing is as follows: (1) Did the Petitioner sustain an accidental injury or was he last exposed to an occupational disease that arose out of and in the course of the employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the respondent liable for unpaid medical bills to IWP, Hispanic Regional, ATI, Metro Anesthesia, ION and MRI Lincoln; (4) Is the Petitioner entitled to TTD from February 13, 2015 through May 19, 2015;(5) What is the nature and extent of the injury; and (6) Should penalties and attorney's fees be imposed.

STATEMENT OF FACTS

The Petitioner is employed by the Respondent as a bus mechanic. He is responsible for servicing and repairing busses, retrieving busses when they break down and bringing them back to the garage. The Petitioner works out of the 77th Street garage. This is a facility that is not open to the public. Petitioner works mainly in the garage but he goes out into the field several times a week to fix broken down busses. He testified that he works the 10:00 p.m. to 6:30 and was a.m. shift.

Petitioner testified that he was in his usual state of good health when on February 12, 2015, when he reported to work at 10:00 p.m. On that date he injured his back twice on the same shift, first while stepping out of a CTA bus at an irregular height and the second time while stepping onto snow and ice and losing traction. According to the Petitioner both accidents occurred on CTA property that is not accessible to the public.

Petitioner testified that he drove a bus into the inspection bay during his shift. After he parked the bus, he stepped off the bus and felt a pain in his back. He admitted there were no hazards on the ground. He did not fall or slip. Petitioner stated that he took a break, but eventually returned to working. He later parked the bus outside in an uncovered lot. Petitioner testified that the parking lot had snow and ice. According to Petitioner, when he stepped off the bus, he felt the same pain in his back. On cross-examination Petitioner testified that the ice contributed to this pain, although he admitted that he neither slipped nor fell. Respondent and Petitioner both admitted written statements from Petitioner's managers and Petitioner taken on the date of the alleged accident. In all three statements, there is no mention of ice being a factor to Petitioner's accident.

Petitioner stated that the distance from the ground would have been 17 inches to 26 inches. Petitioner testified on direct examination that when transporting the public, CTA busses are always lowered to allow for no gap between a bus and the curb. This is called "kneel" or "kneeling" to lower the step before discharging or admitting their passengers. When the bus is kneeled it is at a height of 3 inches from ground level as opposed to an unkneeled bus which rests 17-26 inches off the ground. The parties agreed upon an oral stipulation indicating this testimony was incomplete. While bus operators have the ability to kneel a bus, it is agreed that this does not always occur. Petitioner also testified that passengers board busses at curb level and also at street level.

Petitioner reported the injury timely and sought and received conservative medical care including physical therapy, prescription drugs, an MRI revealing a herniated disc and a bulging disc and one epidural steroid injection. The herniated disc was found at T8-T9. Petitioner received an injection to treat the pain from this disc. (Px. 2) He returned to work full duty on 5/20/15. Petitioner has continued to work full duty since returning.

Petitioner was taken off of work by his treating physician Dr. Ramon J. Castro, on February 13, 2015. (Px. 4) He was continued off of work by Dr. Sajjad Murtaza, the Physical Medicine and Rehabilitation specialist that Petitioner was sent to, on March 5, 2015 because there was no light duty work available for Petitioner with the Respondent. On March 12, 2015, Dr. Murtaza performed a Thoracic epitural steroid injection at T8-9. (Px. 2)

On April 2, 2015, Petitioner followed up with Dr. Murtaza, reporting 60% pain relief. Dr. Murtaza ordered the Petitioner to participate in work conditioning. At that time he wanted to

send Petitioner back to work, but because no light duty was available, Petitioner was kept off of work. (Px. 2)

Petitioner returned to Dr. Murtaza on May 14, 2015. At that time he had full active and passive range of motion, no pain or tenderness and no spasms. Petitioner was discharged from care, returned to work full duty with no restrictions effective Tuesday May 19, 2015. The doctor's assessment was that the disc herniation at T8-9, with thoracic spine pain and myofascial pain was resolved. (Px. 2)

CONCLUSIONS OF LAW

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

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to 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; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

For compensability of a claimed injury, where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is said to have been causally connected to the work-related injury and not simply the natural

sequela process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003).

It is the burden of every Petitioner before the Worker's Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Commission,* (1969), 44 Ill.2d 207 at 214, 254 N.E.2d 522, *Edward Don v Industrial Commission,* (2003) 344 Ill.App.3d 643, 801 N.E.2d 18.

For an employee's workplace injury to be compensable under workers' compensation, Petitioner must establish the injury is due to a cause connected with the employment such that it arose out of the employment. *Hansel & Gretel Day Care Center v Industrial Commission,* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

It is not enough Petitioner is working when accidental injuries are realized; Petitioner must show the injury was due to some cause connected with employment. *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill.2d 207.

In other words, Petitioner must establish her employment subjected her to an increased risk of injury beyond that which the general public is exposed. *Holthaus v. Industrial Commission,* (1984) 127 Ill. App. 3d 732.

Falling while traversing stairs is a neutral risk, and the injuries resulting therefrom generally do not arise out of employment. *Illinois Consolidated Telephone Company v. Industrial Comm'n,* 314 Ill. App3d 347, 353, 247 Ill.Dec. 333, 732 N.E.2d 49.

A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Sisbro,* 207 Ill.2d at 204, 278 Ill.Dec. 70, 797 N.E.2d 665. (quoting *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989)

Risks to employees fall into three groups: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics. *Id.* For an injury caused by an unexplained fall to arise out of employment, a claimant must present evidence that supports a reasonable inference that the fall stemmed from a risk related to the employment. Id. at 106. An injury resulting from a neutral risk, to which the general public is equally exposed, does not arise out of employment. Id. An injury resulting from an idiopathic fall arises out of the employment only where the employment conditions significantly contributed to the injury by increasing the risk of falling or the effects of the fall. *Stapleton v. Industrial Comm'n.*, 282 Ill. App. 3d 12, 16 (1996).

Did the Petitioner sustain an accidental injury or was he last exposed to an occupational disease that arose out of and in the course of the employment?

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

In order to determine whether an injury arose out of employment, the type of risk associated with the injury must first be categorized. Risks to employees fall into three groups: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics. *Id.* For an injury caused by an unexplained fall to arise out of employment, a claimant must present evidence that supports a reasonable inference that the fall stemmed from a risk related to the employment. Id. at 106. An injury resulting from a neutral risk, to which the general public is equally exposed, does not arise out of employment. Id. An injury resulting from an idiopathic fall arises out of the employment only where the employment conditions significantly contributed to the injury by increasing the risk of falling or the effects of the fall. *Stapleton v. Industrial Comm'n.*, 282 Ill. App. 3d 12, 16 (1996).

The Petitioner argues that he is a travelling employee and as such he enjoys "a greater scope of what is deemed compensable even if it would not be for a non-traveling employee." The Arbitrator disagrees with this argument. The Petitioner testified that he works out of the 77th Street garage, and both of the accidents occurred while he was at that facility; One in the garage and the other in the parking area adjacent to the garage where the busses are parked when they are not in use or being serviced. He was not a travelling employee at the time of either fall.

Ordinarily stepping out of a bus would not be a risk distinctly associated with the bus mechanics such that it would be considered a risk distinctly associated with employment. Many people ride busses daily, to and from work or just to get around a city or for site seeing. They step on and off busses on a regular basis. Petitioner, in his position of a bus mechanic, when moving a bus from the lot to be repaired or returning it to the lot after servicing the bus is required to get in and out of busses on a daily basis. The difference in this case and the general public who ride busses daily, is that the passengers do exit the bus in the parking lot where the Petitioner had his second fall. Petitioner's exhibit 5, the photos taken from his cell phone clearly show piles of accumulated snow and ice on the ground where Petitioner had to step and walk when he exited the bus he was parking in the lot after servicing it. The unrebutted testimony was that this lot is not for the public, or accessible to the public. It appears from the pictures that anyone exiting the bus depicted in the picture could not avoid stepping into that snow or the ice around it.

Petitioner's report of incident is silent as to the snow and ice conditions at the time of the second fall, however he testified that the pictures were taken that night and that testimony was not challenged in any way.

The first fall that the Petitioner took, in the building, may not be compensable as he was stepping out of the bus like any other passenger would when exiting the bus. Petitioner agreed that there are times when drivers do not "kneel" the bus so that the general public would be stepping down from the same point he was. However, since both injuries resulted in back pain, and Petitioner was able to continue working between the two falls, it is difficult to determine which fall caused the pain.

Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment on February 12, 2015, when he fell to the ground stepping out of the bus while parking it in the parking lot of the 77th Street garage after the servicing of the bus had been completed.

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

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner's current condition of ill being is causally related to his on the job injury of February 12, 2015. Respondent did not obtain a Section 12 examination. The Respondent based its entire defense on the issue of accident. Based on the unrebutted testimony of Petitioner, the medical records and the finding that the Petitioner did sustain accidental injuries that arose out of and in the course of his employment with the Respondent, Petitioner's current condition of ill-being is causally connected to the accident of February 12, 2015.

Is the Respondent liable for unpaid medical bills to IWP, Hispanic Regional, ATI, Metro Anesthesia, ION and MRI Lincoln?

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Respondent did not challenge the reasonableness or the necessity of the medical treatment that the Petitioner received. No Section 12 examination or UR reports were offered challenging the treatment or the costs of the treatment.

Having found that the Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries in the course of his employment, and that his condition of ill-being was related to those injuries the Respondent is responsible for the costs of the medical treatment and services that were provided to the Petitioner as result of his accidental injuries sustained on February 12, 2015.

What amount is due for temporary total disability?

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner is entitled to receive Total Temporary Disability payments of $622.40 per week for 13 5/7 weeks for the time period from February 13, 2015 through May 19, 2015. Petitioner was taken off of work by his doctors after the injury and when they were ready to return him to light duty work, Petitioner informed them that no light duty work was available so he was kept off of work. The Respondent did not offer any evidence to contradict the Petitioner statements that no light duty work was available so Petitioner is entitled to payment for the entire time he was off work for treatment for the injury to his back.

What is the nature and extent of the injury?

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

This claim arose after September 1, 2011, therefore the 5 factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2) Occupation of the injured employee; 3) Age of the employee at the time of the injury; 4) Employee's future earning capacity; and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: Neither Petitioner nor Respondent presented an AMA Impairment Rating. Based on the failure to submit an AMA Impairment Rating the Arbitrator cannot consider this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a bus mechanic and continues to work for Respondent in that same position, full duty with no restrictions. The Arbitrator gives greater weight to this factor.

3. ***Age of the employee at the time of the injury***: Petitioner was 28 at the time of his accident. There is no evidence that Petitioner's age impacted his injury, recovery or created any permanent disability. The Arbitrator gives little weight to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that he continues to work at the same job that he had before the injury and his pay is the same as before the injury. Petitioner

did not testify to any diminution of his earnings since this accident. There is no evidence of disability due to this factor. The Arbitrator gives some weight to this factor.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained an injury to his back. He sought treatment and received conservative medical care including physical therapy, prescription drugs, an MRI revealing a herniated disc and a bulging disc and one epidural steroid injection. The herniated disc was found at T8-T9, there was no evidence presented by either party to establish if this was a pre-existing condition that was aggravated by the fall or it was an injury caused by the fall. By May 14, 2015, he had full active and passive range of motion, no pain or tenderness and no spasms. Petitioner was discharged from care, returned to work full duty with no restrictions effective Tuesday May 19, 2015. The doctor's assessment was that the disc herniation at T8-9, with thoracic spine pain and myofascial pain was resolved. The Arbitrator gives significant weight to this factor. Petitioner testified that today he cannot bend for long periods of time and cannot do much lifting. He takes muscle relaxers only on his day off. This is not documented in the medical records at the time Petitioner was found to be at MMI and released from further treatment. The medical records indicate that Petitioner has zero pain, he reported that "with significant exercise, his pain can elevate to a 1 or 2 on a scale of 10."

No evidence was offered to establish whether the herniated disc was the result of the fall on February 12, 2015, or was a pre-existing condition that was aggravated by the fall or falls and the Petitioner bears the burden of proof on this issue. An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994). The doctor's assessment was that the disc herniation at T8-9, with thoracic spine pain and myofascial pain was resolved. Petitioner has not proven that he has suffered a permanent injury. The medical reports offered and admitted into evidence establish that the disc herniation at T8-9, with thoracic spine pain and myofascial pain was resolved.

Should penalties and attorney's fees be imposed?

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner filed a petition seeking penalties under Sections 19(k), 19(l), and 16. Section 19(k) of the Illinois Workers' Compensation Act allows for penalties where there is a delay of payment. The delay must have been "unreasonable or vexatious." The delay must be frivolous and not related to any real controversy. Penalties under Section 19(l) are awarded where a delay for an unreasonable delay in payment of benefits under Section 8(a) or 8(b). In *Mlynarczk v. Sophie Orbrocha D/B/A Janitorial By Sophie*, 14 IWCC 0261 (2014), the Commission found where there "was a genuine controversy as to whether Petitioner sustained an accident that arose out of and in the course employment for Respondent," that it was not unreasonable for

Respondent to require Petitioner to prove her case. Here, the essential dispute is whether an accident occurred. The Arbitrator found that an accident did occur which was compensable. The Respondent raised a valid argument that the injuries were not compensable because no accident occurred. In other circumstances a mechanic stepping out of a bus and falling might not be compensable, such as the first fall that the Petitioner experienced the day of February 12, 2015. The Arbitrator does not find Respondent's delay in paying benefits to be unreasonable or vexatious. Penalties are therefore denied.

ORDER OF THE ARBITRATOR

Respondent shall pay for the reasonable and necessary medical services provided to Petitioner, pursuant to the medical fee schedule or by prior agreement, whichever is less, of $2500.00 to Hispanic Regional, $9681.96 to ATI, and $1872.78 to Metro Anesthesia $5582.98 ION $5900.00 MRI Lincoln, and $1256.13 exactly to IWP for prescription charges as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $622.40/week for 13 5/7 weeks, commencing February 13, 2015 through May 19, 2015, as provided in Section 8(a) of the Act.

Petitioner failed to prove that he suffered any permanent injury as result of the accident therefore no award for permanency is ordered.

Deborah L. Simpson

Signature of Arbitrator

March2, 2016
Date

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

Alphie Koester,
Petitioner,

vs.

NO: 16 WC 05571

Spartan Light Metal Products,
Respondent,

17IWCC0669

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 3, 2017, is hereby affirmed and adopted.

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

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

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

DATED: OCT 25 2017
o101217
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

KOESTER, ALPHIE
Employee/Petitioner

Case# **16WC005571**

SPARTAN LIGHT METAL PRODUCTS
Employer/Respondent

17IWCC0669

On 3/3/2017, 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:

4463 GALANTI LAW OFFICE
GIAMBATTISTA PATTI
PO BOX 99
E ALTON, IL 62024

2795 HENNESSY & ROACH PC
RICHARD A DAY
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

17IWCC0669

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)

Alphie Koester
Employee/Petitioner

v.

Spartan Light Metal Products
Employer/Respondent

Case # 16 WC 5571

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 4, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$27,664.00**; the average weekly wage was **$532.00**.

On the date of accident, Petitioner was **74** years of age, *single* with **0** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$67.89** for other benefits, for a total credit of **$67.89**.

Respondent is entitled to a credit of **$67.89** in medical bills paid through group insurance under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent, and that her current condition of ill-being is casually related to her alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit of **$67.89** in medical bills paid through group insurance under Section 8(j) of the Act.

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

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

Melinda M. Pope-Sullivan

Signature of Arbitrator

3/1/17

Date

MAR 3 - 2017

ICArbDec19(b)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Alphie Koester
Employee/Petitioner

Case # 16 WC 5571

v.

Consolidated cases: N/A

Spartan Light Metal Products
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is currently 74 years of age. She testified that she works on alternator brackets and has worked for Respondent for 19 years. She testified that she has done the alternator bracket job since 2014.

Petitioner testified that prior to the arbitration hearing, she had the opportunity to review the job duties video. She testified that she believed it was inaccurate. She testified that she always filed parts ahead and used a big file, and that there was no way the individual in the video could remove the flash filing in that manner. When asked how long it took to file a bracket, Petitioner responded that some can take 5 minutes or longer. She testified that she filed alternator brackets for 3-5 minutes apiece and did 70-80 brackets per day. She testified that these activities caused pain, especially in her left hand. She testified that her left hand goes numb and bothers her during the day and night. She testified that she takes some "pain pills" and that she has trouble doing things for herself.

Petitioner testified that she places six parts in a basket and puts them on a conveyor which takes them to another machine, that she has to roll the parts off and place them on the machine, that she places a bolt and then places them onto the conveyor when they are inspected, stamped and placed in a dunnage. She testified that there were 12 in a dunnage and that you placed them in plastic totes, and that there were 216 in a dunnage when the process was complete. She testified that she also worked on brake rings for a couple of years, but had been on alternator brackets since 2014. She testified that when not working on alternator brackets, she has to assemble bolts and places rubber rings. She testified that there were 750 bolts per box, and that she could usually get 4 boxes done in a day which totals 3,000 bolts per day.

Petitioner testified that she has carpal tunnel syndrome and that she has pain in her palm, wrist, elbow and shoulder. She testified that she has seen Dr. Mirly, who diagnosed her with carpal tunnel syndrome and recommended surgery. She testified that she also saw Dr. Rotman at her employer's request, and that he diagnosed her with carpal tunnel syndrome as well.

Petitioner testified that she has pain and numbness, and that she has trouble buttoning her shirt, putting on her earrings and lifting things like a skillet. She testified that she has reduced strength in her left hand, as well as some loss of strength in the right hand. She testified that she had a carpal tunnel release in the past back in 2000. She testified that she reported issues with both hands to her employer.

On cross examination, Petitioner agreed that she had a cyst in her left thumb in 2007/2008 and that she had her right carpal tunnel release in 2007/2008 by Dr. Prieb. She agreed that she returned from a medical leave in January of 2015 and that was when she started on the alternator bracket line. She agreed that back in January of 2015 it was not a production line and was not run 52 weeks of the year. She testified that if they ran out of parts, they could not do it. She denied doing the brake ring line in addition to working the alternator brake line and the bolt assembly line from January of 2015 until she reported her injury in January of 2016.

On cross examination, Petitioner testified that when she reported the injury to her left hand, she reported it to Bill Reed and then Jason Inselmann as well as having filled out an employee injury statement which was marked as Respondent's Exhibit 1. She agreed that her signature appeared on the document, that she completed it on January 4, 2016 and that her handwriting appeared on the document. She agreed that she indicated that she noticed she was getting worse in October and November of 2015, and that she indicated that she was filing and running the CNC machine. She agreed that she only reported issues with the left hand.

On cross examination, Petitioner agreed that for the first part of her job, she is looking at the bracket and using a file. She agreed that after she files, she puts the bracket upside down into the CNC machine which puts machine holes in the bracket, that she then turns it right side up, that the machine holes the bracket again and that she takes it out. She agreed that the video showed how the machine ran. She further agreed that it took about 4 minutes for the machine to cycle. She agreed that while the machine was cycling, she was doing some of the filing for the bracket. She testified that some of the brackets could take 3-5 minutes to file and that some can take longer. She agreed that after she takes the finished bracket out of the machine, she does a check of the bracket before she puts it in the basket. She agreed that after she has 6 in the basket, she takes the basket to the washer and that the basket goes through the conveyor washer and comes out on the other side.

On cross examination, Petitioner testified that she gauges the bracket before it gets put into the basket. She testified that gauging occurs before washing. She testified that she gauges it when she takes it out of the CNC machine. She agreed that when she was gauging and/or filing, she was using her left hand to hold the bracket and her right hand to file.

On cross examination, Petitioner agreed that she is currently 74 years old and that she is diabetic. She testified that she is taking two diabetes medications and that she was diagnosed 4-5 years ago. She agreed that she takes Biotin for her hair and fingernails, and that she also takes another medication, Furosemide, for fluid reduction.

Jason Inselmann was called as a witness by Respondent at the time of arbitration. He testified that he is employed by Respondent and has worked there for 20 years. He testified that his current position is Team Leader in Bit 5 where Petitioner also works. He testified that he is Petitioner's direct supervisor.

Mr. Inselmann testified that between January of 2015 and January of 2016, one of Petitioner's jobs was on the alternator bracket line. He testified that there were other positions besides the alternator brake line that she would perform during that time, including bolt and O ring assembly that they did for another line. He denied that, during the January of 2015 to December of 2015 timeframe, Petitioner ever reported any problems with her left hand while performing on the alternator brake line or the bolt assembly.

Mr. Inselmann testified that the first part of the process was that of filing of the bracket. He testified that the alternator bracket appeared in Respondent's Exhibit 2 and weighed 1.43 pounds. He testified that the bracket was made of "383 aluminum" which made it a light weight part. He testified that

the part is casted and machined at Respondent, and that after casting and machining, it goes to the alternator brake line area. He testified that when they get the cast part, they file or deflash the part with an 8-10 inch file. He testified that they are expected to deflash, which meant to take off the rough edges. He testified that any excess material was taken off before it gets to them.

Mr. Inselmann testified that he has seen Petitioner do the job. He testified that she typically spends 1-1½ minutes filing each bracket. He testified that Petitioner does in the range of 72-80 pieces per day because he sees the daily reports at the end of each shift. He testified that if Petitioner had to spend 5 minutes taking off the flashing on each part, she would not be able to get 72-80 parts completed.

Mr. Inselmann testified that the CNC cycle was 4 minutes and that after it was taken out of the machine, three holes were gauged and that after gauging, the part was put in a basket and then the basket (containing 6 parts) would be washed. He testified that while the parts were being washed, the operator was making the machine or filing more parts, and that bushing was then installed. He testified that another person did the gauging after the washing on the job video (*i.e.*, RX4).

Mr. Inselmann testified that after washing, a machine puts on a bushing and that after bushing, an inspection number was stamped on the part and it was packed for shipment. He testified that from the time of putting the bushing on to when the parts were packaged, for 6 pieces it may take 5-10 minutes.

Mr. Inselmann testified that in the timeframe of January 2015 through December of 2015, the bracket line typically ran 3-5 days per week. He testified that was a low-volume production line during that timeframe and that it ran approximately 50 weeks per year. He testified that there were times when the line was not running because they either were out of cast parts or their orders were low. He testified that it recently began running 5 days per week.

Mr. Inselmann testified that if parts were not being made, then Petitioner's job would then be in bolt assembly. He testified that there is a guide rod that they put several O rings onto, that they put a bolt into the end and that they then placed rubber washers one at a time. He testified that it was a light duty job and that they have had people on light duty perform that particular task.

On cross examination, Mr. Inselmann agreed that Petitioner was a good employee. He denied having any issues with truthfulness from Petitioner and further denied that she has been disciplined for being untruthful on the job.

On cross examination, Mr. Inselmann agreed that the alternator line was running for the majority of the time in 2015. He agreed that most people used the 8-10 inch file. He testified that he has mostly seen Petitioner use the 8-10 inch files, but agreed that she could use a different file for that job.

On cross examination, Mr. Inselmann agreed that he has filed the parts before and last filed one 2-4 months ago. He agreed that some brackets may need more filing than others. He testified that 3-5 minutes would be a long time to file a part. He agreed that he has not reprimanded Petitioner for taking too long to file a part. He agreed that the bolt ring assembly was one of the alternate jobs that Petitioner did along with filing alternator brackets.

On cross examination, Mr. Inselmann agreed that a couple of months before the arbitration hearing he asked Petitioner for an $800 loan. He testified that Petitioner "never got back with" him. He agreed that he never received the money.

On redirect, Mr. Inselmann testified that the files were supplied by Respondent. He testified that most individuals used the 8-10 inch file.

On further cross examination, Mr. Inselmann identified files that were presented at the time of arbitration as being 12, 8 and 6 inches in length. He testified that all three were the types of files typically used at Respondent's facility.

On further redirect, Mr. Inselmann testified that the 12 inch file was not used on the alternator bracket line and that the average was an 8-10 inch file. He testified that the 12 inch file was excessive for the size of the part.

On rebuttal, Petitioner testified that she heard the testimony of Mr. Inselmann and that some of the things he said were not true. She testified that she did not know who used the 6 inch file. She testified that she used the 8 inch file for flash removal. She demonstrated that she used the medium- and large-sized files as the files that she primarily used in her job. At the time of arbitration, Petitioner identified 18 different locations on the photo marked as Respondent's Exhibit 2 so as to show where the medium file was used to remove flashing from the alternator bracket. She identified one location on Respondent's Exhibit 2 as an area where she would use the largest file, and further testified that she did not use the small-sized file.

On rebuttal, Petitioner testified that she has never seen Mr. Inselmann file an alternator bracket. She admitted, however, that she had recently asked him for help with a bracket and further admitted that he might have done the filing when she was not present.

On rebuttal, Petitioner testified that when you do the alternator brackets in the back you file them, you run them, you inspect them, you blow them off and you gauge them. She testified that she then puts them in the basket and that the process takes time. She testified that when the brackets were wet, they had to be blown off because otherwise they would corrode. She testified that the air gun was not high-pressure and was not as powerful as a hair dryer. She testified that she would sometimes skip a break in order to get 80 brackets done in a day.

On cross examination, Petitioner agreed that when she completed the employee injury form, she did not identify any problems with bolt assembly. She agreed that the parts that were used at the time of arbitration were from Respondent's facility. She testified that no one from Respondent told her she was not supposed to be taking parts. She agreed that she used her right hand to hold the air gun to blow off the parts.

The medical records of Dr. Mirly were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on February 25, 2016 for evaluation of left hand pain. It was noted that Petitioner was recommended to Dr. Mirly by several of her friends. It was noted that Petitioner indicated that the first three fingers of the left hand were numb, and that she had a prior carpal tunnel release on the right hand by Dr. Priebe. It was noted that Petitioner has some pain at the right thumb CMC but resolution of her numbness. The impression was noted to be that of left carpal tunnel syndrome. Treatment options were discussed and Petitioner indicated that she would like to proceed with surgery. It was noted that Petitioner reported that she worked at Sparta Light Metals and had been there for 19 years. It was noted that Petitioner reported that her job duties in the last couple of years had been on the alternator brackets and placing rubber washers on the bolt assemblies. (PX1).

The transcript of the deposition of Dr. Mirly was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Mirly testified that he is an orthopedic hand surgeon. He testified that he first saw Petitioner on February 25, 2016. He testified that Petitioner indicated on the intake form that the first three fingers on her left hand were numb. He testified that Petitioner had been recommended to him by several of her friends, and that she reported having a prior right carpal tunnel release by Dr. Priebe. He testified that Petitioner had some pain at the right thumb CMC joint but resolution of her numbness in the right hand. (PX2).

Dr. Mirly testified that the physical examination revealed no thenar weakness or atrophy and that Petitioner had positive Tinel's, Phalen's and carpal compression. He testified that Petitioner was very clear that she had 3½ finger involvement, which was the anatomic distribution of the median nerve. He testified that his impression was that of left carpal tunnel syndrome. He testified that he discussed treatment options with Petitioner including splints, injections and surgery, and that she wished to proceed with surgery. He testified that Petitioner's decision to proceed with surgery was a reasonable choice. (PX2).

Dr. Mirly testified that he had opportunity to review two different job videos, one of which related to an alternator bracket and the other related to a brake ring. He testified that as to the brake ring video, he did not see any type of vibration, grinding or sanding on the video. He testified that he believed that video related to the alternator bracket demonstrated activity that he felt would be more carpal tunnel productive, and that the holding of the bracket, filing, and the bolt holes would be the type of activities in that line that would be most causative. (PX2).

Dr. Mirly testified that he was provided with two different alternator brackets and three files. He testified that he "played" with the different files. He testified that he had to do a lot of manipulation, holding the bracket with one and changing the angle of his hand, and that he had to keep his fingers closed on the file to maintain control and exert a fair amount of movement with it. He testified that he thought it could cause or aggravate carpal tunnel by holding the part in abnormal posture, holding the file and maintaining a grip on it. He testified that there was vibration with the file hitting the edge, and that you had to keep a tight grip on it or it would not push. He testified that the small files took a tighter grip, depending on hand size. When asked to assume that it required 3-5 minutes to fully file an alternator bracket and whether that would change his opinion, Dr. Mirly responded that it would be more consistent and that holding would be more contributory. (PX2).

Dr. Mirly testified that he believed that filing 70-80 alternator brackets for approximately 3-5 minutes apiece over the course of a five-day workweek for the last 2-3 years would be the sort of repetitive gripping activity that would contribute to the development of carpal tunnel syndrome. He testified that he thought that not everyone subjected to the same work developed carpal tunnel at the same speed. He testified that he believed that Petitioner had other contributing or non-occupational factors that made her more susceptible and contributed as well, including her age, gender, body mass and her other medical issues including diabetes. (PX2).

Dr. Mirly testified that he had opportunity to review Dr. Rotman's IME report, and that the main difference between their opinions pertained to causation. He testified that Dr. Rotman made a statement about Petitioner's prior obesity being a contributing factor, but he was unaware of any study to show any correlation with an individual's prior weight. He testified that once a person became symptomatic with carpal tunnel syndrome, the discontinuation of the activity did not necessarily cause it to resolve. He testified that he also obtained a history from Petitioner where she discussed a different work duty that was not included on either of the videos which was that of assembling a bolt assembly, which he did not get to visualize. (PX2).

Dr. Mirly testified that Petitioner's history of diabetes was a positive predictive risk value for both carpal tunnel syndrome and peripheral neuropathy. He testified that he did not recall seeing any medical records indicating her A1C levels. (PX2).

Dr. Mirly testified that he believed that Petitioner's work activities were a contributing factor to her carpal tunnel syndrome but that they were not the only cause. He testified that he thought Petitioner had some contribution as well from her non-occupational factors. He testified that he believed that a carpal tunnel release was reasonable and necessary to treat Petitioner's current condition, and that he

believed that her job duties could aggravate or accelerate carpal tunnel to the point of necessitating surgery. (PX2).

On cross examination, Dr. Mirly agreed that both he and Dr. Rotman agreed that Petitioner had carpal tunnel syndrome on the left side. He agreed that they both agreed that she might need surgery for her carpal tunnel condition. (PX2).

On cross examination, Dr. Mirly admitted that he did not know what the parts that he was given to look at were made of. He testified that he did not weigh them but believed that they weighed 1.43 pounds, which was a relatively light part. He agreed that he did not take a 19-year history from Petitioner about the jobs that she did. He admitted that he did not know what job Petitioner was performing at the time that she developed right carpal tunnel syndrome. He testified that he did not know if it was different than the job she was performing when she started having the left hand complaints. He agreed that Petitioner did not report to him when her left hand complaints even began. (PX2).

On cross examination, Dr. Mirly admitted that he did not know for how long Petitioner had been performing the brake ring line or alternator bracket positions. He testified that he did obtain some history that sometimes parts were not there so she would be pulled to other jobs like that involving bolt assembly, but that otherwise he assumed that Petitioner was performing the alternator bracket job five days per week, 8 hours or so per day. He agreed that his impression was that her primary assignment was the alternator bracket. (PX2).

On cross examination, Dr. Mirly testified that he was looking at postures of the wrist and that it did not necessarily have to be forceful, but rather the position of sustained wrist flexion. He agreed that repetition was a factor in the kind of work that the person was doing. He also agreed that exposure to vibration was a factor, of which he saw very little in the available videos. He testified that sustained gripping was significant as well as forceful gripping, and that not moving the fingers and keeping them in the same position was important as well. (PX2).

On cross examination, Dr. Mirly agreed that Petitioner was right-handed. He testified that he did not know if Petitioner ever switched hands and files. When asked if it was his understanding that Petitioner was at least using her right hand to file, Dr. Mirly responded that as he worked on the pieces he held the file primarily in his right hand as a right-handed individual. He testified that there was a certain vibration that came through the file and that when you were holding a smaller object, you had to hold your fingers in a tighter grip. (PX2).

On cross examination, Dr. Mirly agreed that Petitioner made no complaints of numbness in her right hand but she did have some pain at the base of her thumb which he attributed to arthritic changes. He testified that he did not know that Petitioner was on the brake ring line until he received the video. He testified that the only portion of that position that he felt would be contributory was the holding of the rings for a short period of time. (PX2).

On cross examination, Dr. Mirly testified that arthritis of specific joints in the wrists and fingers can be a risk factor for the development of carpal tunnel syndrome. He testified that if an individual had the carpal tunnel condition and symptoms for a longer period of time, the less likely removing them from the environment was going to cause alleviation of symptoms. He agreed that he could not comment with a reasonable degree of medical certainty whether or not the bolt assembly job was a contributing factor. (PX2).

On redirect, Dr. Mirly agreed that between January 2016 and July 2016 Petitioner was working on the brake line according to Dr. Rotman, and that this did not affect his opinion on causation. When asked if his opinion on causation regarding work on the alternator bracket line included the presumption

that Petitioner would have held the alternator bracket with her left hand as opposed to filing, Dr. Mirly responded that he had a preference to use his right hand with the file and to hold the item with his left but that he could certainly see changing it around. He testified that he thought most right-handed people would tend to use the file predominantly in the right hand and hold the bracket in the left hand, but he could also see the multiple shapes that would require a different "angle of attack" of the file. He testified that he assumed Petitioner would probably alter to a degree, but that he did not observe her. He agreed that his opinion did not change regardless of which hand she used to file. (PX2).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 3.

The Employee Injury Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report noted a date of injury of "Noticed getting worst [*sic*] in Oct., Nov." and that it was reported on January 4, 2016 to Gill Reed. (RX1).

The Alternator Bracket Photo was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Brake Ring Photo was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Alternator Bracket Line CD was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Brake Ring Line CD was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The transcript of the deposition of Dr. Rotman was entered into evidence at the time of arbitration as Respondent's Exhibit 6. Dr. Rotman testified that he is an orthopedic surgeon with a subspecialty in hand surgery, is board-certified in orthopedic surgery and has added certification and qualifications in hand surgery. (RX6).

Dr. Rotman testified that he performed an IME of Petitioner on July 18, 2016. He testified that he reviewed medical records, two job analysis reports and job videos concerning the two jobs that were identified on the job analysis reports, which were that of the alternator brake job and the brake ring line operator. (RX6).

Dr. Rotman testified that Petitioner had typical complaints of numbness and tingling and carpal-tunnel-type complaints of her left hand, and that she also had some triggering in her right thumb. He testified that Petitioner had a previous carpal tunnel release in the past, that she had a history of diabetes and that she had lost quite a bit of weight over the last few years but was still diabetic. He testified that Petitioner told him her job activities that involved some of the left-hand activities, and that Petitioner told him that since January of 2016 she had been working on the brake ring line machine but also did the alternator bracket job, which she had not done for seven months but was going to restart doing when the need for the parts would come in. He testified that Petitioner reported that on the alternator bracket job, she would file with her right hand and then hold the alternator brackets with her left, and that they were made out of aluminum and were light. He testified that Petitioner reported that she would file the part, place it in a machine, put the parts in a basket and that she would then run them through a washer and inspect them. He testified that Petitioner reported that she would put a bolt in the part with a pen-type device and then would hit a button, inspect them again and pack them. He testified that it was his understanding that there were several different processes that the alternator bracket job involved. He testified that he was also able to view the process in the job analysis report and the video. He testified that it was his understanding that the brake ring line machine operator position also involved a number of different processes. (RX6).

Dr. Rotman testified that it was his understanding that Petitioner previously had surgery on her left thumb to remove a cyst in 2008. He testified that at the time he saw Petitioner, she was on medication for her diabetes. He agreed that he felt that Petitioner had left hand carpal tunnel syndrome

and that he felt she required surgery. He testified that in conjunction with evaluating her condition he also performed neurometric testing, which was a hand-held nerve study device which he felt was fairly accurate except for mild carpal tunnel. He testified that the test results on the left side were consistent with pretty advanced carpal tunnel. He testified that carpal tunnel is generally progressive. He testified that he estimated that Petitioner probably had carpal tunnel for 5-10 years. (RX6).

Dr. Rotman testified that Petitioner's risk factors for carpal tunnel included her female sex, obesity, diabetes and her age. He testified that Petitioner was not morbidly obese like she was a few years ago, but she was still in the obese category. He testified that Petitioner's biggest risk factor was her diabetes. He testified that when a work activity was felt to be an aggravating factor for carpal tunnel it was generally a work activity that involved heavy grasping with or without the association of vibration, as well as without or without awkward wrist positions such as hyperextension or flexion. He testified that if you have a job that had prolonged hyperextension or flexion, it could increase the carpal tunnel pressures and that these had to be done repetitively or for a prolonged period of time during the course of the day and every day. (RX6).

Dr. Rotman testified that the part that Petitioner was lifting was only a couple of pounds, so he would not consider that to be a heavy object for her to handle. He testified that there was nothing that he saw about either job that suggested there was repetition in conjunction with maneuvering of the part. He testified that the job involved multiple steps, that this broke up the repetition and that none of the grasping was heavy with the left hand. He testified that he did not see any awkward positioning of the left hand for a prolonged period of time, but that he saw some grasping with the wrist and some extension and flexion at times but that most of the time the wrist was held in neutral position. He testified that if Petitioner was doing it a day or two every couple of weeks, it would not be a risk factor for carpal tunnel. (RX6).

Dr. Rotman testified that Petitioner did not mention any activity involving placing rubber washers on bolts at the rate of 3,000 per day. He testified that if putting the rubber washers on the bolts was connected to the alternator bracket activity and that she would only do it once or twice weekly every two weeks or so, this was not the kind of activity that would be a risk factor for a carpal tunnel condition. He testified that he did not believe that any of the work activities that Petitioner was performing that he reviewed was an aggravating factor for her carpal tunnel condition because none of the work involved anything that would be a risk factor, that she did not do repetitive heavy grasping activities for prolonged periods of time, and that none of the activities involved high forces, vibration or prolonged awkward positioning. (RX6).

Dr. Rotman testified that Petitioner was obviously predisposed to carpal tunnel considering she had already had it on her right side, she was diabetic, she was in her 70's, she was female and she was obese. He testified that there were no risk factors that he could see from work, only her health factors. (RX6).

On cross examination, Dr. Rotman agreed that it was his understanding that Petitioner's job duties specifically referring to the alternator bracket job were only performed a few days a week. When asked if Petitioner performed those jobs more frequently throughout the week and whether it would affect his opinion, Dr. Rotman responded that he did not see anything in regards to that job that was a risk factor and Petitioner had not done it in seven months. Dr. Rotman denied recalling how long the employee in the job video filed the alternator bracket and testified that he just saw that she held the brackets with her left hand while she filed with the right. He testified that he did not remember how long the person filed and that he did not time it. When asked if the filing depicted in the video was not accurate and whether that could change his opinion, Dr. Rotman denied that it would. (RX6).

On cross examination, Dr. Rotman testified that he was not sure if Petitioner's symptoms started 5-10 years ago, but if she would have been tested for carpal tunnel on a standard nerve study, it certainly

would have been found. He agreed that he was aware that Petitioner worked for Respondent for the last 19 years. He agreed that the only time that he saw Petitioner was on July 18, 2016. He agreed that he understood that Petitioner was on the brake line job between January and July of 2016. He agreed that Petitioner indicated to him that her normal job was with the alternator bracket and that she expected to begin work on that line shortly after the IME. (RX6).

On cross examination, Dr. Rotman agreed that a factor that a doctor takes into consideration on whether or not to proceed with surgery would be how a patient's symptoms affected their quality of life. He testified that he was not sure if he discussed how it affected Petitioner's quality of life, but he agreed that she had good reason to have symptoms considering how advanced her carpal tunnel was and that she definitely needed to have it fixed. He denied ever having toured Respondent's facility and further denied ever having held an alternator bracket. He denied being familiar with how many files were used in finishing an alternator bracket. He denied being aware that it took approximately 3-5 minutes to file an alternator bracket. He further denied being aware that Petitioner would file 70-80 alternator brackets in a given shift. (RX6).

On cross examination, Dr. Rotman testified that if the video was completely inaccurate and if Petitioner did prolonged heavy, repetitive gripping with her left hand, his opinions could change. He agreed that if Petitioner held the alternator for 3-5 minutes over 70-80 units per shift, it would involve more gripping than was seen on the video. He agreed that in his report he described the gripping shown in the job video as only intermittent during the course of different activities. He agreed that he felt that Petitioner's history indicated a predisposition to the development of carpal tunnel syndrome and that he was aware that Dr. Mirly also accounted for these factors in reaching his conclusion. (RX6).

On cross examination, Dr. Rotman agreed that Petitioner's age, obesity and history of carpal tunnel on the right were increased risk factors for the development of carpal tunnel and that he noted Petitioner's weight loss of 125 pounds over a 4-year period. He agreed that he stated that Petitioner's workplace exposure was not the cause of carpal tunnel and further agreed that the cause of carpal tunnel was relatively unknown. He agreed that not all diabetics developed carpal tunnel, that not all individuals with a BMI over 30 developed carpal tunnel and that not all women developed carpal tunnel. (RX6).

On cross examination, Dr. Rotman agreed that he did not discuss how the bolt assembly job affected Petitioner's symptoms and that it was fair to say that he did not evaluate how the activities required her to put rubber washers on the bolt. He agreed that he was unaware that Petitioner would do approximately 3,000 per day. He testified that if Petitioner was doing that many per day it could be repetitive enough to cause or aggravate carpal tunnel and that it would depend on the forces with regard to placing a rubber washer on the bolt. (RX6).

On cross examination, Dr. Rotman agreed that he was not provided with samples of the alternator brackets. He agreed that it was fair to say that he was not familiar with what it took to file them other than what was depicted on the video. When asked whether once someone with carpal tunnel became symptomatic and whether they improved with cessation of the aggravating activities, Dr. Rotman responded that the condition did not regress and that the same nerve studies would continue whether the individual continued with the activity or not. (RX6).

On cross examination when asked if he would agree that assembly line work put Petitioner at an increased risk for carpal tunnel, Dr. Rotman responded that it was really unknown at this point and that the conclusion over the years had been made not necessarily based on scientific data. (RX6).

On redirect when asked to assume that the bolt assembly job that Petitioner was performing involved very minimal force and the rubber bolt that was fitting on the end of the rod easily fit on the rod and whether this was the kind of activity that he felt could cause or aggravate carpal tunnel, Dr. Rotman

responded that it was not. He testified that to put a small washer on a bolt would not involve gripping at all and would involve pinching. He agreed that if the bolt assembly was repetitive, it would still have to be her regular activity every day for months at a time. He testified that if Petitioner was only performing it once or twice a week every two weeks, this was not sufficient. (RX6).

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on April 4, 2016, and that her current condition of ill-being is causally related to her work activities.

In so concluding that Petitioner failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator finds the opinions of Dr. Rotman to be more persuasive than the opinions provided by Dr. Mirly. The Arbitrator finds to be significant Dr. Rotman's testimony that Petitioner's job involved multiple steps, that this broke up the repetition and that none of the grasping was heavy with the left hand, that he did not see any awkward positioning of the left hand for a prolonged period of time and that he saw some grasping with the wrist and some extension and flexion at times, but that most of the time the wrist was held in neutral position. (RX6). This particularly testimony, when coupled with Dr. Rotman's testimony that Petitioner was obviously predisposed to carpal tunnel considering she had already had it on her right side, she was diabetic, she was in her 70's, she was female, she was obese and that there were no risk factors that he could see from work, cause the Arbitrator to place greater weight upon his causation opinion in this matter. (*Id.*)

Furthermore, the Arbitrator notes that while Dr. Mirly testified that he believed that the video related to the alternator bracket demonstrated activity that he felt would be more carpal tunnel productive and that the holding of the bracket, filing, and the bolt holes would be the type of activities in that line that would be most causative, the Arbitrator notes that Dr. Mirly also admitted that he did not know what job Petitioner was performing at the time that she developed right carpal tunnel syndrome, that he did not know if it was different than the job she was performing when she started having the left hand complaints, and that Petitioner did not report to him when her left hand complaints even began. (PX2). Having reviewed and considered the entirety of the testimony and medical evidence in the case, the Arbitrator finds that Petitioner failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on January 4, 2016, and that her current condition of ill-being is causally related to her work activities. All benefits are denied. The remaining issues of medical bills and prospective medical treatment are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darren Wells,
Petitioner,

vs.

NO: 16 WC 04239

McFarland Mental Health Center,
Respondent,

17IWCC0670

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 20, 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.

DATED: OCT 25 2017
o10.12.17
DLG/mw
045

David L. Gore

Stephen Mathis

17IWCC0670

Dissent:

Wells v. SOI, McFarland Mental Health – 16 WC 4239

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain his burden of proving that he sustained a compensable accident, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner suffered a ruptured tendon in his left leg. He testified that he was entering the laundry room through a heavy wooden door. He turned the key and pulled the door open. As he did he had to step back because the door opened inwardly. As he stepped back he felt the pop in his leg.

For an accident/injury to be compensable under the Act, the risk of sustaining the injury must be associated with the claimant's employment. Here the act of opening a door is an activity of everyday life. The claimant was not put at greater risk for sustaining a ruptured calf tendon from opening a door than any member of the public generally. In addition, a person must necessarily step backwards when opening a door that opened inwardly. In addition, the weight of the door does not seem to be relevant to sustaining an injury to the leg and Petitioner did not allege there was any defect in the door or the premises which would be related to his injury. In my opinion, the simple act of stepping backwards to open a door does not constitute a compensable accident under the Act.

Based on the reasoning stated above, I would have 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, reversed the Decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent.

RWW/dw
O-10/12/17
46

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WELLS, DARREN
Employee/Petitioner

Case# **16WC004239**

MCFARLAND MENTAL HEALTH CENTER
Employer/Respondent

17IWCC0670

On 4/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

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

0514 ASSISTANT ATTORNEY GENERAL
RICHARD C GLISSON
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

APR 20 2017

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

17IWCC0670

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Darren Wells,
Employee/Petitioner

v.

McFarland Mental Health Center,
Employer/Respondent

Case # **16** WC **04239**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **February 21, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On January 13, 2016, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,565.16**; the average weekly wage was **$1,222.41**.

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

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

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

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

ORDER

Pursuant to Section 8(b) of the Act, Respondent shall pay Petitioner temporary total disability benefits of **$814.94 per week,** commencing **January 14, 2016** through **January 26, 2016**, a period of **1 3/7 weeks**.

Respondent shall pay Petitioner **$733.45 per week** for a period of **4.3 weeks** under Section 8(e) because the injury caused a **2% loss of use of the left leg.**

Pursuant to Section 8(a) of the Act, Respondent shall pay Petitioner **$5,263.00**, subject to the fee schedule, for the incurred reasonable and necessary medical expenses, and subject to Respondent's 8(j) credit.

Respondent shall pay Petitioner compensation that has accrued between **January 13, 2016** and **February 21, 2017** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Nancy Lindsay
Signature of Arbitrator

April 14, 2017
Date

ICArbDec p. 2

APR 20 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner presented to the emergency room at Memorial Medical Center on January 13, 2016 stating he felt a pop in his left calf at approximately 5:45 p.m. that day. According to the hospital's "Final Report" Petitioner presented with lower extremity pain and a history of a sudden onset of pain and swelling to his left calf[1] after taking a step backward and hearing a pop in his calf followed by swelling to the calf. Petitioner reported a similar episode ten years earlier when he pulled his calf tendon. X-rays of his left tibia, fibula, and ankle were taken and he was diagnosed with calf swelling and a tendon laceration. Petitioner was instructed to follow up with his family doctor, Dr. Peterson, within one to two days. (PX 1; RX 5)

Petitioner completed a Notice of Injury Form on January 14, 2016 stating he was opening the locked laundry room door in the hallway of Monroe Building and put his key in the door, opened the door, and when he stepped backward, heard and felt a pop in his left calf. (RX 1)

Also, on January 14, 2016 an Employer's First Report of Injury was completed. According to it, Petitioner was opening a locked laundry room door when he stepped backwards and felt a loud pop in his left calf. The date of accident was January 13, 2016. (RX 2)

Petitioner presented to Dr. Peterson on January 14, 2016. Dr. Peterson noted Petitioner's history of having been at work the night before when he took a step back and felt a pop in the back of his left calf. Petitioner had gone to the emergency room and had x-rays which were negative. He further reported that he had been taken off work for the next five days. Petitioner recalled a similar thing happening to his right leg about ten years earlier. Petitioner was noted to have an abnormal gait and was tender in the mid-calf to palpation. It was felt Petitioner had ruptured his plantaris tendon and the doctor recommended physical therapy and an MRI. He continued to restrict Petitioner from work. (PX 2; RX 5) Dr. Peterson completed a Tristar Workers' Compensation Medical Report on January 15, 2016 confirming the accident at work and Petitioner's inability to return to work at that time. (PX 2; RX 10)

On "1/15/15" [sic] a Tristar Supervisor's Report of Injury or Illness form was completed. According to it, Petitioner was doing laundry and stepped back and had leg tenderness, swelling, and warmth. (RX 3)

Petitioner began physical therapy on January 18, 2016. Petitioner gave a history of stepping backwards with his left foot as he was opening a door. It was further noted that Petitioner worked as a mental health technician and was in direct contact with individuals and would need the ability to run at a moment's notice, maintain good upright stance, and/or restrain individuals as needed. As of the visit on January 20, 2016 the therapist still didn't feel Petitioner could handle his job demands. (PX 2; RX 5)

Petitioner returned to Dr. Peterson's office on January 20, 2016 reporting he had been attending therapy. Petitioner's calf was better but he now had some ecchymosis in his ankle. The physical therapist didn't feel

[1] The note says right calf but all treatment and examinations were to the left calf.

Petitioner was ready to return to work. Petitioner was advised to continue his current medications and continue physical therapy. (PX 2; RX 5)

Petitioner attended physical therapy on January 22, 2016. (PX 2; RX 5)

On January 25, 2016 Petitioner underwent an MRI of his left calf without contrast. It revealed a plantaris tendon rupture with edema, hemorrhage and post-traumatic myositis. (PX 1; RX 5)

Petitioner reported to therapy on January 26, 2016 reporting he had seen Dr. Peterson earlier in the day. Petitioner told the therapist that January 26th was the last day he had been written off of work and he felt he could return to work at this point. On examination some edema was still noted but the therapist felt Petitioner could return to work and be discharged from therapy. (PX 2; RX 5)

Petitioner was released to return to work with no restrictions on January 27, 2016. (PX 2; RX 6)

Petitioner signed his Application for Adjustment of Claim herein on February 8, 2016. (AX 2)

On February 16, 2016 Dr. Peterson completed a CMS Physician's Statement with regard to Petitioner's left calf injury. He indicated Petitioner could return to work on "January 27, 2016" [sic] with no restrictions. (PX 2; RX 6)

Petitioner followed up with Dr. Peterson's office on February 26, 2016. Dr. Peterson noted that Petitioner had injured his tendon when he stepped back. Petitioner had been undergoing physical therapy and was hoping he could be released to return to work. On examination Petitioner still displayed some generalized swelling to his posterior left calf and medial ankle with fading ecchymosis at the distal tibia. Dr. Peterson advised him to see his therapist that day and he was allowed to return to work but cautioned about possible worsening of pain and swelling upon his return to work. Periodic rest and elevation of his leg and use of ice were discussed. (PX 2)

Petitioner's case proceeded to arbitration on February 21, 2017.

Petitioner testified that he has worked for the State of Illinois for 11 years. He has worked at McFarland Mental Health Center, a State facility, since December 31, 2015. He is a mental health technician. Petitioner testified that as a mental health technician he assists residents with skills of daily living, including laundry and use of money.

Petitioner testified that on January 13, 2016, he was performing his normal job duties at McFarland, including working at Monroe Hall doing laundry. He testified that he started first with laundry, as he does most days. Petitioner testified that to enter the laundry room, one must unlock and open a heavy wooden door that leads from a hallway to the laundry room.

Petitioner described the door area leading to the laundry room. Petitioner testified that RX 7 and RX 8 accurately depicted that area. He explained, and the photos confirmed, that a wall runs to the left of the door. The door is hinged so that it opens away from the wall. Petitioner testified that, because of that and the presence of a wall on his left, he must open the door towards his body and step back to get around the door to enter the room. Petitioner testified that he has to use a key to unlock the door and turn the door handle simultaneously to

open the door. Because of the wall on the left and the fact the door opened towards him, he would need to step back and "sideways" to open the door. In doing so, on January 13th, he felt a pop in his left leg. As he did so, he felt a sudden pop in his left calf. He described an immediate onset of needle-like pain in his left ankle and burning pain radiating up into his left calf. Petitioner's testimony was unrebutted.

Petitioner testified that he enters this and several other doors several times during his work day.

Petitioner testified that he sought immediate medical care that day, receiving emergency medical treatment at Memorial Medical Center.

Petitioner further testified that he underwent physical therapy at Physical Therapists Clinic in Jacksonville, Illinois. He testified the physical therapy helped resolve some of his pain. Petitioner then followed up with Dr. Peterson on January 20, 2016. (PX 2)

Petitioner testified that he is 51 years old. He continues to work as a mental health technician at McFarland. He is earning the same wages as before the accident. He testified he had no prior left leg injuries nor has he had any subsequent left leg injuries. He testified that his left calf is weaker than it was prior to the injury. He testified that the calf now tightens when he is on his feet for prolonged periods of time.

Mr. Kelly Street, Respondent's chief engineer, testified for Respondent. He testified that there are hundreds of wooden doors at Respondent's facility. He agreed that the wooden doors at Respondent's facility are heavier than the doors people typically find in their own home. He also acknowledged that he had not received any work orders pertaining to the laundry room door.

The Arbitrator concludes:

Issue (C) Accident.

Petitioner sustained an accident on January 13, 2016 that arose out of and in the course of his employment.

Petitioner was in the course of his employment as he was working assigned duties during his work day. No evidence was presented suggesting that Petitioner was not in the course of his employment. Respondent's dispute appears to focus on whether Petitioner's accident "arose out of" his employment. The Arbitrator has concluded that it did.

Petitioner described a heavy wooden door leading to the laundry room. He described how he must enter and exit from this door several times daily. He further described how, because of the tight and confined configuration of the area leading to the laundry room, he must open the door with both hands, one using the key and one turning the door handle. He described how he must step back to get around the door because of the way the door is hinged. Respondent's witness agreed that the door is heavier than doors people typically find in their homes. Photos introduced into evidence by Respondent corroborate the way in which the door opens into the hallway with a wall to one's immediate left, thereby negating one's ability to move to the left when opening the door; rather, one must step back as Petitioner did.

The Arbitrator finds that this heavy door, coupled with the tight configuration requiring Petitioner to maneuver around the door to gain access to the laundry room is a risk not faced by the general public. The general public was not allowed in this area and, furthermore, Petitioner would encounter this risk more times than a member of the general public.

Issue (F) Causal Connection.

Petitioner's current condition of ill-being is causally related to his work accident. This conclusion is based upon a chain of events as Petitioner credibly testified to no prior left leg/calf injuries and no injuries to his leg/calf thereafter. The medical records all document Petitioner's history of accident, the symptoms experienced immediately after the accident, and objective evidence of injury contemporaneous to the accident. Respondent provided no evidence to the contrary.

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

Petitioner was temporarily totally disabled from January 14, 2016 through January 26, 2016, a period of 1 6/7 weeks. Respondent's dispute as to TTD benefits was based upon liability and not the dates of temporary total disability. Having found in Petitioner's favor on the issues of accident and causal connection, an award of temporary total disability benefits is appropriate.

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

Respondent shall pay, subject to the fee schedule and any credits, the charges from Memorial Medical Center ($4,777.00) and Memorial Physicians ($486.00). (PX 1, PX 3) The medical treatment Petitioner received was reasonable and necessary to cure the ill-effects of his work accident. The medical records detail that Petitioner's treatment was related to his left calf injury.

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

Pursuant to Section 8.1(b) of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. 820 ILCS 305/8.1(b) states the criteria to be considered are as follows: (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. Applying this standard to this claim:

With regard to paragraph (i) of Section 8.1(b) of the Act: Petitioner did not undergo an impairment rating. Therefore, the Arbitrator places no weight on this factor.

With regard to paragraph (ii) of Section 8.1(b) of the Act: Petitioner testified that he continues to be a mental health technician, his job at the time of the accident. He returned to work with no restrictions and requires no assistance in the performance of his duties stemming from his accident herein. He testified to tightness after standing on his feet all day. Petitioner's job, as noted in the therapy records, requires being on his feet a great deal throughout the day. The Arbitrator places moderate weight on this factor.

With regard to paragraph (iii) of Section 8.1(b) of the Act: The Arbitrator notes that Petitioner is 51 years old. As such, he has several more years of life and work expectancy to deal with his ongoing left calf symptoms. The Arbitrator places moderate weight on this factor.

With regard to paragraph (iv) of Section 8.1(b) of the Act: Petitioner testified that his earnings are the same as they were prior to his injury. The Arbitrator places little weight on this factor.

With regard to paragraph (v) of Section 8.1(b) of the Act: Petitioner testified that his left calf is weaker than it was prior to the injury and he notices tightness in his leg when standing on it all day long. He required no surgery and had to undergo therapy as part of the healing process. The therapist's notes indicate knowledge and familiarity with Petitioner's job duties and the therapist felt Petitioner was capable of returning to work. Petitioner's testimony regarding weakness and tightness in his leg was credible. The Arbitrator places weight on this factor.

Based upon the foregoing factors, the Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 2% loss of use of the left leg.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marlon Bell,

Petitioner,

vs. NO: 13WC 024391

Fresenius Medical,

17IWCC0671

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident and admissibility of IME report, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2017 is hereby affirmed and adopted.

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

17IWCC0671

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: OCT 25 2017

Stephen J. Mathis

David L. Gore

L. Elizabeth Coppoletti

SJM/sj
o-10/19/2017
44

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

BELL, MARLON
Employee/Petitioner

Case# **13WC024391**

FRESENIUS MEDIAL
Employer/Respondent

17IWCC0671

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
JUNIRA CASTILLO
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

17 IWCC0671

☐ 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)

Marlon Bell
Employee/Petitioner

v.

Fresenius Medical
Employer/Respondent

Case # **13** WC **24391**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **10/14/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 17IWCC0671

On the date of accident, **July 12, 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 not* given to Respondent.

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

In the year preceding the injury, Petitioner earned **$28,912.00**; the average weekly wage was **$556.00**.

On the date of accident, Petitioner was **47** years of age, *single* with **1** dependent children.

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

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

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

ORDER

Benefits denied, Petitioner did not sustain an accident that arose out of and in the course of his employment by Respondent.

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

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

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

Deborah L. Simpson

Signature of Arbitrator

January 23, 2017
Date

ICArbDec19(b)

FEB 14 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marlon Bell,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 24391**
	)	
Fresenius Medical,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on July 12, 2013, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, the Petitioner earned $28,912.00, and that his average weekly wage was $556.00.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) Was timely notice of the accident given to Respondent; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is Petitioner entitled to Prospective medical care; and (5) Were the medical services that were provided to the Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services.

STATEMENT OF FACTS

Petitioner, a 47 year old male, was employed by respondent as a primary care technician, (hereafter referred to as "PCT"). Petitioner testified that one of his job duties as a PCT what to perform stocking. At times stocking included stacking boxes of granflo.

Petitioner testified that on July 12, 2013 he was stacking boxes of granflo, which he stated weighed approximately 55lbs each. Petitioner stated that while performing this activity one of the top boxes began to fall. Petitioner testified that he attempted to prevent the box from falling by catching it with his right arm. This act caused the box to push petitioner's right arm and shoulder backwards behind his body. As a result of this petitioner stated he felt immediate pain in his right arm and shoulder. He also testified that his supervisor Willard Spurlock heard the box fall and asked him if he was okay and told him to be careful. After the accident took place petitioner continued to work as a PCT. He took Motrin for pain. Petitioner testified he did not fill out an accident report on the date of the accident or at any time during his employment period after the date of the accident up through his termination on September 20, 2013.

Petitioner testified he did not seek immediate treatment for the accident because he felt it was a little muscle strain. Petitioner testified that initially the pain in his shoulder was minor, but over time it began to increase. Petitioner testified that he continued to work in a full duty capacity for the respondent after the accident up to the date of his termination on September 20, 2013.

Petitioner's first date of treatment was on October 7, 2013. According to the record's history petitioner sustained an injury on July 17, 2013 when he was lifting 50lb boxes. "He fell backwards with the arms in abduction and external rotation and since then has pain on the right shoulder. (Pet. Ex #4) He was diagnosed with impingement of the right shoulder. (Pet Ex #4) Dr. Levi prescribed an MRI of the right shoulder and recommended petitioner start physical therapy.

Petitioner underwent an MRI on November 11, 2013. (Pet Ex #5) The MRI demonstrated rotator cuff tendonitis and/or bursitis involving the distal supraspinatus tendon, with AC inferior hypertrophic spurring indenting the supraspinatus tendon, possibly with mild impingement. (Pet. Ex #5)

Petitioner returned after the MRI to see Dr. Levi on December 4, 2013. Dr. Levi state the MRI revealed rotator cuff tendonitis or bursitis in the distal supraspurnatus tendon with arthritic changes in the AC joint with hypertrophic changes. (Pet. Ex #4) Dr. Levi opined petitioner was unable to lift but could possible return to light duty in six weeks. He prescribed pain medication and recommended continued physical therapy. Dr. Levi did not provide a causal connection opinion as to the results of the MRI and petitioner's work accident. (Pet. Ex #4)

Petitioner initiated physical therapy on October 2, 2013. He participated in physical therapy through January 14, 2014. At the time of petitioner last therapy visit a history was provided indicating petitioner made 60% improvement and his pain had been reduced to a level of three out of ten. Additional treatment was recommended but not undertaken. (Pet. Ex #4)

Petitioner continued to see Dr. Levi for his right shoulder. On March 12, 2014 petitioner was seen by Dr. Levi. The note indicates that despite conservative treatment the pain was persisting. Dr. Levi recommended an arthroscopy and coracoacromial decompression. (Pet. Ex #4)

Petitioner testified that the recommended surgery was denied by respondent. The records indicate that petitioner continued to be examined by Dr. Levi throughout the year in 2014, 2015, and 2016. During these exams petitioner expressed continued complaints of right shoulder pain and Dr. Levi continued to recommend surgery. (Pet. Ex #4)

At the time of hearing October 14, 2016, petitioner testified that he still was experiencing extreme pain in his right shoulder and wanted to undergo the surgery recommended by Dr. Levi.

On cross-examination petitioner confirmed his employment with respondent on July 12, 2013. Petitioner confirmed that he was familiar with the circumstances of sustaining an injury while working for the respondent, as he had sustained an index finger injury six months prior while working for respondent on January 16, 2013.

Petitioner confirmed he did not fill out an accident report for the July 12, 2013 accident, but did remember his supervisor Willard Spurlock filing one out for the January 16, 2013 accident. Respondent presented a copy of the January 16, 2013 accident report (Resp. Ex #5)

Petitioner further testified that after the accident on July 12, 2013 he continued to work full duty for the respondent. He testified that the accident did not cause him to miss any work. Petitioner also testified that during this time he performed the necessary duties needed to run his own business, consisting of the installation of big screen TVs and other electronic equipment. These duties included lifting in excess of 50lbs. (Resp Ex #3,4)

On cross examination petitioner also answered questions regarding posting found on his Face Book page. Petitioner initially testified that he did not personally provide the postings or have any involvement with his Face book page. He testified that his nephews handled his Face book page, with his permission. However, the Arbitrator notes, petitioner went on to admit later in his testimony that he personally posted some of the pictures on his Face book page. Petitioner also corroborated some of the pictures and postings on the Face book page. Petitioner testified that the pictures of him lifting weights were old, but later testified that Dr. Levi told him to lift weights as a form of physical therapy. The Arbitrator does not find petitioner's testimony on this subject credible.

Petitioner also testified that his "hustle business" was not actually a business and his nephews performed all the manual labor. The Arbitrator notes, the hustle business, (hereafter referred to as "MSP") appears to be more than a simple occasional side job. MSP has its own utility van with the MSP name on it and a phone number, which petitioner confirmed was his personal number. (Resp. Ex #1) MSP has it's own Face book page which contains photographic evidence of numerous installations performed. Petitioner testified that he rarely does anything for MSP anymore which is contrary to the posting on April 7, 2016 showing the petitioner performing an installation. (Resp. Ex #2) Petitioner testified that these installations required heavy lifting in excess of 50lbs, but stated his nephews performed this part of the installations. However, petitioner also testified at hearing that he trained his nephews in the business over the last two to three years which would have still been after the date of accident in question. The Arbitrator does not find petitioner's testimony on this subject credible.

The only witness to testify for the respondent was Mr. Willard Spurlock. Mr. Spurlock had been employed with the respondent since August of 2012. He testified his current position with the respondent was a supervisor of the Fresenius Dialysis Clinic. He testified that he is responsible for the investigation and reporting of all work accidents at this clinic. Mr. Spurlock testified that when an accident is sustained and reported by an employee he is required to investigate the details of the accident and discuss the circumstances with the injured employee. After this process is completed he is required complete an accident report and file it with his employer and send it to CNA, the insurance carrier for the respondent. Mr. Spurlock testified that no matter how minor the alleged accident he is required to complete and file an accident report. Mr. Spurlock testified that he went through this exact process with the petitioner when the petitioner sustained an accident while working for the respondent on January 16, 2018.

Mr. Spurlock testified the petitioner was having employment issues immediately prior to the July 12, 2013 accident. He testified petitioner was having attendance issues as well as issues with insubordination. This testimony was corroborated by the email Mr. Spurlock sent to his area manager on July 3, 2013 detailing petitioner's recent employment issues. (Resp. Ex #6) This testimony was also corroborated by the termination document which indicates petitioner was written up for a no show and no call on July 9, 2013 three days prior to that accident. (Resp. Ex #7)

Mr. Spurlock testified he never witnessed or heard a box fall while petitioner was stocking on July 12, 2013. He stated that if petitioner informed him that he sustained a work accident he would have immediately completed an accident report as he is required to do and just as he did on January 18, 2013 when petitioner reported his finger accident.

Mr. Spurlock also testified to having a conversation with the petitioner about the July 12, 2013 accident a few weeks after the accident when petitioner reported it. Mr. Spurlock testified that during that conversation the petitioner told him his lawyer must have been mistaken and he did not sustain a work accident while working for respondent and this was related to his employment with Best Buy. The Arbitrator takes judicial notice that petitioner does have a prior worker's compensation claim against Best Buy, claim 08 WC 5792. Mr. Spurlock also testified that the petitioner told him "you should always claim something from your employer, it's part of your benefit package and that is why they have insurance." Mr. Spurlock drafted the accident report for this case on September 25, 2013. (Resp. Ex #8)

Mr. Spurlock concluded his testimony with details of petitioner's termination of employment with respondent on September 20, 2013. He stated at that at the time petitioner was terminated, he never mentioned sustaining a right shoulder injury or sustaining an accident of any kind on July 12, 2013. The details of petitioner's termination are contained in the corrective action form. (Resp. Ex #7)

CONCLUSIONS OF LAW

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

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972).

It is well established that a claimant carries the burden of proof with respect to each element of his claim by the preponderance of credible evidence. *Parro v. Indus. Comm'n*, 260 Ill.App.3d 551, 554-55 (1st Dist. 1993). The claimant may present witnesses to prove his case. It is the function of the Arbitrator to determine the credibility of those witnesses, draw reasonable inferences based on the testimony, and determine the weight to be assigned the testimony. *Parro*, 260 Ill.App.3d at 554. The Arbitrator need not find for a claimant merely because there is some testimony that standing alone would justify a favorable outcome. *Burrgess v. Industrial Comm'n*, 169 Ill.App.3d 670, 676 (1st Dist. 1988). Rather, the Arbitrator should consider both direct and circumstantial evidence and draw reasonable inferences there from, even if it is contrary to the testimony. (*Id.*) It is the Commission's function to evaluate the evidence and resolve the conflicts that arise. *Beattie v. Industrial Comm'n*, 276 Ill.App.3d 446, 449 (1995).

After carefully reviewing the record, weighing the evidence, and assessing Petitioner's credibility, the Arbitrator finds that the Petitioner was not a credible witness for several reasons as stated above.

In support of the Arbitrator's decision on the issue of whether petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

In order for an accident to be compensable under the Illinois Workers' Compensation Act, a claimant must prove by a preponderance of the evidence that an accident arose out of and in the course of his employment with respondent. *Vill v. Industrial Commission*, 351, Ill.App.3d 798 (1st Dist. 2004).

The Arbitrator finds the petitioner did not sustain an accident that arose out of and in the course of his employment by the respondent on July 12, 2013.

In reaching this conclusion this Arbitrator finds that petitioner testimony of sustaining an accident lacks credibility when compared to the totality of the evidence. Despite the petitioner's allegation that he provided immediate notice to his supervisor, Willard Spurlock, an accident report was not completed until September 25, 2013 after petitioner was terminated from employment. (Resp Ex #8) Mr. Spurlock testified that the petitioner never informed him of the July 12, 2013 accident. Mr. Spurlock also denied hearing boxes fall on July 12, 2013 and asking the petitioner if he was okay. Mr. Spurlock went on to testify that if an accident would have been reported as alleged certain specific steps would have been taken. These steps include

immediate investigation of the accident including the completion of an accident report that details the circumstances of the accident. Mr. Spurlock's testimony as to the steps that are taken upon receiving notice from an employee of a work accident is corroborated by steps he took as a result of petitioner's January 16, 2013 accident while working for the respondent. When petitioner reported that accident, he immediately investigated the accident, completed an accident report and filed it with the insurance company. (Resp Ex # 5) Mr. Spurlock also testified that no matter how minor the accident might have been, he is required to investigate and complete an accident report.

Next, the Arbitrator notes that petitioner did not seek medical treatment for the accident until three months after it allegedly took place and after his employment was terminated by the respondent. (Pet. Ex 4, Resp Ex 7) Petitioner testified that he treated with his family doctor, Dr. Chen in August of 2013. However there is no evidence of this treatment in the record which further calls into question the petitioner's credibility. The records and the behavior of the petitioner do not support the allegation of a work injury. Petitioner also testified that during the three month period between the date of accident and the first date of treatment, he worked full duty for the respondent and he worked his "hustle" job. The Arbitrator notes that his job with respondent and the side business required him to use his right shoulder to lift heavy items as well as working on ladders. (Resp Ex #2) He was also capable of installing a water pump in his truck, which would have required him to use his right shoulder. (Resp Ex #1) The fact the petitioner worked two separate jobs, which required heavy lifting with his right shoulder for three months after the accident without treatment calls into question petitioner's allegation of sustaining an accidental injury in July of 2013.

This Arbitrator also notes the diagnostic medical evidence presented does not support an acute accident. The MRI taken on November 11, 2013 showed no tears and only revealed tendonitis or bursitis with hypertrophic spurring. (Pet Ex #5) These degenerative findings would not be uncommon in a 48 year old male that sustained a prior rotator cuff injury as petitioner testified to. They would also be common in a person that lifted weights on a regular basis as testified to by the petitioner and supported by the social media evidence.

The Arbitrator notes petitioner's credibility is at issue. The Arbitrator recognizes that petitioner is familiar with the Illinois Worker's Compensation system having testified to filing seven different claims against multiple employers. The petitioner was familiar with the requirements of respondent regarding reporting injuries, regardless of the seriousness of the injury, immediately as demonstrated by the injury to his finger in January of 2013. The Arbitrator finds it suspicious that petitioner was provided a written work warning on July 9, 2013 for not showing up to work and three days later he allegedly sustained a work injury. This is compounded by the fact petitioner's hustle business provides a picture of him discussing the installation of an 80 inch screen TV weighing 121lbs on the day he was written up for not showing up to work for respondent. (Resp Ex #2, #3) The Arbitrator notes, petitioner denied on cross examination that this written warning ever took place.

The Arbitrator also finds numerous inconsistencies in petitioner's testimony. Petitioner initially testified the pictures of him posted on his face book page lifting weights were old and prior to the date of accident. However, he goes on to testify that Dr. Levi told him he could lift weights as a form of physical therapy. The Arbitrator also finds no evidence in the records from Dr. Levi recommending the petitioner lift weights as a form of physical therapy. The records

actually contradict this allegation. Dr. Levi repeatedly states petitioner should not be lifting over 10lbs. (Pet. Ex #4) Additionally the Arbitrator finds it unusually coincidental that on May 18, 2016 petitioner was examined by Dr. Levi with complaints of pain in his right shoulder to the point he had trouble sleeping and needed to be off work, but on that very same day a picture of the petitioner bench pressing 225lbs is posted on his face book. Petitioner also tells Dr. Levi on June 25, 2014 that when he extends his elbow he gets pain. (Pet Ex #4) Contrary to that allegation petitioner is seen on his Facebook page nine days prior, June 16, 2014 and June 18, 2014, performing arm curls while lifting weights. On this date this is also a response to the post from one of petitioner's facebook friends which would confirm the authenticity of the time and date of the posting. (Resp Ex #1) The Arbitrator notes petitioner posted at least six separate pictures of him lifting weights in between the time the accident occurred to the date of hearing. When looking at the dates of the postings as compared to the dates of his treatment with Dr. Levi, the allegations of petitioner's physical abilities and extreme pain are in direct contradiction.

The Arbitrator further questions petitioner's credibility when testifying to the details of his business called Maximum Security Electronics Plus, hereafter "MSP". Petitioner testified that this was not a business but a "hustle." Something he described as a way to make money on the side, "it was not a really business". Petitioner further testified that he does not work that hustle anymore. Petitioner's testimony is contradictory to the Social Media evidence presented. First, MSP has its own Facebook page, which was updated as recently as April 7, 2016. It would make no sense to update a Facebook page for a business that is no longer in service. Petitioner also possessed a van that had the MSP name on it with the petitioner's phone number listed on the van as the company's number. (Resp Ex #1) Petitioner also posted a picture and details of a MSP installation he completed a month after the accident. The positing is dated August 15, 2013 and the comment reads, "I did this one with a plasma…" There is a response the very same day posted which would contradict petitioner testimony that the postings were old and not dated correctly. There are too many inconsistencies and contradictory facts to find petitioner's allegation of sustaining a work accident on July 12, 2013 to be credible.

Due to the above, the Arbitrator finds Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment with the respondent. Therefore, Petitioner's claim for compensation is denied.

Based on this Arbitrator's findings on the issue of accident the remaining issues are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson

Signature of Arbitrator

January 22, 2017

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

Hassan Harris

Petitioner,

vs. NO: 16WC015221

Homewood Memorial Gardens, Inc.,

17IWCC0672

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 15, 2017 is hereby affirmed and adopted.

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

17IWCC0672

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: OCT 25 2017
SJM/sj
o-9/28/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

HARRIS, HASSAN
Employee/Petitioner

Case# **16WC015221**

HOMEWOOD MEMORIAL GARDENS INC
Employer/Respondent

17IWCC0672

On 2/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
LYNN TAYLOR
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2837 LAW OFFICES JOSEPH MARCINIAK
NICOLE McNAIR
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

17IWCC0672

☐ 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)

Hassan Harris
Employee/Petitioner

v.

Homewood Memorial Gardens, Inc.
Employer/Respondent

Case # **16 WC 15221**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago** on **December 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0672

FINDINGS

On the date of accident April 11, 2016, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $19,179.48; the average weekly wage was $399.57.

On the date of accident, Petitioner was 48 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 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0.

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

ORDER

Petitioner failed to prove by a preponderance of the evidence that an accident occurred that arose out of and in the course of his employment with Respondent on April 11, 2016 and therefore no benefits are awarded pursuant to 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.

17IWCC0672

Findings of Fact

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; and whether Petitioner is entitled to prospective medical treatment. *See,* AX1.

Petitioner's testimony

Hassan Harris, (the "Petitioner"), was employed as a cemetery worker and groundskeeper at Homewood Memorial Gardens, (the "Respondent"), on April 11, 2016. His duties were to dig graves, cut grass and pick up debris. He had worked for Respondent for approximately five (5) years. On that date, Petitioner alleges that he injured his lower back while shoveling dirt and transporting it via wheelbarrow. Petitioner testified that he had sustained prior injuries while working for Homewood Memorial Gardens, i.e., an injury to his finger in April 2015.

He further testified that he was aware of how to report a work-related injury and knew which health clinic employees were sent to after sustaining work-related injuries. Petitioner testified that he reported this injury to his supervisor, Kelly McCarthy telling her that he needed medical treatment, but he was denied treatment. Petitioner later testified that he actually initially reported the injury to Latricia Parris, then followed-up with Kelly McCarthy. Petitioner did not work on April 12, 2016 but returned to work with continued symptoms. Petitioner testified that he was terminated from his employment with Respondent on April 29, 2016, following an altercation with a co-worker. Petitioner denied that the police were called to this altercation. Petitioner testified that he first sought treatment for his injuries on May 3, 2016, at Cook County Immediate Care.

Respondent's witnesses' testimony

Ms. Kelly McCarthy and Ms. Latricia Parris testified at the hearing. Ms. McCarthy testified that she is a family counselor at Homewood Memorial Gardens and has held that position for ten (10) years. She counsels families on anything related to burials and oversees the cemetery workers and groundskeepers. Ms. McCarthy reports to the manager, Tommy Flynn, Jr., who is not on site on a daily basis.

Ms. McCarthy testified that she was not on site on April 11, 2016 because she was working part-time due to recovery from a knee injury. She testified that Petitioner did not report any injury to her on April 11, 2016 or at any time thereafter. She further testified that she first learned Petitioner was claiming a low back injury in mid-May 2016, when she received the Application in the mail from Petitioner's attorney.

According to Ms. McCarthy, the groundskeepers were supposed to report any injuries to her or to Latricia Parris in her absence. Once reported, Ms. McCarthy stated that she would bring the employee to an Ingalls Health Clinic or to an emergency room if the injury was severe. She stated that Petitioner had sustained a few prior injuries, i.e., a 2013 injury to his low back and a 2015 injury to his finger, and those accidents were properly reported and Petitioner received treatment at the Ingalls clinic.

Ms. McCarthy testified that Petitioner did not follow this procedure regarding an April 2016 low back injury and that she did not deny medical treatment to Petitioner for this alleged low back injury; and

that she terminated Petitioner's employment on order from her manager on April 29, 2016, following his altercation with a co-worker.

Ms. Parris testified that she is also a family counselor at Homewood Memorial Gardens and has been employed there for one and one-half years. While Ms. McCarthy was out of the office, the groundskeepers were to report any injuries or issues to her and that Petitioner did not report any injury to her on April 11, 2016 or at any time thereafter.

Ms. Parris testified that Petitioner worked the day following the alleged accident and through his termination date, without issue. She witnessed the altercation that led to Petitioner's termination on April 29, 2016. She testified that Petitioner threatened a co-worker with a shovel and would not calm down, so she had the office call the police. Petitioner was terminated the following morning. Ms. Parris learned shortly after the termination that Petitioner had applied for a groundskeeper job at a nearby cemetery. Petitioner denied that he applied for this job. Ms. Parris testified that she first learned Petitioner was claiming a low back injury in mid-May 2016, when Ms. McCarthy received the Application for Adjustment of Claim in the mail from Petitioner's attorney.

Petitioner's treatment

Petitioner initially sought treatment on May 3, 2016, at Cook County Health and Hospitals System Immediate Care. Petitioner described pain in his low back radiating down his left leg. He also stated that he would drink one pint of vodka daily on weekends and sometimes on Mondays. Petitioner was started on Robaxin and Tylenol, but no NSAIDs, due to uncontrolled hypertension.

On May 23, 2016, Petitioner presented to Dr. Hector Vydas at Cook County Health and Hospitals System Family Practice. Petitioner requested a note saying he was unable to perform the physical duties of his job. He was referred for physical therapy, which he began on June 3, 2016.

On July 11, 2016, Petitioner had an MRI of his lumbar spine. On September 16, 2016, Dr. Vydas referred Petitioner to neurosurgery for a possible herniated disc. On October 21, 2016, Petitioner saw neurosurgeon, Dr. Sierens, who recommend continued conservative treatment including a trial ESI and continued physical therapy. On October 31, 2016, Dr. Vydas referred Petitioner to the pain clinic, which is scheduled for February 1, 2017. PXs3 & 4.

Petitioner testified that he has been unable to work since May 24, 2016. However, Petitioner also testified that he applied for and was granted unemployment benefits, which ended in November 2016.

17IWCC0672

Conclusions of Law

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

Petitioner brought this case before the Arbitrator based upon a request for hearing on disputed issues. As in any case, the burden of proof is on a claimant to establish the elements of his right to compensation and unless the evidence, considered in its entirety, supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

It is the burden of every Petitioner before the Worker's Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Commission,* (1969), 44 Ill.2d 207 at 214, 254 N.E.2d 522, *Edward Don v. Industrial Commission,* (2003) 344 Ill.App.3d 643, 801 N.E.2d 18.

For an employee's workplace injury to be compensable under workers' compensation, Petitioner must establish the injury is due to a cause connected with the employment such that it arose out of the employment. *Hansel & Gretel Day Care Center v. Industrial Commission*, (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244. It is not enough Petitioner is working when accidental injuries are realized; Petitioner must show the injury was due to some cause connected with employment. *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill.2d 207.

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

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

17IWCC0672

his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

The Arbitrator finds that the petitioner has not proven by a preponderance of the evidence that an accident occurred which arose out of and in the course of his employment by Respondent. Petitioner's testimony that he sustained a work-related injury on April 11, 2016, is not credible.

Petitioner's testimony that he reported the injury to supervisor Kelly McCarthy and/or Latricia Parris is not credible. Both Ms. McCarthy and Ms. Parris testified that Petitioner never reported an injury. Petitioner and supervisor Kelly McCarthy both testified that Petitioner was aware of how to report a work-related injury and where to seek treatment for a work-related injury as he had sustained work-related injuries in the past.

Petitioner did not seek treatment until May 3, 2016, after his involuntary termination on April 29, 2016. According to Ms. Parris, Petitioner subsequently sought employment at a nearby cemetery and applied for unemployment benefits, which were granted. To receive unemployment benefits, Petitioner was required to certify that he was able, available and willing to accept suitable work.

Therefore, the Arbitrator finds that the petitioner has not proven by a preponderance of the evidence that an accident occurred which arose out of and in the course of his employment by Respondent. As Petitioner has not proven that he sustained a work-related accident on April 11, 2016, all other disputed issues are moot and will not be addressed.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
16WC15221
SIGNATURE PAGE

17IWCC0672

Signature of Arbitrator

February 15, 2017
Date of Decision

FEB 15 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Mileur,

Petitioner,

vs. NO: 11WC 032737

State of Illinois/Menard Correctional Center,

Respondent.

17IWCC0673

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 31, 2016 is hereby affirmed and adopted.

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

17IWCC0673

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: OCT 25 2017

SJM/sj
o-10/12/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

MILEUR, JOSH
Employee/Petitioner

Case# **11WC032737**

ST OF IL/MENARD CORR CENTER
Employer/Respondent

17IWCC0673

On 8/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
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

AUG 31 2016

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

17IWCC0673

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)/8(a)

JOSHUA MILEUR
Employee/Petitioner

v.

STATE OF ILLINOIS / MENARD CORR. CENTER
Employer/Respondent

Case # 11 WC 32737

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0673

FINDINGS

On the date of accident, **August 22, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,077.50**; the average weekly wage was **$860.62**.

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 **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$2,000.00** for other benefits, for a total credit of **$2,000.00**.

Respondent is entitled to a credit for **any benefits paid** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained his burden of proving that he sustained accidental injuries arising out of and in the course of his employment with the Respondent on August 22, 2011.

The Arbitrator finds that the Petitioner has sustained his burden of proving that his condition of ill being in the bilateral elbows/ulnar nerves is causally related to the August 22, 2011 accident.

Respondent shall pay reasonable and necessary medical services which are causally related to the treatment of ulnar neuropathy conditions of the bilateral elbows which are contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. The Respondent is not liable for medical expenses that are related to the Petitioner's treatment of chronic gout or any other unrelated conditions. Pursuant to stipulation, all awarded outstanding medical benefits shall be paid by the Respondent directly to the applicable providers.

Respondent shall be given a credit for all related 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 the bilateral elbow/ulnar neuropathy surgeries recommended by Dr. Paletta.

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

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

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

Signature of Arbitrator

August 29, 2016
Date

ICArbDec19(b)

AUG 31 2016

STATEMENT OF FACTS

The Petitioner, a 35-year-old correctional officer for Respondent, began his career at the Menard Correctional Center in October, 1997, and worked as a correctional officer ("CO") for almost 15 years until 9/1/13, when he was promoted to Lieutenant. During that time, he generally worked the 3 to 11 shift, and testified that he worked a significant amount of overtime, which he believed to be approximately 5,800 to 5,900 hours over the course of his career. The Petitioner's testimony regarding overtime appears to be largely corroborated by his time sheets, although it should be noted that the Petitioner missed a significant period of work between November of 2009 and August of 2010. (Px8; Rx11).

Petitioner filed his Application for Adjustment of Claim with the Commission on 8/25/11. (Arbx2). Respondent's attorneys entered their appearance on 9/6/11. The Petitioner called Cindy Cowell, Respondent's Office Coordinator, to testify at the hearing. She testified that Petitioner first reported this alleged claim in February, 2013, but acknowledged that she received the Application for Adjustment on or about 8/25/11, and testified that she would have forwarded it to the Attorney General's Office and to the State's Central Management Services. She also acknowledged that the Attorney General's Office entered their appearance on 9/6/11 and that she received a subpoena from Petitioner's counsel requesting workers' compensation document logs on 9/27/11. However, she also testified that the Petitioner did not follow the Respondent's work injury protocol in 2011, which included calling an "800" number, and that she thus never opened a workers compensation file on the Petitioner until February, 2013.

Petitioner testified his job duties as a CO involved unlocking cell doors, cuffing and uncuffing inmates, opening and closing heavy steel cell doors, bar rapping and escorting inmates. The cell doors are solid steel and slide open rather than being hinged, and Petitioner testified that they are heavy and take two hands to move. He testified that he rapped the cell door bars, striking metal on metal with a metal baton checking for tone differences to see if there are any deficiencies in the bars. This produced a vibration radiating up both arms. The Petitioner testified there were 55 cells on each wing and that he rapped thousands of bars per week. He also testified that there are chuckholes in the segregation unit with a sliding padlock door entrance for cuffing and cuffing inmates and providing items. This is a two-type system that turns a deadlock operated by a key. The Petitioner testified this often required forceful gripping because the door and chuckhole locks did not work easily because of use and age. Petitioner also handled and cuffed resisting inmates and performed shakedowns.

He estimated that 90% of his work days he was assigned to a gallery, including his overtime, and very rarely was he assigned to a tower.

The Petitioner's testimony was generally corroborated by Major Brian Thomas. Major Thomas started at Menard in 1987 as a CO and was promoted through the ranks to Major in a 28-year career. He was a CO for about 4.5 years, and a CO Sergeant for another 4.5 years, and was familiar with the job duties. The Petitioner testified that the duties of a CO and a Sergeant were not really different. Major Thomas testified that a CO, a Sergeant and conscientious Lieutenant would all use their arms and hands in essentially the same fashion. He agreed that the Petitioner worked a lot of overtime, and in fact earned nicknames as a result. Major Thomas further stated that, as a shift commander, it was his opinion that the Petitioner was the type of person where if Thomas needed something taken care, he could ask the Petitioner to do it and it would be done without having to check on him. Major Thomas's testimony was consistent with the Petitioner's in that the locks and doors at Menard do not work smoothly, and that officers have to struggle to get them open on a daily basis.

The Petitioner testified he reviewed the Job Site Analysis of a Correctional Officer at Respondent's Menard facility. (Rx3). This narrative description of the job duties classifies the strength demand of the job as frequent lifting and/or carrying up to 25 pounds, frequent pulling open of doors from 2.5 hours to 5.5 hours per day, up to 66% of the time, or up to 200 times per day. This includes pulling open chuckhole doors as needed, and cuffing and uncuffing of inmates. Wrist turning is required 34-66% of the time, 2.5 to 5 hours per day, or 33 to 300 times per day. (Rx3).

The Petitioner also reviewed Respondent's DVD depicting various duties of a CO at Menard. (Rx4), which the Arbitrator also reviewed. It depicts demonstrations of CO duties by a variety of COs in the armory, shakedowns, bar rapping, opening of cell doors and gates, turning gallery cranks, control room and receiving area duties, segregation unit cell and shower doors, chuckholes and tower work. Each area requires opening and closing multiple door locks and using multiple keys. Bar rapping was simulated, and the demonstrating officer explained that COs are to listen to the sound to ensure that the bars have not been tampered with. One cell involves bar rapping on 5 to 6 bars in 12 separate sections. COs perform bar rapping at the beginning of each shift on the gallery where they are assigned, and there are 55 cells per gallery. Some galleries have half solid doors and half open bars.

The demonstration showed that COs used both hands to complete tasks. On one occasion, when the videographer asked a CO if he always turned keys with his left hand, the officer switched hands and stated, "You learn to use both hands in here because you need about four of them." On another occasion, when the videographer asked a CO to demonstrate the unlocking maneuver in slow motion, the officer tried to do so and the lock stuck. He had to turn it multiple times to try to get it to work and explained that the locks were difficult to turn in slow motion. The DVD was stopped when a Correctional Officer struggled to open a cell door and pulled on it with both hands. This difficulty was consistent with the Petitioner's testimony regarding the condition of the doors and locks at Menard.

Petitioner also prepared a job description which was admitted into evidence as Px10. This corroborated Petitioner's testimony, and in addition indicated that Petitioner loaded and unloaded 80 to 100 pound property boxes weekly, including carrying them for 50 to 100 feet, and writing and typing reports. Respondent also admitted a 2/8/13 "Demands of the Job" form which indicates that Petitioner uses his hands for gross manipulation for 2 to 4 hours a day and fine manipulation for up to 2 hours per day. (Rx1).

During the course of performing his job duties, Petitioner testified that he began developing symptoms in his arms and hands. These gradually got worse over the years. Petitioner initially started with over-the-counter

medication, anti-inflammatories, and bracing, but nothing provided lasting relief. On 8/21/09, Petitioner was evaluated by Dr. Alam for symptoms including numbness and tingling of both hands. Bilateral EMG/NCV testing was performed which showed no evidence of ulnar neuropathy on either side. It was, however, positive for bilateral carpal tunnel syndrome. On 4/2 and 5/7/10, Petitioner underwent bilateral carpal tunnel release surgeries with Dr. Brown. He made a satisfactory recovery and was released to return to work in September 2010.

On 8/22/11, Petitioner sought treatment with orthopedic surgeon Dr. Paletta, who noted that after Petitioner's prior carpal tunnel release surgeries, he continued to have numbness and tingling in the ulnar side of the hands. Dr. Paletta noted that he previously treated Petitioner for a subscapularis tear of his left shoulder (January, 2010), and that Petitioner had undergone the bilateral carpal tunnel releases with Dr. Brown in 2010. The Petitioner asked Dr. Paletta whether the ulnar numbness and tingling was due to gout and gouty deposits. Dr. Paletta noted a history of significant underlying gout issues with multiple gouty tophus deposits about the elbows and the extensor surfaces of the MCP joints. Exam noted significant gouty deposits at the right elbow area in the area of the olecranon bursa and distal to that. On the left was noted a prior surgical incision consistent with previous gouty tophi removal, and that as to the gout there were "less significant findings on the left side", with no evidence of obvious significant recurrent tophi. The diagnosis was probable residual carpal tunnel, possible cubital tunnel, and "gouty tophi without probable etiologic relationship to his numbness and tingling". Dr. Paletta recommended updated NCV testing, noting that if gout was the main etiologic factor, which he didn't believe was the case, then the complaints were likely not work related. (Px3).

An "addendum" to this report states that the Petitioner's elbow was carefully examined, not noting which elbow, that Petitioner had a firm mobile nontender deposit directly over the ulnar nerve in the cubital tunnel, and that a gouty tophi could be causing compression of the ulnar nerve. Dr. Paletta noted that if the NCV showed ulnar nerve involvement, he would recommend an MRI to further evaluate if the mass was gouty tophus, and if so that surgical excision could help. (Px3).

The 8/22/11 NCV with Dr. Phillips revealed mild bilateral ulnar neuropathy consistent with cubital tunnel syndrome with no evidence of recurrent carpal tunnel. Dr. Phillips noted that Petitioner had gouty tophi extruding from the skin at the right elbow. (Px4). Dr. Paletta reviewed the results, diagnosed mild bilateral cubital tunnel, and recommended night splints for Petitioner's elbows, non-steroidal anti-inflammatories, and if there was no improvement at a 6 week follow up, that Petitioner should consider surgery. (Px3).

For the gout problem, Dr. Paletta referred Petitioner to Washington University, where he underwent IV infusions. This was noted to have significantly reduced Petitioner's gout, as reflected in his lab testing. Despite this treatment, Petitioner continued to have symptoms of numbness and tingling in his arms.

Respondent had the Petitioner evaluated by upper extremity surgeon Dr. Sudekum on 4/15/13 pursuant to Section 12 of the Act. Dr. Sudekum opined that Petitioner's ulnar nerve condition was due to his severe gout condition. He further opined that there was no objective evidence of ulnar neuropathy or cubital tunnel syndrome on either side according to his Neurometrix NCV study, and that the Petitioner would thus not be a good candidate for cubital tunnel surgery. He did, however, offer to excise Petitioner's gouty tophi from the elbow.

Dr. Sudekum testified in this case in a two part evidence deposition on 11/20/14 (Rx6) and 4/2/15 (Rx7). While he testified that he needed to use his report to refresh his recollection, he also testified that he had some independent recollection of the Petitioner, as he was an unusual patient due to "the most severe form of gouty arthritis and gouty tophi deposition disease" he had ever seen. His diagnosis of Petitioner was severe gouty

arthritis affecting both upper extremities, including the bilateral elbows, wrists and hands, and he did not feel that Petitioner's upper extremity conditions/complaints were caused or aggravated by his employment at Menard. He testified that his examination of the Petitioner reflected severe gouty tophi deposits on both elbows, so significant that the crystals were extruding from the skin.

On cross-examination, Dr. Sudekum was asked about the validity of his Neurometrix NCV test versus the type performed by Dr. Phillips, and he testified that he believed the studies were the same and of good quality. He admitted that he, although owning and using a Neurometrix machine, still at times refers patients to Dr. Phillips for NCV testing. With regard to various medical literature opinions to the contrary, Dr. Sudekum essentially testified that many of these opinions were provided by biased stakeholders. He acknowledged that Dr. Phillips' study confirmed the existence of cubital tunnel syndrome, testifying that Dr. Phillips was a very good physician, and that the difference in their test results could be explained by the passage of time between tests and improvement in the Petitioner's condition. Dr. Sudekum's testimony was taken prior to the positive results of Petitioner's new nerve conduction studies performed on 7/9/15. (Px4).

Dr. Phillips also testified by way of deposition, on 3/18/15. (Px7) Dr. Phillips indicated he was familiar with the Neurometrix device and testified that it is very different from the NCV device used in his practice. He explained that essentially the testing was not as thorough as his NCV testing, and that the data is interpreted by a facility at some distance away for the results. He further testified that there are a significant amount of false positives and false negatives with the Neurometrix test, and that he didn't rely on the findings in the diagnosis and treatment of patients. Dr. Phillips testified that he is an electrical and biomechanical engineer who thoroughly understands this technology and how it works.

Dr. Paletta's deposition was obtained on 6/13/14. (Px6). In addition to his examinations and treatment of the Petitioner, he reviewed multiple documents; a deposition of Dr. Sudekum given on the position of a "Menard Correctional Officer," a post description for Correctional Officer at Menard Correctional Center, the CorVel Job Site Analysis, the deposition of Dr. Sudekum taken in the case of the "Menard Correctional Officer" (James Bauersachs), and a DVD prepared by CorVel Corporation purporting to outline the duties of a Correctional Officer at Respondent's Menard facility. He testified that he relied on these in the formation of his opinions.

It should be noted that the Arbitrator rejects the admission of the deposition of Dr. Sudekum in the Bauersachs case (Paletta Deposition Exhibit 4), as it involved a different claimant and thus was not subject to cross examination in this case, as well as a report of Dr. Sudekum (Paletta Deposition Exhibit 1) in the same case as a hearsay document. The Arbitrator noted that Dr. Sudekum was deposed in this case, and that is the best evidence of his opinions with regard to the specific Petitioner in the case at bar. The remainder of the exhibits offered at Dr. Paletta's deposition are admitted.

Dr. Paletta had seen Petitioner before he saw him for his elbows for a traumatic injury of his left shoulder. He performed surgery and Petitioner made a full recovery and returned to work. Dr. Paletta took the history of Petitioner's work activities and prior medical problems, and he noted the results of the NCV results he obtained from Dr. Phillips, showing mild demyelinating ulnar neuropathy across both elbows with no evidence of recurrent carpal tunnel syndrome. His diagnosis was mild ulnar neuropathy of both elbows consistent with cubital tunnel syndrome. He recommended a trial of non-surgical treatment as outlined in his notes consisting of night splints, non-steroidal anti-inflammatories, and follow-ups.

Dr. Paletta agreed that he also treated the Petitioner for a knee condition subsequent to the first visit of the Petitioner for his upper extremities on 8/22/11, and that the Petitioner still had not been released from care at the

time of the deposition following a long delay in actually performing the knee surgery. He did anticipate a full recovery from his knee surgery. (Px6).

Noting he hadn't seen the Petitioner in some time, he recommended updated NCV studies. At the time of his deposition, Dr. Paletta's opinion on causation was as follows: "When I initially saw him on 8/22/11, one of Mr. Mileur's underlying medical problems is he has a severe case of gout, and there was a question of whether he had some gouty deposits that may have been contributing to his cubital tunnel syndrome. It was my opinion at the time when I saw him on August 22nd that we needed electrophysiologic studies to determine that. Given the fact that those electrophysiologic studies showed abnormalities on both sides and he only had a gouty deposit on one side, it was my opinion that the gout was not a contributing factor, and in my opinion, his work activities are at least a contributing factor in his underlying cubital tunnel diagnosis made at that time." (Px6, p. 14). Dr. Paletta explained that if gout was Petitioner's problem, it would be a local compressive force on the nerve and Petitioner would have gouty tophi bilaterally if that were to cause the problem.

Following his deposition, Dr. Paletta saw Petitioner again on 6/29/15, presenting with complaints of chronic hand pain as well as intermittent numbness and tingling involving his fourth and fifth fingers. He noted that Petitioner was sent to Dr. Sudekum, and that Dr. Sudekum found Neurometric testing showed no evidence of cubital tunnel and he thus had no additional treatment. Petitioner also reported pain at the elbows with night pain and loss of strength. Activities at work seemed to precipitate or worsen the symptoms, particularly with turning keys on multiple locks. Dr. Paletta's examination showed positive findings all relating to cubital tunnel, including tenderness to palpation, a positive ulnar nerve compression test and positive Tinel's sign. Dr. Paletta's impression was probable bilateral cubital tunnel syndrome with possible mild carpal tunnel syndrome and recommended repeat NCV studies, which were performed by Dr. Phillips on 7/9/15. (Px3 & Px4). The results showed a reduction in the ulnar sensory responses consistent with further deterioration in the test results with no evidence of recurrent carpal tunnel syndrome. His impression was mild bilateral ulnar neuropathy with intervening deterioration, and he recommended surgery. (Px4).

Petitioner saw Dr. Mall on 3/22/16 for bilateral elbow symptoms, with the doctor noting the 2011 NCV reflected bilateral ulnar neuropathy at the elbows. Dr. Mall noted that Petitioner had tried and failed conservative treatment for his condition and his symptoms were ongoing and nagging. Following positive findings on exam, Dr. Mall diagnosed bilateral cubital tunnel and recommended bilateral cubital tunnel releases with possible ulnar nerve transposition depending on the stability of the ulnar nerve. Dr. Mall indicated he reviewed multiple records of Petitioner, one of which was the examination performed by Dr. Sudekum. He noted that Dr. Sudekum's opinion was based on the fact that Petitioner was old (36 years), obese, and long-standing gouty arthritis along with his past hobby of weightlifting. Dr. Mall opined that for Petitioner's gouty arthritis/tophi to be causing or contributing to his carpal and cubital tunnel syndrome, the tophi would have to be directly in relation to the median nerve at the wrist or ulnar nerve at the elbow, and he did not see evidence of this on exam. Dr. Mall did not opine with regard to a causal relationship between the diagnosis and the Petitioner's work duties with the Respondent. (Px5).

Respondent submitted the records of Dr. Young, which reflect bilateral elbow complaints going back to 2000. (Rx9). Records with regard to mainly Petitioner's bilateral carpal tunnel treatment were submitted as Respondent's Exhibit 10. These records do also indicate that the Petitioner had gouty tophus masses removed in both May 2004 and April 2010. (Px10).

The Respondent submitted a number of medical records from the Medical Arts Clinic. (Rx8). On 1/18/07 the Petitioner saw Dr. Pfalzgraf for "migratory arthritis", and the doctor noted Petitioner had a history of bursectomy of the olecranon bursa at the elbow due to gouty tophus deposits. A significant family history of

gout was noted as well. On 9/11/07, Petitioner saw rheumatologist Dr. Moore for longstanding gout. It was noted that at age 23 he started developing right elbow swelling and hand pain and started taking gout medication. Dr. Moore came up with a medication therapy plan, and continued to treat the Petitioner. On 6/8/08 the Petitioner's right olecranon bursa was removed. On 3/13/09, Dr. Blaise noted complaints of a swollen left elbow with pain and gout symptoms, and Petitioner received a Kenalog injection to the left elbow. On 3/20/09, cellulitis developed at the left elbow. (Rx8 & 9).

The Arbitrator notes that some of the gout outbreaks of the Petitioner appeared to be tied to activities, such as working on a roof, working on a fence and jogging/biking. Other times, it appears that the symptoms were of gradual insidious onset. On 10/19/09 he reported to Dr. Blaise's assistant symptoms including a left elbow problem after a struggle with an inmate, and an inflammation of gout. On 8/24/10, it appears that Petitioner began treating with Dr. Kamran, who appears to have been treating the Petitioner for chronic kidney disease, as well as for proteinuria. On 7/26/11, Dr. Hanson noted right elbow gout pain and inflammation. On 8/25/11 the Petitioner was noted to have gouty arthropathy to the right elbow and bilateral knees. On 2/23/12, Dr. Kamran noted Petitioner had episodes of gout 3 to 4 times a year for 10 years. Petitioner reported joint pain bad all over. (Rx8)

These also include a number of notes from Dr. Kamat. On 3/13/12 the Petitioner, in a gout-related visit, complained of pain and swelling in the left elbow and left 1st MCP joint. Lab testing indicated evidence of systemic inflammation and elevated uric acid, and clinical exam suggested inflammatory arthritis. There was evidence of gouty tophus formations, but it does not appear that Dr. Kamat indicated such findings at the elbows. He was noted to be having a gout flare up given the redness and swelling at the left elbow and MCP joint, however. On 4/12/12 the Petitioner complained of his knees, denying aggravating factors, and reported he was improving to where he was running two miles per day. On 7/26/12 Petitioner indicated gradual onset of gout with complaints of bilateral elbow and hand pain, and Petitioner's report that the symptoms are aggravated with gripping and activity. At the same time, he also complained of lower extremity symptoms that were worse at work based on walking and standing, which generally are activities most people perform daily whether at work or home. (Rx8).

On 6/1/12 the Petitioner saw Dr. Hanson with complaints of swelling to the left elbow from gout, as well as intermittent swelling of the knees, especially after long shifts at work. (Rx8).

Petitioner presented the medical bills he was submitting for payment by Respondent, alleged to be causally related to his cubital tunnel treatment, as Petitioner's Exhibit 1. The parties stipulated at the hearing that if any bills were awarded in this case, that the Respondent would pay those expenses directly to the providers.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of his employment on 8/22/11. The key issue in this case is the "arising out of" element. The evidence presented supports the finding that the Petitioner's job duties were significantly repetitive enough to constitute an increased risk of injury.

The Petitioner testified in unrebutted fashion that the vast majority of his time with the Respondent was spent as a correctional officer working in galleries, as opposed to tower work or other areas where he would not be as involved with policing the general population and segregation units. He performed multiple gripping activities including opening cell locks with keys, opening chuckhole locks and various other locks throughout the prison. He opened and closed chuckhole locks. He did handcuffing and uncuffing. All of these activities involved gripping a key and turning it. Additionally, there was a need to grip bars and doors tightly with force, in order to move them. He was required to rap bars, which caused a vibration up the Petitioner's arms, and he estimated he did rapped thousands of bars every week. Based on the job video, it also appears that COs would often have their elbows in a flexed position in order to provide the additional necessary force.

The Arbitrator notes three factors that he believes were key to the compensability of this case. First, the Petitioner worked a very significant amount of overtime over his career. Major Thomas' testimony regarding the reliability of the Petitioner, as well as the amount of overtime he worked, made it clear to the Arbitrator that the Petitioner was one of the hardest working COs at Menard. Secondly, the Corvel job video and the testimony of both the Petitioner and Major Thomas reflected that a significant number of both the locks and the doors themselves at Menard were not in proper working order, and required additional force to accomplish opening and closing of locks and doors. Finally, the Arbitrator viewed the Petitioner during his testimony, and found the Petitioner to be a very credible witness. All of these factors lead the Arbitrator to the conclusion that the Petitioner's work duties constituted an increased risk of injury to the bilateral upper extremities. As such, the Arbitrator believes the Petitioner has proven, by a preponderance of the evidence, that he sustained accidental injury in this case which arose out of his employment with the Respondent.

The Arbitrator notes there was no specific dispute in this case with regard to the date of accident, and that the date of the 8/22/11 NCV, which disclosed cubital tunnel, was a proper manifestation date.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

With regard to the issue of notice, it appears that the Respondent's defense is based on a failure to notify the employer of the injury according to the Respondent's normal protocol until February, 2013. However, the Petitioner testified, as supported by Arbitrator's Exhibit 2, that an Application for Adjustment of claim was filed on 8/25/11. The Respondent's representative, Cindy Cowell, who handled workers compensation claims for the employer, acknowledged that she received the Application from Petitioner's attorney's office, and testified: "I would have forwarded it to the Attorney General's Office and to CMS at the time that handled the workmen's comp claims." She acknowledged that the Attorney General's Office entered their appearance on 9/6/11 (Px15), and that she received a subpoena from Petitioner's counsel requesting workers' compensation document logs on 9/27/11.

The issue of notice in a workers compensation claim in Illinois is not dictated by a particular employer's reporting protocol. Sufficient notice simply must be given within the applicable 45 day period. Here, based on the 8/22/11 accident date, the 8/25/11 Application clearly constitutes sufficient notice within the 45 day period. It is unclear what better notice could be provided of a workers' compensation claim than the Application for workers' compensation benefits. The Attorney General's appearance on 9/6/11 also shows receipt and acknowledgement of the claim within the prescribed 45 day period. As such, the Arbitrator finds that the Petitioner provided proper notice of the claim within the requirements of Section 6(c) of the Act.

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

This was a very difficult issue for the Arbitrator to determine. The Arbitrator believes that the primary cause of the Petitioner's problems in his upper extremities is his severe gout. At the same time, the Arbitrator believes that there are two axioms of workers compensation law at this time are applicable to this case: 1) the employer takes the employee as it finds him or her, and 2) a claimant needs to prove that a work activity or activities which constitute a compensable accident are a cause of their condition of ill-being. In the former, the Respondent takes the Petitioner as it finds him, which includes in this case the Petitioner's gout condition, the cause of which apparently has not been determined. As to the latter, even if another cause can be determined to be the primary or proximate cause of the condition, under Illinois law so long as the Petitioner proves by a preponderance of the evidence that a work accident/activities are a contributing cause of the condition, the claim is compensable.

The evidence and the facts are conflicting with regard to how bad the Petitioner's gout was at the elbows and whether it impacted both sides or not. There are NCV tests which show very mildly positive cubital tunnel and Neurometrix NCV testing indicating no evidence of cubital tunnel, and repeat NCV testing in 2015 which reportedly showed bilateral ulnar neuropathy.

The degree to which he Petitioner had gout is so significant in this case that it is entirely possible that it is the sole cause of the Petitioner's upper extremity condition. However, it is impossible to ignore the evidence in this case regarding number of hours the Petitioner worked for the Respondent over the course of years, the poor condition of many of the cell door and chuckhole locks the Petitioner had to operate, and the amount of bar rapping performed by the Petitioner in making a determination with regard to causal connection. The greater weight of the evidence, in the Arbitrator's view, supports the finding that the Petitioner's noted work activities were a cause of his bilateral cubital tunnel condition and need for surgery.

The Arbitrator notes that while he has rejected some of the evidence that Dr. Paletta relied on in providing his causation opinions, namely the report and deposition of Dr. Sudekum in a separate case (Bauersachs), the doctor still had plenty of valid evidence that he relied on in giving such opinions. Thus, the Arbitrator finds, in his view, that this rejected evidence does not diminish the causation opinions of Dr. Paletta in this particular case.

The Arbitrator also notes that his findings regarding the Petitioner being a credible witness also are applicable to this issue.

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

The Petitioner presented medical expenses alleged to be related to the 8/22/11 accident in Px1. The bills total $5,708.54. Given the Arbitrator's findings with regard to accident and causation, the bills contained in Px1 are awarded. The Respondent is entitled to credit for any bills previously paid prior to hearing, and is entitled to Section 8(j) credit for any bills previously paid via the applicable group carrier so long as the Respondent holds the Petitioner harmless with regard to same.

The Petitioner is not entitled to any expenses contained in Px1 which may be related to the Petitioner's shoulder or knee treatment with Dr. Paletta, or which specifically are related to treatment for gout.

As noted above, pursuant to the stipulation of the parties, the Respondent shall pay the outstanding causally related medical expenses directly to the applicable providers.

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

The Respondent shall authorize the bilateral cubital tunnel surgeries recommended by Dr. Paletta. The reasonableness of the surgeries are supported by the opinions of both Dr. Mall and Dr. Sudekum.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Todd Gottschall, as Widower of
Carolyn Gottschall, Deceased,

Petitioner,

vs.

NO: 98WC 58841

Illinois Veterans' Home,

17IWCC0674

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2016 is hereby affirmed and adopted.

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

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

17IWCC0674

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: OCT 25 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM.sj
o-10/19/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOTTSCHALL, TODD AS WIDOWER OF GOTTSCHALL, CAROLYN
Employee/Petitioner

Case# **98WC058841**

09WC019721

ILLINOIS VETERANS HOME
Employer/Respondent

17IWCC0674

On 7/6/2016, 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 0.34% 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:

0274 HORWITZ HORWITZ & ASSOC
MARC A PERPER
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 6 = 2016

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

17IWCC0674

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Todd Gottschall, as Widower of Carolyn Gottschall, Deceased,
Employee/Petitioner,

v.

Illinois Veterans Home,
Employer/Respondent.

Case # 98 WC 58841

Consolidated cases: 09 WC 19721

An *Application for Adjustment 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 **Kankakee**, on **June 17, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 28, 1998** , 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 **$6,386.28** ; the average weekly wage was **$420.15** .

On the date of accident, Petitioner was **39** years of age, *married* with **two** 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 **$112,562.98** for TTD, $ **- 0 -** for TPD, $ **- 0 -** for maintenance, and $ **- 0 -** for other benefits, for a total credit of **$112,562.98** .

ORDER

Temporary Total Disability

Respondent shall pay to Petitioner the sum of $280.10 /week for a period of 527-3/7 weeks, representing compensation for temporary total disability from July 29, 1998 through September 5, 2008 , as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner the temporary total disability benefits that have accrued ~~from _____ through _____, and shall pay the remainder of the award, if any, in weekly payments~~.

Respondent shall be given a credit of $ 112,562.98 for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay the further sum of $98,548.14 , representing reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Robert E Abrams — June 30, 2016

Signature of Arbitrator — Date

JUL 6 - 2016

17IWCC0674

STATE OF ILLINOIS)
) SS.:
COUNTY OF KANKAKEE)

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

TODD GOTTSCHALL, as Widower of CAROLYN GOTTSCHALL, Deceased,	)	
Petitioner,	)	
	)	No. 98 WC 58841
-v.-	)	(consolidated with No. 09 WC 19721)
ILLINOIS VETERANS HOME,	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT:

Petitioner's Decedent, CAROLYN GOTTSCHALL, was employed as a certified nursing assistant at Illinois Veterans' Home. On July 28, 1998, at approximately 4:00 PM, Decedent noticed pain in her right shoulder while cranking a patient's bed (PX 1; RX 1). She was seen at Provena St. Mary's Medical Center, where she complained of tenderness at the top of the shoulder and at the supraspinatus, with pain on lifting the shoulder and reaching behind her head and behind the low back. Dr. Ronald Jurzejka prescribed a sling and advised her to follow up with corporate health. He placed her on restrictions of no use of the right arm. Decedent ceased working at that time. Respondent commenced payment of TTD (RX 2; RX 6).

Respondent referred Decedent to St. Mary's Occupational Health, where she came under the care of Dr. Michael Panuska. He maintained the one-armed work restriction but instructed the patient to cease using the sling. He prescribed physical therapy. When improvement was not obtained, Dr. Panuska discontinued physical therapy on August 31, 1998 and ordered an MRI of the right shoulder, which was performed on September 1, 1998 and revealed evidence of rotator cuff tear. Dr. Panuska referred the patient to Dr. Alexander Michalow, an orthopedic surgeon, who on September 24, 1998 performed surgery consisting of right shoulder arthroscopy with debridement of scapular tendon tear and arthroscopic glenoid labrum repair. Postoperative diagnosis was partial tear of the subscapular tendon, anterior glenoid labrum tear, rotator cuff intact (PX 1; PX2; PX 11).

Dr. Michalow referred the patient to TPTC Physical Therapy Center for postoperative physical therapy. On November 9, 1998, she began complaining of cervical pain. By November 11, 1998, she was complaining of neck soreness during activity, with irritation and pain radiating down to the right hand (RX 8). By February 22, 1999, Decedent was still complaining of shoulder and arm pain radiating up into the neck. Dr. Michalow continued to advise no work

during this period (PX 2). On March 9, 1999, Decedent underwent a repeat right shoulder MRI, which revealed evidence of a small rotator cuff tear (PX 1). On March 18, 1999, Dr. Michael Corcoran examined Decedent at Dr. Michalow's request for a second opinion. Dr. Corcoran diagnosed right shoulder impingement with questionable rotator cuff tear. He recommended a repeat right shoulder arthroscopy with subacromial decompression and to address the rotator cuff as well (PX 2).

Dr. Brian Cole examined Decedent at Respondent's request on April 29, 1999 pursuant to Section 12 of the Act. He recommended an injection into the subacromial space from the anterior position. If symptomatic improvement were obtained, the patient would then be a candidate for arthroscopy and subacromial decompression (RX 3). On May 12, 1999, Dr. Michalow administered the injection recommended by Dr. Cole. By June 21, 1999, the injection had achieved 50% pain relief. Dr. Michalow suggested arthroscopic evaluation, subacromial decompression and possible labral repair, which might require open shoulder surgery with possible capsular shirt and capsulopathy. He requested a second opinion from Dr. Corcoran, who on June 28, 1999 concurred with Dr. Michalow's surgical recommendation (PX 2; RX 8). On August 3, 1999, Dr. Michalow performed a second right shoulder surgery consisting of arthroscopy with subacromial decompression, bursectomy, coracoacromial ligament incision and acromioplasty. Postoperative diagnosis was right shoulder impingement syndrome (PX 1).

Dr. Michalow referred the patient to TPTC for postoperative physical therapy, which took place from August 23 through September 1, 1999. During this period, Ms. Gottschall continued to complain of pain in the back of the shoulder extending up into her neck with finger lock-up, and that her neck muscles were cramping up (RX 8). On September 1, 1999, Dr. Michalow expressed concern that the patient might be showing signs and symptoms of reflex sympathetic dystrophy; however, a triple-phase bone scan at St. Mary's Hospital on September 2, 1999 revealed no evidence of RSD (PX 1; PX 2). On September 8, 1999, Dr. Michalow opined that it might be several months before the patient would be able to return to her regular job, due to increased risk of re-injury. He prescribed non-steroidal anti-inflammatories and suggested that she begin weaning off of Vicodin, a narcotic (PX 2).

On October 6, 1999, Dr. Michalow reported that the patient was still in persistent pain. He referred her to Dr. Corcoran for a second opinion. Dr. Corcoran examined the patient on October 11, 1999 and noted pain on extremes of rotation of the neck and over the anterior part of the right shoulder. He ordered X-rays of the cervical spine, which revealed degenerative changes at multiple levels, most significantly at C2-3. He referred her back to Dr. Michalow, who on December 8, 1999 suggested work hardening followed by a functional capacity evaluation (PX 2). At her work conditioning evaluation on December 15, 1999, Decedent reported that she had pain extending up into the neck, which she rated between 4 and 9 on a scale of 10. During the evaluation, the patient complained that her "neck was throbbing" and felt "ready to explode." The therapist, Malcolm Fraser, stated that improvement potential was moderate to improve beyond current tolerances, due to pain symptomatology. The primary limiting factor was the patient's complaints of pain in the right side of the neck, right shoulder and upper extremity.

17IWCC0674

Fraser found the patient capable of light work (PX 1). On January 19, 2000, Dr. Michalow placed her on permanent work restrictions consistent with the Fraser FCE (PX 2).

Decedent continued treatment with her primary care physician, Dr. Miguel Castro at Riverside Community Health. On February 20, 2001, she complained of diminished strength and grip at the right upper extremity, with persistent, burning discomfort and inability to perform simple dexterity. Dr. Castro diagnosed right shoulder arthropathy, status-postoperative. He prescribed continued Vicodin, Ultram and Elavil and recommended home exercise (PX 3).

On May 1, 2001, Dr. Castro referred Decedent to Dr. Mary Belford, a psychiatrist. The patient complained of depression. She stated that her husband wanted her to be functional around the house and even go out and get a job, as if she was not injured. She had trouble falling asleep and would awaken at least four times a night with pain. Mental status examination revealed evidence of psychomotor retardation. Speech was slow and monotone. Mood was "okay," but her affect was tearful and anxious. Dr. Belford diagnosed major depression, single episode, moderate. She prescribed Elavil (amitriptyline), a tricyclic antidepressant also used for pain, and Effexor (venlafaxine), an antidepressant of the selective serotonin and norepinephrine reuptake inhibitor (SSNRI) variety. Decedent remained under Dr. Belford's care through August 25, 2008 (PX 4).

Dr. Castro saw the patient on September 7, 2001. He diagnosed chronic right shoulder pain with secondary depression (PX 3). He prescribed a repeat MRI of the right shoulder, which took place on September 12, 2001. The nuclear radiologist, Dr. Brian Mulligan, reported small areas of increased signal in the musculotendinous portion of the supraspinatus, indicating small, partial tears (PX 1). On October 12, 2001, Dr. Castro referred the patient back to Dr. Michalow for further orthopedic evaluation (PX 3). On January 10, 2002, the patient complained to Dr. Belford that she was hesitant to see Dr. Michalow, who had already performed two surgeries on her right shoulder. By now she was feeling hopeless and irritable. Dr. Belford diagnosed major depression and added Wellbutrin, an antidepressant, to the patient's medication regimen. By February 13, 2002, she was feeling better, more hopeful and more energetic. However, on April 29, 2002, she complained to Dr. Belford of numbness traveling down the arm when lifting her head straight up, which she feared was "a worrisome sign of nerve impingement" (PX 4).

Dr. Castro referred Decedent "concurrently" to Dr. Michael Sergeant, a neurologist, for evaluation on June 21, 2002, and "secondly" for further psychiatric consult to Dr. Belford. On neurologic examination by Dr. Sergeant, the patient complained of numbness radiating down her right arm on hyperextension of her neck. Physical examination revealed decreased pinprick sensation in the palmar surface of the right hand toward the ulnar side, with decreased sensation in the right index finger. Tenderness was noted over the Tinel sign at the wrist. Adson's maneuver was positive for reproduction of symptoms and diminished pulse. Dr. Sergeant stated as follows:

> I'm wondering if she may not have had an injury to her neurovascular bundle in her right arm from the injury and her obesity. In other words, she may have a

17IWCC0674

> thoracic outlet syndrome. It's important to rule out cervical radiculopathy. So we'll try to obtain her cervical CT ... she does seem to have a positive Adson's maneuver which may or may not be helpful in diagnosing thoracic outlet.

(PX 3). On July 2, 2002, Dr. Sergeant referred the patient to Neurology, Ltd. for EMG/NCV, which was suggestive of thoracic outlet syndrome ("TOS") (PX 3). On July 23, 2002, Dr. Castro diagnosed right supraspinatus injury with secondary depression. He opined that the patient was functional, but that she was unable to do strenuous activity with her right arm. He recommended continued psychiatric consult and treatment by Dr. Belford (PX 3).

On August 16, 2002, Dr. Castro referred Decedent to Dr. Michel Malek, a neurosurgeon. She complained of worsening neck pain and headaches, with tingling and numbness down the right arm. On examination, cervical range of motion was about 75% restricted. Reflexes were hypoactive. The EMG/NCV finding of thoracic outlet syndrome was noted. Dr. Malek observed that the TOS diagnosis was controversial. He prescribed a whole-body bone scan and cervical and thoracic spine MRI's (PX 5). The total body scan and thoracic MRI were grossly normal. However, the cervical MRI revealed evidence of focal disc protrusion at C6-7, C5-6 and C4-5 with subligamentous herniation. On September 13, 2002, Dr. Malek ordered a myelogram and post-myelogram CT scan, which took place on September 30, 2002 and revealed significant, multi-focal disc protrusion at multiple levels from C3 through C7, most significantly at C5-6 and C6-7 (PX 1; PX 5). On October 2, 2002, Dr. Malek suggested a second opinion, for which the patient saw Dr. Alexander Ghanayem, an orthopedic surgeon. Dr. Ghanayem recommended referral to a physiatrist. Dr. Malek concurred. He referred Decedent to Dr. George Charuk, a physiatrist, on May 5, 2003 (PX 5; PX 6).

On January 16 and April 18, 2003, Dr. Belford again diagnosed major depression and continued the patient's current medications (PX 4). On February 18, 2003, Dr. Castro again diagnosed right supraspinatus injury, postoperative state, with secondary depression. On March 29, 2003, Dr. Castro's diagnosis was unchanged. He recommended physical therapy (PX 3).

Decedent was under the care of Dr. Charuk from June 5, 2003 through March 18, 2004. His diagnoses were:

(1) Myofascial pain syndrome secondary to work-related injury in 1998;
(2) Status-post right rotator cuff repair with revision;
(3) Depression; and
(4) Suspected fibromyalgia.

(PX 6). Dr. Charuk prescribed a course of physical therapy and continued the patient's medication regimen, which by now included Vicodin, Robaxin, Effexor and Wellbutrin, as well as medications for her non-work related allergies and asthma (PX 6). Physical therapy took place from February 23 through March 18, 2004, but only limited improvement was achieved (PX 5; PX 6). Dr. Charuk referred Decedent to Dr. Corcoran for reevaluation of the right rotator cuff (PX 6). On May 3, 2004, Dr. Belford continued the patient's current medications (PX 4).

17IWCC0674

Petitioner returned to Dr. Malek on May 10, 2004 with complaints of ongoing right shoulder and neck pain. Dr. Malek suggested a cervical epidural steroid injection ("ESI") for both diagnostic and therapeutic purposes (PX 5).

Petitioner saw Dr. Corcoran on June 16, 2004. He noted her cervical spine complaints and that she had been evaluated by Dr. Malek. Repeat X-rays of the right shoulder revealed glenohumeral arthropathy, status-post subacromial decompression. Dr. Corcoran "really did not have anything to offer her from a surgical perspective" with reference to the right shoulder. He opined that the patient had reached maximum medical improvement and that her work restrictions were permanent. He suggested a repeat diagnostic workup, if authorized by the employer (PX 2; RX 8).

Dr. Malek performed a cervical epidural block on June 21, 2004 at St. Mary's Hospital. Pre- and postoperative diagnosis was cervical herniated disc (PX 1). Dr. Malek next saw the patient on June 25, 2004. She reported having some relief from the injection, albeit not 100%. Dr. Malek recommended completing a series of three injections (PX 5). The second injection took place on July 19, 2004. On July 26, 2004, Dr. Malek reported that the second injection did not achieve symptomatic relief (PX 1; PX 5). Dr. Malek suggested a repeat evaluation by Dr. Ghanayem (PX 5).

Decedent returned to Dr. Ghanayem on September 9, 2004. She reported symptoms largely unchanged from her 2002 visit. On physical examination, Dr. Ghanayem observed muscular discomfort involving the shoulder and neck regions. Dr. Ghanayem did not recommend spinal surgery. He recommended that the patient see a pain management specialist (PX 25).

On July 27, 2004, Decedent saw Dr. Saw M. Oo, who had taken over Dr. Castro's practice. Ms. Gottschall reported no success in attempting to reduce her narcotic pain medication and substitute it with Tylenol. Dr. Oo diagnosed chronic pain syndrome with fibromyalgia and depressive disorder. She recommended referral to a pain clinic (PX 3). On August 2, 2004, Decedent returned to Dr. Belford. She expressed frustration with her medical treatment (PX 4).

Dr. Malek referred Decedent to Dr. James Kelly, a specialist in pain management. Dr. Kelly first saw the patient on September 22, 2004. She complained that her physicians had largely addressed only her right shoulder problem and had only recently begun to address her complaints of neck pain. Dr. Kelly diagnosed chronic right shoulder pain as a residual effect of the shoulder injury and apparently unsuccessful surgeries, with a component of cervical radiculopathy. He prescribed a Duragesic patch – a delivery device for Fentanyl, a narcotic -- with continued use of Norco for breakthrough pain, and Robaxin, a muscle relaxant (PX 7). Dr. Kelly prescribed a series of three ESI's. These were performed on October 15, October 29 and November 12, 2004, with minimal symptomatic improvement (PX 1; PX 7).

Dr. Oo referred Decedent to Rehabilitation Institute of Chicago, where she saw Dr. Maria Villegas, a physiatrist, on November 11, 2004. The patient complained of right shoulder, neck and neck pain. On physical examination, cervical range of motion was limited on lateral bending and rotation. Dr. Villegas diagnosed myofascial pain syndrome, neuropathic pain, chronic low back pain and depression. She prescribed outpatient physical therapy and recommended that Decedent continue with Dr. Belford for supportive psychotherapy, as depression can aggravate pain. She gave the patient a sample of Neurontin, 300 mg., for pain (PX 3).

Decedent returned to Dr. Kelly on December 3, 2004. She reported only short-term improvement following ESI. She complained of pain radiating up into the right side of the neck. She reported her pain level at about 5 on a scale of 10, increasing to 7-8 at its most severe. She denied low back pain. Dr. Kelly diagnosed persistent cervical radicular pain and right shoulder pain. He recommended repeat MRI of the neck and right shoulder (PX 7).

Decedent saw Dr. Villegas again on December 13, 2004. The doctor diagnosed myofascial pain syndrome with probable fibromyalgia, neuropathic pain, depression, and right shoulder pain likely secondary to myofascial pain syndrome. Dr. Villegas prescribed continued outpatient physical therapy for myofascial release and instructed the patient to return in six weeks (PX 3).

Whole body bone scan on January 5, 2005 revealed degenerative arthritic changes at the shoulders, wrists, knees, ankles, feet, and the first metatarso-phalangeal joints of both feet, largely unchanged from the August 2002 study (PX 1; PX 3).

Decedent underwent MRI scans of the right shoulder and cervical spine. Cervical MRI revealed disc pathology at C3-4, C4-5 and C5-6 (PX 5). Right shoulder MRI showed a full-thickness tear of the rotator cuff (PX 7). On January 7, 2005, Dr. Malek recommended a cervical discogram, to be performed by Dr. Kelly (PX 5).

On January 21, 2005, Dr. Oo reviewed the right shoulder MRI. She noted tears of the supraspinatus tendon and of the subacromial and subdeltoid bursa. She again diagnosed severe right shoulder pain with depression. Dr. Oo suggested a surgical consult at Rush University Medical Center for the right shoulder. She did not comment on the cervical MRI (PX 3).

On January 24, 2005, Decedent underwent cervical discography by Dr. Kelly at C3 through C7. The discogram was abnormal at C4-5 and C5-6, with concordant pain elicited at both levels. The discogram was normal at the control levels of C3-4 and C6-7 (PX 1). On February 2, 2005, Dr. Kelly diagnosed cervical discogenic pain with a radicular component and recommended follow-up with Dr. Malek. Dr. Kelly also administered an intra-articular steroid injection to the patient's non-work related arthritic right knee (PX 7). Decedent saw Dr. Malek, who opined, based upon the cervical discogram, that the patient would likely require surgery (PX 5).

Decedent next saw Dr. Belford on February 1, 2005. The patient complained that none of her doctors seem to be addressing the right shoulder, which she felt was of greater urgency than

the neck (PX 4). On March 10, 2005, Dr. Oo referred the patient to Dr. Anthony Romeo for consideration of right shoulder surgery (PX 3).

Decedent saw Dr. Malek on March 21, 2005. He reported that Decedent had seen Dr. DePhillips for her cervical spine condition, and that Dr. DePhillips had advised holding off on any neck surgery pending resolution of the right shoulder issue (PX 5).

Petitioner remained under the care of Drs. Belford, Kelly, Oo and Malek throughout 2005, 2006 and 2007 for her right shoulder, neck, chronic pain and depression (PX 3, PX 4, PX 5, PX 7). On September 6, 2005, Dr. Belford noted that Respondent had ceased paying for Petitioner's psychotropic medications, claiming for the first time that they were unrelated to the work injury. In response, Dr. Belford pointed out that Petitioner never suffered from depression prior to the injury, and that the medications were keeping the patient's depression under control. The Axis I psychiatric diagnosis remained major depressive disorder, single episode, moderate (PX 4).

Dr. Andrew Zelby examined Decedent at Respondent's request on October 19, 2005, pursuant to Section 12 of the Act. On review of treating medical records, Dr. Zelby incorrectly claimed that "there was no indication of any symptoms in the neck for many months" post-accident (RX 4). (In fact, the TPTC physical therapy notes found at RX 8 indicate that Decedent began complaining of cervical pain as early as November 9, 1998, during her very first round of postoperative physical therapy following the first right shoulder surgery by Dr. Michalow).

Dr. Zelby stated that in his opinion, Decedent sustained only a right shoulder injury and not a neck injury. According to Dr. Zelby, Decedent's complaints did not correlate with a finding of cervical spondylosis; she was neurologically normal; and the etiology of her complaints was unclear. Dr. Zelby further opined that no causal connection existed between the work injury and Decedent's complaints, and that no restrictions were required in relation to any vocational or avocational activities that the patient performed prior to July 1998 (RX 4).

On May 10, 2006, Dr. Kelly reported that Petitioner continued to have cervical radicular pain radiating down the right arm; that she was still awaiting evaluation by Dr. Romeo for the right shoulder; and that review of symptoms was positive for depression. Dr. Kelly diagnosed cervical radiculopathy and prescribed ESI, which took place on May 17, 2006 and yielded symptomatic relief (PX 7).

On August 31, 2006, Dr. Oo reported that the patient was permanently and totally disabled from employment, because she was in severe pain most of the time and on narcotic-related medications prescribed by the pain clinic. In Dr. Oo's opinion, the patient was physically and mentally incapable of performing her regular occupation (PX 3).

On September 18, 2006, Decedent reported to Dr. Belford that Respondent had finally authorized a surgical consult with Dr. Romeo (PX 4).

17IWCC0674

Decedent saw Dr. Romeo on October 27, 2006. On review of right shoulder MRI dated July 24, 2006, Dr. Romeo diagnosed tendinosis in the supraspinatus and infraspinatus tendons. He diagnosed chronic right shoulder pain, chronic neck pain, and bilateral upper extremity parasthesias. He opined that the condition had reached maximum medical improvement. Because of the plethora of upper extremity symptoms, including parasthesias, arm pain, neck pain and forearm pain, Dr. Romeo did not feel that an isolated right shoulder surgery would achieve symptomatic improvement (PX 8).

Dr. Kelly saw Decedent on November 8, 2006. Given that Dr. Romeo did not find her to be a candidate for right shoulder surgery, Dr. Kelly first referred her to Dr. Malek to address her cervical spine condition (PX 7). However, when her right shoulder pain continued to worsen, Dr. Kelly referred her to Dr. Bradley Dworsky of Hinsdale Orthopedics on January 12, 2007 for further surgical consult regarding the shoulder (PX 7).

Decedent saw Dr. Dworsky on June 27, 2007. She had significant limitations on forward elevation of the shoulder. Abduction was painful at 90 degrees. Moderate significant weakness was present on internal and external rotation. Crepitation was noted on circumduction of the shoulder. O'Brien's test was mildly positive. Crossover pain was positive. Weakness was noted on empty beer can sign. Dr. Dworsky noted the abnormal discogram at C4-5 and C5-6 and the July 2006 right shoulder MRI showing only tendinosis of the supraspinatus and infraspinatus tendons. However, Dr. Dworsky also reviewed the earlier, January 5, 2005 right shoulder MRI, which showed signal transversing into the supraspinatus tendon consistent with either full thickness or very large partial thickness tear, along with possible tearing of the inferior and superior margins of the glenoid labrum. Dr. Dworsky opined that the January 5, 2005 MRI indicated a possible recurrent tear of the rotator cuff, which most likely had become progressive in nature to a point where the patient was experiencing further difficulty. Dr. Dworsky diagnosed a chronic right rotator cuff tear. He recommended an MR arthrogram (PX 9).

Petitioner underwent an MR arthrogram of the right shoulder by Dr. Dworsky on August 9, 2007 at St. Mary's Medical Center. Findings included an articular surface partial tear of the supraspinatus tendon, with hypertrophic changes at the AC joint and mild impingement at the myotendinous junction of the supraspinatus, and tendinosis of the suprascapular tendon (PX 1).

On February 21, 2008, Dr. Dworsky performed right shoulder surgery at St. Joseph Medical Center in Joliet consisting of arthroscopic rotator cuff repair of the subscapularis tendon, with debridement of the labrum and subacromial decompression. Postoperative diagnosis was right shoulder rotator cuff tear. On March 12, 2008, the sutures were removed. Dr. Dworsky prescribed a course of postoperative physical therapy and instructed the patient to return for follow-up in four weeks (PX 9).

On March 24, 2008, the patient returned to Dr. Malek. She expressed frustration with her pain. Cervical MRI on March 21, 2008 showed focal kyphosis with evidence of moderate stenosis and disc herniation at C4-5 and C5-6, with evidence of tear at C3-4 as well. Dr. Malek

17IWCC0674

recommended consideration of anterior cervical spinal fusion surgery. Dr. Malek also prescribed a lumbar discogram for a non-work related low back condition (PX 5).

Dr. Malek testified via evidence deposition on August 27, 2008. He had last seen the patient on March 24, 2008. At that time, her diagnosis was cervical radiculopathy in a mid-cervical distribution. She had undergone a host of diagnostic and treatment modalities including physical therapy, physiatry, ESI, passage of time, muscle relaxants, anti-inflammatories, activity restriction, orthopedic evaluation of the right shoulder, and cervical discography. Dr. Malek's recommendation was anterior cervical diskectomy and fusion. As to her orthopedic care, he would defer to Dr. Dworsky Dr. Malek testified that the patient's condition had progressed over her course of treatment, albeit more isolated to the neck following the right shoulder surgery by Dr. Dworsky (PX 15 at 13-14).

Dr. Malek testified that in his opinion, the condition of ill-being of Decedent's cervical spine was causally related to her July 28, 1998 work injury. The doctor explained that at the time of her injury, Ms. Gottschall had underlying asymptomatic degenerative changes at the cervical spine, which became symptomatic by acceleration, aggravation or precipitation and required treatment as a result of the work accident. The condition manifested itself in a cervical radiculopathy to a level beyond the natural and expected progression of a degenerative condition. The fact that her earliest complaints involved only right shoulder pain did not affect his opinion. Dr. Malek explained that it is not uncommon for a patient with cervical spine pathology to have initial complaints of only shoulder pain, just as patients with lumbar disc herniation may initially complain of buttock or leg pain. Furthermore, Ms. Gottschall had concurrent injuries to both her neck and right shoulder. As the shoulder constituted the "major precipitating condition," one would expect the shoulder to be the primary source of her early complaints (PX 15 at 22-24).

In Dr. Malek's opinion, the events of July 28, 1998 aggravated an underlying, silent and asymptomatic condition of the cervical spine requiring intervention and treatment. He agreed that the right shoulder condition needed to be taken care of prior to addressing the cervical spine. Now that the right shoulder surgery was finally completed, Dr. Malek recommended addressing the patient's cervical spine condition (PX 15 at 24-25). In Dr. Malek's opinion, the condition of ill-being of Decedent's cervical spine was yet of a temporary nature at the time of his testimony, and would be expected to improve with surgical intervention. Dr. Malek opined that Decedent had been temporarily totally disabled since August 22, 2002, when he first saw the patient, and that she would remain temporarily totally disabled until her treatment has been completed; namely anterior cervical spinal fusion from C4 through C6, and possibly through the adjacent levels of C3 and/or C7. Dr. Malek stated that it was too early to discuss whether any permanent restrictions should be placed on the patient in the workplace (TA 24-28).

Decedent's postoperative physical therapy was delayed by a hospitalization from March 25 through April 1, 2008 for removal of a suspected sarcoma invading the right pelvic area (PX 1; PX 9). She next saw Dr. Dworsky on April 21, 2008, at which time she reported improvement in range of motion of the right shoulder and decreased overall soreness. Examination showed relatively good range of motion, with slight restriction in abduction and external rotation and

mild weakness. Dr. Dworsky ordered a course of physical therapy at Flexeon Rehabilitation for rotator cuff strength, scapular stabilization and range of motion (PX 9; PX 10).

The patient remained under the care of Dr. Dworsky for her right shoulder, Dr. Kelly for pain management, Dr. Belford for depression and Dr. Oo for primary care (PX 3; PX 4; PX 5; PX 7; PX 9). On July 14, 2008, Dr. Dworsky ordered another month of physical therapy (PX 9). On August 14, 2008, Decedent was found to have met her goals and was discharged from therapy in favor of a home exercise program (PX 10). On August 15, 2008, Dr. Dworsky discharged Decedent from his care, noting that she was awaiting further intervention for the cervical spine, for which she was to follow up with Dr. Malek (PX 9).

Decedent last saw Dr. Kelly on August 15, 2008. He noted that the patient had completed her course of postoperative physical therapy for the right shoulder and was awaiting possible surgical intervention by Dr. Malek for her cervical spine. Her medication regimen included Avinza (morphine sulfate), 90 mg. per day for pain, and Skelaxin, a muscle relaxant, 800 mg. three times daily. By now the patient rated her pain at 4 on a scale of ten. On examination, range of motion of the cervical spine had improved, albeit with increased pain on right lateral rotation and tilt. Range of motion of the right arm at the shoulder was excellent. Dr. Kelly recommended continuing the patient on her current doses of Avinza and Skelaxin for one month. At that point, if she continued to improve, Dr. Kelly planned to titrate the Avinza down to 60 mg. per day (PX 7).

Decedent last saw Dr. Belford on August 25, 2008. Her medication regimen as of that date was as follows:

Wellbutrin XL oral tablet 24 hr 300 mg., 1 every morning.
Cymbalta oral capsule enteric coated 30 mg., 1 Every Morning with 60 mg.
Cymbalta oral capsule enteric coated 60 mg., 1 every morning.
Wellbutrin XL oral tablet 24 hr 300 mg., 1 po daily.
Singulair oral tablet 10 mg., 1 po daily.
Advair diskus inhalation miscellaneous 500-50 mcg/dose, 1puff BID.
Cymbalta oral capsule enteric coated 30 mg., 3 tabs daily.
Prevacid oral capsule delayed release 30 mg., 1 every day.
Norco oral tablet 7.5-325 mg., 1 two times a day.
Avinza oral capsule 24 hr. 120 mg., 1 every day.
Amitriptyline HCL oral tablet 150 mg., 2 every day at bedtime.
Xanax oral tablet 1 mg., four times a Day, as needed for anxiety.
Lyrica oral capsule conventional 100 mg., one twice a day.
Furosemide oral tablet 40 mg., 1 every morning.
Potassium chloride tab 10 MEQ, 1 every day.

(PX 4). Decedent reported to Dr. Belford that her pain was about the same, although she had made progress in physical therapy. She was trying to get by with minimal pain medication. She stated that she lies to her husband when he asks whether she is taking her medication. She was

17IWCC0674

sleeping better and trying to do a bit more around the house. She was tolerating her medication without much trouble. Her affect was brighter, and she was trying to maintain a positive attitude. She was working with Dr. Kelly to wean down on some of the narcotics. For that reason, Dr. Belford agreed to leave her dosages at their current levels, because overall her depression was under control. She needed refills of only the Xanax and Amitriptyline. A three-month return appointment was scheduled (PX 4).

The following unpaid medical, hospital and surgical expenses were admitted in evidence:

Provider	Service Dates	Amount
Associated Radiologists of Joliet	12/09/2001 to 01/24/2005	$732.00
Dr. Michel Malek MD	05/10/2004 to 03/24/2008	$1,935.45
Emergency Care & Health	08/26/2004	$120.00
Hinsdale Orthopedic Assoc.	06/27/2007 to 08/15/2008	$18,902.19
Kankakee Radiology Assoc.	05/05/2004	$57.00
Loyola Univ. Physicians Foundation	11/21/2002 to 09/09/2004	$163.00
Metro Area Pain Consultants	09/22/2004 to 08/15/2008	$19,315.00
Performance Physical Therapy	04/28/2008 to 09/02/2008	$4,025.01
Provena St. Joseph Medical Center	02/08/2008 to 02/21/2008	$16,327.41
Provena St. Mary's Hospital	07/19/2004 to 03/31/2008	$35,740.95
Riverside Community Health Centers	07/20/2001 to 01/31/2007	$1,230.13
Totals		$98,548.14

(PX 12; PX Group 13).

Petitioner's Exhibit 14 is a compilation of paystubs with attached wage analysis indicating that Decedent earned $6,386.28 in straight-time pay while working 15-1/5 weeks for Respondent in the year preceding the injury, which would yield an average weekly wage of $420.15 (PX 15).

Respondent's Exhibit 2 is a "summary of disability" form generated by the Illinois Department of Central Management Services. The summary includes a "computation of workers' compensation rate" stating that Decedent's "total yearly salary" was $14,529.00 and that her "average weekly salary" was $375.32. The summary was not signed. No pay stubs or payroll records were attached to the summary (RX 2).

Carolyn Gottschall died on September 5, 2008 (PX 18). At the time of her death, Decedent was lawfully married to Petitioner TODD GOTTSCHALL (PX 17). Amended Application for Adjustment of Claim was filed on behalf of Mr. Gottschall as Decedent's widower, who substituted as Petitioner in case no. 98 WC 19721 (PX 22). Decedent's death is the subject of a claim for death benefits under Section 7 of the Act filed on behalf of Mr. Gottschall in companion case no. 09 WC 58841 (PX 23).

17IWCC0674

CONCLUSIONS OF LAW:

With reference to (F) (CAUSAL CONNECTION), the Arbitrator finds:

The Arbitrator finds that the conditions of ill-being involving Decedent's right shoulder, neck, chronic pain and depression are causally related to her work injury of July 28, 1998. Petitioner's right shoulder pain began immediately following the accident. The onset of her neck pain was not immediate, but the condition manifested itself during the very first round of postoperative physical therapy following Decedent's first right shoulder surgery by Dr. Michalow. Dr. Malek testified that the work accident aggravated pre-existing but asymptomatic degenerative changes in the patient's cervical spine, and that the lapse in time between the accident and the first complaints of neck pain did not defeat causality. While Respondent's examining physician, Dr. Zelby, disagreed with Dr. Malek regarding causation in relation to the neck condition, Zelby based his opinion in part on the incorrect assumption that the patient did not complain of neck symptoms for "many months." In reality, Decedent's first reported complaints of neck pain occurred on November 9, 1998, barely six weeks after she underwent her first right shoulder surgery by Dr. Michalow on September 24, 1998. To the extent that the opinions of Drs. Malek and Zelby are irreconcilable, the Arbitrator assigns greater evidentiary weight to the findings, opinions and conclusions of Dr. Malek, who as the treating neurosurgeon was in a better position to ascertain causality. The Arbitrator finds extremely credible DR. Malek's opinion that the shoulder problems likely masked the radicular component of Petitioner's cervical problems and that they did not become plainly apparent until the shoulder problems had been dealt with to a certain extent.The Arbitrator assigns little or no evidentiary weight to the findings, opinions and conclusions of Dr. Zelby, who examined Decedent on but one occasion and based his opinions in part on incorrect assumptions.

As the conditions of ill-being of Decedent's right shoulder and cervical spine were causally related to the work accident, the Arbitrator further finds that the pain management treatment she received for chronic pain, myofascial pain syndrome and fibromyalgia was likewise causally related to the accident, to the extent that such treatment involved the right shoulder and cervical spine. To the extent that Decedent received pain management treatment involving her lumbar spine and arthritic knees, such treatment was not causally related to the accident.

Decedent's psychiatric condition, which was variously diagnosed as major depression and depressive psychosis, was likewise causally related to the work accident. Dr. Castro, the primary care physician, diagnosed depression secondary to chronic right shoulder pain and referred the patient to Dr. Belford for psychiatric care. Dr. Belford herself noted that Decedent did not suffer from depression prior to her work accident. For its part, Respondent never requested or obtained a psychiatric evaluation and offered no psychiatric evidence to rebut the opinions of Drs. Castro and Belford regarding causality in relation to the patient's depression.

17IWCC0674

Based upon the above, the Arbitrator concludes that the conditions of ill-being involving Decedent's right shoulder, neck, chronic pain and depression were all causally related to the injuries sustained on July 28, 1998.

17IWCC0674

With reference to (G) (EARNINGS), the Arbitrator finds:

Petitioner's wage analysis includes Decedent's actual pay stubs showing $6,386.28 in straight-time pay, excluding overtime, over 15-1/5 weeks worked for Respondent during the 52 weeks preceding the injury, which yields an average weekly wage of $420.15. Respondent's wage exhibit was an unsigned summary setting forth Decedent's annual salary of $14,529.00 and an "average weekly salary" of $375.32, but with no payroll data attached, and no indication as to how Respondent arrived at the $375.32 figure, as well as no indication of how many weeks Petitioner had worked during the period. The Arbitrator therefore adopts Petitioner's earnings analysis and finds an average weekly wage of $420.15, with corresponding weekly compensation rates of $280.10 for TTD and $252.09 for PPD.

With reference to (K) (TTD) and (L) (NATURE AND EXTENT), the Arbitrator finds:

Drs. Belford, Castro, Dworsky, Kelly, Malek, Michalow and Oo were all of the opinion that Decedent was unable to return to her pre-injury job for Respondent as a result of her work injuries. Dr. Malek testified that the patient remained temporarily totally disabled from work pending surgery to her cervical spine, and that the condition had not yet reached a state of permanency. Decedent then met her demise before she was ever able to undergo the prescribed neck surgery.

Only Dr. Zelby, who saw Petitioner on but one occasion at Respondent's request, opined that she was capable of unrestricted work return; yet Zelby examined only her cervical spine. Zelby stated no opinions regarding Decedent's right shoulder or psychiatric conditions, nor did he opine as to whether those conditions were disabling.

Based upon the above, the Arbitrator finds that Decedent was temporarily totally disabled from July 29, 1998 through September 5, 2008, the date of death, representing 527-3/7 weeks.

As Decedent was temporarily totally disabled at the time of her death, her condition of ill-being had not yet reached a state of maximum medical improvement. Permanency is therefore not ascertainable. No compensation is awarded for permanent disability in this case.

Decedent's widower, Todd Gottschall, filed an amended application for adjustment of claim substituting as Petitioner under Sections 8(e)(19) and 8(h) of the Act. Section 8(e)(19) deals only with cases in which the employee sustained "specific loss" and died from causes unrelated to the injury. *See* 820 ILCS 305/8(e)(19). In contrast, Section 8(h) deals with cases in which death has occurred from any cause before the total compensation to which the employee would have been entitled has been paid. *See* 820 ILCS 305/8(h). In the instant case, Decedent sustained injuries to her right shoulder and neck, as well as psychiatric injuries, none of which are compensable as specific loss. Accordingly, Section 8(h) provides the appropriate statutory

17IWCC0674

basis for recovery of benefits by Petitioner Todd Gottschall in this case. *See Electro-Motive Div., Gen. Motors Corp. v. Industrial Comm'n,* 250 Ill.App.3d 432, 621 N.E.2d 145 (1993).

Petitioner Todd Gottschall, as widower, is therefore entitled to receive the sum of $280.10 per week from Respondent for a period of 527-3/7 weeks, representing TTD from July 29, 1998 through September 5, 2008, the date of death, in accordance with Section 8(h) of the Act.

With reference to (J) (MEDICAL), the Arbitrator finds:

The Arbitrator finds that the following unpaid medical, hospital and surgical expenses were reasonable, necessary and causally related to the injuries sustained by Decedent:

Provider	Service Dates	Amount
Associated Radiologists of Joliet	12/09/2001 to 01/24/2005	$732.00
Dr. Michel Malek MD	05/10/2004 to 03/24/2008	$1,935.45
Emergency Care & Health	08/26/2004	$120.00
Hinsdale Orthopedic Assoc.	06/27/2007 to 08/15/2008	$18,902.19
Kankakee Radiology Assoc.	05/05/2004	$57.00
Loyola Univ. Physicians Foundation	11/21/2002 to 09/09/2004	$163.00
Metro Area Pain Consultants	09/22/2004 to 08/15/2008	$19,315.00
Performance Physical Therapy	04/28/2008 to 09/02/2008	$4,025.01
Provena St. Joseph Medical Center	02/08/2008 to 02/21/2008	$16,327.41
Provena St. Mary's Hospital	07/19/2004 to 03/31/2008	$35,740.95
Riverside Community Health Centers	07/20/2001 to 01/31/2007	$1,230.13
	Total:	$98,548.14

Respondent shall therefore pay the sum of $98,548.14 for reasonable and necessary medical services. Of that amount, medical expenses incurred prior to February 1, 2016 shall be paid based upon the actual charges.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANAKEE)

☒ 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

Todd Gottschall, as Widower of
Carolyn Gottschall, Deceased,

Petitioner,

vs. NO: 09WC019721

Illinois Veterans' Home,

17IWCC0675

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2016 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: OCT 25 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM.sj
o-10/19/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOTTSCHALL, TODD AS WIDOWER OF GOTTSCHALL, CAROLYN DECEASED
Employee/Petitioner

Case# **09WC019721**

98WC058841

ILLINOIS VETERANS HOME
Employer/Respondent

17IWCC0675

On 7/6/2016, 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 0.34% 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:

0274 HORWITZ HORWITZ & ASSOC
MARC A PERPER
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 6 - 2016

Richard A. Perrin, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0675

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Todd Gottschall, as Widower of Carolyn Gottschall, Deceased,
Employee/Petitioner,

v.

Illinois Veterans Home,
Employer/Respondent.

Case # 09 WC 19721

Consolidated cases: 98 WC 58841

An *Application for Adjustment 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 **Kankakee**, on **June 17, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Decedent's earnings?

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

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

J. ☐ Who was dependent on Decedent at the time of death?

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

L. ☐ What compensation for permanent disability, if any, is due?

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

N. ☐ Is Respondent due any credit?

O. ☒ Other death benefits, burial benefit

17IWCC0675

FINDINGS:

On the date of accident, **July 28, 1998 and September 5, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Decedent's death *is* causally related to the accident.

In the year preceding the injury, Decedent earned **$6,386.28** ; the average weekly wage was **$420.15** .

On the date of accident, Decedent was **50** years of age, *married* with **no** 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 $ **N/A** for TTD, $ **N/A** for TPD, $ **N/A** for maintenance, and $ **N/A** for other benefits, for a total credit of $ **N/A** .

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

The Arbitrator finds that Decedent died on **September 5, 2008** , leaving **one** survivor~~(s)~~, as provided in Section 7(a) of the Act, ~~including~~ **to wit: Todd Gottschall, widower** .

ORDER:

Respondent shall pay death benefits, commencing **September 5, 2008** , of **$456.28** /week to the surviving spouse, TODD GOTTSCHALL, on his own behalf, until the sum of $500,000.00 has been paid or 25 years, whichever is greater, because the injury caused the employee's death, as provided in Section 7(a) of the Act.

If the surviving spouse dies before the maximum benefit level has been reached, then upon the death of the surviving spouse, payments shall cease.

If the surviving spouse remarries, and no children remain eligible, then Respondent shall pay the surviving spouse a lump sum equal to two years of compensation benefits, and all further rights of the surviving spouse shall thereafter be extinguished.

Respondent shall pay the further sum of $8,000.00 for burial expenses to the surviving spouse, as provided in Section 7(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

Robert E. Abrams — June 30, 2016

Signature of Arbitrator — Date

JUL 6 - 2016

17IWCC0675

STATE OF ILLINOIS)
) SS.:
COUNTY OF KANKAKEE)

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

TODD GOTTSCHALL, as Widower of CAROLYN GOTTSCHALL, Deceased,	)	
Petitioner,	)	
	)	No. 09 WC 19721
-v.-	)	(consolidated with No. 98 WC 58841)
ILLINOIS VETERANS HOME,	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT:

Petitioner TODD GOTTSCHALL, widower of CAROLYN GOTTSCHALL, Deceased, was lawfully married to Decedent on September 5, 2008, the date of her death (PX 17; PX 18). Decedent left surviving two minor children, Ben Gottschall and Chris Gottschall, both of whom were over eighteen years of age and not enrolled in school at the time of Decedent's death. Accordingly, Todd Gottschall is the only eligible claimant pursuant to Section 7(a) of the Act. Mr. Gottschall brings this claim for fatal injuries under Section 7(a) (see PX 22).

Petitioner's Decedent was employed as a certified nursing assistant at Illinois Veterans' Home. On July 28, 1998, at approximately 4:00 PM, Decedent noticed pain in her right shoulder while cranking a patient's bed (PX 1; RX 1). She was seen at Provena St. Mary's Medical Center, where she complained of tenderness at the top of the shoulder and at the supraspinatus, with pain on lifting the shoulder and reaching behind her head and behind the low back. Dr. Ronald Jurzejka prescribed a sling and advised her to follow up with corporate health. He placed her on restrictions of no use of the right arm. Decedent ceased working at that time. Respondent commenced payment of TTD (RX 2; RX 6).

Decedent's course of medical treatment is set forth in the Arbitrator's decision in companion case no. 98 WC 58841 and will therefore not be repeated here. In brief, Decedent underwent three right shoulder surgeries: (1) a right shoulder arthroscopy with debridement of subscapularis tendon tear and arthroscopic glenoid labrum repair by Dr. Alexander Michalow, an orthopedic surgeon, on September 24, 1998; (2) right shoulder arthroscopy with subacromial decompression, bursectomy, CA ligament excision and acromioplasty by Dr. Michalow on August 3, 1999; and (3) right shoulder arthroscopy with repair of the subscapularis tendon, debridement of labrum and subacromial decompression by Dr. Bradley Dworsky, an orthopedic surgeon, on February 21, 2008 (PX 1; PX 2; PX 9; RX 8).

Decedent reported symptoms of neck pain and cervical radiculopathy beginning November 9, 1998, when she commenced her initial course of postoperative physical therapy following the first right shoulder surgery on September 24, 1998 (RX 8). She was treated conservatively for her neck pain with medication, therapy and injections by her primary care physicians, Drs. Castro and Oo, by physiatrists Drs. Charuk and Villegas, and by a pain management specialist, Dr. Kelly (PX 3; PX 6; PX 7). Decedent's cervical spine condition was variously diagnosed as myofascial pain syndrome, fibromyalgia, aggravation of pre-existing but asymptomatic degenerative changes, cervical radiculopathy, and herniated cervical disc (PX 1; PX 3; PX 5; PX 6; PX 7; PX 15 at 12; PX 15 at Dep. Exh. 2).

Upon failure of conservative treatment modalities, Dr. Michel Malek, a neurosurgeon, prescribed a multi-level anterior cervical spinal fusion, but he postponed the neck surgery pending resolution of the patient's right shoulder condition, for which she was then treating with Dr. Dworsky (PX 15 at 26-27). Dr. Malek testified that in his opinion, the patient's cervical spine condition was causally related to the July 28, 1998 work injury, in that her activities on that date aggravated pre-existing but asymptomatic degenerative changes in the cervical spine, resulting in cervical radiculopathy (PX 15 at 23-25).

Dr. Castro referred Decedent to Dr. Mary Belford, a psychiatrist, for treatment of depression secondary to chronic right shoulder pain. Drs. Castro and Belford both opined that the patient's depression was causally related to chronic pain stemming from her July 28, 1998 work injury (PX 3; PX 4).

Carolyn Gottschall died at home in her sleep on September 5, 2008 (PX 18). Her body was found by Mr. Gottschall when he awakened that morning. At the time of her death, Ms. Gottschall's prescribed medication regimen included the following:

Wellbutrin XL oral tablet 24 hr 300 mg., 1 every morning.
Cymbalta oral capsule enteric coated 30 mg., 1 every morning with 60 mg.
Cymbalta oral capsule enteric coated 60 mg., 1 every morning.
Wellbutrin XL oral tablet 24 hr 300 mg., 1 per os daily.
Singulair oral tablet 10 mg., 1 per os daily.
Advair diskus inhalation miscellaneous 500-50 mcg/dose, 1puff BID.
Cymbalta oral capsule enteric coated 30 mg., 3 tabs daily.
Prevacid oral capsule delayed release 30 mg., 1 every day.
Norco oral tablet 7.5-325 mg., 1 two times a day.
Avinza oral capsule 24 hr. 120 mg., 1 every day.
Amitriptyline HCL oral tablet 150 mg., 2 every day at bedtime.
Xanax oral tablet 1 mg., four times a Day, as needed for anxiety.
Lyrica oral capsule conventional 100 mg., one twice a day.
Furosemide oral tablet 40 mg., 1 every morning.
Potassium chloride tab 10 MEQ, 1 every day.

(PX 4).

The report of the Kankakee County Coroner's investigation was admitted in evidence (PX 19). On September 5, 2008, investigator Pam Kinsley reported the following prescription medications found in Decedent's home:

Furosemide 20 mg., 1 tablet every morning (Dr. Saw M. Oo)
Klor-Con 10 MEq tab, 1 every morning (Dr. Oo)
Amitriptyline 150 mg., 1 tablet at bedtime (Dr. Mary Belford)
Skelaxin 800 mg., 1 tablet 4x/daily (Dr. James Kelly)
Alprazolam 1mg. tab, 1 tablet 4x/daily (Dr. Belford)
Hydrocodone APAP (dosage and prescribing physician left blank on report)
Potassium 10mEq, t tablet 3x/week (Dr. Oo).

(PX 19). Later that same afternoon, Officer Brown reported the following additional prescription medications found in a container in the home:

Ten 1 mg. alprazolam tablets;
Two 800 mg. Skelaxin tablets;
Ten 10/325 mg. hydrocodone/apap;
One 60 mg. Cymbalta
One 30 mg. Cymbalta
Four oval white tablets with "L84" on one side.

(PX 19). Investigator Kinsley reported that Decedent was found unresponsive by Mr. Gottschall, who found her face down on the bed with her face flat on the mattress and purple in color. He called 911, whose dispatcher notified the Coroner's Office. Mr. Gottschall stated that he last saw Decedent around 9:00 PM on September 4, 2008 when she was sitting up in bed. He told her to shut off the TV and go to sleep. He acknowledged that she was under the care of multiple physicians and was taking numerous medications that caused her to fall asleep, especially at night. Investigator Kinsley reported that the "whole family said they knew this was going to happen someday and tried to talk her out of taking so much medication." Mr. Gottschall stated that Decedent would function normally during the day, but at night she would fall asleep anywhere. He did not believe she overdosed, but rather was just prescribed too many pills. It appeared to Kinsley that Decedent had fallen over in bed and could not breathe due to being face down in the mattress. The medications were removed from the residence by the investigator. Decedent was taken to the morgue by ambulance (PX 19).

On September 5, 2008 at 4:00 PM, Officer Brown spoke with Dr. Oo, who related that the patient's main health problem was "arthritis," for which Dr. Kelly was prescribing pain medication. Decedent also had a history of mild asthma, and in March 2008 she underwent surgery to remove a benign tumor at the right hip. Officer Brown removed additional medications from the home (PX 19).

Dr. Bryan R. Mitchell, a forensic pathologist, performed an autopsy on Petitioner's Decedent on September 6, 2008. Dr. Mitchell made the following diagnoses:

(1) Cerebral edema with cerebellar tonsillar notching;

(2) Petechiae, frontal subgaleal area and face and chest;
(3) Moderate pulmonary congestion and edema;
(4) Hepatic, renal and splenic congestion;
(5) Cholelithiasis;
(6) status-post abdominal surgery, not otherwise specified;
(7) History of benign tumor, right hip;
(8) No pulmonary embolism, myocardial infarction, coronary atherosclerosis, malignancy, trauma, infection or congenital anomalies;
(9) History of prescription medication use; and
(10) Hydrocodone and morphine intoxication, based upon toxicology. Also present were Amitriptyline and its metabolite, alprazolam, diphenhydramine and acetaminophen. See toxicology report for levels.

(PX 19).

The toxicology report was received on September 16, 2008. The results were as follows:

Analysis by Enzyme-Linked Immunosorbent Assay (ELISA):
- ✓ Positive for opiates, benzodiazepines and acetaminophen.

Analysis by Colorimetry (C):
- ✓ Positive for acetaminophen

Analysis by Gas Chromatography (GC) and Gas Chromatography/Mass Spectrometry (GC/MS):
- ✓ Positive for Amitriptyline, 1,200 ng/mL; Nortriptyline, 1,100 ng/mL; Bupropion metabolite; Metaxalone; Diphenhydramine 630 ng/mL; Diphenhydramine metabolite. Incidentally positive for caffeine.

Analysis by High Performance Liquid Chromatography (HPLC):
- ✓ Acetaminophen, 20 mcg/mL (usual therapeutic range, 5-20 mcg/mL).

Benzodiazepines: Analysis by GC/MS:
- ✓ Alprazolam, 51 ng/mL (therapeutic range: 10-50 ng/mL at trough. Potentially toxic at >75 ng/mL).

Opiates: Analysis by GC/MS:
- ✓ Dihydrocodeine/Hydrocodol-Free, 43 ng/mL (usual therapeutic range: 50-100 ng/mL).
- ✓ Hydrocodone-Free, 170 ng/mL (following a single 10 mg. oral hydrocodone bitartrate dose: up to 32 ng/mL at 1.5 hours post-dose).
- ✓ Morphine-Free, 17 ng/mL (usual range following therapeutic doses: 10-70 ng/mL).

(PX 19).

Dr. Mitchell reported his findings and conclusions to the Kankakee County Coroner on September 20, 2008. Dr. Mitchell concluded that Ms. Gottschall died on September 5, 2008 at 5:48 AM, and that the immediate cause of death was opiate intoxication. Dr. Mitchell based his conclusions on the autopsy findings, the coroner's reports, and the toxicology results (PX 19).

Decedent's death certificate is in evidence. The immediate cause of death stated on the death certificate is "opiate intoxication" (PX 18).

Dr. Ronald Henson reviewed pertinent records, the coroner's report and a medical abstract at Petitioner's request. Dr. Henson is a Ph.D. in Applied Management and Decision Sciences. His doctoral dissertation was entitled, "Workplace Substance Abuse Testing and Factors that Influence Policy." He currently serves as Executive Academic Chair for the School of Criminal Justice at Aspen University in Colorado, where he instructs graduate and undergraduate level courses in criminal investigation, drug enforcement, criminology, criminal law, clandestine laboratory investigation, police supervision, criminal investigations, criminal procedure, patrol procedure, law enforcement technology, crime scene investigation and police administration. Dr. Henson was a police officer from 1979 to 1990 and has taught law enforcement classes since 1986. He has served on advisory committees for numerous police departments, governmental agencies, colleges and universities. He has authored several publications on the subject of alcohol and drug use (PX 16 at 4-10; PX 16 at Dep Exh. 1).

Dr. Henson noted that Decedent was treated for several years for her work injuries with multiple prescription drugs, including hydrocodone, morphine, and other opioids that included Avinza (morphine sulfate), and that these narcotic / opiate-related prescriptions were administered for pain control due to the work injury. Based upon the report of Dr. Mitchell, Dr. Henson opined that the Decedent's cause of death was opiate intoxication, secondary to opiate-related medication prescribed for her July 28, 1998 work injuries. In Dr. Henson's opinion, Decedent's death from opiate intoxication cannot be ascribed to drug abuse. Rather, because of the type of medications prescribed and the use and interactions of other prescribed drugs, opiate intoxication leading to death can occur without a knowing mindset of the individual taking the prescribed drugs in this case. Dr. Henson found no evidence of intentional overdose, suicide or foul play involving Decedent's opioid medications. Dr. Henson agreed that there is a "fine line" between a therapeutic dose of narcotic pain medication and a toxic dose (PX 16 at 10-16; PX 16 at Dep Exh. 2).

Dr. John Bederka, a pharmacologist, testified for Respondent. Dr. Bederka disagreed with both Dr. Mitchell and Dr. Henson as to the cause of death. In Dr. Bederka's opinion, Decedent's death was caused not by opiate intoxication, but rather by multiple drug interaction involving Amitriptyline, nortriptyline and diphenhydramine. According to Dr. Bederka, Decedent was taking those drugs at "extreme levels." Any of the three could have been a lethal agent. Taken together, "it's likely that they were easier to kill." The only other drug found to be "near" toxic range was hydrocodone; however, Dr. Bederka opined that Decedent had been taking hydrocodone for so long that she had likely become tolerant of its effects (RX 5 at 32-36).

On cross-examination, Dr. Bederka agreed that Decedent's hydrocodone level was 170 nanograms per milliliter of plasma. Dr. Bederka admitted that 100 nanograms of hydrocodone

constitutes a toxic level, and that Decedent's hydrocodone level of 170 nanograms exceeds the toxic level of 100 nanograms by some seventy percent. Dr. Bederka claimed that 170 nanograms is "just above the toxic level" of 100 nanograms. Yet he admitted that a hydrocodone level of even 120 to 130 nanograms can be lethal, and that Decedent's own hydrocodone level of 170 nanograms, according to the literature, can cause death (RX 5 at 45-46, 68).

With reference to his opinion that Decedent's cause of death was attributable to amitriptyline, nortriptyline and diphenhydramine, Dr. Bederka claimed that those drugs were prescribed for "health events prior to July of '98, including arthritis and anxiety/depression." Yet Dr. Bederka was unable to point to anything in Decedent's medical records indicating that she was treating for depression or anxiety prior to the 1998 work accident. Dr. Bederka denied knowledge of Dr. Belford having prescribed medication to Decedent for depression, and he denied knowing that Dr. Castro had referred Decedent to Dr. Belford for depression secondary to chronic pain due to her right shoulder injury. When asked whether he knew of any treating doctor in the case who had ever expressed an opinion that the patient's depression was unrelated to her work injury, Dr. Bederka refused to answer (RX 5 at 44-64).

Dr. Bederka was asked whether, if the finder of fact in this case determined that Decedent's depression and anxiety were causally related to the work injury, it would follow that her toxic levels of nortriptyline, amitriptyline and diphenhydramine were themselves causally related to the injury. He responded that "just because this person ... state[s] that these are causally related doesn't mean that they're causally related. It's just his bloody opinion, and that's the way the world is" (RX 76-77). Dr. Bederka did agree that there was no evidence of suicide, intentional overdose or foul play in this case. Instead, he characterized Decedent's death as an accidental overdose (RX 77-78).

CONCLUSIONS OF LAW:

With reference to (G) (EARNINGS), the Arbitrator finds:

In a claim for benefits based upon fatal injuries in which the date of death postdates the date of accident, the applicable version of the Act is the version in effect on the date of death. Accordingly, "the amount of compensation to be awarded must be determined under the statute in force on the date of the decedent's death." *A.O. Smith Corp. v. Industrial Comm'n,* 109 Ill.2d 52, 57; 485 N.E.2d 335, 338 (1985). Accordingly, the amount and duration of Petitioner's weekly benefits for fatal injuries will be determined by the version of the Act in effect on September 5, 2008, the date of death.

The minimum weekly compensation rate for fatal injuries in effect on September 5, 2008 was fifty percent (50%) of the statewide average weekly wage in covered industries under the Unemployment Insurance Act, or $456.28. *See* 820 ILCS 305/8(b)(4.1). That weekly sum is payable for the life of the widower under Section 7(a) of the Act, 820 ILCS 305/7(a), but not to exceed the greater of $500,000.00 or 25 years of benefits. 820 ILCS 305/8(b)(4.2).

In the instant case, Petitioner's wage analysis found at PX 14 includes Decedent's actual pay stubs showing $6,386.28 in straight-time pay, excluding overtime, over 15-1/5 weeks

worked for Respondent during the 52 weeks preceding the injury, which yields an average weekly wage of $420.15. Respondent's wage exhibit found at RX 2 was a summary setting forth Decedent's annual salary of $14,529.00 and a "average weekly salary" of $375.32, but with no payroll data attached, and no indication as to how Respondent arrived at the $375.32 figure and no indication of how many weeks Petitioner had worked during this period of time.

The Arbitrator finds that Petitioner's earnings analysis is supported by actual wage data and is therefore more likely to represent Decedent's actual earnings. Accordingly, the Arbitrator finds that the average weekly wage was $420.15.

However, even if the Arbitrator were to adopt Respondent's proposed average weekly wage of $375.32, it would make no difference to the computation of the weekly compensation benefit in this case, because the minimum compensation rate for fatal injuries in either event would still be $456.28, as provided in Section 8(b)(4.2) of the Act, 820 ILCS 305/8(b)(4.2).

With reference to (C) (ACCIDENT) and (F) (CAUSAL CONNECTION), the Arbitrator finds:

The Arbitrator finds most credible the findings, opinions and conclusions of Dr. Mitchell, who personally performed the autopsy and concluded, based upon the coroner's investigation, the toxicology results and his own autopsy findings that the cause of death was opiate intoxication. The Arbitrator notes that the opiates were being prescribed for treatment of chronic pain secondary to Decedent's right shoulder and neck conditions, which were found to be causally related to the July 28, 1998 work injury in companion case no. 98 WC 58841. The Arbitrator further notes that Dr. Mitchell's opinions are bolstered by those of Dr. Henson. The Arbitrator finds that the opinions of Drs. Mitchell and Henson, taken together, are more credible than the testimony of Dr. Bederka, whose opinion stands alone. In particular, the Arbitrator finds Dr. Bederka's testimony that Decedent's hydrocodone level of 170 nanograms per milliliter could not have caused her death to be lacking in credibility and unworthy of belief, in light of literature produced by Dr. Bederka himself stating that 100 nanograms of hydrocodone constitutes a toxic level, and that a hydrocodone level of 120 to 130 nanograms can be fatal.

However, even if the Arbitrator were to credit Dr. Bederka's claim that Decedent died due to toxic levels of nortriptyline, amitriptyline and diphenhydramine, the Arbitrator would still find that Decedent's death was causally related to the work injury, as those medications were prescribed by Dr. Belford, who was treating Decedent for depression secondary to chronic pain stemming from her right shoulder condition.

Based upon the above, the Arbitrator finds that Petitioner's Decedent sustained accidental injuries arising out of and in the course of her employment for Respondent on July 28, 1998, and that the said injuries caused the death of Petitioner's Decedent on September 5, 2008.

With reference to (O) (DEATH AND BURIAL BENEFITS), the Arbitrator finds:

Petitioner Todd Gottschall, as widower, is the only eligible claimant in this case under Section 7(a) of the Act.

Accordingly, Respondent shall pay to Petitioner the sum of $456.28 per week for life, but not to exceed the sum of $500,000.00 or 25 years of benefits, whichever is greater.

If Petitioner remarries, and no children remain eligible, then Respondent shall pay to Petitioner a lump sum equal to two years of benefits, and all further rights shall be extinguished.

Respondent shall pay to Petitioner the further sum of $8,000.00 for burial expenses, as provided in Section 7(f) of the Act.

Commencing on the second July 15th following entry of this award, Petitioner may become eligible for benefits under the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

With reference to (K) (MEDICAL), the Arbitrator finds:

The Arbitrator finds that the medical bills contained in Petitioner's Group Exhibit 13 and summarized in Petitioner's Exhibit 12 were all related to the non-fatal injury claim, which was adjudicated in companion case no. 98 WC 58841.

17IWCC0675

basis for recovery of benefits by Petitioner Todd Gottschall in this case. *See Electro-Motive Div., Gen. Motors Corp. v. Industrial Comm'n,* 250 Ill.App.3d 432, 621 N.E.2d 145 (1993).

Petitioner Todd Gottschall, as widower, is therefore entitled to receive the sum of $280.10 per week from Respondent for a period of 527-3/7 weeks, representing TTD from July 29, 1998 through September 5, 2008, the date of death, in accordance with Section 8(h) of the Act.

With reference to (J) (MEDICAL), the Arbitrator finds:

The Arbitrator finds that the following unpaid medical, hospital and surgical expenses were reasonable, necessary and causally related to the injuries sustained by Decedent:

Provider	Service Dates	Amount
Associated Radiologists of Joliet	12/09/2001 to 01/24/2005	$732.00
Dr. Michel Malek MD	05/10/2004 to 03/24/2008	$1,935.45
Emergency Care & Health	08/26/2004	$120.00
Hinsdale Orthopedic Assoc.	06/27/2007 to 08/15/2008	$18,902.19
Kankakee Radiology Assoc.	05/05/2004	$57.00
Loyola Univ. Physicians Foundation	11/21/2002 to 09/09/2004	$163.00
Metro Area Pain Consultants	09/22/2004 to 08/15/2008	$19,315.00
Performance Physical Therapy	04/28/2008 to 09/02/2008	$4,025.01
Provena St. Joseph Medical Center	02/08/2008 to 02/21/2008	$16,327.41
Provena St. Mary's Hospital	07/19/2004 to 03/31/2008	$35,740.95
Riverside Community Health Centers	07/20/2001 to 01/31/2007	$1,230.13
	Total:	$98,548.14

Respondent shall therefore pay the sum of $98,548.14 for reasonable and necessary medical services. Of that amount, medical expenses incurred prior to February 1, 2016 shall be paid based upon the actual charges.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Connie Marshall,
Petitioner,

17IWCC0676

vs.

NO: 11 WC 21928

Citizen's Bank of Chatsworth,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2016, is hereby affirmed and adopted.

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

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

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: OCT 26 2017
o10/12/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0676

MARSHALL, CONNIE
Employee/Petitioner

Case# 11WC021928

11WC021929

CITIZEN'S BANK OF CHATSWORTH
Employer/Respondent

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

0264 HEYL ROYSTER VOELKER & ALLEN
JAMES J MANNING
PO BOX 6199
PEORIA, IL 61601-6199

17IWCC0676

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Connie J. Marshall
Employee/Petitioner

v.

Citizen's Bank of Chatsworth
Employer/Respondent

Case # 11 WC 21928

Consolidated cases: 11 WC 21929

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on March 30, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On June 14, 2011, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $20,800.00; the average weekly wage was $400.00.

On the date of accident, Petitioner was 58 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

May 25, 2016

Date

ICArbDec p. 2

MAY 26 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which, as amended, alleged that she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case number 11 WC 21929, the Application alleged that on June 16, 2010, "while working" Petitioner sustained an injury to her left hand (Arbitrator's Exhibit 4). In case number 11 WC 21928, the Application alleged that on June 14, 2011, "while working" Petitioner sustained an injury to her right hand (Arbitrator's Exhibit 3). Although neither Application described the alleged injuries as being caused by repetitive trauma, this was the basis of both claims. Respondent denied liability in both claims on the basis of accident, notice and causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner became employed by Respondent on April 19, 2010, as a bank teller. The basis of both of her claims was that her job duties as a bank teller required the repetitive use of both of her hands. Petitioner stated that she worked a five day work week, 40 hours per week. Petitioner testified at length regarding her job duties which included counting cash by hand, stacking/sorting money, filling the ATM machine, pinching/grasping of currency, counting coins and putting them in a machine, recording various bank transactions and doing some data entry.

Petitioner estimated that she spent about three hours per day counting cash. This included cash left in the night drop by various businesses. Tuesday was the busiest day because a local church would leave their deposits on Monday nights. Petitioner stated that she spent about three to five hours per day doing customer transactions that included deposits, withdrawals, check cashing, etc. Two to three times per week, Petitioner would fill an ATM machine, a job that took about 45 minutes and also required counting cash by hand. Petitioner would also handle give gallon buckets full of coins and scoop them by hand into a counting machine. Petitioner performed this task about three times per week, but even more frequently during the summer because one of the bank's customers was a car wash. Petitioner also handled opening mail and processing payment of bills for the water company. In late 2010, Petitioner also performed the duties of a vault teller which included the verification of other tellers' transfers in/out of the vault, counting currency and wrapping coins.

Wanita Thompson testified on behalf of the Respondent when this case was tried. Thompson was Respondent's branch manager and began working for Respondent in July, 2013. Even though Thompson did not work for Respondent during the period of time that Petitioner did, she stated that she has worked in the banking industry since 1978. Thompson testified that she was knowledgeable about the job duties of a bank teller and that they were the same now as they were when Petitioner worked there.

Thompson identified a log of transactions performed by Petitioner for the entire time Petitioner worked for Respondent from April 22, 2010, through May 24, 2011. Specifically, Thompson noted that on April 22, 2010, Petitioner scanned 64 items between 11 AM and 12 PM which amounted to six transactions. For the remainder of the workday to 4 PM, Petitioner scanned 25 items which was a total of four transactions. Accordingly, for April 22, 2010, Petitioner had a total of 10 transactions. For April 27, 2010 (a Tuesday), between 8 AM and 10 AM, Petitioner scanned 591 items which amounted to 20 transactions. This included the night depository items. (Respondent's Exhibit 44).

The Arbitrator also reviewed the log of transactions and noted that, for the period of time Petitioner worked for Respondent, the number of daily transactions varied from 9 to 57.

On cross-examination, Thompson agreed that the amount of time required for one transaction was not stated in the exhibit. She also agreed that a deposit of 100 $1 bills would require counting of the bills, but would only be considered as one transaction.

Respondent tendered into evidence a video dated January 31, 2012 (a Tuesday), which depicted tellers' activities of approximately 54 minutes on that date. This included the processing of night deposits as well as transfers to/from the vault. The Arbitrator watched this video and noted that the tellers worked at a quick pace (Respondent's Exhibit 2).

Respondent also tendered into evidence of video dated February 17, 2012, which was of a teller working her station for approximately 43 minutes. The Arbitrator watched this video and noted that the teller work at a much slower pace than in the video obtained on January 31, 2012 (Respondent's Exhibit 3).

Thompson testified that the teller's activities depicted in the video obtained on February 17, 2012, was an accurate representation of the job activities performed by a teller on a daily basis. Petitioner agreed that the video was an accurate depiction of her job duties; however, she stated that it was not accurate in regard to the pace which she worked.

Petitioner initially sought medical treatment from Dr. Eric Farinas, her family physician, on Junc 16, 2010. According to Dr. Farinas' record of that date, Petitioner had complaints of left hand pain/swelling that had been present for one and one-half months. His diagnosis was that of left de Quervain's tenosynovitis (Petitioner's Exhibit 1).

Petitioner later sought treatment from Zozzaro Chiropractic on July 22, 2010. Petitioner gave a history of left hand and thumb pain since May and advised that she worked at a bank counting cash (Petitioner's Exhibit 2).

Petitioner subsequently sought treatment at McLean County Orthopedics where she was initially seen by John Nelson, a Physician's Assistant, on September 21, 2010. Petitioner advised that she had swelling of the left hand that had been present since May, 2010. Petitioner informed PA Nelson that she worked as a teller and did a lot of work with her hands including counting money which caused an increase in her pain symptoms. X-rays were ordered which revealed end stage degenerative osteoarthritis of the first CMC joint (Petitioner's Exhibit 3).

Petitioner later sought treatment from Dr. Anthony Dustman, an orthopedic surgeon, on November 8, 2010. At that time, Petitioner had complaints of pain in the CMC joint of the left thumb. Petitioner informed Dr. Dustman that she was a bank teller and used the left hand to hold and squeeze money while she counted. Dr. Dustman opined that Petitioner had arthritis of the CMC joint and opined that an arthroplasty of the left thumb might be required. He did not comment as to whether Petitioner's job duties caused her problem; however, he noted that Petitioner had a history of hypothyroidism and was 4' 11" tall and weighed 140 pounds (Petitioner's Exhibit 4).

Petitioner was again seen by Dr. Dustman on January 10, 2011, and still had left thumb symptoms. Dr. Dustman's diagnosis remained the same and he restated his surgical recommendation of an arthroplasty (Petitioner's Exhibit 4).

Petitioner continued to work full time for Respondent and did not seek any further medical treatment until she was seen by Dr. Farinas on June 14, 2011. At that time, Petitioner complained of left thumb pain since June, 2010. Dr. Farinas noted that Dr. Dustman had seen Petitioner and recommended joint replacement. He also noted that Petitioner had hypothyroidism and had reduced her cigarette smoking. He authorized Petitioner to be off work and referred her to Dr. David Fletcher for a second opinion (Petitioner's Exhibit 1).

Dr. Fletcher saw Petitioner on July 11, 2011. At that time, Petitioner complained of left and right hand symptoms that began on June 19, 2010, and April, 2011, respectively. He diagnosed Petitioner with left and right CMC arthritis and mild bilateral carpal tunnel syndrome. He opined that the conditions were related to her work activities as a bank teller. He also confirmed that Petitioner had hypothyroidism and recommended that she stopped smoking (Petitioner's Exhibit 5).

Dr. Fletcher referred Petitioner to Dr. Stuart Baker, a plastic surgeon, who also saw Petitioner on July 11, 2011. Dr. Baker opined that Petitioner had osteoarthritis of the left CMC joint. He subsequently saw Petitioner on October 17, 2011, and opined that Petitioner had left and right de Quervain's as well as left and right CMC joint arthritis (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Jay Pomerance, an orthopedic surgeon, on February 23, 2012. In connection with his examination of Petitioner, Dr. Pomerance reviewed medical records provided to him by Respondent. Dr. Pomerance noted Petitioner's medical history of hypothyroidism, smoking, and obesity. Dr. Pomerance opined that Petitioner had bilateral CMC arthritis and suggested an initial attempt at conservative treatment such as medications, splinting and injections. If these did not relieve her symptoms, then there were various surgical procedures that could be attempted (Respondent's Exhibit 8).

In a supplemental report dated February 24, 2012, Dr. Pomerance provided an opinion regarding causality. Dr. Pomerance watched both videos (Respondent's Exhibits 2 and 3) of a teller performing tellers' job duties as well as a written job description of a teller. He opined that Petitioner's exposure as a bank teller did not cause, aggravate or accelerate Petitioner's bilateral CMC osteoarthritis. He based this opinion upon the incidence of CMC osteoarthritis in women and the fact that Petitioner was obese. Further, he did not diagnose either de Quervain's or carpal tunnel syndrome (Respondent's Exhibit 9).

Petitioner was again seen by Dr. Fletcher on January 14, 2013. Her complaints were the same as they were previously. He referred Petitioner to Dr. Edward Trudeau for nerve conduction studies. Dr. Trudeau performed nerve conduction studies on January 31, 2013, which were positive for moderately severe bilateral carpal tunnel syndrome, greater on the left than the right (Petitioner's Exhibit 8).

At the direction of the Respondent, Petitioner was again examined by Dr. Pomerance on October 24, 2013. In connection with this examination, Dr. Pomerance reviewed medical records provided to him by Respondent. Dr. Pomerance opined that Petitioner had bilateral carpal tunnel syndrome as well as the bilateral CMC joint osteoarthritis. In regard to causality, Dr. Pomerance opined that neither the osteoarthritis nor carpal tunnel syndrome were related to Petitioner's job activities as a teller. In regard to the osteoarthritis, Dr. Pomerance referenced the Petitioner's age, gender and degenerative changes associated with same. In regard to the carpal tunnel syndrome, Dr. Pomerance attributed this to Petitioner's age, gender, obesity, smoking, CMC osteoarthritic condition and hypothyroidism (Respondent's Exhibit 10).

Petitioner was evaluated by Dr. Lawrence Li, an orthopedic surgeon, on October 25, 2013. At that time, Petitioner informed Dr. Li of her hand and thumb symptoms. Petitioner related her hands symptoms to her work as a bank teller which required her to count money all day long. Dr. Li opined that Petitioner had bilateral CMC joint arthropathy and bilateral carpal tunnel syndrome, both of which were caused and aggravated by her duties as a bank teller (Petitioner's Exhibit 7).

Dr. Li performed surgeries which consisted of a left carpal tunnel release, CMC arthropathy and ligament reconstruction on November 5, 2013. He performed the same surgical procedures on the right hand on April 18, 2014. He released Petitioner from care on July 2, 2014, and deferred determination of her work status to Dr. Fletcher (Petitioner's Exhibit 7).

Petitioner saw Dr. Fletcher on July 22, 2014. At that time, Petitioner still had complaints of pain/numbness in both hands, but she thought that it had improved compared to what it had been previously. Dr. Fletcher opined that Petitioner was at MMI and imposed permanent work restrictions of no grasping or lifting of the right hand as well as no constant high force or high frequency tasks, no fine dexterity work and no lifting more than 20 pounds occasionally. There was no specific reference to restrictions in regard to the left hand (Petitioner's Exhibit 5).

Dr. Fletcher ordered a functional capacity evaluation (FCE) which was performed on August 12, 2014. The examiner described Petitioner's efforts during the testing as being "Inconsistent" and further noted that Petitioner demonstrated "self-limiting behaviors." (Petitioner's Exhibit 5).

Dr. Fletcher saw Petitioner for the last time on September 23, 2014. At that time, Petitioner's symptoms remained essentially the same as what they had been previously. Dr. Fletcher restated the restrictions that he previously imposed (Petitioner's Exhibit 5).

Again, at the direction of Respondent, Dr. Pomerance examined Petitioner on August 28, 2014. Dr. Pomerance opined that Petitioner could return to work as a bank teller. He also provided an AMA impairment rating of 18% of the whole person (Respondent's Exhibit 11).

Petitioner tendered into evidence a job search log and testified that she conducted most of her job searches or submitted applications online (Petitioner's Exhibit 9). Petitioner also testified that in July, 2014, she went to the Respondent to determine if there was a position available for her that conformed to the restrictions imposed by Dr. Fletcher. Respondent did not have such a position to offer to Petitioner. Respondent tendered into evidence a labor market survey which identified various jobs available to the Petitioner (Respondent's Exhibit 43).

At trial, Petitioner testified that she has not worked since June 14, 2011, when she was last seen by Dr. Farinas. Petitioner still has complaints of weakness in both hands and a tendency to drop things. She does not believe that she could return to work as a bank teller.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive, injury arising out of and in the course of her employment for Respondent that manifested itself on June 14, 2011, and that her current condition of ill-being is not related to her work.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that she was subject to continuous repetitive use of both of her hands for all of the time she worked for Respondent was not credible.

The Arbitrator finds that, although there were periods of time which required more intensive use of Petitioner's hands than others, i.e., Tuesdays doing the night deposits and transfers to/from the vaults, there were greater periods of time in which Petitioner worked at a much slower pace.

Even though Thompson was not working for Respondent at the time Petitioner did, her testimony regarding the repetitiveness of Petitioner's work duties was credible and consistent with the videos tendered by Respondent.

Petitioner was female and had pre-existing osteoarthritis, obesity, hypothyroidism and smoked. Dr. Pomerance attributed Petitioner's bilateral carpal tunnel syndrome conditions to these factors and not her job duties as a bank teller.

While Dr. Fletcher and Dr. Li both opined that Petitioner's hand complaints were related to her job duties, their opinions were based on an incorrect assumption that Petitioner's job duties as a bank teller subjected her to continuous repetitive use of her hands. Further, neither commented on what effect, if any, the other factors may have had.

Based on the preceding, the Arbitrator finds the opinion of Dr. Pomerance to be more persuasive than those of Dr. Fletcher and Dr. Li.

In regard to disputed issues (E), (J), (K) and (L), the Arbitrator makes no conclusions of law because these issues are rendered moot as result of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Connie Marshall,
Petitioner,

17IWCC0677

vs.

NO: 11 WC 21929

Citizen's Bank of Chatsworth,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary disability, permanent disability, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

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: OCT 26 2017
o10/12/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0677

MARSHALL, CONNIE
Employee/Petitioner

Case# 11WC021929

11WC021928

CITIZEN'S BANK CHATSWORTH
Employer/Respondent

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% 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:

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

0264 HEYL ROYSTER VOELKER & ALLEN
JAMES J MANNING
PO BOX 6199
PEORIA, IL 61601-6199

17IWCC0677

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Connie J. Marshall
Employee/Petitioner

v.

Citizen's Bank of Chatsworth
Employer/Respondent

Case # 11 WC 21929

Consolidated cases: 11 WC 21928

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on March 30, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On June 16, 2010, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $3,200.00; the average weekly wage was $400.00.

On the date of accident, Petitioner was 57 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 25, 2016
Date

MAY 26 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which, as amended, alleged that she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case number 11 WC 21929, the Application alleged that on June 16, 2010, "while working" Petitioner sustained an injury to her left hand (Arbitrator's Exhibit 4). In case number 11 WC 21928, the Application alleged that on June 14, 2011, "while working" Petitioner sustained an injury to her right hand (Arbitrator's Exhibit 3). Although neither Application described the alleged injuries as being caused by repetitive trauma, this was the basis of both claims. Respondent denied liability in both claims on the basis of accident, notice and causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner became employed by Respondent on April 19, 2010, as a bank teller. The basis of both of her claims was that her job duties as a bank teller required the repetitive use of both of her hands. Petitioner stated that she worked a five day work week, 40 hours per week. Petitioner testified at length regarding her job duties which included counting cash by hand, stacking/sorting money, filling the ATM machine, pinching/grasping of currency, counting coins and putting them in a machine, recording various bank transactions and doing some data entry.

Petitioner estimated that she spent about three hours per day counting cash. This included cash left in the night drop by various businesses. Tuesday was the busiest day because a local church would leave their deposits on Monday nights. Petitioner stated that she spent about three to five hours per day doing customer transactions that included deposits, withdrawals, check cashing, etc. Two to three times per week, Petitioner would fill an ATM machine, a job that took about 45 minutes and also required counting cash by hand. Petitioner would also handle give gallon buckets full of coins and scoop them by hand into a counting machine. Petitioner performed this task about three times per week, but even more frequently during the summer because one of the bank's customers was a car wash. Petitioner also handled opening mail and processing payment of bills for the water company. In late 2010, Petitioner also performed the duties of a vault teller which included the verification of other tellers' transfers in/out of the vault, counting currency and wrapping coins.

Wanita Thompson testified on behalf of the Respondent when this case was tried. Thompson was Respondent's branch manager and began working for Respondent in July, 2013. Even though Thompson did not work for Respondent during the period of time that Petitioner did, she stated that she has worked in the banking industry since 1978. Thompson testified that she was knowledgeable about the job duties of a bank teller and that they were the same now as they were when Petitioner worked there.

Thompson identified a log of transactions performed by Petitioner for the entire time Petitioner worked for Respondent from April 22, 2010, through May 24, 2011. Specifically, Thompson noted that on April 22, 2010, Petitioner scanned 64 items between 11 AM and 12 PM which amounted to six transactions. For the remainder of the workday to 4 PM, Petitioner scanned 25 items which was a total of four transactions. Accordingly, for April 22, 2010, Petitioner had a total of 10 transactions. For April 27, 2010 (a Tuesday), between 8 AM and 10 AM, Petitioner

scanned 591 items which amounted to 20 transactions. This included the night depository items. (Respondent's Exhibit 44).

The Arbitrator also reviewed the log of transactions and noted that, for the period of time Petitioner worked for Respondent, the number of daily transactions varied from 9 to 57.

On cross-examination, Thompson agreed that the amount of time required for one transaction was not stated in the exhibit. She also agreed that a deposit of 100 $1 bills would require counting of the bills, but would only be considered as one transaction.

Respondent tendered into evidence a video dated January 31, 2012 (a Tuesday), which depicted tellers' activities of approximately 54 minutes on that date. This included the processing of night deposits as well as transfers to/from the vault. The Arbitrator watched this video and noted that the tellers worked at a quick pace (Respondent's Exhibit 2).

Respondent also tendered into evidence of video dated February 17, 2012, which was of a teller working her station for approximately 43 minutes. The Arbitrator watched this video and noted that the teller work at a much slower pace than in the video obtained on January 31, 2012 (Respondent's Exhibit 3).

Thompson testified that the teller's activities depicted in the video obtained on February 17, 2012, was an accurate representation of the job activities performed by a teller on a daily basis. Petitioner agreed that the video was an accurate depiction of her job duties; however, she stated that it was not accurate in regard to the pace which she worked.

Petitioner initially sought medical treatment from Dr. Eric Farinas, her family physician, on June 16, 2010. According to Dr. Farinas' record of that date, Petitioner had complaints of left hand pain/swelling that had been present for one and one-half months. His diagnosis was that of left de Quervain's tenosynovitis (Petitioner's Exhibit 1).

Petitioner later sought treatment from Zozzaro Chiropractic on July 22, 2010. Petitioner gave a history of left hand and thumb pain since May and advised that she worked at a bank counting cash (Petitioner's Exhibit 2).

Petitioner subsequently sought treatment at McLean County Orthopedics where she was initially seen by John Nelson, a Physician's Assistant, on September 21, 2010. Petitioner advised that she had swelling of the left hand that had been present since May, 2010. Petitioner informed PA Nelson that she worked as a teller and did a lot of work with her hands including counting money which caused an increase in her pain symptoms. X-rays were ordered which revealed end stage degenerative osteoarthritis of the first CMC joint (Petitioner's Exhibit 3).

Petitioner later sought treatment from Dr. Anthony Dustman, an orthopedic surgeon, on November 8, 2010. At that time, Petitioner had complaints of pain in the CMC joint of the left thumb. Petitioner informed Dr. Dustman that she was a bank teller and used the left hand to hold and squeeze money while she counted. Dr. Dustman opined that Petitioner had arthritis of the CMC joint and opined that an arthroplasty of the left thumb might be required. He did not

comment as to whether Petitioner's job duties caused her problem; however, he noted that Petitioner had a history of hypothyroidism and was 4' 11" tall and weighed 140 pounds (Petitioner's Exhibit 4).

Petitioner was again seen by Dr. Dustman on January 10, 2011, and still had left thumb symptoms. Dr. Dustman's diagnosis remained the same and he restated his surgical recommendation of an arthroplasty (Petitioner's Exhibit 4).

Petitioner continued to work full time for Respondent and did not seek any further medical treatment until she was seen by Dr. Farinas on June 14, 2011. At that time, Petitioner complained of left thumb pain since June, 2010. Dr. Farinas noted that Dr. Dustman had seen Petitioner and recommended joint replacement. He also noted that Petitioner had hypothyroidism and had reduced her cigarette smoking. He authorized Petitioner to be off work and referred her to Dr. David Fletcher for a second opinion (Petitioner's Exhibit 1).

Dr. Fletcher saw Petitioner on July 11, 2011. At that time, Petitioner complained of left and right hand symptoms that began on June 19, 2010, and April, 2011, respectively. He diagnosed Petitioner with left and right CMC arthritis and mild bilateral carpal tunnel syndrome. He opined that the conditions were related to her work activities as a bank teller. He also confirmed that Petitioner had hypothyroidism and recommended that she stopped smoking (Petitioner's Exhibit 5).

Dr. Fletcher referred Petitioner to Dr. Stuart Baker, a plastic surgeon, who also saw Petitioner on July 11, 2011. Dr. Baker opined that Petitioner had osteoarthritis of the left CMC joint. He subsequently saw Petitioner on October 17, 2011, and opined that Petitioner had left and right de Quervain's as well as left and right CMC joint arthritis (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Jay Pomerance, an orthopedic surgeon, on February 23, 2012. In connection with his examination of Petitioner, Dr. Pomerance reviewed medical records provided to him by Respondent. Dr. Pomerance noted Petitioner's medical history of hypothyroidism, smoking, and obesity. Dr. Pomerance opined that Petitioner had bilateral CMC arthritis and suggested an initial attempt at conservative treatment such as medications, splinting and injections. If these did not relieve her symptoms, then there were various surgical procedures that could be attempted (Respondent's Exhibit 8).

In a supplemental report dated February 24, 2012, Dr. Pomerance provided an opinion regarding causality. Dr. Pomerance watched both videos (Respondent's Exhibits 2 and 3) of a teller performing tellers' job duties as well as a written job description of a teller. He opined that Petitioner's exposure as a bank teller did not cause, aggravate or accelerate Petitioner's bilateral CMC osteoarthritis. He based this opinion upon the incidence of CMC osteoarthritis in women and the fact that Petitioner was obese. Further, he did not diagnose either de Quervain's or carpal tunnel syndrome (Respondent's Exhibit 9).

Petitioner was again seen by Dr. Fletcher on January 14, 2013. Her complaints were the same as they were previously. He referred Petitioner to Dr. Edward Trudeau for nerve conduction studies. Dr. Trudeau performed nerve conduction studies on January 31, 2013, which were positive for

moderately severe bilateral carpal tunnel syndrome, greater on the left than the right (Petitioner's Exhibit 8).

At the direction of the Respondent, Petitioner was again examined by Dr. Pomerance on October 24, 2013. In connection with this examination, Dr. Pomerance reviewed medical records provided to him by Respondent. Dr. Pomerance opined that Petitioner had bilateral carpal tunnel syndrome as well as the bilateral CMC joint osteoarthritis. In regard to causality, Dr. Pomerance opined that neither the osteoarthritis nor carpal tunnel syndrome were related to Petitioner's job activities as a teller. In regard to the osteoarthritis, Dr. Pomerance referenced the Petitioner's age, gender and degenerative changes associated with same. In regard to the carpal tunnel syndrome, Dr. Pomerance attributed this to Petitioner's age, gender, obesity, smoking, CMC osteoarthritic condition and hypothyroidism (Respondent's Exhibit 10).

Petitioner was evaluated by Dr. Lawrence Li, an orthopedic surgeon, on October 25, 2013. At that time, Petitioner informed Dr. Li of her hand and thumb symptoms. Petitioner related her hands symptoms to her work as a bank teller which required her to count money all day long. Dr. Li opined that Petitioner had bilateral CMC joint arthropathy and bilateral carpal tunnel syndrome, both of which were caused and aggravated by her duties as a bank teller (Petitioner's Exhibit 7).

Dr. Li performed surgeries which consisted of a left carpal tunnel release, CMC arthropathy and ligament reconstruction on November 5, 2013. He performed the same surgical procedures on the right hand on April 18, 2014. He released Petitioner from care on July 2, 2014, and deferred determination of her work status to Dr. Fletcher (Petitioner's Exhibit 7).

Petitioner saw Dr. Fletcher on July 22, 2014. At that time, Petitioner still had complaints of pain/numbness in both hands, but she thought that it had improved compared to what it had been previously. Dr. Fletcher opined that Petitioner was at MMI and imposed permanent work restrictions of no grasping or lifting of the right hand as well as no constant high force or high frequency tasks, no fine dexterity work and no lifting more than 20 pounds occasionally. There was no specific reference to restrictions in regard to the left hand (Petitioner's Exhibit 5).

Dr. Fletcher ordered a functional capacity evaluation (FCE) which was performed on August 12, 2014. The examiner described Petitioner's efforts during the testing as being "Inconsistent" and further noted that Petitioner demonstrated "self-limiting behaviors." (Petitioner's Exhibit 5).

Dr. Fletcher saw Petitioner for the last time on September 23, 2014. At that time, Petitioner's symptoms remained essentially the same as what they had been previously. Dr. Fletcher restated the restrictions that he previously imposed (Petitioner's Exhibit 5).

Again, at the direction of Respondent, Dr. Pomerance examined Petitioner on August 28, 2014. Dr. Pomerance opined that Petitioner could return to work as a bank teller. He also provided an AMA impairment rating of 18% of the whole person (Respondent's Exhibit 11).

Petitioner tendered into evidence a job search log and testified that she conducted most of her job searches or submitted applications online (Petitioner's Exhibit 9). Petitioner also testified that in

July, 2014, she went to the Respondent to determine if there was a position available for her that conformed to the restrictions imposed by Dr. Fletcher. Respondent did not have such a position to offer to Petitioner. Respondent tendered into evidence a labor market survey which identified various jobs available to the Petitioner (Respondent's Exhibit 43).

At trial, Petitioner testified that she has not worked since June 14, 2011, when she was last seen by Dr. Farinas. Petitioner still has complaints of weakness in both hands and a tendency to drop things. She does not believe that she could return to work as a bank teller.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury arising out of and in the course of her employment for Respondent that manifested itself on June 16, 2010, and that her current condition of ill-being is not related to her work.

In support of this conclusion the Arbitrator notes the following:

Petitioner had only worked for Respondent for a period of approximately six weeks as of the date of alleged manifestation, June 16, 2010.

Petitioner's testimony that she was subject to continuous repetitive use of both of her hands for all of the time she worked for Respondent was not credible.

The Arbitrator finds that, although there were periods of time which required more intensive use of Petitioner's hands than others, i.e. Tuesdays doing the night deposits and transfers to/from the vault, there were greater periods of time in which Petitioner worked at a much slower pace.

Even though Thompson was not working for Respondent at the same time Petitioner did, her testimony about the repetitiveness of Petitioner's work duties was credible and consistent with the videos tendered by Respondent.

Petitioner was female, had pre-existing osteoarthritis, obesity and smoked. Respondent's Section 12 examiner, Dr. Pomerance, attributed Petitioner's thumb conditions to these factors and not her job duties as a bank teller.

While Dr. Fletcher and Dr. Li both opined that Petitioner's thumb conditions were related to her job duties, their opinions were based on the incorrect assumption that Petitioner's job duties as a bank teller subjected her to continuous repetitive use of both of her hands. Further, neither of them opined as to what effect, if any, the other factors may have had in respect to Petitioner's thumb conditions.

Based on the preceding, the Arbitrator finds the opinion of Dr. Pomerance to be more persuasive than those of Dr. Fletcher and Dr. Li.

In regard to disputed issues (E), (J), (K) and (L) the Arbitrator makes no conclusions of law because these issues are rendered moot as a result of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brittany Wood,

Petitioner,

17IWCC0678

vs.

NO: 10 WC 37864

Bed, Bath and Beyond,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, medical, prospective medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: OCT 26 2017
o10/19/17
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner reached maximum medical improvement from her work injury as of January 6, 2014 and would have terminated temporary total disability and denied medical expenses incurred after that date.

Petitioner testified she suffered an injury to her lumbar spine on March 16, 2010, when she lifted a heavy box of candles in glass jars. In a previous Decision, the Arbitrator found her then condition of ill-being was caused by her accident and ordered Respondent to authorize and pay for disc replacement surgery recommended by Dr. Bernstein. After the previous Arbitration decision, Dr. Bernstein performed disc replacement surgery on February 8, 2012.

Petitioner continued to complain of pain and continued to treat with Dr. Bernstein. She had numerous injections. On August 29, 2013, Dr. Bernstein noted he was disappointed with Petitioner's condition because she should be at maximum medical improvement by that time. However, she was still complaining of significant pain. On October 21, 2013, Petitioner had a second set of facet injections. She had more significant improvement than after previous injections. Dr. Bernstein could not discern any abnormalities in her spine. He recommended bilateral rhizotomies at L4-5. When Petitioner returned to Dr. Bernstein on January 16, 2014, Petitioner reported increased pain three weeks after rhizotomy procedure, but then had dramatic improvement. Physical therapy was very helpful. Dr. Bernstein hoped Petitioner could "ride this out" and become stable where no treatment was necessary.

Petitioner continued to treat with Dr. Bernstein. Petitioner testified that on July 19, 2014, she fell off a horse while vacationing in Minnesota. Records from an emergency department in Minnesota noted she suffered a "significant loss of consciousness" and a concussion and was admitted to hospital. On August 21, 2014, Dr. Bernstein noted that Petitioner had a setback when she fell off a horse in Minnesota and suffered a concussion, sprained ankle, and flare-up of low-back pain. Dr. Bernstein prescribed physical therapy for the flare-up and a new MRI. On October 13, 2014, the new MRI was compared to the MRI of November 9, 2012. The new MRI showed new edema in a muscle of the lower lumbosacral spine with no evidence of bone marrow edema, which would suggest fracture. No herniation or stenosis was identified.

In his deposition, Dr. Bernstein agreed that Petitioner reported a flare-up of low back pain after she fell off the horse in Minnesota. Such an injury could aggravate or cause "an injury to the motion segment at L4-5." Dr. Bernstein also testified that Petitioner changed her version of the incident at a later appointment to indicate she was just walking the horse in a ring and not riding aggressively.

Petitioner continued to treat with Dr. Bernstein and continued to complain of subjective low-back pain. Dr. Bernstein ordered a CT. On December 12/3/14, he talked to Petitioner by phone and told her the CT was normal. Dr. Bernstein's only explanation for her pain was motion segment at L4-5. She could either live with the condition and be at maximum medical improvement or have spinal fusion. Petitioner last saw Dr. Bernstein in December 14, 2015. Petitioner again reported persistent low back pain. Dr. Bernstein found "nothing fairly responsible for her pain." Dr. Bernstein again noted the only options of living with the condition or fusion.

The Commission is bound by the first Arbitrator's decision in which he found Petitioner's initial condition of ill-being was caused by her work-related accident. Nevertheless, throughout her treatment all the doctors who reviewed her imaging could not find objective findings to corroborate her subjective complaints. Even Dr. Bernstein could not find anything wrong with her spine and speculated that her pain was caused by possible overload of the facet joints due to a tilting of the prosthetic disc. However, he seemed perplexed by her condition and concluded the only treatment he could offer for her subjective complaints was fusion. The Arbitrator and Commission have awarded the prospective fusion surgery he recommended.

In my opinion, Petitioner achieved maximum medical improvement for her work accident on January 6, 2014. At that time, Petitioner reported dramatic improvement after the radiofrequency ablations. It is also important to remember that several months earlier, Dr. Bernstein expressed his disappointment with Petitioner's condition because she should have been at maximum medical improvement by that time. In addition, Petitioner suffered a major traumatic injury on July 19, 2013 when she fell off the horse and Dr. Bernstein testified such an injury could aggravate or cause "an injury to the motion segment at L4-5." The MRI taken after that incident showed new edema. Therefore, the accident of falling off the horse could have constituted an intervening event breaking causation.

17IWCC0678

Based on the reasoning stated above, I would have found that Petitioner did not sustain her burden of proving the current and continuing condition of ill-being of her lumbar spine was still caused by her accident on March 16, 2010 and that Petitioner reached maximum medical improvement from her work injury as of January 6, 2014. Therefore, I would have terminated temporary total disability and denied medical expenses incurred after that date. For these reasons, I respectfully dissent.

DLS/dw
O-10/19/17
46

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

17IWCC0678

WOOD, BRITTANY
Employee/Petitioner

Case# **10WC037864**

BED BATH & BEYOND
Employer/Respondent

On 3/16/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0247 HANNIGAN & BOTHA LTD
KEVIN S BOTHA
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW A WRIGLEY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

17IWCC0678

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Brittany Wood
Employee/Petitioner

v.

Bed, Bath & Beyond
Employer/Respondent

Case # 10 WC 37864

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 **Woodstock**, on **February 1, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **March 16, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$13,991.64**; the average weekly wage was **$269.07**.

On the date of accident, Petitioner was **24** years of age, ***single*** with **1** dependent child.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$35,207.69** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$35,207.69**.

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 $245.33/week for 359 weeks, commencing March 17, 2010 through February 1, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$35,207.69** for TTD paid.

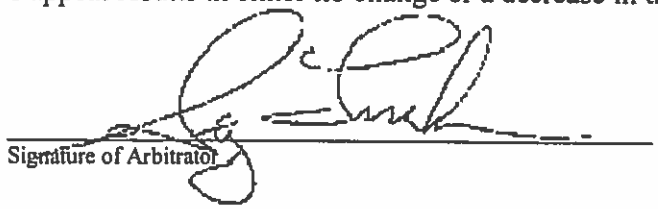
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$5,215.00** to **Accelerated Physical Therapy**, **$26,941.00** to **Aquatic Therapy and Wellness**, **$282.00** to **Associated Imaging Specialists**, **$1,286.82** to **Dr. Avi Bernstein**, **$11,127.40** to **Illinois Physicians Network**, **$2,764.28** to **Injured Worker's Pharmacy**, **$1,773.95** to **Presence St. Joseph Hospital**, and **$3,377.53** to **Summit Pharmacy**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid.

Respondents shall authorize and pay for additional reasonable and necessary treatment for Petitioner consistent with the recommendations of Dr. Bernstein including an L4-5 spinal fusion, ongoing medication, and other reasonable and necessary care.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.



Signature of Arbitrator

March 13, 2017
Date

ICArbDec19(b)

MAR 16 2017

Statement of Facts

This matter was previously heard on a 19(b)/8(a) hearing on July 7, 2011 before Arbitrator Lee. Petitioner testified that while working as a stocker for Respondent, she injured her lower back while lifting a box of candles. She was initially treated by Dr. Gregory Brebach at Lake Cook Orthopedics who ultimately recommended an anterior lumbar interbody fusion at L4-5 based upon a positive discogram and post-discogram CT in August 2010. Petitioner then sought a second opinion from Dr. Avi Bernstein on October 11, 2010. Dr. Bernstein felt that she was a candidate for disc replacement surgery. Petitioner opted for the disc replacement surgery instead of anterior lumbar fusion surgery. Respondent denied the disc replacement surgery based upon the opinions of its Section 12 examining physician, Dr. David Zoellick.

Arbitrator Lee issued his decision on September 12, 2011 (PX 9). In that decision Arbitrator Lee found Petitioner's condition of ill being causally connected to the accident and awarded temporary compensation through the July 7, 2011 trial date and prospective medical as recommended by Dr. Bernstein including an L4-5 disc replacement surgery. No review of that Arbitration Decision was taken. The Arbitrator has reviewed the prior decision as well as the transcript of evidence and exhibits of the prior hearing. The findings of law and fact rendered at that time became the law of the case for this matter. Under the law-of-the-case doctrine, the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. *Miller v. Lockport Realty Group, Inc.*, 377 Ill. App. 3d 369, 878 N.E.2d 171, 315 Ill. Dec. 945 (2007).

Petitioner returned to Dr. Bernstein on January 12, 2012 for her preoperative visit. Her exam was unchanged. Dr. Bernstein recommended an updated MRI (PX 1, p 34). The MRI performed on January 20, 2012 was interpreted by Dr. Catherine Kim-Gavino to reveal a very small right foraminal disc protrusion at L4-5 unchanged from April 12, 2010. This does not result in significant foraminal stenosis. There is no disc herniation, central canal, or foraminal stenosis throughout the remainder of the lumbar spine (PX 1, p 49). On February 8, 2012 Petitioner underwent an L4-5 decompressive lumbar discectomy and L4-5 total disk arthroplasty using Prodisc prosthesis performed by Dr. Bernstein. The post operative diagnosis was L4-5 discogenic low back pain and right L4-5 herniated disc and annular tear (PX 1, p 38-39).

Post operative care noted initial improvement. Dr. Bernstein noted no neurological symptoms on February 23, 2012. Petitioner was taken out of her brace and advised to start physical therapy on March 19, 2012 (PX 1, p 32-33). Petitioner began therapy at Accelerated Rehab on March 29, 2012 (PX 3). Petitioner began experiencing sciatica in her left leg. On May 9, 2012, Petitioner's therapy was placed on hold (PX 1, p 31; PX 3, p 14).

Petitioner was placed under surveillance from May 18, 2012 through May 25, 2012. Petitioner was observed looking out of her patio door and walking to her car. 18 seconds of video of her approaching her car was obtained (RX 8).

Petitioner was examined on May 25, 2012 by Dr. Andrew Zelby at Respondent's Request (RX 7). Dr. Zelby challenged the appropriateness of the testing and treatment to date, including the surgery performed. Dr. Zelby opined Petitioner's ongoing subjective complaints cannot be explained in the context of her objective medical findings. Petitioner exhibited 3/5 positive Waddell signs, consistent with significant symptom magnification. He further opined that Petitioner did not have any objective medical condition which justified treatment with narcotic medications. Petitioner should be weaned off her narcotic medications over the next 3-

4 weeks. Dr. Zelby opined Petitioner's treatment has been prolonged and protracted without any medical basis. He noted that if Ms. Wood's regular job duties in fact fall in a medium physical demand level as she indicated, then she may return to full duty within the next six weeks after completion of a work conditioning program (RX 7).

Petitioner called Dr. Bernstein on May 23, 2012 to report that she hit her back on a doorknob and reported swelling (PX 1, p 17). Petitioner testified that the pain was gone by the next day. Therapy resumed May 31, 2012. Petitioner reported that she had several adjustments to her medication that were not well tolerated. She continued to complain of 9/10 pain in the left leg, but no longer constant. She reported striking her back on a door handle. She reports that her surgeon does not think this caused any damage to the operative site (PX 1, p 17; PX 3, p 15). Petitioner had limited improvement in strength and flexibility but continued to advance complaints of pain (PX 3, p 39-41). On August 9, 2012, Dr. Bernstein stated he is concerned about her worsening complaints. He noted that X-rays show a left sided asymmetric collapse and that this may be resulting in facet impingement. He recommended a trial of facet injections and ordered a new MRI (PX 1, p 30). On November 8, 2012, Petitioner underwent a left L4-5 facet injection under fluoroscopic guidance by Dr. Jay Kiokemeister at Health Benefits Pain Management Services (PX 4). The MRI was taken November 19, 2012 (PX 1, p 48). Dr. Bernstein found the MRI was completely normal. He ordered hydrotherapy on November 26, 2012 (PX 1, p 29).

On December 21, 2012, Petitioner saw Dr. Zelby for a follow up IME (RX 7). Dr. Zelby opined Petitioner continued to have subjective complaints that have no anatomic structural basis. This suggests her symptoms are not related to any condition in her spine. Dr. Zelby opined Petitioner's subjective complaints were in no way related to a type of facet syndrome. He found, based upon Petitioner's objective medical condition, that there was no medical indication to pursue further diagnostics or treatment. Dr. Zelby opined Petitioner was at maximum medical improvement from her disc arthroplasty and required no additional diagnostic studies or any further treatment. Dr. Zelby opined that Petitioner was qualified to safely return to all of the same vocational and avocational activities that she pursued prior to March, 2010 without restrictions (RX 7). Temporary total disability benefits were discontinued by Respondent as of December 27, 2012 (RX 1).

Petitioner began hydrotherapy at Aquatic Therapy and Wellness on January 18, 2013. Petitioner was noted on initial evaluation to be extremely sensitive to touch, painful to light palpation. Petitioner complained of trouble with simple activates (PX 5). The records through March 13, 2013 document steady progress. On March 13, 2013, she reported a sudden motion on March 12th caused a sudden severe increase in pain (PX 5). On March 14, 2013, Dr. Bernstein stated that Petitioner looked terrible. She was using a cane and had difficulty changing position due to difficulty ambulating. She was a year out from surgery and he considered this an unreasonable result. Dr. Bernstein ordered a CT scan of the lumbar spine and advised Petitioner to remain off work (PX 1, p 28). Petitioner continued in hydrotherapy, reported some improvement in her symptoms, but periodic increases due to various activities. She was noted to have spasm and pain with limping and difficulty with stairs and household chores (PX 5). On May 9, 2013, Dr. Bernstein records continued pain in the back radiating to the buttock and thigh. Petitioner is neurologically intact. He notes the CT report of the lumbar spine finds post operative changes. The thoracic MRI is normal. He concludes that anatomically things look normal. He recommends a trial of L4-5 facet injections (PX 1, p 27).

Petitioner saw Dr. Zelby for another examination on June 5, 2013 (RX 7). Petitioner reported taking Flexeril and Norco daily. Dr. Zelby viewed a thoracic spine MRI and found it revealed minimal degenerative changes.

Dr. Zelby opined that Petitioner had persistent subjective complaints in the context of a well-placed disc arthroplasty, an otherwise normal spine structurally and a normal neurologic exam. He noted pursuit of further treatment to her spine would be unsuccessful as Petitioner reported it had been for the last three years. Her subjective symptoms had nothing to do with her spine. Dr. Zelby opined Petitioner had not required extensive physical therapy and did not require aquatic therapy as there was no medical basis to suggest any additional treatment. Petitioner was at MMI and was able to return to unrestricted vocational and avocational activities (RX 7).

Petitioner continued with hydrotherapy with some improvement, but periodic exacerbations from various activities such as vomiting during the flu or being jostled in a store (PX 5). She was seen by Dr. Alzoobi on July 1, 2013 for evaluation for the L4-5 injection recommended by Dr. Bernstein. Dr. Alzoobi recommended left sided facet joint blocks at L3-4, L4-5 and L5-S1. The injections were performed on July 8, 2013 (PX 4). Petitioner saw Dr. Bernstein on August 29, 2013, and reported having undergone a facet injection with about one week's worth of relief. She also went back to wearing her lumbar brace and was still taking Norco and Flexeril. Dr. Bernstein recommended additional facet injections and if she demonstrated temporary relief again, she should consider a facet rhizotomy. The second option would be converting her to a spinal fusion, and the third option would be for her to accept her condition and live with it (PX 1, p 26). Petitioner underwent bilateral L4-5 facet injections on October 7, 2013 (PX 4). She noted more significant improvement to Dr. Bernstein (PX 1, p 25), who recommended she proceed with bilateral L4-5 facet rhizotomies (PX 1, p 25). Dr. Alzoobi performed L4-5 medial branch blocks on November 11, 2013 (PX 4).

Petitioner continued in hydrotherapy. She noted improvement with the injections. She had some increased symptoms following slipping in the shower on November 27, 2013 and standing up for a wedding. On December 27, 2013, the assessment notes that Petitioner is now able to perform HEP and is gradually gaining strength and endurance (PX 5). Petitioner saw Dr. Bernstein on January 6, 2014, and she reported increased pain for 3 weeks after the procedure, but now is dramatically improved. She found therapy to be very helpful. Dr. Bernstein was hopeful that they would be able to get her to a stable point where no further care would be necessary. She was to follow up in 8-12 weeks after she had completed conditioning and strengthening (PX 1, p 24).

Petitioner continued with hydrotherapy with reports of good days and bad days. She did report a fall on a ceramic floor on March 12, 2014 with increased pain most significantly in the thoracic spine and traps (PX 5). On March 27, 2014, Dr. Bernstein notes that Petitioner had been doing well but has had a progressive recurrence of low back pain. He states that this was not uncommon after successful rhizotomy and recommended one further rhizotomy procedure. Dr. Bernstein states that if she only has temporary relief, he would have to consider a surgical alternative (PX 1, p 23). On May 8, 2014, Dr. Alzoobi performed a median branch radiofrequency at L3-4, L4-5 and L5-S1 bilaterally (PX 4). Petitioner continued hydrotherapy with ongoing complaints in the back and legs. She also reported ongoing headaches and nausea. On June 25, 2014, she reported increased low back and left leg symptoms following having her foot slip as she opened her car door (PX 5).

Petitioner testified that she took a trip to Minnesota in July, 2014 to visit her grandfather. She fell off a horse. She testified that she did not injure her back. On July 19, 2014, Petitioner was admitted to North Memorial Medical Center in Minnesota (PX 6). She reported a traumatic fall after being bucked off of a horse. She was over a concrete surface at the time of the incident. She did lose consciousness. Petitioner reported pain in her head, right shoulder, hip, and knee as well as chronic back pain and chronic left leg nerve pain. She reported

that she used no assistive devices and was independent with activities of daily living. Petitioner underwent negative CT of the head and cervical spine. X-rays of the right knee, shoulder, foot and pelvis were negative for fractures. Petitioner was discharged from the hospital on 7-21-14 (PX 6).

On August 21, 2014 Petitioner saw Dr. Bernstein. She reported a setback recently when she fell off a horse. She was in Minnesota. She suffered a concussion, she sprained her ankle, and she has had a flare up of her low back complaint. She has been on strong medications and her back more recently has become more problematic. Dr. Bernstein recommended physical therapy for this recent flare-up and an updated MRI scan. He noted Petitioner has to decide if she can live with her condition or requires more aggressive treatment (PX 1, p 22). A lumbar MRI done at Premier Open MRI on October 13, 2014, was compared to the November 9, 2012 MRI and showed new edema within the right multifidus muscle of the lower lumbosacral spine with no evidence for bone marrow edema to suggest fracture. This indicated a paraspinal muscular strain. There was no obvious disc herniation, central canal or foraminal stenosis (PX 1, p.43).

On October 27, 2014, Dr. Bernstein reported Petitioner wanted to clarify that the horse event that happened recently was with her seated on a horse in a ring. She was not out doing aggressive horseback riding, but basically only walking a horse. He notes the benign MRI study. He opined that Petitioner has chronic persistent low back pain related to the L4-5 level. Dr. Bernstein recommended a follow up CT scan to confirm that there are no facet abnormalities outside of the L4-5 level. He notes that Petitioner's options are either living with her condition or considering spinal fusion (PX 1, p 21). Petitioner underwent a CT lumbar spine without contract on November 3, 2014, interpreted to reveal mild bulging of the L3-4 disc which is slightly progressive when compared to the previous examination in May, 2013. No other changes are noted (PX 1, p 41). Petitioner continued with hydrotherapy through December 2, 2014 (PX 5). Dr. Bernstein spoke with Petitioner on December 3, 2014. He advised Petitioner her CT scan is completely normal and the facet joints appear healthy at the level of disc replacement with perhaps some minor wear. He opined that he can only attribute Petitioner's pain potentially to the motion segment at L4-5. Dr. Bernstein stated Petitioner's options are to live with her condition or undergo a spinal fusion (PX 1, p 2).

Petitioner saw Dr. Zelby for another IME on April 29, 2015. Petitioner reported taking Norco and Flexeril daily and that her doctor had now recommended an L4-5 fusion. Dr. Zelby opined that Petitioner has ongoing complaints of low back pain without any findings on any of her radiographic studies to explain her symptoms. Her modest degenerative changes were not the cause for her subjective complaints. Her ongoing subjective complaints remain equally inexplicable. He further opined there was no objective medical evidence to suggest that her subjective back complaints were related to a structural problem related to her spine. Dr. Zelby opined his opinions were unchanged from his prior reports. Petitioner reached MMI long ago. She is in need of no further treatment and has no identifiable condition treated with narcotic medication. She could return to unrestricted duty (RX 7).

Dr. Khalid M. Yousuf prepared a Utilization Review report dated October 22, 2015 (RX 9). Dr. Yousuf noted that Petitioner had undergone 167 sessions of hydrotherapy. Relying upon the Official Disability Guidelines (ODG), Dr. Yousuf opined the number of these sessions were not reasonable, necessary, or medically appropriate. Dr. Yousuf found 26 sessions to be appropriate under the ODG.

Petitioner saw Dr. Bernstein on December 14, 2015 noting persistent severe low back pain. Physical exam notes tenderness to palpation at the L4-5 level. Neurological examination is normal. Straight leg raising causes left sided low back pain. Dr. Bernstein finds mechanical symptoms in the lumbar spine. He again notes

the option of a spinal fusion. He did not find Petitioner abusing her pain medication. He did not identify any Waddell signs. He stated that the rhizotomies were necessary and helpful in supporting her current diagnosis. He did not find her at maximum medical improvement because she is considering surgical intervention (PX 2).

Dr. Bernstein testified by evidence deposition taken December 6, 2016 (PX 7). He testified to his initial treatment beginning October, 11, 2010 through the disc replacement surgery performed February 8, 2012. He testified to his follow up treatment and his concern about left sided asymmetrical tilting to her disc replacement. This could cause foraminal narrowing, asymmetric compression of the annulus, or facet related pain, left sided sciatic symptoms. He testified that he recommended facet injections and hydrotherapy. Petitioner was having increasing pain and symptoms with traditional therapy, so hydrotherapy eliminates gravity to reduce stress while the patient is recovering from fusion or replacement. He testified to his further recommendation for a CT scan, MRI studies and rhizotomy. He testified that the radiographic studies were normal. He testified that Petitioner's pain could be related to motion at L4-5 and recommended a fusion at L4-5. He opined that this would be related to the injury on March 16, 2010. Petitioner is still taking Norco and Flexeril (PX 7).

On cross examination, Dr. Bernstein testified to Petitioner reporting that she hit her back on a doorknob at home. Petitioner reported swelling. This mechanism could cause a soft tissue injury. It is unlikely to have caused an aggravation or an injury to the motion segment at L4-5, but it is possible. The finding of foraminal narrowing and facet joint loading would be post operative consequences. Dr. Bernstein does not think the striking on the doorknob would have caused this collapse or tilting. Dr. Bernstein testified to his August 21, 2014 office note reporting Petitioner fell off a horse with a flair up of her low back complaints. Those complaints were attributable to her falling off a horse. They could cause an aggravation or injury to the motion segment at L4-5. The minor wear at the L4-5 facet noted on the November 3, 2014 CT scan could be considered a degenerative finding. On December 14, 2015, the examination found no evidence of a nerve injury (PX 7).

Petitioner testified that she had constant low back pain radiating down her left leg and described the radiating pattern going down the outside of her left thigh into her left foot. She testified that she takes narcotic pain medication prescribed by Dr. Bernstein. She gets some relief. She got more relief from therapy. Petitioner testified she has not sought employment since her accident. Petitioner testified that she wanted to proceed with the fusion procedure as she felt that this would give her the best opportunity at a normal life.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner bears the burden of showing by a preponderance of credible evidence that her current condition of ill-being is causally related to the workplace injury. The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. Based upon the prior Arbitration Decision rendered, as of the date of that earlier hearing on July 7, 2011, Petitioner's condition of ill being in the low back was causally connected to the March 16, 2010 accident and Petitioner was temporarily totally disabled and in need of further medical care including the disc replacement surgery. Respondent has now disputed ongoing causal connection based upon Dr. Zelby's opinions that Petitioner has no objective evidence of ongoing disability and that her subjective symptoms have nothing to do with her spine. He opined that

Petitioner is at maximum medical improvement, and capable of unrestricted work. Respondent further has challenged ongoing causation based upon the May, 2012 incident when Petitioner hit her back on a doorknob and the July, 2014 injury when Petitioner fell off a horse. As discussed herein, the Arbitrator rejects these arguments and finds that Petitioner's current condition of ill being remains causally connected to the injury on March 16, 2010.

Petitioner testified to her medical treatment, ongoing complaints and desire to pursue the fusion surgery recommended by Dr. Bernstein. Dr. Bernstein testified to his treatment of Petitioner from October, 2010 through December 14, 2015, his findings, interpretation of the multiple diagnostics and treatment modalities and his recommendations. He opined that the Petitioner's pain could be related to motion at L4-5 and recommended a fusion at L4-5. He opined that this would be related to the injury on March 16, 2010.

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. 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.

Based upon review of the Petitioner's unrebutted testimony and the totality of the medical evidence, the Arbitrator finds the opinions of Dr. Bernstein more persuasive that those of Dr. Zelby. The Arbitrator notes that Dr. Zelby initially disputes the reasonableness of the treatment already found appropriate by Arbitrator Lee's initial 19(b) Decision. He rejects that Petitioner's symptoms are related to any facet syndrome, but provides no explanation or recommendation for her complaints from an orthopedic basis. His opinions are in large part based upon his opinion that there is no legitimate medical reason for Petitioner's subjective complaints, an opinion which is contrary to Dr. Bernstein and the Petitioner's presentation during her treatment and at trial.

Petitioner's complaints are consistent throughout her treatment. She notes some progress with care, but repeatedly reports exacerbations with increased physical activity or minor mishaps. Respondent's surveillance in May, 2012 is brief and unenlightening. No evidence was presented of any behavior or activity by Petitioner markedly inconsistent with her medical presentation and subjective complaints. Dr. Bernstein has treated Petitioner for over 5 years and has had the better opportunity to observe her behavior and manage her care. He specifically notes the absence of Waddell signs in his December 14, 2015 record. The Arbitrator has reviewed his testimony and the explanation for his current surgical recommendation and finds them persuasive and consistent with the evidence presented.

The Arbitrator also finds that the evidence presented does not establish an intervening injury to break the chain of causation. 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 between the work-related injury and an ensuing disability or injury. *National Freight Industries v. Illinois Workers' Compensation Comm'n*, 2013 IL App (5th) 120043WC, 993 N.E.2d 473. 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. 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. A work-related injury need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. As long as there is a "but-for" relationship between the work-related injury and subsequent condition of ill-being, the employer remains liable. *Dunteman v. Illinois Workers' Compensation Comm'n,* 2016 IL App (4th) 150543WC, 52 N.E.3d 718 (4th Dist. 2016).

The Arbitrator notes Dr. Bernstein's persuasive opinion that Petitioner's current condition is causally related to the March 16, 2010 accident. Dr. Zelby's opinions do not address causation to either alleged subsequent incident, but simply state that there is no causal relationship to any spinal condition. There is no evidence of other that a brief increase in pain following the May, 2012 doorknob incident. Dr. Bernstein opined that it was unlikely to have caused an aggravation. The Arbitrator has reviewed the medical records following the July, 2014 injury when Petitioner fell off a horse. The records contain no documentation of a specific back injury or any treatment for the lumbar spine. The follow up with Dr. Bernstein notes a flair up of symptoms, but the medical records are replete with such incidents from multiple activities and exertions. Dr. Bernstein did not identify any acute change in Petitioner's condition following this incident and his recommendations for care are consistent with the condition identified prior to the incident. The diagnostic testing performed after this incident does not identify any acute findings which would be related to the fall. Dr. Bernstein's recommendation for fusion surgery was advanced before the fall and there is no change in his diagnosis or his treatment recommendation following this fall. The Arbitrator does not find that either alleged incident rises to an intervening accident resulting in a permanent change in Petitioner's condition or break in causation.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that her current condition of ill being in the lumbar spine is causally connected to the work related accidental injuries sustained on March 16, 2010.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are necessary to diagnose, relieve, or cure the effects of her injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470, 949 N.E.2d 1158, 1165, 351 Ill. Dec. 63 (2011). Based upon the Arbitrator's finds with respect to causal connection, reasonable and necessary treatment for Petitioner's condition of ill being in the lumbar spine is compensable.

Petitioner submitted alleged unpaid medical bills as Petitioner's Exhibit 8 including:

1. Accelerated Physical Therapy	$5,215.00
2. Aquatic Therapy and Wellness	$26,941.00
3. Associated Imaging Specialists	$282.00
4. Dr. Avi Bernstein	$1,286.82
5. Illinois Physicians Network	$11,127.40
6. Injured Worker's Pharmacy	$2,764.28
7. Presence St. Joseph Hospital	$1,773.95
8. Summit Pharmacy	$3,377.53
	$52,767.98

The Arbitrator has reviewed the medical exhibits submitted and finds that these bills are substantiated as relating to treatment Petitioner received for the condition of ill being in her lumbar spine. Respondent submitted payment logs as Respondent's Exhibits 2-6. With the exception of Aquatic Therapy and Wellness, Respondent's only evidence disputing the reasonableness and necessity of said treatment was the opinions of Dr. Zelby that Petitioner needed no further treatment of any kind. The Arbitrator finds the opinion of Dr. Bernstein more persuasive with respect to the reasonableness and necessity of the care provided.

With respect to the hydrotherapy at Aquatic Therapy and Wellness, Dr. Zelby stated in his June 5, 2013 report that aquatic therapy was not necessary. Respondent also submitted the Utilization Review prepared by Dr. Yousuf on October 22, 2015 (RX 9) noting that that Petitioner had undergone 167 sessions of hydrotherapy. Relying upon the Official Disability Guidelines (ODG), Dr. Yousuf opined the number of these sessions were not reasonable, necessary, or medically appropriate. Dr. Yousuf found 26 sessions to be appropriate under the ODG. The Arbitrator has reviewed the report of Dr. Yousuf and the cited guidelines. The Arbitrator notes the guideline discusses appropriate therapy following surgery, but neither the guideline nor the analysis by Dr. Yousuf addresses the extended period of years of postoperative care that Petitioner has received or the multiple procedures including the initial disc replacement and two subsequent rhizotomies. Nor does the guideline address the extended care during consideration for the additional fusion for mechanical pain recommended by Dr. Bernstein. The Arbitrator takes into consideration the poor recovery by Petitioner as well as Petitioner's testimony supported by the medical records of Dr. Bernstein and the therapist at Aquatic Therapy and Wellness which note Petitioner's improvement in her pain and other symptoms as a result of the continued therapy. Based on the totality of this evidence, the Arbitrator finds that the prescription of this extended therapy by Dr. Bernstein is reasonable and necessary, given the specific facts of this matter which do not appear to have been taken fully into account by the ODG cited.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $5,215.00 to Accelerated Physical Therapy, $26,941.00 to Aquatic Therapy and Wellness, $282.00 to Associated Imaging Specialists, $1,286.82 to Dr. Avi Bernstein, $11,127.40 to Illinois Physicians Network, $2,764.28 to Injured Worker's Pharmacy, $1,773.95 to Presence St. Joseph Hospital, and $3,377.53 to Summit Pharmacy, as provided in Sections 8(a) and 8.2 of the Act. Respondent Exhibits 2-6 indicate that some of these charges may have been processed. Therefore, Respondent shall be given a credit for any medical benefits that have been paid.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection and the Arbitrator's finding that the opinions of Dr. Bernstein are more persuasive that those of Dr. Zelby, the Arbitrator finds that Petitioner is in need of further prospective medical care as recommended by Dr. Bernstein consisting of a spinal fusion at L4-L5, ongoing medication, and other reasonable and necessary treatment.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Causal Connection and Prospective Medical, the Arbitrator has found that Petitioner's current condition of ill being in the lumbar spine is causally

connected to the work accident on March 16, 2010 and that she is in need of further medical treatment. Dr. Bernstein's persuasive opinion is that Petitioner is not at maximum medical improvement.

When a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App.3d 527, 542, 310 Ill. Dec. 18, 865 N.E.2d 342 (2007). The employer's obligation to pay TTD benefits continues until the employee's medical condition has stabilized and she has reached maximum medical improvement. *Interstate Scaffolding v. Illinois Workers Compensation Comm'n*, 236 Ill.2d 132, 923 N.E.2d 266, 337 Ill. Dec. 707 (2010). Petitioner has not been released to work by her treating physicians since her February, 2012 surgery and continues under medical care. She is entitled to ongoing temporary total compensation.

The earlier 19(b) decision awarded 68 2/7 weeks of TTD from March 17, 2010 through the date of hearing on July 7, 2011. The parties stipulated that Petitioner was temporarily disabled December 26, 2012, a total period of 145 weeks. The stipulation of the parties and RX 1 confirms payment of $35,207.69. This results in an underpayment for this period of $355.72. The Arbitrator also finds Petitioner is entitled to further temporary total disability from December 27, 2012 through the date of hearing on February 1, 2017 a further period of 214 weeks.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that she is entitled to temporary total disability from March 17, 2010 through February 1, 2017, being the date of hearing, a total of 359 weeks. Respondent is entitled to credit for $35,207.69 for TTD paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Briana Conway,
Petitioner,

17IWCC0679

vs.

NO: 12 WC 10568

Bloomington Public School Dist. #87,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability, medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 16m 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 26 2017
o10/12/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0679

CONWAY, BRIANA
Employee/Petitioner

Case# **12WC010568**

BLOOMINGTON PUBLIC SCHOOL DIST #87
Employer/Respondent

On 8/16/2016, 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 0.44% 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:

2460 KOTH & GREGORY PC
WILLIAM L GREGORY
420 N MAIN ST
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
VINCENT M BOYLE
PO BOX 6199
PEORIA, IL 61602

17IWCC0679

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Briana Conway
Employee/Petitioner

v.

Bloomington Public School Dist. 87
Employer/Respondent

Case # 12 WC 10568

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on June 29, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On November 23, 2011, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose out of and in the course of employment.

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 $12,526.08; the average weekly wage was $240.89.

On the date of accident, Petitioner was 21 years of age, single 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 $2,200.01 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $2,200.01.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of $220.00 per week for a period of 25 weeks because the injuries sustained caused the five percent (5%) loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Based upon the Arbitrator's Conclusions of Law attached hereto, no further medical or compensation benefits are awarded to Petitioner.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator

August 7, 2016
Date

AUG 16 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on November 23, 2011. According to the Application, Petitioner was injured while "Restraining student" and the injury was to the "Back and torn ligaments" (Respondent's Exhibit 1). There was no dispute that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship. Respondent disputed liability for various medical bills as well as the duration of and Petitioner's entitlement to temporary total and temporary partial disability benefits (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in August, 2011, as a Paraprofessional Teaching Assistant for elementary grade school students with special needs. Petitioner's job required her to monitor students, push wheelchairs and, on a regular basis, physically restrain students.

Petitioner testified that on November 23, 2011, she had to deal with an uncooperative student on the playground. The student did not want to come inside and Petitioner had to climb up a slide to get her. At that time, the student had what Petitioner described as a tantrum/meltdown. To prevent the student from running away, Petitioner restrained her by holding her from behind by locking her arms around the student. At that time, the student started rocking forward and backward which caused the Petitioner to be bent forward and backward. Petitioner described the student as being female and weighing 130 to 140 pounds and the student was taller than Petitioner. Petitioner is 5'5" tall and, at the time of the accident, weighed 100 pounds. When the case was tried, Petitioner testified that she weighed 112 pounds.

Petitioner testified that she felt an immediate onset of back pain at the time of the accident. However, Petitioner did not seek medical treatment because the accident occurred shortly before the Thanksgiving weekend.

Petitioner initially sought medical treatment at OSF Medical Group on November 30, 2011, and was seen by Dr. Regina Powers. Petitioner complained of mid-back pain but without radiation into either the arms or legs. Dr. Powers ordered x-rays of the thoracic spine and prescribed some medications. The x-rays were normal (Petitioner's Exhibit 15).

Petitioner was subsequently seen by Dr. Jyotir Jani, another physician at OSF Medical Group, on December 7, 2011. Dr. Jani examined Petitioner and noted that there was tenderness of the medial and inferior muscles of the bilateral scapula. He ordered physical therapy (Petitioner's Exhibit 15).

Petitioner was seen by Dr. Jani on December 16, 2011, and advised that she had been to two physical therapy sessions, but that her symptoms had not improved. Dr. Jani authorized Petitioner to be off work. When he saw Petitioner on January 4, 2012, he ordered an MRI of the thoracic spine (Petitioner's Exhibit 15).

The MRI was performed on January 12, 2012. According the radiologist, the MRI did not reveal any disc herniation or neural impingement and was "Essentially unremarkable" (Petitioner's Exhibit 15).

Petitioner was seen by Dr. Jeffrey Wingate, an orthopedic surgeon, on January 31, 2012. Petitioner continued to complain of thoracic back pain. On examination, Dr. Wingate noted tenderness between T8 and T9 and opined that Petitioner had probably sustained an injury to the interspinous ligaments at that level. He prescribed a back brace and medications (Petitioner's Exhibit 6). Petitioner was seen by Dr. Jani on February 3, 2012. At that time, Petitioner stated that she was unable to tolerate working because of the pain. He authorized Petitioner to be off work for one month (Petitioner's Exhibit 15).

Petitioner saw Dr. Wingate on February 24, 2012. He noted that Petitioner's back brace was well fitted; however, Petitioner still had upper/mid thoracic back pain. He opined that Petitioner had clinical signs of a tear of the interspinous and supraspinous ligaments in thoracic spine. He ordered a high-resolution MRI scan (Petitioner's Exhibit 6).

Petitioner was seen by Dr. Jani on March 2, 2012. He authorized her to remain off work for another two months. (Petitioner's Exhibit 15).

On March 2, 2012, the MRI scan ordered by Dr. Wingate was performed; however, the radiologist's report regarding it was not tendered into evidence at trial. Dr. Wingate reviewed the MRI on March 7, 2012, and opined that it had a high intensity signal change within the supraspinous and interspinous tendons bilaterally. He gave a diagnostic injection in the back of Petitioner's and stated that Petitioner could continue with normal activities that day (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Michael Stover, an orthopedic surgeon, on March 21, 2012. In connection with his examination of Petitioner, Dr. Stover reviewed medical records provided to him by Respondent. At that time, Petitioner complained of pain with flexion, extension and rotation of the spine. On examination, Petitioner had tenderness at T6 to T9. Dr. Stover opined that Petitioner sustained a thoracic sprain/strain and that the ligaments of the thoracic spine should heal without difficulty. He reviewed the MRI of March 2, 2012, and opined that it did not reveal any abnormalities of ligamentous complex or posterior spinal structures of the thoracic spine. He recommended Petitioner have physical therapy for six to eight weeks and that she could return to work to light duty and then subsequently progress to full duty over the next six to eight weeks at which time Petitioner would then be at MMI (Respondent's Exhibit 12; Deposition Exhibit 2).

Petitioner was subsequently seen by Dr. Wingate on March 27, 2012. At that time, Dr. Wingate recommended Petitioner have an epidural steroid injection to the thoracic spine. Petitioner had an epidural steroid injection on April 12, 2012, at T9-T10. She saw Dr. Wingate on April 20, 2012, and advised that the epidural steroid injection did not help her. Dr. Wingate then referred Petitioner to Millenium Pain Center for further treatment (Petitioner's Exhibit 6). Petitioner was evaluated by Dr. Ricard Vallejo at Millennium Pain Center on May 21, 2012. From May through August, 2012, Dr. Vallejo who treated Petitioner and performed several facet injections and

nerve blocks. These only gave Petitioner some temporary relief from her symptoms. (Petitioner's Exhibit 8).

Petitioner saw Dr. Wingate on June 27, 2012. At that time, Dr. Wingate indicated that Petitioner might need an instrumental posteriolateral thoracic fusion. He also suggested the possibility of a spinal cord stimulator. (Petitioner's Exhibit 6).

Petitioner south chiropractic treatment from Dr. Jeffrey Stout who initially saw her on August 22, 2012. Dr. Stout initially diagnosed Petitioner with thoracic radiculitis, costochondritis and thoracic myofacitis and myalgia. He prescribed chiropractic treatment to Petitioner through December, 2012 (Petitioner's Exhibit 5).

Petitioner was seen by Dr. Wingate on September 19, 2012. Petitioner advised that nothing had helped her and she continued to have severe thoracic back pain. Dr. Wingate again suggested a fusion, but he also wanted to obtain another MRI scan (Petitioner's Exhibit 6).

When Dr. Wingate saw Petitioner on November 13, 2012, he recommended Petitioner have an upright thoracic MRI. That MRI was performed on November 27, 2012. According the radiologist who performed the study, there was no evidence of acute fracture or subluxations, mild kyphosis and the spinal cord/canal and neural foraminal where unremarkable (Petitioner's Exhibit 6).

Dr. Wingate saw Petitioner on December 5, 2012, and he reviewed the MRI scan. Dr. Wingate opined that the MRI revealed torn supraspinous and interspinous ligaments. Petitioner subsequently saw Dr. Wingate on January 14, February 26, and March 19, 2013. Dr. Wingate again recommended that they proceed with the thoracic spinal fusion (Petitioner's Exhibit 6).

Dr. Wingate ordered a CT scan of Petitioner's thoracic spine which was performed on April 12, 2013. Other than some early degenerative changes in the upper and middle thoracic spine, it was normal (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was again examined by Dr. Stover on May 1, 2013. In connection with his examination of Petitioner, Dr. Stover reviewed medical records for treatment provided to Petitioner since his prior examination of her. He also reviewed the MRIs and x-rays of Petitioner. In that regard, Dr. Stover stated that he agreed with the radiologists that the MRIs did not reveal any abnormalities of the thoracic spine and there was no evidence of interspinous or supraspinous ligamentous injuries. He opined that a spinal fusion was not indicated. His diagnosis was that Petitioner had "Back pain", and that while it was reasonable for her to attempt chiropractic care, no further chiropractic treatment was recommended. He recommended that Petitioner undergo a functional capacity evaluation (FCE) (Respondent's Exhibit 12; Deposition Exhibit 3).

Dr. Wingate saw Petitioner on May 7, 2013, and he opined that Petitioner had discogenic instability in the mid and lower thoracic spine. He renewed his recommendation that Petitioner undergo a spinal fusion (Petitioner's Exhibit 6).

Dr. Wingate subsequently referred Petitioner to Dr. Richard Kube, an orthopedic surgeon, who saw Petitioner on August 23, 2013. Dr. Kube opined that Petitioner had significant thoracic based pain. He opined that Petitioner might require a dorsal column stimulator, but was reluctant to proceed with it at that time because of Petitioner's age. He opined that Petitioner was at MMI and ordered an FCE to determine her restrictions (Petitioner's Exhibit 3; Deposition Exhibit 2).

An FCE was performed on September 30, 2013. The examiner opined that Petitioner could work at the medium work demand level. There were some lifting and pushing/pulling weight restrictions indicated; however, the examiner opined that Petitioner could frequently stand, walk, bend, squat, climb and kneel/crawl (Petitioner's Exhibit 3; Deposition Exhibit 3).

Dr. Kube saw Petitioner on October 17, 2013, and reviewed the FCE. He again opined that Petitioner was at MMI and subject to the work restrictions noted in the FCE (Petitioner's Exhibit 3; Deposition Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Ryon Hennessy, an orthopedic surgeon, on June 11, 2014. In connection with his examination of Petitioner, Dr. Hennessy reviewed medical records provided to him by Respondent as well as the MRIs and x-rays. Dr. Hennessy opined that Petitioner sustained a thoracic strain on November 23, 2011. He opined that Petitioner was at MMI and capable of returning to work without restrictions as of March 2, 2012, the date of the second MRI. Dr. Hennessy noted that all three MRIs failed to reveal any ligamentous or disc injuries (Respondent's Exhibit 13; Deposition Exhibit 2).

Petitioner obtained further chiropractic care from Dr. Jeffrey Hoekstra in May and June, 2014. He treated Petitioner for neck, upper back and mid-back pain (Petitioner's Exhibit 7).

Dr. Wingate and Dr. Stout were both deposed on April 9, 2013. Their deposition testimony was received into evidence at trial.

Dr. Wingate's deposition testimony was consistent with his medical records regarding his treatment of Petitioner and his surgical recommendation. He reaffirmed his opinion that Petitioner tore the ligaments between T8 and T9 which created instability between those two bones. He opined that this condition was causally related to the accident of November 23, 2011. In regard to the MRIs performed on March 2, 2012, and November 27, 2012, Dr. Wingate opined that both scans revealed tears of the ligaments between T8 and T9 (Petitioner's Exhibit 2; pp 19-20, 25-26, 51-52).

On cross-examination, Dr. Wingate agreed that he disagreed with the opinions of the radiologists who performed the MRIs of March 2, 2012, and November 27, 2012. Both radiologists opined that the MRIs were essentially normal (Petitioner's Exhibit 2; pp 90-93).

Dr. Stout's testimony was consistent with his records regarding his treatment of Petitioner which he opined was reasonable and necessary. Dr. Stout initially diagnosed Petitioner with various mid-back conditions; however, his final diagnosis was thoracic disc syndrome. He did review the MRI November 27, 2012, and agreed that it was essentially normal (Petitioner's Exhibit 4; pp 29, 37-38, 47-48).

Dr. Stover was deposed on May 8, 2013, and his deposition testimony was received into evidence at trial. Dr. Stover's testimony was consistent with his two medical reports regarding his examinations of Petitioner and he reaffirmed the opinions contained therein. In regard to his reading of the MRIs of March 2, 2012, and November 27, 2012, he testified that both diagnostic studies did not reveal any tearing or signal changes or interruption of the ligaments in the thoracic spine (Respondent's Exhibit 12; pp 17-20, 33-37).

Dr. Kube was deposed on November 12, 2015, and his deposition testimony was received into evidence at trial. Dr. Kube's diagnosis was chronic thoracic pain. He suggested a dorsal column stimulator, but opined that it was not indicated at that time due to Petitioner's age. He stated that Petitioner was at MMI as of the October, 2013, visit subject to the work restrictions noted in the FCE (Petitioner's Exhibit 3; pp 11, 13-15, 19-24).

Dr. Kube reviewed the MRI of November 27, 2012, and opined that it was normal. He did not diagnose any ligamentous tears in the thoracic spine (Petitioner's Exhibit 3; pp 30 – 33).

Dr. Hennessy was deposed on May 6, 2015, and his deposition testimony was received into evidence at trial. Dr. Hennessy's testimony was consistent with his medical report and he affirmed the opinions contained therein, in particular, that Petitioner sustained a thoracic strain as a result of the accident of November 23, 2011. He further stated that there was no medical evidence to support Dr. Wingate's diagnosis of interspinous ligamentous injuries or surgical recommendations. He reviewed the MRIs of March 2, 2012, and November 27, 2012, and opined that they were both normal. He further stated that Petitioner would have been at MMI as of the time of the March 2, 2012 MRI and that she could have returned to work without restrictions (Respondent's Exhibit 13; pp 19-22, 28-29).

Petitioner claimed that she was entitled to temporary total disability and temporary partial disability benefits of 17 2/7 weeks and 76 weeks, respectively. The period of temporary total disability claimed was December 9, 2011, through January 5, 2012, and February 3, 2012, through May 2, 2012. The temporary partial disability claimed was from May 3, 2012, through October 18, 2013 (Petitioner's Exhibit 14).

Subsequent to Petitioner's leaving the employment of Respondent, she worked at a number of part-time jobs. This included working at a bar, LA Fitness at the front desk, a sales job for a remodeling company and a job for an apartment complex. Eventually, Petitioner obtained a full-time job as a nanny. When this case was tried, Petitioner testified that she was going to start earning $42,000.00 per year with an effective date of July 1, 2016.

Respondent obtained surveillance video of Petitioner in March/April, 2012, and March, 2014. The Arbitrator watched the video and it revealed Petitioner getting in/out of her car, walking, standing behind a desk and carrying what appeared to be a bag. Petitioner moved about in a normal manner and did not exhibit any outward signs that she was uncomfortable or in pain (Respondent's Exhibit 14).

At trial, Petitioner testified that she still has back spasms once or twice per day. She continues to work out; however, not to the extent that she did prior to the accident.

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, in part, causally related to the accident of November 23, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a thoracic strain as result of the accident of November 23, 2011.

Petitioner has had three MRIs of the thoracic spine performed, two of which have been reviewed by Respondent's Section 12 examiners, Dr. Stover and Dr. Hennessy, who opined that they were normal/unremarkable. Two of Petitioner's treating physicians, Dr. Stout and Dr. Kube, likewise opined that the MRIs were unremarkable. Further, the radiologists had likewise opined that the MRIs were normal/unremarkable.

The only physician who has opined that the MRIs revealed some ligamentous injuries between T8 and T9 was Dr. Wingate. Based on the preceding, the Arbitrator does not find Dr. Wingate's opinion to be credible.

Petitioner has been seen and treated by various doctors and chiropractors primarily because of her ongoing subjective complaints. The Arbitrator does note that Petitioner was placed under surveillance in March/April 2012, and again in March, 2014, and moved about without any observable difficulties.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner was at MMI as of March 2, 2012, the date of the second MRI, and that no further medical expenses are owed by Respondent thereafter.

In support of this conclusion the Arbitrator notes the following:

As is noted herein, Petitioner sustained a thoracic strain as a result of the accident of November 23, 2011.

Considering all of the medical evidence and the surveillance video of Petitioner, the Arbitrator finds the opinion of Dr. Hennessey that Petitioner was at MMI as of March 2, 2012, to be persuasive.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is not entitled to any further payment of temporary total disability or temporary partial disability benefits.

In support of this conclusion the Arbitrator notes the following:

As aforestated, the Arbitrator has found that Petitioner was at MMI as of March 2, 2012.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA rating. The Arbitrator gives this factor no weight.

Petitioner was employed as a Paraprofessional Teacher Assistant at the time of the accident. She no longer works in that job and, at the time of trial, was employed full-time as a nanny. The Arbitrator gives this factor minimal weight.

Petitioner was 21 years old at the time of the accident. There was no evidence that Petitioner's age had any effect on her disability. The Arbitrator gives this factor no weight.

Petitioner is now making substantially more income than she was at the time of the accident in a full-time job as a nanny. The Arbitrator gives this factor no weight.

As noted herein, the medical opinions as to the nature and extent of Petitioner's disability varied considerably; however, the Arbitrator has determined that Petitioner sustained a thoracic strain as a result of the accident and not a ligamentous injury. The Arbitrator gives this factor significant weight.

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

Tammy Coughlin,

Petitioner,

17IWCC0680

vs.

NO: 15 WC 25280

Eden Village Retirement Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical, prospective medical, temporary disability, permanent disability, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 30, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

17IWCC0680

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,800.00. 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: OCT 26 2017
o10/12/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

17IWCC0680

COUGHLIN, TAMMY
Employee/Petitioner

Case# **15WC025280**

EDEN VILLAGE RETIREMENT CENTER
Employer/Respondent

On 3/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5370 THE BRADLEY LAW FIRM
PATRICK HINRICHS
1424 WASHINGTON AVE SUITE 300
ST LOUIS, MO 63103

1505 SLAVIN & SLAVIN LLC
KATHARINE BARNES
100 N LASALLE ST SUITE 2500
CHICAGO, IL 60602

17IWCC0680

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)

TAMMY COUGHLIN
Employee/Petitioner

v.

EDEN VILLAGE RETIREMENT CENTER
Employer/Respondent

Case # **15** WC **25280**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 25, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **June 21, 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 **$N/A**; the average weekly wage was **$440.00**.

On the date of accident, Petitioner was **45** 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 **$4,399.97** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,399.97**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of her employment with Respondent on June 21, 2015. Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her accident. Petitioner reached maximum medical improvement on November 23, 2015. All benefits after that date are denied.

Respondent shall pay reasonable and necessary medical services totaling $13,035.12, as reflected in Petitioner's Exhibits 1-7 that remain unpaid. Specifically, Respondent shall pay the following bills, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act: Gateway Regional Occupational Health $2,482.62; Jersey Community Hospital $7,686.00; Dr. Matthew Gornet $609.00; MRI Partners of Chesterfield $2,257.50.

Respondent shall pay Petitioner temporary total disability benefits of $293.33 per week for 20 5/7 weeks, for the period of July 2, 2015, through November 23, 2015, for a total of $6,076.12. As stipulated to by the parties, Respondent shall receive credit for previously paid benefits of $4,399.97, and shall therefore pay the remaining amount of $1,676.15.

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 Hamos

March 27, 2017

MAR 30 2017

17IWCC0680

Signature of Arbitrator

Date

ICArbDec19(b)

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TAMMY COUGHLIN
Employee/Petitioner

v. Case #: 15 WC 25280

EDEN VILLAGE RETIREMENT CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On June 21, 2015, Petitioner was 45 years of age, single, and had no dependent children. She testified that on that date she was transferring a resident from his wheelchair to his bed in a sit-to-stand lift. She explained that the lift was designed to take a resident from a sitting to a standing position. It is a C-shape, with a harness that goes underneath the resident's arms. It is designed for people that can bear weight but not stand on their own. It is a mechanical device, operated by a button, which takes the resident from a sitting to a standing position. It is then wheeled to wherever needed, the resident is lowered, and the harness is removed.

She placed the lift up to the wheelchair and placed the harness around the resident and under his arms, then removed the lift from the wheelchair and started to roll the resident towards his bed. The resident had only been in the lift a couple of days and was not quite used to it. He turned around toward his bed and grabbed for the bed rail. Petitioner testified she reached around to try and steady the lift and keep him from falling, as they were not yet to his bed. When this occurred, her left arm was extended forward on the arm of the lift, attempting to steady the lift with the resident in a standing position. In the process of doing so she heard and felt her neck and left shoulder pop and felt pain as if she had been shot. She cried out and the nurse in the hallway came in, asked what happened, and helped Petitioner get the resident into his bed. She asked Petitioner if she would finish the day on light duty, and they could figure out what to do the next day.

Petitioner went to work the next day, arriving at 7:00 a.m. She testified there was no administrator or Director of Nursing present when she arrived so she went to the floor. She was on the Alzheimer unit that day and the nurse on duty had heard her talk about the incident. She told Petitioner she could not allow her to work and instructed her to wait in the administrator's office, which she did. She spoke with the administrator's secretary, whose name she could not

recall, who informed her she needed to go to Gateway (Regional Occupational Health Services). Petitioner testified she believed she filled out an injury report at that time.

Petitioner presented to Gateway and was seen by Dr. Knapp. She reported she had pain in her shoulder and neck and slight tingling in her fingers and toes. She was placed on light duty of no lifting over 10 pounds. She attempted to work but called off a couple of times due to headaches. She returned to Dr. Knapp a week or so later and he recommended a shoulder/neck MRI and work restriction of no lifting over 5 pounds. She underwent the MRI and returned to Dr. Knapp, who took her off work completely and referred her to a specialist, Dr. DeGrange. Petitioner testified she never saw Dr. DeGrange, in that her employer denied the visit.

Petitioner eventually saw Dr. Gornet for her neck complaints. He recommended physical therapy, which was approved and which Petitioner attended. Dr. Gornet then recommended injections, which were denied, and surgery if needed. He took Petitioner off work at her first visit, and has continued to keep her off. She has not worked since June 21, 2015.

Petitioner testified she currently has numbness and tingling in the third through fifth fingers of her left hand and in the third through fifth toes of her left foot. Her neck is "always tingling and it feels like it's on fire, like it burns". She has frequent headaches and testified she previously had never had headaches.

Petitioner testified she had prior treatment to her left shoulder in 2009 following an injury while working at a hotel. She was taking out a 55-gallon trash can and injured her shoulder when lifting the can to pour it out into the dumpster. She underwent decompression surgery for the injury and filed a worker's compensation claim. Her last treatment was in May or June 2010, and she received no treatment to her left shoulder from that time until her recent accident. She had no treatment for her neck prior to the work accident of June 21, 2015. Petitioner testified she had prior pain and numbness in her hands due to carpal tunnel syndrome, which was surgically repaired. She has recently sought medical treatment for pain in her hands, from the wrists up to her thumbs. She denied any associated numbness and testified the diagnosis was tendonitis.

Petitioner was asked about an injury while working at Green Earth Greenhouse on May 9, 2015. She testified that she mentioned to her boss that her left shoulder hurt, and her boss stated that she had to notate it. She was unaware that a claim had been turned in until she received a letter in the mail from workmen's comp, after her seasonal job with the Greenhouse had ended. She testified she "was never treated for, never even seen a doctor for" her shoulder, as respects the Greenhouse. She had no treatment for her left shoulder between May 9 and the work accident of June 21 and during that time was able to perform all her job duties at both the Greenhouse and Eden Village Retirement Center. She did present to Jerseyville Community Hospital earlier in June 2015 for bronchitis. She provided a history of prior surgeries but was not having any issues with her neck, shoulder, left hand, left foot, or low back at that time.

On cross-examination, Petitioner could not recall when she started working for Respondent, but agreed it was sometime in May 2015. She acknowledged that she filled out a job application by hand and signed it on May 4, 2015, and that as of that date she was still employed at Green Earth Greenhouse. She acknowledged that she filed an Application for

Adjustment of Claim against Green Earth Greenhouses, alleging a left shoulder injury which occurred on May 9, 2015, five days after she applied for employment with Respondent. She continued to maintain, however, that no injury actually occurred on May 9. She could not recall the last day she worked for Green Earth, but noted it was a seasonal job. She conceded she then began working for Respondent on May 19, 2015, the Application against Green Earth was filed on June 12, and her alleged injury at Respondent's facility occurred nine days later, on June 21. She acknowledged that the claim against Green Earth Greenhouses was still open and pending, that no hearing had taken place, and that no settlement had been reached.

She testified that when she got the letter in the mail from Green Earth about her injury she did not understand what to do and contacted an attorney. She denied asking the attorney to file an Application for Adjustment of Claim against Green Earth and testified, "I was not even aware it happened or that it was going on." She admitted, however, that she had hired attorneys in the past and had filed two prior worker's compensation claims against previous employers. In May 2004 she filed an Application for Adjustment of Claim against her employer for bilateral carpal tunnel, for which she underwent surgery and received a settlement. In November 2009 she filed an Application against her employer for a left shoulder injury, for which she underwent surgery and received a settlement.

Upon questioning, Petitioner admitted that she had previously been convicted of a crime involving deception or untruthfulness.

Petitioner testified that she knew it was important to report what happened with her accident and injuries truthfully and accurately, and to report any and all complaints so that the medical providers could properly treat her. She further testified that she did so report to all of the medical providers, including the IME physician. She confirmed that Dr. Knapp referred her to Dr. DeGrange, but that she never treated with Dr. DeGrange because it was denied. She testified she was referred to Dr. Gornet by her first attorney and that she has treated with him even though it was denied as well. She testified that she had not undergone the cervical injections recommended by Dr. Gornet, as they were denied, and that she would like to proceed with surgery even though she has not undergone the injections. She does not have any health insurance, but acknowledged that in March 2016 she underwent treatment for unrelated bilateral DeQuervain's syndrome, which was paid for under a medical card. She further acknowledged that since June 21, 2015, she has reported to various physicians that in addition to neck pain she also had pain in her left foot with numbness in the toes, pain her arms, pain in her left hand, pain in her right buttock, and pain in her ribs.

Petitioner testified she has not worked since approximately July 1, 2015, and that she has not looked for employment.

Following the accident, Petitioner presented to Gateway Occupational Health ("Gateway") on June 22, 2015, and was examined by Dr. Christopher Knapp. She reported she worked as a CNA and was helping a patient go from a seated to standing position when he tensed up and pulled back on the bed rails, yanking her left shoulder. She had immediate pain in the left upper and medial aspect of the shoulder anteriorly and had since developed some swelling in the upper aspect of the shoulder. She rated her pain at 7/10. Dr. Knapp noted she had prior history

of left shoulder impingement resulting in an acromioplasty with good outcome. She reported the pain radiated down towards her left wrist. Dr. Knapp noted, "She denies any numbness. No back pain or neck pain." On examination, she had tenderness at the left sternoclavicular joint with no inflammation, ecchymosis, edema, crepitus, or fluctuance. She also had tenderness in the left mid to lateral upper third of the trapezius muscle with mild edema, and minimal AC tenderness. Range of motion of the left shoulder was limited and she had pain with resisted abduction and internal and external rotation. X-rays of the left shoulder and left clavicle were normal. Dr. Knapp's assessment was sternoclavicular strain and trapezius strain on the left. He recommended continued use of Meloxicam, which Petitioner took chronically for gout, as well as alternating ice and moist heat, and range of motion exercises, and return in one week. PX2.

Petitioner returned to Dr. Knapp on June 29, 2015. He noted it was for "follow up of cervical and left shoulder strain", but the Arbitrator notes that this is the first mention of cervical pain. Petitioner reported she had had five days of constant numbness in the heel and fourth and fifth toes of her left foot. She had been on modified duty and reported it caused a slight increase in the swelling of her left shoulder as well as headaches associated with the neck pain. She denied numbness in the left arm. Examination revealed decreased range of motion on the left but no inflammation or edema. Dr. Knapp also noted decreased sensation to light touch in the fourth and fifth toes and lateral aspect of the left foot, which did not progress above the ankle. His assessment was continued cervical and left shoulder pain with new onset of left foot numbness and he noted the symptoms suggested a potential cervical disc injury. He recommended a cervical MRI, continued Meloxicam and heat/ice, and modified duty of no lifting more than five pounds over the shoulder with no patient transfers. PX2.

On July 1, 2015, Petitioner underwent a cervical spine MRI. It revealed: (1) congenitally narrow cervical spinal canal with superimposed spondylosis causing moderate central canal stenosis at C5-6; mild central canal stenosis at C3-4 and C6-7; mass effect on the anterior margin of the cervical cord at C3-4, C5-6, and C6-7; and (2) degenerative disc disease and facet arthropathy, causing significant neural foraminal stenosis bilaterally at C5-6, great on the right; no other high-grade neural foraminal stenosis throughout the cervical spine. PX2.

On July 2, 2015, Petitioner returned to Dr. Knapp and reported continued pain of 6-7/10, headaches, numbness in her left fourth and fifth toes, neck pain, and left shoulder pain. Medications were not providing relief. She reported she had been unable to continue working "due to prolonged car ride and difficulty with a headache and with posture at work". Dr. Knapp reviewed the MRI results with her. Assessment was continued left shoulder pain, left foot numbness, cervical pain, headache, and significant cervical spinal disease. He recommended referral to Dr. DeGrange for orthopedic spine evaluation. Petitioner was to continue medication and ice/heat and to be off work until seen by Dr. DeGrange, and was released from care. PX2.

On July 3, 2015, Petitioner signed the Application for Adjustment of Claim. She testified that the handwritten portion was not her handwriting, but that it was her signature. The description of the accident was, "Reached to grab patient before falling out of bed." AX2, RX8.

On July 23, 2015, Petitioner presented to the Emergency Department at Jersey Community Hospital. She reported she had injured her neck at work one month prior and that an

MRI showed four bulging discs. She complained of a headache to the back of her head above the spine, left foot numbness, and stated her neck was "on fire". She was examined by Dr. Thomas Hanson, who noted her chief complaint was headache. She reported she was hurt lifting a patient a month ago and had neck pain, numbness and weakness to the left foot, and headache that started in the neck and radiated up with associated photophobia and some nausea. Dr. Hanson recorded her past medical history to include arthritis, rheumatoid arthritis, cervical disc disease, and fibromyalgia; and past surgeries to include bilateral carpal tunnel, left foot, and left shoulder. On examination, she was in moderate pain and had posterior neck tenderness. She also had weakness to plantar and dorsiflexion of the left foot, along with decreased sensation. Dr. Hanson's diagnosis was cervical degenerative disc disease with spinal stenosis. He prescribed hydrocodone and instructed her to follow up with her primary physician. PX3.

On August 22, 2015, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis. She complained of neck pain with headaches to the base of her neck, left trapezius, left shoulder, and down her left arm to her hand; scapular pain to both sides in her mid-back; mild low back pain; some right buttock and hip pain; and occasional numbness and tingling in her left lateral toes. She reported she was injured at work on June 21 while using a lift to move a patient and the patient became anxious. She was concerned he was going to fall off and he grabbed the rail. She tried to adjust him and felt a pop with electrical sensation in her neck and headache. She reported that initially the neck, shoulder, and arm were predominant, but that her hip pain and tingling in her left leg developed "over the last four to six weeks". Dr. Gornet noted, "She saw a work comp doctor and was treated and released. I am the second provider that she has seen and the first provider beyond the employer insured." Petitioner reported her symptoms were constant and worse with arm activity, reaching, pulling, or fixed head positions. Her hip symptoms were worse with prolonged sitting or standing. Dr. Gornet noted, "Again, she has left arm symptoms. She has right leg symptoms. She has tingling in her left foot." Examination findings were slightly abnormal. PX4.

Dr. Gornet reviewed the MRI scan, which he described as moderate quality, and noted a disc fragment on the left side at C5-6 and to a lesser extent at C6-7. He opined that Petitoner's symptoms in her mid back, neck, shoulder, arm, and legs were causally connected to her work injury. He recommended Petitioner be off work and undergo physical therapy to the neck and low back, oral steroids for two weeks, and a new MRI. If there was no improvement at six week follow up, injections at C5-6 and C6-7 would be considered. PX4.

On August 26, 2015, Petitioner presented to Jersey Community Hospital for an initial physical therapy evaluation. She reported she was injured at work on June 21 while transferring a client from sitting to standing. He panicked and began to reach for the bed and she overextended with her left arm to reach out for him and felt a pop in her shoulder/neck area. Since that time she had had neck and upper back pain and headaches with prolonged sitting, driving, lifting, and reaching behind her back. In the Occupation section it was noted she was off work and that she was "fired from job as CNA". It was noted she had cervical pain and tenderness with palpation. Petitioner attended therapy on August 28 and September 2, at which time it was noted she had seen another neurosurgeon due to continued pain and he wanted her to continue therapy but avoid overhead activities. PX3.

On September 1, 2015, Petitioner presented to Dr. Jose Espinosa, a neurosurgeon with SIU HealthCare. It is unclear to the Arbitrator whether she was referred to Dr. Espinosa, or how she came to seek an opinion from him. She reported a history of arthritis and fibromyalgia, for which she had been taking hydrocodone for the last three years. She further reported she had worked at a nursing home for 13 to 14 months and was transferring a patient with a lift. She used her left hand to steady the patient so the lift would not tilt and she immediately felt an electric type shock in her neck and down the left arm. The next day she noticed her left clavicle was swollen and she was having intermittent pain in her left foot. More recently she noticed a lack of sensation on the left side of her body and an exacerbation of her right hip pain. She reported when she walked for several blocks her left leg became weak and she felt she had to drag it. There was no mention of Petitioner's prior bilateral carpal tunnel surgeries, prior shoulder surgery, or left foot surgery in the "previous surgeries" section. PX6.

Dr. Espinosa conducted an examination and noted some weakness in the left upper extremity, no range of motion limitations in the neck, no pain to palpation of the neck, full power of the left foot, and some weakness in the left hip flexor. There was some decreased sensation to light touch and pinprick in the left side of the body, from the clavicle below. Dr. Espinosa noted Petitioner had "a myriad of complaints" and had not returned to work due to the complaints. He had no explanation for the lack of sensation on the left side of her body or the pain and numbness of the left foot, based on the cervical MRI. He recommended thoracic and lumbar MRI scans at a facility closer to her home, which was two and a-half hours away. The Arbitrator notes this is the only record from Dr. Espinosa. PX6.

As ordered by Dr. Espinosa, Petitioner underwent a thoracic MRI on September 3, 2015. It revealed small central disc protrusions at T8-9 and T9-10 without impingement on the cord. She underwent a lumbar MRI on September 4. It revealed broad base disc bulging with facet hypertrophy and thickening of the ligamentum flavum, producing moderate central and bilateral lateral stenosis at L3-4 and L4-5. There was no large focal disc herniation identified. PX3.

She returned to physical therapy on September 4, 11, 14, 21, and 23, 2015. She reported fatigue following treatment on these days and continued to report pain and headaches. PX3.

On September 18, 2015, Petitioner was scheduled to be evaluated by Respondent's Section 12 physician, Dr. Peter Mirkin of Tesson Ferry Spine & Orthopedic Center. As she testified to, she arrived late to the appointment and the evaluation did not proceed. Dr. Mirkin authored a report that day, after reviewing the medical records that had been provided to him by Respondent. Based on his review of the records, "particularly the first report from Dr. Knapp dated 6/22/15", Dr. Mirkin opined that Petitioner sustained a shoulder strain. He pointed out that in Dr. Knapp's record of June 22 he noted several times that Petitioner had no numbness and that her cervical examination was normal. RX3, Dep. RX2.

Petitioner returned to Dr. Gornet on October 29, 2015, and reported continued pain in the base of her neck, left trapezius, left shoulder down left arm to the hand, scapular pain, and low back pain to the right buttock and right hip. A repeat cervical MRI was done that day, which revealed a small herniation at C3-4, disc disease and herniations at C5-6 and C6-7 with annular fissures and foraminal narrowing, and C7-T1 left lateral disc herniation with annular tear. Dr.

Gornet recommended injections at C3-4 and C6-7 on the left. He noted Petitioner's headaches were the majority of her pain and symptoms, but she still had radicular symptoms. Her exam was unchanged. He noted if she did not improve a CT myelogram would be in order and consideration could be given to disc replacement at C5-6, C6-7, and potentially C3-4. He continued to keep Petitioner off work and to opine that her symptoms were causally connected to her work injury of June 21, 2015. PX4, PX5.

On November 23, 2015, Petitioner was evaluated by Respondent's Section 12 physician, Dr. Peter Mirkin. She reported she worked for Respondent for about three months when she was injured on June 21, 2105. On that day she was transferring a patient on a lift when he "freaked out". She reached out with her left arm to stabilize him and her left arm pulled and she felt pain in her left shoulder and some burning in the back of her neck. She reported the incident but continued to work and saw Dr. Knapp the next day. He referred her to Dr. deGrange, whom she never saw. Her attorney then referred her to Dr. Gornet, who took her off work and eventually recommended multilevel disc replacements. Petitioner reported she "really had no treatment other than a short course of therapy". Her current complaints were burning pain in the back of her neck and occasional tingling in her left upper extremity and left foot (not present that day). She denied difficulty walking and denied any numbness or tingling in her hands, fingers, or feet on the day of the exam. RX3, Dep. RX3.

Dr. Mirkin noted his prior records review and reviewed additional medical records, including those from Dr. Espinosa and Dr. Gornet. He conducted a physical examination of Petitioner. It revealed full range of motion of her cervical spine; negative Spurling sign; full range of motion of her elbows, shoulder, and wrists; healed incisions in shoulder from prior arthroscopy; intact deep tendon reflexes in the biceps, triceps, brachioradialis, knee and Achilles; ability to heel and toe walk; ability to squat and rise from a squat position; negative finger escape sign; and no muscle atrophy in the upper extremity. Cervical x-rays taken that day showed mild spondylosis. Dr. Mirkin reviewed the cervical MRI of July 1, 2015, which showed a congenitally narrowed spinal canal with stenosis from C3-4 through C6-7. He also reviewed the cervical MRI of October 30, 2015, which showed degenerative disc disease and herniations at C5-6 and C6-7, along with mild congenital stenosis and foraminal narrowing and annular fissures which were consistent with the degenerative process. RX3, Dep. RX3.

Dr. Mirkin concluded that Petitioner sustained a strain in her left shoulder. Although she reported she had episodic numbness and tingling in the left arm and foot, they were not present on the day of the exam. Although it appeared she had some congenital stenosis, he did not see any significant injury to her cervical spine, and noted her full range of motion, intact deep tendon reflexes, and intact motor and sensory exam. He saw no indication for cervical surgery and opined that Petitioner was medically stationary and could work without restrictions. She reported she had been terminated from her previous job and was currently looking for a job. Dr. Mirkin acknowledged that she had some mild stenosis and spondylitic disease, which were long-standing, but noted she had no signs of neurologic abnormalities or symptoms of any significance. Her major complaint was headaches and burning behind the neck, and he opined that cervical spine surgery was unlikely to address that. She had no radicular symptoms and no neurologic symptoms, and there was no medical indication for any type of cervical spine surgery. RX3, Dep. RX3.

On January 21, 2016, Petitioner returned to Dr. Gornet and presented him with the IME report from Dr. Mirkin of November 23, 2015. Dr. Gornet's entire page-long note from that day discusses, criticizes, and disagrees with Dr. Mirkin's findings and conclusions. It does not appear that Petitioner actually underwent an examination on this date, such that the record is not a true treatment record. PX4.

On May 11, 2016, Petitioner followed up with Dr. Gornet. He noted her examination was unchanged and she continued to show "decreased biceps on the left at 4/5 and right at 4/5". She also had low back pain, which Dr. Gornet stated "has been placed on hold". He went on to state, "From our standpoint, I do believe I can help her." He continued to recommend disc replacement surgery at C3-4, C5-6, and C6-7. He dispensed Cyclobenzaprine in his office that day to help her manage her symptoms. PX4.

Dr. Mirkin testified by way of deposition on July 8, 2016. He is a Board Certified Orthopedic Surgeon. Dr. Mirkin testified consistent with his reports of September 18, 2015, and November 23, 2015. He confirmed that Petitioner reported to him that she had pain in her left shoulder and burning in her neck immediately following the incident. He was asked to review Dr. Knapp's record of June 22, 2015, (RX3, Dep. RX4) which stated Petitioner denied any numbness and had no back or neck pain. Her only complaint was pain that radiated toward her left wrist. RX3.

Dr. Mirkin testified that following a physical examination and review of Petitoner's records, he concluded she had strained her left shoulder. The diagnosis was consistent with the mechanism of her described injury, the complaints she had to Dr. Knapp, and the fact that she had a history of prior shoulder complaints. With regard to her neck, she had some arthritis and congenital stenosis but had no symptoms of pain or numbness or significant radiculopathy when he examined her. Assuming the accident occurred as she reported, Dr. Mirkin did not believe she suffered injury to any body part other than her left shoulder. He testified, "No, I mean her overall story is a little bit bizarre, she starts out with shoulder and ends up with neck, back, hip, a variety of things that are inconsistent with her original complaints." RX3.

Dr. Mirkin testified the appropriate treatment for Petitioner was a course of physical therapy. He did not believe there was any indication for cervical surgery, particularly secondary to her work injury, as she had no signs of radiculopathy or myelopathy. He testified, "You don't just do surgery because they have arthritis in their neck. You do it from symptomatology." When he examined Petitioner, she did not have the criteria that would be helped with surgery. He believed Petitioner could work without restrictions and noted she worked for ten days after the incident. Although some restrictions may have been appropriate for a period of time, at this point they were not necessary.

On cross-examination, Dr. Mirkin acknowledged that the records from the Emergency Department of Jersey Community Hospital dated June 4, 2015, did not indicate that Petitioner presented for current wrist and shoulder problems. Rather, she presented for a sore throat and dehydration. The noted wrist and shoulder problems were listed as part of her past medical history. He agreed he did not review any medical records regarding prior neck or shoulder

treatment, and it appeared from the records that Petitioner had not had shoulder treatment for at least three years prior to the injury date of June 21, 2015. RX3.

Dr. Mirkin agreed that when Petitioner saw Dr. Knapp on June 22, 2015, she reported pain that radiated down towards her left wrist, and agreed that radicular pain extending down into an extremity can be caused by a neck injury. However, he testified that since Petitioner denied any numbness or neck pain, it was unlikely that her symptoms were caused by a neck injury. He explained that the trapezius muscle is a broad muscle behind the shoulder, going from the clavicle down to the thoracic spine, and extending laterally to the outside of the back and outside of the chest. He agreed the upper part of the trapezius could be interpreted to include the area of muscle around the cervical spine. He agreed that Dr. Knapp's note of June 22, 2015, stated Petitioner had tenderness and mild edema "in the left mid to lateral upper third of the trapezius muscle". While Petitioner's counsel interpreted that anatomical description to refer to the cervical region, Dr. Mirkin interpreted it to refer to the back of the shoulder blade area. RX3.

Dr. Mirkin was asked to review Dr. Knapp's record of June 29, 2015, which noted Petitioner had "continued cervical and left shoulder pain with new onset of left foot numbness, symptoms suggest a potential of cervical disc injury". While Dr. Mirkin agreed that the term "*continued*" meant a continuation of what was previously seen, he disagreed that this meant Petitioner initially had a cervical strain. He pointed to Dr. Knapp's first record of June 22, which specifically stated that Petitioner had no neck or back pain, so that the use of the word "continued" was not consistent with his record and did not make sense. Dr. Knapp's assessment was different on the second visit, and the anatomical area described was different. RX3.

Dr. Mirkin described an MRI finding of a mass effect as something extending into the margin of the spinal cord that can press on a nerve and cause pain, numbness and radiculopathy. He agreed that if the mass effect extends to the left side it could affect the nerve roots exiting on the left and further agreed that left neural foraminal stenosis could cause some nerve root irritation at that particular level. He agreed that Petitioner's MRI were supportive in part of her complaints. RX3.

On August 1, 2016, Petitioner returned to Dr. Gornet. His record from that date notes he had requested a three-level disc replacement at C3-4, C5-6, and C6-7, that he continued to believe her symptoms were causally related to her work activity, and that they discussed it in the office that day. He continued to have Petitioner off work. There is no indication that a physical examination took place that day. PX4.

Respondent's Exhibit 1 is the Application for Adjustment of Claim filed by Petitioner against Green Earth Greenhouses. The date of accident is listed as May 9, 2015, and the part of body affected is listed as "left shoulder". Respondent's Exhibit 2 is a printout of the Commission's ICDW screen on August 23, 2016, showing the case was open and pending. Respondent's Exhibit 6 is a printout of the ICDW and IC3W screens, for a left shoulder injury on October 12, 2009, which was settled for 25% of the left arm on May 2, 2011. Respondent's Exhibit 7 is a printout of the ICDW and IC3W screens, for injury to bilateral hands and wrists on April 1, 2003, which was settled for 15% of each hand on March 9, 2005.

Respondent's Exhibit 5 is an Application for Employment with Eden Retirement Center, completed by hand by Petitioner on May 4, 2015. The Arbitrator notes that the first page of the application includes the question, "Have you ever been convicted of a crime...?" Petitioner answered as follows: "Yes, deceptive practice. My daughter passed away of a heroin overdose and she stole some of our checks. They were all taken care of after she passed away and we became aware of them." During cross-examination, Petitioner admitted to being convicted of this crime and the Arbitrator takes notice of the circumstances surrounding same.

Respondent's Exhibit 9 contained prior medical records from Jersey Community Hospital from 2013, 2014, and 2015. They document treatment for various things, including left foot injury, intoxication, mammogram, lab tests, chest x-rays, bronchitis, pharyngitis, and dehydration. Respondent's Exhibit 11 was an Occupational Therapy Evaluation at Jersey Community Hospital on March 30, 2016. Petitioner had been referred by Dr. Mark Stern for "right and left CMC splints for DeQuervain's syndrome", due to pain in both wrists and base of thumb. She reported she had been trying to manage the pain since November 2015 and had taken steroid therapy without success. Daily tasks were painful and awkward and she was modifying how she did things. Her past medical history included rheumatic fever, rheumatoid arthritis, appendectomy, and gallbladder removal.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The Arbitrator notes that at the time of arbitration Petitioner objected to Respondent's proffered Exhibit 10 on the basis of a lack of foundation. In that foundation was not established during testimony, Petitoner's objection was sustained and the exhibit was rejected.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Worker's Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

The Arbitrator finds that Petitioner has met her burden of proof in establishing that an accident occurred which arose out of and in the course of her employment. In so concluding, the Arbitrator finds significant that Petitioner gave a consistent history of the accident to all of the treating and examining physicians and at trial. Although Respondent argued there were inconsistencies in the history, close review of the records shows the differences to be minor and attributable to the different individuals recording the history as given by Petitioner. These minor differences are not enough to conclude that an accident did not occur. In addition, Petitioner's testimony concerning the facts of the occurrence was unrebutted.

The Arbitrator is mindful that Petitioner allegedly injured her left shoulder on May 9, 2015, while working for a different employer, and that the case is pending before another Arbitrator at the Commission. However, none of the medical records admitted in the case at bar reference the May accident or any treatment following the accident. Petitioner testified she did not actually sustain an injury on May 9, 2015, and that she was confused about what to do following the discussion she had with her employer about her sore left shoulder, so she hired an attorney. Although the Arbitrator found Petitioner to be less than credible on this point, the fact remains that she testified she did not seek any medical treatment after that date, until the accident which occurred on June 21, 2015, and the Arbitrator found no evidence to refute this testimony.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994). Liability cannot be premised upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that the work-related accidental injury aggravated or accelerated the preexisting disease, such that the employee's current condition of ill-being can be said to have been causally connected to the work injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v Industrial Commission*, 207 Ill.2d 193, 204-206 (2003). The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill.App.3d 289, 296 (1st Dist. 1986).

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that her current left shoulder and cervical conditions are causally related to her work accident of June 21, 2015. In so concluding, the Arbitrator finds significant the inconsistencies in Petitioner's subjective complaints and objective findings as recorded by various physicians, and further finds the opinion of Dr. Mirkin to be more persuasive than that of Dr. Gornet.

When Petitioner first presented to Dr. Knapp on June 22, 2015, she reported only left shoulder pain, specifically in the upper and medial aspect of the shoulder anteriorly. She specifically denied any numbness, neck pain, or back pain. Range of motion of the neck was normal and there was no spasm. Objective findings included mild edema in the mid to lateral upper one-third of the trapezius muscle, slightly reduced range of motion in the left shoulder with pain, normal sensation, and normal deep tendon reflexes. When she returned to Dr. Knapp one week later she continued to have shoulder pain, but her complaints now included numbness in the heel and fourth and fifth toes of her left foot, headaches, and neck pain. She again denied any left arm numbness or weakness. Objective findings now included twenty degree limitation

in her neck range of motion; tenderness in the left trapezius, left AC and acromion regions of the shoulder without edema; reduced range of motion of the left shoulder; and decreased sensation in the left fourth and fifth toes. When Petitioner returned to Dr. Knapp on July 2, 2015, her complaints continued to be shoulder pain, neck pain, headaches, and numbness of the left fourth and fifth toes. Interestingly, in the "Objective" section of his record, Dr. Knapp notes only that Petitioner was in no acute distress, was alert and oriented, and that her gait was normal. There are no other objective findings listed. He noted that the cervical MRI showed significant cervical spine disease, for which he referred Petitioner to Dr. DeGrange.

The next treatment record is Dr. Gornet's initial examination of August 22, 2015, which the Arbitrator notes was a Saturday and was seven weeks after Petitioner's July 2 appointment with Dr. Knapp. Her complaints included neck pain with headaches; pain in her left trapezius, left shoulder, and down her left arm to the hand; scapular pain to *both sides* in the mid-back; mild low back pain; some pain in the right buttock and hip; and occasional numbness and tingling in the left lateral toes. The only objective findings were a mild decrease in biceps strength *bilaterally* and decreased sensation to the S1 left region. She had normal sensation in the upper extremities and normal strength in the lower extremities.

Ten days after she was seen by Dr. Gornet, Petitioner was examined by Dr. Espinosa. She complained of pain in her neck and down her left arm, but also complained of a lack of sensation on the entire left side of her body. Objectively, Dr. Espinosa noted Petitioner did not seem to be in any distress. She had normal strength in the trapezia and sternocleidomastoids. She had ***no limitation*** on flexion, extension, rotation or lateral bending of the neck, and ***no pain to palpation*** of the neck. She had some weakness in the left deltoid and supraspinatus. She had full power in her left foot, though seemed unable to dorsiflex her foot completely. Dr. Espinosa noted the MRI showed mainly degenerative changes, along with a small bulge at C5-6. He further noted Petitioner had "a myriad of complaints" and he could not explain her symptoms.

When Petitioner returned to Dr. Gornet on October 29, 2015, she continued to complain of pain in her neck, left trapezius, left shoulder down her arm to the hand, scapular pain, and low back pain. Dr. Gornet did not record specific test results or objective findings that day, but rather only stated, "Her exam is unchanged."

Dr. Mirkin examined Petitioner on November 23, 2015. Her complaints were burning pain in the back of her neck and "occasional tingling" in her left arm and left foot, which was notably not present that day. He conducted a thorough examination with testing, which yielded normal objective findings. Specifically, Petitioner had ***full range of motion*** of the cervical spine, ***negative*** Spurling sign, ***full range of motion*** of the elbows, shoulder, and wrists, ***intact deep tendon reflexes*** in the biceps, triceps, and brachioradialis, and ***no muscle atrophy*** in the upper extremity. Dr. Mirkin testified that based on the records reviewed, his examination and testing, and Petitioner's affirmative denial of neck pain to Dr. Knapp the day after the accident, Petitioner's only injury on June 21, 2015, was a strain to the left shoulder. He acknowledged she had some mild cervical stenosis and spondylitic disease, but emphasized that she had no signs of neurologic abnormalities, no radicular symptoms, and no neurologic symptoms. As such, there was no medical indication for any type of cervical spine surgery.

The Arbitrator finds Dr. Gornet's records sorely lacking in objective findings on examination. There is no indication he conducted thorough testing, but rather it appears he based his recommendations on Petitoner's pain complaints and MRI findings of degenerative disease alone. He saw Petitioner on five occasions, but only two office notes document any testing. The Arbitrator notes on both occasions this testing was limited in comparison to the testing done by both Dr. Espinosa and Dr. Mirkin. In addition, it appears that Dr. Gornet did not actually perform an examination on January 21, 2016, or on August 1, 2016, as his records are completely void of any documentation as to an examination and/or testing.

The Arbitrator relies heavily upon the thorough examination and testing performed by Dr. Espinosa, a physician chosen by Petitioner rather than by her attorney or her employer. Her examination and testing were essentially normal, and Dr. Espinosa had no explanation for her "myriad of complaints". Dr. Mirkin also performed a thorough examination and testing, which were likewise essentially normal. Based on these results, he testified Petitioner did not need further treatment and specifically did not need cervical surgery, irrespective of causation.

The Arbitrator finds Dr. Mirkin to be more persuasive than Dr. Gornet, especially in light of Dr. Espinosa's similar lack of objective findings, and his opinions are given greater weight than those of Dr. Gornet. While it is reasonable to conclude that the jerking of Petitioner's left arm during the accident may have also strained her neck, the record does not support a conclusion that either injury persisted. Rather, the record shows that on September 1, 2015, Petitioner had a normal cervical and shoulder examination by Dr. Espinosa and that on November 23, 2015, she likewise had a normal cervical and shoulder examination by Dr. Mirkin. In addition, the record does not support a finding that Petitioner's complaints with respect to her low back, hips, or lower extremities are at all related to her work accident.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that her current condition of ill-being relative to her neck, left shoulder, left arm, low back, and left foot are causally related to her work accident of June 21, 2015. The Arbitrator further finds that Petitioner reached maximum medical improvement on November 23, 2015, that being the date of the independent medical evaluation by Dr. Mirkin.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered from June 22, 2015, through November 23, 2015, were reasonable

and necessary in Petitioner's care and treatment relative to her accident of June 21, 2015. In light of the Arbitrator's finding that Petitioner was at maximum medical improvement on November 23, 2015, the Arbitrator finds that any and all bills for medical services rendered beyond that date are denied. Respondent is liable for the following outstanding medical bills as set forth in Petitioner's Exhibits 1-7, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act and credit for any prior payments.

1. Gateway Regional Occupational Health. 6/22/15-7/2/15	$ 2,482.62
2. Jersey Community Hospital. 7/23/15-10/2/15	$ 7,686.00
3. Dr. Matthew Gornet. 8/22/15	$ 519.00
10/29/15	$ 90.00
4. MRI Partners of Chesterfield. 10/29/15	$ 2,257.50
TOTAL	**$13,035.12**

The Arbitrator declines to award charges billed by Dr. Gornet for CPT code 99080, Special Report. A provider may not charge a fee for writing a standard report that is generated in the normal course of treatment. Although a provider may charge an additional fee for a special report that is unusual or outside the standard reporting form, the Arbitrator finds that none of the medical reports admitted into evidence meet this standard. As such, charges for such reports are not reasonable and the Arbitrator finds that Respondent is not liable for them. Specifically, the following charges are not reasonable and Dr. Gornet is not entitled to payment: (1) 8/22/15, $33.00; and (2) 10/29/15, $33.00.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care.

In support of the Arbitrator's decision relating to issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (5th Dist. 1996). The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized. *Gallentine v. Industrial Comm'n*, 201 Ill.App.3d 880, 887 (2nd Dist. 1990)

The Arbitrator finds that Petitioner was temporarily and totally disabled from July 2, 2015, the date Dr. Knapp took her off work, through November 23, 2015, the date of maximum medical improvement. The Arbitrator finds that Petitioner is entitled to a total of 20 5/7 weeks of temporary total disability benefits. The parties stipulated at trial that Petitioner's average weekly wage was $440.00, and the Arbitrator finds her temporary total disability rate is $293.33. Respondent is liable for temporary total disability benefits of $6,076.12. The parties stipulated and the Arbitrator finds that Respondent previously paid benefits of $4,399.97 and is entitled to a credit for same. Respondent is therefore liable for the remaining amount of $1,676.15.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donna Nelson,

Petitioner,

vs.

NO: 10 WC047989
10 WC017121

Northwestern Lake Forest Hospital,

Respondent.

17IWCC0681

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of permanent disability and causal connection, and being advised of the facts and law, affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decisions of the Arbitrator filed April 25, 2017 and March 24, 2017 are 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.

17IWCC0681

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: OCT 26 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
o-9/28/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

NELSON, DONNA
Employee/Petitioner

Case# **10WC047989**

10WC017121

NORTHWESTERN LAKE FOREST HOSPITAL
Employer/Respondent

17IWCC0681

On 4/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0147 CULLEN HASKINS NICHOLSON ET AL
CHARLES HASKINS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINA M JAGODZINSKI
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
CORRECTED

17IWCC0681

Donna Nelson
Employee/Petitioner

Case # 10WC047989

v.

Consolidated cases: 10WC017121

Northwestern Lake Forest Hospital
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **October 25, 2016 and January 24, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ 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 11/22/2010, Respondent *was* operating under and subject to the provisions of the A

17IWCC0681

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 $62,791.04; the average weekly wage was $1,207.52.

On the date of accident, Petitioner was 57 years of age, *single* with 0 dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $18,975.98 for TTD, $5,001.86 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $23,977.84. The parties stipulated that all temporary total disability and temporary partial disability have been paid.

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $various amounts/week for 11-4/7 weeks, commencing 06/15/2011 through 09/03/2011, as provided in Section 8(a) of the Act. All temporary partial disability has been paid.

Respondent shall pay Petitioner temporary total disability benefits of $805.02/week for 23-4/7 weeks, commencing 02/11/2011 through 06/14/2011 and 06/05/2013 through 07/15/2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 87½ weeks, because the injuries sustained caused the 17½% 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

3/23/17
Date

APR 25 2017

FINDINGS OF FACT:

On December 5, 2009 Petitioner was employed as a mammographer with Respondent. Petitioner testified that in 1973 or 1974, she became certified as an x-ray technician and worked at West Suburban Hospital and Belmont Community Hospital. She was required to move patients from carts onto the x-ray table, maneuver equipment into position that had been mounted in the ceiling as well as push portable x-ray machine to various floors. Petitioner provided that she would utilize the portable x-ray machine in surgery and would be required to position patients and lift equipment. Petitioner stated that she performed this type of work for approximately 3 years and thereafter was a homemaker and raised a family until approximately 2002 when she became the sole support for herself and her three children.

Petitioner testified that she returned to the workforce in 2002 working for AON in Glenview as a receptionist in its school for agents. In 2004 she went to work as a secretary at Lake Forest Hospital and took classes and passed tests to re-obtain radiology certification in 2004. She became a mammographer after taking additional classes in 2005. Petitioner testified that as a mammographer, she was required to maneuver the patients into the machine so that the breast and adjacent tissues are compressed to obtain the image. Petitioner provided that the mammographer is required to adjust overhead controls to properly set the plate. Weights required depended upon the size of the patient. Petitioner stated the images are taken from multiple angles requiring that the patient be repositioned. Mammographers also perform biopsies, which can require overhead work.

Petitioner testified that she never experienced any injuries to either of her shoulders or to her cervical area prior to December 5, 2009. Nor had she had any prior treatments to those parts of her body.

It is agreed that Petitioner was injured on December 5, 2009. On said date, she was performing mammography on a wheelchair bound patient whose weight was over 300 pounds. As the patient was standing up, the patient lost her balance and started falling backwards, grabbing Petitioner's right arm and pulling it downwards. Petitioner felt pain in her right arm but continued working. (See also PX8 and ICT RX5)

On December 7, 2009 Petitioner went to Lake Forest Hospital Occupational Health in Gurnee. Petitioner provided a consistent history. She was diagnosed with right shoulder pain and a MRI study was recommended to rule out a rotator cuff tear. (PX 8)

Petitioner underwent MRI studies of her right shoulder on December 7, 2009. The study revealed subdeltoid bursitis, with infraspinatus and supraspinatus tendinopathy, and partial intrasubstance tearing. No full-thickness tears or retracted fibers were seen. (PX 8) On December 8, 2009, Petitioner was referred to Dr. Summerville. She was also instructed to return to work with no use of the right arm. On December 9, 2009, she was restricted to sedentary work. Also noted was that she had a visit scheduled with Dr. Logue on that date. (PX8)

Petitioner was seen at Illinois Bone & Joint beginning on December 9, 2009 by Dr. Logue. Therapy was instituted and Petitioner was next seen by Dr. Pavlatos of Illinois Bone & Joint Institute on January 25, 2010. The therapy regimen was adjusted and when she returned on February 22, 2010 the doctor recommended MR arthrogram which was performed, revealing hypertrophic changes at the acromioclavicular joint with a Type II acromion process. The labrum was intact, the long head biceps tendon was intact, and no full-thickness rotator

cuff tears were noted. Partial undersurface tearing of the scapularis and undersurface fraying/superficial tearing of the junction of the infraspinatus and supraspinatus tendons were noted. (PX11, pp3-4)

17IWCC0681

On February 26, 2010, Dr. Pavlatos diagnosed Petitioner with a questionable healing superior labral tear. He administered a cortisone injection and prescribed physical therapy. By May 21, 2010, Petitioner had continuing pain complaints. Dr. Pavlatos recommended proceeding with surgery. (PX11, pp.7-9)

On May 28, 2010, Petitioner underwent right shoulder arthroscopy, debridement of the labrum and rotator cuff with arthroscopic subacromial decompression. Operative findings noted the probing of the rotator cuff revealed a 25% thickness tear involving the supraspinatus with fraying of the cuff edges. Significant bursitis was noted. (PX11, pp10-11)

Thereafter, Petitioner continued in therapy and on June 29, 2010 told the doctor that she wanted to try to avoid additional injection. By July 22, 2010 the rotator cuff was inflamed and she had AC joint pain and injection was performed. (PX11, pg15) By September 2, 2010, she continued to complain of right shoulder pain which was impacting therapy and she also complained of pain in the left shoulder as she was utilizing the left arm more. Injection was performed to the left shoulder. (PX11, pg16)

On September 30, 2010, Petitioner returned to Dr. Pavlatos who recommended repeat MR arthrogram of the right shoulder and stated that a distal clavicle resection would be necessary. Additionally, the left shoulder was again injected. (PX11, pg17)

Petitioner returned on October 14, 2010 and indicated that she was doing well and that the pain had decreased. Examination showed full strength and negative impingement sign. It was recommended that Petitioner continue exercise and follow up in 2 months. She was released to regular duty on October 18, 2010. (PX11, pg18)

Petitioner testified that she returned to work in October 2010. She returned to Dr. Pavlatos for a follow up visit on November 19, 2010. At that time she complained that since being back at work, she continued having flare ups in the area of her AC joint. The doctor noted decent strength but tenderness in the area of the AC joint. The doctor injected her right shoulder but opined that she may require distal clavicle resection. (PX11, pg19)

Petitioner testified that just prior to November 22, 2010 she was continuing to experience problems with both arms.

On November 22, 2010, Petitioner suffered a new injury. Petitioner testified that a mammography patient who was being positioned had a seizure. Petitioner testified that she put her right arm around the patient so the patient wouldn't strike her head and as a result all of the patient's body weight was on Petitioner's right arm. (ICT RX6). Later that day, Petitioner presented to Occupational Health at Northwestern Lake Forest Hospital in Gurnee. She related a history of a patient falling onto her right upper extremity after she had a seizure during a mammogram. She felt sudden discomfort in her right upper extremity and shoulder area, where she had a previous injury. Her pain was still present, although it was more severe earlier in the day. Petitioner was diagnosed with right shoulder pain, rule out strain and possible injury or exacerbation of previous injury. Petitioner was instructed to follow-up with Dr. Pavlatos and work with light duty restrictions. (PX 9)

Petitioner was seen by Dr. Roger Chams of Illinois Bone & Joint Institute on November 23, 2010. The doctor noted Petitioner had been seen Dr. Pavlatos in the past after she sustained a work injury and that she had increasing pain in her right shoulder since that time. Upon examination, Dr. Chams noted her right shoulder was positive for tenderness over the AC joint as well as for AC joint pain with cross arm adduction. She reported tenderness at the lateral bursa and anterior impingement area. Dr. Chams noted positive Jobe, Neer,

and Hawkin's signs. Her motor strength was normal in her left shoulder and slightly decreased on the right. Dr. Chams diagnosed her with right shoulder acromioclavicular degenerative joint disease with rotator cuff tear. The doctor recommended surgery consisting of a right shoulder arthroscopy, Mumford procedure and possible rotator cuff repair. He placed restrictions of no lifting, carrying, pushing, or pulling greater than 20 pounds and no repetitive above the shoulder activities. (PX11, pp 20-22)

On February 11, 2011, Dr. Chams performed a right subacromial decompression and distal clavicle resection with Mumford procedure, rotator cuff repair and debridement of labrum. (PX11, pp 23-25)

Post-surgery, Petitioner continued with Dr. Chams. She was off work and receiving physical therapy. At her March 17, 2011 visit, Petitioner she reported increasing left shoulder pain and noted that she saw Dr. Pavlatos in the past for her left shoulder.. She reported increased pain since she had her right shoulder surgery. Dr. Chams recommended she discontinue use of the sling for her right shoulder in two weeks. (PX11, pg.27) On a return visit to the doctor on May 5, 2011, Petitioner reported that her right shoulder was doing well and that she had increased pain in her left shoulder recently. She exhibited full range of motion of her left shoulder with reduced strength. Dr. Chams diagnosed her with bilateral shoulder rotator cuff tears. He referred her for MRI studies of her left shoulder. (PX11, pg.29)

Petitioner underwent MRI on her left shoulder on May 20, 2011. The radiologist noted minimal infraspinatus tendinosis, moderate subacromia/subdeltoidl bursitis, minimal subacromial encroachment secondary to anterior downsloping of the acromion with minimal AC joint degenerative changes and no evidence of instability. (PX11, pg.56)

Petitioner received injection to her left shoulder on June 14, 2011. She was instructed to continue physical therapy for her right shoulder and released to return to light duty work. (PX11, pg 30)

Petitioner testified that she went back to work in a restricted capacity as of June, 2011. She provided that she was sore while working. Petitioner indicated she utilized a shoulder wrap that would hold an ice pack in front and back of her shoulder while she was working. She was also taking medication. Her neck was stiff and sore on the right side.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Scott Sagerman on August 1, 2011. Petitioner related a history of a work injury on December 5, 2009 (The Arbitrator notes that her second accident is not documented in Dr. Sagerman's report.). Her complaints included pain in both shoulders, worse on the right. Her left shoulder started hurting after the work injury, but not as severely. Dr. Sagerman diagnosed her with right shoulder rotator cuff tear and left shoulder impingement syndrome with AC joint arthritis and bursitis. He recommended continued postoperative therapy for her right shoulder until her progress plateaued in approximately two to three months. Dr. Sagerman opined that her left shoulder condition is degenerative in nature. Although Dr. Sagerman noted Ms. Nelson reported to him that her left shoulder symptoms began at the time of her work injury in December of 2009, he did not find this documented in the records of her treating physician. He noted that the left shoulder problems did not occur until approximately two months after the injury in the therapy progress reports. Dr. Sagerman noted that since her right shoulder had been injured, it was possible that her left symptoms arose due to overuse. Dr. Sagerman opined that conservative treatment was appropriate for the left shoulder consisting of therapy, a steroid injection, and anti-inflammatory medication. He indicated that surgery could be considered on an elective basis for her left shoulder if symptoms warrant. He did not restrict her in terms of work hours for her right shoulder, but noted that she should avoid heavy lifting and limit overhead use of her right arm. (ICT RX1)

Petitioner returned to Dr. Chams on August 9, 2011. Petitioner's pain complaints continued. The doctor continued her therapy regiment. He restricted her to no lifting, carrying, pushing or pulling greater than five pounds and no more than three days of work each week. Dr. Chams noted she could return to a full five day

work week beginning September 1, 2011. (PX 11, pg.32) Dr. Chams saw her again on October 20, 2011. She reported continued pain in her left shoulder. He instructed her to progress with therapy exercises and her restrictions remained the same. (PX 11, pg.33)

17IWCC0681

On January 3, 2012, Petitioner saw Dr. Chams. Petitioner reported that her left shoulder was giving her more trouble. She had occasional discomfort in the right shoulder and had been unable to work. She was also unable to lift her right shoulder overhead. Dr. Chams injected both of her shoulders. He diagnosed her with left shoulder bursitis and status post right shoulder rotator cuff repair. Dr. Chams instructed her to resume limited work activities with no lifting over five pounds and scheduled a follow-up visit in two months. (PX 11, pp.34-36)

On February 2, 2012, Petitioner reported persistent pain with burning pain in both elbows. She was sensitive to touch while putting on clothes. She denied improvement with the cortisone shots and continued to work as a mammography tech. Physician's Assistant, David Gaida, examined her on that date. He diagnosed her with left shoulder tendonitis, status post right shoulder rotator cuff repair, and possible cervical radiculopathy versus RSD. MRI studies of her cervical spine was ordered to rule out radicular symptoms. Also noted was an option of a referral to a Pain Specialist. (PX11, pp 37-38)

Petitioner underwent the MRI studies of her cervical spine on February 28, 2012. Mild narrowing at C5-6 was noted. The radiologist noted an altered signal intensity suggesting disc dehydration. Moderate left neuroforaminal stenosis was present at C5-6 and C6-7 secondary to loss of disc height, as well as a disc osteophyte complex, with no focal disc herniations. Mild degenerative disc disease was noted at C3-4 and C4-5 without any focal disc herniations. (PX11, pp.58-59) On February 28, 2012, Physician's Assistant David Gaida discussed the results of her cervical MRI studies by phone with Petitioner. He noted that the findings on MRI correlated with the symptoms she had of numbness and tingling in both of her elbows. He referred her to Dr. Tack or Dr. Schell for further treatment recommendations. (PX11, pg.39)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Karen Levin on May 23, 2012. After performing an examination and reviewing medical records, Dr. Levin provided that there was nothing on Petitioner's exam to suggest that she had CRPS/RSD. Dr. Levin opined that her continued pain was not of a neurologic nature. The doctor provided that instead, it was nondermatomal and somewhat unusual. She recommended EMG studies if there was any question of cervical radiculopathy. She opined Petitioner did not require long term pain management from a neurological standpoint and she could work full duty with no restrictions. Dr. Levin also noted that there was evidence of symptom magnification from Petitioner. (ICT RX3)

Petitioner also underwent a Section 12 examination at Respondent's request with Dr. Kern Singh. In his report dated August 27, 2012, Dr. Singh diagnosed degenerative disc disease at C5-C6 and C6-7. He noted she could work full duty without restrictions with regard to her cervical spine and he did not believe her current symptoms were causally related to any cervical spine pathology. The doctor noted that while Petitioner had degenerative disc disease at C5-6 and C6-7, her bilateral shoulder pain did not correlate to any of the incidental findings on the cervical spine MRI studies. He did not recommend treatment for her cervical spine and noted that there was no injury to her cervical spine. The doctor did not note symptom magnification but questioned drug usage based upon monitoring program. (ICT RX4)

Petitioner testified that she has never taken medication beyond what was prescribed. She indicated that during this period of time she moved as she could no longer perform the upkeep on her single family home. She provided that she moved into a development where outdoor maintenance was provided. Petitioner identified as Petitioner's exhibit 17 a listing of medications that she had taken between May 5, 2011 and May 12, 2012. (PX17)

Petitioner testified that Dr. Chams referred her to Dr. Buvanendran in September, 2012. Records submitted show she presented to Dr. Asokumar Buvanendran on September 14, 2012 with complaints of bilateral shoulder pain. (PX13). She reported that she was in good health and had no shoulder difficulties until her work injury on December 5, 2009. She described hyperalgesia and allodynia in the bilateral shoulders with radiating pain down both upper extremities with any touching of her shoulders. Later in the notes, the doctor states she denied skin color changes, erythema, allodynia or hyperhidrosis. Dr. Buvanendran noted the affected shoulders showed no significant atrophy, erythema, swelling, cyanosis, hyperhidrosis, or blanching. Her temperature in her right shoulder was 89.5°F and her left shoulder was 90.2°F. Dr. Buvanendran noted that she appeared to be suffering from symptoms of neuropathic pain. He prescribed topical cream containing Ketamine, Gabapentin, Clonidine, and Lidocaine. He noted that if her symptoms did not abate, she should return for a right Bier block. He also prescribed Lyrica. (PX13)

Petitioner returned to Dr. Chams on January 28, 2013. The doctor noted Petitioner still had not seen Dr. Tack for evaluation of her MRI results from 2012. She reported some RSD type symptoms throughout her bilateral upper extremities. The doctor also noted that she had seen a pain management specialist and injections were recommended, but she had not undergone those injections. At that visit, Petitioner reported that she had left greater than right shoulder pain. Dr. Chams administered an intraarticular injection into the left shoulder. He recommended she follow-up with Dr. Tack and consider surgery if she failed conservative management for her left shoulder. (PX11, pp.40-41)

Dr. Chams saw her again on March 25, 2013. She denied any relief after the last injection into her left shoulder. Dr. Chams noted she should remain on full duty with no restrictions and begin physical therapy. If she continued to have persistent problems, left shoulder surgery would be considered. (PX11, pp.42-44)

On April 9, 2013, Petitioner presented to Associates in Pain Management for treatment with Dr. Jay Hurh. After performing an examination, the doctor diagnosed her with reflex sympathetic dystrophy of the upper limb and cervicalgia. He prescribed Gabapentin, a Butrans patch, and gave her samples of Cymbalta. He ordered neuropathic cream to apply to both shoulders. Dr. Hurh indicated that if conservative measures failed, he would consider stellate ganglion blocks. He also ordered physical therapy for the shoulders and cervical spine for CRPS type II. (PX 14, pp.2-3)

On May 28, 2013, Petitioner returned to Dr. Chams who noted Petitioner continued with bilateral shoulder pain. The doctor also noted that she had been recently diagnosed with RSD. Dr. Chams injected her left shoulder and recommended bilateral shoulder MRI studies to rule out internal derangement. (PX11, pp46-47) Meanwhile, Petitioner returned to Dr. Hurh on May 30, 2013. Petitioner's examination findings remained the same as the prior visit. Her diagnosis had not changed. He prescribed a Butrans patch, Lorazepam, and renewed her prescription for Gabapentin. (PX14, pp4-5)

On June 13, 2013, Petitioner underwent MRI studies of her bilateral shoulders. Her right shoulder MRI studies were compared to her prior studies on October 8, 2010. The radiologist noted a shallow partial thickness tear involving the articular surface of the proximal supraspinatus tendon, new when compared to her prior evaluation. A small amount of fluid was present, representing bursitis. Left shoulder MRI studies revealed mild supraspinatus tendinosis, unchanged over the two year interval. She also had mild bursitis in her left shoulder, slightly more prominent than previously noted. Her AC joint degenerative changes and anterior downsloping of the acromion remained unchanged. (PX 11, pp.62-63)

Petitioner was again seen by Dr. Sagerman on June 24, 2013. The doctor felt that arthroscopic surgery for subacromial decompression and distal clavicle resection was a treatment option for the left shoulder. The doctor felt Petitioner had reached maximum medical improvement as far as the right shoulder. The doctor indicated that the performance of lifting, pushing and pulling and overhead use could contribute to the

impingement syndrome by accelerating or aggravating the degenerative process. The doctor stated that he did not see any evidence of symptom magnification or of drug abuse or dependency. (PX4) 17IWCC0681

Petitioner followed-up with Dr. Hurh on July 3, 2013 and July 30, 2013. The doctor noted that her CRPS symptoms significantly improved due to oral and topical medications. She was instructed to follow-up in three months. (PX14, pp. 6-9) Petitioner testified that Dr. Hruh's treatment and the medications prescribed by him were submitted through her own group insurance.

On July 15, 2013, Petitioner presented to Dr. Chams. The doctor noted that Petitioner was doing well with no major concerns. She advanced to a home exercise program in physical therapy. Her bilateral shoulder exams were normal. Dr. Chams released her to return to work full duty with no restrictions. He pronounced her at maximum medical improvement and instructed her to follow-up as needed. (PX11, pp.47-48)

Petitioner testified that she returned to work performing her mammography duties. She indicated that that the more she did at work the pain increased. As a result, she resumed wearing the ice packs within a few days of returning to regular duty.

In support of the Arbitrator's decision relating to item F, causation, the Arbitrator finds as follows:

Relying on Petitioner's unrebutted testimony, the records of Illinois Bone & Joint Institute as well as the opinions of Dr. Sagerman, the Arbitrator finds that a causal relationship exists between Petitioner's condition of ill-being in both the right and left shoulders and the accidents of both December 5, 2009 and November 22, 2010.

With regard to pain management and the reported diagnosis of CRPS, the Arbitrator finds the opinions of Dr. Levin more persuasive than the opinions of Dr. Hurh. Dr. Hurh's records fail to outline how Petitioner met the Budapest clinical diagnostic criteria for CRPS, which suggests his diagnosis was not supported by any objective criteria. Further, Dr. Levin did not find any evidence that Petitioner had RSD or CRPS based upon her examination.

With regard to the stiffness in her neck and pain prior to September 9, 2013, the Arbitrator notes that Dr. Singh's opinions are more persuasive. Therefore, the Arbitrator adopts Dr. Singh's opinions and finds that her neck condition prior to September 9, 2013 is not causally related to either of her claimed work injuries on December 5, 2009 or November 22, 2010.

In support of the Arbitrator's decision relating to Item L, Nature and Extent, the Arbitrator finds as follows:

The Arbitrator has deferred findings of permanent partial disability stemming from the accident of December 5, 2009 (case 10WC017121) to this case (case 10WC047989).

As a result of the accidents, Petitioner sustained injuries to her bilateral shoulders. With respect to her right shoulder, Petitioner underwent two separate surgeries to her right shoulder. Her first shoulder surgery consisted of an arthroscopic debridement of the labrum and rotator cuff, with a subacromial decompression. The second right shoulder surgery consisted of a right shoulder arthroscopy with subacromial decompression, distal clavicle resection, and Mumford procedure with rotator cuff repair and debridement of the labrum. With respect to the left shoulder, Petitioner underwent conservative treatment consisting of therapy, steroid injections, and anti-inflammatory. Following her first two accidents, Petitioner resumed her full duties as a mammographer until she sustained a third work injury on September 9, 2013, which is the subject matter of her 13 WC 29912 claim. ,

Based on all the above, the Arbitrator finds Petitioner is entitled to permanent partial disability benefits under Section 8(d)(2) to the extent of 17.5% loss of use of a person.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NELSON, DONNA
Employee/Petitioner

Case# **10WC017121**

10WC047989

NORTHWESTERN LAKE FOREST HOSPITAL
Employer/Respondent

17IWCC0681

On 3/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0147 CULLEN HASKINS NICHOLSON
CHARLES G HASKINS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINA M JAGODZINSKI
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

17IWCC0681

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Donna Nelson
Employee/Petitioner

Case # 10WC017121

v.

Consolidated cases: 10WC047989

Northwestern Lake Forest Hospital
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **October 25, 2016 and January 24, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ 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 _____

17IWCC0681

FINDINGS

On **12/05/2009**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**62,791.04**; the average weekly wage was $**1,207.52**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**16,445.41** for TTD

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $805.02/week for 20-3/7 weeks, commencing 05/28/2010 through 10/17/2010, as provided in Section 8(b) of the Act.

In light of the accident occurring on November 22, 2010 (10WC047989) which was consolidated with this case, the Arbitrator defers findings regarding permanent partial disability to case 10WC047989.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

3/23/17
Date

ICArbDec p. 2

MAR 24 2017

FINDINGS OF FACT:

On December 5, 2009 Petitioner was employed as a mammographer with Respondent. Petitioner testified that in 1973 or 1974, she became certified as an x-ray technician and worked at West Suburban Hospital and Belmont Community Hospital. She was required to move patients from carts onto the x-ray table, maneuver equipment into position that had been mounted in the ceiling as well as push portable x-ray machine to various floors. Petitioner provided that she would utilize the portable x-ray machine in surgery and would be required to position patients and lift equipment. Petitioner stated that she performed this type of work for approximately 3 years and thereafter was a homemaker and raised a family until approximately 2002 when she became the sole support for herself and her three children.

Petitioner testified that she returned to the workforce in 2002 working for AON in Glenview as a receptionist in its school for agents. In 2004 she went to work as a secretary at Lake Forest Hospital and took classes and passed tests to re-obtain radiology certification in 2004. She became a mammographer after taking additional classes in 2005. Petitioner testified that as a mammographer, she was required to maneuver the patients into the machine so that the breast and adjacent tissues are compressed to obtain the image. Petitioner provided that the mammographer is required to adjust overhead controls to properly set the plate. Weights required depended upon the size of the patient. Petitioner stated the images are taken from multiple angles requiring that the patient be repositioned. Mammographers also perform biopsies, which can require overhead work.

Petitioner testified that she never experienced any injuries to either of her shoulders or to her cervical area prior to December 5, 2009. Nor had she had any prior treatments to those parts of her body.

It is agreed that Petitioner was injured on December 5, 2009. On said date, she was performing mammography on a wheelchair bound patient whose weight was over 300 pounds. As the patient was standing up, the patient lost her balance and started falling backwards, grabbing Petitioner's right arm and pulling it downwards. Petitioner felt pain in her right arm but continued working. (See also PX8 and ICT RX5)

On December 7, 2009 Petitioner went to Lake Forest Hospital Occupational Health in Gurnee. Petitioner provided a consistent history. She was diagnosed with right shoulder pain and a MRI study was recommended to rule out a rotator cuff tear. (PX8)

Petitioner underwent MRI studies of her right shoulder on December 7, 2009. The study revealed subdeltoid bursitis, with infraspinatus and supraspinatus tendinopathy, and partial intrasubstance tearing. No full-thickness tears or retracted fibers were seen. (PX 8) On December 8, 2009, Petitioner was referred to Dr. Summerville. She was also instructed to return to work with no use of the right arm. On December 9, 2009, she was restricted to sedentary work. Also noted was that she had a visit scheduled with Dr. Logue on that date. (PX8)

Petitioner was seen at Illinois Bone & Joint beginning on December 9, 2009 by Dr. Logue. Therapy was instituted and Petitioner was next seen by Dr. Pavlatos of Illinois Bone & Joint Institute on January 25, 2010. The therapy regimen was adjusted and when she returned on February 22, 2010 the doctor recommended MR arthrogram which was performed, revealing hypertrophic changes at the acromioclavicular joint with a Type II acromion process. The labrum was intact, the long head biceps tendon was intact, and no full-thickness rotator cuff tears were noted. Partial undersurface tearing of the scapularis and undersurface fraying/superficial tearing of the junction of the infraspinatus and supraspinatus tendons were noted. (PX11, pp.3-4)

On February 26, 2010, Dr. Pavlatos diagnosed Petitioner with a questionable healing superior labral tear. He administered a cortisone injection and prescribed physical therapy. By May 21, 2010, Petitioner had continuing pain complaints. Dr. Pavlatos recommended proceeding with surgery. (PX11, pp.7-9)

On May 28, 2010, Petitioner underwent right shoulder arthroscopy, debridement of the labrum and rotator cuff with arthroscopic subacromial decompression. Operative findings noted the probing of the rotator cuff revealed a 25% thickness tear involving the supraspinatus with fraying of the cuff edges. Significant bursitis was noted. (PX11, pp10-11)

Thereafter, Petitioner continued in therapy and on June 29, 2010 told the doctor that she wanted to try to avoid additional injection. By July 22, 2010 the rotator cuff was inflamed and she had AC joint pain and injection was performed. (PX11, pg15) By September 2, 2010, she continued to complain of right shoulder pain which was impacting therapy and she also complained of pain in the left shoulder as she was utilizing the left arm more. Injection was performed to the left shoulder. (PX11, pg16)

On September 30, 2010, Petitioner returned to Dr. Pavlatos who recommended repeat MR arthrogram of the right shoulder and stated that a distal clavicle resection would be necessary. Additionally, the left shoulder was again injected. (PX11, pg17)

Petitioner returned on October 14, 2010 and indicated that she was doing well and that the pain had decreased. Examination showed full strength and negative impingement sign. It was recommended that Petitioner continue exercise and follow up in 2 months. She was released to regular duty on October 18, 2010. (PX11, pg18)

Petitioner testified that she returned to work in October 2010. She returned to Dr. Pavlatos for a follow up visit on November 19, 2010. At that time she complained that since being back at work, she continued having flare ups in the area of her AC joint. The doctor noted decent strength but tenderness in the area of the AC joint. The doctor injected her right shoulder but opined that she may require distal clavicle resection. (PX11, pg19)

Petitioner testified that just prior to November 22, 2010 she was continuing to experience problems with both arms.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Scott Sagerman on August 1, 2011. Petitioner related a history of a work injury on December 5, 2009 (The Arbitrator notes that her second accident is not documented in Dr. Sagerman's report.). Her complaints included pain in both shoulders, worse on the right. Her left shoulder started hurting after the work injury, but not as severely. Dr. Sagerman diagnosed her with right shoulder rotator cuff tear and left shoulder impingement syndrome with AC joint arthritis and bursitis. He recommended continued postoperative therapy for her right shoulder until her progress plateaued in approximately two to three months. Dr. Sagerman opined that her left shoulder condition is degenerative in nature. Although Dr. Sagerman noted Ms. Nelson reported to him that her left shoulder symptoms began at the time of her work injury in December of 2009, he did not find this documented in the records of her treating physician. He noted that the left shoulder problems did not occur until approximately two months after the injury in the therapy progress reports. Dr. Sagerman noted that since her right shoulder had been injured, it was possible that her left symptoms arose due to overuse. Dr. Sagerman opined that conservative treatment was appropriate for the left shoulder consisting of therapy, a steroid injection, and anti-inflammatory medication. He indicated that surgery could be considered on an elective basis for her left shoulder if symptoms warrant. He did not restrict her in terms of work hours for her right shoulder, but noted that she should avoid heavy lifting and limit overhead use of her right arm. (ICT RX1)

Petitioner was again seen by Dr. Sagerman on June 24, 2013. In his report dated July 3, 2013, the doctor opined that arthroscopic surgery for subacromial decompression and distal clavicle resection was a treatment option for the left shoulder. The doctor felt Petitioner had reached maximum medical improvement as far as the right shoulder. The doctor indicated that the performance of lifting, pushing and pulling and overhead use could contribute to the impingement syndrome by accelerating or aggravating the degenerative process. The doctor stated that he did not see any evidence of symptom magnification or of drug abuse or dependency. (ICT RX2)

In support of the Arbitrator's decision relating to item F, causation, the Arbitrator finds as follows:

It is agreed that Petitioner was injured on December 5, 2009. On said date, she was performing mammography on a wheelchair bound patient whose weight was over 300 pounds. As the patient was standing up, the patient lost her balance and starting falling backwards, grabbing Petitioner's right arm and pulling it downwards. Petitioner felt pain in her right arm but continued working. Ultimately, on May 28, 2010, Petitioner underwent right shoulder arthroscopy, debridement of the labrum and rotator cuff with arthroscopic subacromial decompression. Operative findings noted the probing of the rotator cuff revealed a 25% thickness tear involving the supraspinatus with fraying of the cuff edges.

Post-operatively, Petitioner underwent a course of physical therapy. By September 2, 2010, she began complaining of left shoulder pain as she was utilizing the left arm more. Thereafter, injections was performed to both the right and left shoulders.

On October 14, 2010, Petitioner reported that she was doing well and that the pain had decreased. She was released to regular duty on October 18, 2010. Petitioner testified that she returned to work in October 2010. She returned to Dr. Pavlatos for a follow up visit on November 19, 2010. At that time she complained that since being back at work, she continued having flare ups in the area of her AC joint. The doctor injected her right shoulder but opined that she may require distal clavicle resection.

Respondent's Section 12 examiner Dr. Sagerman diagnosed her with right shoulder rotator cuff tear and left shoulder impingement syndrome with AC joint arthritis and bursitis. Dr. Sagerman opined that her left shoulder condition is degenerative in nature. Dr. Sagerman noted that since her right shoulder had been injured, it was possible that her left symptoms arose due to overuse.

Based upon the above, the Arbitrator finds that a causal relationship exists between the condition of ill-being in both the right and left shoulders and the accident of December 5, 2009. The Arbitrator defers further findings to case 10WC047989.

In support of the Arbitrator's decision relating to Item L, Nature and Extent, the Arbitrator finds as follows:

The Arbitrator defers findings of permanent partial disability stemming from the accident of December 5, 2009 (case 10WC017121) to the case involving the accident occurring on November 22, 2010 (case 10WC047989).

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donna Nelson,

Petitioner,

vs. NO: 13WC029912

Northwestern Lake Forest Hospital - Grayslake Campus,

Respondent.

17IWCC0682

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of medical expenses, causal connection, temporary total disability, permanent disability, duration of maintenance; credit against permanent disability for overpayment of maintenance, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 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.

17IWCC0682

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: OCT 26 2017

Stephen J. Mathis

SJM/sj
o-9/28/2017
44

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NELSON, DONNA
Employee/Petitioner

Case# **13WC029912**

17IWCC0682

NORTHWESTERN LAKE FOREST HOSPITAL-GRAYSLAKE CAMPUS
Employer/Respondent

On 3/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0147 CULLEN HASKINS NICHOLSON
CHARLES G HASKINS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0081 LORENZ & BERGIN PC
JOHN BERGIN
120 N LASALLE ST SUITE 1420
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

17IWCC0682

☐ 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

Donna Nelson
Employee/Petitioner

Case # **13WC029912**

v.
Northwestern
Lake Forest Hospital- Grayslake Campus
Employer/Respondent

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **October 25, 2016 and January 24, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ 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

17IWCC0682

On **09/09/2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**66,391.52**; the average weekly wage was $**1,276.76**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has not* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**42,558.50** for TTD, $**0** for TPD, $**94,479.87** for maintenance, and $**0** for other benefits, for a total credit of $**137,038.37**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical of $156.00, as provided in Section 8(a) of the Act, subject to the limitations contained in Section 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $851.17/week for 50 weeks, commencing 09/10/2013 through 08/25/2014, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $42,558.50 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of $851.17/week for 113 1/7 weeks, commencing 08/26/2014 through 10/25/2016, as provided in Section 8(a) of the act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 175 weeks, because the injuries sustained caused the 35% 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

3/23/17
Date

MAR 24 2017

FINDING OF FACTS:

On September 9, 2013 Petitioner was employed as a Resource Coordinator in the mammography department. She had been in that position since approximately 2011. Petitioner offered as Petitioner's Exhibit #1 the job description of Resource Coordinator. In addition to performing mammography examinations, Petitioner performed a variety of supervisory roles such as assisting in selection of new staff, conducting training at quality levels, assessing staff performance, inspecting equipment and dealing with patients. (PX1) Mammographers are required to position patients in a machine so that the breast and surrounding tissues can be compressed in order to obtain an image. There are a number of different views that have to be taken (straight and a variety of other angles). The Mammographer is required to both maneuver the patient and hold the breast in position. The facility where Petitioner worked had equipment suitable for large patients and the majority of the patients at the facility where Petitioner was employed were women with large breasts. Petitioner described the weights as being very heavy. Petitioner would also be required to work overhead utilizing both overhead controls as well as reaching overhead to position patients. When performing stereotactic biopsies, the table would be raised and the patient would be at the Mammographer's chest level. The patient's breast would hang through a hole and the Mammographer would work underneath the table on a stool in order to position the breast.

Petitioner was previously injured in accidents occurring on December 5, 2009 (case 10WC017121) and November 22, 2010 (case 10WC047989). Those cases also dealt with injuries sustained while employed by Respondent. Those cases were presented at the same time as the instant matter. The Arbitrator has issued Decisions on each of those cases and the findings therein are incorporated by reference as are pertinent here.

Petitioner had originally injured her right shoulder in the accident occurring on December 5, 2009. She sustained re-injury on November 22, 2010 and underwent two surgeries to her right shoulder. Additionally, Petitioner began experiencing problems with her left shoulder attributed to overuse and left shoulder surgery was discussed as an option.

Petitioner was released and had returned to work without restrictions in early 2013 and on July 15, 2013 Petitioner had been released from the care of Dr. Chams. (PX11, pg.48)

Petitioner testified that she was performing a biopsy on September 9, 2013. Petitioner indicated that after the procedure, a patient slipped off the edge of the biopsy table, grabbed and pulled Petitioner's left arm. Petitioner stated she immediately felt a burning rip.

Petitioner was seen at the Lake Forest/Northwestern Emergency Room on that date, complaining of left shoulder pain and decreased mobility. (PX10, pg.2) X-rays which were taken showed no fracture or dislocation. The joint space appeared grossly normal. The AC joint was normal. Petitioner was diagnosed with left shoulder strain. It was recommended that she take Ultram for pain and follow up with Dr. Chams (PX10, pp.1,12,27)

Petitioner was seen by Dr. Roger Chams on September 16, 2013. Petitioner presented for evaluation and consultation concerning her bilateral shoulder pain and neck pain. Dr. Cham noted the new injury in which a patient pulled down her arm. She had increased amounts of pain and discomfort. The doctor also noted she had weakness which she did not have before. She was also experiencing radicular symptoms down her left arm. Dr. Cham's impression was impingement bursitis, bilateral shoulders with possible re-tear of rotator cuffs. He also

diagnosed cervical radiculopathy. He recommended bilateral shoulder MRIs, cervical spine MRI and a cervical spine evaluation. (PX12, pp.1-2) 17IWCC0092

Petitioner returned to Dr. Chams on October 22, 2013. Petitioner reported that her pain was still persistent, especially at night. The MRI was reviewed during the appointment. The impression was left shoulder impingement and bursitis. Dr. Chams recommended surgical intervention of decompression; Mumford procedure; and possible biceps tenodesis. (PX12, pp.4-6)

Petitioner was seen by Dr. Stanford Tack at the request of Dr. Chams on October 1, 2013. Dr. Tack noted that Petitioner complained of persistent neck pain and stiffness after an occupational incident on September 9, 2013. An examination revealed diminished spontaneous cervical range of motion. The doctor noted that her cervical spine was nontender and she had moderate stiffness in lateral flexion as well as stiffness and discomfort with neck rotation right and left. X-rays obtained showed moderate spondylitic changes at C5-6, C6-7 with grade 1 degenerative spondylolisthesis C4-5. Dr. Tack diagnosed exacerbation cervical spondylosis and recommended initial symptomatic treatment with Medrol Dosepak. (PX15)

Petitioner returned to Dr. Tack on October 22, 2013. Petitioner symptoms had improved however, she continued to complain principally of pinching pain in the neck with rotation. She had no radicular symptoms. The doctor noted that she had undergone a cervical MRI which demonstrated significant spondylitic changes at C5-6 and C6-7. Also noted was significant neural foraminal narrowing at both levels due to unconvertabral hypertrophy and focal disc protrusion. Dr. Tack diagnosis was aggravation, cervical spondylosis; no radicular symptoms. The doctor recommended continued symptomatic management. (PX15)

Petitioner also returned to Dr. Hurh on October 22, 2013. Petitioner had previously seen Dr. Hruh beginning on April 15, 2013. Dr. Hurh continued Petitioner's medication regimen. (PX14, pp10-11)

Petitioner last saw Dr. Tack on November 19, 2013. Dr Tack noted Petitioner's neck had significantly improved. Her symptoms were essentially localized to her shoulder and arm. Dr. Tack provided that based on her symptom improvement, Petitioner was at maximum medical improvement relative to her neck. (PX15)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Pietro Tonino on December 2, 2013. Dr. Tonino opined that the September 9, 2013 incident aggravated pre-existing condition and that the surgery recommended by Dr. Chams was appropriate. (Respondent Sedgwick Exhibit 11)

On February 26, 2014, Petitioner underwent left shoulder surgery consisting of examination under anesthesia, left shoulder arthroscopy, debridement of the labrum, debridement of articular side rotator cuff tear with subacromial decompression and open CW biceps tenodesis. (PX12, pp8-10) Thereafter, Petitioner continued to follow up with Dr. Chams and underwent physical therapy. (PX12) Petitioner offered as PX6 the billing of Illinois Bone & Joint for physical therapy reevaluation in 2014 totaling $156.00.

Pursuant to Dr. Chams recommendation, Petitioner underwent a Functional Capacity Evaluation on August 5, 2014. The evaluator provided that Petitioner demonstrated that her functional capabilities were at the light/medium physical demand level. The evaluator noted that Petitioner demonstrated the ability to occasionally lift 25.8 lbs. above shoulder, 36.8 lbs. desk to chair, 36.8 lbs. chair to floor, and 106.3 lbs. push/pull. Also noted in the evaluation was that Petitioner's job description as a mammography/radiographer is considered a heavy physical demand level. (PX16)

On August 25, 2014, Dr. Chams authorized permanent work restrictions consistent with the FCE report. Dr. Chams concluded that Petitioner was at maximum medical improvement and released her from care. (PX12, pg.22)

Petitioner continued with Dr. Hurh's entity and ultimately came under the care of Dr. Kim Katsimas. The doctor continued medications and also performed cervical injections on September 29, 2014, January 13, 2015 and April 10, 2015. (PX14)

At Respondent's request, Petitioner underwent a second Section examination with Dr. Tonino on March 5, 2015. Petitioner complaints consisted of left shoulder pain with some right shoulder discomfort. An examination showed elevation of the left shoulder to 100 degrees compared to 120 degrees on the right. External rotation was at 30dgrees bilaterally. Internal rotation was to the greater trochanter bilaterally. She had pain and weakness with rotator cuff testing of the left shoulder. The rotator cuff strength appeared to be within normal limits on the right. Dr. Tonino provided that based on the physical examination, he would recommend an MRI of the left shoulder. He concurred that Petitioner could work within the restrictions of the FCE. He noted that based upon the job description of a mammographer, Petitioner was not able to work in such position. Lastly, the doctor noted that Petitioner also complained of cervical discomfort with pain radiating down both arms when moving her neck. Dr. Tonino indicated that an evaluation by a cervical spine specialist would be helpful. (Sedgwick Respondent Exhibit 11)

Petitioner started losing work following the September 9, 2013 accident. She has never returned to Respondent. At the time of Petitioner's injury, Petitioner had received a salary increase to $77,209.60 per year. (PX19) On August 15, 2014, Petitioner's employment with Respondent was terminated as Petitioner was unable to return to work to full capacity. (PX5)

On August 25, 2014, Petitioner made written demand to Respondent for placement within the restrictions imposed by Dr. Chams. Petitioner in the alternative requested provision of vocational rehabilitation services including the payment of maintenance. (PX18) Petitioner renewed said request on May 29, 2015 (PX18) Petitioner testified that she has never been offered any type of position from Lake Forest Hospital or Northwestern.

Ultimately, Respondent arranged for a vocational assessment by Sandra Horn of Brown Rehabilitation which occurred on June 22, 2015. Initial vocational report was then completed dated July 3, 2015. Additionally, Respondent issued a wage earning capacity assessment. (Respondent Sedgwick Exhibit 9)

Petitioner testified that she would meet with Ms. Horn and would make applications for job searches both with leads provided by Ms. Horn and with leads that Petitioner located. Petitioner offered as exhibits 7, 7A and 7B, various underlying documentation of job search and positions for which Petitioner had applied.

Petitioner testified that she had originally obtained radiological certification in roughly 1973/1974 when she was 20 years old. She worked as an x-ray technician for approximately 3 years. Initially she worked full time and then on call as she began raising a family. Thereafter, she was not employed outside of the home. In roughly 2002, she returned to the work force as a receptionist and in 2004 began with Lake Forest Hospital as a secretary. Petitioner testified that while in that position, she began studying on her own and taking classes and tested to obtain radiological certification in 2004. Thereafter, she continued her studies and obtained certification as a Mammographer. She was required maintain her radiography license in order to maintain her mammography certification. Certification for mammography is covered by the American Registry of Radiological Technologists (ARRT). One of the requirements for certification incudes performance of a minimum of 75 repetitions of mammography procedures. (PX3)

Petitioner's radiography license expired in April 2015. Her mammography certification expired on February 28, 2015. (PX4) Petitioner provided that she was unable to perform any mammography procedures

after the accident of September 9, 2013. Petitioner was never asked by Respondent to renew either her radiography license or to renew her mammography certification with ARRT.

17IWCC0682

Ms. Horn was asked by Respondent to perform a wage earning capacity assessment after meeting with Petitioner. (Sedgwick X9). The jobs identified were all in the radiological field with a maximum wage earning capacity of $82,461.00. Initially, Respondent placed Ms. Horn's services on hold but by September 3, 2015 Ms. Horn was asked to do job placement. She would meet with Petitioner and give Petitioner job leads. Petitioner would report on the same as well as Petitioner sought employment on her own. Petitioner stated that she did everything that Ms. Horn asked of her.

On October 5, 2016, Ms. Horn completed a labor market survey relative to mammography technician. (Sedgwick X9). On October 23, 2016, Ms. Horn at the request of Respondent prepared a labor market survey relative to position of radiology technician. (Sedgwick X9). Ms. Horn indicated that an error was made relative to employment openings number 2-9 in that mammography certification was not required. Ms. Horn noted that the median income for a radiologic technician was $56,670.00. She opined that there would have been more opportunities available if Petitioner had a radiography certification.

Ms. Horn testified that Petitioner always did everything that was asked of her. Ms Horn indicated she was aware that Petitioner had not worked since the September 9, 2013 accident. Ms. Horn stated that although she was aware that Petitioner's radiological license and mammography certification had lapsed, she never assisted Petitioner in the process of reobtaining licensing or certification. The ARRT rules and regulations require that candidates graduating after January 1, 2015 must have earned at least an Associate's Degree, not necessarily in Radiological Sciences. (Sedgwick X8) Petitioner testified that she has a high school diploma and does not have an Associate's Degree or higher.

In support of the Arbitrator's decision relating to Item F (Causation), the Arbitrator finds as follows:

Petitioner was performing her regular duties, albeit with pain, prior to the accident of September 9, 2013. On said date, Petitioner was performing a biopsy when the patient slipped off the edge of the biopsy table, grabbed and pulled Petitioner's left arm. Petitioner stated she immediately felt a burning rip. Petitioner returned to treat with Dr. Roger Chams. At her initial visit, on September 16, 2013, Petitioner complained of shoulder and neck pain. Ultimately, Dr. Chams recommended surgical intervention for her left shoulder condition. The doctor also recommended an evaluation with a cervical spine specialist.

Petitioner was seen by Dr. Stanford Tack at the request of Dr. Chams on October 1, 2013. Dr. Tack noted that Petitioner complained of persistent neck pain and stiffness after an occupational incident on September 9, 2013. After performing an examination and reviewing diagnostic studies, Dr. Tack diagnosed exacerbation cervical spondylosis. Petitioner treated conservatively through November 19, 2013 when Dr. Tack placed Petitioner at maximum medical improvement relative to her neck.

Respondent had Petitioner undergo a Section 12 examination with Dr. Pietro Tonino on December 2, 2013. Dr. Tonino opined that the September 9, 2013 incident aggravated a pre-existing condition and that the surgery recommended by Dr. Chams was appropriate. Thereafter, Dr. Chams performed left shoulder surgery consisting of examination under anesthesia, left shoulder arthroscopy, debridement of the labrum, debridement of articular side rotator cuff tear with subacromial decompression and open CW biceps tenodesis.

Based upon the above, the Arbitrator finds that a causal connection exists between the accident of September 9, 2013 and the conditions of ill-being in the left shoulder and the cervical region.

In support of the Arbitrator's decision relating to Item J (Medical), the Arbitrator finds as follows:

Petitioner offered as Petitioner's Exhibit number 6, the billing of Illinois Bone & Joint Hospital totaling $156.00. This stemmed from two physical therapy reevaluations at Illinois Bone & Joint for the dates of April 10, 2014 and June 17, 2014, each in the amount of $78.00. The statement was dated August 15, 2016.

It is clear from Dr. Cham's records that physical therapy was ordered. Additionally, the physical therapy progress summaries are contained at pages 44-46 and 50-52 of Petitioner's Exhibit number 12. The therapy clearly relates to her shoulder.

Based on the above, the Arbitrator awards the billing of Illinois Bone & Joint for physical therapy in the amount of $156.00 subject to the limitations contained in Section 8.2 of the Act.

In support of the Arbitrator's decision relating to Item K (Maintenance Benefits), the Arbitrator finds as follows:

It is clear that Petitioner was unable to return to her work as a Mammographer and resource coordinator. Specifically, the functional capacity exam and the release of Dr. Chams as well as the opinions of Dr. Tonino support the finding Petitioner is unable to resume that work.

Respondent terminated Petitioner as of August 15, 2014. Petitioner made demand for placement of job within her restrictions and/or provision of vocational services on both August 25, 2014 and May 29, 2015. As confirmed by Petitioner's letter of May 29, 2015, contained within PX18, Petitioner had not initially sought work based upon Respondent's request. It was after this letter that Respondent had vocational assessment performed and later job placement was begun. Ms. Sandra Horn, Respondent's vocational counselor, confirmed that Petitioner did everything that was asked of her and then some.

Based on the above, the Arbitrator finds that Petitioner is entitled to temporary total disability through August 25, 2014, the date upon which Dr. Chams placed permanent restrictions on Petitioner. Additionally, Petitioner is entitled to maintenance for the period of August 26, 2014 through October 25, 2016, the initial date of hearing when Petitioner opted to seek permanency benefits.

In support of the Arbitrator's decision relating to Item L (Nature and Extent), the Arbitrator finds as follows:

Petitioner indicated that she experiences tingling sensation in her left shoulder on the anterior portion. She will keep her left hand in her pocket to support her shoulder. She has difficulty with overhead activities. After a few overhead activities she will feel a sharp zing in the left shoulder. She indicated it was in the area were her bicep was reattached.

Respondent's October 5, 2016 Labor Market Survey showed that the average median salary for mammographer was $69,480.00 (Sedgwick X9). Sedgwick's Labor Market Survey for Radiology Technicians dated October 23, 2016 showed the average median earnings of radiographers as $56,760.00 (Sedgwick X9). Petitioner's exhibit 19 showed that she was given a raise just prior to her September 9, 2013 injury to $77,209.60

There is no evidence indicating Petitioner is able to continue as a mammographer. Even assuming Petitioner could do work as radiology tech (which she has not performed for a number of years) Petitioner has suffered a significant decrease in earning capacity as a result of the accident of September 9, 2013.

The Arbitrator finds that Petitioner is credible. Regarding her complaints, the medical records support Petitioner's testimony. Respondent did not rebut Petitioner's testimony.

17IWCC0682

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Resource Coordinator Mammography at the time of the accident and that she is not able to return to work in her prior capacity as a result of said injury. The Arbitrator notes Petitioner is seeking an award under Section 8(d)2. Because of this, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 60 years old at the time of the accident. Because Petitioner is an individual who will live with her permanent disability for a shorter period than a younger individual, the Arbitrator gives less weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner is unable to perform mammography and unable therefore be a Resource Coordinator Mammography. Because this results in a decreased earning capacity, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner's credible complaints of problems with her left arm and overhead work as well as the burning and sharp pain she experiences with activity. The Arbitrator also notes the medical records restricting her from returning to this type of work. Because of this, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 35% loss of use of whole person pursuant to §Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amos Black,
Petitioner,
vs.

17IWCC0683

NO: 11 WC 19057

Lorig Construction Company,
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 prospective medical, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: OCT 27 2017
KWL/vf
O-10/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0683

BLACK, AMOS
Employee/Petitioner

Case# 11WC019057

LORIG CONSTRUCTION COMPANY
Employer/Respondent

On 5/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0222 GOLDBERG WEISMAN & CAIRO LTD
JOEL J BLOCK
ONE E WACKER DR SUITE 3900
CHICAGO, IL 60601

1295 SMITH AMUNDSEN LLC
LES JOHNSON
150 N MICHIGAN AVE SUITE 3300
CHICAGO, IL 60601

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

17IWCC0683

AMOS BLACK
Employee/Petitioner

Case #11 WC 19057

V.

LORIG CONSTRUCTION COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Ketki Steffen, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on October 27, 2015. This matter was re-assigned to Arbitrator Robert Williams after the resignation of Arbitrator Steffen and the parties stipulated to a decision based on the transcript of the proceedings and the evidence. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☐ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On May 9, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $66,308.59; the average weekly wage was $1,275.17.
- At the time of injury, the petitioner was 59 years of age, single with no children under 18.
- The petitioner agreed that the respondent paid $196,202.59 in temporary total disability benefits and $13,142.32 in medical benefits.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $850.11/week for 70 weeks, from May 10, 2011, through September 10, 2012, which is the period of temporary total disability for which compensation is payable. The respondent is entitled to a set-off for the $196,202.59 previously paid to the petitioner and for any benefits paid to the petitioner pending a decision.
- The respondent shall pay the petitioner the sum of $669.64/week for a further period of 175 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 35% loss of use of the man as a whole.

- The respondent shall pay the petitioner compensation that has accrued from May 9, 2011, through October 27, 2015, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his cervical and thoracic spine was reasonable and necessary and is awarded. The medical care rendered the petitioner for his shoulders and right hip was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Signature of Arbitrator

May 14, 2016
Date

MAY 16 2016

FINDINGS OF FACTS:

On May 9, 2011, the petitioner, a construction laborer, was struck by a boom when a construction crane overturned. He received emergency care at Advocate Christ Medical Center. A thoracic spine MRI revealed a mild to moderate acute T4 compression fracture and mild acute T2, T3 and T5 compression fractures. A cervical spine MRI revealed a C5 left laminar fracture, mild C6, C9 and C10 vertebral body compression fractures, probable small ligamentum flavum partial-thickness tears at C4-5 and C5-6, probable strains of the posterior interspinous ligament/posterior capsular ligaments between C2 through C6 and the bilateral paraspinal musculature, and a small C6-7 disc bulge. Examination of his upper and lower extremities were negative for deformities, abrasions, lacerations, ecchymosis, bony tenderness or step-offs, or reduced ROM, sensation or motor function of his hips, knees, ankles, shoulders, elbows, wrists and hands. The petitioner was provided a rigid cervical collar. The petitioner followed up with Dr. Kevin Waldron at Advocate Medical Group on May 25th. Dr. Waldron noted that the petitioner reported neck and mid back pain with left-sided chest discomfort, shoulder pain and post-concussive symptoms when he provided a consultation during the emergency care. The doctor opined that there was a progression of the angulation between C5 and C6 and that there was no canal compromise or neural compression or effacement. The petitioner's no-work restrictions were continued. A thoracic spine MRI on June 3rd revealed a vertical fracture of the anterior third of the T4 vertebral body with anterior displacement of the fracture fragment by the inferior endplate of T2 and minimal compression fractures of T2, T3 and T5.

On July 18th, Dr. Waldron noted that the petitioner ambulated with a cane, his cervical ROM was reduced and he had tenderness along the cervicothoracic musculature and some thoracic radiating pain around his rib cage with lying on his left side. Dr. Troy at Midwest Orthopaedic Consultants saw the petitioner on June 5th and opined that he would have performed a cervical fusion from C5 to C7. The petitioner received primary care at PCP Primary Care for a head congestion on September 30th. Dr. Emerito Natanawan noted neck pain and stiffness, a reduced cervical ROM and no cervical tenderness with palpation or motion. An improved cervical ROM and decreased pain was noted by Dr. Waldron on October 24th. The petitioner had physical therapy from September 19, 2011, through February 2, 2012.

The petitioner reported continued neck pain to Dr. Waldron through February 9, 2012, but improved symptoms. Dr. Kern Singh evaluated the petitioner on September 10, 2012, and opined that no surgical intervention was warranted, that the petitioner was at maximum medical improvement, that his compression fractures had resolved and that no work restrictions were needed.

The petitioner returned to PCP Primary Care several times for different health concerns and on January 22, 2013, reported back, shoulders and right hip symptoms. The petitioner saw Dr. Redondo at Midwest Bone & Joint Spine Institute on April 10, 2013, for persistent right lateral hip pain. Dr. Redondo noted good rotation, a negative Faber test but tenderness over the trochanteric region reproducing pain. The petitioner saw Dr. Caleb Lippman at Advocate Medical Group on October 9, 2013, and reported chronic neck, back and shoulder pain. A right hip MRI on March 3, 2014, was unremarkable. The

petitioner reported improvement with his right hip on May 28, 2014, and Dr. Redondo opined that his examination was more consistent with trochanteric bursitis.

The petitioner sought emergency care at Advocate Christ Medical Center on June 22, 2014, for chronic back pain that was aggravated approximately three days earlier when he moved rapidly. The doctor noted minor right paraspinal tenderness around T4-5. Dr. Troy at Advanced Orthopedic Spine Care saw the petitioner on June 27, 2014, for intermittent mid-to-upper thoracic spine pain going across to the right upper thoracic area in the mid lateral region. A CT scan of his chest on June 30, 2014, was unremarkable except for a stable right lower lobe lung nodule consistent with a benign finding. A thoracic MRI on July 1, 2014, revealed a chronic compression deformity and ventral wedging of the T4 vertebral body, epidural lipomatosis and spondylosis changes, a bulging of the T4-5 disc causing mild spinal and bilateral neural foraminal stenosis at T4-5 and mild disc bulging at T7-8 and T8-9 contributing to mild spinal stenosis. Dr. Troy opined on July 11, 2014, that the MRI showed a compression deformity at T4 but no spinal cord compression.

Edward Steffan reported on February 1, 2013, that the petitioner is both placeable and employable in positions earning $10 to $15 per hour. On September 2, 2015, Michael Mooney reported that his vocational employability study indicated that further vocational services for the petitioner were unreasonable and unrealistic.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his cervical and thoracic spine was reasonable and necessary and is awarded. The medical care rendered the petitioner for his shoulders and right hip was not reasonable or necessary and is denied. The medical

examination of his hips and shoulders after his injury on May 9, 2011, was negative for deformities, abrasions, lacerations, ecchymosis, bony tenderness or step-offs, or reduced ROM, sensation or motor function. The first medical note of any shoulder or hip symptoms was not until January 22, 2013, at PCP Primary Care provider. Moreover, on May 28, 2014, Dr. Redondo opined that the petitioner's right hip symptoms were more consistent with trochanteric bursitis.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Dr. Kern Singh opined on September 10, 2012, that the petitioner was at maximum medical improvement, that his compression fractures had resolved and that no work restrictions were needed. The respondent shall pay the petitioner temporary total disability benefits of $850.11/week for 70 weeks, from May 10, 2011, through September 10, 2012, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that he is obviously incapable of employment or that he cannot perform any services except those which are so limited in quantity, dependability or quality that there is no reasonably stable labor market for them. He has a myriad of medical problems which may diminish his employment opportunities; however, considering only his work injuries, he is able to perform light-duty/sedentary work. His cervical compression fractures have resolved. He has no spinal cord injury and has only intermittent right lateral chest symptoms. The petitioner can perform some form of employment without seriously endangering his health or life. The petitioner did not

look for employment. The opinions of Michael Mooney are not consistent with the evidence or believable and are not given any weight.

The petitioner complains of slower speech, difficulty walking and walking straight, back pain, night pain that wakes him and an inability to do a lot of things including intercourse. Also, it is noted that the petitioner believes that his work injury was no accident and that he is entitled to compensation for the deliberate act. The evidence does not validate the petitioner's belief not support all his complaints. The respondent shall pay the petitioner the sum of $669.64/week for a further period of 175 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 35% loss of use of the man as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Olivia Ortega,
Petitioner,

vs.

17IWCC0684

NO: 16 WC 12093

ARAMARK,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical, expenses, 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 15, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: OCT 27 2017
KWL/vf
O-10/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

17IWCC0684

ORTEGA, OLIVIA
Employee/Petitioner

Case# **16WC012093**

ARAMARK MANAGEMENT SERVICES
Employer/Respondent

On 2/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1752 ASHER, RAYMOND L LTD
LISA T AZOORY
200 W JACKSON BLVD SUITE 1050
CHICAGO, IL 60606

0560 WIEDNER & McAULIFFE LTD
PATRICK J MORRIS
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)
x ☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0684

Olivia Ortega
Employee/Petitioner

v.

ARAMARK Management Services
Employer/Respondent

Case # **16 WC 12093**

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On the date of accident, **2/3/16**, Respondent **WAS** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship **DID** exist between Petitioner and Respondent.

On this date, Petitioner **DID** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident **WAS** given to Respondent.

Petitioner's current condition of ill-being **IS NOT** causally related to the accident.

In the year preceding the injury, Petitioner earned **$33,293.75** the average weekly wage was **$640.26**.

On the date of accident, Petitioner was **66** 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 **$3,763.48 for TTD**; N/A for TPD; N/A for maintenance; and **$6,115.19** for other benefits (**Medical**), for a total credit of **$9,878.67**.

Respondent is entitled to a credit for all medical bills paid by the group health insurance carrier under Section 8(j) of the Act.

ORDER

No additional medical bills, additional TTD benefits, or prospective medical treatment shall be awarded to Petitioner as she failed to prove by a preponderance of the credible evidence that her current condition of ill being is causally connected to the accidental injury.

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.

Deborah L. Simpson

Signature of Arbitrator

February 14, 2017
Date

ICArbDec19(b)

FEB 15 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Olvia Ortega,	)	
	)	
Petitioner,	)	17IWCC0684
	)	
vs.	)	**No. 16 WC 12093**
	)	
Aramark,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on February 3, 2016, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, the Petitioner earned $33,293.75, and that her average weekly wage was $640.26.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) Was timely notice of the accident given to Respondent; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is Respondent liable for the unpaid medical bills to Mercy Works in the amount of $364.79, Dr. Wolin in the amount of $1,285.00 and Dolton Medical associates in the amount of $1045.00; (5) Is Petitioner entitled to TTD from April 5, 2016 through September 21, 2016; and (6) Is Petitioner entitled to prospective medical treatment.

The Petitioner does not speak English, her native language is Spanish. She testified with the assistance of Elsa Melgarejo, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties as an interpreter Ms. Melgarejo served as an interpreter for the Petitioner.

STATEMENT OF FACTS

On February 3, 2016, Olivia Ortega ("*Petitioner*") was employed by Aramark ("*Respondent*") as a cafeteria worker primarily responsible for making salads. On this date Petitioner was entering a walk-in cooler when she stepped on pickle slices which had apparently been left on the floor. According to Petitioner, this caused her to slip and fall. She initially fell on her knees and then rolled onto her back. Petitioner testified that during the course of this incident some cans fell off of a shelf and onto her right foot. Petitioner testified that she could not get up after her fall, but a co-worker came to her assistance. She was taken by ambulance to the University of Chicago Medical Center.

Upon arriving in the ER at the University of Chicago Medical Center Petitioner complained of focal pain in her right mid-foot, right knee, low back and the back of her head. She denied any loss of consciousness, headache, or visual symptoms. X-rays of Petitioner's right foot, right ankle, right knee, and lumbar spine revealed no evidence of fracture. However the evaluating radiologist did note mild osteoarthritis affecting the first MTP joint, as well as bipartite medial sesamoid beneath the first metatarsal of the right foot; mild osteoarthritis about the mid-foot, as well as posterior and plantar calcaneal spurs; no evidence malalignment or joint effusion about the right knee; and mild facet joint osteoarthritis of the lower lumbar spine. Petitioner was discharged to home, ambulatory, with instructions to follow up with her primary care physician. (P. Ex. 1)

On February 8, 2016, Petitioner was seen by Dr. Homer Diadula of MercyWorks, whereupon she complained of occipital pain, but she denied experiencing any loss of consciousness, dizziness, or blurred vision. She also complained of pain along the sides of her neck, left shoulder, mid-back, low back, waist, right ankle, right knee, left knee, and left elbow. She was diagnosed with contusions to the scalp, neck, shoulders, left upper back, thoracic spine, lumbar spine, right hip, both knees, right ankle, and left elbow, as well as abrasions to her right knee. She was advised to take Ibuprofen and to apply heat and warm soaks to the affected areas. She was also instructed as to a home exercise program for her back, neck, shoulders, hip, knee, and ankle, and a course of physical therapy was also ordered. (P. Ex. 3)

Petitioner followed up with Dr. Diadula on February 19, 2016. As of this date, she had not started the previously recommended course of physical therapy. Dr. Diadula noted that X-rays had previously been done at the University of Chicago for petitioner's lumbar spine, right knee, and right ankle which showed multi-focal osteoarthritis. The diagnoses and treatment plan on this date were unchanged. Pursuant to a return to Dr. Diadula on March 8, 2016, Petitioner still had not commenced physical therapy. (P. Ex. 3).

Petitioner had an initial physical therapy evaluation at MercyWorks Physical Therapy on March 9, 2016, whereupon she gave a history of having arthritis in her hands and her back. She advised the therapist that she had been instructed by Dr. Diadula to obtain a cane from physical therapy, but she was advised that the physical therapist that the facility could not provide such a device. Petitioner complained of pain in her neck, shoulders (*right worse than left*), lower back, knee, and ankle. She stated that she had trouble walking, and could not perform any housekeeping or driving due to pain. The physical therapist noted that she was unable to palpate any of the injured areas, as Petitioner was extremely guarded. The therapist commented that she anticipated slow progress in therapy due to petitioner's poor tolerance for pain and movement. Petitioner was instructed as to the importance of moving her body, specifically her shoulders, to prevent further complications. She was also instructed as to various exercises to do at home. (P. Ex 2)

Petitioner was to undergo additional physical therapy on March 14, 2016, but she apparently petitioner called the facility to cancel the appointment. She did participate in physical therapy on March 16, 2016, but the physical therapist noted that Petitioner required constant supervision to perform exercises since she would not put forth full effort. To that end Petitioner apparently refused to do the shoulder pulley exercises. As to various other exercises, petitioner either flatly refused to do them or she did so very slowly and deliberately. (P. Ex. 2)

On March 22, 2016, Petitioner was once again advised that the four-point cane that she had been using was unsteady and wobbly, and that she should obtain a straight cane which would allow better weight bearing on the right. According to the physical therapist, this was the third time that Petitioner had been instructed to obtain a straight cane and she apparently refused to do so. It appears that Petitioner was still reluctant to undergo the recommended physical therapy exercises allegedly due to pain. (P. Ex. 2)

Petitioner underwent a Section 12 examination with Dr. Lawrence Lieber on March 23, 2016. Dr. Lieber's impression was status post-contusions of the neck, lower back, bilateral shoulders, bilateral hips, and right ankle. He opined that there was a direct relationship as between Petitioner's contusion-type injuries and the alleged work accident of February 3, 2016. However, Dr. Lieber also opined that there was no evidence of any knee abnormalities and/or left elbow abnormalities which could be associated with the alleged work accident of February 3, 2016. He opined that Petitioner would benefit from additional physical therapy for a period of two to three weeks for her neck, low back, bilateral shoulders, hips, and right ankle area consisting of modalities and exercises. He also opined that Petitioner was capable of returning to full duty with no restrictions. Dr. Lieber opined that Petitioner would be at MMI following completion of the three week course of physical therapy. (R. Ex. 1).

As of March 28, 2016, Petitioner advised the therapist that she would not obtain the straight cane as she had been instructed, because she preferred the four-point cane even though she had been advised on numerous occasions of the safety risks involved with using the four-point cane. Petitioner and her daughter were instructed as to the use of pulley exercises at home, and they were counseled as to the importance of movement to prevent shoulder tightness. (P. Ex. 2)

On March 31, 2016, the therapist had explained once again the importance of range of motion exercises in regard to Petitioner's alleged shoulder complaints, but Petitioner's daughter claimed that the therapist was "*hurting*" her mother. Accordingly, due to the family's request, the therapist was only doing active exercises with Petitioner with regard to her shoulder. (P. Ex. 2)

Of note, Petitioner did not show up for and did not call to cancel physical therapy on April 4, 2016, April 5, 2016, and April 7, 2016. Accordingly, she was discharged from physical therapy on April 7, 2016, due to non-attendance/compliance. (P. Ex. 2)

Petitioner sought treatment from her primary care physician, Dr. Rama Medavaram, of Dolton Medical Center on April 11, 2016, with complaints of right knee, right hip, and low back pain. (*The Arbitrator notes that Petitioner had previously complained of right knee pain during a visit to Dr. Medavaram on June 12, 2015. At that time, she was diagnosed with degenerative joint disease of the right knee. X-rays of Petitioner's right knee taken on June 19, 2015 revealed degenerative changes, as well as subluxation of the patella on the left side.*) On April 11, 2016, Petitioner was diagnosed with strain/contusion-type injuries to her right hip, lumbar spine, and cervical spine. She was advised to take Ibuprofen for pain. (P. Ex. 5)

Petitioner followed up with Dr. Medavaram on April 22, 2016, with ongoing complaints and she was diagnosed with left and right knee pain, as well as a lumbar spine strain and a hip strain. She was again advised to take Ibuprofen and to have bed rest and engage in a home exercise program. (P. Ex. 5).

Petitioner returned to Dr. Medavaram on May 9, 2016, at which time her complaints and the doctor's recommendations were essentially unchanged. On June 2, 2016, Dr. Medavaram referred Petitioner to Dr. Preston Wolin. (P. Ex. 5).

Petitioner was seen by Dr. Wolin on June 8, 2016, whereupon she appears to have advised Dr. Wolin that she had not had the physical therapy which had previously been recommended. Dr. Wolin's assessment was pain in the right shoulder; a lumbar sprain; and patellofemoral disorders, unspecified knee. He recommended that Petitioner have an MRI for her right shoulder to rule out a rotator cuff tear, as well as physical therapy for her lumbar spine. He also recommended bilateral steroid injections for petitioner's knees for what he characterized as an aggravation of patellofemoral arthrosis. (P. Ex. 4).

Petitioner was seen by Dr. Medavaram again on June 16, 2016 and August 16, 2016, with no apparent changes in her alleged condition of ill-being and/or treatment recommendations. (P. Ex. 5)

On August 22, 2016, Petitioner underwent a repeat Section 12 examination with Dr. Lieber. She continued to complain of bilateral knee pain, left greater than right. She stated that her knees bothered her at night, as well as going up and down stairs and bending. She also complained of swelling about her knees but with no stiffness. However according to Dr. Lieber's physical examination findings no swelling was noted in either the right or the left knee. Dr. Lieber's diagnosis was patellofemoral pain syndrome of the bilateral knees. He stated that he disagreed with Dr. Wolin as to the alleged causal relationship as between Petitioner's bilateral knee complaints and the alleged accident of February 3, 2016. Specifically, Dr. Lieber did not believe that Petitioner's bilateral knee condition was causally related to the alleged work accident of February 3, 2016. (*However on close inspection of Dr. Wolin's June 8, 2016, report it does not appear as though he provided a causation opinion of any kind. (P. Ex. 4)*) Dr. Lieber opined that Petitioner was at MMI and she required no further medical treatment in relation to the alleged work accident of February 3, 2016. He opined that Petitioner could return to full duty work with no restrictions. (R. Ex. 2)

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

As to F, whether petitioner's current condition of ill-being is causally related to the alleged work accident of March 3, 2016, the Arbitrator notes the following:

The Arbitrator finds that Petitioner's current condition of ill-being is NOT causally related to the alleged work accident of February 3, 2016.

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence all elements of her claim. *Peoria County Nursing Home v. Industrial Commission,* 115 Ill.2d 524, 505 N.E.2d 1026 (1987). Since the burden proof of is on the Petitioner to establish the elements of her claim and/or right to compensation, unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission,* 44 Ill.2d 214 (1969).

Here, it is clear that Petitioner did suffer some bumps and bruises and sprain/strain-type injuries as a result of the alleged work accident of February 3, 2016. However the question is whether her *current* complaints are causally related. Petitioner's medical records clearly show that she had osteoarthritis in her lumbar spine, right knee, and right ankle and foot prior to the alleged accident in question. Moreover, the records of Dr. Medavaram reveal that Petitioner had been diagnosed with degenerative joint disease of her right knee approximately one year prior to the alleged accident in question.

The Arbitrator also notes that on various occasions Petitioner complained of and received treatment for different alleged injuries. Specifically, the records of Dr. Medavaram reveal that on some occasions she complained about her neck, back and hip, but said nothing about her knees, while on other occasions she would complain about her knees as well. This would seem to reflect the natural progression of the osteoarthritic and degenerative joint disease processes.

For the reasons cited above the Arbitrator finds that Petitioner failed to sustain her burden of proof by a preponderance of the credible evidence that Petitioner's *current* condition of ill-being is causally related to the alleged work accident of February 3, 2016.

As to J, whether the medical services provided to petitioner thus far have been reasonable and necessary and whether all appropriate medial charges have been paid and/or resolved, the Arbitrator notes the following:

The Arbitrator does note that pursuant to the TTD and medical bills payment itemization (*R. Ex. 4*) introduced into evidence by Respondent at trial Petitioner's medical bills were paid by Respondent through April 4, 2016. In light of the Arbitrator's findings and opinions as to the issue of causation as listed above Respondent will not be responsible for any medical charges pertaining to treatment provided to petitioner after April 4, 2016. The Arbitrator also notes that Petitioner stipulated to Respondent's Section 8(j) credit for any and all medical bills paid on Petitioner's behalf by the group health insurance carrier.

As to K whether petitioner is entitled to any prospective medical care, the Arbitrator notes the following:

In light of the Arbitrator's findings and opinions as to the issue of causation this issue is moot. However even if that were not the case the medical care in question – MRI of Petitioner's right shoulder,

physical therapy for her lumbar spine, and epidural injections for her bilateral knees – would not be awarded. Instead the Arbitrator finds the opinions of Dr. Lieber, Respondent's Section12 examiner, to be more reasonable and adopts the same. As such the Arbitrator will not award such course of medical care to petitioner. First, the Arbitrator notes that Petitioner's complaints in regard to her bilateral shoulders seem to come and go, as she complained about her shoulders to Dr. Medavaram on some occasions but not on others.

As to Petitioner's bilateral knees, notwithstanding the Fact that it does not appear as though Dr. Wolin causally linked the same to the alleged work accident of February 3, 2016, the records clearly show that she had a history of degenerative joint disease prior to the alleged date of accident.

With regard to the course of physical therapy for Petitioner's back, the Arbitrator notes Dr. Lieber's March 23, 2016, opinion that Petitioner required only two to three weeks of physical therapy following the first Section 12 examination. Moreover it appears as though Petitioner advised Dr. Wolin that she had not had physical therapy for her alleged injuries, and she gave similar testimony at trial. This, despite the fact that the medical records introduced into evidence by Petitioner at trial clearly show that she did, in fact, undergo a course of physical therapy from March 9, 2016 through March 30, 2016, after which Petitioner simply stopped attending therapy and did not call in to the physical therapy facility to advise as to the same. As such, Petitioner was found to be non-compliant with the physical therapy program, and she was discharged from the same on or about April 7, 2016. Taking this into consideration, it is inconceivable that the Arbitrator could award physical therapy as recommended by Dr. Wolin in light of the fact that Petitioner previously, unilaterally decided not to continue to participate in the very course of physical therapy that she is now requesting.

Therefore, for the reasons cited above, no further medical benefits will be awarded.

As to L, whether petitioner is entitled to any further temporary total disability benefits, the Arbitrator notes the following:

The Arbitrator notes that Respondent's payment itemization (*R. Ex. 4*) shows that Respondent paid TTD benefits to Petitioner during the period from February 4, 2016 through April 4, 2016. Thereafter Petitioner's TTD benefits were terminated following the Section 12 examination of Dr. Lieber, i.e., that Petitioner could return to full duty with no restrictions on or after March 23, 2016. The Arbitrator adopts the opinions of Dr. Lieber in this regard and no further TTD benefits shall be awarded.

As to N, whether respondent is due any credit, the Arbitrator notes the following:

Pursuant to Joint Exhibit 1 Petitioner stipulated to receiving TTD benefits during the period from February 4, 2016 through April 4, 2016. Pursuant to Respondent's payment itemization (*R. Ex. 4*), the Arbitrator notes that the total amount of TTD paid to Petitioner during the aforementioned period is $3,763.48. The Arbitrator also notes that during the same period medical bills were paid on behalf of Petitioner by Respondent totaling $6,115.19. Accordingly, Respondent is entitled to a credit for the aforementioned amounts paid by Respondent up through the date of April 4, 2016. The Arbitrator also notes that pursuant to Joint Exhibit 1 Petitioner stipulated to Respondent's Section 8(j) credit. Therefore Respondent shall have a credit for any and all medical bills paid on Petitioner's behalf by the group health insurance carrier.

ORDER OF THE ARBITRATOR

No additional medical bills, additional TTD benefits, or prospective medical treatment shall be awarded to Petitioner as she failed to prove by a preponderance of the credible evidence that her current condition of ill being is causally connected to the accidental injury.

Deborah L. Simpson

Signature of Arbitrator

February 14.2017

Date

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Squires,

Petitioner,

vs.

NO: 15 WC 4397

Schindler Elevator,

Respondent.

17IWCC0685

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice provided to all parties, the Commission, after considering the issues of accident, causal relationship, temporary total disability benefits, medical expenses and prospective medical care and being advised of the facts and the law, modifies the Decision of the Arbitrator as stated below and otherwise affirms the Decision of the Arbitrator which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of an amount of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

Findings of Fact

The Commission affirms the Arbitrator's finding of accident occurring on January 15, 2015. Petitioner's foreman Michael Perez testified Petitioner reported his accident to him on January 15, 2015. T. 91-94, 97-98, 107-108. Superintendent Steve Probst testified Petitioner informed him on January 18, 2015 regarding the January 15, 2015 accident. T. 116-117, 135. Based on Petitioner's testimony, the testimony of those supervisors, the Illinois Form 45 dated January 28, 2015 (PX1) and the Supervisor Incident Report with Attachment dated January 27,

2015 (PX1), which verify the accident occurrence, the Commission affirms the Arbitrator's finding of accident occurring on January 15, 2015.

The Commission modifies the Arbitrator's Decision and finds Petitioner reached maximum medical improvement on August 20, 2015 and failed to prove a causal relationship for his current condition of ill-being based on the opinions of Dr. Lami.

The medical records evidence on January 22, 2015 Dr. Gitelis evaluated Petitioner who reported multiple episodes of low back pain in the past with an exacerbation over the last number of days. Dr. Gitelis noted Petitioner's vigorous job as an elevator constructor. Following his examination, Dr. Gitelis assessed recurrent low back pain and ordered a lumbar MRI. Further Dr. Gitelis prescribed a Medrol Dosepak as well as narcotic medications. On that same day, the records memorialize the pharmacy contacted Dr. Gitelis and advised Petitioner filled a prescription for narcotics two-days prior which he failed to advise Dr. Gitelis. As such Dr. Gitelis cancelled the prescription for narcotics as well as the Medrol Dosepak. PX4.

On January 23, 2015, Petitioner underwent a lumbar MRI evidencing mild intervertebral height loss and disc desiccation at L3-L4 and L4-L5 specifically at L3-L4 there was a mild diffuse disc bulge with a superimposed central disc protrusion, moderate spinal canal stenosis and no neuroforaminal stenosis, and at L4-L5 there was a mild diffuse disc bulge with a superimposed broad-based central disc protrusion and a central annular tear, mild bilateral facet joint osteoarthritis, mild spinal canal stenosis and mild bilateral neuroforaminal stenosis. The radiologist's impression was mild to moderate degenerative changes in the lower lumbar spine as detailed above, worst at L4-L5. PX4.

On January 29, 2015, Dr. Gitelis re-evaluated Petitioner and found his neurologic, motor and sensory results were all entirely normal. Dr. Gitelis reviewed the lumbar MRI scan and noted at L4-L5 facet arthritis and a broad-based central disc protrusion as well as a protrusion at L3-4 with moderate spinal stenosis. Dr. Gitelis' plan was to treat Petitioner conservatively, and to that end he ordered physical therapy and prescribed medication. Dr. Gitelis indicated he would consider an injection if Petitioner's symptoms did not resolve. Dr. Gitelis noted a discussion with Petitioner regarding his use of pain medications and thereafter felt more comfortable prescribing narcotics. PX4.

On February 12, 2015, Dr. Gitelis noted Petitioner had moderate spinal stenosis at the L4-L5 level. Petitioner reported his pain did not travel down his legs, and his symptoms were improving with physical therapy. On examination Dr. Gitelis found Petitioner's neurologic, motor and sensory of the lower extremities were normal. Dr. Gitelis continued the medications, physical therapy, and authorized Petitioner off work. PX4.

On March 5, 2015, Dr. Gitelis re-evaluated Petitioner who was clinically much better with reported decrease in back pain. Dr. Gitelis continued physical therapy, medications, and

released Petitioner to return to work at light duty with restrictions of no lifting over 15 pounds. PX4.

On March 12, 2015, Dr. Gitelis again noted the lumbar MRI evidenced disc herniation at the L3-L4 and L4-L5 levels. Dr. Gitelis memorialized a long discussion with Petitioner about pain medication and his use of the same. Dr. Gitelis concurred with limiting Norco use to four pills a day and recommended a referral to Dr. Yu for possible injections. PX4.

On April 2, 2015, Dr. Gitelis re-evaluated Petitioner who complained of right buttock pain, and Dr. Gitelis continued to recommend a referral to Dr. Yu for evaluation. On May 13, 2015, Dr. Gitelis noted on examination Petitioner's neurologic, motor and sensory were intact, but he continued to seek approval for an injection. Dr. Gitelis noted he was attempting to wean Petitioner from his pain medication. On June 16, 2015, Dr. Gitelis noted Petitioner continued to await approval for the recommended injections and renewed Petitioner's light duty restrictions. PX4.

On August 20, 2015 Dr. Lami evaluated Petitioner at the request of the Respondent pursuant to §12 of the Act. In his report of the same date (RX1), Dr. Lami noted Petitioner reported working for Respondent for four to five years with an injury to his lower back on January 15, 2015 "when he was on a ladder working overhead. He stated that he did this for eight hours. He repetitively went up and down the ladder. He does not report any particular event, fall or accident. He describes the repetitive and overhead nature of the job as the mechanism of injury. This resulted in pain to his lower back which radiated to his thoracic spine area. There is also some radiation to his buttocks." Dr. Lami noted Petitioner's treatment with Dr. Gitelis and physical therapy. Petitioner rated his current pain at 7/10, down from his initial pain of 10/10. Dr. Lami noted Petitioner localized the pain to his lower lumbar area which went across the flanks and was aching to his bilateral buttocks. Moreover, Dr. Lami noted no radiation of pain past the buttocks into the thighs, knees or ankles.

On examination, Dr. Lami noted Petitioner walked with a slight limp since the day prior; cervical, thoracic and lumbar spines were nontender to palpation; there was no spinal deformity; straight leg raises resulted in tightness in his back, but no radicular symptoms; Faber test resulted in low back pain which Petitioner described as slight; he was able to stand tippy-toe and on heels; motor examination in all lower extremity muscles were 5/5; reflexes were symmetric; sensation was intact; Petitioner flexed his lower back to only 45 degrees, extended to 20 degrees and lateral bending was to 20 degrees bilaterally. Dr. Lami reviewed records of Dr. Gitelis, U.S. HealthWorks, ATI and the January 23, 2015 lumbar MRI report as well as the films. Dr. Lami noted the lumbar MRI findings were not acute, and all were consistent with degenerative changes. RX1.

Dr. Lami diagnosed degenerative discs, mainly at the L3-L4 and L4-L5 levels. Dr. Lami opined, "The mechanism of injury at best can support a back sprain. I cannot support any aggravation or acceleration of his spinal column as a result of his employment activities of

January 15, 2015." Dr. Lami opined physical therapy was reasonable treatment. Dr. Lami noted Petitioner was taking three to four Norco 7.5 tablets per day and opined, "This amount of narcotic use for length prolonged is not well supported by subjective findings and mechanism of injury." Dr. Lami opined Petitioner was not a candidate for epidural injection, explaining Dr. Gitelis noted many times Petitioner did not complain of persistent leg pain. Dr. Lami noted epidural injections are reserved for someone with significant radicular symptoms, and Petitioner did not report any such radicular symptoms. Dr. Lami did not agree with the recommendation of epidural steroid injections and opined epidural steroid injections would not be any effect treatment for Petitioner's pain complaints. Dr. Lami opined Petitioner had reached maximum medical improvement and no further treatment was indicated. Dr. Lami also opined Petitioner should have been at maximum medical improvement within a week or two of January 15, 2015 and certainly less than a month from that injury. RX1.

In a "To Whom It May Concern" letter dated September 9, 2015, Dr. Gitelis noted, "Patient has not been able to work since 8/20/15 and will be off until further notice." It does not appear Dr. Gitelis evaluated Petitioner on September 9, 2015 as the next office note is dated September 13, 2015 where Petitioner presented with the same complaints, and Dr. Gitelis noted the same physical exam. The Commission notes Dr. Gitelis completed and signed a National Elevator Industry Health Benefits Plan Request for Extended Benefits Coverage for Participants on Extended Benefits after 1 Year on September 9, 2015 the same date of the off work note. Dr. Gitelis noted the disability period began August 6, 2015, and Petitioner was prevented from performing his occupation due to back pain, spinal stenosis, herniated disc and osteoarthritis. He noted Petitioner was still under his care for this condition and was unimproved. PX4.

On November 3, 2015, Dr. Gitelis re-evaluated Petitioner who reported attending the evaluation pursuant to §12 of the Act. Dr. Gitelis noted he reviewed Dr. Lami's report and agreed with most of his findings. Dr. Gitelis felt Dr. Lami understood Petitioner was having some back-pain complaints, but failed to appreciate such complaints extended into the left buttock. Dr. Gitelis noted Dr. Lami's agreement with his findings of moderate spinal stenosis at the L4-L5 and L3-L4 levels. Dr. Gitelis disagreed with Dr. Lami's finding of no radicular symptoms therefore no need for an injection but instead felt Petitioner suffered from sciatica which required an injection. PX4.

On December 30, 2015 Dr. Gitelis re-evaluated Petitioner whose overall symptomatology was unchanged, and he limited the pain medications to 20. Dr. Gitelis hoped the epidural steroid injections would be approved. In a "To Whom It May Concern" letter of the same date, Dr. Gitelis noted Petitioner was unable to return to work at that time. PX4.

In his evidence deposition given on April 5, 2016, Dr. Gitelis testified he is a board certified orthopedic surgeon and recited from his records as noted above. Dr. Gitelis testified Petitioner complained of low back pain and referred pain to his buttocks with a physical examination which was normal for motor or sensory deficit. PX4, p.15. Dr. Gitelis testified Petitioner suffered from low back pain and moderate spinal stenosis. PX4, p. 16. Dr. Gitelis

testified the recommended Petitioner be evaluated by Dr. Yu for possible injections but the need and type of injections would be determined by Dr. Yu. PX4, p. 20. Dr. Gitelis testified he agreed with Dr. Lami's diagnosis but disagreed with how to manage Petitioner's condition. PX4, p. 31-32.

On cross-examination, Dr. Gitelis testified he has not performed surgery to the back since 1986. PX4, p. 34. Dr. Gitelis testified to reviewing Petitioner's lumbar MRI numerous times, and it evidenced findings consistent with degenerative changes as opposed to acute findings. PX4, p. 34-35. Dr. Gitelis testified he agreed with Dr. Lami's diagnosis of degenerative arthritis meaning spinal stenosis at the L3/L4 and L4/L5 levels. Px4, p 45-46. Dr. Gitelis was not aware of Petitioner's current medical condition, having last seen him on December 30, 2015. PX4, p 50. Dr. Gitelis did not know if Petitioner was currently treating with another physician, and it was possible Petitioner's condition could have improved in the four months since he last saw Petitioner and that his work status might have changed. PX4, p 51. Dr. Gitelis opined Petitioner would not be a surgical candidate until every conservative mechanism was tried to relieve his pain complaints. *Id.* Dr. Gitelis testified an epidural steroid injection would reduce inflammation of the nerve and therefore can help with radiculopathy. PX4, p 55.

In his evidence deposition given on May 5, 2016, Dr. Lami testified he is a board certified orthopedic surgeon with a spine subdivision. Dr. Lami recited from his report as noted above. Dr. Lami testified he performed a physical examination of Petitioner which included the straight leg raising test which resulted in complaints of tightness in the back but no radicular symptoms. RX2, p. 17. Dr. Lami explained the purpose of the straight leg test as well as it subjective nature. RX2, p 18. Dr. Lami testified Petitioner did not exhibit symptoms of radiculopathy as such symptoms would be shooting pain to the ankle and foot. *Id.* Following the physical examination and review of records including review of the MRI films, Dr. Lami testified as to his diagnosis- a low back strain. RX2, p. 22.

Dr. Lami testified Petitioner did not report radiculopathy but instead reported pain in his midback, lower back and bilateral buttock. RX2, p 24. Dr. Lami explained buttock pain does not mean radiculopathy as radiculopathy is a pain in a particular nerve distribution which corresponds to MRI findings. *Id.* Dr. Lami testified a person can exhibit buttock pain from muscles, ligaments and referred pain from the back. RX2, p 25. When Dr. Lami personally reviewed Petitioner's lumbar MRI scan, he did not see any compromise of any nerves. *Id.* Mild stenosis and moderate stenosis are common findings, but the question is whether there is compromise of the neuro-elements. *Id.* Dr. Lami noted he did not see any compromise of neuro-elements on Petitioner's lumbar MRI, and further Petitioner's subjective complaints were not consistent with compromise of the nerves. RX2, p 25-26. Dr. Lami was aware of the recommendation for epidural steroid injections but felt such treatment would not relieve Petitioner's pain. *Id.*

Dr. Lami testified to his knowledge of Dr. Gitelis' recommendation for epidural steroid injections but further understood Dr. Gitelis was not necessarily recommending injections *per se*

but a referral to Dr. Yu for his evaluation and recommendations for pain management. RX2, p.29. Dr. Lami testified he did not agree with a referral to pain management as it was unnecessary. RX, p. 29-30. Dr. Lami testified he would recommend weaning Petitioner from opioid medications as prolonged use was detrimental to his health. RX, p. 32-33. Dr. Lami testified Petitioner should have been at MMI one or two weeks from the injury and certainly within a month of injury and required no work restrictions. RX, p. 35-36.

On cross-examination, Dr. Lami testified he personally reviewed the MRI films, and in his opinion Petitioner's symptoms were not related to a work injury regarding the bulging discs at L3-L4 and L4-L5. RX2, p 37, 42. Dr. Lami opined a L3-L4 disc bulge superimposed on the central protrusion can possibly cause low back pain. RX2, p 38-39. Dr. Lami opined a disc bulge is not caused by traumatic event as it is a degenerative finding. RX2, p 39. Dr. Lami opined lifting can cause L3-L4 to be symptomatic. RX2, p 40. Dr. Lami acknowledged a person can aggravate a preexisting condition of spinal stenosis and explained if there is stenosis of the L4 nerve, the pain starts in the back and radiates all the way to the anterolateral aspect of the thigh and down to the medial aspect of the ankle. RX2, p 44-45. Dr. Lami noted at L4-L5 level, Petitioner has a mild diffuse bulge superimposed broad-based disc protrusion and opined for most people, there are no symptoms of this, but back pain is possible. RX2, p 49-51. Dr. Lami opined most annular tears are caused as degenerative processes, but trauma can cause annular tears; a person could have back pain or no pain. RX2, 51-53. Petitioner did have pain in the L4-L5 area, among other areas. RX2, p 53.

On September 13, 2016, Dr. Gitelis re-evaluated Petitioner who complained of an exacerbation of his low back pain. On examination, Petitioner's deep tendon reflexes were +2 and equal; motor was 5/5 and sensory was intact to sharp touch; there was no pain with range of motion of his hips, knees or ankles. In a "To Whom It May Concern" letter of the same date, Dr. Gitelis noted Petitioner was under his care and was unable to return to work at that time. PX4.

Conclusions of Law

The Commission finds the Petitioner failed to prove a causal relationship between his accident of January 15, 2015 and his current condition of ill-being and need for treatment. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith Corporation v. The Industrial Commission*, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972).

The Commission weighs the competing medical opinions of Dr. Lami and Dr. Gitelis and affords greater weight to the opinions of Dr. Lami finding such opinions more persuasive. The January 23, 2015 lumbar MRI evidenced no compression of Petitioner's spinal nerves. Dr. Lami reviewed the lumbar MRI films which evidenced no compression of the spinal nerves. Dr. Lami

explained in detail the anatomically process which leads to radiculopathy i.e. compression on the nerves. Dr. Lami further explained Petitioner's symptoms did not correspond to radicular symptoms nor did the MRI evidence nerve compression. Dr. Lami additionally explained an epidural steroid injection would provide no benefit to Petitioner as his pain complaints did not stem from a compressed nerve. Instead Dr. Lami diagnosed a low back strain and recommended Petitioner wean from his narcotic medication and continue strengthening his core muscles.

Dr. Gitelis agreed with Dr. Lami's diagnosis of degenerative arthritis/spinal stenosis based on the lumbar MRI findings. Dr. Gitelis opinioned Petitioner's complaint of pain in his buttocks might be radicular pain but conceded in his deposition, during the multiple examinations of Petitioner, he noted such finding on a single occasion. Further Dr. Gitelis conceded he was not recommending epidural steroid injections at the time of his deposition but merely a referral to Dr. Yu who would determine the need and type of injection. Additionally, in Dr. Gitelis' records he indicates a concern regarding Petitioner's continued use of narcotic medication, and the Commission notes the same.

The Commission finds Dr. Lami's opinions are grounded on objective findings and medical science whereas Dr. Gitelis' opinions are speculative at best. Petitioner suffered a low back strain and reached maximum medical improvement as of August 20, 2015.

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). Petitioner sustained a back strain due to his accident of January 15, 2015 with maximum medical improvement being reached by August 20, 2015. As such all treatment rendered after August 20, 2015 is neither reasonable nor necessary nor is it causally related to Petitioner's accident. The Commission vacates the Arbitrator's award of prospective medical care.

Regarding specific medical expenses, the Commission modifies the Arbitrator's award to vacate the medical bills incurred after August 20, 2015. The medical bills are evidenced in PX8. The Commission awards the following medical bills pursuant to §8(a) and §8.2:

1) Orthopedic & Spine Surgery in the amount of $3,896.00 which includes billing for the MRI;
2) ATI Physical Therapy in the amount of $14,150.26.

Medical bills payment itemization, RX7, evidences medical payments of $6,042.39, which included payments for medical case management. The Arbitrator provided Respondent an §8(j) credit of $6,042.39. However, at the arbitration hearing Respondent's attorney indicated based upon the medical bill exhibit, PX8, the group health carrier did not make any payments. Therefore, Respondent was not claiming any specific credit pursuant to §8(j) of the Act. T. 5.

17IWCC0685

The Commission vacates the §8(j) credit of $6,042.39. RX7 evidences payments to Orthopedic & Spine Surgery and ATI Physical Therapy in the amount of $3,988.74, and Respondent is provided credit for this amount. The Commission affirms the Arbitrator's finding not to award Respondent credit for medical case management payments also reflected in RX7.

"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. Petitioner reached maximum medical improvement as of August 20, 2015 and was able to work full duty. As such, no temporary total disability benefits are awarded beyond August 20, 2015. The parties stipulated Petitioner was temporarily totally disabled for the period from January 26, 2015 through March 5, 2015. T. 6-7. Petitioner testified he returned to work light duty on March 11, 2015 through April 29, 2015. T. 32-33. Petitioner was not provided work within his restrictions after April 29, 2015, but Respondent continued his usual and customary rate of pay through August 12, 2015 with an additional payment in the amount of $942.85 on January 15, 2016. T. 34, 82. Petitioner reached maximum medical improvement on August 20, 2015. Therefore, the Commission modifies the Arbitrator's temporary total disability award and awards TTD benefits from January 26, 2015 through March 5, 2015 (a period of 5-4/7 weeks) and from August 13, 2015 through August 20, 2015 (a period of 1-1/7 weeks). The total award is 6-5/7 weeks. Respondent is provided credit of $7,740.93 for TTD benefits paid.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's November 18, 2016 decision is modified for the reasons stated herein and otherwise affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,330.66 per week for a period of 6-5/7 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act and as provided in §19(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $18,046.26 for reasonable, necessary and related medical expenses 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 the Arbitrator's award of §8(j) credit is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of prospective medical care is vacated.

17IWCC0685

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 $7,740.93 in TTD benefits and $3,988.74 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, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 30 2017
LEC/maw
o08/30/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

SQUIRES, ROBERT
Employee/Petitioner

Case# **15WC004397**

SCHINDLER ELEVATOR
Employer/Respondent

17IWCC0685

On 11/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1727 LAW OFFICES OF MARK N LEE LTD
1101 S SECOND ST
SPRINGFIELD, IL 62704

0560 WIEDNER & McAULIFFE LTD
PATRICK J MORRIS
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
19(b)

Robert Squires
Employee/Petitioner

v.

Schindler Elevator
Employer/Respondent

Case # **15 WC 4397**

Consolidated cases: D/N/A

17IWCC0685

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **October 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **01-15-15**, 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 **$103,793.56**; the average weekly wage was **$1,996.00**.

On the date of accident, Petitioner was 33 years of age, ***married*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$7,740.93** for **TTD**, $0 for TPD, $0 for maintenance, and **$0** for other benefits, for a total credit of **$7,740.93**. Respondent paid TTD from 1/26/15 – 3/5/15. Arb Exh 1.

Respondent is entitled to a credit for **$6,042.39** paid under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner reasonable and necessary medical expenses in the amount of $16,406.67 (PX 8), as provided in Sections 8(a) and 8.2 of the Act. As against this award, Respondent is entitled to credit for the payments totaling $3,988.74 it made to Orthopedic Spine Surgery and ATI, per RX 7.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, a return visit to Dr. Gitelis along with the pain management referral and injections Dr. Gitelis previously recommended.

Respondent shall pay temporary total benefits at the rate of $1,330.66 per week from 8/13/15 through 10/14/16, a period of 61 1/7 weeks.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason

Signature of Arbitrator

NOV 18 2016

11/18/16
Date

Robert Squires v. Schindler Elevator
15 WC 4397

17IWCC0685

Summary of Disputed Issues

Petitioner, an elevator mechanic, alleges a back injury of January 15, 2015. The disputed issues include accident, causal connection, medical expenses, temporary total disability (from August 13, 2015 through the hearing of October 14, 2016) and prospective care in the form of injections.

Arbitrator's Findings of Fact

Petitioner testified he has been a member of Local 2, the elevator construction union, for more than ten years. T. 14. He began working as an elevator mechanic for Respondent three years before his claimed accident of January 15, 2015. [A job application in PX 1 reflects a hire date of July 18, 2012.] He described his job with Respondent as "very physical." T. 15. His duties included hanging pipe while working off of a ladder.

Petitioner acknowledged having some low back problems before his claimed accident. He characterized these problems as "a couple small things." T. 16. He testified he saw Dr. Marian, his personal care physician, for these problems. He maintained that Dr. Marian never restricted his activities. He also saw a local chiropractor on one occasion. He could not recall the name of this chiropractor. T. 16-18.

Dr. Marian's records reflect that Petitioner, a "new patient," consulted her on February 8, 2011 due to severe, non-radiating low back pain of one day's duration. She noted that Petitioner reported being unable to get out of bed that morning. She also noted that Petitioner "works in construction" and "lifts weights a lot during the day." On examination, the doctor noted paraspinal muscle spasm in the lumbar spine and positive straight leg raising bilaterally at 45 degrees. She assessed Petitioner as having "low back pain, likely secondary to a herniated disc." She administered a Toradol injection and prescribed a Medrol Dosepak, Flexeril (to be taken at night) and Norco "for breakthrough pain." She directed Petitioner to return in a week or two. She addressed restrictions as follows: "He did not want to take off from work. He was recommended to avoid lifting weights." PX 3. RX 4, pp. 4-5.

Petitioner saw Dr. Marian again on March 20, 2013, with the doctor noting complaints of a sore throat, left shoulder pain and occasional low back pain. She indicated that Petitioner expressed a desire to have some medication, "like Norco," at home that he could use when he experienced pain. With respect to the back, she prescribed "some Norco 30 tablets to use as needed" and "some Flexeril 10 mg at night." There is no indication she imposed restrictions. PX 3. RX 4, pp. 16-17, 25.

Petitioner returned to Dr. Marian on August 19, 2013, with the doctor noting complaints of left-sided chest pain, shoulder pain and low back pain "for which he was given medication repeatedly in the past." The doctor noted that Petitioner reported working long hours and seeing a chiropractor. With respect to the back, she referred Petitioner to an unidentified spine specialist and prescribed a tapering dose of Prednisone and a muscle relaxant. There is no indication she imposed restrictions. PX 3. RX 4, pp. 31-33.

Petitioner testified he was fully able to perform his usual duties for Respondent prior to the accident. RX 9, a wage verification document, reflects that Petitioner grossed $174,302.15 in 2014. RX 9 also shows that Petitioner worked 60 or more hours per week in eleven weeks in 2014.

Petitioner testified his duties on January 15, 2015 consisted of climbing up and down an eight-step ladder all day and working overhead while running two kinds of pipe (2- inch and 2 ½-inch) from an elevator motor to a machine room. T. 19. He had to lean the ladder at an angle in order to run the pipe. When he got to the top of the ladder he had to turn backward in order to perform the installation. T. 19-20. He worked alone that day but his job foreman, Michael Perez, who was working nearby, "popped in and out" at various points. T. 23.

Petitioner testified his low back became "real sore" while he was working on January 15, 2015. The pain he experienced that day was "way more intense" than the pain he had experienced on prior occasions. T. 22. During the day, he told Perez he was experiencing back pain due to the lifting and twisting he engaged in while installing the pipe. T. 23.

Petitioner identified a document in PX 2 as a mandatory general contractor form that was completed concerning his injury on January 15, 2015. Petitioner testified he did not complete this form but initialed it. T. 24.

Petitioner testified his back pain worsened after he arrived home on the evening of January 15, 2015. After sitting for a while, while eating dinner, he stood up and experienced intense back pain. He was not holding anything when he stood up. He does not consider getting up from the table to be an accident. T. 25-26.

Petitioner testified he reported to work the following day, January 16, 2015, a Friday. At that point he felt "awful" and could barely work. T. 26. He left work after six hours. T. 26. On Sunday, January 18, 2015, he called the job superintendent, Steve Probst, and told him he hurt his lower back while climbing up and down a ladder and installing pipe. T. 28. He also told Probst he was experiencing a lot of back pain and needed to see a doctor. At some point thereafter, Probst got back to him and directed him to seek treatment at U.S. Healthcare.

Petitioner testified that the first medical provider he saw after the accident was Dr. Marian. T. 29. The doctor's note of January 20, 2015 sets forth the following history:

> "A 32-year-old male patient comes in for evaluation of severe intractable low back pain located in the middle of his lumbar spine. Intensity is moderate to severe depending on his activity level or position. Any change in position will trigger the pain. The pain started about 3 days ago. He used some Norco he had at home from previous episodes of low back pain. He does work as a mechanic and lifts heavy stuff. The pain started after he stood up from the chair from the dining table."

Dr. Marian described Petitioner's gait as antalgic. On examination, she noted tenderness in the lumbosacral area and a decreased range of lumbar spine motion. She administered a Toradol injection. She prescribed a tapering dose of Prednisone, a muscle relaxant, Norco and physical therapy. She

issued a note indicating Petitioner missed work from January 16, 2015 through January 22, 2015 due to medical reasons. PX 3. RX 4, pp. 49-50.

During direct examination, Petitioner reviewed Dr. Marian's January 20, 2015 history and testified his pain did not start when he stood up at home. His pain "started at work." He did not specifically mention the ladder-related activity to Dr. Marian because he had already reported his work accident to Perez and Probst and had been directed to see a doctor of Respondent's selection. T. 29-30.

On January 22, 2015, Petitioner saw Dr. Gitelis, an orthopedic surgeon. The doctor's certified records contain a two-page "medical history form" dated January 22, 2015. This form reflects a complaint of back pain and sets forth the following handwritten history of injury: "got up from kitchen table and pulled something." Petitioner acknowledged writing this history on the form but testified his accident actually occurred while he was working off of the ladder, installing pipe. T. 30-31.

In his typed note of January 22, 2015, the doctor recorded the following history:

> "He has had multiple episodes of low back pain. He is 32 years of age. He says it has been about twice a year for the last 3 years. He does a vigorous job as an elevator constructor. He comes in today with exacerbation over the last number of days."

On examination, Dr. Gitelis noted intact sensory and back pain with straight leg raising. He obtained lumbar spine X-rays. He interpreted the films as showing some disc space narrowing at L5-S1. He felt that Petitioner's pain "could be related to a disc herniation." He prescribed a Medro Dosepak and Norco, along with a lumbar spine MRI. He directed Petitioner to rest and apply warm packs to the affected area. [The doctor later cancelled the medication prescription, after learning from a pharmacy that Petitioner had obtained pain medication from a physician two days earlier. He indicated this made him suspect drug-seeking behavior.]

The lumbar spine MRI, performed on January 23, 2015, showed mild diffuse disc bulging at L3-L4, with a "superimposed central disc protrusion" and moderate stenosis, and mild diffuse disc bulging at L4-L5, "with a superimposed broad-based central disc protrusion and a central annular tear." PX 4.

On January 26, 2015, Petitioner underwent care at U.S. Healthworks in Schiller Park. The note of that date is jointly authored by a physician's assistant and a physician, Dr. Garala.

The note sets forth a consistent account of the January 15, 2015 work injury. It also reflects that, on the night of the injury, after completing work, Petitioner experienced "increased lower back pain" when he "stood up from the dining room table." The note further reflects a history of "previous back strains that have been treated with medicine only."

The note accurately describes the post-accident treatment rendered to date, with Petitioner indicating he saw his personal care physician on January 20th and Dr. Gitelis thereafter and was currently taking Prednisone, a muscle relaxant and Norco.

The providers at U.S. Healthworks noted a complaint of constant 5/10 lower back pain that worsened with prolonged positioning. They also noted that Petitioner denied radicular symptoms.

They described Petitioner's posture as antalgic and noted he appeared to be in pain, particularly when changing position. They noted tenderness over the lower lumbar spinous processes and paraspinal musculature. They indicated Petitioner stood in a slightly forward flexed position and would not extend backward. Straight leg raising was significant for lower back pain and negative for radicular symptoms.

The providers diagnosed a lumbar strain and lumbar paraspinal muscle spasm. They released Petitioner to seated work only with "allowances to stand, stretch and walk as needed." They indicated Petitioner should complete his Prednisone taper, continue the muscle relaxant and reserve Norco for severe pain. They directed Petitioner to return on February 3, 2015. PX 6. The providers indicated they left a detailed message with Dave Vanderpool concerning causation, diagnoses, prognosis and work status. PX 6.

Petitioner returned to Dr. Gitelis on January 29, 2015. In his note of that date, the doctor described his neurologic, motor and sensory examination as entirely normal. The doctor reviewed the MRI results with Petitioner and prescribed Meloxicam and Hydrocodone. He indicated he felt more comfortable prescribing pain medication "because [Petitioner] has clear-cut pathology to his back [and] a clear-cut mechanism of injury with his back." He released Petitioner to a "sit-down job" and recommended that Petitioner return to him in two weeks. He addressed the etiology of Petitioner's complaints as follows:

> "It should be noted that he is an elevator operator and he lifts heavy devices and that started his most recent episode when he lifted. He has the underlying pathology but he certainly exacerbated by lifting at his place of work and that would be his spinal stenosis and arthritis and disc herniation at L3-L4 and L4-L5."

PX 4.

Petitioner testified he received temporary total disability benefits from January 26 through March 5, 2015. T. 32. Between March 11 and April 29, 2015, he performed light duty at Respondent's office, per the restrictions imposed by U.S. Healthworks. T. 32-33. The light duty consisted of filing paperwork. T. 33. He could sit or stand while performing this work. T. 33.

Petitioner testified that Respondent last provided him with light duty on April 29, 2015. He would have continued to perform light duty had Respondent continued to provide it. T. 33-34. He has not worked in any capacity since April 29, 2015. Dr. Gitelis has never lifted his restrictions. His condition has not improved. He still experiences low back pain as well as shooting pain in his legs. He has a newborn daughter and cannot lift her. Dr. Gitelis has referred him to a physician for pain management and injections. He has not yet seen this physician due to lack of authorization. T. 34-36.

Petitioner identified the documents in PX 8 as bills relating to his medical care. He does not know whether these bills have been paid. T. 36.

Under cross-examination, Petitioner admitted seeing Dr. Marian for low back pain in February 2011. T. 37. He did not recall telling the doctor he was unable to get out of bed or walk due to the severity of this pain. T. 39-40. He also did not recall being told the doctor felt his pain was "likely secondary to a herniated disc." He would have seen a specialist had he been told this. T. 42. He

recalled Dr. Marian prescribing more Norco and Flexeril for low back pain on March 20, 2013 but did not recall telling the doctor his symptoms returned as soon as he stopped taking this medication. T. 44-45. The chiropractor he saw before his claimed accident had an office near his home. He found this chiropractor by looking in the Yellow Pages but cannot recall the chiropractor's name. He was living in Chicago at the time he saw this chiropractor. T. 45-47.

Petitioner testified he was "running" EMT pipes as well as raceways at the site where the accident occurred. T. 48-49. A raceway is a metal channel. Together, the duct, piping and Unistrut weighed 60 to 70 pounds per combined unit. T. 51. He did not have a helper. Mike Perez was "in and out" but he (Petitioner) was the one carrying the combined units up the ladder. T. 51. The piping he lifted came in 10-foot-long pieces, with each piece weighing 10 to 20 pounds, depending on the diameter. He had to cut a few of the 10-foot raceways to create a 90-degree angle. T. 53. He was running the combined duct, piping and Unistrut a distance of 60 feet from the elevator car to the motor. T. 50.

Petitioner testified his normal workday as of the accident was 8 hours long. He was technically allowed to take lunch and breaks but believes he skipped lunch on January 15, 2015. T. 56. He did take bathroom breaks that day. T. 56. He began experiencing low back pain in the afternoon. The pain worsened over time. T. 57. He told Perez his back was bothering him due to the work activities he was performing. T. 57. The next day, January 16, 2015, a Friday, he "limped around" and left early. It was not customary for workers to leave early on Fridays. He left early that day due to his back pain. T. 58. When he called Probst on Sunday, January 18, 2015, he told him he hurt his back at work and would not be in to work the next day. T. 59. He called Probst again on January 20th to say he was experiencing low back pain due to the accident and could not resume working. T. 60-61.

Petitioner disagreed with part of the history that Dr. Marian recorded on January 20, 2015. His pain did not start when he stood up at home, although his back was "getting more stiff" at that point. T. 62.

Petitioner testified his parents referred him to Dr. Gitelis. His parents had previously treated with physicians who were in the same practice. T. 65-66. He was honest and truthful with Dr. Gitelis as to how he injured his back. T. 66. He acknowledged completing and signing a history form on January 22, 2015 indicating he "got up from the kitchen table and pulled something." The form had another line that he could have used to expand on this information but he did not write anything on this line. The form also had a section in which he could have listed an onset or accident date. He left this section blank. In the section concerning medications, he wrote "Norco" but he had not been taking Norco on a regular basis since February 2011. T. 66-71. He took it regularly for a while and stopped when he felt better. During the couple of years before the accident, he probably took Norco three times. T. 72. He still takes Norco but did not take it on the morning of the hearing. He only took aspirin and Aleve. T. 72.

Petitioner denied having leg pain during the interval following the accident. His leg pain started about a year before the hearing. It is intermittent and can be in either leg or both. T. 73-76.

Petitioner denied seeing a female physician's assistant at U.S. Healthworks on January 22, 2015. He saw a male physician that day. He told this physician about both his work tasks and getting up from a chair. T. 77-78.

On February 2, 2015, Petitioner began a course of physical therapy at ATI. The evaluating therapist noted a date of injury of January 15, 2015. She recorded the following history: "Pt was at work and doing overhead piping. Noticed discomfort at end of his day. Discomfort did not improve so saw his MD. Did report to his boss and was examined." She also noted that Petitioner previously worked as an elevator mechanic, with that job requiring a heavy physical demand level. PX 4.

Petitioner testified the therapy he underwent at ATI did not provide lasting relief. He experienced only transient relief from the massages and E-stimulation he underwent at therapy.

On February 12, 2015, Dr. Gitelis issued another note keeping Petitioner off work. PX 4.

Therapy notes dated February 12, 18, 19, 20, 23 and March 3, 2015 reflect that Petitioner reported improvement but remained symptomatic. The note of March 3, 2015 reflects Petitioner reported the onset of pain after walking for about 20 minutes. PX 7.

On March 5, 2015, Petitioner returned to Dr. Gitelis, with the doctor describing him as "much better clinically." The doctor re-reviewed the MRI with Petitioner and prescribed additional therapy, as well as an evaluation by Dr. Yu to see whether Petitioner would benefit from injections. He renewed the Norco prescription and advised Petitioner to limit his intake to four per day. He released Petitioner to light duty as of March 11, 2015, with no lifting over 15 pounds and with the proviso that he continue attending therapy. PX 4.

At the next visit, on April 2, 2015, Dr. Gitelis noted that Petitioner complained of right buttock pain and had not yet been able to undergo an injection. He again recommended an evaluation by Dr. Yu. PX 4.

On May 13, 2015, Dr. Gitelis noted complaints of occasional leg pain. He updated the injection prescription and renewed the Norco. PX 4.

On June 16, 2015, Dr. Gitelis noted that the recommended injections still had not been approved. He released Petitioner to seated work with no lifting over 10 pounds as of June 17th. PX 4.

Petitioner was discharged from physical therapy on July 31, 2015, with the therapist indicating Petitioner reported he was still having pain if he did too much and was also having difficulty sleeping. PX 7.

On September 9, 2015, Dr. Gitelis issued a note indicating Petitioner had been unable to work since August 20th and "will be off until further notice." PX 4.

In a note dated November 3, 2015, Dr. Gitelis indicated he had reviewed the IME report. He stated he agreed with most of the IME's findings but disagreed with the IME's conclusion that Petitioner was not a candidate for epidural injections. He opined that Petitioner "is having sciatica" and has "clear cut pathology." He indicated he hoped to avoid surgery and again recommended an epidural injection. PX 4.

On December 30, 2015, Dr. Gitelis noted that Petitioner was self-limiting his Norco intake. He prescribed 20 Norcos and again recommended the injections. He continued to keep Petitioner off work. PX 4.

Dr. Gitelis testified by way of evidence deposition on April 5, 2016. Dr. Gitelis testified he initially practiced general orthopedics. After he underwent fellowship training, he started also performing minimally invasive surgery, including arthroscopies. PX 4 at 6-7. Gitelis Dep Exh 1.

Dr. Gitelis testified he briefly met with Petitioner's counsel before the deposition. During that meeting, he looked at records from U.S. Healthworks and ATI Physical Therapy. PX 4 at 8.

Dr. Gitelis testified he first saw Petitioner on January 22, 2015. Petitioner completed a history form on that date, indicating he works as an elevator constructor and pulled something in his back when he got up from his kitchen table. In his note of January 22, 2015, he indicated that Petitioner reported having multiple episodes of low back pain, performing a vigorous job and experiencing an exacerbation over the last few days. PX 4 at 9. On examination, he noted no neurological deficits. Petitioner guarded his back and did not want to bend. Straight leg raising caused pain on the right side. PX 4 at 10. X-rays showed disc space narrowing at the lower back, "reflective of arthritis." His impression was "recurrent low back pain." PX 4 at 10. He told Petitioner his pain could be due to a disc herniation. He prescribed pain medication. He did not impose restrictions. PX 4 at 11-12.

Dr. Gitelis testified that, at the next visit, Petitioner provided a clear-cut mechanism of injury, i.e., lifting. He does not know what Petitioner lifted or whether Petitioner was at work when he performed the lifting. PX 4 at 12-13. He recommended an MRI. The MRI showed evidence of bulging at two levels, L3-L4 and L4-L5. It also showed a central disc protrusion at L4-L5. Petitioner complained of low back pain as well as "some referred pain towards his right buttock area." PX 4 at 15.

Dr. Gitelis testified that, when he saw Petitioner on March 5, 2015, he reviewed the history and noted that Petitioner reported lifting 50 pounds at work and later feeling something pull when he got up from the dinner table. It was his impression that the injury resulted from the lifting. PX 4 at 18. He imposed light duty, with no lifting over 15 pounds. He has never released Petitioner to full duty. PX 4 at 18. He later referred Petitioner to Dr. Yu, a "very superb pain doctor," to see whether injections would be appropriate. It would be up to Dr. Yu to determine what kind of injections would be appropriate for Petitioner. PX 4 at 20-21. Petitioner later complained of right buttock pain. "Whenever you start talking about buttock pain, you're talking about radiculopathy," i.e., irritation of the sciatic nerve. As of June 16, 2015, the injections had not been approved. He released Petitioner to seated work. He is still of the opinion that Petitioner should be restricted to seated work. Petitioner never told him he was carrying items on his shoulder or working overhead off of a ladder. Petitioner simply told him he was lifting around 50 pounds. Lifting that weight could exacerbate low back pain with the pathology shown on Petitioner's MRI. PX 4 at 27-29.

Dr. Gitelis testified he never felt that Petitioner was dishonest or magnifying his symptoms. Petitioner's pathology was "there on the MRI." PX 4 at 30.

Dr. Gitelis testified he does not disagree with Dr. Lami's diagnosis but, unlike Dr. Lami, he believes Petitioner needs to be evaluated, injection-wise, because he showed signs of radiculopathy and other conservative measures were not helping. PX 4 at 31. As for Dr. Lami's opinion that Petitioner should have reached maximum medical improvement within a week or two of the accident, he has had "many, many, many patients with back pain and some just don't get better." He does not believe it is okay to send someone with underlying pathology back to work. PX 4 at 32.

Under cross-examination, Dr. Gitelis testified he performs knee and shoulder surgery. He performed spine surgery when he first started his practice but has done no back surgery since 1986. PX 4 at 34. He agrees that Petitioner's MRI shows degenerative changes at two levels. It is possible that all of the findings on Petitioner's MRI are degenerative in nature. PX 4 at 36. It is Petitioner who wrote on the initial intake form that he felt back pain when he got up from the kitchen table. PX 4 at 36. He did not write that his pain started at work. PX 4 at 37. It was in his note of March 5, 2015 that he indicated Petitioner reported lifting 50 pounds at work. PX 4 at 41. Petitioner used the word "repetitive" to describe the lifting he performed on the job. PX 4 at 42. It was when he met with Petitioner's counsel, just before the deposition, that he became aware of what Petitioner was expected to testify to at a trial. PX 4 at 45.

Dr. Gitelis testified he did not observe drug-seeking in Petitioner in that he never received reports from a pharmacy that Petitioner was receiving opioids from several doctors. With all of his patients, he worries about them getting on and off pain medication. PX 4 at 48. Petitioner called him at some point to request pain medication. At that time, he was prescribing Norco. Petitioner also took Tramadol until he developed some issues with nausea. PX 4 at 49-50. He last saw Petitioner on December 30, 2015 and is not aware of Petitioner's current physical condition. PX 4 at 50. It is possible that Petitioner has improved. If so, it would be reasonable to change his work restrictions. PX 4 at 51. In his opinion, Petitioner "would not be a surgical candidate until every conservative mechanism that is reasonable" has been tried. PX 4 at 52. It was on one particular date that Petitioner exhibited radicular symptoms. At a later date, Petitioner did not. PX 4 at 53-54. He wanted Petitioner to be evaluated by Dr. Yu to see if his pain could be reduced. PX 4 at 55. If Petitioner, hypothetically, performed no lifting but had pre-existing complaints, simply getting up from a table could cause the kind of pathology shown on his MRI. PX 4 at 55-57.

On redirect, Dr. Gitelis opined that "it's much more likely that you would get an exacerbation of underlying pathology by the lifting mechanism that [Petitioner] described than by just getting up from a kitchen chair." PX 4 at 57. His opinions concerning treatment needs and work restrictions have not changed. PX 4 at 58.

Dr. Lami testified by way of evidence deposition on May 5, 2016. Dr. Lami testified he is board certified in orthopedic surgery. He underwent fellowship training in spine surgery. RX 2 at 5. On an annual basis, he sees between 3,000 and 3,500 patients, performs 200 independent medical examinations and performs 100 to 200 spine surgeries. RX 2 at 9-10.

Dr. Lami testified he examined Petitioner on August 20, 2015 and generated a report thereafter. Lami Dep Exh 2. He has no independent recollection of the examination. RX 2 at 12-13. Petitioner did not provide a history of a specific event. Rather, he indicated he injured his back on January 15, 2015 due to repetitive ladder usage and overhead work. RX 2 at 15-16.

Dr. Lami testified Petitioner displayed a slight limp and told him he had started limping the day before the examination. RX 2 at 16. Straight leg raise testing resulted in back tightness but no radicular symptoms. RX 2 at 17. A patient has to have pain shooting down to his feet in order for straight leg raise testing to be considered positive. RX 2 at 18. The testing is somewhat subjective because the results depend on a patient's report. RX 2 at 18. Petitioner was able to stand on his heels and toes. Sensation was intact. Petitioner could flex forward only to 45 degrees. Extension and side bending were also slightly limited. RX 2 at 20.

Dr. Lami testified he reviewed records from the following providers: U.S. HealthWorks and ATI Physical Therapy. He also reviewed images and a report concerning a January 23, 2015 lumbar spine MRI and the deposition testimony of Dr. Gitelis. RX 2 at 21.

Dr. Lami testified that, based on the MRI, he diagnosed degenerative disc disease, mainly at L3-L4 and L4-L5. In his opinion, the work accident caused, at best, a back strain. The work accident did not aggravate or accelerate the underlying degenerative condition. RX 2 at 22. The mechanism of injury that Petitioner described did not support anything more than a sprain and the MRI showed no traumatic findings. RX 2 at 23. Additionally, Petitioner had no neurological deficit. RX 2 at 23. Petitioner did complain of buttock pain but, to him, "buttock pain doesn't mean radiculopathy." Radiculopathy "is a pain in a particular nerve distribution which corresponds to MRI findings." RX 2 at 24, 26. In his opinion, Petitioner should not undergo epidural steroid injections because such injections will not help the kind of mechanical back pain Petitioner has. RX 2 at 26. Petitioner complained of pain in his lower back, mid-back and both buttocks. RX 2 at 27. Even if you assume Petitioner has "incomplete radiculopathy," his pain "doesn't go all the way to his butt," based on the pain diagram he completed. RX 2 at 28. He would not agree with interventional pain management for Petitioner regardless of causation. Petitioner is taking too many narcotics, in his opinion, but he does not need to see a pain physician to wean off those narcotics. RX 2 at 30. Petitioner reported taking three to four 7.5 Norco tablets daily. Norco is an opioid. He would not prescribe this kind of dosage for a non-cancer patient on a chronic basis. RX 2 at 32. While the accident might have caused a sprain, resulting in thoracic and lumbar spine pain, that would not still be creating symptoms in August 2015. RX 2 at 34.

Dr. Lami opined that Petitioner requires no work restrictions as a result of the January 25, 2015 accident. RX 2 at 35. He acknowledged he has no information as to the weight of the items Petitioner regularly lifted. Petitioner simply described his job as very heavy. RX 2 at 36.

Dr. Lami opined that Petitioner should have reached maximum medical improvement within a week or two of the accident and, at most, within a month of the accident. RX 2 at 36.

Under cross-examination, Dr. Lami acknowledged that a degenerative disc can be symptomatic. In his opinion, a disc bulge cannot be caused by the type of work Petitioner performed on January 15, 2015. Lifting could, however, cause L3-L4 to become symptomatic. RX 2 at 40. A traumatic event could aggravate pre-existing stenosis but Petitioner did not describe a traumatic event. RX 2 at 44. For most people, mild diffuse bulging at L4-L5 superimposed on a broad-based protrusion will not create symptoms. A bulge at that level could "possibly" cause pain. Annular tears can result from trauma but "most of them are degenerative." RX 2 at 52. An annular tear can cause pain or be asymptomatic. RX 2 at 53. Pain in the buttocks can be caused by an SI joint problem or by referred back pain. Hip arthritis can also cause buttock pain. A degenerative stenosis at L3-L4-L5-S1 can also cause buttock pain. RX 2 at 54-55.

On redirect, Dr. Lami testified that the MRI findings of January 21, 2015 were not significant enough to prompt someone to expect that Petitioner would still be symptomatic in August 2015. RX 2 at 55.

Under re-cross, Dr. Lami testified he would have prescribed a maximum of one month of physical therapy had Petitioner been his patient. RX 2 at 56. If Petitioner had still been symptomatic after undergoing therapy for a month, he would have told him that only he could help himself by keeping himself strong and strengthening his core muscles. RX 2 at 57.

Petitioner returned to Dr. Gitelis on September 13, 2016. In his note of that date, the doctor indicated that Petitioner complained of an exacerbation of his back pain. He noted no neurological or sensory deficits on re-examination. He again recommended an injection. He continued to keep Petitioner off work. PX 4.

Dave Vanderpool testified by way of evidence deposition on September 14, 2016. PX 9. RX 8. Vanderpool testified he has worked for Respondent for 30 years. He started out as an elevator constructor apprentice and worked his way up the ranks. During the last 9 years, he has worked as Respondent's senior area safety and health manager, covering an 8-state territory in the Midwest. PX 9 at 2-5.

Vanderpool testified he knows of Petitioner but does not know the duration of Petitioner's employment. PX 9 at 7. He believes the accident date of January 15, 2015 to be accurate. He learned of Petitioner's accident from Stephen Probst, the superintendent at the Chicago jobsite where Petitioner worked. PX 9 at 8. Probst called him after January 15, 2015 and told him he had received a call from Petitioner. PX 9 at 9. Probst told him Petitioner was running raceway near an elevator shaft on January 15, 2015. PX 9 at 10. A raceway is made of galvanized sheet metal. It is 2 inches by 4 inches in size and typically 10 feet long. PX 9 at 11. It houses wires that run from point A to point B. Typically, it runs from an elevator controller to the hoistway where the elevator resides. PX 9 at 10-11. A 10-foot piece of raceway would weigh maybe 25 to 30 pounds. PX 9 at 11, 12.

Vanderpool testified that Respondent elevator constructors such as Petitioner typically construct and install raceway while working alone. PX 9 at 11. The amount of raceway that has to be installed depends on the distance between the machine room and the hoistway. PX 9 at 12-13.

Vanderpool testified that Petitioner, as a union member, is afforded a 30-minute lunch break and a 15-minute morning break. PX 9 at 13. Petitioner would also have been entitled to take smoking and bathroom breaks as needed. PX 9 at 14.

Vanderpool testified he believes two or three Respondent employees worked with Petitioner at the subject site on January 15, 2015. After he learned of the accident, he went to the site and talked with Petitioner's foreman, Mike Perez. It is his understanding that Perez worked near, but not alongside, Petitioner on January 15, 2015. PX 9 at 15.

Vanderpool testified that new hires at Respondent undergo mandatory safety training. New hires are not necessarily asked to disclose pre-existing health conditions or injuries. PX 9 at 16. To the best of his knowledge, Petitioner was healthy, showed up for work and did his job. PX 9 at 16.

Under cross-examination, Vanderpool testified he is not aware of Petitioner having any disciplinary issues. He does not know Petitioner as well as he would like to but Petitioner "seemed like a fine standing employee." PX 9 at 18-19. If Petitioner had longstanding back problems, that would be noted in his personnel file if those problems were reported. PX 9 at 19. To his knowledge, Petitioner performed his regular assigned duties prior to January 15, 2015. PX 9 at 19.

Vanderpool testified he believes he learned of Petitioner's accident from Probst about a week after the accident occurred. PX 9 at 19.

After looking at the daily reports for January 15 and 16, 2015, Vanderpool testified he believes the term "incident," as used in those reports, could be a "near miss" and not necessarily an actual injury. PX 9 at 20-21. The person who completed the January 15th report marked "no" in response to a question asking whether the day was incident-free. The person who completed the January 16th report marked "yes" in response to the same question. PX 9 at 20-21. The daily reports are forms used by Power, the general contractor at the site. PX 9 at 22.

Vanderpool testified that Probst was also present when he went to the site and talked with Mike Perez. PX 9 at 22-23. Probst had completed an incident report before he (Vanderpool) went to the site. He added some comments to this report. PX 9 at 23-24. [The report was not available at the deposition. PX 9 at 24].

Vanderpool testified he directed Respondent's local office to report Petitioner's claimed accident to Gallagher Bassett, the third party administrator. He did not directly communicate with Gallagher Bassett. PX 9 at 25. At the outset, he did not ask a question he should have asked, i.e., whether the claim fell under a contractor-controlled policy. He simply treated the claim as if Respondent was insuring the project. It was only later that a workers' compensation manager asked him whether the policy was owner- or contractor-controlled and he realized it was contractor-controlled. He then remedied the error. PX 9 at 26. He learned of the accident about a week after it took place and he believes the carrier was notified two weeks after the accident. PX 9 at 27.

Vanderpool testified it is his understanding that Petitioner did not report a work injury on January 15, 2015. Rather, he believes Petitioner simply told Perez he was experiencing back discomfort. He also believes that, when Petitioner called Probst on the Sunday after the accident, he again related only that his back was hurting and that he would not be coming in to work the next day. He could be "off a bit on [his] dates" but believes it was not until the week after the accident that Petitioner actually told Probst his back pain stemmed from something he did on the job. PX 9 at 27, 29.

Vanderpool testified that Respondent sends injured employees to U.S. Healthworks in Schiller Park. PX 9 at 28. Respondent typically makes the appointments for these employees. He likes to call U.S. Healthworks in advance of the visit to give them a heads up. PX 9 at 28. He does not know exactly when Petitioner went to U.S. Healthworks. PX 9 at 28. The doctor at this facility released Petitioner to seated work so he (Vanderpool) tried to make arrangements for Petitioner to go to Respondent's Elmhurst office to perform sedentary work. PX 9 at 31. He does not know whether Petitioner ended up performing light duty for Respondent. PX 9 at 31-32. Respondent typically accommodates injured employees. PX 9 at 32. Respondent does not accommodate a worker who is injured outside of work because it cannot legally track the treatment for such an injury. PX 9 at 32.

Petitioner testified he is still seeing Dr. Gitelis but is not paying the doctor for this care. He is a union member in good standing and has health coverage but has submitted only a couple of his bills to his group carrier.

Petitioner testified that, after he stopped performing light duty for Respondent, he received his regular salary until August 12, 2015. On January 15, 2016, he received a check in the amount of $942. He has not applied for short- or long-term disability benefits.

Petitioner testified he smoked for years but has quit.

Petitioner testified he experiences low back pain with any extended sitting or standing. If he is up on his feet for more than 20 minutes, the pain increases to the point where he "can't deal" with it.

On redirect, Petitioner testified that, before he underwent any treatment, he reported his accident to Perez and Probst and had been directed to a company medical facility.

Michael Perez testified on behalf of Petitioner. Perez testified he has worked as an elevator mechanic for fifteen years. He has worked in this capacity for Respondent for the last five years. T. 90.

Perez testified he was a job foreman at a Loyola University worksite on January 15, 2015. Petitioner installed pipe and duct work at this site on that date. T. 90-91.

Perez testified he would have been the person to whom Petitioner would have reported any work injury on January 15, 2015. Petitioner did report such an injury. Petitioner told him he was injured while using a ladder to install pipes and duct work. He remembers Petitioner saying, "I think I did something to my back" that day. As the day went on, Petitioner began hobbling around. T. 93-94.

Perez testified he was required to complete and turn in certain reports on a daily basis at the site, per the requirements of Power, the general contractor. T. 96. He identified the first page of PX 2 as a Power "daily report" form he completed on January 15, 2015. In response to a question asking whether the day was "incident-free," he responded "no," referring to Petitioner's accident. PX 2, p. 1. When he completed the same form the following day, January 16, 2015, he checked the box indicating that no incidents occurred. PX 2, p. 2.

Perez testified that Petitioner reported to work on Friday, January 16, 2015, but was "not walking straight." T. 97. He "gave Petitioner crap" about this, as was the custom, adding "we're not very mature." T. 97-98. On that date, he reported Petitioner's injury to Probst. The following Monday, January 19, 2015, he "re-enacted" Petitioner's injury, at Probst's direction, while Probst took photographs of him. He cannot recall whether Dave Vanderpool, Respondent's "head safety guy," was present at that time. T. 98-99.

Perez testified he is Petitioner's friend but would not lie for Petitioner under these circumstances. T. 99.

Perez testified he still works for Respondent, albeit in a different division. T. 99.

Under cross-examination, Perez testified that, on January 15, 2015, he worked in an elevator bank that was "right around the corner" from where Petitioner was working. T. 100. He did not perform the same kind of work Petitioner was performing, however. He was working on other elevators. T. 101. On that day, he talked with Petitioner about every twenty minutes.

Perez clarified a previous answer by saying he would not lie for Petitioner under any circumstances. T. 101. He and Petitioner are not as close as they once were, due to Petitioner being away from work for so long. When they worked together, they would also go out and have beers together. T. 101-102.

Perez testified that Dave Vanderpool is Respondent's safety manager. Perez indicated he has never discussed Petitioner's accident with Vanderpool. He has never seen the other accident report

that appears in PX 1. T. 103. To his recollection, the "re-enactment" of Petitioner's accident took place on Monday, January 19, 2015. Petitioner was not present during the re-enactment. He cannot recall whether Vanderpool was present. T. 105-106.

Perez testified that the word "incident," as used in the Power daily report forms, means an accident involving a worker. He would never use this form to report any incident involving materials or structures. T. 106.

Perez testified that, on Friday, January 16, 2015, he told Probst Petitioner got hurt at work and was going home for the day. T. 107.

Perez testified he "ribbed" Petitioner on January 16th because of the funny way Petitioner was walking. He did not tell anyone Petitioner was hobbling. T. 107-108.

On redirect, Perez reiterated that the accident occurred on Thursday, January 15, that Petitioner reported to work on January 16 and that the "re-enactment" took place on January 19. T. 108-109. He recalled completing another form concerning Petitioner's accident but was later told this document could not be found. He cannot recall what the form looked like. T. 109.

Under re-cross, Perez testified that Power's safety man was named "Cody." Power maintained an office at the site. Each subcontractor, including Respondent, was required to leave daily paperwork in folders outside Power's office. He is sure he completed another accident report. The foremen at the site met each Wednesday. They would have met on Wednesday, January 21. T. 111-112.

Stephen Probst also testified on behalf of Petitioner. Probst testified he worked as a construction superintendent for Respondent for three years before January 15, 2015. T. 114-115. He now works as a maintenance supervisor for Otis Elevator. T. 114. As a construction superintendent, he visited jobsites, mobilized manpower, ordered equipment and acted as a liaison between the customer and the subcontractors. He also dealt with work accidents. T. 115.

Probst testified he knew Petitioner for three years before January 15, 2015. As of that date, Petitioner had worked at a particular site for about a month. T. 116.

Probst testified he learned of Petitioner's accident on Sunday, January 18, 2015, when Petitioner called him. During that call, Petitioner told him he hurt his back while working overhead off a ladder. T. 116-117. In the same conversation, he told Petitioner to see the company physician. T. 119.

Probst testified he completed the typed portion of a narrative accident report that appears in PX 2. He believes he completed this portion of the report around January 26, 2015. T. 119.

Probst testified he took the photographs (A – C) that appear in PX 1. He testified he took these photographs at the direction of Dave Vanderpool. The photographs show the work Petitioner performed at the time of the accident. T. 120.

Under cross-examination, Probst testified he was not at the jobsite on January 15, 2015. He received no notice of an accident on that date. T. 121. He shared his report with Dave Vanderpool and later discussed the accident with Vanderpool via phone and in person. It was only recently that he again saw the report. Before the hearing, he never saw the handwritten portion of the report. He believes

Vanderpool wrote this portion. T. 124-125. The initials "DV" appear at the bottom of the report. To his knowledge, no Respondent employee other than Vanderpool had those initials. T. 128. It was his policy to call Vanderpool after any work accident. T. 129. Having now read the handwritten portion of the report that Vanderpool apparently completed, he believes Vanderpool's chronology is wrong. It was on Sunday, January 18, 2015, that Petitioner reported the accident to him (Probst) via telephone. T. 130. He acted as Vanderpool's intermediary in directing Petitioner to a company clinic. Vanderpool wanted Petitioner to "immediately go to an urgent care [facility] on a Sunday" while Petitioner wanted to see his own doctor. He acted as a go-between between Vanderpool and Petitioner. T. 130.

Probst testified he left Respondent to work for Otis because he had worked for Otis in the past. T. 131. He is no longer a union member. When he began working as a superintendent for Respondent, he withdrew from the union. T. 132. He knows Petitioner through work. He and Petitioner socialized at work but not outside of work. T. 132. Before he became a superintendent, he and Petitioner both worked as elevator mechanics for Respondent. He has no recollection of Petitioner complaining of low back pain before the accident. T. 132-133.

Probst acknowledged talking with Petitioner before the hearing. Petitioner wanted to make sure he would be attending the hearing. He also spoke briefly with Petitioner before taking the stand. Petitioner was agitated and expressed a desire to get the case over with. Petitioner also told him he did not like the tenor of the questions posed by Respondent's counsel. T. 134.

On redirect, Probst testified he called Dave Vanderpool on Sunday, January 18, after Petitioner called him and reported the accident. T. 135.

Ryan Strickland testified on behalf of Respondent. Strickland testified he has worked as a private investigator for six or seven years. He is licensed. T. 138-139. An entity called Merge retained him to conduct surveillance of Petitioner. He prepared a report concerning his surveillance. T. 140.

Strickland testified that, prior to conducting surveillance of Petitioner, he was given Petitioner's address along with driver's license and social media information. He correctly identified Petitioner in the hearing room. T. 141.

Strickland testified he first conducted surveillance of Petitioner on September 15, 2016. T. 143. On that date, he did not observe much. He saw Petitioner go to the bank. T. 144. He observed no relevant activity the following day. On September 17, 2016, he conducted surveillance for eight hours, from 8 AM to 4 PM, and obtained ten minutes of video of Petitioner. T. 145. He observed Petitioner for twenty to twenty-five minutes but was only able to obtain ten minutes of footage because of obstacles and having to move his car. T. 146. The video showed Petitioner and a male child walking in a park in Huntley, Illinois. He saw Petitioner walking, climbing up some gazebo stairs, sitting on a park bench, bending over and kneeling. T. 147-148. He observed no limping or grimacing. T. 147. Petitioner appeared to be walking normally.

Strickland identified RX 12 as a copy of the DVD to which his footage was transferred. As the Arbitrator began watching this DVD, during the hearing, she noted that the initial images were dated March 13, 2015. T. 152. Petitioner raised an objection, at which point the video was stopped. The Arbitrator left the hearing room to allow the attorneys and Petitioner an opportunity to watch the entire DVD off the record. After the Arbitrator returned to the hearing room, Respondent's counsel indicated

that Respondent was not going to be offering the DVD into evidence. Strickland did not re-take the stand. T. 152-153.

Arbitrator's Credibility Assessment

Dr. Gitelis described Petitioner as honest. Respondent's safety director, Dave Vanderpool, testified that Petitioner appeared to be a fine employee and always performed his elevator mechanic duties before the claimed accident.

Petitioner's description of his pre-accident back condition was inconsistent with Dr. Marian's records to the extent he denied that the doctor imposed restrictions. The doctor's records reflect that, on February 8, 2011, about four years before the accident, she recommended Petitioner avoid lifting weights. PX 3. RX 4.

Petitioner's testimony that he was able to perform his job during the year preceding the accident was supported not only by Vanderpool and Probst but also by Respondent's own exhibit, i.e., a wage verification document showing that, in 2014, Petitioner often worked overtime and grossed $174,302.15. RX 9.

Petitioner's description of his work activities and positioning on January 15, 2015 was detailed and fully supported by his foreman, Michael Perez. The description was also consistent with the "re-enactment" photographs that Probst took at the worksite, at Vanderpool's direction.

Respondent stipulated to timely notice but, in reliance on Vanderpool, maintained that, when Petitioner first reported back pain, he did not describe that pain as work-related. With respect to this issue, the Arbitrator finds Perez and Probst more credible than Vanderpool. The Arbitrator notes that Petitioner's first communications were with Perez and Probst, not Vanderpool, and that Vanderpool conceded he was "off a bit on [his] dates." PX 8, p. 27.

Arbitrator's Conclusions of Law

<u>Did Petitioner sustain an accident arising out of and in the course of his employment on January 15, 2015? Did Petitioner establish a causal connection between his January 15, 2015 accident and his current condition of ill-being?</u>

The Arbitrator finds that Petitioner sustained a work accident on January 15, 2015, secondary to cumulative trauma, and that this accident was a cause of Petitioner's current lumbar spine condition of ill-being. The Arbitrator further finds that the accident led to the need for the treatment Petitioner has undergone to date.

In so finding, the Arbitrator relies on the following: 1) Petitioner's credible description of the extent of the back-related care he underwent prior to the accident; 2) the fact that Petitioner successfully performed a strenuous job for Respondent for three years prior to the accident; 3) RX 9, which show that Petitioner often worked overtime and grossed $174,302.15 in 2014; 4) Petitioner's credible description of the nature of the work he performed on January 15, 2015; 5) the "re-enactment" photographs taken by Probst (Photos A-C in PX 1), which show that Petitioner worked off the top of an 8-rung ladder, with both arms overhead; 6) Perez's credible testimony as to Petitioner's reporting of an injury and what he observed about Petitioner on the day after the accident; 7) the initial histories

recorded by Dr. Gitelis and Dr. Garala of U.S. Healthworks; 8) Dr. Gitelis's causation-related opinions; and 9) Dr. Lami's admission that the accident resulted in an injury, albeit one he viewed as a sprain that required only a month of therapy.

In finding in Petitioner's favor on the issue of causation, the Arbitrator acknowledges that Petitioner underwent some back-related care before January 15, 2015 and that this care involved the prescription of Norco for pain. PX 3. RX 4. The Arbitrator also acknowledges that the earliest post-accident record, Dr. Marian's note of January 20, 2015, while referencing the heavy nature of Petitioner's job, reflects that Petitioner described his back pain as starting when he rose from a chair at home. The Arbitrator notes that Petitioner took issue with the accuracy of this history. The Arbitrator also notes that, according to Petitioner's foreman and supervisor, Petitioner reported his work injury to them before January 20, 2015. The Arbitrator is not surprised that Dr. Marian's note does not mention a specific work trauma because Petitioner never claimed to have sustained a specific trauma such as a fall. Rather, he alleged cumulative trauma over the course of a workday. The Arbitrator is also persuaded by Dr. Gitelis's testimony that the innocuous act of rising from a chair can in no way be equated with the ladder usage and overhead lifting Petitioner performed at work on January 15, 2015. [See PX 4 at 57.] That Petitioner might have experienced increased pain when getting to his feet at home does not mean the work activity was not a cause of his condition. In Illinois, it is axiomatic that an employer takes an employee as it finds him. It has also long been held that an injured worker need only prove that an accident was a cause of his condition. He is not required to exclude all other possible contributing causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003).

The Arbitrator finds Dr. Gitelis more persuasive than Dr. Lami, insofar as causation and work capacity are concerned. Dr. Gitelis treated Petitioner over an extended period while Dr. Lami saw him once. Dr. Lami did not have an understanding of the weights Petitioner was required to lift.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from August 13, 2015 through the hearing of October 14, 2016. The parties agree Respondent paid temporary total disability benefits in the amount of $7,740.93 during an earlier period, January 26, 2015 through March 5, 2015. Arb Exh 1. The evidence also shows that Petitioner performed desk duty for Respondent from March 6, 2015 until April 29, 2015 and that he received his regular salary thereafter through August 12, 2015.

The Arbitrator has already found in Petitioner's favor on the issues of accident and causation. The Arbitrator views Petitioner's causally related lumbar spine condition as unstable. There is no evidence indicating Respondent offered Petitioner light duty at any point between August 13, 2015, at which point Dr. Gitelis was still imposing restrictions, and August 20, 2015, when Dr. Gitelis took Petitioner off work altogether. In reliance on Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010), the Arbitrator finds that Petitioner was temporarily totally disabled from August 13, 2015 through the hearing of October 14, 2016.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The Arbitrator has also elected to rely on Dr. Gitelis rather than Dr. Lami as to Petitioner's treatment needs. The Arbitrator awards Petitioner the following reasonable and necessary medical expenses, pursuant to the fee schedule and subject to a $3,988.74 credit which Respondent established via RX 7:

Orthopedic & Spine Surgery		
1/22/15, Dr. Gitelis	$	360.00
1/23/15, Dr. Cannestra	$	124.00
1/23/15, Royal Open MRI, lumbar spine MRI	$	2,376.00
1/29/15, Dr. Gitelis	$	148.00
2/12/15, Dr. Gitelis	$	148.00
3/5/15, Dr. Gitelis	$	148.00
3/12/15, Dr. Gitelis	$	148.00
4/2/15, Dr. Gitelis	$	148.00
5/13/15, Dr. Gitelis	$	148.00
6/16/15, Dr. Gitelis	$	148.00
9/3/15, Dr. Gitelis	$	148.00
11/3/15, Dr. Gitelis	$	148.00
12/30/15, Dr. Gitelis	$	148.00
9/13/16, Dr. Gitelis	$	218.00
TOTAL:	$	4,558.00
ATI Physical Therapy		
2/2/15 – 6/19/15	$	11,848.67

Based on RX 7, Respondent is entitled to credit for the payments of $3,988.74 it made to Orthopedic Spine Surgery and ATI. [The Arbitrator does not award Respondent credit for the medical case management payments also reflected in RX 7.]

Is Petitioner entitled to prospective care?

The Arbitrator awards prospective care in the form of a return visit to Dr. Gitelis along with the pain management referral and injections the doctor previously recommended.

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Peverelle,
Petitioner,

vs.

No: 13 WC 14290

17IWCC0686

Gibson Area Hospital,
Respondent.

DECISION AND OPINION ON REMAND

This case now comes before the Commission on remand from the Appellate Court of Illinois, Fourth District. Briefly, this claim involves a disputed injury to the claimant's low back with an asserted accident date of December 20, 2012. This matter proceeded to hearing pursuant to Sections 19(b) and 8(a) before Arbitrator Maureen Pulia on May 30, 2014. At hearing, the claimant requested prospective lumbar fusion surgery as prescribed by Dr. Singh. The respondent disputed causal relationship relying on a Section 12 examination with Dr. Beatty, who believed the surgery was reasonable but not causally related to the accident, and disputed the reasonableness and necessity of the medical care via utilization review performed by Dr. Munoz.

Arbitrator Pulia noted the claimant had only worked for the respondent for two months prior to the date of loss, that the accident was unwitnessed, and there was a discrepancy in the initial treating records as to the description of accident; the petitioner testified she was moving a surgical bed, and some of the records assert this history, but she reported pushing a cart to the emergency room doctor. Nevertheless, Arbitrator Pulia determined that on consideration of all the facts and circumstances, a workplace accident had been credibly proven. Arbitrator Pulia further awarded temporary total disability benefits from January 8, 2013 through May 30, 2014, a total of 72 & 3/7 weeks, and awarded the prospective anterior L5-S1 fusion. Respondent timely petitioned the claim for review by the Commission.

17IWCC0686

On June 8, 2015, the Commission issued its decision (case 15 IWCC 0431). affirming the Arbitrator's findings as to accident, causal relationship, and prospective medical care. However, the Commission reversed the Arbitrator's findings as to temporary total disability for the period of May 24, 2013 through January 9, 2014. During this time, the petitioner had been prescribed light duty, and the claimant acknowledged that prior to the asserted accident she had a concurrent job at Christie Clinic, which was a sedentary-level job. The Commission noted that restrictions she was under during this period were effectively full duty for that concurrent employment, and there was no supporting documentation to demonstrate inability to work at that job or to prove loss of income during that period. On January 10, 2014, her treating physician prescribed her totally off work, and the Commission affirmed the period of TTD from January 8, 2013 through May 23, 2013 and from January 10, 2014, through May 30, 2014, resulting in a total TTD award of 39 & 4/7 weeks. The petitioner timely appealed the Commission's decision to the Circuit Court of Ford County on the issue of TTD; the respondent did not appeal the Commission's decision. The Circuit Court confirmed the Commission on February 25, 2016 (case 15MR30).

On May 31, 2017, the Appellate Court issued an order pursuant to Supreme Court Rule 23 (case 4-16-0231WC). Following review of the record, the Appellate Court found that the claimant's other job for Christie Clinic "was infrequent and only on an as-needed basis" and observed that the evidence was clear that the claimant's light duty restrictions were not consistent with her regular work for the respondent. Moreover, the respondent did not present a witness from Christie Clinic to refute the claimant's testimonial assertion that "Christie Clinic refused to allow her to work following her accident because she was 'a liability'" and, therefore, the record did not adequately support the Commission's denial of benefits. Following consideration of the record, the Appellate Court reversed the Circuit Court and Commission regarding the denial of TTD benefits from May 24, 2013, through January 9, 2014, and remanded the case accordingly with instructions.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the sum of $409.25 per week for a period of 72-3/7 weeks, from January 8, 2013 through May 30, 2014, 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 shall have credit against the above award for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injuries, including but not limited to the $7,751.08 paid in TTD and the $2,000 paid as an advance, as noted in the July 7, 2014 decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical services associated with the anterior L5-S1 fusion and post-operative treatment recommended by Dr. Singh, as provided in Sections 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.

17IWCC0686

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.

Bond for 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: OCT 30 2017

Joshua D. Luskin

L. Elizabeth Coppoletti

Charles J. DeVriendt

o-10/24/17
jdl/mcp
68

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wayne Bergmann,
Petitioner,

vs.

No. 14 WC 09315
14 WC 13613

17IWCC0687

Star Leasing, LLC, Illinois Guaranty Fund,
Swift Transportation Company, Inc.,
Respondents.

DECISION AND OPINION ON REVIEW

Petitioner, a 48-year-old truck driver, asserted two separate injuries: (1) a right shoulder injury (rotator cuff strain) sustained when he slipped while exiting his truck on February 17, 2014, and (2) a "cumulative trauma" lumbar condition of spinal stenosis that had manifested a few days earlier, on February 14, 2014, along with ongoing residual low back pain following a multilevel laminectomy to address the stenosis. These matters were heard on November 20, 2015 before the Arbitrator under Section 19(b) of the Workers' Compensation Act, with Swift Transportation Company, Inc. ("Swift") and the Illinois Guaranty Fund ("IIGF") in attendance. As for Star Leasing, LLC ("Star Leasing"), this co-Respondent evidently abandoned defending itself around April 2015 and chose not to participate in the hearing.

17IWCC0687

The Arbitrator found fully in favor of Petitioner and against Swift. Not only did the Arbitrator find that the entirety of Petitioner's current condition of ill-being (in both shoulder and back) was work-related, he found that Petitioner was Swift's employee under a "borrowing employer" theory (and that Star Leasing -- by Petitioner's account, his "direct employer" -- was the "loaning employer.") The Arbitrator dismissed IIGF from this action insofar as he decided that Petitioner's claim was not a "covered claim" under the Guaranty Fund Act. The Arbitrator awarded temporary total disability benefits from February 17, 2014 up through the date of the Section 19 hearing. Finally, the Arbitrator assessed more than $85,500 in penalties and attorney's fees against Swift under Sections 19(l), 19(k) and 16 of the Workers' Compensation Act.

Now before the Commission is Swift's timely Petition for Review. Notice has been given to all parties. After considering issues including employer-employee relationship, causal connection, temporary total disability, medical expenses (incurred and prospective), and penalties and fees, and being advised of the facts and law, the Commission hereby modifies the Arbitrator's Decision as stated below. In salient part, the Commission: (1) reverses with regard to Swift; (2) modifies with regard to Star Leasing; and (3) reverses with regard to IIGF insofar as the Commission finds that Petitioner's claim is *not* excluded from coverage under the Guaranty Fund Act. Lastly, the penalties and fees are vacated.

The Arbitrator's Decision, a copy of which is attached hereto and made a part hereof, is otherwise affirmed and adopted. The Commission remands this case to the Arbitrator for further proceedings for determination of a further amount of temporary total or permanent disability, if any, pursuant to *Thomas v. Industrial Commission,* 78 Ill. 2d 327 (1980).

The Commission's modifications to the Arbitrator's Decision are summarized below:

(1) **Employer-employee relationship**: The Commission finds that there is no employer-employee relationship between Petitioner and Swift. The Commission finds that Petitioner is Star Leasing's employee. The Arbitrator's invocation of the "borrowing employer" doctrine to impose employer status on Swift is inapposite. The relationship between Swift and Petitioner was, at most, an independent contractor relationship. This conclusion logically follows from the fact that Star Leasing – asserted by Petitioner to be his "direct employer" – was itself in an independent contractor relationship vis a vis Swift -- Star Leasing having entered an explicit, contract for service with Swift in September 2013.

(2) **Causation as to current condition of ill-being in the right shoulder:** Petitioner did prove he suffered a work-related rotator cuff strain in February 2014 (for which Star Leasing, not Swift, is liable). Petitioner testified that he slipped while exiting his truck and wrenched his right shoulder. Petitioner received conservative treatment, including an injection, and the shoulder strain was resolved long before the time of the hearing – no later than November 3, 2015, according to Swift's Section 12 shoulder examiner Dr. John Cherf. As Dr. Cherf convincingly opined, the accident caused a temporary exacerbation of a preexisting

degenerative condition in his shoulder. Petitioner's current complaints are subjective, vague and have not been proven to be work-related.

Relatedly, Petitioner has not proven that any prospective treatment, including right shoulder surgery, is reasonable or necessary. His treating physician, Dr. Brent Johnson, did testify that he felt Petitioner was a surgical candidate as of the last office visit on August 25, 2014, based largely on Petitioner's subjective complaints of discomfort and ongoing dysfunction. However, Dr. Johnson's own records undercut any purported urgency or need for surgery, as these records indicate that Petitioner was in a much-improved condition at that time.

(3) **Causation as to current condition of ill-being in the low back:** Petitioner does not state a cognizable claim as to his lumbar spine stenosis and low back pain under the Workers' Compensation Act. Petitioner does not identify any single, acute incident as a precipitating event. Instead, he asserts that his years of performing standard truck-driving activities represent "cumulative trauma" or otherwise "aggravated" his preexisting, congenital lumbar spinal stenosis. He alleges, in the most general terms, that his job duties gradually contributed to the overall worsening condition of his spine until the point where multilevel laminectomy, performed in April 2014, was required to relieve stenosis-related nerve compression. Regarding low back pain, Petitioner alleges that he has ongoing, residual pain following this surgery. He attributes this back pain to "repetitive" job-related activities – that is, he alleges this back pain was caused by his being required to regularly, repeatedly, or "repetitively" climb in and jump out of his truck, bend and squat while performing regular pre-trip inspections of his truck, etc. over the course of his employment. He also alleges that prolonged exposure to vibration while driving was a contributory factor.

Petitioner has not proven that his current condition of ill-being in his low back was caused by his employment. The Commission here relies on the opinion of Swift's Section 12 spine examiner, Dr. Jesse Butler, who testified convincingly that that Petitioner's condition is the result of the natural progression of a preexisting, degenerative condition, Petitioner's congenital stenosis.

(4) **Coverage of claim under Guaranty Fund Act:** The Arbitrator erred in his determination that Petitioner's claim was not a "covered claim" under the Guaranty Fund Act and in his dismissal of IIGF from this proceeding. The Arbitrator accepted IIGF's hyper-technical argument that Star Leasing – who never invited the protection of IIGF in the first place; it was Petitioner who sought to bring IIGF into this matter – ignored requests to cooperate with the mandatory requirements for identification of covered claims under the Guaranty Fund Act. Specifically, IIFG argues that Star Leasing failed to respond to a request to fill out an affidavit that would confirm that Star Leasing's net worth was not in excess of $25 million. This request was sent to Star Leasing in August 2014 shortly after Star Leasing's workers' compensation insurance carrier became insolvent and was ordered liquidated. Under the circumstances of the instant case – wherein the claimant-employee is hardly in a position to

assist IIGF with determining the net worth of his (now apparently defunct) employer – IIGF's argument misses the mark as to the purpose of the Guaranty Fund Act.

The background of this matter and the Commission's conclusions are discussed in more detail below.

I. BACKGROUND

A. Introduction to the Parties: Star Transport Company, Inc., Star Leasing Services, LLC, and Swift Transportation Company, Inc.

Petitioner began driving for a trucking company named Star Transport Company, Inc. ("Star Transport") in 1994. Star Transport apparently was founded in the 1940s and incorporated in Illinois. Petitioner drove semi-trucks out of Star Transport's facility in Morton, Illinois, transporting the freight of its customers located mostly in the Midwest region. Petitioner was not an "owner-operator" or independent contractor; he was a company driver, an employee of Star Transport.

According to the testimony of David Berry, Swift's Vice President, Star Transport principals approached the Phoenix, Arizona-based Swift in 2013 to inquire about becoming a "fleet owner" for Swift. (Mr. Berry testified that "fleet owner" is "short for independent contractor" in the industry.) Swift is a much larger interstate motor carrier with routes covering the 48 contiguous states. Mr. Berry stated that the smaller, regional carrier approached Swift because "they were, you know, struggling with finding enough customers and enough freight." (Tr. 86). Pursuant to these discussions, Star Leasing Services, LLC was incorporated in Indiana on September 17, 2013. (IIGF 's Exh. 3). On September 19, 2013, Mr. Berry, on behalf of Swift, signed a "Contractor Agreement" ("Agreement") with Star Leasing, LLC. (Swift's Exh. 3).

Under the Agreement, Star Leasing was described as a "contractor" that leased trucks to and provided drivers for Swift, for the transportation of the freight of Swift's customers under Swift's federal "DOT [Department of Transportation] number" or "DOT authority." Under this arrangement, Swift would manage "front end" operations, including maintaining a sales force, managing customer relationships, and billing and receiving payments from the customer. According to Mr. Berry, "Star" -- the Commission notes here that the parties' witnesses and even their counsel had the unfortunate habit of making reference to a "Star" entity without specifying whether the subject is Star Transport or Star Leasing – through this arrangement was enabled to have a more stable income stream and was also freed to focus on fewer things, including improving the lifestyle of its drivers. (Tr. 86). "Star" and Swift previously had some customers in common, but under the Agreement, any load of this shared customer transported under this Agreement would be billed under Swift's pricing schedule. (Tr. 166-167).

Mr. Berry testified regarding the control that "Star" would retain over its own business. For example, Swift did not assign any specific loads that Star Leasing was required to service. Instead, Swift offered a collection of loads from which Star Leasing could select loads it wished to accept; Star Leasing was not obligated to accept every load so tendered. The Agreement permitted Star Leasing to provide

services to another carrier (so long as markings on the trucks that would otherwise identify that the truck was hauling under Swift's DOT authority was removed). Mr. Berry did not have knowledge of whether "Star" after November 2013 made deliveries under the DOT authority of any non-Swift carrier. (Tr. 93-113).

Mr. Berry also testified that, contrary to Petitioner's belief, Swift personnel did not communicate with, much less direct and control, Petitioner (or any other "Star" employee). In Mr. Berry's telling, a Swift planner would electronically forward the collection of loads/routes to Star Leasing personnel, who would then select appropriate loads for Star Leasing's own distribution to its drivers. Star Leasing personnel would forward an electronic message about assigned loads to Star Leasing's drivers. Petitioner would receive this communication – in effect, an email -- over the "QualComm" box installed in his truck. (Tr. 109- 114). Petitioner did not communicate orally with any sender of this message. He believed however that, after November 2013, it was exclusively Swift personnel who were directly transmitting the QualComm messages to him and assigning him his loads because his previous Star Transport dispatcher told him so. Petitioner stated this previous dispatcher "told me he no longer had control over what I get" and that he (the dispatcher) was being replaced by a Swift planner. (Tr. 45-46). This Star Transport dispatcher did not testify.

Petitioner testified that, as far as he was concerned, when Swift Transportation "partnered" with Star Transport in November 2013, Swift in practical effect took over the operations of Star Transport ("everything switched over to Swift"). (Tr. 54). Also at that point, in Petitioner's telling, Star Transport was now known as Star Leasing Services, LLC, and Petitioner now understood that he was a Star Leasing employee. (The Commission notes here that Petitioner did not submit any written pay statements or other documentary evidence that he at any time became an employee of Star Leasing, as opposed to remaining an employee of Star Transport.) However, for all intents and purposes, he believed that Swift was his employer. (Tr. 66).

In any event, the Agreement required Star Leasing to provide workers' compensation insurance for its employees. (RX 3). Star Leasing's workers' compensation insurance carrier was Freestone Insurance Company. After Petitioner's 2014 injuries, he received some temporary total disability payments from Freestone. Freestone became insolvent and was ordered liquidated in July 2014. "Star" then made temporary total disability payments to Petitioner until March 6, 2015. Soon after that, "Star" apparently decided to stop paying bills and participating further in this proceeding.

March 2015 was also when Swift terminated the Agreement with Star Leasing. Mr. Berry testified that Star Leasing breached the Agreement by failing to maintain workers' compensation insurance coverage for its employees. Although it appears that neither Star Leasing nor Star Transport have formally filed for bankruptcy, it is apparent that both entities are now defunct. Mr. Berry testified that Swift "did not purchase Star" or any of its affiliates. (Tr. 87).

17IWCC0687

B. Petitioner's Injuries and Treatment

On February 17, 2014, Petitioner injured his right shoulder when he slipped in icy conditions while exiting his truck. He stated that he grabbed the steering wheel with his right hand to break his fall, and felt a pop in his shoulder. Petitioner sought treatment from orthopedic surgeon Dr. Brent Johnson of Midwest Orthopedics on February 21, 2014. After obtaining a right shoulder MRI, Dr. Johnson diagnosed a right "rotator cuff strain/syndrome." (PX 9 at 15). Initially, Dr. Johnson recommended conservative treatment. Petitioner underwent an injection. On August 25, 2014, largely due to Petitioner's reports of persistent pain and dysfunction, Dr. Johnson recommended surgery. (PX 9 at 18-20). In September 2015, Dr. Johnson testified that he has not seen Petitioner since August 2014, but if Petitioner returned with similar symptoms, Dr. Johnson would still recommend surgery.

Regarding Petitioner's back-related issues, in late 2013, Petitioner testified that he experienced back pain that became problematic enough for him to seek treatment. (Tr. 30-31). He was referred to spine surgeon Dr. Patrick O'Leary of Midwest Orthopedics. Petitioner saw Dr. O'Leary on February 14, 2014, complaining of chronic neck and back pain, pain radiating to his legs, and increasing difficulty with walking. Dr. O'Leary provided a provisional diagnosis of lumbar spinal stenosis. An MRI was ordered and showed severe stenosis at three levels in his lumbar spine. Over subsequent visits to Dr. O'Leary, Petitioner's difficulty with walking became increasingly more severe. He reached the point of being incapable of walking further than 200 yards. (PX 6 at 14-22). On April 24, 2014, Dr. O'Leary performed a multilevel laminectomy at L3-S1 to decompress the spinal nerves. (PX 6 at 26-27).

After the laminectomy, Petitioner experienced relief for his leg symptoms and reported he was able to resume walking greater distances. However, he thereafter complained of right-sided low back pain. In December 2014, seven months post-surgery, the low back pain complaints were severe and persistent. (PX 6 at 33). Dr. O'Leary testified that he could not discern the etiology of this low back pain. Therefore, at that point, the spine surgeon suggested that Petitioner see a pain specialist at Midwest Orthopedics to evaluate for the possibility facet joint-related pain and the appropriateness of lumbar injections. (PX6 at 34-37). Petitioner alleges he has not seen this pain specialist due to inability to receive authorization for this consultation. In the meantime, since the surgery Petitioner has been prescribed high amounts of Norco and is also using a Fentanyl patch. Swift's Section 12 spine examiner, Dr. Jesse Butler, testified in September 2015 that Petitioner's narcotics use is problematic and that Petitioner's apparent ongoing severe back pain is not consistent with a good outcome post-laminectomy. (RX 1 at 13-14).

II. DISCUSSION

A. There Was No Employer-Employee Relationship Between Swift and Petitioner

There was no employer-employee relationship between Swift and Petitioner. The Arbitrator's invocation of the "borrowing employer" doctrine to impose liability on Swift is in error. The relationship between Swift and Petitioner was, at most, an independent contractor relationship. This conclusion logically follows from the fact that Star Leasing – Petitioner's acknowledged "direct employer"– was

17IWCC0687

itself in an independent contractor relationship with Swift, having entered an explicit, independent contractor agreement with Swift in September 2013. (RX 3). Under the terms of this contract, Star Leasing agreed to lease its trucks and provide drivers for Swift, for Swift's utilization in transporting the freight of Swift's customers across the country. In that same contract, Star Leasing agreed to maintain workers' compensation insurance on its employees (including Petitioner).

Swift's VP, David Berry, signatory to the contract on behalf of Swift, testified at hearing that Swift and Star Leasing intended to enter into an independent contractor relationship. His testimony regarding the ways in which "Star" retained control over itself – including its freedom to decline loads proffered by Swift and to transport non-Swift loads under Star Transport's own federal "DOT authority" – is consistent with the contract. Petitioner is in no position to opine as to the larger relationship between his "direct employer" and Swift, and his testimony about his own personal impressions that Swift exclusively controlled his work does not impugn the accuracy of Mr. Berry's description of the independent contractor relationship between Swift and Star Leasing.

B. There is No "Borrowing-Loaning Employer" Relationship Between Swift and Star Leasing

The Arbitrator erroneously characterized the relationship between Swift and Star Leasing as a "borrowing employer" and "loaning employer." He cited Section 1(a)(4) of the Workers' Compensation Act (regarding "Borrowing-Loaning Employers"), which states that where the borrowing employer does not pay benefits due to the injured employee, "the liability of such loaning and borrowing employers is joint and several." This section typically pertains to the scenario of a "temp agency" who has loaned out its employee to the agency's client (the borrower), where the employee is injured at the client's worksite. The section goes to the liability between the temp agency and its client (in the event that there is no written agreement between these two special employers regarding the subject).

Here, the Commission finds that there is no borrowing-loaning employer relationship between Swift and Star Leasing. Swift and Star Leasing entered into a contract for service, as evidenced by the Agreement of September 2013. (RX 3). (The Commission notes, however, that assuming this "borrowing-loaning employer" relationship exists, Star Leasing would be the employer with primary liability under this section.)

C. Petitioner's Work-Related Right Shoulder Strain Has Resolved

Petitioner proved at most that he suffered a work-related rotator cuff strain in February 2014 (for which Star Leasing, not Swift, is liable). Petitioner received an injection and that strain resolved in due time. At most, the accident caused a temporary exacerbation of a preexisting degenerative condition in his shoulder, as opined by Swift's Section 12 examiner, Dr. John Cherf. Petitioner's current, vague complaints to his shoulder area – subjective as they are, persisting long after the accident, and inclusive of pathology to, for example, the AC joint, which pathology is not supported by the mechanism of injury – are, if anything, due to the natural history of Petitioner's deteriorating overall physical condition. Petitioner is not in good physical condition. He is morbidly obese -- 6'2", about 320 pounds -- diabetic, and smokes two packs of cigarettes per day. In fact, it appears that Petitioner's left shoulder – not alleged

to be the subject of any work-related accident – was even less functional than his "injured" right shoulder upon Dr. Cherf's Section 12 examination.

Furthermore, Petitioner has not proven that any prospective treatment, including his sought-after right shoulder surgery, is reasonable or necessary. His treating shoulder physician, Dr. Brent Johnson, did testify that he felt Petitioner was a surgical candidate as of August 25, 2014 (about six months post-accident, the date of the last visit to Dr. Johnson) -- due largely to Petitioner's subjective complaints of discomfort and ongoing dysfunction. However, Dr. Johnson's own records undercut any purported urgency or need for surgery, as they relate that Petitioner was reporting a much-improved condition at that time. Notably, Petitioner had rated his pain at only 3 out of 10.

Dr. Cherf's Section 12 examination took place on November 3, 2015 (about a year after the last visit with Dr. Johnson, and a year and a half post-accident). Dr. Cherf testified convincingly that, certainly by the time of the examination, the objective evidence showed Petitioner's shoulder had recovered on its own (without further treatment) to the point where his shoulder's range of motion and strength was good. (RX 2 at 16). And although Petitioner's condition – in both shoulders -- was expected to keep degenerating with time, Dr. Cherf testified unequivocally that surgery was not indicated for the time being. (RX 2 at 16).

D. Petitioner Does Not State a Cognizable Claim Regarding His Lumbar Spinal Stenosis and Low Back Pain

Petitioner was suspected of having congenital lumbar spinal stenosis by treating spine surgeon Dr. Patrick O'Leary on February 14, 2014. This was the date of Petitioner's first presentation to Dr. O'Leary, to whom Petitioner had been referred for his complaints of difficulty walking and radiating leg pain. Dr. O'Leary's first office note indicated that Petitioner orally related that he had undergone a lumbar MRI in Ohio two years prior (2012). Petitioner did not bring this prior MRI or any prior treatment records to Dr. O'Leary. Although Dr. O'Leary did not recollect the specifics of this discussion during his evidence deposition, his February 14, 2014 office note documented Dr. O'Leary's impression that this prior MRI described congenital spinal stenosis. (PX 6 at 17, 52-53; PX 17).

In any event, Dr. O'Leary ordered a (new) MRI upon that February 2014 visit. It showed that Petitioner's stenosis was "high grade" at three levels (L3-4, L4-5 and L5-S1). It was further confirmed that Petitioner's stenosis was indeed congenital. Petitioner was born with a more narrow, triangular-shaped (as opposed to normal oval) spinal canal; individuals with this condition manifest stenosis-related symptoms 10 to 20 years earlier than normal. (PX 6 at 19-20, 57-58; RX 1 at 10).

Petitioner does not cite any acute incident as a precipitating event for any ill-being in his spine or for the onset of low back pain. Instead, he generally avers that his years of being a truck driver contributed to the worsening condition of his back in general and of his spine, including the worsening of his stenosis, to the point where he required multilevel laminectomy. Such allegations do not state a cognizable claim under the Workers' Compensation Act. Ultimately, there is no evidence that Petitioner's job as a truck driver was causally related in any way to his congenital spinal stenosis, nor that his job "aggravated" this

17IWCC0687

preexisting condition. Dr. O'Leary's causation opinion in favor of his patient is vague, conclusory, and not persuasive. Swift's Section 12 spine examiner, Dr. Jesse Butler, was far more persuasive on the subject of the natural progression of Petitioner's stenosis. Dr. Butler does not challenge the reasonableness of Dr. O'Leary's diagnosis and treatment – just the notion that Petitioner's job was a causal factor.

Regarding low back pain, both Dr. O'Leary and Dr. Butler explained that the laminectomy was to address the significant lifestyle impact of Petitioner's difficulty with walking, not low back pain. (PX 6 at 44-45; RX 1 at 20). Dr. Butler opined that medical literature suggested only a loose association between whole body vibratory forces and back pain, and that in his opinion, Petitioner's job activities did not cause his (longstanding) low back pain. (RX 1 at 35-36).

E. The Arbitrator's Finding of No "Covered Claim" Under the Guaranty Fund Act Is Unreasonable

The Illinois Insurance Guaranty Fund (IIGF) was created to assume the obligations of insolvent insurers to provide primary insurance coverage. Traditionally, the IIGF was designed to provide a last recourse for insureds who sustained economic loss due to the insolvency of an insurance company.

The Arbitrator erred as to his determination that Petitioner's claim was not a "covered claim" under the Guaranty Fund Act, especially on the grounds cited. As mentioned above, this determination is based on acceptance of the Fund's odd, hyper-technical argument that Star Leasing – who never invited the protection of the Fund in the first place; it was Petitioner who sought to bring the Fund into this matter – ignored requests to cooperate with the mandatory requirements for identification of covered claims under the Guaranty Fund Act. In particular, the IIGF points out that Star Leasing did not respond to an August 2014 request to fill out an affidavit that would confirm that Star Leasing's net worth was not in excess of $25 million.

As alternative grounds for dismissal, the Arbitrator also wrote that even if this were a covered claim, Petitioner and "the alleged insured" (that is, Star Leasing) have a duty to exhaust other available remedies against other insurance policies "as well as the duty to establish that Star Leasing is not affiliated or controlled by an entity worth in excess of $25 million" (that is, a duty to establish that Star Leasing is not controlled by Swift).

It is odd that Petitioner -- who amended his Applications to name IIGF and filed a "Motion to Join" IIGF in April 2015 to ensure IIGF's appearance at the Section 19(b) hearing -- has not taken exception to IIGF's dismissal. Instead, it is Swift who has argued against IIGF's dismissal. In a response to IIGF's motion to dismiss Swift's review petition as it pertained to IIGF, Swift argued that IIGF is a "necessary party" to this action to protect Petitioner's interests. Swift's response weirdly argues for protection of *Petitioner's* interests.

Under the circumstances of this case, it is not reasonable to find that Petitioner's claim was not a "covered claim," and any "dismissal" of IIGF from this action based thereon is in error. Moreover, as

17IWCC0687

Swift's review brief points out, IIGF cannot escape liability when the carrier for a loaning employer that is paying for an injury becomes insolvent by arguing that the carrier for the borrowing employer must begin paying as a means of exhaustion of other remedies (assuming *arguendo* again that any "borrowing-loaning employer" relationship exists here). *Illinois Ins. Guaranty Fund v. Liberty Mutual Ins. Co.*, 1 N.E.3d 956, 962 (2013). Otherwise, borrowing employers would be placed in the position of having to purchase duplicate insurance coverage for a temp agency's loaned employees, even when there is an agreement between the borrowing employer and the temp agency that the temp agency maintain its own insurance policy.

Finally, as there is no employer-employee relationship between Swift and Petitioner, the penalties and fees against Swift are vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 24, 2016 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision as it applies to Swift is reversed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision as it applies to IIGF is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Star Leasing shall pay to the Petitioner the sum of $ $533.33 per week for the period commencing February 17, 2014 through November 3, 2015 (89 and 1/7 weeks), as provided under § 8(b); Respondent shall be given credit for all temporary total disability benefits that have been paid and shall be given further credit for any non-occupational disability payments paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified. Star Leasing shall pay only the reasonable and necessary medical expenses incurred for treatment to the right shoulder up through November 3, 2015 under § 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Star Leasing 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 the accidental injury.

17IWCC0687

Bond for removal of this cause to the Circuit Court by Star Leasing is hereby fixed at the sum of $50,000.00 The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 30 2017

Joshua D. Luskin

o-08/30/17
jdl/ac
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Floyd Hinton,
Petitioner,
vs.

NO: 14 WC 02894

Caterpillar Inc.,
Respondent,

17IWCC0688

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 30 2017
o101217
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HINTON, FLOYD
Employee/Petitioner

Case# **14WC002894**

16WC019748

CATERPILLAR INC
Employer/Respondent

17IWCC0688

On 3/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0293 KATZ FRIEDMAN EAGLE ET AL
KEITH SPARKS
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Floyd Hinton
Employee/Petitioner

v.

Caterpillar Inc.
Employer/Respondent

Case # **14** WC **02894**

Consolidated case(s): 16 WC 19748

17IWCC0688

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **January 19, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 9, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being is partially causally related to the accident.

In the year preceding the injury, Petitioner earned **$36,728.12**; the average weekly wage was **$706.31**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** 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 credit for weekly nonoccupational indemnity benefits paid to the Petitioner during the period for which he was entitled to temporary total disability benefits, as referenced below.

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 for treatment involving the Petitioner's sartorious muscle injury. The specific treatment allowed is explained in the attached conclusions of law.

ORDER

ACCIDENT

The Arbitrator finds that the Petitioner has proven an accident arising out of and in the course of the employment occurring on September 9, 2013, by a preponderance of the evidence.

CAUSATION

The Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being as it pertains to his lumbar spine condition was causally related to his accident but has proven a causal relationship between is right sartoroius muscle injury and said accident..

MEDICAL

The Arbitrator finds that the Petitioner is entitled to receive payment of medical related to his sartorious muscle injury subject to the Fee Schedule, while not being entitled to receive payment for medical related to his lumbar injury as explained in the above section on Causation.

TTD

The Arbitrator finds that the Petitioner shall be entitled to temporary total disability benefits under Section 8(b) of the Act in the amount of $470.87 per week from September 10, 2013 through January 15, 2014, a period of 18 2/7 weeks, said period being the time in which he was temporarily totally disabled for injuries causally related to his accident.

PERMANENCY

The Arbitrator finds that the Petitioner shall be entitled to permanent disability benefits pursuant to Section 8(e) in the amount of $423.79 per week for a period of 10.75 weeks representing 5 % loss of use of the right leg.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Glenn McEnty

Signature of Arbitrator

2/23/17
Date

MAR 13 2017

STATE OF ILLINOIS)
)
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

FLOYD HINTON, Petitioner, v. CATERPILLAR INC., Respondent.	Case No.	14 WC 02894

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Petitioner began working for the Respondent at its Decatur, Illinois plant in 2005. He started as a forklift operator, eventually moving to assembly. In 2013, he was an assembler on the large truck line installing hoses, tubes, and parts on the large mining trucks. On 9/9/13, he was at work, working inside the frame of a truck installing hoses. He was standing on a three-step ladder without hand rails, about two and a half to three feet tall. Petitioner estimated that the ladder was approximately three to four feet long and two to three feet wide. Photographs of the ladder in question were admitted at arbitration. (R's Ex. 2, P's Dep. Ex. 2).

In his job, Petitioner would use wrenches, sockets, and air guns. On that day, Petitioner recalled that he was using two two foot long wrenches weighing four to five pounds a piece. He suggested that he might have been using other tools, such as additional wrenches or an air gun, but he was vague on this and could not specifically recall that he had those at the time. He would use one wrench to tighten a bolt or coupling and one wrench to hold the coupling or tube in place. He testified that after he had finished the task he was performing, he began to descend the ladder. He described that he had positioned the ladder width wise within the frame and that there was barely enough room to stand at the bottom of the steps of the ladder. He did acknowledge that he positioned the ladder initially and was able to stand and then step up in order to get up and down the ladder. He described that after his task, he was descending the ladder "backwards," that is facing the platform and the steps.

He indicated that the nearest part of the frame was in front of the front of the ladder and he could not reach it. Respondent's witness and Petitioner's supervisor at the time, Shawn Casey, testified that the employee should be maintaining three points of contact by holding on to the frame and the employee is to position the ladder in a way that they can maintain that third point of contact. Petitioner told Respondent's examiner, Dr. Stephen Weiss at the time of his IME on November 10, 2015, that during the event in question, he did not fall because he was able to grab on to the frame of the truck. (R's Ex. 3, p. 8).

Petitioner testified that as he descending the ladder, he had in his hands the tools he was using and he was stepping "backwards" off the bottom step onto the floor. He testified first at arbitration "that's when my leg gave out on me." He then testified "well, my right leg twisted as I was coming down off the ladder." He testified that after this happened, he had pain in his right groin area down through his leg into his knee. He stated at arbitration that when he was taken to the Caterpillar plant medical department, he told them that he had his hands full of tools and his right leg twisted and "my leg just gave out on me." He was sent from Caterpillar medical to the hospital and by the time he got back from the hospital, his shift was over. On cross-examination, he stated that he thought that "when my leg twisted, I was on the bottom part." He stated that his foot "touched the floor at some point." He did not "believe" his foot went flat on the floor. He stated that "when my leg twisted, I don't really know how I hit the floor" and he did not know one way or the other. He knew he had tools in one hand, he did not know if he had tools in both hands. He did not really know whether the wrenches threw him off balance or anything like that. He stated that "all I know is my leg twisted and I came down off the ladder." He did not bang into the frame that he knew of. He did not get thrown off balance hitting the frame or anything like that. There could have been something like a bolt or a tool or something that he stepped on on the floor, but not that he could remember. There was not any oil or grease or material on the floor that he was aware of. He did not catch his right leg on the ladder or anything like that. The photographs of the ladder reflect that the steps are ten inches high from tread to tread (R's Ex. 3, P's Dep. Ex. 2), Petitioner testified he thought this was higher than usual. Dr. Fabrique, the plant physician, testified that viewing the photographs, the last step down to the floor appeared to be less than the ten inches. (R's Ex. 4, p. 74).

Shawn Casey testified that he was the Petitioner's supervisor on the date in question and that he was summoned to the area where this incident occurred. He had a conversation with the Petitioner regarding the incident at the time. The Petitioner told him that he stepped down off the ladder and felt a pull in his right inner thigh. Petitioner did not say anything about twisting or losing his balance. He did not say anything about injuring his back. Mr. Casey asked Petitioner to give him a quick run down of what happened. He asked Petitioner if he had stepped on something, causing his foot to slip out and Petitioner denied this. He asked Petitioner if the ladder moved when he stepped off of it, and Petitioner said no. He asked him if he perhaps got his foot caught in the track system that runs down the length of the shop and Petitioner denied this as well.

At the plant medical department, the Petitioner filled out and signed an incident report. (R's Ex. 1, p. 136). On it, the Petitioner stated that he went to step off a ladder and "my leg just felt like it gave out." He complained of pain in the right leg groin area shooting down to his knee. Under the question on the form "describe type of injury/pain," he wrote the one word "twisted." (R's Ex. 1, p. 136). He was seen first by a triage nurse, Sheila Hale, who recorded a history that "as he stepped off bottom step on right leg, felt like right leg went out and almost fell down." (R's Ex. 1, p. 137). His description of illness or injury was listed as "right groin/leg." (R's Ex. 1, p. 137). He was seen at the plant medical department by Dr. Keith Fabrique, an occupational medicine physician, on that date; Dr. Fabrique recorded a history that "the employee's right leg gave in while stepping off a ladder." (R's Ex. 1, p. 141). Fabrique recorded a history that he did not slip or misstep on any floor or ladder defect. (R's Ex. 1, p. 141).

Petitioner authenticated at arbitration a signed statement he filled out on September 9, 2013, referable to the incident. (R's Ex. 9). On this statement, he wrote that "I went to step down, just felt like leg gave out." (R's Ex. 9). He acknowledged that his handwriting is on an application for disability benefits that he made based on the incident of September 9, 2013. (R's Ex. 8). He described at that time "I was standing on a ladder installing a hose and went to step down off ladder and pulled something in my right leg. My leg gave out on me but I didn't fall all the way down. I had pain shooting from my right hip down through my knee." (R's Ex. 8, p. 1). He saw a Dr. Chen whom he had treated with previously on September 12, 2013, and complained of pain in

the right thigh that started from the inguinal fossa going down to the knee. (R's Ex. 2, p. 4). To Dr. Chen, he stated that he "missed a step at work and felt like his knee was giving out on him." (R's Ex. 2, p. 4). He later told his primary care physician, Dr. Cunnington, that he "fell off a ladder." (P's Ex. 2, p. 79). He told his first pain management physician, Dr. Rehman, on November 20, 2013, that he was going up and down a ladder and "twisted wrong." (P's Ex. 4, p. 25). He told his second pain management physician, Dr. Glaser, on June 7, 2014, that he was injured after "falling coming down a ladder." (P's Ex. 5, p. 27). To his independent medical examiner, Dr. Coe, he stated on July 26, 2016, that he was climbing down the ladder and as he stepped to the floor, he "twisted," feeling pain with the twist. (P's Ex. 11, p. 14). Dr. Coe recorded in his notes from the IME that the Petitioner stepped down off the last step backwards and twisted around to begin to move away from the ladder, and that is when he felt a sharp pain. (P's Ex. 11, p. 73). On November 10, 2015, Dr. Weiss, Respondent's IME, understood from the Petitioner that as he stepped on the floor, his right foot gave way and rolled outward, and that he did not fall to the ground because he was able to grab on to the frame of the truck. (R's Ex. 3, pp. 7-8).

Petitioner acknowledged to Respondent's examiner, Dr. Weiss, that he had had prior chronic low back pain dating back to at least 2009. (R's Ex. 3, p. 7). His post-offer questionnaire at the time of employment with Caterpillar, dated July 2, 2005, acknowledged past low back problems for which he had seen a chiropractor. (R's Ex. 1, pp. 344-346). The records of Chiropractor Beyers reflect that he had a complaint on May 14, 2012, of low back pain radiating into the legs that he just woke up with although he noticed it mostly at work. (P's Ex. 9, p. 2). That episode improved by May 18, 2012. (P's Ex. 9, p. 3). Petitioner reported to Respondent's plant medical department on January 25, 2013, that he was having pain in the back and legs after returning to work following a layoff. (R's Ex. 1, p. 156). He went to the emergency room on this occasion. (R's Ex. 1, p. 156). By February 6, 2013, he was released to return to work without restrictions, but still with a pain level of 4/10. (R's Ex. 1, p. 159). He had improved motion on March 6, 2013, but still indicating that his pain level was 1/10. (R's Ex. 1, p. 159). He had seen Dr. Chen for this on January 30, 2013, and indicated that he had

improvement with medications and physical therapy, but he still at that time had tenderness at the lumbar spine, and decreased extension and flexion. (P's Ex. 1, p. 7).

After the September 9, 2013 incident, he saw a nurse at the plant medical department on the following day, September 10, 2013, and professed complaints regarding the right groin and hip with a slow gait, and pain in the upper thigh radiating down to the knee. (R's Ex. 1, p. 141). He saw Dr. Chen on the following day, September 12, 2013, and had the aforementioned pain from the inguinal fossa going down to the knee, and an inability to flex his leg without pain. (P's Ex. 1, p. 5). Dr. Chen felt that there was an obvious tear in the sartorius muscle which was quite tender. (R's Ex. 2, p. 4). He had complaints of leg pain and knee pain on that date. (R's Ex. 2, p. 5). He was then seen in the physical therapy department of Pana Community Hospital, first on September 20 and had complaints of pain and weakness in the left thigh. (P's Ex. 3, p. 127). The therapist did record, however, on that date that Petitioner had tenderness at the lumbar facets at L1, 2, and 3. (P's Ex. 3, p. 128). Then, on September 24, 2013, the therapist records that he has low back pain of 3/10 intensity before and after treatment. (P's Ex. 3, p. 131). He is then seen by Dr. Cunnington on September 30, 2013, and has complaints of right sided low back pain and a positive straight leg raise on the right, but no spasm on palpation of the back. (P's Ex. 2, pp. 84-85).

Thereafter, Petitioner complained of low back pain and radiation of pain to the right leg, to March 26, 2014. (P's Ex. 2, pp. 71-82). He was referred to Dr. Rehman of the Millennium Pain Center on November 20, 2013, and thereafter underwent a series of injections through May 28, 2014; he also received a Butrans patch which he professed decreased his pain. (P's Ex. 4, pp. 6-25). At arbitration he testified that these injections provided him with minimal relief. He then sought treatment from Dr. Glaser, a pain management physician in the Chicago area, who provided another series of injections. (P's Ex. 5, pp. 26-27; 43; 50-51). At arbitration he professed that he received somewhat more relief from these but it was temporary. The November 12, 2014 note of Dr. Glaser indicates that he had 60% relief for a week, but the pain returned. (P's Ex. 5, p. 18). Based on this, Dr. Glaser placed a trial spinal stimulator on March 18, 2015. (P's Ex. 5, p. 49). He referred the Petitioner to a Dr. Lubenow for a permanent stimulator implantation. (P's Ex. 7, pp. 17-19). Dr. Lubenow implanted a

permanent spinal stimulator with the battery placed at the left flank on May 12, 2015. (P's Ex. 8, pp. 28-31). Petitioner testified at arbitration that he understood that the stimulator pulse generator had to be moved from his flank to his chest area because it had been placed in the wrong location. However, the second surgeon, Dr. Young, in his operative report of May 26, 2015, notes that the spinal stimulator pulse generator had migrated from the left flank to the midline resulting in incisional pain for the Petitioner necessitating the removal. (P's Ex. 8, pp. 183-185). He repositioned the stimulator to the Petitioner's left anterior abdomen. (P's Ex. 8, pp. 183-185). Post-operatively on July 6, 2015, Dr. Glaser noted that the Petitioner's low back pain and buttock and leg pain had been decreased both in frequency and area and he had excellent coverage. (P's Ex. 5, p. 6). He noted that Petitioner was sleeping better and his activity levels were substantially higher. (P's Ex. 5, p. 6). On July 6, 2015, Dr. Glaser released the Petitioner to return to work at regular duty. (R's Ex. 1, p. 110). Dr. Fabrique, the plant physician, testified that he maintained the Petitioner on his previous restrictions until his physical capacities could be better determined and suggested a physical capacities evaluation. (R's Ex. 4, p. 16). Fabrique had an in-house athletic trainer evaluate some of Petitioner's job tasks, and then referred him for a full FCE at St. Mary's Occupational Health in Decatur. (R's Ex. 4, pp. 16-17). The functional capacities evaluation was conducted on August 10, 2015. (R's Ex. 5, p. 2-3). To the therapist conducting the FCE, he reported that he sustained an injury on September 9, 2013, when he fell while descending a ladder with heavy work equipment due to his right leg "giving out." (R's Ex. 5, p. 3). The therapist conducting the functional capacities evaluation compared Mr. Hinton's performance on the functional testing to his job description and determined that he was capable of returning to work as an assembler at Caterpillar. (R's Ex. 5, p. 3). Dr. Fabrique recorded that he gave the Petitioner a full medical release for regular duty effective August 11, 2015. (R's Ex. 4, p. 18). In follow up on August 26, 2015, Petitioner had some complaints of difficulty lifting and some shoulder difficulties, but he was continued on regular duty. (R's Ex. 4, pp. 18-19). He had one subsequent report of back pain while doing a job which required him to bend over to get into and out of a truck frame, but this was addressed with a job modification to use a stool to roll under and out from under the frame. (R's Ex. 4, pp. 22-23).

Petitioner was examined at his own request by Dr. Jeffrey Coe, an occupational medicine physician, on July 26, 2016. (P's Ex. 11). Dr. Coe's understanding of the Petitioner's September 9, 2013 incident was that he as climbing down the ladder backward and as he stepped to the floor, he twisted. (P's Ex. 11, pp. 13-14). He clarified from his notes that the history he received was that the Petitioner stepped down off the last step and twisted around to begin to move away from the ladder and felt a sharp pain, feeling as if his right leg would give out and he almost fell down. (P's Ex. 11, p. 72). Dr. Coe offered the opinion that the work activities described were a factor in causing an aggravation of the Petitioner's pre-existent lumbar degenerative disc disease and arthritis resulting, in his opinion, in acute break down of the L4-5 disc and the onset of acute back pain. (P's Ex. 11, p. 49). He felt that the mechanism as he understood it was capable of causing injury to the lumbar spine through an "unbalanced eccentric load twist" causing breakdown in the annular ring of a disc. (P's Ex. 11, p. 50). He rated the Petitioner's permanent impairment under the Sixth Edition of the AMA Guides at 12% whole person impairment. (P's Ex. 11, p.57). He testified that the history of twisting was part of the basis for his causation opinion in the case. (P's Ex. 11, p. 74). He could not say that the Petitioner holding a tool in his hand had anything to do with what had happened, although the Petitioner did say he had a tool in his hand. (P's Ex. 11, pp. 73-74). Given a hypothetical question that would eliminate the twisting mechanism, he indicated that it would not be clear that anything happened to the Petitioner's back. (P's Ex. 11, p. 77). He stated that it was possible that a condition of polyneuropathy or foraminal encroachment such as the Petitioner had, can cause an episode of a leg giving out. (P's Ex. 11, pp. 66-67, 78). He testified that the hypothetical of simply stepping down could be a competent mechanism of a low back injury if there was "something off balance" which causes eccentric loading of the spine such as with a stumble or jerk. (P's Ex. 11, pp. 86-87). Unpredictable movement can place an unbalanced load on the spine. (P's Ex. 11, p. 87). He would not expect this to occur, however, from simply stepping down. (P's Ex. 11, p. 87).

Respondent had the Petitioner examined by Dr. Stephen Weiss on November 10, 2015. (R's Ex. 3, p. 7). Dr. Weiss took the history that as Petitioner was stepping down, his right foot gave way and rolled outward, and he grabbed on to the frame so he did not fall down. (R's Ex. 3, pp. 7-8). The history that he understood from

the medical records was that the Petitioner was coming down a stepladder and basically, his leg gave way. (R's Ex. 3, p. 7). He noted that the initial description of pain was on the inner aspect of the right thigh and that the pain diagram filled out by the Petitioner at the time was consistent with right anterior hip and thigh pain. (R's Ex. 3, p. 8). Dr. Weiss's diagnoses were of pre-existing degenerative disc disease with a stimulator implantation, and an injury in the nature of either a strain or a rupture to the sartorius muscle, which had resolved by the time of the IME. (R's Ex. 3, p. 10). He rated impairment under the Sixth Edition of the AMA Guides based upon the sartorius strain diagnosis of 0%. (R's Ex. 3, p. 12). Dr. Weiss indicated that at the time of the examination, the Petitioner was talking primarily about back pain running down the leg, but those were not the symptoms he had at the time of the injury. (R's Ex. 3, p. 14). He thought that the history the Petitioner gave at the time of the IME was more consistent with a sartorius muscle tear than the history in the medical records; he did not see how coming down a ladder, one could tear the sartorius muscle in the absence of some sort of a twist or some other such mechanism. (R's Ex. 3, pp. 36-37). He felt that if the back pain, spasm, or stiffness, were related, there would have needed to have been symptoms within 48 to 72 hours although after that point, the pain could worsen or change in character. (R's Ex. 3, pp. 42-44). He noted that if the Petitioner's pain were radicular pain, it would have corresponded to a high lumbar level of the spine, at L2-3, not at L4-5 or L5-S1. (R's Ex. 3, pp. 75-76). He did not know precisely when the sartorius muscle strain would have resolved, but noted that by March of 2014, the Petitioner was clearly having pain coming from his back because he had complaints in both legs, inconsistent with a right sartorius muscle strain. (R's Ex. 3, p. 48). Radicular symptoms usually come from the lower lumbar levels and 98% to 99% of radicular cases come from the L3-4 level and below. (R's Ex. 3, pp. 75-76).

Dr. Keith Fabrique, the plant physician, testified that his understanding from the initial incident report and the triage note was that the Petitioner stepped off a ladder and felt his right leg give in on him, and that there was no strength for a moment. (R's Ex. 4, pp. 8-9). Petitioner's history to him on September 9, 2013, was that he had an onset of right hip and groin pain immediately during the incident and that his right leg gave in while he was stepping off a ladder. (R's Ex. 4, p. 9). Petitioner did not slip or misstep on the floor and there was no

ladder defect. (R's Ex. 4, p. 9). Petitioner did not voice any low back complaints at the time. (R's Ex. 4, p. 10). Dr. Fabrique indicated that he did not believe that anything had happened in the way of an injury at work, basing that on the understanding that Petitioner's leg simply gave out with simply no other explanation. (R's Ex. 4, p. 12). He acknowledged that there was no indication before September 9, 2013, that the Petitioner had had any hip or groin pain or pain radiating to the right knee. (R's Ex. 4, p. 30). His opinion was that the diagnosis of lumbar radiculopathy was not related to coming down the ladder. (R's Ex. 4, p. 33). He felt that there did not appear to have been an event that caused an injury, although he was coming down the ladder when the symptoms developed. (R's Ex. 4, pp. 43-44). Given the history that the Petitioner had his leg give out for no apparent reason, he did not inquire whether or not the Petitioner was coming down the ladder facing toward it or away from it. (R's Ex. 4, p. 46). He felt that the back condition and surgery were not the result of the September 9, 2013 incident. (R's Ex. 4, p. 88).

Petitioner testified at arbitration that he is working regular duty as an assembly and test specialist 3. He currently performs assembly work building parts up on motors for large trucks. He might have to use one small ladder but most of the work is on the floor. He is not supposed to lift over 30 lbs in this job. He does use wrenches, ratchets, and air guns. Some of the job is done while sitting on a stool, but it involves more standing than sitting. He works a full 40 hour week in this job, but has not worked any overtime since he returned. He testified that the spinal cord stimulator helps 40% to 50%, but he still has ongoing pain. He avoids playing basketball, which he used to do, due to stiffness and he does not do as much gardening as he used to do. As of his independent medical examination, Dr. Coe felt Petitioner had a mildly antalgic gait; tenderness over the lower lumbar facet joint; decreased range of motion of the low back; and an absent right knee jerk with mild atrophy in the right leg. (P's Ex. 11, Dep. Ex. 2, p. 9). Dr. Weiss at the time of his examination found the Petitioner to have a normal gait; symmetrical reflexes; negative straight leg raising; no EHL weakness; and mild to moderate paravertebral muscle spasm in the areas adjacent to the stimulator scar. (R's Ex. 3, Dep. Ex. 2, p. 7). At the time of the Petitioner's functional capacities evaluation, Petitioner complained of dull achy pain affecting his low back, bilateral knees, and ankles in addition to a professed muscle weakness in the back and

legs. (R's Ex. 5, p. 4). His current pain at the time of the evaluation was 2/10. (R's Ex. 5, p. 4). At the time of the FCE, the Petitioner demonstrated a normal gait; the ability to squat and balance on each leg; the ability to climb stairs; and the ability to maintain good balance and stability on even and uneven surfaces. (R's Ex. 5, p. 5).

CONCLUSIONS OF LAW

Issue (C): Did an accident occur that arose out of and in the course of the Petitioner's employment by Respondent?

As is indicated in the Arbitrator's order, the Petitioner did prove an accident arising out of his employment on September 9, 2013. In arriving at this conclusion, the Arbitrator first has to glean from the evidence exactly what happened to the Petitioner as he performed his job as an assembler. On said date, the parties agree that he was using a device known as a Cotterman 3-step ladder in order to gain access to the truck on which he was applying hoses. The ladder, depicted in RX 1, is obviously an industrial device not seen in an average home. It is a rolling step ladder consisting of three steps. It is sized so that it can fit within the large truck frame in which the Petitioner was performing his job. There are no hand rails on the ladder. There are 10 inches between each of the three steps and the distance between the bottom step and the ground, according to the photos and the testimony of the plant physician, is of a lesser distance. (RX 4 at 74) The physician, Dr. Fabrique, also said that 10 inches between steps is higher than what he normally would encounter as he walked on the normal staircases at the Respondent's facility. (Id at 77)

The evidence further establishes that the Petitioner, after finishing his job, was descending the steps in a backwards fashion, facing his machine. His supervisor, Mr. Casey, testified that the Petitioner had been instructed to descend from the steps in that fashion. It was further established that the Petitioner was carrying at least one tool, weighing something less than five pounds, as he made his descent. If that weren't the case, then it's unlikely that Mr. Casey, who investigated the accident beginning on the date that it occurred, would have bothered to weigh the tool. (See Dep. X 3-5, RX 4)

So exactly what happened as the Petitioner made his descent? Respondent argues that a clear scenario was not established because the many histories that the Petitioner provided to his many medical providers and examiners, along with his testimony at arbitration contained inconsistencies. The Arbitrator acknowledges the variations but does not feel that they adversely affect neither the Petitioner's credibility nor the meeting of his burden of proof. It is understandable that the histories recorded long after the occurrence might not be identical. The Arbitrator has looked at the histories provided by the Petitioner in the days following the accident are consistent and provide the most likely account of what happened as he made his descent. The Arbitrator is also mindful of the validity findings on the Petitioner's FCE, along with the numerous references in the medical evidence that the Petitioner was telling the truth.

In his incident report filed on September 9, the Petitioner wrote that as he went to step off the ladder, he felt pain down the right leg, from his groin to the knee. (RX 2 at 136) He also said that it felt like his leg gave out and he twisted. Later that day, he told Mr. Casey that as he was coming down from the ladder, he felt a pull in his right inner thigh. (RX 4, Dep. X 3) When he saw Dr. Chen on September 12, he said that he missed a step coming off the ladder. (PX 1) Importantly, he also said that his right leg felt like it gave out on him when he saw Dr. Fabrique at St. Mary's Hospital on September 9. He also said that he did not fall to the ground because he was able to grab onto the truck frame.

The Arbitrator believes that this evidence allows him to make some reasonable presumptions. First of all, the Petitioner was heading backwards down a set of stairs with steps of uneven heights after performing his job. He no doubt had other thoughts in his mind besides whether to make sure he slowly hit each step and then the ground safely. He unexpectedly missed a step, probably the last step, and in doing so injured his right groin area. Again, if the step heights were of no concern, it's unlikely that Mr. Casey would have measured them as part of his investigation. (Rx 4, Dep X 5) When his foot hit the ground, his leg likely did give out on him. Whether he twisted after hitting the ground is not really important, given the Arbitrator's conclusions on causation, but the Arbitrator agrees with Dr. Weiss that it certainly would have been likely. (RX 3 at 74)

If, on the other hand, the Petitioner hit the ground before injuring his groin, then it would be most likely that the injury occurred when he twisted immediately thereafter. Either way, the accident arose out of his employment.

In order to prove that he sustained an accident that arose out of and in the course of the employment, must show an increased risk associated with the employment. *Brady v. Louis Ruffolo & Sons Construction Co*, 143 Ill.2d 542, 578 N.E.2d 921 (1991). There are three types of risk to which employees may be exposed: (1) risks that are distinctly associated with the employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Commission*, 378 Ill.App.3d 113, 116 (2007).

The facts found above establish that the Petitioner's accident came from a risk distinctly associated with his employment. Alternatively, the facts clearly established that if this was a neutral risk, it was qualitatively enhanced by the Petitioner's employment. There was really no evidence from which the Arbitrator could conclude that the accident resulted from risks personal to the employee.

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

The Petitioner has the burden to establish that his or her work is a causative factor to his or her condition of ill-being. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Commission*, 371 Ill.App.3d 882, 887, 864 N.E.2d 266 (2007). In assessing causation in this matter, certain facts are significant. Petitioner's incident report in this case reflected that he had pain in the right leg and groin traveling down to the knee. (R's Ex. 1, p. 136). Dr. Fabrique recorded a history of acute right hip pain and groin pain. (R's Ex. 1, p. 141). Petitioner's supervisor, Shawn Casey, testified credibly that the Petitioner stated after this event that he stepped down off the ladder and felt a pull in his right inner thigh. Dr. Chen, the first outside treating physician to see the Petitioner, indicated that Petitioner had pain in the right thigh that started from the inguinal fossa going down to the knee and that he obviously tore the sartorius muscle. (R's Ex. 2, p. 4). None of these close in time histories indicate

any low back complaints, low back pain and most importantly, any posterior or lateral leg radiation consistent with an injury to the lower lumbar spine.

Petitioner did not actually give a history of any low back complaint until September 20, 2013, while in physical therapy after his visit with Dr. Chen. (P's Ex. 3). Even then, his initial complaint was anterior pain in the leg when trying lift it into his car and moving his right foot to his brake. The therapist' only finding concerning the back was of tenderness to palpation over L1-3. Later on that week, his therapists did provide treatment to both his low back and his anterior right upper leg, and that treatment to both areas in therapy continued through the latter part of 2013. Dr. Cunnington of the Pana Medical Clinic did focus on the Petitioner's lumbar spine after his initial visit on September 30, and of course the treatment which followed for the next several years primarily concerned itself with that body part as well. Nonetheless, the Arbitrator cannot reconcile the Petitioner's initial symptoms of pain specifically over the area above his Sartorius muscle in the front of his leg and an injury to the lumbar spine, especially given his obvious longstanding arthritis and disc degeneration in the areas of his back from L3 to S1, as seen on his initial MRI of October 14, 2013.

The Arbitrator also finds significant the prior lumbar treatment in 2012 by Dr. Beyers and in 2013 by Dr. Fabrique, which on both occasions also involved posterior leg radiation. In fact, Dr. Chen's office note of January 23, 2013 suggested that the Petitioner might need an epidural steroid injection. (PX 1)

As to the opinions of the two medical examiners, the Arbitrator finds Dr. Weiss more persuasive than Dr. Coe on the causation issue as it pertains to the lumbar spine. While Dr. Coe did state that sometimes these symptoms in the front and the back of the leg can mask each other, he never really did discount the fact that all of the Petitioner's complaints from the accident date until September 20 excluded any reference to the posterior or lateral aspect of the leg or the low back.

The opinion of Dr. Weiss is that the Petitioner sustained a sartorius strain as a result of the event in question. (R's Ex. 3, p. 31). It is consistent with Dr. Chen's opinion that the Petitioner had an obvious sartorius muscle strain. (R's Ex. 2, p. 4). More fundamentally, the opinion of Dr. Weiss regarding the temporal relationship of back pain, spasm, and stiffness as a result of a spinal injury aggravating degenerative disease is

entitled to substantial weight. Dr. Weiss testified that if back pain, spasms and stiffness were related to the event on September 9, 2013, it would have needed to have been present in the first 48 to 72 hours after the event. (R's Ex. 3, p. 42). Certainly, the symptoms can progress over time, for example, from back pain to radicular pain, or from radicular pain to back pain, but within that two to three day window, there should be some back symptoms. (R's Ex. 3, pp. 42-44). It is difficult, however, to understand how the Petitioner could have injured his low back on September 9, 2013, and not have any documented back symptoms or findings until almost two weeks later. That is a long time, given the nature of degenerative spinal disease, and is substantial evidence that there was no relationship in a Petitioner who already had documented chronic degenerative disease leading to episodes of back and leg pain. (P's Ex. 1, p. 7; P's Ex. 9).

It is clear from the evidence that the Petitioner did injure his sartorious muscle as a result of his accident. It is also clear that this condition which caused him pain in the front of his thigh to his knee continued for quite some time and was the subject of much of his therapy in Pana. At arbitration, among the Petitioner's ongoing complaints was his inability to move his right leg from the gas pedal to his brake. The Arbitrator feels this symptom is consistent with and causally related to his accidental injury. On the other hand, for the reasons referenced above, the Arbitrator does not feel the posterior lumbar conditions for which the Petitioner has treated are causally related to said 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?

Consistent with the Arbitrator's conclusions on causation, the Petitioner is entitled to have received from the Respondent payment for the medical treatment involving the sartorious muscle injury. In reviewing all of the medical evidence, it is hard to separate it from that involving the lower back. The Arbitrator concludes that the initial treatment, all of the treatment from Dr. Chen, the treatment from the Community Medical Clinic of Pana through the visit of January 15, 2014 and all of the therapy at the Pana Hospital, which ran through February 6, 2014, is the Respondent's responsibility. The rest of the treatment is not, as it pertained to the Petitioner's lumbar condition.

Issue (K): What temporary benefits are in dispute – TTD?

The Petitioner is entitled to TTD benefits for the period until his Sartorius Muscle injury reached a point of maximum medical improvement. It is agreed that the Petitioner was unable to work from the accident date forward. The Arbitrator believes the medical evidence fairly establishes the date of January 14, 2014 as the date of MMI. On that date he was seen by Dr. Cunnington with complaints mostly involving his low back, but still with complaints of anterior pain from the hip to the knee. Under the law, that date would be the last date of entitlement to temporary benefits.

Issue (L): What is the nature and extent of the injury?

In considering the five factors set forth in Section 8.1b of the Act, the Arbitrator concludes as follows:

The AMA rating of Dr. Weiss is given no weight. The Petitioner sustained a torn sartorious muscle, as diagnosed by Dr. Chen three days after the accident. Dr. Weiss characterized the injury as a strain, which is completely different than an obvious tear.

The Petitioner is an assembly worker, which is a position which involves a considerable amount of standing and bending, despite the fact that he has been provided a stool to sit on when working under large trucks and other equipment. This factor favors the Petitioner insofar as his injury is concerned.

At the time of his injury the Petitioner was 55. This factor weighs in the Respondent's favor, as it will likely be a relatively short time until the Petitioner is no longer performing his job.

There is no evidence from which the Arbitrator can conclude a future wage loss. This factor favors the Respondent.

Finally, the Arbitrator noted above the injury. The Petitioner consistently complained of related symptoms of that injury for almost six months and received treatment. He credibly testified that he still has trouble with the injured area at the time of arbitration.

Based upon the above, the Arbitrator awards 5 % loss of use of the right leg.

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

Stephen Krol,

Petitioner,

vs. NO: 16 WC 06538

Spur Electrical,

Respondent, 17IWCC0689

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 total disability, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

17IWCC0689

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 $60,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 30 2017
o030817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

KROL, STEPHEN
Employee/Petitioner

Case# **16WC006538**

SPUR ELECTRICAL
Employer/Respondent

17IWCC0689

On 3/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
JEFF GIBELLINA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

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)

Stephen Krol
Employee/Petitioner

v.

Spur Electrical
Employer/Respondent

Case # **16** WC **6538**

Consolidated cases: ___

17IWCC0689

An *Application for Adjustment 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 **Wheaton**, on **1/25/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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, **11/13/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$98,696.00**; the average weekly wage was **$1,898.00**.

On the date of accident, Petitioner was **58** 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 **$22,572.49** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,000.00** for other benefits, for a total credit of **$27,572.49**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $8,475.67, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,265.33/week for 62 4/7 weeks, commencing 11/14/15 through 1/25/17 , 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

3/2/17
Date

MAR 8 - 2017

FINDINGS OF FACT

17IWCC0689

This case involves a Petitioner alleging that he sustained injuries while working for the Respondent on November 13, 2015. Respondent disputes Petitioner's claims, with the issues in dispute being: 1) accident; 2) causal connection; 3) medical expenses; 4) prospective medical care; and 5) TTD. This matter proceeded to hearing pursuant to Section 19b of the Act.

Petitioner was working for the respondent as a union electrician on November 13, 2015. Petitioner testified that the day before he was crawling in a tight space with no pain about the right knee and otherwise completing his job duties with no difficulties. On the morning of the accident, he was working on a roof changing pipe work. In attempting to move pipe from the west side of the roof to the east side, he slipped on moisture on the roof. He believed it might have been dew. In the process of slipping, his body went one way and his right leg went another. He was able to grab onto a bar to prevent a fall. He felt immediate and sharp pain in the front and all around his right knee. He immediately told a co-worker.

When Petitioner finished his work that afternoon, he had immense swelling about the knee. He called his supervisor and was directed to seek immediate treatment. He went to Riverside Medical Center. He advised that he had been walking on a roof when he injured his right knee. Edema was noted and Petitioner was diagnosed with a strain of the right knee. On that day, he was also seen at Excel Occupational Health. There he had an x-ray, which showed tricompartmental arthritis in the knee, which appeared to be similar to a 2012 x-ray.

Prior to the accident date, Petitioner testified that he had had an x-ray of the right knee in 2012 that noted degenerative changes. Petitioner testified that since the x-ray, he had not had any symptoms or treatment. Petitioner's treatment with Dr. Villegas in 2013 and prior to the accident in 2015 was for a multitude of issues: hyperlipidemia, coronary arthrosclerosis, esophageal reflux, malaise and fatigue, benign hypertension, and psoriasis. For the latter, Petitioner had been prescribed Humira. There was no indication that Petitioner had any right knee symptoms.

Following the November 13, 2015 incident, Petitioner continued to follow-up at Excel Occupational Health where his employer had sent him. He was placed on sedentary duty and Dr. Pillar ordered an MRI. The right knee MRI, taken on December 3, 2015, showed a completely torn medial meniscus, destroyed articular cartilage, bone marrow edema, moderate to severe irregular cartilage thinning about the entire trochlea, and grade 1 change in the patellar cartilage but no defects or areas of thinning. Overall, it was noted that Petitioner had severe osteoarthritis.

On January 8, 2016, Dr. Pillar referred petitioner to Dr. Maday who noted bone on bone changes in the medial compartment and noted that Petitioner may be a candidate for total knee replacement. Dr. Maday evaluated the Petitioner on January 15, 2016, reviewed the MRI, and noted both degenerative changes and a bone bruise on the tibial and femoral articular surface. Additionally, there was a tear of the entire meniscus with grade 4 chondromalacia. Dr. Maday did not think arthroscopic repair was an option.

Petitioner returned to Dr. Pillar on January 21, 2016 and described instability in the right knee and recent giving out. Dr. Pillar noted swelling throughout the right knee. On February 5, 2016, Petitioner advised Dr. Maday that he was still having pain despite medication and a recent injection. Dr. Maday noted the meniscal pathology and that a total knee replacement may be required.

17IWCC0689

Respondent retained Dr. Lieber for an IME on February 24, 2016. Dr. Lieber opined that the Petitioner's current knee condition was not causally related to the November 13, 2015 incident, that at most, Petitioner's sustained a strain that had resolved, and that Petitioner could return to regular duty work.

On March 3, 2016, Petitioner followed-up with Dr. Pillar, who indicated that Petitioner sustained a knee sprain and meniscal tear but was found to have significant underlying degenerative changes in the right knee. Dr. Pillar discussed total knee replacement and released Petitioner from care. The doctor then wrote a follow-up note on April 7, 2016 wherein he indicated his disagreement with Dr. Lieber's assessment that Petitioner could return to regular work duties.

On August 8, 2016, with his other treatment options denied, Petitioner sought the consult of Dr. Hallman. The doctor reviewed Petitioner's diagnostic studies of the right knee and concluded that a traumatic event likely aggravated Petitioner's significant pre-existing arthritis. He continued to treat Petitioner through December 29, 2016 at which time he was awaiting authorization to proceed with a right total knee replacement.

On August 10, 2016, Dr. Lieber testified via evidence deposition. He testified regarding the Section 12 examination he conducted on February 24, 2016. On physical examination, he found pain at extremes of motion, tenderness about the medial and lateral joint line, positive McMurray and Steinman tests (used to detect meniscal pathology), and tenderness about the patellofemoral joint. He diagnosed degenerative joint disease and osteoarthritis of the right knee. He did not believe there was a causal relationship between the accident and the present symptoms or diagnosis. The doctor testified that he had reviewed the x-rays for any potential acute problem and that "there was no evidence of any acute abnormality within those x-rays that in [his] opinion could be related to the alleged November event." Rx 2, p. 11. The doctor was not sure if he reviewed the x-ray films himself or just the report. Rx 2, p. 11. When asked about what he would be looking for to determine whether an acute trauma had occurred on the date of accident, Dr. Lieber testified that "on the MRI, which is more sensitive, you would see evidence of acute bone lesions or injuries that could have been associated with a more recent event, of which there were none, such as bone edema, soft tissue swelling, things like that." Rx 2, p. 12-13. Based upon "history as given, indicating a prior history of knee problems, physical exam, diagnostic studies, record review, and [his] medical knowledge", Dr. Lieber opined that "100 percent [Petitioner] had symptoms within his knee prior to that November event". Rx 2, p. 13.

On cross-examination, the doctor acknowledged that there was no evidence that Petitioner had been previously recommended for total knee replacement. Rx 2, p. 16. In terms of pre-accident symptomology, he posited that perhaps Petitioner did not understand his questions during examination when Petitioner said he did not have pain prior to the accident. Rx 2, p. 21. The doctor believed that Petitioner's degenerative osteoarthritis was not aggravated or accelerated in any way and that increased symptoms after the accident were coincidental. Rx 2, p. 23. He believed that the strain that Petitioner had sustained as part of the accident, had resolved and could not account for even 1 percent of Petitioner's right knee pain. Rx 2, p. 24.

Dr. Hallman testified via deposition on December 7, 2016. The doctor testified that he is an orthopedic surgeon who performs adult reconstructive surgery with the bulk of his practice in the knee and hip areas. Px 5, p. 6. He testified that Petitioner was in need of a total knee replacement due to arthritic changes at the joint. Px 5, p. 14. He believed that Petitioner's arthritic changes have been developing for an extended period of time but that the November 2015 incident probably aggravated the condition. Px 5, p. 14-15. Dr. Hallman commented that Dr. Maday did "a lot of arthroscopic surgery and sports medicine type of work" and that Petitioner may have been referred to Dr. Maday "with the hope that his main problem was due to the meniscus and perhaps amenable to arthroscopic surgery, but Dr. Maday had advised the patient that he wasn't really a candidate for an arthroscopic

17IWCC0689

procedure and that he would ultimately require a total knee replacement." Px 5, p. 16-17. The doctor testified that the November 13, 2015 accident did accelerate the need for right total knee replacement. Px 5, p. 21.

Petitioner testified that he wants to pursue the medical treatment recommended by his various treating physicians.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. This finding is based on the Petitioner's unrebutted testimony regarding the events of November 13, 2015. Petitioner was working on a rooftop at the time and slipped on moisture on the roof surface, which he believed may have been dew. Although he did not fall, Petitioner credibly testified that he experienced immediate pain in his right knee after he slipped. Respondent disputes this issue based on the argument that there was no increased risk of injury present when the incident occurred. However, this argument overlooks the fact that the Petitioner was working on top of a roof, which in itself presents a great deal of increased risk, particularly the exposure to the elements that would make it very foreseeable for a worker to slip on a wet surface. There was no evidence presented to rebut Petitioner's testimony. Therefore, the Arbitrator concludes that the Petitioner sustained an accident arising out of and in the course of his employment with Respondent on November 13, 2015.

2. Regarding the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on both the Petitioner's testimony and the medical evidence. Given Petitioner's unrebutted testimony that he did not have any problems with his right knee prior to the accident date and that the Petitioner's prior medical records do not show any significant treatment to or complaints regarding Petitioner's right knee, the Arbitrator finds persuasive the opinions of Petitioner's treating physician Dr. Hallman - who acknowledge Petitioner's pre-existing degenerative arthritis, but puts forth a reasonable opinion that the condition was aggravated or accelerated to the point of the need for surgical intervention. The Arbitrator notes that the Respondent disputes this issue based on the opinions of their IME, Dr. Lieber, who did not believe Petitioner sustained an accident, in part because he did not see any evidence of any acute injury in any of the objective tests. However, Dr. Lieber failed to note that the MRI taken just after the accident shows bone bruising on the tibial and femoral articular surface. Dr. Lieber's explanation as to why the Petitioner did not have any complaints of right knee pain prior to the date of accident is also not persuasive. In light of all the medical evidence, the Arbitrator concludes that the Petitioner's current condition of ill-being in his right leg is causally related to his November 13, 2015 work accident.

3. Based on the Arbitrator's conclusions with regard to the issues of accident and causation, the Arbitrator further finds that the Petitioner's medical treatment and the expenses stemming from that treatment, have been reasonable and necessary in the treatment of Petitioner's work-related right knee condition. Accordingly, the Respondent shall pay for the following medical expenses totaling $8,475.67: $6,424.00 from Excel Occupational - which is the employer's directed clinic (Px. 1); $1,012.67 from Midland Orthopedic - where petitioner was referred by the company clinic; and $1,039.00 from Dr. Hallman.

4. In accordance with the Arbitrator's findings above, the Arbitrator further finds that the prospective medical treatment recommended by Petitioner's treating physicians is reasonable and necessary in addressing Petitioner's work-related condition. Respondent shall authorize and pay for the recommended treatment, including the proposed knee replacement surgery for Petitioner's right knee as indicated by Dr. Hallman and Dr. Maday.

17IWCC0689

5. With regard to the issue of TTD, the Arbitrator finds that the Petitioner has been temporarily totally disabled from November 14, 2015 through the date of trial, January 25, 2017. This finding is supported by both the Petitioner's testimony and the medical evidence, which show that the Petitioner has been unable to return to his pre-injury job since the accident. This is clear in the opinion of the company clinic physician, Dr. Pillar, who specifically disagreed with Dr. Lieber's contention that Petitioner was at MMI and could return to full duty. Accordingly, the Arbitrator awards Petitioner 62 5/7 weeks of TTD commencing November 14, 2015 through the date of trial, January 25, 2017 in accordance with Section 8(b) of the Act.