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

JESSICA DEWITT,

Petitioner,

vs. NO: 13 WC 002574

LISA THOMAS SALON,

Respondent.

19IWCC0539

DECISION AND OPINION ON REVIEW

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

The Commission strikes the following clause from the Arbitrator's decision found on page three "and her Application for Adjustment of Claim is dismissed."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 24, 2017 is hereby affirmed and adopted.

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

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

No bond for removal of this cause to the Circuit Court is required as no award for payment has been entered. 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 1 - 2019
LEC/mav
O: 07/23/19
43

L. Elizabeth Coppoletti

Maria E. Portela

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision in its entirety. Petitioner certainly met her burden of proving by a preponderance of the evidence that her repetitive work duties as a hair stylist aggravated or accelerated her preexisting carpal tunnel syndrome on or around February 13, 2012.

Petitioner alleged she developed carpal tunnel syndrome due to work-related repetitive trauma in a companion to this case (case no. 13 WC 2575). In that case, she alleged a manifestation date of January 25, 2011. Unfortunately, the majority determined Petitioner did not meet her burden of proving she sustained a compensable injury due to repetitive trauma on or around January 25, 2011. As I explained in my dissenting opinion in the companion case, I believe the credible evidence clearly supports a finding that Petitioner's work as a hair stylist at the very least aggravated her carpal tunnel syndrome. Petitioner's job duties include tasks involving repetitive manipulation of her hands such as applying highlights using foils, touching up roots, and blow-drying hair. A cortisone injection in her right hand alleviated her symptoms for a period; however, as Petitioner's clientele continued to increase, so did the physical toll of her job. After a year of experiencing gradually increasing symptoms, Petitioner once again sought treatment. The majority seems to believe the correlation between Petitioner's steadily increasing work load and her gradually worsening symptoms is merely a coincidence. I believe the totality of the evidence proves this correlation is not by happenstance; instead, it is powerful evidence that supports a finding that repetitive trauma due to the constant manipulation of Petitioner's hands while styling hair at a minimum aggravated her underlying condition. Given Petitioner's testimony regarding the trajectory of her complaints, increasing clientele, and

Petitioner's very young age, I believe Petitioner presented more than ample evidence proving her work duties at the very least aggravated or accelerated her preexisting carpal tunnel syndrome.

For the forgoing reasons, I would reverse the Decision of the Arbitrator and would award appropriate benefits.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEWITT, JESSICA
Employee/Petitioner

Case# **13WC002574**

13WC002575

LISA THOMAS SALON
Employer/Respondent

19IWCC0539

On 10/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
AMYLEE HOGAN SIMONOVICH
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

2837 LAW OFFICES OF JOHN MARCINIAK
ROBERT P SABETTO
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jessica Dewitt
Employee/Petitioner

Case # **13 WC 2574**

v.

Consolidated cases: **13 WC 2575**

Lisa Thomas Salon
Employer/Respondent

19IWCC0539

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **June 27, 2017; August 24, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

E. [x] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] 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?

19IWCC0539

O. ☐ Other ______

FINDINGS

On **February 13, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $ **24,090.31**; the average weekly wage was $ **463.28**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received ~~all~~ reasonable and necessary medical services.

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

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

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

ORDER

Petitioner did not sustain an accident that arose out of and in the course of her employment with Respondent as alleged in the case at bar. No causal connection exists between her employment and her bilateral carpal tunnel syndrome as it relates to the case at bar.

Accordingly, her claim for compensation is denied and her Application for Adjustment of Claim is dismissed. All other issues are moot.

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

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

#001 George J. Andros
Arbitrator

October 20, 2017
Date

OCT 24 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jessica Dewitt Case # **13 WC 2574**
Employee/Petitioner

v. Consolidated cases: **13 WC 2575**

Lisa Thomas Salon
Employer/Respondent

STATEMENT OF FACTS

Petitioner filed two separate Applications for Adjustment of Claim alleging bilateral hand injuries (or, more accurately, repetitive trauma injuries to both wrists) that she claims are related to her employment with Respondent. The cases are consolidated and were heard together, but this Decision addresses only the claim for an alleged manifestation date of February 13, 2012.

Petitioner is a 28-year-old female and Respondent is a hair salon. Respondent has employed Petitioner since April 2009. *Tr., 8.* Petitioner attended Capri Beauty School ("Capri") full time for a full year from September 2007 until she graduated in September 2008. *Tr., 8, 49-50, 58; 2RX1.* She was required to complete 1,500 hours for her degree, and she testified that these hours were not all "hands on" but rather included books, tests, and classroom time. *Tr., 8-9.* According to Petitioner, the majority of her school work was "book work" in the classroom. *Tr., 53.* She admitted on cross exam, though, that she performed facials, waxing, manicures, and pedicures at school. *Tr., 54.* She earned certificates in "pivot point hair sculpture" and "men's hair sculpture," and she won an award from demonstrating superior proficiency in blow drying. *Tr., 54-55, 56, 57.* The Capri records show that Petitioner consistently attended school between 22 and 30 hours a week, and occasionally more than that. *RX1.*

Before her employment with Respondent, Petitioner worked as a receptionist for two or three years at another hair salon, Salon 151 or Alessandra Salon and Spa, which she started in 2004 and continued until after she completed beauty school. *Tr., 9-10, 50, 51.* Her job duties for this employer included answering phones, shampooing clients, and doing laundry. *Tr., 10, 51.* Sometimes she blow dried clients' hair, but it was "messy dry," which she described as a "quick dry" without using a brush to style it just so the client's hair was not wet. *Tr., 91-92.* According to Petitioner, it took one minute. *Tr., 93.* She denied that she ever worked as a stylist until she began working for Respondent. *Tr., 10.*

Petitioner testified that she initially worked as an associate for Respondent. *Tr., 11, 60.* This was a training position under a stylist, Jill, and Petitioner's job consisted of assisting Jill with tasks like applying color, shampooing, blow drying, and checking out clients. *Tr., 11.* She estimated that she assisted with 115 clients per month, and between five and nine per day depending on the hours she worked. *Tr., 11, 12.* Petitioner described holding a color brush in her right hand and sometimes a foil in her left hand. *Tr., 13.* She explained that she placed a piece of foil behind the hair and pulled the hair over the foil. *Tr., 43.* She estimated that she applies between 10 and 70 pieces of foil on each customer. *Tr., 44-45.* She estimated that she spent half her workday performing this task, and testified that time slots of a half hour were allotted to apply color "touchups" to the roots and an hour to apply highlights using foils. *Tr., 13.* She conceded that she did not hold these items in her hands for the entire time slot, but estimated that she spent half the time slot gripping them. *Tr., 13-14.* Petitioner likened the grip she used to apply color as similar to holding a pen. *Tr., 18.*

According to Petitioner, it is harder to blow dry than apply color, and she uses more strength and tension to straighten a client's hair than apply color. *Tr., 20.* As for foiling, she did not work on several clients in a row but rather "here and there." *Tr., 64.*

Petitioner used both hands to shampoo a client, and she testified that it took five minutes. *Tr., 14.* She did not grip anything while shampooing. *Tr., 14.* She also used a blow dryer on clients after Jill cut their hair. *Tr., 64.* It took between 30 and 45 minutes to blow dry hair. *Tr., 14-15.* Petitioner held the dryer with her right hand and a brush with her left. *Tr., 14-15.* She estimated that she blow dried half the clients she assisted on any given day. *Tr., 15.* She worked shifts between six and nine hours for five days a week. *Tr., 17.* A full time week is 32 hours. *Tr., 18.* Petitioner estimated that she spent half her workday using her hands. *Tr., 18.* As an assistant, Petitioner did not cut hair while she was on the floor, but she did cut hair on models about once a week. *Tr., 15, 16.* She also attended continuing education classes at Respondent's corporate offices. *Tr., 17.* On cross exam, Petitioner conceded that she did "something on one of [Jill's] clients" each day, but had periods of downtime where she did not do anything. *Tr., 61-62.* The associate program lasted ten months. *Tr., 62.*

Petitioner was promoted to stylist in February 2010. *Tr., 21-22.* She testified that she "did everything" with every client that sat in her chair. *Tr., 22.* She did not have an assistant. *Tr., 23.* She estimated that she saw four clients a day. *Tr., 23.* Once she became a stylist, Petitioner began cutting hair. *Tr., 24.* She uses scissors with her right hand and a comb with her left. *Tr., 24.* She blow dries each of her own clients. *Tr., 45.* She testified that she spends 30 to 45 minutes blow drying clients and using a brush to "finish a style." *Tr., 92, 93.* She estimated that she used both hands for 85% of the time she worked. *Tr., 24.* She gained more clients as she worked more. *Tr., 23.* She estimated that she works on 110 clients a month now. *Tr., 23.* The chairs are adjustable, allowing her to change the height of each client's head to accommodate her hand position. *Tr., 64.*

Petitioner denied that she noticed any numbness or tingling in her hands when she attended beauty school, but testified that she first noticed symptoms while she was in Respondent's training program. *Tr., 25.* Initially, her symptoms were numbness and burning at night. *Tr., 26.* The first doctor she consulted for her symptoms was Dr. James Schlenker on January 25, 2011. *Tr., 27-28.* Her mother, who works for the firm that represents her in this matter, directed her to him. *Tr., 78.*

Dr. Schlenker's office note of January 25, 2011, documents Petitioner's right wrist complaints that she reported she had for two to three years. *RX2.* Petitioner denied that she told him this. *Tr., 65.* Dr. Schlenker further documented that Petitioner's symptoms had increased in severity by one to two years of "repetitive work." *PX2.* She testified that she discussed her job duties with him, and his record notes her occupation as a hairdresser. *Tr., 28; PX2.* She complained of numbness in her right thumb while sleeping and popping and cracking in her right wrist. *PX2.* He recommended that she be checked for thyroid disease. *PX2.* Dr. Schlenker administered a cortisone shot and ordered an EMG. *Tr., 28; PX2.*

Petitioner testified that she called Respondent's general manager, Sue Kmak, from her car in the parking lot of Dr. Schlenker's office and told her she went to see a doctor for her right wrist and he administered an injection and took her off work for a day. *Tr., 29, 69, 82.* Dr. Schlenker referred Petitioner for an EMG, which she underwent on February 8, 2011. *Tr., 29-30, 68; PX2.* The EMG study – which documents Petitioner's complaints of tingling in the middle of the night and intermittent numbness, weakness, and burning that was worse when she woke up – was positive for bilateral carpal tunnel syndrome that was worse on the right. *Tr., 79; PX2.*

Petitioner testified that the cortisone shot relieved her symptoms, and that she was symptom free for six months to a year. *Tr., 30, 31, 93-94.* She did not seek any treatment for either hand during this time. *Tr., 68.* However, she testified that she worked extended hours during the holiday season, which she identified as November and December 2011. *Tr., 20, 33.* She testified that she noticed symptoms again after the holiday season in 2011. *Tr., 33, 80.* She conceded that she could not remember whether her symptoms were any worse in early 2012 than they were a year before in 2011. *Tr., 33-34.* On cross exam, she testified that her symptoms were "definitely the same if not worse." *Tr., 88.* However, she conceded that the burning and numbness she felt in 2012 was the same as what she felt leading up to treatment a year before in 2011. *Tr., 88.* She conceded that the symptoms in her left hand at present are also no different than what she felt leading up to treatment in 2011. *Tr., 89-90.*

Petitioner sent an email to Respondent's owner Tom Kmak on February 14, 2012. *Tr., 31-32, 70, 82, 94.* The email is contained in *PX11.* She testified that she asked for approval to schedule an appointment with a doctor for the "new return" of her hand symptoms. *Tr., 94.* In her email, Petitioner referenced telling Sue about wrist pain she had in January 2011, at which time a doctor gave her a cortisone shot that helped until "a couple weeks ago." *PX11.* Petitioner did not mention anything about working extended hours, any specific activities that provoked her pain, or the holiday season in 2011. *PX11.* She asked about approval from "the workers' compensation insurance carrier," and within two hours Tom responded that Sue made some calls and would be in touch with her. *PX11.*

Petitioner recalled giving a statement to a claims adjuster, Monica Schooler, around this time—in February 2012. *Tr., 83-84.* She remembered telling Schooler that she did not report her symptoms to Respondent when she noticed them in 2011 because she was new and was afraid of how that would look. *Tr., 84.* Although she did not remember whether she received a letter, she confirmed that the address on Respondent's letter dated February 22, 2012, was the address where she lived at the time. *Tr., 89, 2RX4.* The letter states that there was no coverage for her date of loss in January 2011. *2RX4.* Petitioner had no idea whether she ever received any other letter from Respondent's carrier, but she understood that her claim was disputed after she spoke with Schooler. *Tr., 97, 98.*

After waiting to see Dr. Schlenker for four hours, Petitioner decided to consult another physician, Dr. I.H. Durudogan, on March 29, 2012. *Tr., 34; PX1, PX3.* Petitioner related a history of cutting hair, and she complained of increased bilateral wrist pain that she noticed on January 1, 2012. *PX1, PX3.* She reported that she felt it was related to work, but Dr. Durudogan's impression was "age appropriate changes" in both wrists without any evidence of acute injury. *PX1, PX3.* Noting that she had an EMG/NCV a year before, he did not recommend repeating it. *PX1, PX3.* Instead, he ordered injections for both wrists, which Dr. Salman Chaudri administered on May 7, 2012. PX3. In the history section of his chart note, Dr. Chaudri noted that Petitioner had injections in the past, and that they helped. *PX3.* He noted that Petitioner related her symptoms to increased activity at work in January 2012. *PX3.* Petitioner testified that the injections again relieved her symptoms. *Tr., 35-36.*

Petitioner remembered attending the medical exam with Dr. Prassant Atluri and telling him about her job. *Tr., 46.* Dr. Atluri examined her on May 21, 2012. *2RX2.* Petitioner gave a history of onset of symptoms in approximately January 2011, which reported as numbness and tingling in both hands primarily involving the thumb and index finger. *2RX2.* Dr. Atluri noted that she was a hairdresser, which involves cutting hair, blow drying, and applying foil and touchups. *2RX2.* Petitioner reported an injection in her right wrist in January 2011 that helped for a year, and injections into both wrists in May 2012. *2RX2.* Her symptoms subsided after her then-recent injections. *2RX2.* Although she had a negative Tinel sign over both wrists on exam, Dr. Atluri's impression was bilateral carpal tunnel syndrome. *2RX2.* According to the doctor, Petitioner had moderately severe carpal tunnel syndrome when she underwent the EMG in February 2011, and her condition at that time had been progressing over the preceding two years. *2RX2.*

Dr. Atluri opined that Petitioner's bilateral carpal tunnel syndrome reached MMI with her last injection, but he further opined that her symptoms would recur in the future and would likely require surgery at some point. *2RX2.* In his opinion, her bilateral carpal tunnel syndrome was the same condition as the one that caused symptoms in January 2011 and would eventually require surgery. *2RX2.*

Petitioner continued working as a stylist after her injection in May 2012, and her symptoms did not return until December 2012. *Tr., 36; PX1, PX3.* She underwent another EMG on her right wrist on January 17, 2013. *Tr., 38.* Dr. Chaudri recommended a carpal tunnel release, which she underwent at Advocate Christ Medical Center on March 15, 2013. *Tr., 39.* Postoperatively, Petitioner completed physical therapy at ATI. *Tr., 40; PX4.* She was released to return to regular work duties on May 6, 2013. *Tr., 40.* She was off work from surgery on March 15, 2013, until May 6, 2013. *Tr., 40-41.* She returned to work as a stylist for Respondent, where she has remained at least as of the date of arbitration. *Tr., 41.* She consulted Dr. Chaudri two more times for symptoms in her left hand, once on February 9, 2015, and again on August 15, 2016. *Tr., 41-42.* Both times, he administered a cortisone injection. *Tr., 41-42.*

In response to a letter from Petitioner's attorney dated November 18, 2015, Dr. Chaudri wrote a letter "to whom it may concern" stating his opinion that Petitioner's bilateral carpal tunnel syndrome was "causally related, aggravated, and accelerated by her occupation as a hair stylist." *PX3.* He opined that the injection she received in January 2011 "most likely" decreased the inflammation around the median nerve to alleviate her symptoms, but it did not alleviate the compression across the nerve. *PX3.* He stated his belief that "the recurrence of symptoms and the need for surgery is an aggravation and acceleration of the previous diagnosis." Based on the EMG in January 2013, he connected a progression of right carpal tunnel syndrome to an increased workload during the "December 2011 – January 2012 holiday season." *PX3.* He did not identify any specific tasks or activities that contributed to the progression of Petitioner's condition. *PX3.*

In a later report from 2016, Dr. Atluri opined that the activities Petitioner performed in school and while working for Respondent were not typically done so with the intensity or frequency required to contribute to carpal tunnel syndrome. *2RX3.* Based on the onset of her symptoms and the activities she performed, he opined that Petitioner's condition was most likely idiopathic, noting her history of smoking. *2RX3.*

Petitioner's right wrist is much better at present, but she experiences numbness, tingling, and burning in her left wrist. Tr., 47. She notices symptoms most in her left hand while blow drying or foiling, and at night. *Tr., 42, 47.* She testified that when she first sought treatment, she was 250 pounds and workup for thyroid disease was recommended. *Tr., 66.* She testified that she started smoking in 2009 and continued to do so as of the date of arbitration. *Tr., 67, 71-72.* She has been working full duty for Respondent. *Tr., 71.* Her group carrier paid her medical bills, but some balances remain outstanding. *Tr., 45.*

Tom Kmak and his wife, Lisa, have been owners of Respondent's salon for 27 years. *Tr., 100-01.* Sue, Respondent's general manager, is Tom's sister. *Tr., 101-02.* Sue has been Respondent's general manager for 15 years. *Tr., 102.* Tom is familiar with Capri Beauty School. *Tr., 104-05, 145.* According to him, Capri is a school but also a hair salon where students service customers. *Tr., 105.* He agreed that Capri has book training, but he testified that students do in fact work on hair and customers pay for services at the school. *Tr., 105.* Students have customers for training purposes before they take their exams. *Tr., 106.*

Tom differed as to the amount of client work Petitioner performed during the associate program. *Tr., 109.* According to him, associates are "pretty much observing" for the first couple months, though they may do some hair. *Tr., 109.* The do not touch customers at first. *Tr., 110.* In fact, customers often did not want associates touching their hair. *Tr., 119-20.* Petitioner would not work any more than the stylist she assisted, and full time is 32 hours a week. *Tr., 110.* Tom estimated that Petitioner actually performed about 30% of the stylist's work. *Tr., 119.*

According to Tom, Respondent has different levels for its stylists based on skill and technique. *Tr., 111-12.* Level 1 is "entry level," and Petitioner was at this level from February 2010 until approximately August or November 2011. *Tr., 111, 112.* At Level 1, Petitioner performed hair services as well as waxing. *Tr., 113.* Some months, Petitioner services as few as 52 clients and in others as many as 83. *Tr., 121.* She has worked 32 hours a week. *Tr., 121.* On average, she serviced 50 to 60 clients a month. *Tr., 113.* Respondent tracked Petitioner's service and documented it in "growth sheets" through the years. *Tr., 114; 1RX1.* In February 2010, Petitioner serviced 68 guests, and among those guests she performed 16 "chemical" treatments that include touchups, highlighting, and foils. *Tr., 115, 116.* Between February 2010 and December 2016, Petitioner's clientele increased by about 200 clients. *Tr., 117, 152.* Tom's office was in the salon where Petitioner worked, and Tom observed her working both as an associate and a stylist. *Tr., 117.* On average, it takes an hour to service a client. *Tr., 120.* The workload, which is the number of clients, for each level is different, but the complexity is the same. *Tr., 128-29.* Petitioner is not "double-booked" at the salon. *Tr., 161.*

Respondent's accident reporting policy requires employees to report a work injury and bring a doctor's note. *Tr., 124.* At the time, only Tom, Lisa, and Sue would take such reports. *Tr., 124.* Tom was not notified of a work injury in January 2011. *Tr., 125.* He recalled no time when Petitioner was having difficulty performing any of her assigned tasks. *Tr., 126.* As of arbitration, Petitioner was working full duty without any complaints of difficulty. *Tr., 127-28.* Tom recalled the email about her hand that Petitioner sent him on February 14, 2012. *Tr., 130-31, 141.* This was the first time she made Tom aware of her condition. *Tr., 132.* He had not been given any medical record regarding Petitioner's wrist until her attorney sent him a fax on March 1, 2012. *Tr., 133.* Tom sent a copy of Respondent's personnel file for Petitioner to her attorney in response to a subpoena in 2013. *Tr., 135; PX10.* The records document that Petitioner used a sick day on January 26, 2011. *Tr., 136; PX10.* The reason noted was "carpal tunnel syndrome (pain in hand)." *Tr., 136; PX10.* A handwritten note from Petitioner referencing an earlier doctor's note she "forgot to give you on 1/26/11" accompanies a form completed by Dr. Schlenker that indicates "return to work status effective 1/26/11" and "Patient unable to work for 1 – 2 days after injection given 1/25/12." *PX10.* This is the extent of what was submitted regarding Petitioner's condition. *Tr., 158.*

CONCLUSIONS OF LAW

In support of his decision relating to (C), did an accident occur that arose out of and in the course of Petitioner's employment with Respondent; and (F), is Petitioner's present condition of ill being causally related to the injury, the Arbitrator makes the following conclusions of law:

A claimant alleging a repetitive trauma injury must meet the same standard of proof as an employee who alleges a sudden injury from a discrete event. Durand v. Industrial Commission, 224 Ill. 2d 53 (2006). Liability cannot rest on imagination, speculation, or conjecture. Chicago Park District v. Industrial Commission, 263 Ill.App.3d 835 (1994).

Petitioner claims that while working for Respondent she sustained a repetitive trauma injury affecting both wrists that manifested on February 13, 2012. The Arbitrator finds for a number of reasons that Petitioner has failed to meet her burden of proof.

First, nothing in the medical records or the testimony of either witness establishes that anything happened on February 13, 2012. Petitioner herself did not report anything that happened on this date to her multiple treating physicians, Respondent, or Dr. Atluri. The only place where this date appears is on her Application for Adjustment of Claim.

Second, the medical records are conflicting about when Petitioner's symptoms started. The histories she gave to her physicians vary extensively. She told Dr. Schlenker in January 2011 that she had experienced symptoms for two to three _years_ at that point. This timeframe is corroborated by the histories documented in both EMG studies: Dr. Manisha Saraf Khanna noted "an approximately two-year history" of symptoms in her EMG on February 18, 2011, and Dr. Roy Adair noted a "greater than 4-year history of bilateral right greater than left hand symptoms" in his EMG on January 17, 2013 *PX1, PX3*. Clearly, Petitioner was in beauty school when her symptoms started. By her own admission, she noticed symptoms not while she was working but at night and when she woke up in the morning. *Tr., 79; PX1, PX2*.

Third, Petitioner already had bilateral carpal tunnel syndrome on February 13, 2012. She identified different accident dates to different physicians, but again she has not established that anything happened on either date. However, a positive EMG confirmed that she had bilateral carpal tunnel syndrome in February 2011—a year before the manifestation date she alleges here. Petitioner wavered in her testimony but ultimately conceded that that symptoms that prompted her to seek medical treatment in 2011 were the same ones that prompted her to return for treatment in 2012. *Tr., 33-34, 88, 89-90*. She further conceded that her current left wrist symptoms are also the same as before 2012. *Tr., 89-90*.

Fourth, Petitioner has not demonstrated that she performed any activities in a manner that would cause or aggravate her carpal tunnel syndrome. She specifically identified blow drying and using foils as the cause of her symptoms. By her own admission, though, she did not perform these activities in a sustained or forceful manner. She testified that she worked more hours during the holiday season, and Respondent's "growth sheets" document that she serviced 78 clients in November 2011 and 96 in December 2011. *1RX1*. However, these numbers are well within the average Petitioner admitted she has normally serviced each month throughout her tenure with Respondent: between four and five clients a day.

Dr. Chaudri gave a positive causal connection statement based on correspondence from Petitioner's attorney: he opined that even though her carpal tunnel symptoms existed before February 13, 2012, her condition nonetheless was "causally related, aggravated, and accelerated by her occupation as a hair stylist." *PX3*. The problem with his opinion is that it shows a general understanding of Petitioner's job activities and provides "nothing from which one might conclude his opinion was a truly informed one." _Runyon v. Pincckneyville Correctional Center_, 15 IWCC 0367 (2015). This is insufficient to prove by a preponderance of the credible evidence that Petitioner's employment activities with Respondent caused her bilateral carpal tunnel syndrome because it fails to explain _how_. See, _Barrow_ at 15-17, _Scheppers v. Wal-Mart_, 14 IWCC 1036 (2014), page 20.

Conversely, Dr. Atluri gave a negative causal connection statement based on the activities Petitioner described to him: cutting hair, blow drying, and applying foil and touchups. *2RX2*. He specifically identified the basis for his opinion: the physical activities that Petitioner performed both in school and while working for Respondent _*were not done with the intensity or frequency required to contribute to carpal tunnel syndrome*_. *2RX3* (Emphasis added). Dr. Atluri's comments as to Petitioner's work activities are consistent with her testimony as well as Tom's. Furthermore, Dr. Atluri identified another cause of her condition, which he called "idiopathic:" smoking. *2RX2, 2RX3*. Petitioner testified that she has smoked since 2009. *Tr., 67*.

The totality of evidence establishes that Petitioner developed symptoms of carpal tunnel syndrome as early as 2009, and that her condition steadily progressed over time. Indeed, Dr. Atluri opined in May 2012 that Petitioner already had a moderately severe bilateral carpal tunnel syndrome, and that her symptoms would recur despite recent injections that relieved her symptoms and would ultimately require surgery. *2RX2*. This is exactly what happened: Petitioner's symptoms returned in December 2012, and she underwent a right carpal tunnel release in March 2013. She currently has symptoms in her left wrist. The Arbitrator finds Dr. Atluri's opinion to be credible and convincing: not only does Dr. Atluri demonstrate a better understanding of Petitioner's work activities, but his opinion is also entirely consistent with the course of treatment as documented in the medical records after his exam. Accordingly, the Arbitrator places greater weight on Dr. Atluri's opinions than those of Dr. Chaudri, and therefore adopts them.

Based upon the totality of the evidence, the Arbitrator finds the Petitioner did not sustain an accident in the course and scope of her employment as alleged in the case at bar.

Based upon the totality of the evidence, the Arbitrator finds the Petitioner's condition of ill being is not related to his employment with the Respondent as alleged in the case at bar.

In support of his decision relating to (E), was timely notice of the accident given to Respondent; (J), were the medical services provided to Petitioner reasonable and necessary; (K), what amount of compensation is due for temporary total disability; (L), what is the nature and extent of Petitioner's injury; and (M), should penalties or fees be imposed upon Respondent, the Arbitrator makes the following conclusions of law:

Because of his findings that Petitioner failed to prove accident and causal connection, the Arbitrator finds that Petitioner is not entitled to any compensation or medical benefits, and Respondent is not subject to penalties. All other issues are moot.

#001 George J. Andros
Signature of Arbitrator

10/20/17
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JESSICA DEWITT,

Petitioner,

vs. NO: 13 WC 002575

LISA THOMAS SMITH,

Respondent.

19IWCC0540

DECISION AND OPINION ON REVIEW

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

The Arbitrator found Petitioner did not sustain an accidental injury that arose out of and in the course of her employment with Respondent. The Arbitrator further found even assuming Petitioner sustained an accidental injury, she failed to demonstrate her current condition of ill-being, bilateral carpal tunnel syndrome, is causally related to her employment. The Commission agrees with the findings of the Arbitrator, in particular, with respect to both accident and causal connection and provides additional analysis in support of the same.

As the Court noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." "There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet the legal definition of 'repetitive.'" *Edward*

Hines Precision Components v. Industrial Commission, 356 Ill. App. 3d 186, 192, 825 N.E.2d 773 (2005). Instead, the Commission may review the manner and method of a claimant's job to determine if such duties are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory of recovery. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993), citing *Perkins Product Co. v. Industrial Commission*, 379 Ill 115, 120 (1942) ("the claimant's injury 'was directly connected with the manner and method in which she was required to do her work, and to use her arm in the discharge of her duties'").

The Arbitrator noted Petitioner failed to introduce any evidence of an accidental injury to her left hand manifesting itself on the claimed accident date of January 25, 2011. On January 25, 2011, Petitioner sought treatment from Dr. Schlenker complaining of right wrist pain for an approximate two to three-year duration. Petitioner makes no mention of any left wrist pain. Dr. Schlenker provides an injection to the right wrist and recommends further diagnostic testing. PX2. On February 8, 2011, Petitioner underwent an EMG/NCV study which was positive for bilateral carpal tunnel syndrome but sought no additional treatment for more than a year. During this period, Petitioner sought treatment with Dr. Lentzou, her primary care physician, on April 4, 2011 and failed to voice any complaints relative to either hand. PX1.

In April of 2013, Dr. Chaudri authored a report opining Petitioner's "condition of bilateral carpal tunnel syndrome was causally related, aggravated and accelerated by her occupation as a hairstylist." Dr. Chaudri further stated Petitioner reached MMI as of January of 2011 but her continued work as a hairstylist caused her symptoms to return. ON November 23, 2015, Dr. Chaudri authored an additional report in response to questions posed by Petitioner's attorney. Specifically, Dr. Chaudri was provided information as to Petitioner's job duties as follows: "Duties include using her hands to apply touch-up, foiling hair for hours at a time, blowdrying [*sic*] for 30-40 minutes at times, and cutting hair remaining time." Dr. Chaudri reaffirmed his opinion as to causation. PX5.

On June 4, 2012, Dr. Atluri authored a report following the evaluation of Petitioner at Respondent's request pursuant to Section 12 of the Act. Dr. Atluri concurred with the diagnosis of bilateral carpal tunnel syndrome which would likely require surgery. During the evaluation, Petitioner provided a history of her work duties as a hairstylist which was consistent with the information provided to Dr. Chaudri. On August 18, 2016, Dr. Atluri authored an addendum report opining Petitioner's work duties did not cause or contribute to Petitioner development of carpal tunnel syndrome as such duties were not "performed with the intensity or frequency required to actually contribute to carpal tunnel syndrome." Moreover, Dr. Atluri identified Petitioner's history of smoking as a contributing factor. RX2.

The Commission affords greater weight to the opinions of Dr. Atluri than those of Dr. Chaudri. Both doctors possessed a clear understanding of Petitioner's job duties but arrived at differing opinions concerning causation. In affording greater weight to Dr. Atluri's opinion, the Commission finds Dr. Atluri provided a basis as to his opinion where Dr. Chaudri did not. See *Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC. Dr. Atluri specifically stated Petitioner's work duties were not of sufficient intensity or frequency to cause or contribute to carpal tunnel syndrome. In opposition, Dr. Chaudri provided a conclusory opinion as to causation but provided no explanation in support of

such opinion. Therefore, the Commission finds Petitioner failed to prove that the method and manner of her work duties were sufficiently repetitive to cause or aggravate carpal tunnel syndrome.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on October 24, 2017, is hereby affirmed as modified above.

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

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

No bond for removal of this cause to the Circuit Court is required as no award for payment has been entered. 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 1 - 2019
LEC/mav
O: 07/23/19
43

L. Elizabeth Coppoletti

Maria E. Portela

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision in its entirety. After considering the totality of the evidence, I believe Petitioner met her burden of proving by a preponderance of evidence that repetitive trauma relating to her work duties caused or contributed to her carpal tunnel syndrome diagnosis in January 2011. The credible evidence supports a finding that Petitioner sustained a compensable work-related injury that manifested on or around January 25, 2011.

Petitioner began working for Respondent as a trainee in April 2009. After completing a year of training, Petitioner became a stylist in February 2010. Her duties included washing, blow drying, cutting, coloring, and styling each client's hair. Petitioner testified that she used both hands when completing her tasks. While the majority views the evidence regarding the history of Petitioner's symptoms as contradictory, I view this evidence very differently. Petitioner credibly testified that she initially began experiencing sporadic symptoms of numbness and a burning sensation in her hands in 2009 while working as a trainee. She credibly testified that her symptoms worsened as she began developing a larger clientele and spent more time performing duties

involving her hands and wrists. This history makes perfect sense and mirrors the way many repetitive trauma injuries manifest.

Petitioner's history of gradually worsening symptoms over the course of approximately a year does not disqualify her from proving her work duties either caused or contributed to her symptoms. After all, the proper inquiry in this type of case is not when Petitioner's symptoms first began. In cases alleging injury due to repetitive trauma, courts have determined that while a claimant may have endured symptoms for years, the condition did not manifest until treatment was finally necessary. The majority also fails to properly consider whether Petitioner's job duties aggravated or accelerated her carpal tunnel syndrome. Dr. Atluri, Respondent's IME doctor, notably does not even consider the question of whether Petitioner's duties aggravated or accelerated her underlying condition. This glaring omission significantly diminishes the doctor's credibility. Furthermore, Petitioner has no history of complaints of numbness and a burning sensation in her hands prior to becoming first a trainee and then a stylist. Absent some unknown traumatic event, there is no reasonable explanation as to how an otherwise healthy 22-year-old young lady developed worsening symptoms of carpal tunnel syndrome once she began working as a trainee and stylist. The correlation between Petitioner's increasing complaints and her increasing work load cannot be ignored. Dr. Atluri does not have a credible alternate explanation for the timing of Petitioner's increasing complaints.

For the forgoing reasons, I would reverse the Decision of the Arbitrator and would award appropriate benefits.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEWITT, JESSICA
Employee/Petitioner

Case# **13WC002575**

13WC002574

LISA THOMAS SALON
Employer/Respondent

19IWCC0540

On 10/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
AMYLEE HOGAN SIMONOVICH
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF)

- [ ] 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

Jessica DeWitt
Employee/Petitioner

Case # **13WC 02575**

v.

Consolidated cases: **13WC 02574**

Lisa Thomas Salon
Employer/Respondent

19IWCC0540

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **June 27, 2017 & August 24, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/25/2011**, 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 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 $**14,751.34**; the average weekly wage was $**283.68**.

On the date of accident, Petitioner was **22** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $**0** 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 the Petitioner did not sustain an accidental injury arising out of and in the course of her employment with Respondent, manifesting of January 25, 2011 as claimed.

The Arbitrator makes the additional findings that Petitioner failed to provide timely notice and that there is no causal connection between any claimed injury manifesting on January 25, 2011 and any claimed condition of ill being after February 6, 2011.

All claim for any 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.

#001 George J. Andros
Signature of Arbitrator

October 20,2017
Date

OCT 24 2017

Jessica DeWitt v. Lisa Thomas Salon 13 WC 2575

Statement of Facts: Petitioner enrolled in Capri Beauty College to become a hair stylist. She graduated in September, 2008, having completed 1500 hours of work which included classroom instruction, tests, on the floor working on clients and mannequins to demonstrate knowledge of cutting, coloring, blowing dry and styling hair. (Rx.#1 in 13 WC 2574; Rx.#2) Concurrent with her education she worked at Salon 151 doing receptionist work as well as shampooing clients and doing laundry. She admitted this work as well as her school work had involved use of both hands, but at trial denied any problems with her hands either before, or while working at Salon 151 and concurrently attending school through 2008.

She was hired by Respondent in April, 2009 as an "associate," working under another stylist and applying color, shampooing and blow drying that stylist's clients. She testified in a month she would probably work on some aspect of 115 client's hair, but also admitted there were "down times" when she did nothing at all. She worked at an adjustable height chair. She claimed she worked on about ½ of the stylist's clients each week. She admitted there was no one activity done all day. If she worked 32 hours in a week, about ½ of that was doing actual physical activities of some sort.

Respondent's general manager Tom Kmak testified that during Petitioner's one year training from April, 2009 to February, 2010 she probably worked on as few as 30% of the clients as most "did not like the trainee touching their hair."

In February, 2010 she became a stylist herself. She then worked on each client's hair completely. She didn't know how many customers she had each day, and thought maybe four. She held the scissors in her right hand, the comb in her left. She reported she first began experiencing problems with her hands after she started as stylist in February, 2010.

In the months of February, 2010 through December, 2010, Petitioner averaged about 18 clients per week. (Rx.#1) Mr. Kmak testified their average client's appointment took about an hour.

Petitioner is claiming a repetitive hand injury manifesting January 25, 2011. On that date she sought medical care with Dr. Schlenker, however, at this time reported only right wrist pain, for the past two to three years, with increased severity in the past year or two. She denied any injury although reported she worked as a hairdresser. It was noted she had been referred to this doctor by her mother's law firm. Dr. Schlenker recommended Petitioner undergo a thyroid scan, but also suspected right carpal tunnel syndrome. He ordered an EMG and provided a cortisone injection to her right wrist. (Px.#2)

Petitioner was seen by Dr. Khanna for the EMG February 8, 2011. She provided his office with a history of two years' numbness, weakness and burning in her right wrist and fingers. She was noted to smoke ½ pack of cigarettes per day. The EMG showed bilateral median neuropathy at the wrists, right worse than left. (Px.#7) No further medical care was sought at that time.

Petitioner testified following the cortisone injection she was symptom free for nine to twelve months. When seen by her primary care physician Dr. Lentzou for other issues April 4, 2011, Petitioner made no mention of any right hand problems at all. (Px.#1)

As she left Dr. Schlenker's office on January 25, 2011 she called Respondent and spoke to Sue Kmak, advising her she had just had an injection to the right wrist and would be off work for one day. That was the extent of the conversation. Petitioner testified she returned back to full duty after January 26, 2011, and continued working full duty into 2012. She has filed a second Application for Adjustment of Claim alleging further repetitive trauma resulting in injury to both wrists manifesting on February 13, 2012. That claim is maintained under **13 WC 2574** and will be addressed in that matter.

Petitioner did not receive further treatment after February 6, 2011 until after February 13, 2012. When then seen by Dr. Durodogan March 29, 2012 she reported an onset of symptoms only as of January 1, 2012, although elsewhere in the note advised her right wrist pain had started about a year earlier but that she had been *symptom free for about a year.* (Px.#3) When seen by Dr. Atluri for a Section 12 exam in her second case she advised him of symptoms first manifesting in January, 2011 but that she had then been fine for about a year following an injection to the right wrist. (Rx.#2 in 13 WC 2574)

When seen by Dr. Chaudri December 20, 2012 she advised of bilateral hand pain with onset January 1, 2012; elsewhere he recorded the onset as May, 2012. When seen again by Dr. Chaudri January 24, 2013 he now recorded a history of initial right wrist pain in 2011, and that she was *symptom free for about a year until this past January, 2012* when she began getting symptoms in both hands. (Px.#3)

Dr. Chaudri's narrative at the request of Petitioner's counsel dated April 29, 2013 discussed her bilateral hand condition, noting the injection received in January, 2011 decreased the inflammation around the median nerve, alleviated symptoms and allowed her to return to functional level, stating *at that time (she) was at maximum medical improvement.* He reiterated that opinion in an addendum dated November 23, 2015. While he did relate her condition to her work as a hair stylist, he did so with the belief she

worked on 90 – 100 clients per month, was performing styling duties about five hours per day and had no breaks. (Px.#5)

In Dr. Atluri's addendum of August 18, 2016 he concluded Petitioner's symptoms had been present since 2009, and that the duties she performed for Respondent did not cause or contribute to her condition. He noted she had not been performing extensive hairstyling duties before first manifesting her symptoms. He noted some carpal tunnel syndrome is idiopathic in nature, and may also be caused or contributed to by smoking. (Rx.#3 in 13 WC 2574) The medical records had documented her ongoing cigarette smoking along with her obesity.

Conclusions of Law

Regarding D) did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

Petitioner is claiming the repetitive work of a hair stylist between February, 2010, when she assumed that position, and January, 2011 resulted in a repetitive trauma injury to both hands. The Arbitrator notes that in that time frame, she was actually performing some aspect of hair styling about 18 hours per week. Petitioner admitted her styling duties varied, from shampooing to cutting to styling hair using a hair brush in one hand and a dryer in the other, and that she worked at an adjustable height chair. She admitted there was no particular force required in any of these activities with the exception of the "pulling" of the hair with a hair brush while drying it out.

The Arbitrator notes that while Petitioner claimed to have developed bilateral hand symptoms only during this time frame, in her earliest visit to Dr. Schlenker January 25, 2011 she told him she had been having symptoms for two to three years, with increased severity in the past year or two. That would place the earliest manifestation of symptoms to January, 2010 before she became a stylist, at best, and to either before she became employed with Respondent at all in April, 2009, or perhaps as early as back when she was still in school at Capri. Petitioner provided a similar, much more longstanding history of the problem when she saw Dr. Khanna February 8, 2011 for the EMG.

The discrepant manifestation dates only continue in later medical records: only as of January 2, 2012 to Dr. Durodogan February 13, 2012, later "about a year earlier" to the same doctor; since January 1, 2012 to Dr. Chaudri December 20, 2012, elsewhere since May, 2012.

The Arbitrator also notes that while Petitioner claimed bilateral hand problems at trial, she only complained of her right hand to Dr. Schlenker when seen by him for that first time January 25, 2011.

Dr. Atluri concluded Petitioner's duties as a hair stylist did not cause or contribute to her eventually diagnosed bilateral carpal tunnel syndrome. He noted contribution could be offered by Petitioner's cigarette smoking, which is both documented in the medical records and which Petitioner admitted to at trial. While Dr. Chaudri opined Petitioner's work duties caused her bilateral carpal tunnel condition, he did so without a correct understanding of her actual work load.

The Commission has rejected a carpal tunnel claim for a hair stylist on medical evidence the nature of the work varies, does not cause any particular stress on the affected body part, the activities involved different use patterns of the hands, and there was very limited forceful work; Lori Smith v. Havana Amusements d/b/a Hair Studio Spa and Fitness, 12 IL.W.C. 09395, 16 IWCC 598, 2016 WL 6435266.

The Arbitrator therefore finds Petitioner has failed to prove an accidental injury to either hand manifesting on January 25, 2011. Claim for compensation is denied.

Regarding E) was timely notice provided to Respondent, the Arbitrator makes the following additional finding:

Petitioner testified she called Sue Kmak as she left Dr. Schlenker's office on January 25, 2011 to tell her she'd just had an injection to the right wrist and would be off work for one day. She did not tell Ms. Kmak what her condition was, or that it might be work related. She returned back to work the following day and worked full duty for well over another year before seeking further medical attention and/or putting forth another workers' compensation claim. Tom Kmak testified to his knowledge Petitioner was working during that entire time frame without lost time or any difficulty.

There is absolutely nothing to suggest any notice of a claimed work injury was provided to Respondent at all in 2011. Petitioner did not file her Application claiming this injury until 2013. The Arbitrator therefore finds Petitioner filed to provide timely notice as required under the Act.

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

Even were the Arbitrator to have found an accidental injury manifesting on January 25, 2011 and that timely notice had been provided, the Arbitrator fails to find any evidence of a left hand injury at all. Petitioner made no mention of injury or symptoms to either of her treating physicians from whom she obtained care in 2011.

With respect to the right hand, Petitioner testified she was symptom free after receiving one injection to the right wrist on January 25, 2011. She did not seek any further medical care at the time after undergoing the EMG on February 6, 2011. She did not make mention of any hand issues when seen by her primary care physician Dr. Lentzou April 4, 2011. She continued working full duty for Respondent. She herself admitted her symptoms did not return until several months later.

For the foregoing reasons, the Arbitrator finds no causal connection between any alleged manifestation on January 25, 2011 and any subsequent condition of ill being alleged after February 6, 2011.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christine Braunseis,

Petitioner,

19IWCC0541

vs.

NO: 17WC 7168

Lincoln Surgical Associates,

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, prospective medical care, 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 21, 2018 is hereby affirmed and adopted.

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

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

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 1 - 2019
O081319
MEP/ypv
049

Maria Portela

Deborah Simpson

DISSENT

I believe that the Arbitrator's attempt to characterize the injury in question as occurring off the employer's premises is misplaced. Petitioner credibly testified that she was knocked off balance by an elevator door and thrown into a corner as she was entering the building where Respondent's offices were located. This was not a situation where Petitioner was injured in a parking lot or some other location off-premises. On the contrary, the incident was decidedly on-premises and as such did not warrant the "general premises rule" analysis that the Arbitrator employed.

Instead, given the hazard presented by the elevator in question, which Petitioner claimed shut hard and unexpectedly fast on her, the risk of injury in this case was one that was most assuredly related to her employment. Along these lines, Petitioner credibly testified that she had experienced problems with this particular elevator in the past and that she had even gotten stuck in it once before. Other times, she related that the elevator doors would inexplicably open and shut, open and shut, and she would eventually get off and go to the other elevator. She also noted that on several occasions she had told the person who works at the front desk in the lobby about problems with the elevator. As such, the elevator door represented a hazard of her employment. It matters not one bit that the elevator was not owned or maintained by the Respondent, and it was entirely reasonable and foreseeable for Petitioner to use the elevator in question to gain access to her workplace on the fifth floor.

Furthermore, the injury would be compensable even if one were to utilize a neutral risk analysis, given the frequency with which Petitioner necessarily utilized the elevator in question when entering and exiting work on a daily basis throughout the work week. In addition, Petitioner testified that she was carrying a steel/metal divider or tray, in addition to her purse and iced tea, that she had had at home and that she intended to use at work to divide papers for the

plastic surgery department. She also noted that at the time of the incident she had charts for plastic surgery in her purse that she had brought home to help out a fellow employee write down names. Thus, from a quantitative and a qualitative standpoint, Petitioner was exposed to a greater risk of injury than members of the general public due to her employment, and as such the matter was compensable.

Accordingly, I would find that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on 2/20/17 and that her current condition of ill-being is causally related to said accident. As a result, I would reverse the Arbitrator and award benefits accordingly.

Thomas J. Tyrrell

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

BRAUNSEIS, CHRISTINE
Employee/Petitioner

Case# **17WC007168**

LINCOLN SURGICAL ASSOCIATES
Employer/Respondent

19IWCC0541

On 2/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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)

CHRISTINE BRAUNSEIS
Employee/Petitioner

Case # **17** WC **7168**

v.

Consolidated cases: _____

LINCOLN SURGICAL ASSOCIATES
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **September 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 20, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned $**28,713.20**; the average weekly wage was $**552.18**.

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

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 failed to prove by a preponderance of the evidence that she sustained an accident that arose out of and in the course of her employment on February 20, 2017. All benefits are hereby denied. All other 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.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 18, 2018
Date

ICArbDec19(b)

FEB 21 2018

STATE OF ILLINOIS)
) ss
COUNTY OF JEFFERSON)

19IWCC0541

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTINE BRAUNSEIS
Employee/Petitioner

v. Case #: **17 WC 7168**

LINCOLN SURGICAL ASSOCIATES
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Testimony of Petitioner Christine Braunseis

On February 20, 2017, Petitioner was 53 years old, married, and had no dependent children. She was employed by Respondent as a medical assistant and had been so employed for approximately four years. Her job duties included answering phones, pulling patient charts, and putting patients into examination rooms. She testified that organization and having the patient charts complete and accurate prior to an appointment is a necessary and important part of her job. She works primarily for a plastic surgeon in the practice, Dr. Shankaran.

Petitioner testified that Respondent is a medical group made up of general and plastic surgeons. Respondent has two offices, one located at St. Elizabeth's Hospital and one located at Memorial Hospital. The St. Elizabeth's office is located on the fifth floor of a medical office building attached to St. Elizabeth's Hospital. The building is called Southern Illinois Heart Institute, commonly referred to as SIHI. The SIHI building is connected to the hospital but does not have overnight patient rooms, a cafeteria, or a gift shop. Petitioner reviewed and identified photos contained within Respondent's Exhibit 3, and described them as depicting the SIHI building. The building has two offices on the first floor, five offices on the second floor, one office on the third floor, two offices on the fourth floor, and four offices on the fifth floor including Respondent. RX3 at 7. The only access points to the fifth floor of the building are a set of elevators and a staircase on the first floor of the SIHI building. The set of elevators is located within the first-floor lobby of the SIHI building. RX3 at 3, 4, 6. The staircase is through a separate set of doors off the lobby to the left of the elevators on the first floor of the building. RX3 at 4. Floors one, two, and three of the SIHI building can also be reached directly from the hospital. Floors four and five cannot be reached directly from the hospital.

No evidence was entered as to the exact operating hours of the SIHI building, but both Petitioner and Respondent's witness/office manager Jo Anne Gagen testified that the building was open before and after Respondent's office hours. Respondent opens their office at 8:30 a.m. and phones are turned on at that time. Respondent closes their office at 4:30 p.m.

The SIHI building is not owned by Respondent. Respondent rents Suite 500 from St. Elizabeth's Hospital, as evidenced by Respondent's Exhibit 1, the Lease agreement. Respondent is not responsible for and does not have control over the elevators or other maintenance of the building. According to the lease, Respondent's rent payments to the hospital include their portion of the hospital's expenses for elevator maintenance, property tax, janitorial services, insurance, utilities, waste removal, recycling, garbage, and shredding. RX1 at 15.

Petitioner testified that when she arrives on a daily basis, she parks in an outdoor parking lot in front of the SIHI building and enters the building through the automatic doors into the lobby. She then walks to the elevator about 50 feet from the entrance and takes the elevator to the fifth floor. She leaves work the same way. She rarely uses the stairs. Petitioner testified that she is paid for her lunch period and sometimes leaves the office for lunch. When she does, she uses the elevator to get to the first floor and back to the fifth floor. She acknowledged that all employees, patients, and customers of all the offices in the building use the same parking lot and the same elevator involved in her fall.

Petitioner testified that her job requires her to leave the fifth floor of the SIHI building during working hours. While it varies, typically about once every two weeks she takes CDs to the radiology department on the third floor. About once every three to four weeks she takes lab work to the medical lab on the second floor. Occasionally she takes work to the greeter on the first floor. Twice a week she takes a suitcase full of patient files to Respondent's other office in Memorial Hospital. Petitioner testified that she uses the elevator almost exclusively for all the trips. She further testified that the elevator going from the first to the fifth floor had malfunctioned in the past. On one occasion she was stuck in the elevator and on another occasion the elevator door opened and closed repeatedly and she eventually took the other elevator.

Petitioner testified that on February 20, 2017, she arrived in the parking lot at work at about 7:50 a.m. She arrived early that day, as Ms. Gagen had contacted her earlier that morning and asked her to cover the job assignments of a co-worker who was not coming in. Petitioner testified that she arrived early to complete the extra work and specifically to get the patients' charts ready for the doctor. She entered the SIHI building around 8:00 a.m., at the same time as her co-worker Sarah Feazel. Petitioner testified she was carrying her purse and "a big glass of iced tea" in her right hand and a bag with handles containing a metal divider in her left hand. She brought the divider from home to help organize work on her desk. She had some patient files in her purse, which she had worked on over the weekend. She testified that none of the items she was carrying caused or contributed to the fall which occurred. Rather, the elevator door caused the fall.

Petitioner testified that she and Sarah walked to the elevators on the first floor of the building and pushed the button. The elevator opened and she began to walk in. She testified that as she walked into the elevator, "the door came flying shut and it—it didn't stop.... It continued

to close so it knocked me off balance and threw me in the back left corner of the elevator…." The door of the elevator struck the left side of her body.

As a result of the fall, Petitioner sustained a spiral fracture to her left femur. Since the accident she has had three surgeries, including a revision of her previous left knee replacement. She had physical therapy and periods of non-weight bearing on the left leg. She testified that she had pre-existing osteoarthritis in her right knee. She had an arthroscopically repaired meniscal tear in the right knee in 2015, due to degenerative changes in the knee. She continued to have problems after the meniscal repair and prior to the accident on February 20, 2017, resulting in the need for an injection in 2016 and discussion with her treating physician of a future total knee replacement on the right at some point. After the elevator accident in February 2017, Petitioner had three injections to her right knee.

Testimony of Jo Anne Gagen

Jo Anne Gagen testified on behalf of Respondent. She is Respondent's office manager and is also a Registered Nurse. She has been employed by Respondent nearly 20 years, since 1998. She was not working on February 20, 2017. She testified that Respondent leases Suite 500 on the fifth floor of the building at 340 Lincoln Street, the SIHI building. The building is owned by St. Elizabeth's Hospital of the Hospital Sisters of the Third Order of St. Francis (hereinafter "Landlord St. Elizabeth's"). The lease agreement, identified as Respondent's Exhibit 1, provides that Landlord St. Elizabeth's is responsible for the maintenance of the elevators and the common areas of the building. Ms. Gagen testified that whenever there is a problem with the elevators or anything in the common area, she emails Balke Brown, the management company used by Landlord St. Elizabeth's. This is the protocol requested by the management company, Balk Brown. If there was an urgent need, she would call St. Elizabeth's Hospital Security.

By referencing the photos in Respondent's Exhibit 3, Ms. Gagen noted that several medical offices are on the fifth floor in addition to Lincoln Surgical Associates. Those include HSHS Gastroenterology, HSHS Home Health, HSHS Neuroscience Center, and Medical Records. RX3, at 11-16. The employees and patients of those businesses use the elevators and/or the stairs to get to the fifth floor. The same is true for the medical offices on the second, third, and fourth floors of the SIHI Building.

On cross-examination, Ms. Gagen testified that the SIHI building has a cardiac rehabilitation center on the first floor, nuclear medicine on the second floor, and a cardiac cath lab on the second or third floor. She testified that the cardiac cath lab opened as early as 6:30 a.m. She acknowledged that she had been told about problems with the elevators by other employees of Respondent.

Office Space Lease

The Office Space Lease identifies Respondent as the lessee and St. Elizabeth's Landlord as the lessor of Suite 500 in the SIHI building. The lease places all control for maintenance of the elevator in the hands of the Landlord. It states that Landlord St. Elizabeth's "shall keep common areas in good condition and use reasonable efforts to keep all equipment used in common with

other lessees, such as elevators, plumbing, heating, air conditioning, and similar equipment in good condition and repair." Respondent's rent payment contributed to payment of costs for the common areas of the building. RX1.

Pre-Accident Medical Records

On October 8, 2014, Petitioner presented to Dr. Corey G. Solman for a "new" *right* knee problem. It was noted that she had experienced pain, instability, and swelling when the back of her knee popped then totally gave out later in the day. She had pain in the upper thigh and down into the calf. On October 16, 2014, Petitioner underwent a right knee medial meniscectomy and chondroplasty. She was released to return to work on November 3, 2014. On November 26, 2014, Dr. Solman released Petitioner with regard to her *right* knee, but diagnosed her with *left* knee osteoarthritis and recommended a total knee replacement. On December 12, 2014, Petitioner underwent a left total knee arthroplasty. PX4.

On February 4, 2015, Dr. Solman diagnosed osteoarthritis in Petitioner's right knee. He administered an injection and ordered physical therapy. On April 15, 2015, he administered an injection into Petitioner's left knee. He released her at that time, but noted she continued to have pain secondary to a pes anserine bursa and continued to have a lot of pain in her right knee. PX4.

On June 2, 2016, Petitioner presented to PA Jeffrey Todd and reported she was doing well with the left knee but had pain, swelling, and difficulty weight bearing on the right knee. An MRI was obtained, which showed Grade IV osteoarthritis of the right knee. PA Todd administered an injection into the right knee. PX4. Petitioner testified that the injection improved her right knee symptoms and that she had no more visits for her right knee until after February 20, 2017.

On January 4, 2017, Petitioner was diagnosed by Dr. Solman with right carpal tunnel syndrome. She underwent right carpal tunnel release on January 16, 2017, and she was released for that condition on March 9, 2017. PX4.

Post-Accident Medical Records

Following the accident, Petitioner presented to the emergency room at St. Elizabeth's Hospital. The History of Present Illness was recorded as such: ***"Pt was at the hospital and fell while running to jump on elevator while door was closing. She fell and landed on her left knee."*** Petitioner complained of severe pain in the left knee and advised she had had knee replacement two years prior. Left knee x-rays showed a complete comminuted fracture through the distal femur just above the prosthesis. It was noted there was no periprosthetic lucency to suggest hardware loosening or failure. Reduction of the fracture was accomplished after sedation, but some offset remained afterward. Arrangements were made for Petitioner to be transported to St. Clare Hospital by ambulance for further surgery. PX2.

Petitioner was transported to St. Clare Hospital in Fenton, Missouri, so that she could treat with Dr. Michael Bradley. Dr. Bradley is a partner of Dr. Solman, who performed Petitioner's left knee replacement surgery. PX1.

On February 20, 2017, Petitioner was admitted to St. Clare Hospital, where she remained inpatient until February 25. The admitting history recorded was: ***"Patient was walking to the elevator, it started to close, hit something she was carrying, fell…."*** The same history was recorded by Dr. Matthew Bradley, the orthopedic surgeon. On February 22, 2017, Petitioner underwent surgery by Dr. Bradley, consisting of open reduction and internal fixation of the left distal periprosthetic femur fracture. The discharge summary of February 25, 2017, recorded a history that, ***"Patient was walking to an elevator, got bumped, fell, broke her left leg…."*** PX3.

On March 3, 2017, Petitioner presented to Dr. Judith Weis, her primary care physician. She recorded a history that, ***"She was walking into an elevator at the SIHI building on 2/20/17 and her hands were full. The elevator door was closing and it knocked her over and she fell onto her left knee inside the elevator and fractured her femur above her knee replacement."*** It was noted that she had undergone surgery and was currently in a brace and non-weightbearing. Petitioner was being seen at Dr. Bradley's recommendation, as her hemoglobin hematocrit dropped secondary to surgery. She also reported some right elbow pain and noted she did not know if she had hit it with the fall but that it was not bothering her prior to that. She also reported an abscess on her right buttock, which was removed. Dr. Weis noted that Petitioner was doing remarkably well after such a serious fracture. She prescribed Bactrim for the abscess and iron for anemia that was present on lab results. PX5.

On March 9, 2017, Petitioner followed up with Dr. Bradley and reported she had been experiencing a decrease in appetite and some nausea. X-rays that day showed the prosthetic/hardware was in place, with no signs of loosening or failure. Petitioner was to remain non-weightbearing and to begin therapy. PX4.

On March 22, 2017, Petitioner presented to Dr. Solman. He recorded a history that ***"an elevator door struck her leg and knocked her over"***. Petitioner reported moderate to severe aching and sharp pain from her *right knee* osteoarthritis, which she indicated was exacerbated because she was now relying more on the right leg, due to her left leg injury. Examination of the right knee revealed no erythema, bruising, swelling, or instability. There was mild crepitus with range motion and mild tenderness to palpation. Strength, sensation, and reflexes were normal. Dr. Solman administered an injection into the right knee, with assessment of primary osteoarthritis. PX4.

On April 13, 2017, Petitioner returned to Dr. Bradley and reported she was doing well. She was non-weightbearing with a hinged knee immobilizer. She noted she was doing well with physical therapy and was controlling her pain with Norco. The note indicates that x-rays were taken, but is void as to the results. Petitioner was to start weight bearing 25% the first week, 50% the second week, 75% the third week, and full weight bearing the fourth week. She was also to continue therapy for strengthening, range of motion, weight bearing, and gait training. PX4.

On April 28, 2017, Petitioner followed up with Dr. Solman and reported she had been working on range of motion but was having increased pain in the left knee, especially with any weightbearing. X-rays that day showed some early callus formation at the fracture site. The films also showed that the prior total knee arthroplasty was intact, but there was some lucency over the medial tibial plateau. In addition, the knee was in slight varus secondary to some mild medial collapse of the fracture site. Dr. Solman noted that Petitioner was having pain and it was unclear

whether it was coming from her fracture site or the total knee arthroplasty. He ordered a CT scan to evaluate whether the total knee tibial component had loosened, evaluate callus at the distal femur fracture site, and evaluate her tibial tray. PX4.

Petitioner underwent a left leg CT scan on May 8, 2017. It revealed (1) mild periosteal reaction and callus formation of the distal femoral fracture without evidence of bridging callus; (2) no evidence of loosening of the side plate fixation device or the knee arthroplasty; (3) no fracture; and (4) mild to moderate osteoarthritis of the left hip. PX6.

On May 24, 2017, Petitioner returned to Dr. Solman and reported continued and worsening pain in the anterior and medial side of her left knee. She was having trouble putting any weight on the leg. Examination revealed tenderness over the pes anserine bursa and the medial knee area, as well over the fracture site. Dr. Solman noted concern for possible loosening of the tibial component or dissociation of the medial polyethylene liner of the total knee arthroplasty. He ordered a bone scan to further evaluate. PX4.

On May 31, 2017, Petitioner underwent the bone scan. It revealed hyperemia of the distal left femur and knee at the site of the fracture. It also showed moderate intensity delayed uptake, "which may be positive for 2+ years following the fracture". PX6.

Petitioner returned to Dr. Bradley on June 19, 2017, and reported continued pain in her knee and quad, as well as popping with flexing of her quad. She was 50% weight bearing and was continuing to use her bone stimulator. She was advised to continue weight bearing and increase as tolerated, continue use of the immobilizer and restrict range of motion, and continue physical therapy for strengthening, range of motion, weight bearing, and gait training. Dr. Bradley noted discussion regarding synthetic bone insertion if the bone was not healing well. He noted the CT scan was not available and would be acquired and reviewed. PX4.

Petitioner underwent physical therapy at Apex Physical Therapy on a consistent basis from March 21, 2017, through June 27, 2017. PX7.

On July 5, 2017, Petitioner underwent surgery by Dr. Bradley due to nonunion of the left distal femoral periprosthetic fracture. Surgery consisted of open bone grafting and deep bone culture of the nonunion in the *left* knee, and corticosteroid injection of the *right* knee. PX4.

On July 20, 2017, Petitioner followed up with Dr. Bradley and reported moderate to severe pain at times. X-rays showed hardware was in place with appropriate reduction, no signs of hardware loosening or failure, fracture healing well, and no callus or new bone noted. Dr. Bradley noted discussion of possible distal femoral replacement with revision of the total knee arthroplasty if there was no healing in four to five weeks. On August 17, 2017, Petitioner returned and reported continued pain. X-rays showed hardware was in place with no loosening or failure, but very minimal amount of callus formation at the fracture site. Dr. Bradley noted there had been only very minimal callus formation, and recommended hardware removal with distal femur replacement. Petitioner was to continue non-weightbearing in the interim. PX4.

On August 23, 2017, Petitioner underwent a third surgery by Dr. Bradley, consisting of hardware removal and distal femoral replacement with a hinged knee prosthesis. The postoperative plan was for weightbearing and activity as tolerated. Therapy was to be initiated one day after surgery. PX4. The Arbitrator notes this is the final treatment record.

At the time of trial, Petitioner remained on crutches and testified that she uses a wheelchair at times. She testified she currently takes Oxycodone, Morphine extended release, an anti-inflammatory, and Diazepam for muscle spasm.

CONCLUSIONS OF LAW

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

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

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

When an employee slips and falls at a point off of the employer's premises while traveling to or from work, the resulting injuries do not arise out of and in the course of claimant's employment and are not compensable under the Act. *Illinois Bell Telephone Company v. Industrial Comm'n*, 131 Ill.2d 478, 483-484 (1989); see also *Butler Manufacturing Co. v. Industrial Comm'n*, 85 Ill.2d 213, 216 (1981); *Reed v. Industrial Comm'n*, 63 Ill.2d 247, 248-249 (1976). This rule has come to be known as the "general premises rule", and there are two exceptions to this rule. First, recovery has been permitted for off-premises injuries incurred by an employee when the employee's presence at the place where the accident occurred was required in the performance of his duties and the employee is exposed to a risk common to the general public to a greater degree than other persons. *Illinois Bell Telephone Company*, 131 Ill.2d at 605; see also *Butler Manufacturing Co. v. Industrial* Comm'n, 85 Ill.2d at 216; *Wal-Mart Stores, Inc. v. Industrial Comm'n*, 326 Ill.App.3d 438 (4th Dist. 2001). Second, recovery has also been permitted for injuries sustained by an employee in a parking lot provided by and under the control of the employer. This exception applies in circumstances where the employee is directed where to park in the lot. *Wal-Mart Stores, Inc. v. Industrial Comm'n*, 326 Ill.App.3d 438 (4th Dist. 2001); *Suter v. Ill. Workers' Compensation Comm'n*, 2013 IL App (4th) 130049WC.

The Arbitrator finds that the facts of the instant case do not fit either of the above exceptions to the general premises rule. With regard to the first exception, Petitioner was off premises at the time of the accident, as Respondent does not own, maintain, or control the elevator or the lobby of the building. Petitioner provided no testimony to the contrary. The lease specifically sets out that

Landlord St. Elizabeth's is responsible for maintenance of the elevator. Jo Anne Gagen managed the office and any complaints from employees related to the property. She testified that Lincoln Surgical Associates does not handle the maintenance of the elevator where the fall occurred.

The facts also fail to establish that Petitioner was exposed to a risk common to the general public to a greater degree than other persons. The risk that caused the injury was the closure of the elevator door. The risk that caused the fall and subsequent injury was not Petitioner's act of arriving earlier in the day than other employees. The risk was also not Petitioner's act of carrying a hospital chart in her purse. In fact, she testified that the items she was carrying did not cause or contribute to her fall. The elevator in the common area where Petitioner fell was open to the general public from as early as 6:30 a.m. until late at night. It may in fact be open to the general public 24 hours a day, due to the cardiac catheterization lab in the building. The elevator was used by employees, patients, and other members of the public for the other medical offices throughout the five-story building and the hospital. The photos in evidence document three other medical offices on the fifth floor, Prairie Cardiovascular on the fourth floor, six medical offices on the third floor, and five medical offices on the second floor. Despite the option of using the stairs to reach her job, Petitioner argues that she was compelled to use the elevator for access to reach her place of employment and thus her risk was greater than that of the public. The Illinois Supreme Court has held that "the mere fact that the duties take the employee to the place of the injury and that, but for the employment, she would not have been there, is not, of itself, sufficient to give rise to the right to compensation." *Illinois Bell Telephone v. Industrial Comm'n*, 131 Ill.2d at 485,486, citing *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989).

In a similar case, *Reed v. Industrial Commission*, the Petitioner slipped and fell on an icy public sidewalk between her place of employment and a parking lot where employees were allowed to use the lot at a reduced rate. The Supreme Court applied the general premises rule and denied compensation, noting that the "crosswalk in which the claimant fell is used by patients and visitors entering or leaving the hospital, as well as by employees." *Reed v. Industrial Commission,* 63 Ill.2d 247, 249-250 (1976); cited by *Illinois Bell Telephone v. Industrial Commission*, 131 Ill.2d at 486. The Court stated that a common area of malls and buildings is not considered the premises of the employer simply because it is the only way to get to and from the place of employment. *Illinois Bell Telephone v. Industrial Commission*, 131 Ill.2d at 486.

The Supreme Court in *Illinois Bell Telephone* distinguished *Bommarito v. Industrial Comm'n*, 82 Ill.2d 191 (1980), which Petitioner cites. In *Bommarito*, all employees were required to enter and exit the store through a rear door in an alley for the convenience of the employer. The court noted that the alley was hazardous and congested, to the substantial detriment of the employees. On the morning that Petitioner was injured, the alley was crowded with trucks getting ready for a big sale. The court in *Illinois Bell Telephone* noted that the claimant's injuries in *Bommarito* fell under the Act "because of the employer's *requirement that employees enter through a particular door* and the hazardous risks presented by an alley through which employees had to pass in order to enter through the rear door. The court specifically noted that the case did not involve a situation where a claimant freely chooses to use a certain route and is injured in doing so." *Illinois Bell Telephone v. Industrial Commission*, 131 Ill.2d at 484, citing *Bommarito v. Industrial Comm'n*, 82 Ill. 2d at 196-197.

In the instant case, Petitioner had several options to enter the workplace, aside from the entrance to the elevator on the first floor where the accident occurred. Petitioner testified she could use any entrance of the hospital and enter or exit the SIHI building through the second or third floor where it connected to the hospital. Petitioner could choose either of two elevators and she indicated she used the stairs on occasion. Because she had the option of the stairs or the elevator, any claim of frequent use of the elevator as the increased risk is moot.

Petitioner attempted to establish that the elevator in question malfunctioned, thereby causing the doors to close erratically and unexpectedly. However, she presented no evidence to corroborate this assertion. The Arbitrator finds significant that Petitioner did not call co-worker Sarah Feazel to testify. Ms. Feazel was apparently present at the time of the accident and presumably could have corroborated Petitioner's assertion that the elevator doors malfunctioned. In addition, Petitioner presented no documents which would indicate that an elevator malfunction was reported following her fall.

Further, and more significant, none of the medical records mention or even allude to a malfunction of the elevator doors. In fact, the initial medical record from the emergency room immediately after the accident states that ***"Pt was at the hospital and fell while running to jump on elevator while door was closing. She fell and landed on her left knee."*** Not only does this history give no hint at an elevator malfunction, it also gives an alternative explanation for Petitioner getting caught by the elevator door, one that the Arbitrator finds both reasonable and rather telling. Given that this was the first history provided by Petitioner, the Arbitrator finds it to also be most accurate.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident that arose out of and in the course of her employment. All benefits are denied. The remaining issues 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 LA SALLE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Geoffrey Knafelc,
Petitioner,

vs. No: 09 WC 48294

19IWCC0542

Practical Builders Construction,
Respondent.

DECISION AND OPINION ON REVIEW

Cross Petitions for Review having been timely filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, permanent partial disability and maintenance, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 9, 2018, is hereby affirmed and adopted.

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

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 1 - 2019

Marc Parker

mp/wj
08-15-19
68

Barbara N. Flores

CONCURRENCE IN PART AND DISSENT IN PART

I concur in part and dissent in part with the decision of the majority. I concur with the majority in affirming the Decision of the Arbitrator that Petitioner proved only that the condition of ill-being of his right-foot was causally related to his work accident. However, I respectfully dissent from the decision of the majority affirming the Decision of the Arbitrator in which she awarded Petitioner a permanency award of 250 weeks, representing loss of 50% of the person-as-a-whole for loss of trade. Rather, I would have modified the Decision of the award, vacated the 250-week permanency award, and awarded Petitioner 100.2 weeks of permanent partial disability benefits representing loss of the use of 60% of the right foot.

Petitioner sustained an injury to his right foot after a work-related fall on October 25, 2005. He sustained a fracture of his right calcaneus. He had surgery on November 4, 2005 and returned to part-time work on July 10, 2006 as a cement finisher for his family-owned business, of which he was President. He returned to full duty on January 2, 2007. He continued to work in that capacity until August of 2012. Petitioner testified that at that time he simply could no longer work in that capacity and the business failed because he could no longer work as efficiently as he could prior to his injury. However, an opinion of an economic expert introduced into evidence noted the drastic contraction of businesses in construction industry after 2009 and beyond.

Petitioner alleged that besides his foot injury, he suffered gastrointestinal illness because of his excessive intake of Ibuprofen. He also alleged a lumbar condition was aggravated by his fall. At hearing and on review, Petitioner alleged that he was permanently and totally disabled from any employment. It is important to note that Petitioner was diagnosed and hospitalized for diverticulitis and was diagnosed with chronic degenerative disc disease both prior to his accident.

19IWCC0542

Petitioner testified he graduated from Bradley University, completed one-year of graduate studies at Northern Illinois University, and had a paralegal certificate. Petitioner had Functional Capacity Evaluations in 2007 and 2012, both of which found that he could work with certain restrictions. While Petitioner's hired vocational rehabilitation counselor opined that there was no stable job market for Petitioner, Respondent's expert noted there were 309 jobs involving transferable skills for which Petitioner was qualified, 109 in the sedentary physical demand level, and 150 in the light physical demand level.

I disagree with both the Arbitrator and the majority that an award of loss of 50% of the person-as-a-whole is appropriate here. First, it is difficult to conclude that Petitioner sustained his burden of proving a loss of trade because he worked in the job as cement finisher for more than five and a half years after recovery from his injury. Second, Petitioner did not introduce any evidence of any potential loss of income after his accident. At the time of his accident, Petitioner's average weekly wage was $1,000. Even assuming that Petitioner could not continue in his job as cement finisher, he did not sustain his burden of proving that he could no longer earn such a salary in a different job, given his education and transferable skills. Therefore, I do not believe that a person-as-a-whole permanency award for loss of trade is appropriate in this case and would have awarded permanency for partial loss of the use of his right foot.

For the reasons stated above, I concur with the majority in affirming the Decision of the Arbitrator that Petitioner only proved that the condition of ill-being of his right-foot was causally related to his work accident. However, I respectfully dissent from the decision of the majority on its affirmation and adoption of the Decision of the Arbitrator in which she awarded Petitioner a permanency award of 250 weeks, representing loss of 50% of the person-as-a-whole for loss of trade. Rather, I would have modified the Decision of the award, vacated the 250-week permanency award, and awarded Petitioner 100.2 weeks of permanent partial disability benefits representing loss of the use of 60% of the right foot.

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KNAFELC, GEOFFREY
Employee/Petitioner

Case# **09WC048294**

PRACTICAL BUILDERS CONSTRUCTION
Employer/Respondent

19IWCC0542

On 1/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

0358 QUINN JOHNSTON HENDERSON ET AL
JOHN F KAMIN
227 N E JEFFERSON
PEORIA, IL 61602

19IWCC0542

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GEOFFREY KNAFELC
Employee/Petitioner

Case # **09** WC **48294**

v.

Consolidated cases: **N/A**

PRACTICAL BUILDERS CONSTRUCTION
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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Kankakee**, on **November 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. ☒ 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 25, 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 alleged accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident subsequent to 4/23/07. SEE DECISION

In the year preceding the injury, Petitioner earned $**52,000.00**; the average weekly wage was $**1,000.00**.

On the date of accident, Petitioner was **52** years of age, *single* with **2** dependent children.

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

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

Respondent shall be given a credit of $**39,082.20** for TTD, $**0** for TPD, $**12,314.58** for maintenance, and $**0** for other benefits, for a total credit of $**51,396.78**.

ORDER

Causal Connection
The Arbitrator finds that Petitioner's right heel facture is related to his fall on October 25, 2005, through 4/23/07 but denies causal connection for any other claimed conditions of ill-being.

Medical Benefits
Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's causally related condition through 4/23/07 pursuant to Section 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid including credit under Section 8(j) of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $666.67 for a period of 36 5/7th weeks commencing October 26, 2005 to July 9, 2006, as provided by Section 8(b) of the Act.

Maintenance
Respondent shall pay Petitioner a temporary partial disability/maintenance benefit of $333.33 per week for a period of 41-1/7 weeks commencing July 10, 2006 through April 23, 2007, as provided by Section 8(a) of the Act.

Permanent Partial Disability
Respondent shall pay permanent partial disability benefits in the amount of $591.77 per week for a period of 250 weeks as Petitioner sustained 50% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

Penalties

Based upon the Arbitrator's findings, Petitioner's Petition for Fees and Penalties is denied.

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

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

Carolyn M. Doherty

Signature of Arbitrator

1/5/18

Date

JAN 9 - 2018

FINDINGS OF FACT

Petitioner, Geoffrey Knafelc, was 52 years old on 10/25/05, the date of the undisputed work accident. ARB EX 1. Petitioner testified that prior to working for Respondent Practical Builders, he attended Bradley University and graduated with a bachelor of science in psychology in 1976. He also obtained a paralegal certificate in 1978. Petitioner testified that Practical Builders is a business owned and operated by his family. From 1965 to 1977, he worked as a laborer for Respondent Practical Builders. He also worked on-call for a temporary employment agency doing phone solicitation in 1978. He then worked as a laborer from 1979 to 1982 in Colorado. Thereafter, he returned to the LaSalle-Peru area in 1982 and worked again at Practical Builders Construction from 1982 to 2012. He stated that the company had up to 5 or 6 employees. His father, George, owned the company and Petitioner was the President of the company, although he did not have any specific duties in relation to that position. Petitioner worked as a carpenter and cement finisher.

Petitioner testified that in 2005, he worked for the Cement Finishers Local 11 and was paid hourly. His job duties included framing forms, pouring concrete, finishing cement, carpentry, and roofing. He noted he was frequently on ladders and used a number of tools which would require him to lift over 20 pounds. On October 25, 2005, he went up a ladder to work on an eve. Petitioner testified that the ladder began to fall and he pushed away from it, landing on his feet. He estimated he fell 17 feet. He could not get up due to pain in his right foot and crawled to his truck and called for assistance. He went to the ER and treated with Dr. Norris from October 27, 2005 to August 10, 2006 for a right heel fracture. He stated that shortly after the event, while recovering from his foot injury, he attempted to get out of a recliner and his back went out. He stated that he could not walk because of the back pain. He returned to work July 10, 2006, working 4 hours per day. He stated that he went back to his old job at that time performing the same job duties for Respondent. Dr. Norris eventually referred him to Dr. Sorkin, who performed an FCE in April 2007. He returned to work full time but stated that he was hardly ever able to do a 40-hour week thereafter.

After being released to regular duty by Dr. Norris and Dr. Sorkin, Petitioner continued to treat with his family physician, Dr. Schlagheck, for complaints regarding his feet, ankles, knees and back. He stated that he was taking ibuprofen five times a day and eventually Dr. Schlagheck referred him to Dr. Orteza in January 2010. Dr. Orteza told him that he could not help him. He was then seen by a GI specialist, Dr. Dodda, for intestinal problems and diarrhea. He was also referred to Dr. Tsung, a neurosurgeon, who performed an MRI on his back and prescribed physical therapy. He did not recommend any surgery. Petitioner was subsequently seen by Dr. Nazeer, who ordered an EMG that was performed on September 23, 2010, because of bilateral lower extremity numbness.

Petitioner testified that he had difficulty doing his regular job duties, but that he worked for 5 years following his full duty release from January 2, 2007 until September 28, 2012. He stated that he was the "main guy" and he could not work the way he had before. Petitioner testified that competitors had taken over many of his clients because he was too slow, and he was frightened to work at heights and that it was too painful to work. Petitioner testified that his last day worked was on September 28, 2012. He testified that he stopped working because of difficulties with his ankles, knees, back and balance. He stated that his co-workers at that time were primarily family members and one other individual. His father was 90 years old at the time of arbitration. Another individual, Steve, had passed away. He also worked with two uncles, one of which had passed away and the other was currently 75 years old. They had not hired anybody else to do the work.

Petitioner further testified that he had also gone to Mayo Clinic as a self-referral. He noted that he had been diagnosed with polyarticular gout, gout and other conditions. In October 2015, he returned to Ortho Illinois, the successor to the prior orthopedic practice, for his feet. He was seen by Dr. Bush, who ordered custom orthotics.

Petitioner testified that he looked for work from May 18, 2016 to August 19, 2016 but was not successful. With regard to his current condition, he noted his mobility was decreased, he had pain, fatigue, and weight gain. He felt tremendously older, had no leg strength, and a lack of range of motion in his ankles and feet. Petitioner wore ankle braces. He does not sleep an entire night, but is not taking any pain medications, either by prescription or over the counter.

On cross-examination, Petitioner testified that he had told the emergency room doctor that he had chronic low back pain which pre-existed the accident. He stated that he did tell them that his low back pain was the same as it was before, but that he had said that to protect the company. He also confirmed that on October 27, 2005, he told the medical providers that he had been previously diagnosed with diverticulitis. He did not recall telling therapists on June 6, 2006 that he was working occasionally and doing well, nor did he recall telling them on June 8, 2006 that he had worked 6 hours yesterday. When he did return to work half time, he was earning $25.00 per hour, working 20 hours per week. That was 1/2 of his full time pay. Dr. Sorkin did release him to full duty on January 9, 2007, and he had advised Dr. Sorkin on April 9, 2007 that he was doing well and working full-time as of January as a cement finisher and carpenter. The functional capacity evaluation that was performed in April 2007 indicated the Petitioner could safely lift 70 pounds and was a job match except for doing roofing (see RX 15). Petitioner noted that he had also seen Dr. Lisa Snyder who did not offer any treatment for his low back. He also noted that as of 2010, when he was referred to Dr. Orteza he had indicated that he attributed his low back pain to working full days as a cement finisher with bending and squatting.

In 2004, the year prior to his injury, he earned approximately $39,000. In 2005, through the date of his injury, he had earned $32,128 working at Practical Builders Construction. He then returned to part time work in late 2006 and in calendar year 2007 earned $47,600. In 2008, he earned $28,000 and collected unemployment compensation of $13,185. In 2009, he earned $38,000 and collected additional unemployment compensation. In 2010, he earned $23,700 and collected approximately $17,000 in unemployment compensation. Through September 2012, he had earned approximately $24,000. (See Petitioner's tax returns identified PX 32 and RX 4, 5). When he stopped working in 2012, he was 59 years old and subsequently collected distributions from retirement accounts. He also owned several parcels of property in the LaSalle County area which he rented and managed (RX 12). His father also owned approximately 16 properties in LaSalle County, which he also had helped manage.

Petitioner agreed that new housing construction diminished significantly from 2008 through 2010, but that Practical Builders did not suffer due to the general economic condition but rather solely because he could not work as he did before the accident. Petitioner further explained that Respondent's competition grew in that other businesses previously doing residential construction were now doing commercial work. He again testified that since he could not work, Practical Builders became unsuccessful and uncompetitive.

The Arbitrator viewed the video surveillance offered at RX 23 and 24. The video was taken in May 2014, 9 years after Petitioner's accident at work and 2 years after Petitioner stopped working in 2012. Petitioner is seen walking freely but slowly and with a slight limp. He is seen carrying a saw or small hand held tool, bending, mowing a small lawn using a push mower, bending to pick up debris and removing a small tree on a rental property owned by his father. Petitioner is also seen reaching into his truck bed, and lifting and carrying buckets, coolers and a duffle bag to and from his truck. Petitioner also viewed the video and testified that he

did not recall seeing himself use any type of saw, but he did mow a lawn at a piece of property that was owned by his father. He also removed a small tree from that property which he stated was rotted.

With regard to Petitioner's specific medical treatment, Petitioner offered treatment records which included the records from the initial emergency room visit at Illinois Valley Community Hospital. (PX 1). Petitioner was diagnosed with a displaced right calcaneus fracture. Petitioner denied striking his head, neck pain, and upper or lower back pain. The records indicate that he had chronic low back pain that was the same as before the accident. He had no pelvic pain or pain in the hip area. (PX 1). The records confirm that Petitioner fell 8 feet from a ladder on 10/25/05.

Petitioner saw Dr. Norris at Rockford Orthopedic Associates. At his initial visit on October 27, Petitioner reported his right heel injury. X-rays showed a depressed, displaced inter articular calcaneal fracture. Dr. Norris noted the Petitioner was a surgical candidate. He ordered a CT scan and scheduled surgery for the following week when the swelling subsided. PX 2. Petitioner underwent an open reduction with internal fixation to repair the right calcaneal fracture on 11/4/05. PX 2. He was seen in follow-up on several occasions, including November 17 and December 15, 2005. He was placed in therapy on January 12, 2006. On 1/12/06, Petitioner also reported a significant back pain episode over the Christmas holiday which he related to activity and weight gain. PX 2. He noted that he had a previous injury to his back and that this was more of a flare up. PX 2. The doctor's impression was a flare-up of underlying back problem with no acute injury. In May 2006, Dr. Norris noted that Petitioner was doing well but that he may never be able to return to heavy duty but that he should continue strengthening, therapy and work hardening. PX 2. Thereafter, Petitioner returned to modified duty working 4 hours per day. Petitioner was paid TTD through July 9, 2006. ARB EX 1. Petitioner continued to complain of his foot pain and was placed in a work hardening as of August 10, 2006. PX 2.

As of November 13, 2006, Petitioner started seeing Dr. Sorkin because Dr. Norris left the practice at Rockford Ortho. At that point, Petitioner reported working 4 hours a day, 5 days a week. He noted that the labor that he was doing did not change but the length of time he worked was diminished. Again, there is no reference of lumbar complaints. He then returned to Dr. Sorkin on April 9, 2007. He noted that he had been working full time since January 2007 and not doing well and that he felt he was "no longer competitive in his field of work." PX 2. He said that he was achy all over his hips, knees, back and feet. The doctor recommended a functional capacity evaluation which was performed on April 23 -24, 2007. Petitioner was found to be able to perform at the heavy physical demand level 8 hours per day 5 days per week. It was noted that the Petitioner may have difficulty due to balance deficits which may be a safety issue to perform high level balance activity or activity above ground level. He also could not lift or carry objects over 70 pounds.

Dr. Norris authored a report dated March 2009. He noted that he had not seen the Petitioner since June 27, 2006. He stated that Petitioner may have suffered an acute on chronic injury to his lumbar spine at the time of his fracture, which did not manifest until he began mobilizing. He noted Petitioner had a good outcome with his calcaneus, but may have long term problems with his lumbar spine. (PX 6). He further stated that Petitioner could not return to work as a concrete finisher but deferred to an FCE. PX 6.

Petitioner also offered the records of his primary care physician, Dr. Schlagheck. Those records confirm that Petitioner had GI complaints dating to 2004, at which time he would have been diagnosed with back pain, adnominal pain, nausea and vomiting. He was referred to treatment for early diverticulitis. In December 2007, Dr. Schlagheck had referred Petitioner to Dr. Lisa Snyder for an evaluation of his low back pain. (See PX 4). Dr. Snyder evaluated Petitioner on December 13, 2007. At that time, Petitioner indicated that he had returned to work and was back at full duty level. He reported working full time as a cement finisher short of weather

problems. He complained of stiffness in his low back in the morning and discomfort and stiffness in his low back, hips and proximal legs. He stated that it was worse since the accident and he believed it was related to his fall at work. He also noted he had back problems in the past periodically. Dr. Snyder diagnosed low back pain, likely secondary to lumbar spondylosis and noted in her recommendations that she explained to Petitioner she did not think there was any way that he could directly relate the current back pain that he was having to the trauma he experienced a few years ago. She indicated that she reminded him that he was 54 years old and that some aches and pains and arthritic changes are common at that age, and that she suspected that is what the x-rays revealed. She noted that he seemed disappointed in hearing there was no easy way to make a causal relationship evident. (RX 16).

Petitioner was also seen by Dr. Dodda and Dr. Orteza. Dr. Dodda diagnosed diverticulosis, colitis and polyps in the colon. Dr. Dodda does not provide any opinion relating those conditions to his work injury. Dr. Orteza also evaluated the Petitioner. (See PX 9). The consult was for bilateral thigh and leg pain with activity. He noted it was brought about by doing a whole day's work involving bending and squatting since he was a cement finisher. At that point, Petitioner noted he had a history of low back pain, but that his back did not seem to be bothering him. X-rays showed multi-level degenerative disc disease and the doctor diagnosed thigh and leg pain most likely related to his work involving the current bending and squatting with etiology undetermined. He did not recommend pain management.

Dr. Tsung also evaluated Petitioner's low back. (PX 10). On December 14, 2010, Dr. Tsung noted a past medical history of chronic low back pain, arthritis, irritable bowel syndrome, and Osgood-Schlatter's disease. He diagnosed Petitioner with lumbar spondylosis and lumbar stenosis on MRI which did not correlate clinically. He recommended physical therapy and did not believe surgery was warranted. He noted Petitioner may have difficulties carrying on current activities in his occupation and did not see the Petitioner in follow-up. (PX 10).

Petitioner testified he sought treatment with Dr. Nazeer. (PX 11). He evaluated the Petitioner on September 23, 2010. His exam showed good motor strength and good lumbar flexion and motion. He diagnosed moderate to severe degenerative disc disease and ordered an EMG/NCV study, which showed peripheral neuropathy, but not radiculitis. (PX 11).

A repeat FCE was ordered by Dr. Schlagheck and was completed in April 2012. At that time, Petitioner was found to be able to work at the medium/heavy level with balance deficits noted. PX 12. As of December 2013, the current treating orthopedist, Dr. Zussman, noted that Petitioner was capable of working within the restrictions set out in the functional capacity evaluation. However, Petitioner had stopped working at that time.

Petitioner also offered Mayo Clinic records. Petitioner testified that he had sought treatment at Mayo Clinic on his own. As of October 2014, a multi-system evaluation noted multiple diagnoses, including degenerative joint disease, low back pain, osteoarthritis of the knee, ulcerative colitis, GERD disease, BPH, mild neuropathy, ethanol abuse, episodes of pneumonia, episode of AKI, preventative health exam and hearing impairment. (See PX 13).

Petitioner produced payroll records. PX 31. These records confirm that he was earning $500 per week and working 20 hours per week on a regular basis from his return to work in July 2006 through at least November 2006.

The deposition of Mr. Grezsik was taken on March 28, 2017. PX 28. Mr. Grezsik was retained to provide Petitioner with vocational services. After reviewing Petitoiner's medical records and performing a vocational

assessment which included a determination of Petitoiner's education abilities and levels, Mr. Grezsik determined that Petitioner was physically incapable of returning to work as a cement finisher based on the FCE results of April 2012. He further opined that Petitioner was not a candidate for vocational rehab and that no stable labor market exists for Petitioner given his "work restrictions" including difficulty with standing, sitting and walking for more than 1/3 of the work day. PX 28, p. 35-37,69. He further testified that although Petitioner had earnings from Respondent after his accident for work he performed, Petitioner would not have been able to perform those services for a company other than a family owned business and no stable labor market existed for Petitioner after 2012.

Mr. Minnich testified as Respondent's vocational counselor on October 16, 2017. RX 1. He was retained to review records and materials pertaining to Petitioner and to prepare a voc report. Petitioner was not interviewed by Mr. Minnich. P. 6. After consideration of the April 2012 FCE placing Petitioner at the medium to heavy work level with additional restrictions on sitting, standing, walking, bending, overhead reaching, kneeling and crawling, as well as Petitioner's medical treatment records and the transferable skills analysis he performed, Mr. Minnich opined that a reasonable stable job market existed for Petitioner. He concluded that Petitioner had good transferable skills in the construction field including management, estimating and supervision. He further determined that Petitoiner's self directed job searches in 2012 and 2016 were not reasonable such that he could use those searches in an analysis of available or stable job markets. The search he performed was without voc assistance and through layman's terms only. P. 16. He believed Petitioner had stable work prospects available to him when he stopped working in 2012 based on his skills, work history and educational levels. P. 18. RX 1.

CONCLUSIONS OF LAW

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

In support of the arbitrator's decision with regard to F, is Petitioner's current condition of ill-being causally related to the injury, the arbitrator finds the following facts and makes the following findings:

At trial, Petitioner asserted that his conditions of right calcaneal fracture, low back and GI complaints are causally related to the undisputed accident on 10/25/05. Based upon a preponderance of the credible evidence at trial, the Arbitrator finds that only Petitioner's right calcaneus fracture and its attendant care is causally related to the accident on 10/25/05 through April 23, 2007, the date of the FCE. This finding is based on the supportive medical records including the treatment records of Petitioner's treating physicians, Drs. Norris and Sorkin. Following the FCE, Petitioner returned to work within his FCE restrictions which included medium to heavy work, no lifting or carrying over 70 pounds and balance limitations which hindered but did not prohibit Petitioner from performing his work duties. These restrictions were permanent and Petitioner returned to work between 2007 and 2012 performing work within these restrictions.

The Arbitrator finds no causal connection for any other asserted injury including the low back or the GI complaints and treatment. In so finding, the Arbitrator notes that Petitioner had prior GI problems and that there is no medical testimony offered that Petitioner's GI complaints are related to the fall or any treatment received in relation to same. Petitioner also has a past medical history of chronic low back pain. Dr. Norris does discuss causation in a narrative report dated 2009. However, that report is given little weight as of the date of that report he had not seen the Petitioner since June of 2006. He also did not have available any of the subsequent diagnostic tests or past medical treatment records. A subsequent treating physician, Dr. Snyder, noted that she would not attribute the Petitioner's lumbar complaints to the fall. Further, Petitioner related the

onset of his complaints to an event where he was getting out of a recliner and the medical records from the orthopedic surgeon indicate that Petitioner had a flare-up of back pain during the holidays, well after the initial accident, with no acute injury. The remainder of the medical records contains multiple references to a variety of complaints which Petitioner attributed to his continued work as a cement finisher and carpenter. The Arbitrator thus finds that the record in its entirety does not support a finding of causal connection between Petitioner's subsequently developed low back pain or his GI complaints.

In support of the arbitrator's decision with regard to J, were the medical services provided to Petitioner reasonable and necessary, the arbitrator finds the following:

Petitioner offered a number of medical bills for treatment of the low back and GI complaints. Based upon the findings concerning causal connection, the medical bills for treatment associated with Petitioner's low back and GI complaints are unrelated to the work injury and are denied. In light of Petitioner's heel fracture and the finding of causal connection for that condition through April 23, 2007, the Arbitrator further finds that Respondent shall pay Petitioner's reasonable, necessary and causally related medical expenses incurred in the care and treatment of that condition through April 23, 2007 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, including credit under Section 8(j) of the Act.

In support of the arbitrator's decision with regard to K, what temporary benefits are in dispute, the arbitrator finds the following:

Based on the Arbitrator's findings on the issue of causal connection for Petitioner's condition of ill-being through April 23, 2007, the Arbitrator notes that Petitioner and Respondent stipulated Petitioner was temporarily and totally disabled from October 26, 2005 to July 9, 2006, a period of 36 5/7 weeks. That period of TTD is so awarded and Respondent shall be given credit for amounts paid. Respondent also conceded liability for "maintenance" related to Petitioner's 50% earnings loss from July 10, 2006 to January 9, 2007 a period of 26-2/7 weeks. ARB EX 1. Given the Arbitrator's finding of causal connection for Petitioner's condition through April 23, 2007, the Arbitrator further finds that Petitioner is entitled to an additional period of temporary partial disability from January 10, 2007 through April 23, 2007, an additional period of 14-6/7 weeks for a total period of 41-1/7 weeks for the period of July 10, 2006 through April 23, 2007.

Petitioner's wage was $1,000 per week, and the payroll records offered by Petitioner as Exhibit 31 indicate Petitioner was working 20 hours per week earning $500 during that time frame. The Arbitrator calculates the temporary partial benefit for the 41-1/7 week period at $333.33 per week. Respondent shall receive credit for amounts paid. The Arbitrator denies Petitioner maintenance benefits thereafter. The Arbitrator notes that although Petitioner may have earned less while working at Respondent, the Arbitrator attributes the loss to economic and business reasons unrelated to Petitioner's accident, right heel injury, or ability to work within his FCE restrictions as of April 2007 based on the evidence at trial in its entirety.

In support of the arbitrator's decision with regard to L, what is the nature and extent of injury, the arbitrator finds the following:

The Arbitrator incorporates the findings with regard to F, J and K above. The Arbitrator further notes the accident date of 10/25/05 pre-dates the 2011 Act amendments. Petitioner claims that he is permanently and totally disabled as of September 28, 2012. However, based upon the trial record as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 50% loss of use of the person as a whole

pursuant to Section 8(d)(2) of the Act based upon his loss of trade as a cement finisher following the causally related injury of right heel fracture.

The Arbitrator again notes the finding of causal connection for the heel fracture only. The disability stemming from this causally related condition does not support Petitioner's request for a finding of permanent total disability or the opinion and findings of Petitioner's vocational expert Mr. Grzesik. Specifically, the Arbitrator notes that Petitioner returned to work for Respondent for 5 years before voluntarily leaving the business in 2012 after which he claims his permanent total disability began. Furthermore, the activity level of Petitioner as depicted in the 2014 video surveillance noted above does not comport with Petitioner's request for a finding of permanent total disability.

However, the Arbitrator finds support in the record for a finding that Petitioner was unable to completely return to the full duties of a cement finisher due mainly to his limitations with balance and uneven work surfaces making the job unsafe for him to perform. The Arbitrator does place credibility on Petitioner's testimony that he was never able to perform his same full job functions as a cement finisher after his return to work in 2007. Petitioner unsuccessfully attempted to do so for the next 5 years until he voluntarily left the business in 2012. These limitations stemming from Petitioner's causally related heel injury are further supported by Petitioner's treating physicians and the restrictions of the 2007 and 2012 FCE exams. Based on the foregoing, the Arbitrator finds that Petitioner sustained 50% loss use of man as a whole pursuant to Section 8(d)(2).

In support of the Arbitrator's decision with regard to M, whether fees and penalties should be imposed on the Respondent, the arbitrator finds the following:

Based on the record in its entirety, the Arbitrator finds that Respondent's conduct was neither so unreasonable nor vexatious so as to justify the imposition of penalties or fees under the Act. Petitioner's request for fees and penalties 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 Accident/Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Ferega,

Petitioner,

vs. No. 13 WC 42340

State of Illinois/CMS,

Respondent.

19IWCC0543

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, permanent disability, penalties and attorney fees, and being advised of the facts and law, reverses the Decision of the Arbitrator and awards workers' compensation benefits for the reasons stated below.

On December 30, 2013, Petitioner filed an application for adjustment of claim alleging repetitive trauma to the right hand, wrist and arm (carpal tunnel), with the manifestation date of August 29, 2013. On November 20, 2017, testimony was heard by then-Arbitrator Robert Luedke. On August 11, 2018, Arbitrator Kurt Carlson admitted exhibits and closed proofs.

At the outset of the hearing, Petitioner made an oral motion to amend the manifestation date from August 29, 2013 to September 25, 2013. The Arbitrator granted the motion, there being no objection. The accident date in the request for hearing form was correspondingly changed to September 25, 2013.

At the time of the testimony, Petitioner was 67 years old. Petitioner, who is right hand dominant, testified that he worked for Respondent since 1995. In September of 2013, Petitioner

was a facility manager. Petitioner described his job as follows: "My duties consist of helping facilities relocate and taking care of their needs, when something isn't the way they want it or something breaks at a facility." Petitioner used a Respondent-issued Blackberry phone and a computer to do his job. Petitioner described his computer use as follows: "I'm on it constantly. I get anywhere between 45 and 100 emails a day, depending on the day and what's going on. If there are storms or something, I get a lot more calls from our facilities or texts. ¶ We also have at CMS Property Management what is called a Work Order System where the clients submit work orders. I have to go in, open up that system, look at the work orders, determine the facility. And usually that necessitates some type of repair where I have to type up what is known as an RFE, Request for Expenditure, that has to go up, be prepared. I enter that into a spread sheet system. And then when the RFE comes back, I process the bill for payment, after we receive the invoice. And check it against the contract with the vendor to make sure it is correct. That's in addition to answering all those emails." Petitioner's office computer sits on a credenza, and the keyboard is on the edge of the credenza. There is no place for Petitioner to rest his hands when he is keyboarding. Petitioner holds his wrists "[d]own this way, downward." His wrists feel "strained" while he types. As to the Blackberry, Petitioner "was doing mostly with [his] thumbs on the little key pad."

Petitioner further testified that he generally worked from 8 a.m. until 4:30 p.m., trying to split his workweek evenly between the office and the field (various facilities). When Petitioner was in the office, he was "on the computer all the time," eating lunch at his desk while continuing to work on the computer. He used the "hunt and peck" method of typing. Petitioner used the Blackberry when he was not in the office. Petitioner did not use his computer at home much, usually for personal emails and to surf the web.

Petitioner testified that he first noticed symptoms in August or September of 2013, which consisted of "an ache and pain in [the] wrist, and then tingling in [the] thumb and *** index finger." The symptoms were in the right hand only. Petitioner denied having the symptoms while using his home computer, explaining the setup at home was more comfortable. The symptoms coincided with increased duties at work due to "a big consolidation of leases and State facilities, so we were moving offices all the time at that time." Petitioner continued: "We had moving services, *** but in the course of any move, when the movers leave, there is still adjustments to be made, helping people get things set up the way they want them with furniture and file cabinets, *** hanging bulletin boards, making sure that the filters in this building are clean, and doing HVAC work, along with an engineer." Petitioner clarified he "assisted the engineer a lot of times because *** some of these buildings have HVAC systems big enough that you have to crawl into to change filters, and he couldn't crawl in and out to get the filter, so I would hand him filters and hand him tools ***. Same thing, when we get like a DHS office, we have to help arrange the file cabinets, stuff of that nature." On cross-examination, Petitioner affirmed that he helped lift heavier things.

The medical records show that on August 27, 2013, Petitioner consulted Advanced Orthopedic and Spine Care about the symptoms in his right hand and wrist. Petitioner saw Dr.

Daniel Troy's physician's assistant, who noted: "[H]is biggest complaint is numbness and tingling right hand and fingers. He does state that the thumb is worse than the other fingers. However, all his fingertips do go numb at times. This started about a week and a half ago." Physical examination was notable for positive Phalen and Tinel signs on the right. PA Kathy Harley provisionally diagnosed a right carpal tunnel syndrome and prescribed a nighttime wrist brace.

On September 25, 2013, Petitioner saw Dr. Troy, reporting no relief from the carpal tunnel brace. Dr. Troy performed a cortisone injection into the right carpal tunnel and ordered electrodiagnostic studies. Petitioner testified that he understood the condition to be work-related and promptly notified his supervisor, as well as a human resources/workers' compensation coordinator and Caresys, Respondent's third party administrator. The electrodiagnostic studies, performed October 3, 2013, showed "a chronic, mild to moderate, right median mononeuropathy at the wrist (carpal tunnel syndrome), with ongoing denervation." On October 18, 2013, Dr. Troy recommended a right carpal tunnel release.

On December 18, 2013, Dr. Troy performed the right carpal tunnel release. On January 3, 2014, Petitioner reported a slight improvement and declined postoperative physical therapy. On February 4, 2014, Petitioner complained of "numbness and tingling to his right hand first, second and third digits after undergoing a carpal tunnel release." Dr. Troy prescribed physical therapy, which Petitioner attended. On April 29, 2014, Petitioner complained of persistent numbness in the first, second and third digits. "He says it feels about the same as it did before surgery." Dr. Troy ordered repeat electrodiagnostic studies. The electrodiagnostic studies, performed May 19, 2014, were abnormal. On June 7, 2014, Dr. Troy noted: "The repeat EMG test was overall reviewed demonstrating the median nerve demonstrates prolonged latency 8.5 ms with decreased amplitude." Dr. Troy performed an injection into the right carpal tunnel and discussed a revision surgery. On September 9, 2014, Petitioner complained of persistent symptoms and decided to proceed with the revision surgery.

On November 4, 2014, Dr. Troy issued a brief causation letter at Petitioner's request, stating: "It is my impression that for several years you have been performing repetitive activity to your upper extremities not only with the use of a computer but also with a handheld blackberry. The causative nature of developing carpal tunnel syndrome is from repetitive activity. Computer work on a repetitive nature as well as using a handheld device on a repetitive nature would be causative factors to lead to the development of carpal tunnel complaints and subsequent need for surgical intervention."

On November 19, 2014, Dr. Troy performed a revision right carpal tunnel release. On November 26, 2014, Petitioner reported an overall decrease in the numbness and tingling, as well as increased strength. On December 6, 2014, Petitioner presented with an infected surgical site and was prescribed antibiotics. On December 12, 2014, Petitioner reported improvement. The infection was resolving. On January 26, 2015, Petitioner reported that "intermittently he will have shooting pains if he moves his wrist in certain directions but overall he is very happy with

his outcomes to date." On March 20, 2015, Petitioner reported doing very well, although he complained of "some slight residual tingling and numbness in the 1st and 2nd digits but he did have very severe carpal tunnel complaints. He is doing markedly better from the revision carpal tunnel surgery." Petitioner has not followed up regarding the right carpal tunnel since.

On June 9, 2015, Dr. John Fernandez examined Petitioner at Respondent's request. Dr. Fernandez noted the following history: "[The claimant] states that he started to notice complaints of numbness and tingling back in August 2013. He attributed to work activities which included texting and typing. However, [it] also appears that he was involved in physical tasks, which were aggravating his symptoms with examples of assembling furniture, installing cabinets and installing air conditioning units occasionally." Dr. Fernandez further noted: "He did show me some positional factors that may have contributed to including hyperflexion while on the keyboard, but also engages in physical gripping and grasping of a repeated nature with a more physical tasks of assembling furniture, installing air conditioners and/or installing cabinets." Petitioner complained of "moderate residual complaints and numbness in the thumb and index finger with some associated weakness and 'dropping things' " despite the revision surgery. He had returned to work full duty, "although with some difficulties." Physical examination was notable for: numbness and tingling in the thumb, index and middle fingers; "definite irritability in the median nerve at the wrist extending distally into the hand;" significantly expanded two-point discrimination with weakness to pinch and grip; some swelling along the wrist at the carpal tunnel; and pain to direct palpation along the carpal tunnel, with some local crepitus. Dr. Fernandez causally connected Petitioner's carpal tunnel syndrome to his work activities.

Dr. Fernandez, a hand and upper extremity surgeon, testified by evidence deposition on May 18, 2018. Dr. Fernandez expanded his causation opinion as follows: "[T]he BlackBerry would not have any contributory effect on causing *** or aggravating the carpal tunnel syndrome. The reason *** being that there's really no reasonable evidence that supports that, whether it's an iPhone or a BlackBerry. I would say with regards to keyboarding or typing, the act of keyboard or typing in and of itself is also not a significant risk factor for the same or similar reasons. The only risk factor that would be associated with the keyboarding and the typing would be positional factors or pressure factors. For example, if he had the forearm or the wrist resting at the edge of the desk putting direct pressure on the carpal tunnel, something along those lines. *** [I]n his case he reported that based on the way his work station was set up he demonstrated to us what we would refer to as a hyperflexion which is beyond 30 or 40 degrees. That would be the risk factor but not the typing or keyboarding by itself, but the fact of how he was positioned to do that."

On cross-examination, Dr. Fernandez testified the activities of assembling furniture, installing air conditioners and installing cabinets are more strongly correlated with causation and aggravation of carpal tunnel syndrome if the worker performs the activities at least four hours a day. On the other hand, if the worker performs the activities only two hours a day, "[t]he risk factor is almost gone at that point. In which case then the risk factor would then be work station *** assuming that he's then on the keyboard for the other six or eight hours."

Petitioner testified that he continues to suffer from persistent symptoms, including numbness and sensitivity in two fingers, which interfere with some activities of daily living. The group health insurance paid the medical bills, except the deductibles and copays.

The Arbitrator found that Petitioner failed to prove notice, accident and causation, and denied the claim. We disagree and find the claim compensable.

Beginning with the issue of notice, Petitioner claims a manifestation date of September 25, 2013. The preliminary diagnosis of a right carpal tunnel syndrome was confirmed by electrodiagnostic testing on October 3, 2013. Petitioner testified that he understood the condition to be work-related and promptly notified Respondent. Illinois Form 45: Employer's First Report of Injury, dated November 1, 2013, confirms that Petitioner gave timely notice of accident/ repetitive trauma.

Regarding repetitive trauma/causation, the Commission finds credible Petitioner's testimony regarding his computer use and hand positioning while keyboarding. The Commission is persuaded by the opinion of Dr. Fernandez that keyboarding with the hands in a hyperflexed position was a causative factor in Petitioner's right carpal tunnel syndrome.

Petitioner does not claim any temporary disability benefits. The Commission awards the medical bills for the diagnosis and treatment of the right carpal tunnel syndrome, subject to section 8(j) credit due to Respondent.

Turning to the issue of permanent disability, the Commission considers the five factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act): "(i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b). Further, section 8(e)9 of the Act provides: "[I]f the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma, *** the permanent partial disability shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand." 820 ILCS 305/8(e)9.

Regarding factor (i), the Commission notes no impairment rating has been submitted into evidence. The Commission therefore gives no weight to this factor.

Regarding factors (ii), (iii) and (iv), the Commission notes that as of the date of his testimony, Petitioner continued to work as a facility manager, although he was 67 years old. The Commission gives little weight to these factors, as Petitioner reached retirement age with no decrease in earning capacity.

Regarding factor (v), the Commission notes the first right carpal tunnel release surgery proved unsuccessful, necessitating a revision surgery. Petitioner complained to Dr. Troy and Dr. Fernandez of significant residual symptoms despite the revision surgery. The most recent physical examination, performed by Dr. Fernandez, was notable for: numbness and tingling in the thumb, index and middle fingers; "definite irritability in the median nerve at the wrist extending distally into the hand;" significantly expanded two-point discrimination with weakness to pinch and grip; some swelling along the wrist at the carpal tunnel; and pain to direct palpation along the carpal tunnel, with some local crepitus. Petitioner credibly testified that he continues to suffer from persistent symptoms, including numbness and sensitivity in two fingers, which interfere with some activities of daily living. The Commission gives great weight to this factor.

Having carefully considered and weighed the foregoing factors, the Commission believes the proper measure of disability, by clear and convincing evidence, is 20 percent loss of use of the right hand.

Lastly, the Commission finds that penalties and attorney fees are not warranted, as there was a *bona fide* dispute regarding repetitive trauma and causation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 19, 2018, is hereby reversed.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $721.66 per week for a period of 38 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of the right hand to the extent of 20 percent thereof.

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

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

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: OCT 2 - 2019
o-09/11/2019
SM/sk
44

Stephen J. Mathis
Stephen Mathis

D. Douglas McCarthy
Douglas McCarthy

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FEREGA, MICHAEL
Employee/Petitioner

Case# **13WC042340**

STATE OF ILLINOIS/CMS
Employer/Respondent

19IWCC0543

On 10/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST
SPRINGFIELD, IL 62705

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

OCT 19 2018

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Ferega
Employee/Petitioner

Case # 13 WC 42340

v.

Consolidated cases: ______

State of Illinois/CMS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Luedke on November 20, 2017 and Honourable Kurt Carlson on August 11, 2018**, Arbitrator of the Commission, in the City of **Chicago**, County of **Cook**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

E. [x] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

L. [x] What is the nature and extent of the injury?

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

N. [x] Is Respondent due any credit?

O. [ ] Other Prospective Medical

FINDINGS

On **September 25, 2013**, Respondent-Employer *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$107,467.88**, and the average weekly wage, calculated pursuant to Section 10 of the Act, was **$2,066.69**.

On the date of accident, Petitioner was **63** years of age, married with 0 dependent child.

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

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

Respondent-Employer is awarded 0 credit for TTD, TPD, maintenance, or for other benefits.

ORDER

Permanent Partial Disability with 8.1b language *(For injuries after 9/1/11)*

The Arbitrator finds that Petitioner did not give Respondent timely notice of his right hand accident; therefore, the Arbitrator awards no benefits.

Petitioner's current condition is not causally connected to his work activities.

Please see attached document for additional findings of fact and conclusions of law.

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

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

Signature of Arbitrator — 10-17-18
Date

OCT 19 2018

STATE OF ILLINOIS)
)
COUNTY OF COOK)

19IWCC0543

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL FEREGA, Petitioner,

v.

STATE OF ILLINOIS/CENTRAL MANAGEMENT SERVICES, Respondent.

Case No. 13 WC 42340

Chicago, IL

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. INTRODUCTION

An Application for Adjustment of Claim was filed by Petitioner, Michael Ferega, seeking relief under the Illinois Workers' Compensation Act from Respondent, Central Management Services (hereinafter referred to as "CMS"). A hearing was held before Arbitrator Robert Luedke on November 20, 2017, in Chicago, Illinois. Proofs were closed on August 13, 2018 before Arbitrator Kurt Carlson. Petitioner was represented by the Law Offices of Berg & Robeson, P.C. Respondent was represented by the Illinois Attorney General's Office.

II. FINDINGS OF FACT

Petitioner testified that he worked for CMS as a facility manager and that he developed carpal tunnel syndrome in his right wrist as a result of his work for the State of Illinois. Petitioner started working for CMS in 1995 in Springfield. He transferred to Chicago around 2008. Petitioner's job duties entail filing work orders and other tasks to assist facility relocation or repair. Petitioner typically works from 8 a.m. to 4:30 p.m., five days each

week. Petitioner claimed at trial that he spent a lot of time on his Blackberry mobile device responding to emails and that he also uses his office computer for typing the majority of the day. While Petitioner does not use heavy tools or machinery, he does assist some of the facility engineers with their jobs from time to time by handing them tools and similar items. At his independent medical examination, Petitioner was unable to describe the amount of time he spent doing each of those activities. Petitioner neglected to inform his doctors that he underwent a total right hip replacement surgery on May 8, 2013. Further, he led his told his doctors about being at a desk all day, but also testified that he spends half of his time "in the field." (T. 26) He testified that he was involved in crawling into HVAC systems with building engineers. (T. 30) He also helped people get things set up the way they wanted them with furniture, file cabinets and bulletin boards. (T. 30)

Petitioner claims that he started feeling tingling and aching in his right wrist and fingers in August of 2013. Petitioner claims that he notified Gerry Adams, his supervisor in charge of the Northern region of CMS, "several days" after Dr. Troy diagnosed him with CTS on August 27, 2013. Additionally, Petitioner also claimed that he notified Diane Bevell, a workers' compensation coordinator, and Caresys, the State's administrator for handling workers' injuries.

Petitioner first sought treatment from Dr. Daniel Troy on August 27, 2013. Petitioner was diagnosed with carpal tunnel syndrome and released to work with the use of a wrist brace. On September 25, 2013, Petitioner underwent cortisone injections. Dr. Troy performed Petitioner's carpal tunnel release on December 18, 2013. Petitioner claimed at trial that he felt no relief of his symptoms after this first surgery. Petitioner attended physical therapy for six weeks between February 11, 2014 and March 20, 2014.

On April 29, 2014, Petitioner returned to Dr. Troy and reported that his symptoms had not dissipated. Petitioner underwent an additional cortisone injection to the proximal aspect of the carpal tunnel release and, on September 9, 2014, Dr. Troy recommended an additional carpal tunnel release.

On November 4, 2014, Dr. Troy penned a letter that expressed that Petitioner's condition was caused by utilizing a computer and handheld Blackberry.

On November 19, 2014, Dr. Troy performed a carpal tunnel syndrome revision surgery on Petitioner's right hand. Petitioner testified that the revision surgery did not provide him any relief. Conversely, during Petitioner's initial post-operative visit on November 26, 2014, Petitioner reported a decreased amount of numbness and tingling sensation in his hand as well as increased strength. On December 6, 2014, Dr. Troy removed Petitioner's sutures. On January 26, 2015, Petitioner was advised that no further treatment was warranted for his right wrist.

Dr. Troy noted on March 20, 2015 that Petitioner only had some slight residual tingling and numbness in his first and second digits and that Petitioner was doing "markedly better." (PX #1) His most recent visit with Dr. Troy was on August 16, 2017 for unrelated medical issues. At that time, Petitioner did not make any complaints of pain and numbness in his digits or mention his wrist at all. Petitioner testified that his last date of treatment for his right wrist was March 20, 2015.

On June 9, 2015, Dr. Fernandez conducted an independent medical examination of Petitioner and found causation. However, at his deposition, Dr. Fernandez testified he never had Petitioner demonstrate how he typed and that Blackberry usage does not cause carpal tunnel syndrome. Moreover, Dr. Fernandez never reviewed Petitioner's EMG results.

III. CONCLUSIONS OF LAW

C. Was there an injury arising out of employment?

Petitioner failed to testify that he experienced pain, tingling or numbness while performing his work activities with The State of Illinois. Further, Petitioner did not provide adequate notice to Respondent within 45 days of August 27, 2013 for his right hand injuries and Respondent was prejudiced by his failure to notify.

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

Pursuant to the Illinois Workers' Compensation Act, "notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. 820 ILCS 305/6c (2012). This notice requirement applies to employees who suffer repetitive trauma injuries. *Three "D" Discount Store v. Indus. Comm'n*, 198 Ill.App.3d 43, 144 Ill. Dec. 794, 556 N.E.2d 261 (1989).

In this case, Petitioner admitted that he initially began having numbness and tingling in his right hand in August 2013. On August 27, 2013, Petitioner visited Dr. Troy and stated these symptoms had started approximately a week and a half ago. At that time, Dr. Troy diagnosed Petitioner with carpal tunnel syndrome. Petitioner, however, waited until November 1, 2013 to notify Respondent of his injury. (PX #9) This is 66 days after he was diagnosed with carpal tunnel syndrome by Dr. Troy and well outside of the statutory 45-day reporting window. While Petitioner testified that he told several individuals within his workplace in August, the Arbitrator finds Petitioner's Illinois Form 45: First Report of Injury to be more persuasive.

Respondent has been severely prejudiced by Petitioner's failure to inform it of his injury. As set forth in *Ristow v. Indus. Comm'n*, 39 Ill. 2d 410, 235 N.E.2d 617 (1968) "Section 6(c)

explicitly provides that no proceeding can be maintained unless the employer has been given notice of accident within the statutory period. As in other statutes of limitation there is a *conclusive presumption* that the employer has been prejudiced by the failure to notify." *Id.* at 414 (emphasis added).

Had Petitioner informed Respondent within 45 days of August 27, 2013 that he had injured his right hand, Respondent could have been taken measures to avoid his claimed repetitive right hand injury. For example, Respondent could have changed the Petitioner's computer setup with a different mouse, keyboard, chair, etc. to accommodate his condition. Petitioner did testify that his home computer did not aggravate his condition, which shows that changing his workstation could alleviate his condition. Respondent could also have taken Petitioner off work completely. Instead, Petitioner chose not to make Respondent aware of his alleged work injury and chose to continue to work using his right hand.

Based on the above facts, the Arbitrator finds that Petitioner did not provide adequate notice to Respondent within 45 days of August 27, 2013 for his right hand injuries and Respondent was prejudiced by his failure to notify.

F. Is Petitioner's current condition of ill-being causally related to his work accident?

The Arbitrator finds no causal connection in this matter. While it may be true that Dr. Troy stated that Petitioner's "repetitive duties" caused the carpal tunnel, it is clear Troy was led to believe that the Petitioner spend all day typing, whether at a computer or with a Blackberry device. By Petitioner's own admission, half of his time was spent "in the field." (T. 26) It's difficult for the Arbitrator to believe that part-time desk work could cause carpal tunnel

syndrome, especially when you consider that the Petitioner had just recovered from a right total hip replacement surgery and he "hunts and pecks" with the computer. (T. 37)

It may be true that Respondent's own Section 12 examiner, Dr. Fernandez, stated "hyperflexion can cause carpal tunnel syndrome," this opinion is based on the erroneous assumption that Petitioner was sitting at his desk performing data-entry in an awkward position on a full-time basis. Again, by his own admission, Petitioner spent half of his time in the field. (T. 26) He spends a significant time on the telephone. (T. 37) Additionally, a significant portion of his field time had to be in transit from one facility to another. Petitioner supervised over 60 state facilities. (T. 29)

The Arbitrator is unaware of any prior cases where a Petitioner was compensated for carpal tunnel syndrome for a part-time data entry with a Blackberry device (which requires no hyperflexion) or part-time data-entry at an ergonomically incorrect work station. There are no cases where Petitioner was awarded compensation for part-time use of an Blackberry device (P.23) Perhaps in theory, misuse of a Blackberry could cause a thumb injury, but not carpal tunnel. Further, the Petitioner was a 63-year-old CMS facility manager earning over $107K per year. Part of his job is "to help people set up offices the way they want...with furniture, file cabinets, you know, hanging bulletin boards." (T.30) Knowing the above, it is difficult to believe that the Petitioner was incapable of changing his work station at CMS, especially the height of his chair. And if an ergonomic flaw was genuinely part of the part of the problem, why didn't Drs. Troy or Fernandez prescribe a change?

At one point in Petitioner's testimony, he stated that "a lot of times" he helped the engineers lift heavy equipment in the field (T. 36) and crawl into HVAC systems with building engineers (T.30) Again, it is highly unlikely that any of this activity occurred near the claimed

date of accident. Petitioner had recently undergone a total right hip replacement surgery earlier in May. He'd only been discharged from physical therapy on August 1, 2013, only four weeks before he alleged carpal tunnel injury. Even if true, it argues against constant, repetitive, data-entry on a full-time basis, as his doctors believed he was performing. Petitioner is unlike an assembly line worker, Petitioner was not tasked with meeting production goals. He was not folding and unfolding cardboard boxes under the watchful eye of a shift supervisor.

In conclusion, the Arbitrator does not believe either doctor had a clear picture of the Petitioner's work activities when they rendered their opinions about causation and their concept of the Petitioner's everyday work activities was flawed enough to discard both of their conclusions regarding causal connection.

J. Were 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 has already found that Petitioner did not provide adequate notice to Respondent within 45 days of August 27, 2013 for his right-hand injuries and Respondent was prejudiced by his failure to notify.

Thus, no benefits are awarded and the Arbitrator makes no finding in regard to whether the medical services provided to Petitioner were reasonable and necessary or whether Respondent paid for said medical services.

L. What is the nature and extent of the Petitioner's injury?

The Arbitrator has already found that Petitioner did not provide adequate notice to Respondent within 45 days of August 27, 2013 for his right-hand injuries and Respondent was prejudiced by his failure to notify. Likewise, the Arbitrator finds no causation.

Thus, no benefits are awarded, and the Arbitrator makes no finding in regard to the nature and extent of Petitioner's injury.

M. Should penalties or fees be imposed on Respondent?

Finding inadequate notice and no causal connection, the Arbitrator likewise finds no penalties are warranted on this matter. The Arbitrator notes that the issue of accident is problematic in this case. Petitioner failed to testify that he felt pain, numbness or tingling during his work activities with Respondent.

N. Is Respondent due any credit?

The Arbitrator finds that Respondent is entitled to a credit for any medical benefits paid through its group health insurance for which credit may be allowed under Section 8(j) of the Act.

Arbitrator Kurt Carlson

10·18·18
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: Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHELLY MOORE,

Petitioner,

19IWCC0544

vs.

NO: 16 WC 24012

BETHALTO COMMUNITY UNIT SCHOOL DISTRICT 8,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation of Petitioner's condition of ill-being of her left shoulder and medical expenses both current and prospective, reverses the Decision of the Arbitrator and finds that Petitioner sustained her burden of proving her shoulder condition was causally related to the stipulated accident. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total disability 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 - Testimony

Petitioner testified that on February 18, 2015 she was a high school science teacher for Respondent. She had been teaching for 22 years and never had a previous workers' compensation claim. On that date, she was pulling down a projector screen which was attached to the ceiling by S hooks. The screen fell and hit the left wrist "with enough force that it knocked [her] back."

One of her students went to the office to get ice. The student returned with the ice and the school nurse, Karen Martin, came to her classroom with an incident report form. Petitioner sat down with the ice on her wrist. She was "kind of woozy and kind of out of it like what had just happened." She tried to continue class and filled out the incident report that day. Respondent sent her for treatment at Midwest Occupational Medicine. X-rays showed no break in her left hand, but they were worried about soft-tissue damage and provided her a brace. Petitioner acknowledged that she previously had a carpal tunnel release on her left wrist and two ulnar nerve surgeries in her left elbow. Prior to his accident she had "achy, arthritis" in her left shoulder, "but nothing major."

Petitioner treated with Dr. Omotola beginning about three weeks after the accident. She acknowledged that in her history form at Alton Orthopedics she noted left shoulder/clavicle/general neck pain but indicated the conditions were not work-related. It had not occurred to her at the time that that those conditions were work-related; she was concentrating on her hand and wrist. Her shoulder was achy prior to the accident, but she did not seek treatment. She decided to seek treatment when she could not lift her arm and had limited range of motion. Petitioner was offered an epidural steroid injection by Dr. Omotola's assistant, Ms. Stuart, but she declined because she had steroid injections in her back and knee in the past and they made things worse. Later, she accepted an injection from Dr. Omotola because he informed her that because this was a workers' compensation matter, an injection would be the first order of treatment. Later, he recommended surgery on her shoulder. She did not have the surgery but wanted to proceed. She never had any prior injuries to, or MRIs/x-rays of, her shoulder.

Petitioner also testified that currently, "by the end of the evening it is to the point that" she can barely use her left shoulder; sometimes "it's tingling, kind of burning." She did not consider her shoulder condition to be related to her accident until she told Ms. Stuart about her accident and she informed Petitioner that "blunt force trauma could cause some of the issues," and Dr. Omotola concurred.

On cross examination, Petitioner testified that the screen struck her left shoulder. She did not notice pain in her shoulder immediately because she was focused on her hand and wrist which were in excruciating pain. "Actually the entire left side" was achy. She noticed that her left arm was in pain with movement. She acknowledged that she reported that her shoulder had been achy for three or four months. She was doing exercises to relieve the soreness taught to her by a friend who is a physical therapist. Petitioner agreed that had chiropractic treatment "in the past for various reasons," but not for her neck or shoulder. She had been told by doctors that her shoulder was arthritic. She did not remember seeing a doctor for her shoulder but went for her back and that could lead to problems with the shoulder, so her shoulder was discussed. Dr. Omotola related to her that she would need an injection before surgery was approved. She was not informed of that by Respondent or its insurer.

Petitioner agreed that in 2015 she was "treated for an infection to [her] left clavicle which was originally a mass." Her primary care physician investigated a lump because her family has a history of breast cancer. However, he thought there might be an issue with her shoulder. She agreed that she worked for Respondent for about eight months prior to her accident. She agreed that the prior conditions of her hand, wrist, and elbow were not traumatic but rather degenerative.

Petitioner testified that she informed Nurse Martin that the screen hit her shoulder. Petitioner did not notice any bruising around her shoulder. When she first went to a doctor, they did not note any bruising of her shoulder; they were looking at her hand and wrist. She did not believe she initially reported pain in her shoulder. At that time, x-rays were taken of her hand but not her shoulder. She agreed that her accident report noted injury to her wrist but not her shoulder. She then testified that she believed she told Nurse Martin that the screen hit her "in the hand, wrist, left body." Petitioner agreed that the first time she reported that her shoulder condition was causally related to her accident was on March 20, 2015. She also agreed that she did not see Dr. Omotola from March 20, 2015 to July 15, 2016.

On redirect examination, Petitioner testified the screen was about eight feet long. She did not know how heavy it is, but she cannot pick it up herself. After it struck her wrist, it continued and came straight back. In the three weeks after the accident her shoulder hurt more, became swollen, and she could not lift things. The onset of these symptoms was gradual. On re-cross examination, Petitioner related that the screen was swinging with one end still attached to the ceiling and she was struck by "probably at least a quarter of the screen."

Ms. Karen Martin was called by Respondent. In February of 2015 she worked for Respondent as school nurse and had been in the position for about 17 years. In that job, she would report on every injury of students and employees and render first aid. On February 18, 2015, Petitioner reported that she suffered an accident in which the projector screen came loose and swung down and hit her left arm. She reported she hurt her left hand, ring finger, and pinky finger. She did not report any injury to her shoulder. She thought Petitioner should see a doctor because her hand and fingers were bruised and swollen. She did not have complaints, bruising, or pain regarding her shoulder.

On cross examination, Ms. Martin testified she was going mostly on her notes and not independent recollection. She has not personally lowered a projector screen. Seeing the screen, Petitioner's reported mechanism of injury to her left hand seemed plausible. She did not remember Petitioner telling her that it knocked her back a couple of feet and that was not her report. However, because of the size of the projector and that it swung down and hit her, she thought she should get x-rays because something might be broken. She agreed that it was a "pretty significant trauma." She has seen instances in which pain became more significant some days after an accident and/or develop pain related to the accident that they did not express on the day of the accident.

Doctor depositions – Section 12 reports

On February 2, 2017, Petitioner presented to Dr. Anderson for a Section 12 medical examination of her left shoulder. In his resulting report, Dr. Anderson wrote that Petitioner indicated the accident in which "a screen broke loose and came at her. She blocked it with her left hand. Interestingly, at the time there were no complaints of shoulder pain." She now reported that her shoulder hurt, but her hand hurt worse. Dr. Anderson noted that the MRI showed a "SLAP tear, mainly degenerative." He did not see any pull-off of the biceps anchor. He opined that the SLAP tear was in all likelihood degenerative. She appeared to have bicipital tendonitis and a little degeneration of the AC joint. The type of injury she described will typically not cause a shoulder problem and she did not initially complain of shoulder issues.

In his report, Dr. Anderson's diagnosis was bicipital tendinitis. He recommended an injection and that she should minimize overhead activity. He opined that her treatment to date was reasonable, but the shoulder condition was not related to her work-accident.

Dr. Lenarz testified by deposition on May 5, 2017. He is a board-certified orthopedic surgeon specializing in treatment of shoulders and elbows. He performed an Section 12 examination on Petitioner on October 12, 2016, at the request of her lawyer. She reported that "she was closing up a projection screen which was mounted to the ceiling. When she released the screen the screen retracted. The entire apparatus came off the S-hook hanging from the ceiling; and she indicated to [him] that it swung down, struck her in the hand and shoulder." "She complained of significant pain." He noted that physician assistant Stuart's notes indicated that her shoulder pain had been present for three to four months, but the questionnaire she filled out at the time indicated "that the pain had gotten significantly worse within the last two weeks which would coincident with her reported injury while at work." She reported no problems with performing her job activities because of her shoulder prior to the instant accident. The only documentation about a prior shoulder condition was in Ms. Stuart's initial treatment note.

Her MRI showed evidence of a superior labral tear, inflammation or tendinitis around the biceps, and some edema around the AC joint "to suggest a recent injury." He did not believe the edema was from a chronic condition because he would expect to see advanced degenerative changes. One would expect edema could last up to six weeks and sometimes even up to 12 weeks of an acute injury. His clinical examination was consistent with the MRI findings. Dr. Lenarz' diagnosis was biceps tendonitis and AC joint sprain. She had not improved significantly with physical therapy. Possible surgery would include subacromial decompression, distal clavicle excision, and biceps tenodesis versus tenotomy. Dr. Lenarz also noted that she was still symptomatic when he saw her which was a year and a half after her injury. That fact indicated that surgery would be reasonable treatment. Dr. Lenarz opined that the injuries sustained in the accident contributed to the condition of her left shoulder and to the need for the surgery he recommended.

On cross examination, Dr. Lenarz agreed that "usually" the first history patients provide is the most consistent and that "at times" the history may change later with time. He generally gives more credence to the initial histories. He also agreed that he reviewed limited records and that he was provided additional records after his examination prior to the deposition. He did not review records of Petitioner's visit to Midwest Occupational Medicine on February 18, 2015, certain records from Dr. Boyd's, certain records from St. Anthony's Physicians' Group, a chest CT, records of Dr. Bemis, a chiropractor, or records regarding Petitioner's cervical spine.

The labral tear he noted in the MRI was not part of his diagnosis because he did not believe it was causing her pain. Therefore, he would not recommend repair of the labral tear. Dr. Lenarz agreed that biceps tendonitis, tendinopathy of the supraspinatus tendon, and a partial-thickness tear of the rotator cuff can be degenerative in nature. While arthritis is a degenerative condition, Petitioner did not have any in the glenohumeral or shoulder joint.

Based on the edema, Dr. Lenarz could not rule out another injury. Assuming shoulder pain from December 2014, based on the report of Ms. Stuart, that would be within the time frame that edema could be seen on the MRI taken March 13, 2015. His opinion was based on Petitioner's history and the medical records he reviewed. Records of prior treatment of her shoulder could change his opinion. If a patient came to him reporting that something fell on their shoulder and the shoulder really hurt, he would order an x-ray.

Petitioner reported to him that the projector screen struck the front and top of her shoulder. That history would be consistent with AC joint sprain and biceps injury. He did not think it would be consistent with the supraspinatus findings. Typically, he would expect Petitioner to have reported shoulder pain to her treater immediately. "However, if something else hurts more" she might have ignored an injury secondary to that pain. He agreed that the initial medical records made no mention of the screen hitting her shoulder or complaints of left-shoulder pain. Dr. Lenarz indicated that Dr. Omotola administered an injection in her shoulder which provided a couple of weeks of relief. However, he would not expect any more significant relief from another injection.

On redirect examination, Dr. Lenarz agreed that based on the initial report her hand injury was causing more discomfort than her shoulder. X-rays were taken of the hand and there was some discoloration. The initial report was that the screen hit the left side of her body, there was no indication what part of her body was struck. On re-cross examination, Dr. Lenarz indicated that when a patient injures distinct parts of the body, they do not always complain about both areas.

Dr. Omotola testified by deposition on October 2, 2017. He is a board-certified orthopedic surgeon. He first saw Petitioner on March 20, 2015. She complained of "global pain" in her left shoulder, pain in her left biceps, pain her AC joint, and weakness in her rotator cuff. She was in an home exercise program with an athletic trainer from a local high school.

He gave her an injection and recommended she continue with the exercises, but those which were developed by a certified therapist. In his review of her MRI, he did not mention effusion. He had no opinion on whether effusion would suggest recent trauma, but trauma can cause effusion. He thought that the MRI findings were consistent with her complaints.

Petitioner saw Dr. Omotola's physician's assistant twice, saw him on March 20, 2015, and she did return to him until July 15, 2016. Ms. Stuart initially sent Petitioner to see him on March 20th because she was not doing well when she saw her on March 18th reporting 7/10 pain. Petitioner called his office on March 25th asking for an off-work note for her part-time job in a furniture store in which she had to do heavy lifting. Petitioner was informed that there was no indication in the record that she was being taken off work, though she was advised to avoid heavy lifting, and that it would have to discussed with him.

When Petitioner returned on July 15, 2016, she reported the injection lasted for only a few weeks and had an MRI "last year which showed a labral tear." Basically, her condition had not changed since he first saw her and his examination results were similar. He diagnosed impingement syndrome, biceps tendinitis, and labral tear.

They discussed surgery which would include arthroscopic subacromial decompression, biceps tenodesis, and labral debridement. He told her he would schedule surgery once it was approved. Apparently, they wanted a second opinion. Dr. Omotola did not indicate that the injury was covered by workers' compensation. That determination is made by the patient when they check in.

Dr. Omotola was asked a hypothetical question. He was to assume that Petitioner had no pain or loss of function with her shoulder prior to her accident, she was working her usual capacity as a teacher, and when she released the screen it retracted and "the screen came down and struck her hand first and then her shoulder, causing significant pain in her hand and left shoulder." Dr. Omotola responded that the accident could possibly have caused her shoulder pain or aggravated her condition requiring treatment including possible surgery.

On cross examination, Dr. Omotola testified he did not recall Petitioner telling him that the screen hit her shoulder. He was told to read the record from Midwest Occupational and noted that he did not know whether there was any evidence of a shoulder injury because the shoulder was not evaluated. When Petitioner initially came to his office she did not report being struck in the shoulder by a projector screen. That was the first time she had an x-ray of her shoulder. The x-ray findings could be both from acute trauma or degenerative changes.

On redirect, Dr. Omotola testified he personally rarely sees a patient's injury. On re-cross, Dr. Omotola testified he did not remember whether Petitioner reported the screen struck her shoulder.

19IWCC0544

Conclusions of Law

The Arbitrator found that Petitioner's left-shoulder condition was not caused by her stipulated work accident. He noted that there was no immediate complaint of shoulder pain, there was no initial mention of any accident or injury associated with the shoulder condition, and there was no mention of the shoulder condition being related to the accident until March 20, 2015 when she reported that to Dr. Omotola. In addition, the Arbitrator cited Dr. Anderson's Section 12 medical report and discounted the opinions of Dr. Omotola and Dr. Lenarz because they were working under the assumption that the projector screen struck her shoulder.

The Commission acknowledges that there was a delay in Petitioner's reporting that the screen struck her shoulder or shoulder pain. However, we find reasonable Dr. Lenarz' supposition that an acutely more painful injury, though ultimately not severe, can mask the symptoms from another less acutely painful injury which might ultimately be significantly more severe. Thereafter, it is also reasonable to conclude that as Petitioner's hand condition resolved and her shoulder condition worsened she developed increasing shoulder symptoms.

The Commission is also persuaded by the testimony of Dr. Lenarz regarding his opinion that the MRI from March 13, 2015 showed edema which was consistent with a recent acute trauma. He also opined that the mechanism of injury Petitioner reported was consistent with his diagnosis and the MRI findings. Importantly, the date of the MRI finding, consistent with an acute trauma, was temporally coincident with the date of the accident. The Commission also acknowledges that Petitioner initially reported on March 5, 2015 that her shoulder pain began three to four months prior to the accident. However, at the same time she also reported that the pain worsened two weeks earlier. Once again, the report of the onset of worsening symptoms is temporally coincident with the date of the accident.

The Commission concludes that Petitioner was a credible witness. We do not find that her apparent failure to immediately report that the screen struck her shoulder substantially affects her credibility. Respondent's witness, Nurse Martin, actually bolstered Petitioner's credibility. Ms. Martin testified that Petitioner had suffered a "pretty significant trauma," she had obviously significant hand/finger injuries which the nurse thought might include broken bones, and she testified that Petitioner reported that the screen struck her left "arm," which extends from the wrist to the shoulder.

Therefore, based on the reasoning above, the Commission concludes that Petitioner proved that her stipulated accident on February 15, 2015 resulted in at least an aggravation of the condition of ill-being of her left shoulder necessitating treatment. Accordingly, the Commission reverses the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that it finds that Petitioner sustained her burden of proving that the condition of ill-being of her left shoulder is causally related to her stipulated work accident and the Decision of the Arbitrator filed is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical expenses submitted into evidence in Petitioner's exhibits 7, 8, 9, and 10 under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment recommended by Dr. Omotola.

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

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

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

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

DATED: OCT 2 - 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-9/12/19
46

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANNA GOMEZ,

Petitioner,

vs. NOS: 07 WC 18185
07 WC 18186

ASSEMBLEY UNLIMITED PACKAGING and,
INJURED WORKERS' BENEFIT FUND,
Respondents.

19IWCC0545

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of the Arbitrator's denial of Petitioner's Motion to reinstate two cases, and being advised of the facts and law, reverses the Decision of the Arbitrator, reinstates the cases for the reasons stated below and remands the cases to the Arbitrator for further proceedings consistent with this Decision and Order.

The Commission has considered the Arbitrator's Order ("Order") denying Petitioner's Petition to Reinstate the subject consolidated two cases. The Order confirmed Petitioner filed these claims more than 10 years ago, naming Respondent Assembly Unlimited Packaging as the sole respondent. In August 2007, an Amended Application in 07 WC 18186 was filed naming the Injured Workers' Benefit Fund as an additional respondent. The claims were consolidated on November 23, 2009. On February 23, 2016, Petitioner filed an Amended Application in 07 WC 18185 naming the Injured Workers' Benefit Fund ("Fund") as an additional respondent. The Arbitrator specially set the claims for trial on two occasions, September 19, 2016 and December 20, 2016 although they did not proceed to trial on either date. On March 16, 2017, the Arbitrator set a final trial date of June 12, 2017 with the agreement of both parties. The Arbitrator noted the June 2017 setting allowed Petitioner ample time to provide the allegedly uninsured Respondent, Assembly Unlimited Packaging, with notice of the hearing.

On June 12, 2017, a relatively new attorney from the Petitioner's firm appeared. The Petitioner's attorney informed the Arbitrator and counsel for the Fund he could not proceed to trial due to a conflict and a notice-related issue. He indicated the cases were also set for hearing on June 16, 2017 having been set on that date at the status call. Counsel requested to proceed to hearing on June 16, 2017. Counsel represented he planned to notify Assembly Unlimited Packaging of the hearing via a special process server. The Commission reasonably infers that Petitioner's attorney thus represented that that the Respondent Assembly Unlimited Packaging had not received notice of the June 12, 2017 hearing date.

The Arbitrator declined to allow the additional continuance, noting the advanced age of the claims, the multiple continuances, the final and pre-set nature of the June 12, 2017 setting and the fact that, even if Petitioner's counsel managed to locate and serve Assembly Unlimited Packaging at some point between June 12 and 15, 2017, the notice would still be inadequate. The Arbitrator dismissed the claims for want of prosecution.

On June 16, 2017, Petitioner file a timely Petitioner to Reinstate, citing the "confusion" between the June 12 and 16, 2017 hearing dates as a basis for reinstatement On June 29, 2017, the Fund filed a Response outlining the history of the claims and objecting to the reinstatement. In the Response, counsel for the Fund acknowledged receiving a communication from Petitioner's counsel on June 8, 2017 inquiring as to how to proceed with the scheduled hearing on Monday, June 12, 2017 but expressing no confusion as to the hearing date. Petitioner presented the Petition to Reinstate at the Arbitrator's July 11, 2017 status call, and the cases were set for hearing on July 20, 2017. Counsel for Petitioner and the Fund appeared. A court reporter was called and a transcript of the proceedings without testimony was recorded.

The Arbitrator's Order denying the Petitioner's Petition to Reinstate alleges Respondent Assembly Unlimited Packaging never filed an appearance nor did a Respondent representative appear on July 20, 2017. At the July 20, 2017 hearing, the Arbitrator explained the matters were set in March for the June 12, 2017 trial as the uninsured employer must receive adequate notice of the hearing. T. 10. The record, however, is devoid of evidence that any attempt was made to serve notice on Respondent Assembly Unlimited Packaging regarding the Petition to Reinstate proceeding on July 20, 2017.

Moreover, Petitioner's attorney was present at the June 12, 2017 hearing and adequately explained the confusion as to the conflicting trial dates. Petitioner's attorney represented he would provide notice to Respondent and be prepared to proceed on June 16, 2017. Petitioner should have been afforded an opportunity to proceed to hearing on June 16, 2017.

The due process clause of the 14th Amendment to the United States Constitution is binding on administrative agencies. *Paoletti v. Industrial Commission*, 279 Ill. App. 3d 988, 998, 665 N.E. 2d 507 (1996). "[D]ue process of law requires that all parties, in proceeding before administrative agencies, have an opportunity to cross-examine witnesses and to offer evidence in rebuttal." *Id.* The Commission finds that both proceedings on June 12, 2017 and on July 20, 2017 violated the principles of due process. The Commission therefore, reverses the Order of the Arbitrator denying the Petitioner's Petition to Reinstate the Cases. In so reversing, the Commission cautions the

Petitioner's attorney that this reversal is not a license for further delays or continuances but one last opportunity to proceed to hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator Denying Petitioner's Petition to Reinstate the subject consolidated cases is reversed, the cases are reinstated and remanded to the Arbitrator for proceedings consistent with this Decision and Order, but only after the latter of expiration of the time for filing a written request for Summon 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 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 4 - 2019
LEC/bsd
O072319
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

STATE OF ILLINOIS	)	☐ Affirm and adopt	☐ 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

JESUS CAMPOS,

Petitioner,

vs. NO: 11 WC 01632

POLYONE CORPORATION, **19IWCC0546**

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, benefit rates, medical expenses, notice, TTD, PPD, and penalties and attorney's fees, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof, but corrects scrivener's errors found within the same.

In the Order of the Decision of the Arbitrator, the word "not" is struck from the sentence that reads, "The Arbitrator further finds that Petitioner failed to prove his current condition of ill-being is not causally related to an accidental injury." The correct sentence reads, "The Arbitrator further finds that Petitioner failed to prove his current condition of ill-being is causally related to an accidental injury."

The third sentence of the second paragraph in the section of the Decision of the Arbitrator entitled, "Procedural History," is corrected to reflect the correct date of accident is December 1, 2010. Accordingly, the date of accident as written, December 1, 2012, is amended to December 1, 2010.

The wrong word is found to have been used in the second sentence of the seventh paragraph in the section of the Decision of the Arbitrator entitled "Findings of Fact." Rather than "prescribed," the word "proscribed" was used. "Proscribed" is replaced with "prescribed," and

the sentence is to read as, "Petitioner was prescribed physical therapy and diagnosed with a right knee sprain."

The last correction to the Decision of the Arbitrator is made to first sentence of the first paragraph found on page 6 of the section of the Decision of the Arbitrator entitled "Findings of Fact." As written, May 10, 2010 was stated to be one of the dates Petitioner attempted to return to work. Petitioner's testimony indicates the correct date to have been May 10, 2011. The sentence is corrected to read, "Petitioner testified he unsuccessfully attempted [to] return to work with Respondent on March 8, 2011, May 10, 2011, and either June 20th or July 20th and on October 26, 2012."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 29, 2017 is hereby affirmed but with the changes as indicated 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.

No bond for removal of this cause to the Circuit Court is required as no award for payment has been entered. 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 7 - 2019
LEC/mav
O: 08/27/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAMPOS, JESUS
Employee/Petitioner

Case# **11WC001632**

POLYONE CORPORATION
Employer/Respondent

19IWCC0546

On 11/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1042 OSVALDO RODRIGUEZ PC
7704 W NORTH AVE
ELMWOOD PARK, IL 60707

4866 KNELL & O'CONNOR
IAN T WHITNEY
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

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

Jesus Campos
Employee/Petitioner
v.
Polyone Corporation
Employer/Respondent

Case # 11 WC 1632

19IWCC0546

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **April 13, 2016 and December 6, 2016** and Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **September 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] 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: Whether prospective medical should be awarded?

Findings

On **December 1, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the 52 weeks preceding the injury, Petitioner earned **$59,816.64**; the average weekly wage was **$1,150.32**.

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

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 medical benefits under Section 8(j) of the Act, for a total credit of **$0**.

ORDER

Claim for compensation is denied, Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 1, 2010. The Arbitrator further finds that Petitioner failed to prove his current condition of ill-being is not causally related to an accidental injury. The Petition for Penalties and Fees is also 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

11/29/2017
Date

NOV 29 2017

PROCEDURAL HISTORY

This case was tried on April 13, 2016 and December 7, 2017 before Arbitrator Gale and completed on September 20, 2017 before Arbitrator Soto. The parties stipulated to Arbitrator Soto completing the trial and authoring the decision based upon the exhibits submitted into evidence and the transcripts.

Petitioner, Jesus Campos, filed his original Application for Adjustment of Claim, on January 18, 2011, alleging an injury to his right leg which occurred on December 1, 2010 while pushing heavy mixing drum. On September 25, 2012, Petitioner amended the Application for Adjustment of Claim alleging he injured his right and left leg on December 1, 2010 while pushing a heavy mixing drum. On the Request For Hearing, the parities stipulated that, on December 1, 2012, Petitioner and Respondent, Polyone Corporation, were operating under the Worker's Compensation Act and their relationship was one of employee and employer. The parties further stipulated the Respondent received notice of the accident within the time limits stated in the Act and Petitioner's average weekly wage, pursuant to Section 10 of the Act, was $1,200.00. (Arb. Ex. 1)

The disputed issues in this matter are: **(C)** Whether the Petitioner sustained accidental injuries that arose out of and in the course of employment; **(F)** Whether Petitioner's present condition of ill-being wascausally related to the injury; **(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; **(K)** Whether or not Petitioner is entitled to temporary total disability benefits from January 5, 2011 through September 20, 2017; **(L)** The nature and extend of Petitioner's injury. **(M)** Petitioner's petition for penalties and attorney fees pursuant to sections 19(K), 19(L) and 16 of the Act; **(O)** Petitioner requested prospective medical treatment while also placing the nature and extend to Petitioner's injury at issue.

FINDINGS OF FACT

Petitioner testified, prior to December 1, 2010, he had worked for Respondent, Polyone Corporation, for 33 years. On November 6, 2010, several weeks prior to Petitioner's alleged work accident of December, 1, 2010, Petitioner sought medical treatment for knee pain from Dr.

Jarava, his family doctor, who ordered x-rays of Petitioner's knees. Petitioner had the x-trays at Resurrection Medical Center on November 10, 2010. The x-rays showed minimal degenerative changes to the knees with tiny marginal osteophytic spurs and pointing of the tibia eminences.

Petitioner testified, on November 6, 2010, he told Dr. Jarava that he was experiencing right knee pain due to rheumatoid arthritis. (T. 4/13/2016, pg. 84) Petitioner further testified he had been experiencing knee pain for three months prior to his work accident of December 1, 2010. (T. 4/13/2016, pg. 86) At trial, Petitioner testified his knee paid started in September of 2010 but the knee pain did not exist prior to August of 2010. (T. 4/13/2016, pg. 81, 82)

Dr. Jarava's medical records of November 6, 2010 indicate Petitioner reported right knee pain, which started the previous day, while pushing 400 kg of heavy duty. (PX 4) The examination showed that Petitioner's right knee was swollen and tender with crepitus. Dr. Jarava diagnosed a right knee sprain and Dr. Jarava proscribed a knee x-rays, Ibuprofen, a knee immobilizer, ice packs and told Petitioner to return in 4 weeks. (PX 4) Petitioner had the x-rays on November 10, 2010 at Resurrection Medical Center.

At trial, Dr. Jarava testified that a portion of his November 6, 2010 medical records were inaccurate. Dr. Jarava testified that a portion of his records stating Petitioner was having knee pain, which started the day before, while pushing 400 kg of heavy duty, and the proscription for a knee immobilizer should have been written down on the December 2, 2010 office visit an not the November 7, 2010 visit. Dr. Jarava testified the mistake was made by a student and he did not recall the name of that student. (T. 4/13/2016, pg. 161, 162) Dr. Jarava testified sometimes, as a busy doctor, you write things down for some reason and it's not there. (T. 9/20/2017, pg. 33)

Petitioner testified, on December 1, 2010, he injured his right knee when he was pushing a large mixing bowl while at work. Petitioner testified the large mixing bowl was on wheels. (T. 4/13/16, pg. 76) Petitioner testified he was going to start pushing the mixing bowl when he felt pain in his right leg. (T. 4/13/16, pg. 87) Petitioner was asked, during cross examination, at the time of the incident, whether he twisted his right knee. Petitioner responded "*When I pushed it, I didn't notice. What I did was I moved it. But that one always uses to push something to exert the pressure is through the knees.*" (T. 4/14/16, pg. 87)

Petitioner testified he reported the accident to his supervisor, Sergio Burciaga, and he was taken to Concentra Medical Center by his co-worker, Jose Padilla. (T. 4/13/2016, pg. 33-35)

The Concentra Medical Records, dated December 1, 2010, shows that Petitioner reported experiencing right knee pain while pushing a bowl of material. Petitioner also reported the bowl was heavy and his right pain began abruptly. Petitioner's pain was located at the anterior lateral and medical aspects of the right knee. During the examination, Dr. Israel noted an antalgic gait, no erythema, no ecchymosis, no giving way, no locking, a negative McMurray's and Lachman's tests. Dr. Isreal did find tenderness over the quadriceps tendon, patellar tendon and across the medial and lateral joint lines. Dr. Isreal ordered x-rays of the Petitioner's right knee which showed minimal degenerative changes. (PX 2)

The Concentra Medical Center's records do not show that Petitioner reported a three-month history of right knee pain or Dr. Jarava's treatment on November 6, 2010 or x-rays being taken of the knees at Resurrection Medical Center on November 10, 2010. Petitioner was proscribed physical therapy and diagnosed with a right knee sprain. (PX 2)

December 2, 2010, Petitioner returned to Dr. Jarava. Petitioner reported knee pain after being injured at work. Dr. Jarava's examination showed right knee swelling, tenderness and crepitus. The findings from Dr. Jarava's December 2, 2010 examination were very similar to his November 6, 2010 findings. Dr. Jarava's records do not show any significant increases in symptoms, complaints or examination findings. (PX 4)

On December 16, 2010, Petitioner returned to Concentra reporting feeling better and that his symptoms were improving. (PX. 2, pg. 53) Petitioner was examined by Dr. Israel on December 22, 2010. The examination showed mild joint effusion and tenderness across the midline of the patella anteriorly and along the medical joint line, the McMurray and Lachman's tests were negative. Dr. Israel assessed a right knee strain and right knee internal derangement with possible medial meniscus tear. Petitioner was referred to Dr. Suchy for an orthopedic consultation. (PX. 2, pg. 42) Petitioner testified that he continued working until January 5, 2011. (T. 4/13/2016, pg. 41, 44)

On January 11, 2011, Petitioner presented himself to Dr. Levi of Orthopaedic & Rehabilitation Center. Petitioner reported a right knee injury occurring on December 1, 2010 while twisting his knee using a large mixer. Petitioner also reported to Dr. Levi that he had not experienced right knee pain prior to December 1, 2010. (PX 5, pg. 37). During the examination, Petitioner reported left knee pain. Petitioner said his left knee was hurting because he was

limping on his right knee. Dr. Levi examined Petitioner's right knee which showed mild effusion, tenderness along the medical and lateral joint line, positive McMurray test, negative Lachman and negative anterior drawer tests. Dr. Levi examined Petitioner's left knee which showed no effusion, medial and lateral joint line tenderness and a negative McMurray, anterior drawer and Lachman's tests. Dr. Levi reviewed a MRI taken of the right knee on January 6, 2011 ordered by Dr. Jarava. The MRI showed a small tear in the upper surface of the posterior horn of the medial meniscus, mild medial compartment joint space narrowing with small marginal osteophytes, small subcortical defects in the anterior weight-bearing portion of the medial tibial plateau associated with mild subchondral bone marrow edema and geode formation. (PX 6) Dr. Levi recommended right knee arthroscopy and removed Petitioner from work.

On February 1, 2011, Petitioner underwent a left knee MRI, at Edgebrook Radiology, which showed a small joint effusion, medial meniscal tear involving the midbody and posterior horn, generalized OA, greater in the medical compartment, hypertrophic spurring, bony sclerosis, and chondral and subchondral irregularity. (PX 7)

On February 11, 2011, Dr. Levi authored a letter recommending surgery for both knees. In the letter, Dr. Levi wrote Petitioner was treating for an injury that occurred on February 1, 2010 when he twisted right his knee and because Petitioner had been compensating with his left knee caused Petitioner to injury his left knee. (PX 5) On April 26, 2011, Dr. Levi authored a letter correcting the date of accident of February 1, 2010 to December 1, 2010. (PX 5)

On March 14, 2011, Petitioner attended a Section 12 examination with Dr. Raab. At that visit, Petitioner reported a sudden onset of right knee pain after pushing a mixer weighing about 410 kg. Petitioner denied any previous history of right knee complaints and denied having his right knee evaluated prior to his December 1, 2010 injury. Dr. Raab diagnosed early degenerative arthritis of the medical compartment of the right knee with possible degenerative medical meniscal tear. Dr. Raab opined, based upon the history that Petitioner provided, that he was asymptomatic prior to December 1, 2010, the work incident may have aggravated his early degenerative arthritis. Dr.Raab further opined that if a meniscus tear exists, the tear is degenerative, predating Petitioner's work accident of December 1, 2010. (RX 2, PX 10)

On September 12, 2011, Petitioner sought a second opinion from Dr. Rubinstein of Illinois Bone and Joint Institute. At that time, a Patient Information Medial history form was

completed. On that form, Petitioner listed the onset of his symptoms as December 1, 2010 when he felt something pop in his knees. On the form, Petitioner he had never experienced prior knee problems or underwent any diagnostic tests for his knees. Petitioner also reported that his left knee started two days after the incident. (PX 10, pg. 66)

Petitioner reported to Dr. Rubinstein that he was a machine operator who pulls and pushes big mixing bowls weighing up to a few hundred kilos when he felt a twist and a pop in his right knee as he was twisting a mixing bowl. The examination showed mild synovitis in both knees, tenderness over the medical joint line on the right knee, no significant crepitus and effusion was noted.

Dr. Rubinstein indicated his findings were consistent with pre-existing mild osteoarthritis which had increased in pain acutely following Petitioner's injury. Dr. Rubinstein stated that since Petitioner did not report any significant or similar knee symptoms prior to his injury, the Petitioner likely sustained a new meniscal injury superimposed on pre-existing arthritis. Dr. Rubinstein further said Petitioner's work place injury aggravated his preexisting arthritis and the meniscus pathology was acutely caused by the twisting injury to his right knee on December 1, 2010. (PX 10, pg. 70)

On March 7, 2012, Dr. Rubinstein recommended arthroscopy to clean out the joint and take care of the meniscus. Dr. Rubinstein opined the workplace injury brought on Petitioner's symptoms as he was previously asymptomatic prior to the work accident. (PX. 10, pg. 62)

On December 20, 2012, Petitioner underwent a right arthroscopy with resection of the medical meniscus and medial femoral chondroplasty at St. Joseph Hospital. The operative report showed a complex tear of the posterior horn of the medical meniscus and mild fraying of the lateral meniscus. The postoperative diagnosis was internal derangement of the right knee, right tear of the medical meniscus and arthritis of the patellofemoral groove and the femoral condyle. (PX 11, PX 10, pg. 89)

On March 6, 2013, Petitioner returned to Dr. Rubinstein. In his report of March 6, 2013, Dr. Rubinstein found Petitioner to be at maximum medical improvement and he determined Petitioner could return to a sit-down job if one could be found for him that would require no more than 1 hour of the workday walking and standing, preferably not in 1 stretch but cumulatively. (PX 10)

Petitioner testified he unsuccessfully attempted return to work with Respondent on March 8, 2011, May 10, 2010, and either June 20th or July 20th of 2011 and on October 26, 2012. (T. 4/13/16, pgs. 48-52) Petitioner testified his educational background consist of attending 6 years of primary education and 1 year of secondary education in Mexico. Petitioner testified that he wants to look for work but he cannot. (T. 4/13/16, pg. 60) Petitioner testified he had not looked for work after Respondent did not take him back. (T. 4/13/16, pg. 111) At trial, on April 13, 2016, Petitioner testified he had not conducted a job search or looked for work because he is only able to walk for a block or block and a half before his knees hurt. (T. 4/13/2016, pg. 111,112)

At trial, on December 7, 2016, Petitioner testified he was provided a labor market survey with approximately 15 companies in the Chicagoland area and over two days he visited 13 of the companies and submitted 5 applications for employment. (T. 12/7/2016, pg. 10-19) Petitioner testified he had not applied for any other jobs since his work accident and he had not been contacted by any of the companies he submitted applications. (T. 12/7/2016, pg. 18)

At trial, Petitioner testified that he is currently unable to walk for long periods of time and he experiences pain at night. Petitioner also testified his knee gets stuck and frozen and that he feels depressed. (T. 4/13/2016, pgs. 59, 60).

Testimony of Jose Padilla

Jose Padilla testified that at the time of the alleged incident, he oversaw the safety of the site and OSHA logs for Respondent. (T. 4/13/2016, pg. 115). Jose Padilla testified he has known Petitioner for 13 years. (T. 4/13/2016, pg. 116). Jose Padilla testified between 2007 and December 1, 2010, Petitioner told him that he was getting older, having a hard time moving around, and he was experiencing knee pain. (4/13/2016, pg. 118).

Jose Padilla testified Petitioner reported the accident on December 1, 2010. (4/13/2016, pg. 122). Petitioner reported he was in the process of extracting resin into a process container and rotated the bowl to move it forward. (12/7/2016, pg. 23). In doing so, Petitioner reported he felt a pop in his right knee causing him pain. (12/7/2016, pg. 24). Mr. Padilla drove Petitioner to Concentra Medical Center, that day, as required by company policy. (4/13/2016, pg. 122-123).

Jose Padilla testified on the way to the Concentra Medical Center, he and Petitioner discussed whether Petitioner had had any prior knee pain. During that discussion, Petitioner

denied any prior knee pain. (12/7/2016, pg. 30). Petitioner denied any preexisting condition and prior treatment for his knees. (12/7/2016, pg. 31). Jose Padilla testified that after he told Petitioner the company could subpoena his medical records, Petitioner acknowledged he had seen a doctor a couple of times for knee pain. (12/7/2016, pg. 34).

Jose Padilla testified that the bowl Petitioner was using was on rolling wheels and rolled on a very smooth surface. (12/7/2016, pg. 42). He also testified that the bowl in which Petitioner was using, at the time he was injured, was inspected and no defects were found. (12/7/2016, pgs. 42-43).

Deposition Testimony of Dr. Rubenstein

Dr. Rubenstein testified that Petitioner reported injuring his knee, on December 1, 2010, while pushing a mixing bowl that weighted a few hundred kilos when he felt a twist in his knee on the right side and a pop in the knee as he was twisting the bowl. (PX 19, pg. 8) Petitioner's examination showed a synovitis, mild swelling, tenderness over the medical joint line in both knees, right more than the left, no crepitus.

Dr. Rubenstein opined Petitioner was having a combination of his previously asymptomatic arthritis and degrative meniscus tear which probably came about at the time of his 2010 injury. Dr. Rubenstein testified Petitioner had arthritis before his injury that was not symptomatic and when Petitioner twisted his knee, he probably further tore, or tore, his meniscus which brought on the symptoms. (PX. 19, pg. 13) Dr. Rubenstein further opined that Petitioner had a meniscus tear superimposed upon preexisting arthritis and the meniscus probably happened at the time of his injury acutely that got mangled up afterwards in the arthritis and continued to degenerate. (PX 19, pg. 14) Dr. Rubenstein testified Petitioner reached maximum medical improvement as of March 6, 2013. (PX 19)

Dr. Rubenstein testified that his opinions were based upon the history Petitioner provided. Dr. Rubenstein was asked whether his opinion would change if Petitioner had been complaining of right knee pain and had treated with a doctor a month before his work accident. Dr. Rubenstein testified his opinion could change depending upon what the medical records show. Dr. Rubenstein further testified he had did not reviewed any medical records showing Petitioner was experiencing prior knee pain. (PX 19)

Dr. Rubenstein further testified he opined that Petitioner sustained an acute meniscus tear based upon the history provided by Petitioner. Dr. Rubenstein testified that had the meniscal symptoms developed gradually without a specific point, such that you cannot point to the onset, the meniscus tear would be degenerative. (PX 19, pgs. 35-38) Dr. Rubenstein was asked whether Petitioner's meniscus tear predated Petitioner's December 1, 2010 work accident. Dr. Rubenstein responded "*Who knows. Anything is possible, but we deal in symptomatic stuff, not what might of might not have been there on an MRI. Without seeing an MRI previously...there is no way to know that. If you couple an MRI findings with clinical findings, then my conclusion would be that the tear occurred at the time of his injury, the type of injury he had is consistent with one that can create a meniscus tear. And as least as far as I know, he didn't have any complaints prior to his injury*". (PX 19, pg. 36)

Deposition testimony and Section 12 Examination of Dr. Lieber

On October 10, 2012, Petitioner presented to Dr. Lawrence Lieber of M&M Orthopaedics for a Section 12 examination. Dr. Lieber testified Petitioner reported developing right knee pain after pushing a large bowl weighing over 100 pounds. Dr. Lieber testified that Petitioner did not report of any isolated twisting, only that Petitioner reported pain after pushing it. (RX 8, 12/18/2014 pg. 8) Dr. Lieber reviewed Petitioner's right knee MRI of January 6, 2011 which showed evidence of a possible small tear in the posterior horn of the medial meniscus, mild medial compartment osteoarthritis and small joint effusion. Dr. Lieber reviewed Petitioner's left knee MRI of February 1, 2011 which showed a medial meniscal tear. Dr. Lieber assessed Petitioner with bilateral knee internal derangement and degenerative arthritis. (RX 8, 12/18/2014, pgs. 8-9)

Dr. Lieber opined that Petitioner's bilateral knee internal derangement and degenerative arthritis was not the result of Petitioner's work accident of December 1, 2010. Dr. Lieber further testified he based his opinions upon the history given to him by Petitioner, physical examination, a review of the medical records and the lack of any history regarding any twisting injury or event to the right knee during the pushing episode. (RX 8, 12/18/2014, pg. 10) Dr. Lieber further opined the meniscal tears were degenerative which were confirmed by the MRIs and Dr. Rubinstein's arthroscopy. (RX 8, 12/18/2014, pgs. 10, 35)

Dr. Lieber further opined the knee surgery was unrelated to the alleged work injury because one could not tear a meniscus just by pushing a heavy object. (RX 9 10/26/2016, Pgs. 12,15) Dr. Lieber stated after reviewing Dr. Jarava's records from 2000 to 2016, Dr. Levi's records, x-rays dated 11/20/2010 and MRIs dated 1/6/2011, his opinions remained unchanged. (RX 5)

Testimony of Joseph Belmonte, Certified Rehabilitation Counselor

Joseph Belmonte is a certified rehabilitation counselor who specializes in the placement of persons with disabilities. Joseph Belmonte reviewed the work restrictions issued by Dr. Rubinstein. (T. 12/7/2016, pg. 68) Joseph Belmonte testified that Petitioner was at the tail end of his general career life at age 64. (T. 12/7/2016, pg. 78) Joseph Belmonte testified he could not identify any immediately transferable occupations with either sedentary or light-duty functions for Petitioner. (T. 12/7/2016, pg. 88) Joseph Belmonte opined that Petitioner does not have the physical capacity to perform work at a sedentary level nor does Petitioner have access to a meaningful stable labor market because Petitioner does not have transferability of skills, has limited education and English proficiency and is not computer literate. (T. 12/7/2016, pg. 89-90)

Joseph Belmonte opined that vocational rehabilitation is contraindicated for Petitioner. Joseph Belmonte further opined that given the Petitioner's advanced age, less than limited education, limited trainability, he does not believe a vocational rehabilitation effort would be cost-effective. Joseph Belmonte testified he does not believe there is a stable labor market for Petitioner. (T. 12/7/2016, pg. 93-96)

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). It is not enough that Petitioner is working when accidental injuries are realized; Petitioner must show that the injury was due to

some cause connected with employment. *Board of Trustees of the University of Ill. v. Industrial Commission*, 44 Ill. 2d 207, 214 (1969). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses, and assign the weight to the witnesses' testimony. *R & D Thiel v. Illinois Workers' Compensation Com'n*, 398 Ill. App. 3d 858, 868 (1st Dist. 2010); See also *Hosteny v. Illinois Workers' Compensation Com'n*, 397 Ill. App. 3d 665, 674 (1st Dist. 2009).

The Arbitrator found the testimony of the Petitioner not to be credible.

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

To obtain compensation under the Act, a claimant bears the burden of showing by a preponderance of the accidence, that the claimant has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671 (2003). In the course of employment refers to the time, place and circumstances surrounding the injury and, generally, must occur within the time and space boundaries of the employment. *Id*. An injury "arises out of" employment when "the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id* at 203, 797 N.E.2d at 672. The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner failed to prove he sustained an accident which arose out of and in the course of his employment by Respondent on December 1, 2010.

The Arbitrator finds the Petitioner's testimony not to be credible. Petitioner provided inconsistent histories regarding the mechanism of injury. Petitioner did not testify that he twisted his right knee while pushing the mixing bowl. When asked that question, Petitioner testified that he didn't notice twisting his right knee. (T. 4/14/16, pg. 87) Dr. Levi's and Dr. Rubinstein's opinions were based, in part, upon a twisting type of injury, which was not supported by Petitioner's testimony. Additionally, immediately after the incident, Petitioner did not report a twisting type injury to his right knee to either Dr. Israel, on December 1, 2010, or Dr.

Jarava, on December 2, 2010. Petitioner also failed to report a twisting injury to Dr. Raab and Dr. Lieber.

Petitioner also failed to provide any of the doctors an accurate history of the onset of right knee symptoms. Petitioner testified that he had been experiencing knee pain since the beginning of September, three months before the alleged accident, and he had sought medical care and underwent x-rays of his knees weeks before. However, Petitioner failed to disclose this information to Dr. Levi, Dr. Rubinstein, Dr. Raab and Dr. Israel. On Dr. Rubinstein's Medical History forms, Petitioner denied any prior knee problems and undergoing prior diagnostic tests for his knees. Dr. Raab's medical records of March 14, 2011 states that Dr. Raab was unaware of any prior right knee injury or complaints per the Patient's history. (RX 2) Dr. Rubinstein's records states that Petitioner denied prior knee symptoms. (PX 10)

On cross examination, Dr. Rubinstein testified that his opinions were based upon the history provided by Petitioner and Petitioner reported being asymptomatic prior to December 1, 2010. Dr. Rubinstein testified he was unware of Petitioner's prior knee complaints and treatment. (PX 19) Dr. Rubinstein testified, based upon the history provided by Petitioner about being asymptomatic prior to December, 1, 2010, Petitioner stained an aggravation to his preexisting arthritis. Dr. Rubinstein testified his opinion regarding the meniscal tear being acute or generative was based upon the history provided by Petitioner. Dr. Rubinstein was asked whether the meniscus tear pre-dated December 1, 2010. Dr. Rubinstein testify "*Who knows. Anything is possible, but we deal in symptomatic stuff, not what might or might not have been there on an MRI.*" (RX 19, pg. 36) Dr. Rubinstein further testified "*...if you can tell me when things happened, that would be an acute tear. If you sort of develop gradual onset meniscal-type symptoms without a specific point that you can point to as the onset, you then would call it a degenerative meniscus tear.*" (PX 19, pg. 37) Petitioner testified he began to experience right knee pain in September of 2010 and he sought medical treatment from Dr. Jarava on November 6, 2010 and had x-rays of his knees at Resurrection Medical Center on November 10, 2010.

The Arbitrator also takes note that Petitioner's symptoms, complaints and examination findings on November 6, 2010 did not show any significant changes on December 1, 2010 and December 2, 2010. On November 6, 2010, Dr. Jarava's examination showed right knee crepitus, swelling, tenderness and Petitioner was diagnosed with a right knee sprain. On

December 2, 2010, Dr. Jarava's examination showed right knee crepitus, swelling, tenderness and Petitioner was diagnosed with a right knee sprain. It is important to note that Dr. Jarava did not testify that his observations and findings of November 6, 2010 were inaccurate. Dr. Jarava testified that only the description of the injury and knee immobilizer prescription was incorrectly written down on the November 6, 2010 cart notes. Dr. Jarava's findings were not different than the Dr. Israel's findings of the day before. Dr. Israel diagnosed a right knee strain and this examination showed no erythema, no locking, no decease range of motion, negative McMurray's and Lachman's tests. Dr. Isreal found tenderness, mild joint effusion and an antalgic gait.

Based upon the credibility of the witnesses, the lack of a constant mechanism of injury, Petitioner's lack of condor with the various doctors regarding the onset of his symptoms, prior knee complaints and treatment, preexisting arthritic condition, lack of significant objective changes in findings prior to and immediately the occurrence, the Arbitrator finds that Petitioner failed to prove, by a preponderance of the evidence, that he had an accident injury which arose out of and in the course of his employment by Respondent on December 1, 2010.

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

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982).

Despite the Arbitrator's findings regarding accident, the Arbitrator has also carefully reviewed and considered all medical evidence along with all testimony, finds that Petitioner failed to prove, by the preponderance of the credible evidence, that his current condition of ill-being is causally related to a work-related injury.

The Arbitrator does not find the opinions of Dr. Rubenstein to be reliable because of the inaccurate history Petitioner provided. Petitioner denied any prior right knee injury or treatment. Dr. Rubenstein testified that he based his causation opinion upon Petitioner telling him that he had no prior knee problems or treatment prior to the alleged injury on December 1, 2010. (PX 19). Dr. Rubenstein testified is opinion was based upon Petitioner reporting he was asymptomatic prior to December 1, 2010. Additionally, Dr. Rubenstein formulated is opinion that Petitioner's meniscus tears were acute tear rather than degenerative based upon Petitioner's history of being asymptomatic prior to December 1, 2010. However, Petitioner testified that he was experiencing knee pain from the beginning of September 2010 and he had sought treatment for his knees and had x-rays prior to December of 2010.

The Arbitrator finds the opinions of Dr. Lieber to be more reliable than the opinions of Dr. Rubenstein. Dr. Lieber opined that Petitioner had bilateral knee internal derangement, degenerative arthritis, bilateral knees which was not the result of Petitioner's work accident of December 1, 2010. Dr. Lieber testified his opinion were based upon the history given to him by Petitioner, the physical examination, the review of the medical records and the lack of any history regarding any twisting injury or event to the right knee during the pushing episode as well as the lack of symptoms to the left knee for weeks after the December 1, 2010 event. (RX 8) Dr. Lieber opined that Petitioner's meniscal tears were degenerative. (RX 8) Dr. Lieber testified the degenerative process was confirmed by both the right and left MRIs and Dr. Rubinstein's arthroscopy. (RX 8)

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:

In light of the Arbitrator's determination that Petitioner failed to established that he sustained a compensable injury to his right and left knees on December 1, 2010 arising out of and in the

course of his employment with Respondent, and in light of the Arbitrator's determination that Petitioner failed to establish that his current condition of ill being is causally related to a work injury, Petitioner's claims for Section 8 medical benefits pertaining to treatment for his right and left knees are denied.

WITH RESPECT TO ISSUE (K), WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE, IF ANY, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator's determination that Petitioner failed to established that he sustained an injury to his right and left knees on December 1, 2010 arising out of and in the course of his employment with Respondent, and in light of the Arbitrator's determination that Petitioner failed to establish that his current condition of ill being is causally related to a work injury, the Arbitrator concludes Respondent is not liable for payment of any temporary total disability benefits.

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

In light of the Arbitrator's determination that Petitioner failed to prove an accident occurred on December 1, 2010 at work and failed to prove an ongoing causal connection of the present condition to the alleged work accident, this issue is moot.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator's determination that Petitioner failed to established that he sustained a compensable injury to his right and left knees on December 1, 2010 arising out of and in the course of his employment with Respondent, and in light of the Arbitrator's determination that Petitioner failed to establish that his current condition of ill being is causally related to a work injury, the Arbitrator concludes there is no basis for the imposition of penalties and fees in the present case as Respondent's conduct, including denial of TTD and Section 8 benefits, was neither reasonable nor vexatious.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Lachtata,
Petitioner,

19IWCC0547

vs.

NO: 12 WC 41606

City of Chicago, Dept. of Transportation,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 20, 2018, is hereby affirmed and adopted.

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

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

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

DATED: OCT 8 - 2019
o9/18/9
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0547

LACHTATA, JOHN Case# **12WC041606**
Employee/Petitioner

CITY OF CHICAGO DEPT OF TRANSPORTATION
Employer/Respondent

On 12/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.48% 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:

2988 CUDA LAW OFFICES LTD
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0766 HENNESSY & ROACH PC
LAUREN A SERAFIN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

19IWCC0547

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

JOHN LACHTARA
Employee/Petitioner

Case # **12** WC **41606**

v.

Consolidated cases: ______

City of Chicago, Department of Transportation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Charles Watts** , Arbitrator of the Commission, in the city of **Chicago**, on **6/13/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/12/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,977.28**; the average weekly wage was $**1,422.64**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **1** dependent child.

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 $**275,598.28 (&on going)** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits.

ORDER

Respondent shall pay prospective medical treatment as ordered by Dr. Lorenz and Dr. Chudik and payment of TTD relative to said treatment.

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

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

Signature of Arbitrator

December 19, 2018
Date

DEC 2 0 2018

MEMORANDUM OF DECISION OF ARBITRATOR

The matter was heard by an Arbitrator designated by the Commission in the City of Chicago, County of Cook and State of Illinois, on July 13, 2018.

The Arbitrator renders findings on the following disputed issues:

(F) Whether Petitioner's current condition of ill-being causally related to the injury;

(J) Were the medical services provided to Petitioner reasonable and necessary; has Respondent paid all appropriate charges for all reasonable and necessary medical services;

(K) Whether Petitioner is entitled to prospective medical care.

FINDINGS OF FACT

Petitioner, John Lachtara has been employed with the City of Chicago, Department of Transportation for approximately 17 years. (Transcript at 7-8). Petitioner has been employed as a concrete mixer. (T at 8). Petitioner's job as a concrete mixer is considered heavy duty. (*Id.*). His job duties included digging holes, laying out lumber and rebar to prepare for concrete pouring, pouring concrete, grading concrete, breaking up concrete, wheelbarrowing stone, sand, and concrete, and loading and unloading trucks. (*Id*).

About twenty years prior to Petitioner's November 12, 2012 injury, Petitioner sustained a slight meniscus tear in his right knee. (T at 11) He underwent outpatient surgery and recovered such that he was able to return to work full duty. (*Id.*). On June 16, 2006, Petitioner had an L3-L4 spinal fusion surgery. (PX1 at 4). On October 12, 2011, Petitioner's back was examined by Thomas Pittman, PA-C, at Hinsdale Orthopaedics who referred him to pain management and gave him work restrictions of maximum lifting of 10 pounds frequently and 25 pounds occasionally, with occasional bending, squatting, and kneeling. (PX3 at 105). Pittman found him to be at MMI and to be able to work "at permanent light duty and (he) may not return to heavy work as a cement mixer." *Id.*

On January 24, 2013, Dr. Mark Lorenz, a spine specialist at Hinsdale Orthopaedics, examined Petitioner and wrote that Petitioner said that he was forced to return to work full duty as a cement mixer. (PX3 at 56). Petitioner reported that just prior to the November 12, 2012 accident his back pain was a 6 out of 10 and leg pain was 9 out of 10 with the pain worse in the right leg. (*Id.*) Petitioner testified he was later released to work in a full duty capacity on April 1, 2012, with no restrictions related to his back or legs. (T at 12; RX6 at 12). Dr. Lorenz's note indicates that Petitioner reported being forced to go back to work full-duty pursuant to the opinion of Respondent's Section 12 examining physician in a prior workers' compensation case filed by Petitioner. (PX3 at 56 and RX6 at 12). In that prior case, Arbitrator Mason found Respondent's Section 12 physician, Dr. Graf, to be unpersuasive. (RX6 at 14) Petitioner testified that he tried his best to fulfill all his work duties of a concrete mixer following his April 1, 2012 release, and worked full duty, albeit with taking about one day off every week or two because of pain from his sciatic nerve that extended from the top of his hip to the bottom of his foot. (T at 12 and 24). Arbitrator Mason who heard Petitioner's previous case (06 WC 15219 and 11 WC 24090) on October 25, 2012 wrote in her opinion:

> While Petitioner resumed his previous heavy job duties in April of 2012, and was still performing those duties as of the October 25, 2012, hearing, he was struggling to do so and having to regularly take days off. In assessing permanency, the Arbitrator notes the transcript contains no evidence any treating physician released Petitioner to full duty. (RX6 at 16)

Petitioner did not seek treatment for any injury following his return to full duty until November 12, 2012, the date of the accident in question in this case. (*Id.* at 12).

On November 12, 2012, Petitioner continued to be employed for the City of Chicago Department of Transportation as a concrete mixer with the same job duties. (T at 9). Petitioner testified he was carrying 60-pound steel plates to be installed into the sidewalk, when he slipped on mud into a hole causing him to twist his knee and back. (T at 9-10). Petitioner testified something popped in his knee and then he landed on his knee, immediately felt pain and could not stand up straight. (T at 9).

Petitioner testified he immediately reported his injury to Ron Robinson, his supervisor working with him at the time. (T at 13). He also completed an accident report and was taken by a co-worker to MercyWorks in Chicago for examination. (*Id.*).

Petitioner reported that his right foot slipped in mud, and he twisted his right knee and low back. (PX1 at 4) He was diagnosed By Dr. Homer Diadula with a low back and right knee sprain and was placed off of work. (Id.) MercyWorks kept Petitioner off of work and prescribed pain medications. (T at 14 and PX1 at 12-13). Petitioner remained under the care of MercyWorks and an MRI of his right knee was taken. (T at 14 and PX1).

The December 7, 2012 MRI documented lateral and medial meniscal tears, a tear of the fibulocollateral ligament, an MCL sprain, small joint effusion and suspicion of a previous ACL injury. (PX1 at 5; PX2 at 19-20). Following the MRI, Petitioner followed up with Dr. Chudik at Hinsdale Orthopedics on December 21, 2012. (T at 14). Following a physical examination, review of x-ray and MRI films, Dr. Chudik recommended physical therapy and a right knee injection. (TA15; PX3 at 51). Dr. Chudik reported that Petitioner's right knee arthritis was exacerbated by a twisting injury at work. (PX3 at 51). Petitioner completed physical therapy at Athletico from January 3, 2012 through February 21, 2013. (*Id.*) On February 20, 2013, a total right knee replacement surgery was recommended by Dr. Chudik. (PX3 at 64). Petitioner continued to treat with Dr. Chudik through April of 2013 and Dr. Chudik continued his conservative treatment plan. (PX3). In the course of his conservative care, Dr. Chudik performed two injections and his physician's assistant performed two injections on Petitioner's knee. (T at 16 and PX3). Following the conservative care and injections, Petitioner testified that apart from temporary relief after injections, he did not have any improvement with his knee pain. (T at16-17). Dr. Chudik again recommended a total knee replacement on October 9, 2013. (PX3 at 74)

Petitioner testified he remained in pain and returned to Dr. Chudik on September 26, 2014 when Dr. Chudik recommended a total knee replacement. (T at 17-18). Petitioner testified he had difficulty bending his knee and difficulty with stairs. (T at 17-18). Also at this visit, Dr.

Chudik recommended that Petitioner see Dr. Lorenz for his back pain, which he did. (T at 15). Following an MRI taken of Petitioner's back, Dr. Lorenz recommended a spinal fusion. (T at 18). Mr. Lachtara attended an IME with Dr. Ross on July 28, 2015; Dr. Ross also recommended a spinal fusion. (*Id.*).

Petitioner testified he was unable to have the recommended spinal fusion in 2016 due to the condition of his right knee. (T at 18-19). He testified he would be unable to properly rehab without the use of his knee. (*Id.*).

Petitioner returned to Dr. Lorenz in January and July of 2017, Dr. Lorenz continues to recommend a spinal fusion and has not released Petitioner back to work. (T at 19). In May 2018, Mr. Lachtara returned to Dr. Chudik and was treated with an injection in his right knee. (T at 19-20). Dr. Chudik continues to recommend a total knee replacement of his right knee. (T at 20).

In April of 2018 Petitioner returned to Dr. Lorenz for an epidural steroid injection. (T at 20). During the procedure, Petitioner testified that he became ill, was nauseous, sweaty, and could barely stand; the doctor was unable to continue with the injection. (*Id.*). Presently, Dr. Chudik recommends a total knee replacement and Dr. Lorenz recommends a spinal fusion. (T at 20).

Neither Dr. Lorenz nor Dr. Chudik has released Petitioner to return to work. (T at 21). Petitioner continues to receive Workers Compensation benefits as well as disability benefits from the City. (T at 21). Petitioner testified that his knee is not getting any better. (*Id.*). He testified that he cannot do anything that is strenuous and has limited ability to bend over such that he has problems putting on his socks. (T at 22). Petitioner testified he grows a full beard because he is in pain when bending over the sink to shave. (*Id.*). He testified he is constantly in pain that never goes away. (*Id.*).

Evidence Deposition of Dr. Chudik

The evidence deposition of Dr. Chudik took place on January 15, 2018. (Petitioner's Ex. 9) Dr. Chudick testified that weight, age, and prior surgeries can play a role in the formation of osteoarthritis. (PX9 at 25) Further, Dr. Chudik testified that he based his opinion on the causal connection between the work injury and the need for surgery on the understanding that Petitioner had no prior right knee complaints until the date of accident. (PX9 at 26) Further, Dr. Chudik testified that he understood that the Petitioner was performing his full duty job for more than decade before the work injury. (PX9 at 27) Dr. Chudik testified he was unaware that the Petitioner was only working full duty for about six months prior to the work accident, and was taking a number of days off a week for pain. (PX9 at 30) When provided a medical record from October 2011 documenting prior complaints, Dr. Chudik admitted he had not seen that report. (PX9 at 31)

Section 12 Report of Dr. Levine

Dr. Levine prepared a Section 12 examination on May 13, 2014. (Respondent's Ex. 2) Dr. Levine reviewed Petitioner's medical records and performed a physical examination. He diagnosed the Petitioner with significant osteoarthritis based on the radiographs, but noted limited pain on clinical examination. *Id.* Dr. Levine did not believe that the right knee diagnosis

was related to the work injury, as the work injury would have resulted in a slight injury that would have resolved in a few weeks. *Id.* At the time of his injury, Dr. Levine opined the MRI documented substantial osteoarthritis that did not significantly worsen, establishing that the work accident did not advance the condition. *Id.*

Dr. Levine provided the opinion that the Petitioner could return to work as he could tolerate for his right knee and deferred to his low back injury to his spine surgeon. *Id.* Although a total knee arthroplasty was recommended, Dr. Levine noted that the Petitioner could consider this procedure, but it might not be appropriate for him. *Id.* For the work injury, Dr. Levine opined that the Petitioner reached maximum medical improvement. *Id.*

Dr. Levine prepared an addendum IME report on June 30, 2015. (Respondent's Ex. 3) Dr. Levine opined that his findings did not change based upon the narrative report. *Id.* Dr. Levine's opinion was that the radiographs had not changed from the work injury until the date of the examination and thus supported his opinion that his underlying preexisting condition was not aggravated. *Id.*

Lastly, Dr. Levine prepared another report on August 4, 2016. (Respondent's Ex. 4) He opined that Petitioner was at maximum medical improvement and still able to work with osteoarthritis. *Id.* Dr. Levine indicated that Petitioner's osteoarthritis was related to his pre-existing issues and not the work injury. *Id.* Dr. Levine opined that although the Petitioner had osteoarthritis, surgery was not required. *Id.* Dr. Levine based his opinions on the evidence that many individuals are able to work with osteoarthritis. *Id.*

Evidence Deposition – Dr. Levine

Parties proceeded with the deposition of Dr. Levine on February 14, 2018. (Respondent's Ex. 5) Dr. Levine testified that on examination, the Petitioner had little right knee pain, and the condition of osteoarthritis was not related to the work injury as the same exact condition was present previously. *Id.* at 9. Dr. Levine testified that Petitioner would have been a candidate for a total knee replacement, regardless of the work injury. *Id.* at 10. Dr. Levine opined that Petitioner's condition was not progressing on the radiographs after the work injury, and he testified that the work injury did not accelerate the condition. *Id.* Thus, Dr. Levine opined that Petitioner's work injury did not aggravate, accelerate or exacerbate his condition. *Id.* Dr. Levine testified that Petitioner reached maximum medical improvement on account of the work injury. *Id.*

Prior Arbitration Decision

Petitioner's prior trial award for his lower back injury documented reported of bilateral leg pain. (Respondent's Ex. 6, Page 5, 8, & 11). Petitioner testified during the present trial that after the November 12, 2012 work injury, he could not wear socks or regular shoes. In the prior trial, the Petitioner testified that he was unable to tie his shoes. (Respondent's Ex. 6, Page 12).

ANALYSIS

CONCLUSIONS OF LAW

The Arbitrator adopts and incorporates the above Findings of Fact in support of the foregoing Conclusion of Law.

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

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

The Arbitrator finds that the testimony of the Petitioner was credible because Petitioner's responses to questions showed candor and were consistent with the documentary evidence.

(F) In support of the Arbitrator's decision regarding whether Petitioner's current condition of ill being is causally related to her injury, the Arbitrator makes the following conclusions of law:

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948 (2011). 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. Indus. Comm'n*, 128 N.E.2d 718, 720 (Ill. 1955). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder v. Ill. Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

Petitioner's present condition of ill being is causally related to his injuries of November 12, 2012. The arbitrator finds that the prior workers' compensation case is a red herring because, whatever the merits or lack thereof of the decision of Respondent to allow Petitioner to return to work full-duty, Petitioner was returned to work full duty, did work full duty, and was injured. The arbitrator concludes that the Petitioner has proven by a preponderance of the evidence that his present condition of ill being relative to his right knee and lower back is causally connected to his accident of November 12, 2012. This conclusion is based upon the credible, unrebutted testimony of the Petitioner and an examination of the medical records. His injuries were within

the scope of his employment as he was on duty for the City of Chicago Department of Transportation for the occurrence.

To establish causation under the Illinois Workers' Compensation Act, 820 ILCS 305/1 et seq. (2012), a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injury. 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. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453.

In this case, Petitioner would not have been carrying steel plates to be placed into a sidewalk, but for his duties as a concrete mixer. He reported to work and was installing plates to be placed at the corners of a sidewalk in order to make the sidewalk handicap friendly. When doing so he stepped into a hole thereby twisting his knee and back. Prior to his injury of November 12, 2012, Petitioner was working in a full duty capacity. Petitioner's current condition of ill-being is causally related to the incident of November 12, 2012.

The arbitrator's review of the medical records indicates Petitioner's injuries were causally related to his work incident of November 12, 2012. It is undisputed that Petitioner's injuries arose out of and were in the course of his employment. Presently, Petitioner is suffering from injuries that resulted from carrying large steel plates to install into a sidewalk, which is in accord with his job duties. Both Dr. Chudik and Dr. Lorenz, credible doctors with specialties in knee and back respectively, continually keep Petitioner off of work due to his work related injury. (PX3). Petitioner has testified that Dr. Chudik recommends a total knee replacement and Dr. Lorenz recommends a spinal fusion.

Respondent presented an IME report from Dr. Matthew Ross which stated, "Based on the history obtained from the patient and the medical records reviewed, the patient's current back pain is causally connected to the work accident of November 12, 2012." (RX1). Further, Dr. Lorenz states in his records that, "it appears that the patient suffered an exacerbation of underlying spondylitic conditions at L4-5, and L5-S1 where he was lifting a plate around November 12, 2012." (PX3 at 111). Dr. Lorenz then recommends an L4-S1 decompression and posterior spinal fusion. (PX3 at 114).

The arbitrator finds that both injuries are causally related to Petitioner's current condition of ill being. Respondent argues that Petitioner had a pre-existing condition due to his injury that occurred years ago. This argument is null, Petitioner returned to work following the proper treatment and was working full duty, albeit with some pain that caused him to take several days off. There is no doubt that Petitioner had a pre-existing condition, but that does not preclude recovery for this injury under the Workers Compensation Act.

The relevant inquiry is whether the evidence supports an inference that the accident aggravated the condition or accelerated the processes that led to claimant's current condition of ill being. *Freeman United Coal Mining Co. v. Indus. Comm'n*, 318 Ill. App. 3d 170, 173-74, 251 Ill. Dec. 966, 969, 741 N.E.2d 1144, 1147 (2000). A medical expert's opinion that the current

condition could or might have been caused by the accident may be used by the Commission to support a finding of a causal relationship. *Id.*

In *A.C. & S. v. Industrial. Comm'n (Delessio),* 304 Ill. App. 3d 875, 238 Ill. Dec. 40, 710 N.E.2d 837 (1999). Petitioner was awarded Workers Compensation benefits for a preexisting condition of carpel tunnel syndrome due to the continued stress and aggravation arising out of his employment causing the injury to manifest on a specific date. *Id.* "An employee who suffers a gradual injury due to repetitive trauma is eligible for benefits under the Act, but he must meet the same standard of proof as a petitioner alleging a single, definable accident. Proof that the relationship of employer and employee existed at the time of the accident is one of the elements of an award under the Act. The date of the accidental injury in a repetitive-trauma case is the date on which the injury "manifests itself."' *A.C. & S. v. Indus. Comm'n (Delessio)*, 304 Ill. App. 3d 875, 879, 238 Ill. Dec. 40, 43, 710 N.E.2d 837, 840 (1999).

In this case, the Petitioner had pre-existing degenerative changes in his knee and the nature of his work contributed to the development of the degenerative changes, as he has been squatting and stooping and lifting heavy weights repetitively for more than a decade in his job duties. (PX8 at 221). He was able to perform his job duties up until his recent injury at work on November 12, 2012, which resulted in a permanent injury that worsened his knee condition and left him with functional limitations that preclude his ability to perform his duties. (*Id.*). Relative to his back, Petitioner had pre-existing spondylitic conditions at L4-5, and L5-S1, which were exacerbated when he was lifting the steel plates on November 12, 2012. (PX3 at 111).

The Arbitrator relies on Petitioner's credible and unrebutted testimony, the medical records admitted into evidence and the medical opinions of Dr. Chudik. The Arbitrator accords little weight to the opinions of Dr. Levin, Respondent's Section 12 physician. *See International Vermiculite Company v. Industrial Commission*, 77 Ill.2d 1, 394 N.E.2d 1166 (1979) (holding that the Commission can accord greater weight to the medical opinions of the petitioner's treating physicians).

With respect to issue (J), whether Petitioner's medical care and treatment was reasonable, necessary and related to his work accident, the Arbitrator finds the following:

The arbitrator finds that in accord with the Petitioner's credible and unrebutted testimony as well as the evidence presented, Respondent is liable for the outstanding medical bills related to Petitioner's low back and right knee treatment pursuant to the fee schedule.

Based upon the unrebutted and credible testimony of Petitioner and based upon the medical records, the arbitrator finds that the Petitioner sustained injuries of the right knee and lower back on November 12, 2012. Mercy Works, the City of Chicago's employee treatment center, after examination placed Petitioner on a work restriction, recommended prescribed pain medications and a MRI.

Petitioner went under the care of Dr. Chudik at Hinsdale Orthopedic Associates; Dr. Chudik recommended conservative treatment of physical therapy and injections and kept

Petitioner off work. Petitioner's complaints of pain were unchanged following the conservative treatment. Dr. Chudik opines that the injury permanently aggravated the arthritic condition with symptoms and limitations unresponsive to conservative treatment and which requires a total knee arthroplasty surgery.

Petitioner was also under the care of Dr. Lorenz at Hinsdale Orthopedic Associates; Dr. Lorenz initially recommended conservative treatment of physical therapy. The physical therapy was not changing Petitioner's condition and Dr. Lorenz attempted an epidural steroid injection, which was unsuccessful due to a negative reaction with Petitioner's body. Due to continued pain and failure of conservative treatment, Dr. Lorenz recommends a L4-S1 decompression and a posterior spinal fusion. (PX3 at 114).

The doctors and Petitioner are in agreement that Petitioner is to have the knee surgery performed first, prior to the lumber surgery as it will allow him to ambulate safer and more efficiently after the back surgery, he further states that any further delay in his treatment can be detrimental to his health and overall recovery. (PX3 at 82, PX3 at 114). It is evident from the medical records and unrebutted testimony of the Petitioner that due to his injury of November 12, 2012 the Petitioner requires a total knee arthroplasty followed by a L4-S1 decompression and posterior spinal fusion.

The Arbitrator concludes that the medical services provided to Petitioner were reasonable and necessary. Respondent's only defense to payment of the medical expenses was medical causation. Having found that Petitioner's current condition of ill-being is causally connected to the work-related accident of November 12, 2012, the Arbitrator concludes that Respondent is liable for payment of the medical bills.

The Arbitrator finds that the medical bills are subject to adjustments consistent with the provisions of the Medical Fee Schedule. 820 ILCS 305/8.2. The Arbitrator orders Respondent to calculate the exact amount of benefits owed to the medical provider pursuant to Section 8.2. Any further disputes relating to the adjustment of the bill may be addressed at further proceedings, consistent with this decision. The Arbitrator further orders Respondent to make payment of the medical bill to Petitioner's attorney pursuant to Section 7080.20 of the Rules Governing the Practice Before the Illinois Worker's Compensation Commission.

Regarding issue 13, whether Respondent is liable for prospective medical care and related bills, the arbitrator finds as follows:

Arbitrator finds that Respondent is liable for all prospective medical treatment that Petitioner requires as a result of his injuries of November 12, 2012 to his right knee and lower back. Section 8(a) of the Workers Compensation Act entitles a claimant to compensation for all necessary first aid, medical and surgical services and all necessary medical, surgical and hospital services "thereafter incurred" that are reasonably required to cure or relieve the effects of injury. 820 ILCS 305/8(a). Prescribed services not yet performed or paid for are considered to have been "incurred within the meaning of the statute." *City of Springfield v. Ill. Workers' Comp. Comm'n*, 388 Ill. App. 3d 297, 317, 327 Ill. Dec. 333, 349, 901 N.E.2d 1066, 1082 (2009).

Petitioner continues to treat with Dr. Chudik and Dr. Lorenz at Hinsdale Orthopedic Associates. Steroid injections only provide temporary relief to Petitioner. In order to provide relief to the Petitioner, surgery to his right knee and lower back is required. (PX3 and 8). Petitioner is in pain every day and finds difficulty with simple tasks. In accord with the credible and unrebutted testimony of Petitioner and all evidence presented, the Arbitrator finds that the Respondent is liable for all future medical expenses in relation to the accidents of November 12, 2012.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF WILLIAMSON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Greg A. Mayhugh,
Petitioner,

19IWCC0548

vs.

NO: 16 WC 24928

Menard Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

DATED: OCT 8 - 2019
09/12/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0548

MAYHUGH, GREG A Case# **16WC024928**
Employee/Petitioner

MENARD CORRECTIONAL CENTER
Employer/Respondent

On 11/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN
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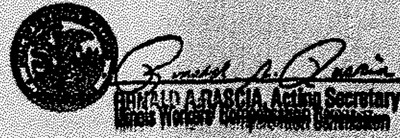
CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

NOV 14 2018



19IWCC0548

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

GREG A. MAYHUGH
Employee/Petitioner

Case # 16 WC 024928

v.

Consolidated cases: **N/A**

MENARD CORRECTIONAL CENTER
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3-14-16**, 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 $**62,530.52**; the average weekly wage was $**1,202.51**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** children under 18.

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

Respondent ***has 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 $**"if any"** for other benefits..

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$801.67/week** for **63 and 2/7** weeks, commencing **June 7, 2016** through **August 24, 2017**, as provided in Section 8(b) of the Act.

Respondent shall pay the following reasonable and necessary medical services pursuant to the medical fee schedule (Section 8(a) and 8.2 of the Act):

Shawnee HealthCare	$ 151.00	(6-9-16 OV)
Shawnee HealthCare	$ 151.00	(6-23-16 OV)
Southern Illinois Podiatry	$ 8,869.06	(6-30-16 – 8-14-17)
Memorial Hospital of Carbondale	$ 641.00	(6-9-16)
Memorial Hospital of Carbondale	$ 4,174.00	(7-18-16)
Memorial Hospital of Carbondale	$ 3,550.00	(8-25-16)
Medical Services	$ 551.00	(10-26-16 EMG)
Herrin Hospital	$ 2,352.00	(11-8-16)
Herrin Hospital	$ 47,328.04	(3-10-17)
Brigham Anesthesia South	$ 1,425.00	(3-10-17)
St. Joseph's Hospital	$ 2,321.02	(4/12-27/17 – PT)
St. Joseph's Hospital	$ 1,383.02	(4/4-9/17 PT)
Cape Radiology	$ 38.00	(6-9-16)
Cape Radiology	$ 325.00	(7-18-16)
Cape Radiology	$ 155.00	(8-25-16)
Cape Radiology	$ 186.00	(11-8-16)
Cape Radiology	$ 37.00	(3-10-17)
Southern Orthopedic Associates	$ 220.00	(2-27-/17 OV)

Southern Orthopedic Associates	$ 133.00	(2-27-17 OV)
Lincare, Inc.	$ 135.13	(crutches)
Zimmer Biomet EBI LLC	$ 5,270.00	(bone healing system)
TOTAL	$ 79,395.27	

Respondent shall receive credit for any medical bills previously paid by it or its group medical plan for which credit is allowed under Section 8(j) and shall hold Petitioner harmless from liability for same.

Respondent shall pay the Petitioner the sum of **$721.51/week** for a period of **37.575 weeks** as provided in Section 8(e) of the Act because Petitioner has been permanently partially disabled to the extent of **22.5% of his left foot**.

Respondent shall pay Petitioner compensation that has accrued between **March 14, 2016** and **September 19, 2018** and shall pay the remainder of the award, if any, in weekly payments.

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

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

Nancy Lindsay
Signature of Arbitrator

11.12.18
Date

NOV 14 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Respondent's "OMR Report" for March of 2016 indicates the following incidents occurred during the month:

3/11/2016 – A fight occurred at "WCH";
3/12/2016 – A fight occurred at "N2-2-09";
3/19/2016 - A fight occurred at "N2 Seg Yard" (RX 6)

On June 8, 2016, Petitioner filed a Notice of Injury regarding an alleged incident. (RX2) In the Notice, Petitioner described the incident (running to a fight on west door, stepped in a hole "on heel") and recorded that he notified Major Chris Bradley, his supervisor." The date and time it was reported was listed as June 6, 2016 at 9:00 a.m.

On June 9, 2016 Respondent prepared its First Report of Injury. (RX 1) Ms. Boisselle, who prepared the report, stated the accident occurred on March 14, 2016 at 10:00 a.m. Petitioner's last day of work was June 9, 2016. With regard to how the accident occurred, Ms. Boisselle wrote "responding to a 1010 code; fight." She further stated that Petitioner was running down the front street and stepped into a hole with his left heel. Under "Comments" she wrote, "Unsure when the incident actually occurred; initial 06/09 @ 1030 Dr. Lutchka; W/C packet being completed; left heel has not healed; day of EE felt nothing, over 3 months EE cannot stand without a cane; ...." (RX 1)

Petitioner completed an Incident Report and gave an incident date of "Approx. 3.14 -18, 2016." He detailed responding to a 10-10 and running down the street when he stepped in a hole on his left heel. (RX 4)

On June 21, 2016, Respondent, through Tristar Risk Management, sent a denial letter, indicating that Petitioner's "claim for benefits does not appear to have arisen out of and in the course of your employment with State of Illinois." (RX5)

On June 9, 2016, Petitioner sought treatment with Dr. Darlene Lutchka at Shawnee Health Care, Carbondale. Dr. Lutchka noted that Petitioner reported injuring his foot running to a prison fight. Dr. Lutchka ordered x-rays, which were performed at Memorial Hospital Carbondale. (PX2) The x-rays were standard three views of the left foot and were interpreted as showing no acute osteosis abnormality.

On June 23, 2016, Dr. Lutchka noted that Petitioner was not any better and that he was seeing a podiatrist on June 30, 2016. Dr. Lutchka noted that Petitioner was not able to bear weight on his foot for very long at all. Dr. Lutchka prescribed Ultram and orthotics and planned to await the podiatry consult. (PX1, 15)

On June 30, 2016, Petitioner saw Dr. David Dickinson at Southern Illinois Podiatry in Herrin, Illinois. (PX4, 1) On a patient questionnaire (marked as Exhibit 3 to the deposition) Petitioner wrote that the injury occurred on March 14, 2016 at work. Petitioner reported numbness and swelling in the left heel from the center of the arch back. Petitioner reported that it felt bruised. Petitioner reported pain level at a 4/10, but while working or walking the pain ranged from 6-8/10, with mornings being the worse. Dr. Dickinson noted that Petitioner had been off work since June 7, 2016, using his vacation days. Dr. Dickinson noted that Petitioner's

complaints began when he ran to a fight at work and stepped on uneven concrete. (PX 4, 1) On physical examination, Dr. Dickinson noted severe pain with palpation to the plantar medial tubercle, plantar heel, and distal posterior heel left foot. Dr. Dickinson also noted that Petitioner walked with an antalgic gait. Dr. Dickinson's initial diagnosis was a non-displaced fracture of the left calcaneous, plantar fasciitis and foot pain. Dr. Dickinson reviewed the x-rays and noted an irregulary plantar calcaneous seen best on the lateral view, but also the oblique view consistent with a fracture. Dr. Dickinson held Petitioner off work until further diagnostic workup could be accomplished. Dr. Dickinson prescribed treatment for the presumed calcaneal fracture, beginning with non-weight bearing with immobilization with cam boot for six weeks. Dr. Dickinson also ordered an MRI. (PX1,3)

On July 18, 2016, Petitioner underwent an MRI of his left hind foot without contrast. (PX3) The MRI revealed: markedly severe plantar fasciitis with partial tearing concentrated over the origin of the central slip; minimal posterior calcaneal spurring with underlying bone marrow edema and stress fracture; adjacent muscle strain; minimal degenerative osteoarthritis; low grade sprain deep layered deltoid ligament; peroneus brevis tendinosis and split; peroneus longus tendinosis and peroneal tenosynovitis; degeneration posterior talofibular ligament; sprain/partial tearing calcaneofibular ligament. (PX 4,5; PX3)

On July 21, 2016, Dr. Dickinson noted that the MRI confirmed both a stress fracture and plantar fasciitis. Dr. Dickinson prescribed non-weight bearing with crutches for six weeks and continued immobilization with cam boot. Dr. Dickinson also indicated that Petitioner could return to work but only with light duty, desk work. (PX4,8) Dr. Dickinson also prepared a physician statement to support Petitioner's light duty restrictions. (PX4, 10-11)

On August 18, 2016, Dr. Dickinson noted that Petitioner did not believe that he was improving. Petitioner reported getting burning, shooting, radiating electrical type pains in both sides of the ankle and the front of the ankle and tingling in the small toe. Dr. Dickinson diagnosed Petitioner with plantar fasciitis, foot pain and tarsal tunnel syndrome. To follow up on the MRI, Dr. Dickinson ordered a three-phase bone scan and spoke with the radiologist, Dr. Mueller. Dr. Dickinson also requested repeat x-rays, which again showed pathology consistent with an old fracture. (PX4, 13) Dr. Dickinson prescribed Lyrica and continued Petitioner's light duty restrictions. (PX4, 13) Dr. Dickinson noted that Dr. Mueller did see a fracture, dorsal to the plantar heel spur area, but not through the cortical bone and noted that the most significant finding by far is marked plantar fasciitis. (PX4, 15)

On August 25, 2016, the three-phase bone scan revealed findings compatible with an acute fracture involving the posterior inferior aspect of the left calcaneous. (PX4,16; PX5)

On September 27, 2016, Dr. Dickinson noted that Petitioner was still non-weight bearing and immobilizing with a cam boot. (PX4, 23) His primary pain was burning and tingling pain along the tarsal tunnel, but also burning and tingling at the bottom of the heel and arch and burning and tingling pain along the lateral foot as well. Petitioner was taking Neurontin, since Lyrica was causing him dizziness. Dr. Dickinson decided to consult neurology for a nerve conduction velocity test. Dr. Dickinson also discussed a tarsal tunnel decompression and endoscopic plantar fasciotomy with Petitioner. (PX4,25)

On October 25, 2016, Dr. Dickinson prescribed physical therapy for Petitioner. Dr. Dickinson wrote Petitioner off work until further notice. (PX4, 28)

On October 26, 2016, Petitioner underwent his EMG, which was a normal electrodiagnostic study. (PX4, 29; PX6)

On November 1, 2016, Dr. Dickinson noted on physical examination that Petitioner still had severe pain with palpation to the plantar medial tubercle and along the proximal aspect of the medial band of the plantar fascia. Petitioner was to begin physical therapy that week. Dr. Dickinson believed that a cortisone injection would help the plantar fasciitis but needed to wait until there was definite fracture healing. Accordingly, Dr. Dickinson ordered x-rays of the left foot, which still showed a persistent fracture line extending from the plantar proximal calcaneous consistent with a non-union or partial healing. Dr. Dickinson ordered a CT scan of the left foot. (PX4,34)

On November 8, 2016, the CT scan did not see an acute fracture dislocation. (PX4,35; PX7)

On November 17, 2016, Dr. Dickinson noted the CT report did not show a fracture but did show stable intraosseous cyst and calcaneous. Dr. Dickinson noted Petitioner's continued complaints of pain around the heel, worse medially and plantarly. Dr. Dickinson further noted that physical therapy was helping Petitioner's symptoms. (PX4,36) Dr. Dickinson performed a cortisone injection to the plantar fascia.

On December 8, 2016, Petitioner reported the cortisone injection did not help much. After reviewing the clinical course, Dr. Dickinson noted "due to the complicated nature, with heel pain and history of stress fracture, plantar fasciitis with partial tear, tarsal tunnel, numbness, and large intraosseous bone cyst, and not responding to conservative treatment, I've discussed with him surgical options including (1) evacuation of bone cyst and filling with bone graft; (2) plantar fasciotomy; (3) tarsal tunnel decompression." Dr. Dickinson recommended that Petitioner seek a second opinion before proceeding with surgery. (PX4, 41) The referral was made to Dr. David Wood. (PX4,42)

On February 27, 2017, Dr. David Wood noted that Petitioner presented with pain, paresthesia, numbness and fracture in his left foot. (PX8,1) Dr. Wood noted the history of injury. Dr. Wood further noted that the MRI of the left foot demonstrated diffuse bone marrow edema, plantar aspect of calcaneous; presence of interosseous ganglion cyst emanating from sinus tarsi. Dr. Wood noted the bone scan confirmed acute stress fracture of calcaneus, which was demonstrated as healed on the November 6, 2017 CT scan. Dr. Wood diagnosed Petitioner with left foot pain, severe plantar fasciitis, tarsal tunnel syndrome, and an interosseous cyst left calcaneus. Dr. Wood recommended surgery consisting of left foot tarsal tunnel decompression with partial plantar fasciotomy and curettage of interosseous calcaneal ganglion cyst with an allomatrix insertion. (PX8,3)

On March 2, 2017, Petitioner returned to Dr. Dickinson, who noted that Dr. Wood agreed with his findings and recommended surgery, which was performed on March 10, 2017. (PX4,48; PX10) On that day, Dr. Dickinson performed three procedures: (1) excision and curettage of a calcaneal bone cyst with bone graft; (2) tarsal tunnel decompression; and (3) endoscopic plantar fasciotomy that Dr. Dickinson chose to change to an open plantar fasciotomy due to the excessive thickness of the plantar fascia. (PX10)

On March 16, 2017, Petitioner's pain level was less than 1/10 in severity. Dr. Dickinson noted that Petitioner had not needed any pain medications for two days. On March 20, 2017, Dr. Dickinson prescribed physical therapy, which Petitioner performed at Rehab Unlimited. (PX11) On May 18, 2017, Petitioner reported being 70% better since the surgery. (PX4,63) On June 29, 2017, Petitioner was 80% better since the surgery. (PX4,71)

On August 24, 2017, Petitioner's last visit with Dr. Dickinson, Petitioner reported pain of 2-3/10, but only when he walked a lot. Petitioner was increasing his walking for exercise, walking a mile every other day. Petitioner reported the feeling was coming back in his foot. Petitioner noted good improvement to the scar area,

reporting that it was getting thinner and thinner. Petitioner reported only needing two tabs of Norco in the past week. Petitioner reported being 95% better than before surgery. (PX4,81) On physical examination, Petitioner reported no further pain with palpation of the left foot. Dr. Dickinson recommended that Petitioner continue his home exercises as described by physical therapy, that Petitioner continue to use custom orthotics and Blaine scar care, and to continue Norco 5/325 as needed for moderate to severe pain.

Dr. Dickinson's deposition was taken on June 20, 2018. (PX 12) Dr. Dickinson testified that he is a podiatrist, board certified in foot surgery and reconstructive foot and ankle surgery. (PX12,7) Dr. Dickinson opined that the initial x-rays showed an irregularity seen on the plantar calcaneus that he believed was consistent with a fracture. (PX12, 10) Dr. Dickinson explained that the fracture diagnosis significantly affected his normal treatment course for plantar fasciitis. Typically, with plantar fasciitis, one of the most effective treatments is a cortisone injection. However, if there was a fracture present, such an injection could worsen the fracture. In addition, orthotics typically would be prescribed and custom arch supports, but, in this case, those were not appropriate since Petitioner was non-weight bearing. (PX12, 11) Dr. Dickinson was concerned about aggravating the fracture. Dr. Dickinson explained that Dr. David Mueller, the radiologist, also confirmed that there was a fracture in Petitioner's heel. (PX12, 12)

Dr. Dickinson testified that Petitioner's pain complaints were consistent with the imaging reports. (PX12, 14) In particular, the MRI finding of markedly severe plantar fasciitis and partial tearing is an injury that would cause symptoms in any patient in that it would be very unusual for a patient to have such a finding and not have symptoms. (PX12, 14) Dr. Dickinson testified that after the CT scan was negative for fracture, he felt more comfortable treating the plantar fasciitis. Dr. Dickinson explained that, in the surgery, he used a drill to cut out the calcaneal cyst and replace it with an injectable bone graft to fill the hole and give strength to the calcaneus. (PX12, 26) Dr. Dickinson opined that his final diagnosis for Petitioner was severe plantar fasciitis, tarsal tunnel syndrome, and the bone cyst/fracture.

Dr. Dickinson was provided a hypothetical, which included Petitioner's history of injury and continued pain. Dr. Dickinson opined that the plantar fasciitis was related to the workplace accident. More specifically, Dr. Dickinson noted that "the plantar fasciitis was at least aggravated by the injury." (PX12, 32) With respect to the tarsal tunnel syndrome, Dr. Dickinson noted that all the nerve symptoms that he described happened following the injury. (PX12, 33) With the severe case of plantar fasciitis, or inflammation around the plantar fascia, Dr. Dickinson has seen that condition aggravate the tarsal tunnel area as well, due to the swelling and inflammation. (PX12, 33) Accordingly, Dr. Dickinson opined that the tarsal tunnel syndrome was also casually related to the workplace injury. With respect to the bone cyst, Dr. Dickinson did not believe that the bone cyst was caused by the injury, but he did believe that there was a fracture coming from the bone cyst and that could be related to Petitioner's symptoms. (PX12, 34) As far as Petitioner's main pain generator at the time of surgery, Dr. Dickinson opined that the plantar fasciitis was the main problem. (PX12, 34) Dr. Dickinson further testified that trauma to the heel can cause or aggravate plantar fasciitis and the stress fracture. (PX12, 35) Dr. Dickinson also opined that all the treatment he has rendered, including the therapy prescriptions, the pain medications, the surgery and the work restrictions were all reasonable and necessary to treat Petitioner. (PX12, 35)

On cross-examination, Dr. Dickinson testified that he based his tarsal tunnel syndrome diagnosis on Petitioner's subjective findings as well as his clinical exam. (PX12, 40)

On July 20, 2018, Petitioner underwent a Section 12 Independent Medical Examination with Dr. Gary J. Schmidt. A written report followed. (PX13) Dr. Schmidt noted that Petitioner still has pain at the incision made for the plantar fascia release and that if he stands for more than four hours he can get some arch pain as well.

However, Petitioner was not taking any pain medication and was pleased with his result. Dr. Schmidt's diagnosis was "status post traumatic plantar fasciitis and tarsal tunnel." Dr. Schmidt further opined as follows "the causal relationship certainly seems to be exactly as he describes it, backed up by the findings on bone scan and MRI." Dr. Schmidt further noted that there "were no abnormal behavioral observations at today's interview and he was an accurate and concise historian."

The Arbitration Hearing

Petitioner's case proceeded to arbitration on September 19, 2018. The disputed issues were accident, notice, causal connection, medical bills, temporary total disability benefits, and the nature and extent of any injury. Petitioner and Major Hughes (Respondent's representative at the hearing) both testified.

Petitioner testified that on March 14, 2016, he was employed as a correctional officer at Menard Correctional Center. Petitioner further testified that on that day he responded to an inmate fight "at one of the cell houses", running down an old road when his left foot struck the side of a pothole, causing immediate pain in the bottom of his foot. Petitioner described the call regarding the fight as a "10-10" call. The road was the only path that Petitioner could take to the fight and is not open to the public. Petitioner testified that the road consists of crumbling asphalt and is used by large trucks. Rocks from the bluff above the road have fallen and caused some of the damage to the road. Petitioner was running with a group of correctional officers who were also responding to the fight.

Petitioner testified that he finished out his shift. The bottom of his foot, at the arch, felt bruised, but he thought it would improve. Petitioner testified that, later that week, he informed Major Chris Bradley, his supervisor, of the injury. Petitioner was in Major Bradley's office and spoke to him face to face. Petitioner testified that Major Bradley told him to get his injury checked out. At that time, Petitioner still believed that his pain would improve and decided to wait to see the doctor.

At the time of the accident, Petitioner was working full duty with no physical restrictions related to his foot. Petitioner's foot progressively worsened and, on June 8, 2016, he filed a Notice of Injury regarding the incident. (RX2) In the Notice, Petitioner described the incident and recorded that he notified Major Chris Bradley on June 6, 2016 at 9:00 a.m. Petitioner explained that he put that date because that was when he received his workers' compensation packet for this injury. Petitioner also recorded in the Notice that he did not tell Major Bradley on the date of the incident because he did not feel pain on that date. Petitioner testified that a Supervisor's Incident Report is typically prepared by the supervisor who received notice of the injury. Petitioner testified that he has not seen any Supervisor's Report with respect to his claim.

Petitioner testified that his symptoms are similar to those documented by Dr. Dickinson in his last office note. Petitioner experiences pain in his arch when he is on his feet or walking. He has also experienced loss of sensation or numbness at the surgical site. He also still performs his home exercises. When Dr. Dickinson released Petitioner back to work in August 2017, Petitioner chose to retire because he did not think that he could handle the walking and stair climbing requirements of the job.

On cross-examination, Respondent's counsel asked Petitioner which cell house he was going to at the time of the injury and he responded, "To the west house."

Major Robert Hughes testified on behalf of Respondent. Major Hughes testified that, the day before the arbitration, he obtained a report of incidents prepared by internal affairs at the correctional center for February, March, and April 2016. The report was admitted into evidence as Respondent's Exhibit 6. The report does not

reflect an incident for the March 14, 2016 date. Major Hughes explained that a 10-10 call over a radio is not automatically recorded. Rather, once an internal affairs officer responds to an incident, an incident report form is supposed to be prepared. Respondent's Exhibit 6 is then prepared based on the incidents reported. Major Hughes also testified that the road at issue was an old road, but that it did not have any potholes in it. Major Hughes also testified that he is not aware of any maintenance performed on the road. Major Hughes also testified that he tells workers to fill out a workers' compensation packet anytime an injury is reported, no matter how small.

On cross-examination, Major Hughes acknowledged that Major Bradley was an appropriate supervisor for Petitioner to notify of his incident. Major Hughes also admitted that he has no personal knowledge of the conversation between Petitioner and Major Bradley and, therefore, could not dispute that the notice was given. Similarly, Major Hughes acknowledged that he could not dispute Petitioner's testimony as to the existence of the pothole or the manner in which Petitioner injured his foot. Major Hughes also acknowledged that road maintenance is not his responsibility, but rather the responsibility of the facility maintenance department. Major Hughes also testified that Petitioner's workers' compensation packet should include a Supervisor's Report prepared by Major Chris Bradley. Major Hughes testified that he saw that Report the day of the hearing, but it was not included in any of Respondent's arbitration exhibits. Respondent did not introduce any additional exhibits at the close of Major Hughes' testimony.

The Arbitrator Concludes:

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

Petitioner sustained an accident on March 14, 2016 that arose out of and in the course of his employment with Respondent. In so finding, the Arbitrator relies upon Petitioner's credible testimony.

Petitioner testified in detail as to the specifics of his accident, which is corroborated in every history he recorded thereafter, including in his written incident report and in his medical chart. At every opportunity, Petitioner reported the incident as occurring on March 14, 2016 when stepping into a hole while running to a fight. Both medical experts, Dr. Dickinson and Dr. Schmidt, opined that Petitioner's injuries, including the fracture, were related to the reported injury. Notably, Dr. Schmidt, Respondent's IME, reported that "[t]here certainly were no abnormal behavioral observations at today's interview and he was an accurate and concise historian." Dr. Schmidt further opined that the causal relationship between Petitioner's traumatic tarsal tunnel and traumatic plantar fasciitis "certainly seems to be exactly as he describes it, backed up by the findings on bone scan and MRI." There is no evidence of any other injuries that could explain Petitioner's symptoms.

Respondent's real dispute with regard to accident does not appear to be that it did not arise out of or in the course of Petitioner's employment; rather, the issue seems to be the date of the accident and whether an accident even occurred.

Major Hughes, the only witness called by Respondent, did not dispute that Petitioner's accident occurred as Petitioner described. Instead, the day before the arbitration hearing, Major Hughes obtained Respondent's Exhibit 6, a report that he did not prepare and for which had no responsibility to prepare or to review. He

simply obtained the report from the warden's office. The report does not list an incident for March 14, 2016, but Major Hughes did not testify that the list was accurate and reliable. The report is not automated and depends on a written report being created for each incident, provided to Internal Affairs, and then someone in Internal Affairs must then accurately transfer the data from the incident report to Exhibit 6. Respondent's defense rests solely on Exhibit 6, as Major Hughes could not testify with personal knowledge as to the incidents that occurred in March of 2016.

The Arbitrator finds it very significant that Major Bradley did not testify. Petitioner testified that within a week of the accident he verbally told Major Bradley, the Shift Commander, about his accident. This testimony, germane to both accident and notice, was unrebutted. Respondent had two opportunities to tender Major Bradley's direct testimony rather than rely on circumstantial evidence. First, knowing that Petitioner alleged that he notified Major Bradley, Respondent could have called Major Bradley to testify regarding accident and notice. Respondent chose not to. Second, the testimony indicates that not only is a Supervisor's Report typically prepared as part of a workers' compensation packet, but also that one was prepared by Major Bradley in this case. Major Hughes testified that he saw the Supervisor's Report the morning of the hearing. Again, however, Respondent did not attempt to present that report into evidence, even though both Petitioner and Major Hughes were questioned about its whereabouts. It was clear to the Arbitrator at trial that only Respondent had the report, not Petitioner. Accordingly, given Petitioner's credible testimony at trial, corroborated by his prior consistent statements to his medical providers, the nature of the traumatic injury, and the lack of direct evidence rebutting his testimony, the Arbitrator concludes that Petitioner has met his burden of proving that he sustained an accident in this case.

Even assuming that RX 6 was accurate and complete, the Arbitrator does not find the lack of mention of a fight on March 14th, 2016 undermining of Petitioner's claim. If one carefully reviews Respondent's accident forms, Petitioner and Ms. Boisselle (who completed the Form 45) both stated that the accident date of March 14th was an approximate one. Petitioner further stated on his Incident Report that he thought it happened some time around the 14th (the 14th to the 18th). Respondent's Exhibit 6 includes an incident date of March 12, 2016 wherein there was a fight at "WCH." The Arbitrator reasonably infers that "WCH" is referring to the West Cell House which is the place where Petitioner stated he was running towards when the 10-10 call was made. Respondent's failure to call Major Bradley or include his Supervisor's Report as an exhibit clearly suggests to this Arbitrator that Petitioner was telling the truth about mentioning the incident to the Major. Thus, the Arbitrator could amend the date of accident to March 12, 2016 to conform with the proof. Either way, Petitioner has proven he sustained an accident that arose out of and in the course of his employment with Respondent.

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

The Arbitrator concludes that timely notice was given to Respondent.

Petitioner testified that he told Major Bradley about the injury within a week of its occurrence. Petitioner testified that Major Bradley told him to get the injury "checked out." Petitioner testified that the conversation took place in Major Bradley's office. As noted above, Major Bradley's testimony and supervisor's report were not presented at trial and, therefore, Petitioner's testimony is unrebutted.

The Incident Report prepared by Petitioner in June 2016, when he decided to seek treatment, does not change the analysis. Notice can be oral or in writing. Petitioner testified that the first time he prepared a written report of the injury was when he filled out the report and so he used that date as the date of the report. In the Incident Report, Petitioner wrote that he did not report the incident on the date of the incident, which is

consistent with his arbitration testimony. Again, it would have been helpful to have Major Bradley's testimony and supervisor's report regarding Petitioner's claim, as such evidence could have shed light on whether Major Bradley was informed of the incident in March 2016 and whether Major Bradley questioned/s Petitioner's testimony regarding notice and/or accident. Without such evidence, the Arbitrator concludes that Petitioner has met his burden of proof on the issue of notice.

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

Respondent's dispute regarding medical causation is based on its notice and accident defenses only. Given the Arbitrator's rulings on those issues, the Arbitrator finds that Petitioner's current condition of ill-being in his left foot/ankle is causally related to the accident.

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

There is no dispute regarding the medical treatment in this case as Respondent's defense was based upon liability. Accordingly, Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule (Section 8(a) and 8.2 of the Act) as follows:

Provider	Amount	Dates
Shawnee HealthCare	$ 151.00	(6-9-16 OV)
Shawnee HealthCare	$ 151.00	(6-23-16 OV)
Southern Illinois Podiatry	$ 8,869.06	(6-30-16 – 8-14-17)
Memorial Hospital of Carbondale	$ 641.00	(6-9-16)
Memorial Hospital of Carbondale	$ 4,174.00	(7-18-16)
Memorial Hospital of Carbondale	$ 3,550.00	(8-25-16)
Medical Services	$ 551.00	(10-26-16 EMG)
Herrin Hospital	$ 2,352.00	(11-8-16)
Herrin Hospital	$ 47,328.04	(3-10-17)
Brigham Anesthesia South	$ 1,425.00	(3-10-17)
St. Joseph's Hospital	$ 2,321.02	(4/12-27/17 – PT)
St. Joseph's Hospital	$ 1,383.02	(4/4-9/17 PT)
Cape Radiology	$ 38.00	(6-9-16)
Cape Radiology	$ 325.00	(7-18-16)
Cape Radiology	$ 155.00	(8-25-16)
Cape Radiology	$ 186.00	(11-8-16)
Cape Radiology	$ 37.00	(3-10-17)
Southern Orthopedic Associates	$ 220.00	(2-27-/17 OV)
Southern Orthopedic Associates	$ 133.00	(2-27-17 OV)
Lincare, Inc.	$ 135.13	(crutches)
Zimmer Biomet EBI LLC	$ 5,270.00	(bone healing system)
TOTAL	**$ 79,395.27**	

Issue K: What temporary benefits are in dispute?

Respondent stipulated that the dates claimed for TTD are accurate. Respondent only disputed liability for TTD on the grounds of notice and accident. Given the Arbitrator's rulings on those issues, Respondent shall pay temporary total disability benefits at the rate of $801.678 per week for the period June 7, 2016 to August 24, 2017, representing 63 2/7 weeks.

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

The Arbitrator notes that 820 ILCS 305/8.1b governs determination of permanent partial disability. In particular, the Arbitrator is to consider the following factors:

(i) The reported level of impairment pursuant to the AMA evaluation under the Sixth Edition;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) Future earning capacity; and
(iv) Evidence of disability as corroborated by the treating medical records.

No one single factor shall be the sole determinant of disability.

With regard to Petitioner's case herein and each of the foregoing factors, the Arbitrator notes the following:

(i) Neither party submitted an AMA evaluation and, therefore, no weight is given to this factor.

(ii) The occupation of the injured employee. Petitioner retired shortly after reaching maximum medical improvement. Petitioner testified that he chose to retire at this point because he did not feel that he could perform his duties of walking and stair climbing as a correctional officer. However, he was not restricted from work by his treating surgeon. The Arbitrator gives some weight to this factor.

(iii) Petitioner's age at the time of his injury. Petitioner was 55 at the time of his injury. No direct evidence was presented as to how Petitioner's age impacts/affects any disability. This factor is given less weight.

(iv) Petitioner's future earning capacity. No direct evidence was presented as to any impact on Petitioner's future earning capacity and Petitioner testified he has voluntarily retired from his employment with Respondent. This factor is given no weight.

(v) Evidence of disability as corroborated by the treating medical records. Petitioner underwent an excision and curettage of calcaneal bone cyst with bone graft; a tarsal tunnel decompression; and an open plantar fasciotomy. The surgery occurred after Petitioner's fracture healed. Petitioner experienced substantial relief of his symptoms, reporting 95% improvement as of his last appointment. Petitioner testified that he still experiences pain at a 2-3 out of 10 on most days while on his feet or walking. He no longer takes medications for his symptoms but does continue to perform home exercises. His testimony was credible, generally corroborated by the treating medical records, and consistent with the nature of the injury he had. This factor is given substantial weight.

While not a treating physician's records, the Arbitrator notes that Dr. Schmidt, in his IME report from July 20, 2018, stated that Petitioner's shoe rubs on the incision made for the plantar fascia release, causing pain. Also, Dr. Schmidt noted that Petitioner has arch pain when he stands for more than four hours.

Having considered all of the factors as required by statute, the Arbitrator concludes that Petitioner has been permanently partially disabled to the extent of 22.5% of Petitioner's left foot.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sean Kilheeney,

Petitioner,

vs. NO: 18 WC 20898

County Waste Systems, Inc., and,
The State Treasurer as Ex-Officio
Custodian of the Illinois Injured Workers'
Benefit Fund,

Respondent.

19IWCC0549

DECISION AND OPINION UNDER SECTION 4(d)

This matter comes before the Commission on Petitioner's motion pursuant to section 4(d) of the Illinois Workers' Compensation Act ("the Act") (820 ILCS 305/4(d). Petitioner seeks a finding that Respondent County Waste Systems, Inc. knowingly failed to carry workers' compensation insurance on the date of accident July 6, 2018, in violation of section 4(a) of the Act. For the reasons that follow, the Commission grants the petition.

Petitioner's application for adjustment of claim alleges that on July 6, 2018 Petitioner sustained severe injuries to his body as a whole while working for Respondent. On November 8, 2018 Petitioner filed his petition pursuant to section 4(d) of the Act. A Preliminary Hearing ("the hearing") was held before then-Commissioner David L. Gore on January 18, 2019. Petitioner's Counsel and Counsel for the IWBF were present. Respondent County Waste Systems, Inc. was not present, but was served with notice via certified mail, return receipt. A record was made on this date.

At the hearing, Petitioner's Counsel presented a stipulation sheet signed by himself and Respondent's Counsel, a certification from the National Council on Compensation Insurance, Inc. ("NCCI"), copies of certified mail receipts regarding the hearing and medical records and bills

related to Petitioner's treatment to date.

The stipulation sheet, which was signed by Respondent County Waste Systems, Inc., through its counsel, stipulated that: 1) Petitioner was Respondent's employee on the date of accident; 2) Respondent was operating under and subject to the Act on the date of accident; 3) Petitioner sustained a work-related injury on July 6, 2018; 4) Petitioner's current conditions of ill-being in his bilateral lower extremities are causally related to said accident; 5) as of the date of accident, Respondent did not carry a valid workers' compensation insurance policy covering Petitioner; and 6) Respondent knowingly failed to carry said insurance.

Furthermore, on August 23, 2018, Roguens Loriston, Proof of Coverage Analyst for NCCI, conducted a search through the NCCI database. The search revealed that Respondent County Waste System, Inc. did not have workers' compensation insurance for Illinois on the date of accident, July 6, 2018.

Respondent County Waste Systems, Inc. admitted via the stipulation sheet that it was subject to the provisions of the Act, pursuant to section 3 of the Act. Section 4 of the Act requires all employers of at least one employee who come within the provisions of section 3 of the Act, and any other employer who shall elect coverage in accordance with section 2 of the Act, to provide workers' compensation insurance for the protection of their employees. 820 ILCS 305/4. Under section 4(a) of the Act, Respondent may elect to apply for approval as a self-insurer, insure his liability to pay such compensation in some insurance carrier authorized to do such insurance business in the State or make some other provision, satisfactory to the Commission, for the securing of the payment of compensation provided for in the Act. No evidence was offered showing that Respondent had pursued any option under section 4(a) of the Act.

Based on the stipulations contained in the stipulation sheet, along with the insurance information provided by NCCI, Respondent County Waste Systems, Inc. is "no longer entitled to the benefits and protections of the Act and may be sued in civil court." See *Keating v. 68th and Paxton L.L.C.*, 401 Ill. App. 3d 456, 466 (2010).

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition pursuant to section 4(d) of the Act is granted.

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 9 - 2019
d: 9/18/19
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard M. Casillas,
Petitioner,

vs.

NO: 09 WC 08001

City of Chicago/ Streets and Sanitation,
Respondent.

19IWCC0550

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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 April 2, 2018, is hereby affirmed and adopted.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund,*** as provided in Section 8(g) of the Act.

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 9 - 2019
o081519
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASILLAS, RICHARD M
Employee/Petitioner

Case# **09WC008001**

CITY OF CHICAGO STREETS & SANITATION
Employer/Respondent

19IWCC0550

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2559 BOWMAN & CORDAY LTD
LANE A CORDAY
134 N LASALLE ST SUITE 1440
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
HEATHER V MacKINNON
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
) SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RICHARD M. CASILLAS, Case # 09 WC 08001
Employee/Petitioner
v.
CITY OF CHICAGO, STREETS & SANITATION
Employer/Respondent

19IWCC0550

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **October 17, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 21, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**59,735.00**; the average weekly wage was $**1148.75**.

On the date of accident, Petitioner was **63** years of age, *married* with **no** dependent children.

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

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

Respondent shall be given a credit of $**39,815.55** for TTD, $**0** for TPD, $**307,963.25** for maintenance, and $**0** for other benefits, for a total credit of $**347,778.80**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $765.83 /week for 52 weeks, commencing January 2, 2009 through December 31, 2009, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $765.83/week for 405-5/7 weeks, commencing January 1, 2010 through, October 17, 2017, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $765.83/week for life, commencing October 18, 2017, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the **Rate Adjustment Fund**, as provided in **Section 8(g) of the Act**.

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

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

Signature of Arbitrator Jeffrey Huebsch

March 29, 2018
Date

APR 2 - 2018

FINDINGS OF FACT

Petitioner was employed by Respondent as a Motor Truck Driver since September of 1988. When he started in this position, he drove dump trucks, plows, garbage trucks – large trucks requiring air brakes. He last worked for Respondent in 2009. In 2004, Petitioner suffered a rotator cuff tear to his left shoulder, and after he returned to work from this injury, Respondent changed his job. He delivered mail to and from various City departments. In the mail delivery job, Petitioner drove a Jeep with an automatic transmission. He would pick up mail from all of the facilities on the south side and go to City Hall and distribute the mail to the commissioners' offices, etc. This was inter-office mail. Petitioner made ten to fifteen stops per day. He carried this mail in a large shoulder bag weighing up to 50 pounds or more, averaging 15 to 30 pounds. Petitioner would sort the mail when he arrived at City Hall before he distributed it. He started at this new job when he returned to work in 2005.

Petitioner is right handed. He has lived at 1743 West 101st Street in Chicago for 40 years. He completed 3 years of high school. He never obtained a GED. He was 63 years old on the claimed accident date of July 21, 2006.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on July 21, 2006. He injured his right shoulder as he was pulling a mailbag out of Respondent's Jeep. The bag had a long handle on it and got hung up on the seat belt. When Petitioner tried to pull it out, he yanked it because it did not come up right away, and then he felt a burning sensation in his right shoulder.

Petitioner notified his supervisor that day and he was sent to MercyWorks at 33rd and Ashland. He was placed on a 20-pound lifting restriction with no overhead lifting. He returned to work within the restrictions. He followed again with MercyWorks on July 28th, August 7th, August 21st, and August 23rd. He was kept on restrictions. (PX 4)

On August 21, 2006, Petitioner had MRI of his right shoulder, which was ordered by Dr. Diadula at MercyWorks. The study was said to show tendinopathy and possible rotator pathology. In September, Petitioner followed up with Dr. Cavanoff, who had performed his prior left shoulder surgery. He again saw Dr. Diadula, who sent Petitioner to Chatham Physical Therapy, beginning September 26, 2006. Petitioner continued to receive therapy at Chatham various times through March of 2009. Petitioner had continued regular follow up visits with Dr. Diadula at MercyWorks on October 12th, November 2nd, November 17th, December 1st, and December 21st of 2006.

While he continued to work, Commissioner Concannon occasionally provided Petitioner with a helper to ride with him if the mail was too much. Commissioner Foil gave Petitioner a small cart for the mail because Petitioner could no longer carry the bags.

On April 4, 2007, Petitioner sought a second opinion with Dr. Mass at University of Chicago. Dr. Mass gave Petitioner an injection and recommended surgery, but Petitioner wanted to hold off on any surgery to his right shoulder, as his recovery had been so bad from the surgery on his left shoulder. He was apprehensive about surgery to his right shoulder. He continued his modified work for Respondent and followed up with Dr. Mass. (PX 7)

Petitioner also continued to follow-up with MercyWorks. On June 28, 2007 it was noted that they wanted to schedule him for surgery. (PX 4)

Petitioner continued to work at his mail delivery job during the rest of 2007 and 2008. Petitioner noticed that his right shoulder was getting worse. He was having a hard time moving it, due to increasing pain. On November 8, 2008, he returned to Dr. Mass, who ordered a new MRI and again recommended surgery. (PX 7)

Surgery took place on January 2, 2009. The procedure was: Arthroscopic joint debridement on the right wityh subacromial decompression and biceps tenodesis. The postoperative diagnosis was: Biceps tendinitis and partial labral tear. The surgeon thought that the rotator cuff looked good at surgery. (PX 6)

Petitioner had been seen at MercyWorks on December 24, 2008, December 31st, then again in follow up on January 16, 2009. After his 2009 surgery, Petitioner stopped working. He resumed physical therapy and followed with Dr. Mass post-surgery on January 15, February 12, and March 26, 2009. Dr. Mass thought that Petitioner could return to light duty in March, but Respondent had no desk work for Petitioner. (PX 4, 7)

Petitioner was paid weekly TTD compensation benefits from Respondent, and he was seen again May 11th, 2009 by Dr. Mass, who gave him another injection. Petitioner saw Dr. Mass again June 29th, and continued physical therapy was ordered. Respondent would not authorize any further physical therapy in late Spring and Summer 2009. Petitioner again saw Dr. Mass on August 17th and October 27, 2009, at which time Dr. Mass ordered an FCE – which was performed at Novacare in Oak Park. (PX 7)

On December 15th, 2009, Dr. Mass released Petitioner to restricted return to work. (PX 1) Petitioner gave a copy of the release to his supervisor and also to MercyWorks. MercyWorks gave Petitioner its stamped work release two (2) days later, on December 17, 2009. (PX 2) Dr. Mass' release ordered no lifting over chest height and no lifting over 20 pounds. MercyWorks restrictions were similar. (PX 1, PX 2)

Petitioner testified that he would have been able to perform the modified mail delivery job that he had been doing at the time of his accident, but Respondent did not make the job available to him. Petitioner continued receiving weekly TTD compensation benefits through the end of 2009. Beginning January 1st, 2010, Respondent paid Petitioner the same weekly benefits, but called it maintenance. (RX 4)

In Spring 2010, Respondent contacted Petitioner regarding job searches. Respondent wanted Petitioner to fill out job search logs and to call or visit places of employment. Respondent offered Petitioner no other assistance, no vocational training, no computer training, no resume preparation, or other vocational services. Petitioner was offered no assistance or direction in his job search. All he was told was to complete ten (10) job searches per week. Petitioner complied with these orders.

Petitioner began this process May 10th, 2010. He reported to Respondent every Monday morning and delivered his job sheets. His contact was Angie Montez. Petitioner kept all of his job search logs that he turned

in to the Respondent from May 17th, 2010 through September 22nd, 2017. (PX 9) On the logs, he wrote whom he called, he would ask the name of the person to whom he was speaking and recorded the name, he also wrote the position that was sought. Some people would not give a name. Some people hung up. Some people made fun of Petitioner. Petitioner was very frustrated by this process – but, he continued to complete these job searches at the request of Respondent for over seven (7) years. Petitioner did not record people who hung up on him or if he did not get a name.

When Petitioner turned in these job search logs every Monday, Respondent never instructed him to do anything differently. No one ever questioned his job sheets. No one offered any vocational assistance. Petitioner did exactly what Respondent instructed him to do. He does not own a computer; his wife does. He does not know how to use a computer. Respondent never trained him to use a computer. Petitioner does not have an email address. Petitioner never had done a job search before. Monitoring the job search logs was the only vocational service that Respondent would offer. In April 2012, the Petitioner met with Angie Montez and Commissioner Tully from respondent about a truck driving job. They thought that Petitioner might be able to drive a truck, but after the meeting thought that it would be too much. At no other time did Respondent notify Petitioner of any available jobs.

Petitioner had periodic follow-up visits at MercyWorks. His work restrictions never were changed. (PX 4)

Respondent sent Petitioner two letters regarding job availability. The first was aletter regarding a watchman position, dated November 9, 2012. Petitioner testified that he never received the letter. The second letter, dated June 21, 2013, from Respondent's Department of Finance, concerned a Traffic Enforcement Technician position. (RX 3) Petitioner never received this letter. Respondent's letters are addressed to 1473 West 101st Street in Chicago. Petitioner's address is1743 West 101st Street and he has lived there for 40 years. Petitioner's testimony that he did receive the letters was unrebutted. Respondent continued to pay maintenance benefits.

Petitioner continued his job search efforts, turning in the weekly job search logs. Respondent did not offer Petitioner any further job opportunities. Petitioner testified that he would have reported for work and for any testing if he had received the job offer letters in RX 3. He never refused anything that Respondent requested he do.

Petitioner testified regarding the names he was given at some of the prospective employers. He recorded the names of the people with whom he spoke. In several instances, he testified that he never was told that another person might be better to contact.

No job was offered to Petitioner. He now is 75 years old. He found his job leads by word of mouth, phone book, seeing companies and getting their number, names on trucks or buildings, and then calling. He did not use a computer or the internet or any job search applications. Petitioner testified that every entry on his job search sheets was a company that he called. He has three (3) years of high school. He does not have a GED. He has had no vocational training.

Petitioner met with a vocational counselor, Edward Steffan, M.S., C.R.C., L.P.C. at the request of his counsel. Steffan, interviewed Petitioner and reviewed his medical records. Steffan discussed with Petitioner what type of jobs he might be able to do, asked him about his age, education, work experience, his injuries and physical condition and abilities. (PX 8a)

Petitioner testified that he has pain every day in his right arm and has no strength in it any more. The pain increases if he uses his right arm too much or moves it too much and cold, damp weather affects it. He ices his shoulder and avoids lifting. Petitioner's ability to play with his great grandchildren is impacted. He is unable to play baseball and run with them. He cannot pick them up. Regarding household chores, Petitioner does no more than sweep his stairs. He has someone who does his yard work for him now.

Petitioner testified that he had not injured his right shoulder prior to July 21, 2006. He further testified that he had no subsequent injuries to his right shoulder.

19IWCC0050

Medical Records

Petitioner sustained injury to his right arm and shoulder while lifting a mail bag from his vehicle. The bag strap caught on something, causing him to yank the bag, resulting in a burning sensation in his right shoulder.

Immediate medical attention was provided by the company clinic, MercyWorks , where he was sent by his supervisor on the date of accident, July 21, 2006. Initial diagnosis was right shoulder strain. He was placed on restrictions of no lifting greater than 20 pounds, no lifting or reaching overhead. He was released to return to work within the restrictions. Physical therapy was provided from September 2006 through May 2007. (PX 4, PX 5) Regular visits were maintained with MercyWorks through July 2007. In July 2007, MercyWorks received authorization for right shoulder surgery from Respondent's Committee on Finance. Petitioner remained on the same work restrictions and was able to perform his mail carrier job. (PX 4)

Petitioner was seen by orthopedic specialist, Dr. Daniel Mass, at University of Chicago, for consultation. Dr. Mass recommended surgery in April and May 2007. Petitioner was not quite ready to undergo shoulder surgery at that time. Petitioner next returned to Dr. Mass on November 4, 2008, with the same symptoms and weakness in his right arm. Physical exam indicated positive impingement test, mildly positive Jobe test and weakness in internal rotation. The original MRI demonstrated a rotator cuff tear. Subsequent MRI demonstrated significant fraying and tendinopathy at the supraspinatus and infraspinatus tendon. Dr. Mass again recommended arthroscopic exploration of the rotator cuff and subacromial decompression. (PX 4, PX 7)

Petitioner underwent surgery by Dr. Mass at University of Chicago Hospital on January 2, 2009. (PX 6) A subsequent course of physical therapy was prescribed and performed. (PX 5, PX 7) Petitioner received a subacromial injection to his right shoulder on May 11, 2009. Petitioner underwent a course of work hardening and FCE prior to his December 15, 2009 visit with Dr. Mass. Based upon the results of the FCE, indicating that Petitioner could return to work as a truck driver, with the exception of job tasks lifting 35 pounds, and Petitioner's subjective complaints, Dr. Mass, on December 15, 2009, placed the following restrictions: no

lifting over chest height with right arm, not greater than 20 pounds. (PX1, PX 7) Petitioner's last visit with Dr. Mass was on December 15, 2009.

On December 17, 2009, MercyWorks placed restrictions of no lifting over chest height more than 20 pounds with the right arm. (PX 2)

Petitioner was seen by Dr. Daniel Troy,for a §12 examination at Respondent's request, on October 1, 2013. (RX 1) Dr. Troy is a board certified orthopedic surgeon. He reviewed medical records and examined Petitioner. Unfortunately, his records review began with the 10/14/2008 MRI, which Dr. Troy thought did not show traumatic induced pathology "from this subjectively based 2006 injury." The first chart note reviewed was the 12/24/2008 entry by Dr. Diadula. The records from 2006 and 2007 and pre-October 2008 were not considered, so Dr. Troy commented that there was no documentation that the patient remained symptomatic after the 7/21/2006 accident. Because the patient worked full duty in 2006, 2007 and 2008, causality was a significantly low probability. The pathology leading to the surgery and current shoulder complaints could be secondary to time, age and activities outside of work. The patient has significant limitations of motion in his right shoulder due to his failure to progress after surgery. He is at MMI. He could return to work as a MTD, based upon the conclusions of the FCE. (RX 1)

Vocational Evidence

Both Petitioner and Respondent submitted vocational opinions.

Petitioner was evaluated by vocational counselor Edward P. Steffan of EPS Rehabilitation Inc. on May 3, 2017. A personal interview was performed by Mr. Steffan. Petitioner's medical records were reviewed, as were Petitioner's job search logs. Steffan opined that given Petitioner's lack of GED, advanced age, lack of skills to be utilized within his diminished physical capabilities and extensive job search, Petitioner is not a viable employment candidate. Petitioner's extensive job search has not lead to employment or the establishment of a readily available or stable labor market. It is more probable than not that Petitioner will not

be hired over other job seekers, and he would not benefit from further participation in the job search program. Mr. Steffan would not recommend further vocational services. (PX 8a).

In a follow-up report of July 17, 2017, Mr. Steffan reviewed the April 14, 2017 Labor Market Survey from Vocamotive. His opinions regarding Petitioner's employability were not altered. He agreed with the Vocamotive counselor that age alone did not preclude Petitioner from securing employment, however, his age, in combination with lack of GED, lack of skills to be utilized within his diminished physical capacities, and extensive job search to date, indicate he is not a viable employment candidate. Steffan opined that there is no reasonable or available or stable market available to Petitioner. (PX 8b)

Respondent presented a Labor Market Survey Report from Rebeca Hanna, CRC, LPC and Joseph Belmonte, CRC of Vocamotive, dated April 14, 2017, and progress reports of August 30, 2017 and October 13, 2017. (RX 2) The Vocamotive counselors are of the opinion that Petitioner is employable, that he has not lost access to his usual and customary job and line of employment, and there is no basis to determine that he sustained any loss of earning potential. They relied on Dr. Troy's report, stating that Petitioner could return to work for Respondent as a MTD. Because Petitioner could return to his regular job, there was no loss of income. Mr. Belmonte's Progress Report of August 30, 2017 criticizes Petitioner's documentation of contacts at prospective employers, stating the Petitioner is not reliable to accurately record documentation regarding employer contacts. The October 13, 2017 report from Belmonte criticizes Petitioner's current job search efforts. Belmonte and Hanna did not meet with Petitioner. They did not provide him with vocational services, job seeking assistance, computer skills training, GED assistance, or job placement assistance through Respondent. The labor market survey does not comment on Petitioner's lack of education.

The Parties agreed that all medical bills had been paid and that Petitioner was paid TTD benefits from January 2, 2009 (the date of surgery) through December 31, 2009 and maintenance benefits from January 1, 2010 to October 13, 2017 (maintenance benefits were up to date as of the October 17, 2017 trial date).

At the beginning of trial, Petitioner amended the Application for Adjustment of Claim to identify the accident date as July 21, 2006. Respondent had no objection and the Amended Application was admitted as Arbitrator's Exhibit No. 2.

CONCLUSIONS OF LAW

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

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

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

Petitioner's testimony is found to be credible.

In support of the Decision of Arbitrator relating to Issue (F) Causal connection, the Arbitrator finds:

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

Dr. Troy's opinion is not persuasive. It is premised on a lack of consistent treatment, which does not comport with the evidence adduced.

In support of the Decision of Arbitrator relating to (K) TTD, and Maintenance, the Arbitrator finds:

Respondent paid all weekly TTD compensation benefits from January 2 through December 31, 2009: $39,815.55. Respondent has paid all maintenance from January 1, 2010 through October 13, 2017: $307,963.25. (AX 1)

TTD benefits were properly paid by Respondent during the period of surgery and physical rehabilitation from said surgery. Maintenance benefits were properly paid during the period of time in which Petitioner participated in Respondent's chosen vocational rehabilitation process, over the course of seven years.

Based upon the Arbitrator's finding regarding causal connection, above, the medical evidence presented, and the diligent job search records presented, the Arbitrator finds that Petitioner is entitled to both TTD and maintenance benefits as paid, and requested.

Maintenance benefits shall be paid through October 17, 2017, the date of the Arbitration hearing. Thereafter, Petitioner shall be entitled to Permanent Total Disability benefits, pursuant to Section 8(f) of the Act, as set forth in Paragraph (L) of this Decision, below.

In support of the Decision of Arbitrator relating to (L) Nature and extent of the injury, the Arbitrator finds:

Petitioner sustained serious injury to his right shoulder and arm as a result of the work-related injury of July 21, 2006, for which surgery was performed by Dr. Mass on January 2, 2009. Following a course of post-surgical physical therapy, injection, work hardening and FCE, Dr. Mass placed restrictions on Petitioner's work activities; no lifting over chest height greater than 20 pounds. Respondent's company clinic, MercyWorks, concurred in those restriction, finding Petitioner at MMI.

Following the restricted release to return to work, Respondent was unable or unwilling to provide Petitioner with a job within those restrictions. In May 2010, Petitioner commenced a course of vocational

rehabilitation/ job placement searches, under the direction and supervision of Respondent. Every Monday, for over seven years, he turned in his job searches to Respondent. At no time, did Respondent offer any other vocational assistance to Petitioner. They did not provide him with interview training, resume preparation, or computer training. They did not help Petitioner obtain a GED. Respondent did not file a Vocational Plan, as required by current Rule 9110.10. Petitioner followed the direction and orders of Respondent. On two occasions, November 9, 2012 and June 21, 2013, Respondent sent notice of potential open positions to Petitioner. Unfortunately, those were never received by Petitioner, as Respondent mailed the letters to the wrong address on both occasions. Petitioner credibly testified that his attorney contacted Respondent regarding return to work issues, with Petitioner present, and Respondent acknowledged its mistake and thereafter continued payment of maintenance benefits. Petitioner continued his job search program under the direction of Respondent. The Arbitrator believes that Petitioner was stoic enough to continue this process, because he was so instructed by Respondent. The Arbitrator does not believe that Petitioner falsified his employment contacts or sabotaged his job search efforts. Any deficiencies in Petitioner's job search efforts are related to Respondent's failure to provide Petitioner with appropriate vocational services and assistance.

Having established the issue of causal relationship, and the permanent restrictions endorsed by Dr. Mass and accepted by Respondent's clinic, the sole issue is the nature and extent of the injury. Petitioner presented evidence of entitlement to total permanent disability benefits (Petitioner is not a viable employment candidate; his extensive job search efforts has not lead to employment or the establishment of a readily available or stable labor market; Petitioner would not benefit from further vocational services at this point) , supported by the opinion of vocational counselor, Edward P. Steffan. Respondent presented the contrary opinions of Rebecca Hanna and Joseph Belmonte of Vocamotive, which are based on the assumption that no loss of access to Petitioner's usual and customary job and line of employment has been demonstrated (relying on the flawed opinion of Dr. Troy). Further, if a loss of Petitioner's usual and customary job and line of employment were

demonstrated, Petitioner would be able to access other jobs or positions, though at a different wage scale (Petitioner is prospectively employable).

All of the vocational experts are highly respected.

The Arbitrator finds the opinions of Mr. Steffan to be more persuasive and to best comport with the evidence adduced. If a job as a MTD was available when Dr. Mass found Petitioner to be at MMI and both he and MercyWorks placed permanent restrictions on Petitioner, Petitioner would have returned to work. A job was not available and Respondent required Petitioner to begin a job search, following their direction. Respondent did not comply with the Rules by filing a Rehab Plan and did not provide Petitioner with appropriate vocational rehabilitation services, as contemplated by §8(a) of the Act.

Steffan, based upon his personal interview of Petitioner, a review of pertinent medical records and job search logs, finds that Petitioner is not a viable employment candidate. His age, in combination with lack of GED, lack of skills to be utilized within his diminished physical capacities, and extensive unsuccessful job search to date, are the basis for said opinion. Petitioner's extensive job search, over seven years, has not lead to employment or the establishment of a readily available or stable labor market. It is more probable than not that he will not be able to be hired over other job seekers and he likely will not benefit from further participation in a job search program.

The opinions of Ms. Hanna and Mr. Belmonte are not persuasive and do not comport with the evidence. They are of the opinion that Petitioner did not lose his usual and customary job and line of employment with Respondent, and that there is no loss of earning potential. Further, the initial LMS did not consider Petitioner's lack of education. Hanna and Belmonte based their opinions on Petitioner's being able to return to work as a MTD, per Dr. Troy. The restrictions set forth by Respondent's clinic and Dr. Mash do preclude Petitioner's return to work as a MTD. Any deficiencies in Petitioner's job search (of more than 7 years without competent professional guidance!) are related to his lack of education, unsophistication and Respondent's failure to provide §8(a) vocational benefits (other than collecting job search logs and paying maintenance benefits).

Given the evidence in this case, the Arbitrator will not endorse a forensic opinion brought forth by an employer seven years after the injured worker reached MMI and was unable to return to his regular job where that employer does not comply with Rule 9110.10 and does not provide an injured worker with the vocational and job placement assistance that he clearly needs in order to return to a productive employment position.

Petitioner, under the supervision of Respondent, though without any meaningful assistance from Respondent, conducted a diligent job search for employment within his restrictions for over seven years, resulting in no offers of employment. He is currently 75 years old, with limited education, and lacks transferrable skills that would induce an employer to hire him.

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. A.M.T.C. of Illinois v. Industrial Comm'n, 77 Ill. 2d 482, 487 (1979) The employee need not be reduced to total physical incapacity before a permanent total disability award may be granted. Ceco Corp. v. Industrial Comm'n, 95 Ill. 2d 278, 286-87 (1983) Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. Alano v. Industrial Comm'n, 282 Ill. App. 3d 531, 534 (1996) If the claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove by a preponderance of the evidence that he fits into the "odd-lot" category-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. Valley Mould & Iron Co. v. Industrial Comm'n, 84 Ill.2d 538, 546–47, (1981); Alexander v. Industrial Comm'n, 314 Ill.App.3d 909 (2000) The claimant ordinarily satisfies his burden of proving that he falls into the odd-lot category 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. Alano, 282 Ill.App.3d at 534–35. Once the claimant establishes that he falls into the "odd-lot" category, the burden shifts to the employer to prove that the

claimant is employable in a stable labor market and that such a market exists. *Waldorf Corp. v. Industrial Comm'n*, 303 Ill.App.3d 477, 484 (1999) As a result of Petitioner's injuries, restrictions, and diligent but unsuccessful job search, he has established a claim of total permanent disability under the odd-lot theory. He has proven that he is entitled to be paid the weekly compensation benefits that he has received from Respondent (ArbX1, RX4), as well as continuing weekly compensation benefits for life, as he has proven permanent and total disability under an odd-lot theory.

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

Adam Michalak,

Petitioner,

vs. NO: 14 WC 037529

A Mirror Image,

Respondent.

19IWCC0551

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 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 $74,000.00. 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 9 - 2019
o081519
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

MICHALAK, ADAM
Employee/Petitioner

Case# **14WC037529**

A MIRROR IMAGE
Employer/Respondent

19IWCC0551

On 11/16/2017, 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 1.36% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 HORWITZ HORWITZ & ASSOCIATES
TYLER D BERBERICH
1403 ESSINGTON RD
JOLIET, IL 60435

1120 BRADY CONNOLLY & MASUDA PC
JEFFREY R GIBELLINA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Adam Michalak
Employee/Petitioner

Case # 14 WC 37529

v.

Consolidated cases: N/A

A Mirror Image
Employer/Respondent

19IWCC0551

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **September 22, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

19IWCC0551

FINDINGS

On the date of accident, **February 17, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$32,984.72**; the average weekly wage was **$710.88**.

On the date of accident, Petitioner was **31** 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 **$13,783.68** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$13,783.68**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of **$13,667.99** to the providers as listed on PX 12 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $473.92/week for 156 1/7 weeks, commencing September 25, 2014 through September 22, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$13,783.68** for TTD paid.

Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Siodlarz including epidural steroid injections, work conditioning or 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

November 14, 2017
Date

ICArbDec19(b)

NOV 16 2017

Statement of Facts

Petitioner Adam Michalak testified that he was employed by Respondent A Mirror Image as a glazer on February 17, 2014. He had worked for Respondent for four or five years. Petitioner testified that his job duties included installing glass enclosures, shower doors, mirrors, and table tops, as well as fabricating materials in the shop. Petitioner would lift materials weighing from 50 to 400 pounds, including his tool box, large panes of glass, metal, polishers, grinders, saws and any other tools or material he needed to perform his job. His tools weigh anywhere from 25 to 100 pounds. Petitioner testified that his job required working on his knees, squatting over using hacksaws to cut metal, or hovering over his toolbox. Petitioner would also have to squat and maneuver through doorways and up stairs with heavy weights in his hands. He testified that he would be doing these activities his entire workday when he was not driving in the truck. Prior to February 17, 2014, he had never had an injury or medical treatment to his low back.

On February 17, 2014, Petitioner was scheduled to do a shower enclosure at a private residence in Naperville. He testified that when he arrived at the home, there was snow on the driveway, causing his work truck to get stuck. The stairs leading onto the porch were covered with snow and ice a couple of inches thick. Petitioner testified that he asked the homeowner if he would clean the snow and ice but was told that he would not. Petitioner then called his boss, Chris Bracken, who told him to cancel the job and leave. Petitioner also called the contractor, who agreed that he should cancel the job and leave. As the Petitioner proceeded down the stairs to leave, his foot slipped on the first step, causing him to fall. His feet came nearly parallel with his head. He landed on his tailbone, striking 9 or 10 steps with his tailbone on the way down. He stood back up and slipped and fell again. He testified that he instantly felt excruciating pain in his lower back and groin. He called and informed Mr. Bracken of his accident and was told to return directly to the shop.

Petitioner testified that he tried to return to work the week after his accident. He noticed throbbing lower back pain. He could not bend over to get his tools or lift much weight. He testified that his boss gave him lighter work to do in the shop. He did not seek immediate medical care because he thought the pain would go away.

Petitioner first sought medical treatment at Cadence Health with Dr. Hina Nawab. Petitioner's history was that he fell from a flight of stairs with back pain ever since. Petitioner complained of back pain and shooting pain down the left leg to his toe. Physical examination noted paraspinal tenderness and positive straight leg raise on the left. The diagnosis was acute back pain status post fall and an acute back strain. Petitioner was sent for x-rays and given pain medications (PX 2). Petitioner underwent thoracic and lumbar x-rays on March 2, 2014. On March 3, 2014, Dr. Nawab recorded continued pain down the left leg and referred the Petitioner for physical therapy and a lumbar MRI. The diagnosis was sciatica (PX 2).

Petitioner began physical therapy at Athletico on March 11, 2014 (PX 4). The pain diagram shows pain in the back running down the left leg to the foot. The subjective complaints record pain in the spine and pain to the left foot. This is not constant. He also has occasional pain in the right thigh (PX 4). Petitioner testified that he had pain into both legs on and off since the accident. During his initial course of therapy, Petitioner continued working for Respondent. He testified that Respondent gave him easy, small jobs to do and provided him with a helper every day. Petitioner testified that he was not able to work every day due to pain. He was paid for the days he missed due to pain and paid for the time off he took for therapy treatment.

On March 29, 2014, Dr. Nawab noted that physical therapy had helped improve the Petitioner's condition a little, but that he continued to have pain when sitting for more than a minute and had shooting pain down both

legs. Dr. Nawab referred Petitioner for an orthopedic examination (PX 2). An April 2, 2014 lumbar MRI revealed multilevel degenerative changes with varying degrees of central canal stenosis and foraminal narrowing (PX 3). Petitioner's initial therapy with Athletico ended on April 21, 2014. Petitioner related that he had improved significantly. He no longer had constant pain and no longer had pain at night. He no longer had difficulty reaching to put on socks. The therapist noted that Petitioner was improved, but still limited with some functional tasks. The assessment was that physical therapy continues to be medically necessary. The May 23, 2014 note states Petitioner did not return to therapy and did not return phone calls and was discharged (PX 4). Petitioner testified that he was told by the manager of Athletico that Respondent was no longer going to pay the bills, and he could not afford to pay himself, so the treatment stopped. Petitioner testified that the therapy was helping him and believed he needed more physical therapy at that time.

Petitioner began treatment with Dr. Craig Popp at Fox Valley Orthopedic Institute on September 25, 2014 (PX 3). Dr. Popp took a history of the February fall down stairs and complaints of low back and bilateral leg pain since that time. The physical examination noted a normal neurological examination, negative straight leg raise, and no Waddell's signs. Dr. Popp noted that the MRI showed a central type disc herniation at L5-S1, but at L4-5 there was a central left-sided disc herniation that was causing some lateral recess stenosis and may have been impinging slightly on the L5 nerve root. Dr. Popp's diagnosed a herniated intervertebral disc and lumbar radiculopathy. Dr. Popp recommended an EMG and to try an injection. Petitioner was placed on work restrictions of 25 pounds lifting, no pushing, pulling or twisting, and no repetitive bending (PX 3). Petitioner testified that he took the restrictions to Chris Bracken, Respondent's owner. He was not offered light duty work. The October 10, 2014 EMG performed by Dr. Christopher Siodlarz at Fox Valley Orthopedics did not show any specific nerve involvement or impingement (PX 3). Petitioner followed up with Dr. Popp on October 14, 2014. The physical examination remained unchanged. Dr. Popp recommended that Petitioner undergo an epidural steroid injection and, if that did not provide relief, consider surgical options. Dr. Popp continued Petitioner's work restrictions (PX 3).

On November 13, 2014, Petitioner underwent a Section 12 examination by Dr. Michael Kornblatt at the request of the Respondent (RX 1). Dr. Kornblatt reviewed medical records. Dr. Kornblatt reviewed films of the April 2, 2014 MRI of the lumbar spine and found disc desiccation at L3-4, L4-5, and L5-S1, moderate disc space narrowing at L5-S1 level. There is a small central L5-S1 annular protrusion without frank herniated disc, spinal stenosis, or nerve root impingement, and no significant facet arthropathy at L5-S1. At L4-L5, there is central left disc protrusion with possibly slight left lateral recess narrowing. There is no significant central or foraminal stenosis at the L4-5 level. There is no facet arthropathy at L4-L5. At L3-4, there is no evidence of herniated disc, spinal stenosis, nerve root impingement, or facet arthropathy. Findings are consistent with longstanding 3-level lumbar degenerative disc disease; greatest left L4-L5. His physical examination noted some tenderness, but negative straight leg raise and a normal neurological exam. Dr. Kornblatt diagnosed multilevel lumbar degenerative disc disease with lumbar myofascial pain with a history of work related lumbosacral strain and contusion occurring on February 17, 2014. Dr. Kornblatt opined that the diagnosis of lumbar degenerative disc disease was not related to the work accident, but the diagnoses of lumbar myofascitis and lumbosacral strain and contusion were related to the February 17, 2014 work accident. Dr. Kornblatt recommended that the Petitioner undergo local trigger point injections and recommended medium duty work restrictions (RX 1).

On November 26, 2014, Petitioner began treatment with Dr. Siodlarz upon a referral from Dr. Popp. Dr. Siodlarz noted Petitioner's February 17, 2014 work accident and current complaints of pain across the low back with radiation down the left leg to the calf and the right leg to the knee. The pain diagram notes these

complaints. The physical examination noted significant back pain at the L4-5 level with spasm and fullness of the paraspinal muscles. Straight leg raise and neurological testing was normal. Dr. Siodlarz diagnosed low back pain and bilateral lower extremity radiculopathy per clinical examination. Dr. Siodlarz recommended diagnostic therapeutic facet injections, beginning on the left side and proceeding to the right side if necessary. He noted that if Petitioner did not improve, an epidural steroid injection would be reasonable (PX 1). On January 14, 2015, Dr. Siodlarz reviewed Dr. Kornblatt's IME report and noted his recommendation of trigger point injections, although Dr. Siodlarz continued to believe facet injections were a reasonable option. On February 18, 2015, Country Financial advised Dr. Siodlarz that the facet injections would not be authorized (PX 1).

On February 25, 2015, Petitioner underwent the lumbar trigger point injections recommended by Dr. Kornblatt. These injections were performed at L4-5 bilaterally, under ultrasound guidance, by Dr. Siodlarz (PX 1). On March 16, 2015, Dr. Siodlarz noted that the trigger point injections had given Petitioner no relief at all. He continued to have lower back pain and intermittent leg pain. Dr. Siodlarz stated that the Petitioner's pain was facet mediated and continued to recommended medial branch blocks at the L4-5 and L5-S1 facet joints (PX 1). On April 8, 2015, Petitioner reported worsening symptoms. Dr. Siodlarz noted that the trigger point injections had not been helpful, but that facet injections had been denied by Respondent. The physical examination noted back pain and reduced range of motion. Neurological testing and straight leg raise remained normal. Petitioner was given medication for pain and inflammation and referred for an updated lumbar MRI (PX 1). The request for the updated MRI was not authorized by Respondent on May 8, 2015. On May 12, 2015 and July 1, 2015, Petitioner was seen by Dr. Siodlarz with continued pain in his lower back and lower extremities. Dr. Siodlarz continued to recommend an updated MRI and, on July 1, 2015, noted that the Petitioner continued to be unable to work due to his pain and the heavy duty nature of his work (PX 1).

On September 18, 2015, Petitioner underwent an updated MRI of the lumbar spine which found bilateral neuroforaminal narrowing at L5-S1 and a moderate L5-S1 broad based disc herniation, stable when compared to the previous study. The report also notes mild broad based herniations with mild effacement at L3-4 and L4-5 (PX 7). On October 6, 2015, Dr. Siodlarz reviewed the MRI and noted that it was stable since the earlier study. He diagnosed discogenic low back pain at L4-5, L5-S1, intermittent radiculopathy of the bilateral lower extremities and neural foraminal stenosis bilaterally at the L5-S1 levels. Due to the fact that Petitioner had significant conservative care and prolonged pain for greater than one year, Dr. Siodlarz recommended epidural steroid injections under fluoroscopic guidance in order to get Petitioner back to work. He noted that if the injections worked, Petitioner would require work conditioning to return to work (PX 1).

On December 15, 2015, Dr. Kornblatt performed a second Section 12 medical examination (RX 2). Dr. Kornblatt reviewed films of the September 18, 2015 MRI of the lumbar spine and found them to be consistent with the April 2, 2014 exam. Current symptoms are recorded as severe central low back pain, non-radicular in nature, with occasional left leg symptoms. Dr. Kornblatt documented tenderness with palpation of lower lumbar spinous process. Petitioner demonstrated full range of motion and a negative straight leg raise test. Neurological testing was normal. Dr. Kornblatt opined that Petitioner was not a candidate for epidural steroid injections as there was no evidence of clinical lumbar radiculopathy. He opined that any treatment after the trigger point injections was unrelated to the lumbosacral strain and contusion sustained on February 17, 2014. He recommended that Petitioner resume an active lifestyle and engage in his normal routine to alleviate the residual mechanical axial low back pain. For the unrelated 3-level lumbar degenerative disc disease, Dr. Kornblatt recommended aerobic conditioning, low back stabilization exercise, core strengthening, weight reduction, and intermittent use of oral anti-inflammatory medications. Dr. Kornblatt opined that Petitioner could

return to full duty work and was at maximum medical improvement with regard to the lumbosacral strain and contusion as of the completion of the February 25, 2015 trigger point injections as he was not expected to improve significantly with future reasonable medical treatment (RX 2).

Petitioner saw Dr. Siodlarz on January 26, 2016. Dr. Siodlarz noted that Petitioner had a recent flare up of back pain. He notes that Petitioner had undergone another IME, which Dr. Siodlarz reviewed. Dr. Siodlarz stated that Petitioner is neurologically intact but has severe disabling low back pain. He stated this does not appear to be due to a myofascial origin. He believed that the spasms are a reaction to symptomatic disc protrusions at L4-5 and L5-S1 (PX 1).

In response to correspondence from Petitioner's attorney, Dr. Siodlarz drafted a report on March 11, 2016. Dr. Siodlarz opined that Petitioner suffered from a disc protrusion at L4-5 centrally and at L5-S1 with an annular tear. He also felt Petitioner had clinical radiculopathy without neurological deficit. Dr. Siodlarz believed that Petitioner's radicular pain was most likely inflammatory in nature and recommended epidural steroid injections, which he noted were more often successful for patients with an inflammatory basis for radicular pain. Dr. Siodlarz further opined that Petitioner's pain was causally related to his February 17, 2014 work accident. He place Petitioner on lifting restrictions. He stated that if the epidural injections were not successful, he would refer Petitioner back to Dr. Popp for surgical consideration (PX 6).

Petitioner did not see Dr. Siodlarz between January, 2016 and August, 2016. During that time, Petitioner testified that he tried some exercises, such as riding a bike, swimming or using an elliptical, as was recommended during his physical therapy and by Dr. Siodlarz's office. Petitioner also continued taking his medications as prescribed by Dr. Siodlarz, which Dr. Siodlarz continued prescribing every 30 days. Petitioner has seen Dr. Siodlarz on August 16, 2016, January 24, 2017, May 8, 2017 and September 8, 2017 for continuing symptom. Dr. Siodlarz continues to recommend epidural steroid injections (PX 1).

Dr. Siodlarz testified by evidence deposition taken May 15, 2017 (PX 8). He is a board certified interventional pain medicine physician. Dr. Siodlarz testified to his March 11, 2016 report, detailing his treatment of Petitioner and his opinions concerning the Petitioner's current condition of ill-being. Dr. Siodlarz testified that Petitioner had undergone an IME with Dr. Kornblatt on November 13, 2014, who recommended trigger point injections. Trigger point injections are intended to decrease pain in the muscle due to localized muscle spasm. They are meant to treat back pain, not pain down the leg. Dr. Siodlarz administered the trigger point injections. Dr. Siodlarz testified that he used ultrasound guidance for the trigger point injections he administered to make sure the medicine is placed in the muscle and not around the nerve, where it would simply numb the nerve. It is Dr. Siodlarz's usual and customary practice to use the ultrasound guidance. Petitioner did not have any relief from those injections. He testified he did trigger point injections rather that his recommended facet injections, because that was what was recommended and approved by the insurance carrier (PX 8).

It was Dr. Siodlarz's opinion that Petitioner's pain was not myofascial. Petitioner's pain was emanating from the spine itself, either from the joints, the disc, or potentially a pinched nerve. Dr. Siodlarz recommended epidural steroid injections or facet injections for both diagnostic and therapeutic purposes administered where the pain was coming from. Dr. Siodlarz felt that the condition of Petitioner's spine was stable comparing the September, 2015 MRI to the April 2, 2014 MRI. He opined that the findings on the MRI were consistent with lower back and left leg pain. Dr. Siodlarz explained that the Petitioner had disc protrusions on his MRI, as well as stenosis. The protrusions and stenosis in combination can cause a narrowing where the nerves leave the spine, which can cause pain (PX 8).

Dr. Siodlarz reviewed Dr. Kornblatt's December, 2015 report. He disagreed with Dr. Kornblatt's conclusion that Petitioner did not have clinical radiculopathy. Dr. Siodlarz testified that Petitioner had pain into his legs, a positive straight leg raise, and a MRI that corroborated those findings. Dr. Siodlarz testified that the negative EMG test of Petitioner's lower extremities does not change his opinion. He testified that 30% of radiculopathies are missed on EMG. You can have a pinched nerve without nerve damage. Dr. Siodlarz opined that the Petitioner's condition of ill-being and the treatment recommended for that condition are causally related to his February 17, 2014 work accident. Dr. Siodlarz continued to recommend a trial of diagnostic injections. If his condition improved from those injections, Dr. Siodlarz would recommend work conditioning. If the injections were not helpful, they would discuss surgical options (PX 8).

Dr. Siodlarz agreed that the Petitioner had a negative EMG of the lower extremities and negative straight leg raise tests on each of his examinations. He testified that Petitioner's radiating leg pain was caused by inflammation in the spine. He notes the initial straight leg testing and the MRI findings corroborating pain in the dermatome described by Petitioner. He testified that he has no evidence that Petitioner is malingering (PX 8).

Dr. Kornblatt testified by evidence deposition taken July 24, 2017 (RX 3). Dr. Kornblatt is a board certified orthopedic surgeon who performed two Section 12 examinations on behalf of the Respondent. Dr. Kornblatt first saw Petitioner on November 13, 2014. Dr. Kornblatt testified that the Petitioner told him he had intermittent leg pain. Patients who have degenerative disc disease, mechanical back pain with referred leg pain will present in that fashion. After reviewing the medical records and his physical examination of the Petitioner, Dr. Kornblatt diagnosed Petitioner with lumbar degenerative disc disease, presenting with lumbar myofascial pain with a secondary history of work related lumbosacral strain and contusion which had occurred when he fell on February 17, 2014. Petitioner's degenerative disc disease pre-dated his accident and had not been worsened by his accident because he did not see any signs of worsening, such as radiculopathy on examination. Petitioner had subjective complaints consistent with mechanical low back pain and referred leg pain. Dr. Kornblatt recommended trigger point injections. He felt Petitioner had myofascial pain trigger points. He did not feel that epidural injections were appropriate, because Petitioner did not have a clinical radiculopathy. Dr. Kornblatt felt that the Petitioner could work within the medium physical demand level, lifting up to 50 pounds occasionally and 25 pounds frequently at the time of the first examination (RX 3).

On December 10, 2015, Dr. Kornblatt reviewed updated medical records and obtained an updated history from the Petitioner. He also performed another physical examination. Physical examination showed excellent range of motion, negative straight leg raise, and no abnormal findings. Dr. Kornblatt diagnosed multilevel degenerative disc disease and mechanical axial low back pain. Dr. Kornblatt disagreed with the need for ultrasound guidance on Petitioner's trigger point injections. Dr. Kornblatt testified that there would be no value in performing an epidural steroid injection on a patient with degenerative disc disease. Dr. Kornblatt testified that without objective findings, Petitioner could return to full duty work. He opined that Petitioner had reached maximum medical improvement after undergoing the trigger point injections (RX 3).

Dr. Kornblatt testified that if there was impingement on the L5 nerve root, there is going to be primarily leg pain associated with numbness at the top of the foot maybe some weakness or loss of the L5 deep tendon reflexes. He testified that physicians don't know for sure how mechanical back pain causes leg pain.
Dr. Kornblatt testified that there was no record of any treatment for the Petitioner's lower back prior to his accident. Petitioner had consistently complained of lower back pain through the dates of Dr. Kornblatt's examinations. Dr. Kornblatt testified that typically after three to six months, Petitioner's lower back pain would

stop being from his work accident and start being from something else, but in this case they gave him until he had the trigger point injections. Dr. Kornblatt could not explain what was causing Petitioner's subjective back pain. It is possible that he now has degenerative disc disease that is causing chronic pain. He testified that you cannot base an opinion solely on subjective complaints. You base opinions on subjective complaints, findings on exam, evaluations such as scanning as well as your experience in treating patients. Dr. Kornblatt disagreed with Dr. Popp and Dr. Siodlarz that the MRIs showed any possible nerve root impingement.

Petitioner testified that he has not returned to work in any capacity since September 25, 2014, when Dr. Popp placed him on restrictions. He continues to take his medications. He wishes to undergo the injections if they are authorized. He testified that he still notices throbbing pain in his low back shooting and pain down his legs. He gets swelling in his low back. He does a lot of stretching and walking a bit.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. The 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. The Commission may find a causal relationship based on a medical expert's opinion that the injury "could have" or "might have" been caused by an accident. However, expert medical evidence is not essential to support the Commission's conclusion that a causal relationship exists between a claimant's work duties and his condition of ill-being. A chain of events suggesting a causal connection may suffice to prove causation. Prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident.

Petitioner's unrebutted testimony and medical histories show that he had no prior back injuries or treatment before the accident on February 17, 2014. Petitioner suffered a significant fall down stairs on ice and reported immediate pain. He sought medical care within a week of the injury and has provided a consistent history of accident and onset of symptom thereafter. He has advanced consistent complaints of pain in the back and symptoms in his legs, primarily the left. Dr. Nawab diagnosed sciatica and prescribed therapy and work restrictions. Dr. Popp diagnosed radiculopathy and continued the restrictions. His records note that Waddell's testing was negative. Dr. Siodlarz has diagnosed radiculopathy and continued restrictions and recommended further treatment including injections, which have not been authorized. He also testified that Petitioner has exhibited no signs of malingering. Even Dr. Kornblatt acknowledges the ongoing, consistent subjective complaints. He attributed these to the degenerative disc disease. The Arbitrator finds that the Petitioner's gaps in care were occasioned, not by any resolution of the symptoms or Petitioner's lack of follow up, but by challenges in obtaining approval from Respondent for ongoing treatment.

In the absence of any prior symptomatic condition, the findings and diagnoses of Dr. Nawab and Dr. Popp can be related to the history of accident reported. Dr. Siodlarz provided a specific causal connection opinion and has described in detail his diagnosis and explanation of Petitioner's current symptoms and his proposed course of care. He continued to diagnose radiculopathy and recommend epidural injections followed by work conditioning. He supported his position with his reading of the MRI scans, his physical examination including the complaints provided by Petitioner.

Dr. Kornblatt initially provided credence to Petitioner's complaints. Kornblatt diagnosed multilevel lumbar degenerative disc disease with lumbar myofascial pain with a history of work related lumbosacral strain and contusion occurring on February 17, 2014. Dr. Kornblatt opined that, while the diagnosis of lumbar degenerative disc disease was not related to the work accident, the diagnoses of lumbar myofascitis and lumbosacral strain and contusion were related to the February 17, 2014 work accident. Dr. Kornblatt recommended that the Petitioner undergo local trigger point injections and recommended medium duty work restrictions.

Petitioner underwent the trigger point injections without relief of his symptoms. Dr. Kornblatt now opines that the ongoing symptoms are no longer work related. He agrees that Petitioner has pre-existing degenerative disc disease. He states that there has been no change in this pre-existing condition because there are no MRI changes. This does not account for the ongoing symptoms, the cause of which he was unable to explain during his deposition testimony. He does suggest that they may be related to the pre-existing degenerative disc disease which is now symptomatic.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

The Arbitrator has observed the Petitioner's testimony and the medical evidence. Petitioner had a consistent work history with Respondent over several years of performing physically demanding work. Respondent initially accommodated his restrictions and paid him for his time off for therapy and initial sporadic missed days. The Arbitrator finds his testimony credible as did all of the treating medical providers. The Arbitrator finds the opinion of Dr. Kornblatt is at odds with all of the treating doctors and does not explain the ongoing condition of ill being. Based upon the evidence in this matter, the Arbitrator finds the opinions of Dr. Siodlarz more persuasive that those of Dr. Kornblatt and finds that his diagnosis and explanation of Petitioner's symptoms more reasonable in light of the evidence and MRI results than Dr. Kornblatt's lack of any clear basis for the consistent symptoms advanced.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that his condition of ill being in the low back and legs is causally connected to the accidental injuries sustained on February 17, 2014.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner would be entitled to reasonable and necessary medical treatment to address the conditions of ill being in his low back. Petitioner admitted the unpaid medical bills as PX 12. Respondent admitted a medical payment ledger as RX 5. The Arbitrator has reviewed the Exhibits and does not find any documentation that the balances alleged in RX 12 were paid pursuant to RX 5. PX 12 lists the following unpaid medical:

Associated Imaging Specialist (9/18/2015)	$325.00
Highland Park CVS (2/24/2014-3/5/2014)	$77.74
Fox Valley Ortho (5/12/2015-5/8/2017)	$1,204.00
Quest Diagnostics (6/13/2017)	$340.22
IWP (7/24/2015-6/30/2017)	$6,760.03
Presence St. Joseph Hospital (9/18/2015)	$4,253.00
Tri City Radiology (3/2/2014-4/2/2014)	$470.00
Walgreens (7/22/2014-12/3/2014)	$238.88
Total Balance	$13,668.87

The Arbitrator has reviewed the medical records presented and the testimony of Petitioner and finds that the bills presented are for treatment that was reasonable, necessary and causally related to the accident.

Based upon the record as a whole, and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of $13,667.99 to the providers as listed on PX 12 as provided in Sections 8(a) and 8.2 of the Act.

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, Petitioner would be entitled to reasonable and necessary medical treatment to address the conditions of ill being in his low back.

As more fully discussed above with respect to Medical, the Arbitrator finds the opinions of Dr. Siodlarz more persuasive that those of Dr. Kornblatt. The Arbitrator finds his diagnosis and outlined course of treatment consisting of epidural injections followed by work conditioning is reasonable and necessary.

Based upon the record as a whole, and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is in need of further prospective medical treatment. Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Siodlarz including epidural steroid injections, therapy or work conditioning and other reasonable and necessary care.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, "[W]eekly compensation *** shall be paid *** as long as the total temporary incapacity lasts," which has been interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement.

As more fully discussed above with respect to Medical and Prospective Medical, the Arbitrator finds the opinions of Dr. Popp and Dr. Siodlarz more persuasive that those of Dr. Kornblatt. Dr. Siodlarz has not yet found Petitioner has reached maximum medical improvement and has recommended further treatment which the Arbitrator has found reasonable and necessary.

On September 25, 2014, Petitioner was placed on light duty work restrictions by Dr. Popp due to the condition of ill being in his lumbar spine. Petitioner provided the restrictions Respondent and was not offered light duty work. Petitioner has continued treatment with Dr. Popp and Dr. Siodlarz. Petitioner has remained on work restrictions through the date of the hearing

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is entitled to temporary total disability benefits for 156 1/7 weeks, commencing September 25, 2014 through September 22, 2017, the date of the hearing, as provided in Section 8(b) of the Act.

In support of the Arbitrator's decision with respect to (M) Penalties, the Arbitrator finds as follows:

Petitioner filed a Petition for Fees under Section 16 and Penalties under Sections 19(k) and 19(l) for failure to timely pay temporary compensation and medical bills (PX 10, PX 11)

Penalties imposed under section 19(l) are in the nature of a late fee. The award of section 19(l) penalties is mandatory if the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay. The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. The employer bears the burden of justifying the delay, and its justification is sufficient only if a reasonable person in the employer's position would have believed the delay was justified.

The standard for awarding penalties and attorney fees under sections 19(k) and 16 is higher than the standard for awarding penalties under section 19(l) because sections 19(k) and (16) require more than an "unreasonable delay" in payment of benefits. For the award of penalties and attorney fees under sections 19(k) and 16, it is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. Instead, penalties and attorney fees under sections 19(k) and 16 are intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose.

In addition, while section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under sections 19(k) and 16 is discretionary.

In the present case, Respondent paid all lost time and medical benefits until Dr. Kornblatt opined that Petitioner was at maximum medical improvement from the work injury and was in need of no further treatment and could return to full duty work. The reports of Dr. Kornblatt and his deposition testimony outline his medical basis for his opinion and the records and findings upon which he relied. Although the Arbitrator has found the treating opinions more persuasive in this matter, the Arbitrator finds that Respondent could reasonable rely on the opinions of Dr. Kornblatt to deny benefits, particularly in light of the lack of objective positive neurological findings in the treating records. When the employer relies on responsible medical opinion or when there are conflicting medical opinions, penalties are not usually imposed. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 302, 412 N.E.2d 468, 470, 45 Ill. Dec. 117 (1980).

Based upon the evidence presented, the Arbitrator finds that a reasonable person in the employer's position would have believed that the denial of further benefits was justified. Petitioner's Petition for Penalties and Attorney's Fees is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CESAR LOPEZ,

Petitioner,

vs. NO: 15 WC 24267

PEPSICO,

Respondent.

19IWCC0552

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, prospective medical care, permanent partial disability, and all issues raised at hearing, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. FINDINGS OF FACT

Petitioner is a 57-year-old employee of Respondent, who described his job as a truck and auto mechanic. He had been so employed for 20 years and previously worked as an auto and truck mechanic since his service in the Army. Petitioner testified that his duties include repairing trucks, tractors, trailers, post leads, electric pallet jacks, and all vehicles.

On June 23, 2015, Petitioner sustained an undisputed accident while cleaning 55-gallon oil drums that were used as garbage cans. He explained that these garbage cans contained all kinds of garbage plus scrap metal, so it was slightly heavier. While emptying garbage into a bigger container, Petitioner felt pain in his right shoulder and biceps.

The decision of the Arbitrator delineates the facts in detail relating to Petitioner's medical

treatment, off work or light duty status, as well as Respondent's Section 12 examinations. As relevant to the issues on review, the Commission notes that Petitioner underwent a right shoulder arthroscopy with extensive debridement including of labral tears, rotator cuff tear as well as intra-articular adhesions, subacromial decompression and open biceps tenodesis on December 16, 2015 with Dr. Schafer. Petitioner then underwent post-operative treatment including physical therapy and medication management. Petitioner testified that he was paid temporary total disability benefits from September 16, 2015 through March 16, 2016.

Petitioner also submitted to three Section 12 examinations with Dr. Cole at Respondent's request. After the first examination on March 17, 2016, Dr. Cole diagnosed right shoulder rotator cuff tendinitis caused by a work-related aggravation of a preexisting condition, which had not yet resolved. Dr. Cole expected Petitioner to reach maximum medical improvement within eight weeks. He did not believe, however, that Petitioner's examination was consistent with a large rotator cuff injury. Consequently, Dr. Cole recommended only non-operative treatment and no further medication beyond over-the-counter medications.

The following day, on March 18, 2016, Petitioner underwent an initial evaluation with Dr. Ronald Silver. On physical examination, Dr. Silver noted reduced range of motion and positive impingement, Hawkins, and drop arm tests. He diagnosed Petitioner with postoperative frozen shoulder/adhesive capsulitis with rotator cuff impingement. Dr. Silver recommended a right shoulder MRI in consideration of surgery.

Petitioner underwent the recommended MRI on April 16, 2016 and returned to Dr. Silver on April 20, 2016. Dr. Silver reviewed the MRI noting persistent inflammation of the rotator cuff consistent with clinical findings of both rotator cuff impingement and post-operative frozen shoulder/adhesive capsulitis. He then recommended arthroscopic surgery with lysis of adhesions, possible further decompression, and immediate use of a continuous passive motion machine post-operatively due to severe frozen shoulder.

Petitioner returned to Dr. Cole at Respondent's request on May 26, 2016 and October 2, 2017. Dr. Cole maintained Petitioner's diagnosis of right shoulder rotator cuff tendinitis, but opined that Petitioner had reached maximum medical improvement, needed no further medical treatment or prescription medications, and could return to work without restrictions. Dr. Cole also issued an impairment rating of 5% of the upper extremity and 3% of the whole person utilizing the AMA Guides 6th Edition.

Respondent refused to authorize the second surgery recommended by Dr. Silver. Notwithstanding, Petitioner testified that although Dr. Silver recommended the second surgery he did not intend to undergo that treatment. Petitioner also testified that Dr. Cole told him that he could return to work, and he did return to full duty work.

Regarding his current condition of ill-being, Petitioner testified that he currently feels pain in his right shoulder. Sometimes he has cramps in his biceps when he has to push/pull. He also testified that he had the same severe cramp-like pain in his chest when pushing. Petitioner further testified regarding the form of his right biceps, which is "kind of down," not regular like his left. He explained that the biceps muscle kind of turns into a ball. The Arbitrator noted viewing

Petitioner's right arm at the time of the hearing. Petitioner indicated that the muscle was rolled down to his elbow and it had been that way since the accident; it had not changed at all. At work, Petitioner testified that his arm bothers him and it affects his work. He explained that he must pay a lot of attention when he is going to lift or push, and he has to concentrate not to create a problem where he feels pain.

Petitioner testified that he still works for Respondent in a full duty capacity. His day-to-day activities at work are identical to what he was doing prior to the accident. Petitioner also testified that he is not under any accommodations and he does not ask anyone to do any part of his job.

Petitioner submitted various medical bills into evidence. The bills from ATI reflect charges for post-operative treatment ordered by Dr. Silver, which were found reasonable pursuant to a utilization review. The April 8, 2016 utilization review of Dr. Fossier, a board-certified orthopedic surgeon, noted: "for rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral." The ATI physical therapy billing shows that Petitioner underwent post-surgical therapy from January 22, 2016 through April 26, 2016. The remaining bills relate to Petitioner's medications and their usage. The RX Development Associates, Inc. ("RX Development") bills totaled $7,081.30. Of that total amount, $5,162.16 related to Terocin patches and the remaining $1,919.14 related to other prescription medications ordered by Dr. Silver. The Infinite Strategic Innovations bills totaled $203.84 for hydrocodone prescribed in 2016. The Vision Laboratories bill totaled $2,829.00 for drug testing ordered by Dr. Silver.

II. ANALYSIS

A. Causal Connection

The Commission agrees with the Arbitrator's finding of causal connection, and further finds that Petitioner's postoperative frozen shoulder/adhesive capsulitis condition is also causally related to the accident in question. Dr. Silver diagnosed the condition postoperatively and opined that it was causally related to the work injury. The medical records also reflect Petitioner's subjective complaints at the conclusion of physical therapy in late April of 2016. While Respondent's Section 12 examiner, Dr. Cole, opined that Petitioner required no further intervention the medical records reflect otherwise. In particular, the physical therapy and treatment records reflect that Petitioner reported continued, unrelenting mobility difficulties with regard to the shoulder postoperatively. The physical therapists and Dr. Silver noted clinical findings corroborating Petitioner's subjective reports. Dr. Silver recommended surgery to release the condition, but Petitioner testified that he did not wish to undergo that treatment. Given the totality of the record, and in the absence of evidence indicating any intervening causation or wholly non-occupational cause for Petitioner's range of motion difficulties, the opinion of Dr. Cole that Petitioner's adhesive capsulitis was unrelated is not persuasive. Thus, the Commission finds that Petitioner's right shoulder proximal biceps tendon rupture, labral tear, partial tear of the supraspinatus and subacromial impingement as well as his post-operative adhesive capsulitis conditions are causally related to the accident in question.

B. Medical Bills

The Commission finds that the medical bills claimed by Petitioner are for reasonable and necessary medical treatment or diagnostic testing to alleviate him from the effects of his injury at work. In so concluding, the Commission notes that Petitioner's complaints throughout his treatment were consistent with objective test results and findings on clinical examination by Dr. Silver and Dr. Schafer. Dr. Cole maintained that Petitioner only required over-the-counter medications and required no treatment beyond May 26, 2016. However, Dr. Cole's examinations and review of records corroborated many of the objective findings by Petitioner's treating physicians. Thus, Dr. Cole's opinions are not persuasive given the totality of this record.

Dr. Silver's records reflect that he prescribed narcotic pain medications and administered regular drug testing to ensure proper use and compliance. With regard to the Vision Laboratories bill for drug tests ordered by Dr. Silver, Petitioner was prescribed a variety of opiate medications to alleviate his ongoing pain symptoms. Regular drug testing may have revealed addiction or abuse issues in this case and the Commission finds that such protocol is reasonable and necessary to avoid these issues. Thus, the Commission awards the Vision Laboratories bill finding that the treatment and testing ordered was reasonable and necessary.

The ATI bills are for treatment ordered by Dr. Schafer for conservative treatment and post-operative care. The medical records support the award of the bills and, moreover, the utilization review offered by Respondent indicates that it is reasonable to treat rotator cuff pain with an intact tendon with three-to-six months of conservative therapy. The ATI bills indicate that the post-operative therapy treatment lasted for approximately three months, which is noted within the utilization review. Thus, the Commission, herein, affirms and adopts the Arbitrator's award of the ATI bill of $870.43.

The RX Development bills were for medications totaling $7,081.30. Of that amount, $5,162.16 was for Terocin patches and the remaining $1,919.14 was for prescription medications ordered by Dr. Silver and reflected in his records. The Infinite Strategic Innovations bills totaled $203.84 for hydrocodone prescribed from March through April of 2016. The Vision Laboratories bill of $2,829.00 was for drug tests.

There is a difference of medical opinion between Dr. Silver and Respondent's Section 12 examiner, Dr. Cole, regarding the type of medication that was appropriate for Petitioner. Dr. Cole opined and testified that Petitioner only required over-the-counter pain medication whereas Dr. Silver prescribed the aforementioned medications. There is no evidence in the record to suggest that the medications were over-prescribed for pain or of overuse by Petitioner, notably, based on the regular drug testing. Dr. Silver was in a better position to determine the most appropriate pain relief modalities for Petitioner who suffered a complex shoulder injury resulting in surgery and extensive conservative treatment. Dr. Cole found that Petitioner had not yet reached maximum medical improvement at the time he was prescribed hydrocodone from March through April of 2016.

Thus, the Commission finds the foregoing medical bills to reflect charges for reasonable and necessary medical treatment to alleviate Petitioner from the effects of his injury at work and,

herein, modifies the arbitration decision and awards $1,919.14 for RX Development bills, $203.84 for Infinite Strategic Innovations bills, and $2,829.00 for Vision Laboratories bills. The Commission affirms the Arbitrator's denial of the remaining bills.

C. Other Issues

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's right shoulder proximal biceps tendon rupture, labral tear, partial tear of the supraspinatus and subacromial impingement as well as his post-operative adhesive capsulitis conditions are causally related to the accident

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $963.62 per week for a period of 13 and 1/7th 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 $735.37 per week for a period of 57.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 11.5% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $5,822.41 for medical expenses pursuant to §8(a) and §8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,100.00. 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 9 - 2019

BNF/jsf
8/15/19
045

Barbara N. Flores

Marc Parker

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOPEZ, CEASAR
Employee/Petitioner

Case# **15WC024267**

PEPSICO
Employer/Respondent

19IWCC0552

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

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

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

0059 BAUM RUFFOLO & MARZAL LTD
V ANDREWS MARZAL
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
TIM ALBERTS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CESAR LOPEZ
Employee/Petitioner
v.
PEPSICO
Employer/Respondent

Case # **15** WC **24267**
Consolidated cases: _____

19IWCC0552

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **AUGUST 14, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 23, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident. Petitioner's adhesive capsulitis and impingement syndrome ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$75,162.88**; the average weekly wage was **$1,445.44**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$14,760.64** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,760.64**. Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$963.62/week** for **13-1/7th weeks**, commencing **December 16, 2015** through **March 16, 2016**, as provided in Section **8(b)** of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **December 16, 2015** through **March 16, 2016** and shall pay the remainder of the award, if any, in weekly payments. Against this award, Respondent shall be given a credit of **$14,760.64** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services from ATI of **$870.43**, as provided in and subject to 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. The charges from Vision Laboratories, Infinite Strategic Solutions and Rx Development charges are ***denied*** as excessive and unnecessary and neither Respondent nor Petitioner shall be liable for same.

Respondent shall pay Petitioner permanent partial disability benefits of **$735.37/week** for **57.5 weeks**, because the injuries to the right shoulder rotator cuff, labrum and proximal biceps tendon sustained caused the **11.5%** 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

OCT 1 1 2018

10-9-2018
Date

FINDINGS OF FACT

19IWCC0552

Background

Cesar Lopez ("Petitioner") alleged injuries arising out of and in the course of his employment with PepsiCo ("Respondent"). Ax1, Rx6. On August 14, 2018, the parties proceeded to arbitration on the disputed issues of causal connection, liability for unpaid medical bills, temporary total disability, nature and extent of the injury. Petitioner specifically asked this court to address Petitioner's bicep injury as loss of use of an arm rather than man as a whole. The following is a recitation of the facts adduced at trial.

Testimony and Other Evidence

Petitioner testified, and it was generally undisputed that on June 23, 2015 Petitioner worked in his usual capacity as a truck and auto mechanic for Respondent and that on that date, he injured his right upper extremity when he attempted to lift and empty a garbage can. He testified he injured his right shoulder and right bicep. He testified he had no prior injuries or symptoms. His injury was reported, and he was sent for medical care.

From June 23, 2015 thru August 4, 2015, Petitioner treated with Concentra. Px2. Diagnosis was shoulder strain and AC strain. There, he was given medications, therapy and full duty work. An MRI was prescribed. On July 30, 2015, MRI of the right shoulder without contrast performed at Advanced Medical Imaging Center showed mild supraspinatus and infraspinatus tendinosis, small low-grade partial thickness articular-sided tear of the subscapularis, degenerative tearing/fraying of the superior glenoid labrum and mild AC osteoarthritis. Px2:35. As to the biceps long head, there was tendinosis and fraying of the intracapsular portion. Petitioner said he eventually switched care.

On August 19, 2015, Petitioner presented for initial evaluation with Dr. David Schafer. Px2:28. He complained of an acute onset of right shoulder pain following a work injury on June 23, 2015 where he felt pain in the right shoulder after attempting to lift a garbage can to empty it into a dumpster.

He had no previous history of injuries or problems with the right children prior to the work accident. He had a very physical job which involves lifting up to 200 pounds tires for trucks. He was employed as a technician and mechanic and doesn't have to lift heavy truck parts from time to time. He was functioning at a very high-level without any issues with his right shoulder prior to this accident. Petitioner was still working his regular job and he was complaining of increased pain with job activities. Petitioner endorsed primarily pain in the anterior shoulder but also posteriorly. It radiated down the arm anteriorly. There was associated weakness. Pain was 4-5 out of 10 constantly but increased with work activities and at night. He was having difficulty secondary to pain with any overhead use or lifting. On exam, there was pain to palpation over the anterior shoulder surrounding the subscapularis and proximal biceps. MRI from July 2015 was reviewed and showed a partial tear of the subscapularis and degenerative fraying of the superior labrum. The doctor could not rule out full SLAP tear. Assessment was right shoulder subscapularis tear and possible SLAP tear. The doctor noted that much of Petitioner's symptoms were likely related to his partial subscapularis tear but that he also may have a SLAP tear causing some of his symptoms. The recommendation was for injection, physical therapy, light duty with no lifting over 10 pounds with the right arm and no overhead use. Petitioner was injected that day into the anterior shoulder overlying the right subscapularis. Petitioner was given work restrictions, medications and ordered to follow up.

On September 15, 2015, Petitioner returned to Premier Physical Therapy for recertification. Px2. Pain was 4 out of 10 at worst. Petitioner was no longer with any resting right shoulder pain except for a short period of time after the right arm usage. Problems included right shoulder pain, tenderness to palpation, restricted right

shoulder range of motion, decreased scapular and rotator cuff strength, positive special testing, impaired functional independence/inability to perform normal work duties.

On September 16, 2015, Petitioner followed up with Dr. Schafer. Px2. The doctor noted that at the time of the last MRI scan, the doctor did not see any evidence of proximal biceps tendon rupture nor did he see any deformity on exam. However, the doctor felt that Petitioner likely ruptured his proximal biceps at the time of his original work accident on June 23, 2015. He had significant pain at the last office visit in the anterior shoulder and the doctor believed Petitioner had progressive deformity as he had retraction of his proximal biceps. It was evident on current physical exam. The doctor recommended repeating the MRI scan of the shoulder and upper arm to see the location of the tearing. The doctor noted it may have been torn at the musculotendinous junction. Petitioner was given light duty.

On September 22, 2015, a second MRI of the right shoulder, without contrast, performed at Archer Open MRI showed AC joint arthropathy with mild inferior spurring and 5 mm subcortical cyst greater tuberosity and intact rotator cuff tendons. Px2:32-33. The bicep labral anchor appeared intact and the bicep tendon was found to be within the bicipital groove. The intrascapular portion of the biceps tendon also appeared intact.

On September 30, 2015, Petitioner followed up with Dr. Schafer, who noted the second MRI did not evaluate the entire upper arm as requested thus he could not rule out rupture. Surgery was discussed. Petitioner was to restart therapy to try to rebuild strength and slowly advance to work activities as tolerated. Light duty work was continued.

On October 12, 2015, Petitioner returned to Premier Physical Therapy. Px2. He continued to tolerate more activities of daily living without any or as much right shoulder pain. Pain was 3 out of 10 at worst. Aggravating factors included lying down and right upper extremity usage. Palpation to the right shoulder exhibited mild tenderness to palpation over the AC joint and biceps. Patient problems were essentially unchanged. Additional therapy was recommended.

On October 14, 2015, Petitioner followed up with Dr. Schafer. Px2. Petitioner had no relief with therapy and a corticosteroid injection. Due to persistent symptoms, the doctor recommended surgery. The doctor explained that because Petitioner may have a rupture at the myotendinous junction, surgical results of reconstruction were less favorable if the tear was at that junction. Petitioner understood that he may have some persistent weakness and a Popeye deformity, even with appropriate surgery. On November 11, 2015, Petitioner followed up with Dr. Schafer. Px2. Assessment was right shoulder proximal biceps tendon rupture. Petitioner continued to be symptomatic despite conservative care. The doctor again recommended surgery. Petitioner was to continue with light duty. On November 18, 2015, Petitioner followed up with Dr. Schafer and recommendations were unchanged. Px2. The doctor noted Petitioner had been back to work light duty.

On December 16, 2015, Petitioner underwent and Dr. Schafer performed right shoulder arthroscopy with extensive debridement including of labral tears, rotator cuff tear as well as intra-articular adhesions, subacromial decompression and open biceps tenodesis. Px2. Post-operative diagnosis was right shoulder proximal biceps tendon rupture, significant adhesions, tears of the labrum and partial tear of the supraspinatus and subacromial impingement. Indications noted acute injury to the right shoulder and subsequent deformity in the biceps consistent with proximal biceps rupture. Risks were discussed and included, and relevant part, loss of shoulder and arm range of motion, strength, function, continued shoulder pain, continued cosmetic deformity within the biceps, re-tear of the biceps and posttraumatic arthritis. Petitioner was particularly aware of the chronic nature of the tear and of the high likelihood of some permanent cosmetic deformity within the biceps and some permanent weakness. Intraoperatively, there was extensive tearing of the labrum anteriorly, superiorly and posteriorly. There was significant fraying with a larger radial tear of the labrum. The superior labrum was severely damaged, degenerative and detached with complete detachment of his biceps. There were severe

adhesions and acute redness in the area consistent with a more acute injury or more accurately a subacute injury given the scarring present. The supraspinatus showed a partial articular sided tear estimated to cover approximately 25% of the width of the tendon. As to the subacromial space, there was bursitis, type II acromion and no evidence of adhesions.

As to the bicep, an incision was made near the anterior aspect of the bicipital groove. The tendon was much smaller than usual, and it showed atrophy from its time of this [sic] use. The tendon was able to go into the tunnel in place but there was significant tightness because of the chronicity. The bicep could not fully mobilize in a normal position and regain normal contour. Petitioner would be held for approximately six weeks in elbow flexion to help with the repair prior to mobilization given the chronicity of the tear.

On December 23, 2015, Petitioner followed up with Dr. Schafer where he was given Codman range of motion exercises to perform only. Px2. He was still not to use the elbow except as necessary for activities of daily living. Petitioner was given medications and removed from work.

On January 20, 2016, Petitioner followed up with Dr. Schafer. Px2. The plan was to begin physical therapy, home exercise range of motion exercises to help regain lost motion. There were no further motion restrictions at that time and Petitioner was allowed to wean from the sling. He was permitted to lift up to 5 pounds with the right upper extremity for therapy and as necessary for activities of daily living. He was unable to work.

On February 17, 2016, Petitioner followed up with Dr. Schafer. Px2. Significant loss of shoulder motion was noted in the doctor recommended Petitioner continue with physical therapy and an aggressive home stretching program. Medications were refilled. Petitioner remained off work. Petitioner testified he switched doctors because Dr. Schafer closed his office.

On February 12, 2016, ATI Physical Therapy progress notes indicated that Petitioner reported increased difficulty with movements and that he was currently unable to lift and carry items and continued to have mild challenges with dressing, washing hair, cooking and cleaning. Px2. He no longer wore a sling. There was increased pain at night despite repositioning. Functional limitations including bathing, caring, cleaning, dusting, washing overhead, vacuuming, sweeping, climbing ladders, crawling, donning and doffing a seatbelt, dressing, donning and doffing pants, undergarments, opening doors, overhead reaching, pushing pulling tasks, reaching into a bank machine or tollbooth and using heavy machinery and power tools. Pain was 7 to 9 out of 10 at rest and 6 to 7 out of 10 during activity. On March 4, 2016, Sedgwick's utilization review medically certified physical therapy for an additional 12 visits for the right shoulder, beginning February 17, 2016 and ending March 25, 2016. Px1.

On March 17, 2016, Dr. Brian Cole performed a Section 12 at the request of Respondent. Rx2. A history was taken, and the doctor noted that MRI showed suspicion for rotator cuff tear but given his failure to thrive, he underwent arthroscopy with rotator cuff, labral debridement and long head of the biceps tenodesis, mini open. Petitioner currently had difficulty with any use of the right upper extremity away from the body or overhead. On exam, the doctor noted significant subjective pain. Forward elevation is capable was to 120° only actively, passively to 125°, external rotation passively to 45° on the right, internal rotation on the right to the posterior hip only. He had full fluid range of motion of the left shoulder on examination for comparison purposes. There was mild Popeye deformity of the right biceps and incision from arthroscopy. Impression was right shoulder rotator cuff tendinitis, partial thickness rotator cuff tear possible, work-related aggravation a pre-existing condition, unresolved.

Dr. Cole opined that Petitioner's right shoulder condition warranted further treatment. He concluded that this treatment was related to the injury in question. He noted this was a first-time injury with no pre-

existing problem whatsoever prior to the date of injury. Petitioner had pain immediately and there was no evidence to suggest he had any need for care established prior to the date of injury. The doctor recommended subacromial cortisone injection in the right shoulder followed by appropriate physical therapy continuing with focus on scapular stabilization 2 to 3 times weekly for 6 to 8 weeks. MMI was eight weeks out. He would then be capable of full duty. In the meantime, the doctor recommended limited use of the right upper extremity with nothing overhead, nothing lifted, pushed or pulled more than 5 pounds with anticipated full duty in eight weeks. Specifically, the doctor noted that objective findings did in fact support subjective complaints. Namely, Petitioner had pain with overhead positioning which was consistent with his exam. He had pain with rotator cuff testing but no significant strength loss and this is consistent with a partial thickness or minimal to no rotator cuff tear. It was not consistent with a large rotator cuff tear injury and recommendations were non-operative.

On March 18, 2016, Petitioner underwent an initial evaluation with Dr. Ronald Silver for his right shoulder. Px1:8-11. A history was taken. On exam, active and passive motion in forward flexion were equal at 90°. Active and passive lateral abduction was to 60° and he had no internal rotation actively or passively. Impingement, Hawkins and drop arm test were all positive. Impression was post-operative frozen shoulder/adhesive capsulitis with rotator cuff impingement. The doctor noted Petitioner had done poorly despite extensive physical therapy, pain medication and anti-inflammatory medication. The recommendation was for an MRI, to continue physical therapy, medications and that Petitioner remain temporarily disabled.

On April 8, 2016, Sedgwick's utilization review found that the recommended physical therapy three times a week for six weeks for the right shoulder was not medically certified. Px1:19. The history noted that Petitioner was status post arthroscopic repair of the right shoulder rotator cuff on December 15, 2015. Postoperatively, he was diagnosed with adhesive capsulitis, having failed physical therapy and other non-operative treatment. The current recommendation was for a repeat MRI and then a surgical release of the shoulder, yet the request was for additional physical therapy. The review noted that Petitioner failed physical therapy and no rationale was provided for why additional physical therapy would be indicated. Therefore, it was determined medically unnecessary. That same date, Vision Laboratories collected urine sample and toxicology results showed results inconsistent with the prescribed medication Tramadol but consistent with Hydrocodone use. Px3.

On April 16, 2016, Petitioner's third MRI of the right shoulder performed at MRI Lincoln imaging Center showed supraspinatus and infraspinatus signal abnormality from tendinopathy, status post biceps tendon surgery with residual bony edema and deltoid muscle tiny intramuscular lipoma. Px1:12. The findings were separated by rotator cuff, labrum & biceps tendon and coracoacromial arch.

On April 20, 2016 Petitioner followed up with Dr. Silver. Px1. Dr. Silver interpreted the most recent MRI as showing persistent inflammation of the rotator cuff consistent with clinical findings of rotator cuff impingement and post-operative frozen shoulder/adhesive capsulitis. The doctor recommended arthroscopic surgery with lysis of adhesions and possible further decompression and immediate use of continuous passive motion machine post operatively due to severe frozen shoulder. Petitioner remained temporarily disabled.

On April 26, 2016, ATI issued its progress note for Petitioner. Px1. Petitioner had participated in 40 sessions of skilled physical therapy and was demonstrating improved functional range of motion and strength in the right upper extremity. Petitioner was currently working full-time on light duty. The plan was to have Petitioner finished with physical therapy in transition work conditioning/hardening to address functional strength and activity tolerance to allow for safe return to full duty work. Petitioner related that he took pain medication at night because that is when it bothers him the most. Pain was located in the front of the shoulder. Quick movements of the arm caused pain. He had trouble reaching for things but was able to do it with pain. The pain came and went. Pain at rest was 4-5 out of 10, during activity, 7-8 out of 10. On exam, active range of motion with shoulder flexion was to 140°, with shoulder extension to 57°, with shoulder abduction to 127° and

internal rotation was from thumb to base of the sacrum. Regarding joint mobility, Petitioner continued to demonstrate hypomobility with inferior and posterior glides. There was continued tenderness upon palpation to the right proximal biceps, supraspinatus tendon insertion and upper trap.

On April 28, 2016, Dr. Silver indicated he was still awaiting approval for revision arthroscopic surgery of the right shoulder for adhesive capsulitis with rotator cuff impingement. Px1:4-5. Exam continued to show active and passive motion in forward flexion were equal at 90°. Active and passive lateral abduction was to 60° and he had no internal rotation actively or passively. Impingement, Hawkins and drop arm test were all positive. Pain was 8/10 and Petitioner could barely sleep. Pain was 5/10 with medications. The doctor related this to the work injury. The doctor noted Petitioner continued to demonstrate active and passive motion and forward flexion to 90° with lateral abduction actively and passively to 60° with no internal rotation actively or passively. Petitioner was taken off work.

On May 15, 2016, Petitioner was discharged from therapy. Rx1, Rx4:2. Petitioner conveyed his shoulder was feeling okay, that he took pain medication at night as that is when it bothered him the most and pain was located in the front of the shoulder.

On May 26, 2016, Petitioner was re-evaluated by Dr. Cole. Rx3. The doctor reviewed records from Dr. Silver regarding the suspected frozen shoulder with adhesive capsulitis. According to Dr. Cole, on exam, the right shoulder was nearly within normal limits. Petitioner maintained only mild impingement signs with pain in the sub deltoid region with overhead positioning with Neer and Hawkins impingement maneuver. Rotator cuff strength in abduction and adduction was full, 5/5 against resistance. Dr. Cole found that the new MRI from April 2016 showed rotator cuff tendinitis only. There was no frank full thickness tear. Impression was resolved right shoulder pain after nonoperative management of a work-related injury, at MMI. The doctor continued to maintain his prior diagnosis. Dr. Cole found that Petitioner's treatment was causally related to the injury in question and that opinion had not changed. The doctor found that the arthroscopic surgery recommended by Dr. Silver was not medically necessary nor causally related to the accident. Dr. Cole reasoned that Petitioner had improved, could work full duty with no restrictions and did not warrant surgical management. Regarding medications, the doctor opined that Petitioner could use over-the-counter medications only and does not need prescriptions by Dr. Silver. The doctor concluded that Petitioner had reached maximum medical improvement.

On October 2, 2017, Petitioner presented for re-evaluation with Dr. Cole at the request of Respondent. Rx4. Subjectively, Petitioner reported the right shoulder was doing well overall. He was tolerating full duty work fine. He had not pursued any further care of the right shoulder. Impression/assessment was right shoulder at MMI, residual subjective discomfort after a prior work-related injury treated arthroscopically with debridement, subacromial decompression and biceps tenodesis. The doctor did not recommend anything further in terms of care. Petitioner was fully capable of full duty work noting that Petitioner may be left with some mild impairment from strength and pain standpoint but overall had done well with the nearly full recovery. The doctor opined that Petitioner could substitute over the counter medications as alternatives with equal efficacy and more cost effective compared to what was previously prescribed. Dr. Cole continued to maintain that revision arthroscopic right shoulder surgery was not necessary. He noted Petitioner was not pursuing further care and that he was satisfied with his condition as is and was capable of full duty work.

On October 2, 2017, Dr. Cole issued an AMA impairment rating. Rx5. The doctor diagnosed tendinitis and used the lower half of the class category, which was 1-5% as it was equal to labral lesion and bicep tendon categories. Regarding functional history adjustment, QuickDash score was 43 indicating moderate level of self-perceived subjective impairment. The doctor gave a modifier of 2 noting it corresponded well with Petitioner's level of independence. Regarding physical examination adjustment, Petitioner had mild-moderate findings including mild strength loss and rotator cuff provocation, subjective discomfort with positioning the arm overhead and no measurable atrophy in the upper extremity. There was mild motion loss in both internal and

external rotation of 10 to 20°. Findings on exam were most consistent with the grade modifier 1. Regarding clinical studies adjustment, prior MRI did demonstrate some changes at the biceps proximally and glenoid labrum, which defaulted to a grade modifier of 2. The net adjustment resulted in grade E resulting in a right upper extremity impairment rating of 5% or 3% whole person.

On May 8, 2018, the parties took the evidence deposition of Dr. Brian Cole. Rx1. The doctor testified consistent with his reports. When asked whether it was his opinion that Petitioner was over prescribed pain medication throughout his treatment, the doctor had no opinion. On cross-examination, the doctor stated that he could not recall if he reviewed a job analysis report. The doctor agreed Dr. Schaefer's diagnosis leading up to his March 2016 exam. Dr. Cole agreed that at the time of his March 2016 exam, he did in fact notice a mild Popeye deformity in the right bicep. He said that it could be due to biceps treatment at the time of surgery leading to sagging of the biceps. He was asked whether this was a separate injury apart from the shoulder pathology, but doctor responded only that "in our initial treatment he had the biceps treated by Dr. Schafer." *Id.* at 23:3-6. The doctor testified that the biceps tenodesis procedure would be done open near the armpit and would be a separate incision apart from the arthroscopic holes. Regarding the Popeye deformity, it would have been located in the anterior arm, which he said was part of the shoulder. *Id.* at 24:1-6. Dr. Cole categorized the bicep rupture as a cosmetic issue and that the rupture was a "surgical-induced entity." *Id.* at 25. The doctor testified that it would not have made a lot of sense to perform arthroscopy and subacromial decompression separate from the biceps procedure. The doctor clarified that the Popeye deformity came about from the biceps procedure that was done surgically as a cosmetic deformity only. The deformity very minimally affected strength or weakness.

The essential functions and required physical demands for a GTM fleet mechanic submitted by Petitioner indicated that such a worker would be responsible for the preventative maintenance of PBC delivery trucks, forklifts and all other moving equipment and for the diagnosis and repair of PBC delivery trucks, tractors, trailers, forklifts and all other moving equipment. Px2:51-64. Lifting and pulling frequencies or occasionally anywhere from 5 pounds as high as 65.4 pounds. Reaching above the shoulder was performed occasionally.

As to his current complaints, regarding his shoulder, Petitioner testified that he has right shoulder pain. Regarding his bicep, Petitioner testified that he has pain when he has to push or pull and that it goes into a cramp. He said his chest feels cramping pain, indicating his right chest wall from his shoulder into his breast. Petitioner testified that there is a deformity in his right arm on the bicep. He said his muscle is rolled downward and that it bothers him because he has to pay a lot of attention when he has to lift or push. Petitioner still works in his pre-injury job for Respondent as an automobile mechanic. Petitioner admitted to being able to work his pre-injury job in a full duty capacity without complaint, complication or accommodation. Petitioner admitted that the accident has caused no adverse impact on Petitioner's earning capacity. Petitioner admitted that he did not have the second right shoulder surgery recommended by Dr. Silver because he was not interested in having it. Petitioner further admitted that he currently has no interest or intention of having the second surgery recommended by Dr. Silver.

CONCLUSIONS OF LAW

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator finds Petitioner's testimony was credible. Having considered all evidence, 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 right shoulder proximal biceps tendon rupture, labral tear, partial tear of the supraspinatus and subacromial impingement are causally related to his undisputed work accident. In so finding,

the Arbitrator relies on the history given by Petitioner has to his mechanism of injury and the fact that he credibly testified he had no prior issues with his right arm or shoulder. Further, the Arbitrator adopts the opinions of Drs. Schafer and Cole, both of whom causally related Petitioner's condition(s) and injuries to the work accident. Based on the foregoing and on the record as a whole, the Arbitrator concludes that Petitioner's aforementioned condition(s) are causally related to his work accident.

The causation dispute in this case is whether Petitioner's condition of ill-being also resulted in or should include frozen shoulder/adhesive capsulitis. Petitioner began treating with Dr. Silver in March 2016, having testified that his old doctor's office closed. Dr. Silver diagnosed Petitioner with adhesive capsulitis and shoulder impingement. He based this conclusion on his findings on initial exam and on the third MRI. However, Dr. Silver's findings and conclusions are not supported by other evidence. First, utilization review correctly pointed out that while Dr. Silver alleged failure of post-operative care, including physical therapy, he nonetheless recommended that Petitioner undergo physical therapy, without further explanation. Second, ATI records during this time demonstrate near opposite physical exam findings, subjective complaints and objective conclusions when compared to the findings Dr. Silver made. Px1:25-36; *Cf.* Px1:4-5. Third, his interpretation of the third MRI was that it was consistent with adhesive capsulitis, yet the MRI report concluded findings were consistent with tendinopathy. Fourth, while Dr. Silver recommended a revision arthroscopic surgery for the right shoulder, Petitioner testified that he was never interested in having that surgery because he knew he did not need it; moreover, Petitioner confirmed that he has no intention or interest in ever pursuing additional right shoulder treatment and/or surgery. Finally, Dr. Cole, in the Arbitrator's opinion, correctly found that Petitioner's adhesive capsulitis was not related to the work accident. Rx1. Based on the foregoing and on the record as a whole, the Arbitrator concludes that Petitioner's adhesive capsulitis, if it existed, is not causally related to his work 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?

The Arbitrator incorporates the foregoing findings of fact and delusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator finds that Respondent has not yet paid all appropriate reasonable and necessary medical charges for Petitioners causally related right shoulder and arm injury. Petitioner alleged outstanding medical charges for ATI Physical Therapy, Vision Laboratories, Infinite Strategic Innovations and Rx Development. Ax1, Px4.

As to the ATI Physical Therapy charges, the Arbitrator finds that this treatment was rendered pursuant to the recommendations of Dr. Schafer. Px2. This treatment consisted of post-operative care following surgery that was reasonable and necessary to treat Petitioner's shoulder and bicep condition(s). The bills submitted correspond to dates of service contained in the medical record. Dr. Cole found Petitioner's treatment to be reasonable and related to his accident. Utilization review found therapy with ATI medically necessary. Therefore, Respondent shall pay reasonable and necessary medical services of **$870.43**, as provided in and subject to 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. Rx7.

As to the Vision Laboratories, Infinite Strategic Solutions and Rx Development charges, the Arbitrator notes that these prescriptions and drug testing were rendered pursuant Dr. Silver's treatment protocol. The bills submitted correspond to dates of service contained in the medical record. As of May 2016, Cole's opinion was that although he disagreed with Dr. Silver's diagnosis and recommendation for further surgery, he agreed that treatment had been related to Petitioner's work accident. Dr. Cole further concluded that Petitioner could use OTC medications only and that he did not need the medications prescribed by Dr. Silver. Dr. Cole testified that he had no opinion as to whether the Petitioner was over-prescribed pain medication throughout his treatment.

Rx1:18. The Arbitrator agrees with the opinion of Dr. Cole that Petitioner did not need the medications prescribed by Dr. Silver. Dr. Silver's recommendations were made pursuant to his opinion that Petitioner had impingement and adhesive capsulitis, which is not supported by the record. Petitioner did not provide any testimony as to the benefit, if any, of the prescribed medications. Although Dr. Cole did not opine Petitioner was over-prescribed medications, the record does not support such a need where there was insufficient evidence of impingement and adhesive capsulitis. Therefore, the Arbitrator finds these prescriptions and related charges as excessive and unnecessary and neither Respondent nor Petitioner shall be liable for same.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as a fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits as a result of his work-related injuries. Beginning on August 19, 2015, Petitioner was given light duty work restrictions by Dr. Schafer. Px2. However, Petitioner only seeks TTD benefits beginning on September 16, 2015. Ax1. Records show that on September 16, 2015 and continuing through December 15, 2015, Dr. Schafer gave Petitioner light duty work restrictions. Px2. Dr. Schafer's records demonstrate Petitioner was in fact working light duty during this time, noting that Petitioner "has been back to light duty work as a mechanic." Px2:14. Petitioner provided no contrary evidence as to this fact nor gave any explanation why he should be entitled to TTD during this time. The Arbitrator adopts Dr. Schafer's records on this issue.

Beginning December 16, 2015 and continuing through March 16, 2016, Petitioner was taken completely off work following his surgery by either Drs. Schafer or Silver. Px2. Petitioner credibly testified that he returned to work after March 16, 2016. Based on the foregoing, Respondent shall pay Petitioner temporary total disability benefits of **\$963.62/week** for **13-1/7th weeks**, commencing **December 16, 2015** through **March 16, 2016**, as provided in Section **8(b)** of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **December 16, 2015** through **March 16, 2016** and shall pay the remainder of the award, if any, in weekly payments. Against this award, Respondent shall be given a credit of **\$14,760.64** for temporary total disability benefits that have been paid.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as a fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator find that Petitioner reached maximum medical improvement on May 15, 2016, which is the date he was discharged by ATI Physical Therapy. He has not sought treatment since that time for his right arm and shoulder. Therefore, any claims for permanency, if any, disability are ripe for adjudication.

At trial, Petitioner specifically indicated that he was seeking an award for his rotator cuff injury under Section 8(d)(2) and seeking a determination of an award for his bicep injury under Section 8(e)(10). Petitioner's counsel asserted that Petitioner's injuries resulted in a torn rotator cuff injury with bicep muscle injuries and a Popeye deformity. Petitioner argues that the bicep, anatomically speaking, is not part of the shoulder.

In looking to evidence presented by Respondent, Dr. Cole testified that the Popeye deformity was part of the shoulder. Dr. Cole also testified that the proximal bicep rupture was addressed during the same operation but utilized a separate incision located near the armpit whereas the rotator cuff injury and subacromial decompression was address arthroscopically via the portals. Dr. Cole issued an AMA impairment rating of 5% for the upper extremity, noting the biceps rupture. The Arbitrator notes that the AMA Guides assign a diagnosis of a distal biceps rupture to the elbow regional grid and assign a diagnosis of a biceps tendon

dislocation/subluxation to the shoulder regional grid. Dr. Cole did not testify the biceps is anatomically part of the arm or shoulder. The Arbitrator concludes that the medical findings, conclusions and opinions of Dr. Cole fail to adequately or persuasively address whether the proximal biceps tendon rupture in this case is or could be anatomically different than the shoulder.

In looking to evidence presented by Petitioner, treatment records showed that Dr. Schafer found that while he could not appreciate a bicep rupture on initial exam, he noted Petitioner had significant pain in the anterior *shoulder* [emphasis added]. He believed Petitioner had progressive deformity as he had retraction of his proximal biceps and thus recommended a repeat MRI of the shoulder and *upper arm* [emphasis added] to visualize the location of the tearing. Px2. The doctor noted it may have been torn at the musculotendinous junction. Anatomically, Dr. Schafer noted the second MRI showed that the bicep labral anchor appeared intact and the bicep tendon was found to be within the bicipital groove. The intrascapular portion of the biceps tendon also appeared intact. Physical therapy records discuss tenderness in the biceps with palpation of the *shoulder* [emphasis added]. Px2. When surgery was recommended, Dr. Schafer discussed a possible Popeye deformity if the tear was at the myotendinous junction. The doctor did not specify which tendon and muscle (junction) he was referring to. At the time of surgery, Dr. Schafer's intraoperative findings described the arthroscopic procedure and the open bicep tenodesis procedure separately. However, during the arthroscopic procedure, Dr. Schafer visualized a complete detachment of the biceps and performed a debridement of the biceps stump. The open portion of the surgery was described as a suprapectoral biceps tenodesis. Post-operatively, Dr. Schafer did not make recommendations to the shoulder and bicep separately but rather generally prescribed physical therapy for the shoulder. Further, physical therapy records did not describe symptoms or limitations separately by shoulder or biceps. Dr. Schafer advised the Petitioner to expect "some permanent loss of strength due to the Popeye deformity of the bicep muscle. Px2:2. The Arbitrator concludes that the medical findings, conclusions and opinions of Dr. Schafer fail to adequately or persuasively address whether the proximal biceps tendon rupture in this case is or could be anatomically different than the shoulder.

Petitioner's complaints in the medical record showed he complained of pain anteriorly and radiating down to his elbow. It was aching, constant but occasional with sharper pain, particularly with overhead stretching and activities. He described pain at night but did not specify the location of the pain. At the time of his last exam with Dr. Schafer, there was no evidence of swelling or deformity of the right shoulder, including the tenodesis site. He had only mild loss of range of motion. Regarding his shoulder, Petitioner testified that he has right shoulder pain. Regarding his bicep, Petitioner testified that he has pain when he has to push or pull and that it goes into a cramp. He said his chest feels cramping pain, indicating his right chest wall from his shoulder into his breast. Petitioner testified that there is a deformity in his right arm on the bicep. He said his muscle is rolled downward and that it bothers him because he has to pay a lot of attention when he has to lift or push. The Arbitrator concludes that Petitioner's complaints as contained in the medical records, as well as his testimony, fail to adequately or persuasively demonstrate different, separate or distinct disability as to the biceps tendon rupture.

Neither party presented case law addressing Petitioner's argument. The Arbitrator can find no case directly on point. There are awards under Section 8(e)(10) for solely distal bicep injuries. *Lakin v. City of Evanston*, 11 WC 2950, 12 IWCC 1243 (Nov. 15, 2012) (distal full thickness bicep rupture); *Kazun v. A Finkl & Sons Co.*, 04 WC 1769, 08 IWCC 0946 (Aug. 8, 2008) (distal biceps tendon); *Santoria v. State of Ill. Dept. of Transp.*, 03 WC 26164, 07 IWCC 0579 (May 14, 2007) (distal bicep tear).

Likewise, there are awards under 8(e)(10) for unspecified (i.e. neither proximal or distal) biceps tendon injuries. *Nelson v. Ameren UE*, 04 WC 30466, 10 IWCC 0075 (Jan. 28, 2010) (unspecified bicep tendon tear, where it was noted claimant's partial rotator cuff tear did not predispose him to tearing the bicep tendon and where the tendon was noted to be completely pulled away from the bone); *Stumpf v. Sara Lee Baking Co.*, 04 WC 17515, 61193, 08 IWCC 0703 (Jun. 13, 2008) (unspecified bicep tendon tear with repair but where pain

was at the elbow and detachment at the radial tuberosity); *Booker v. Ford Motor Co.*, 02 WC 62276, 06 IWCC 0511 (Jun. 14, 2006) (unspecified biceps rupture with credit given for prior left arm awards noting no evidence given as to what part of the arm those injuries were sustained).

The Arbitrator found one award under Section 8(e)(10) for solely proximal bicep injury. See, *Hood v. Hypac Div., a United Dominion Co.*, 94 WC 24818, 95 IIC 856 (Jul. 25, 1995) (15% for "proximal biceps tendon rupture, right shoulder.")

None of these decisions address specifically or find that the award was necessarily dependent on whether the injury to the bicep was distal or proximal. The Appellate Court has noted, however, that "proximal" can refer to the shoulder specifically or can merely refer to the "nearest" to the point of attachment of a specific body part. *Dorsey v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 143044WC ¶ 20. In *Dorsey*, the appellate court affirmed the decision of the Commission, which reversed the Arbitrator's man as a whole award under 8(d)(2) for claimant's distal biceps tendon injury and instead awarded the claimant under 8(e)(10) for his distal bicep injury where the overwhelming evidence noted that his injury occurred near the elbow.

Based on the foregoing, the Arbitrator finds Petitioner failed to carry his burden as to the question he presented regarding whether his proximal biceps tendon rupture and resultant Popeye deformity is anatomically different than the shoulder. The Arbitrator concludes that the most appropriate way to address Petitioner's permanency for the biceps and cuff injuries is via Section 8(d)(2) and to award a singular global finding. Consistent with the Act, the Arbitrator considers the following factors:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 5% for the right upper extremity or a 3% whole person impairment as determined by Dr. Cole, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. Rx5. Dr. Cole did not give a separate rating for the biceps rupture. The Arbitrator notes that while Dr. Cole appears to have correctly and reasonably addressed all possible diagnoses, 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 therefore gives ***lesser*** weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner was employed as a mechanic at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. As of the date of trial, Petitioner continued to be employed in that same capacity. The Arbitrator notes Petitioner's job description or essential demand functions. The Arbitrator therefore gives ***some*** weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 57 years old at the time of the accident. Petitioner's advanced age and his expected shorter work-life expectancy is noted. The Arbitrator therefore gives ***some*** weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner testified his earning capacity has not been impacted as a result of his work accident. Therefore, the Arbitrator therefore gives ***no*** weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the aforementioned regarding Petitioner's treatment records and his subjective complaints noted both in the record and at trial. The Arbitrator finds that Petitioner's disability as to his right shoulder, arm and biceps is adequately supported by the treatment records. The Arbitrator therefore gives ***greatest*** 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 **11.5%** loss of use of **man as a whole** pursuant to § **8(d)(2)** of the Act.

Signature of Arbitrator

10-9-2018
Date

STATE OF ILLINOIS	)
	) SS.
COUNTY OF COOK	)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LARISSA WILLIAMSON,

Petitioner,

19IWCC0553

vs. NO: 15 WC 11470

STATE OF ILLINOIS – STATEVILLE 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 issue of the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact

Petitioner was a correctional officer for Respondent. She sustained a stipulated accident on April 12, 2012 while transporting a prisoner in the University of Illinois Hospital. The inmate was in shackles that were being held by Petitioner. He began to fall, Petitioner tried to stop him from falling, and felt a jerk in her arm and neck.

Petitioner had a round of physical therapy and two epidural steroid injections for both cervical and shoulder conditions. On December 19, 2012 she came under the care of Dr. Sweeney. Dr. Sweeney diagnosed cervical radiculopathy, stenosis, and intractable pain after six months of conservative treatment. He recommended three-level laminectomy/foraminectomy at C3-4, C4-5, and C5-6, which he eventually performed on January 27, 2014.

Petitioner continued to have significant symptoms post surgery. A post-surgical cervical MRI performed on October 6, 2014 showed right-sided protrusions at C4-5 and C5-6 which deformed the cord and which "should impinge on the ventral nerve roots at C5 and C6 nerve roots," and a two millimeter protrusion at C3-4. She had more physical therapy for both her cervical and shoulder conditions. Eventually, Dr. Sweeney diagnosed adhesive capsulitis of her right shoulder, residual cervical complaints post surgery, and occipital neuritis associated with the cervical condition. As Petitioner's condition did not improve, Dr. Sweeney discussed with her possible three-level cervical fusion surgery, but Petitioner was reluctant and eventually declined to proceed with the additional surgery.

Dr. Sweeney referred Petitioner to Dr. Patel for pain management. She first saw him on January 2, 2015. He treated her with numerous injections and medications, most notably Norco and Gabapentin. She continued to treat with Dr. Patel. The last treatment note from Dr. Patel was on May 18, 2018, and Petitioner testified at arbitration that she continued to treat with Dr. Patel on a monthly basis.

Dr. Sweeney ordered a Functional Capacity Evaluation ("FCE"), which was performed on June 17, 2015. The FCE placed Petitioner in the sedentary to light physical demand level with the ability to lift 12.6 pounds occasionally for a four-hour work day. Her job as correctional officer was rated at the medium physical demand level. On July 22, 2015, Petitioner and Dr. Sweeney discussed the FCE results, Dr. Sweeney administered an injection in the right shoulder and restricted her to a four-hour work day.

At Respondent's request, Dr. An examined Petitioner on September 15, 2017. He also noted that he previously examined her on July 22, 2014 and January 17, 2017. Dr. An's prior reports were not submitted. He noted Petitioner had underlying cervical spondylosis which was aggravated by the work injury. Dr. An's "recommendation was that she gets conservative treatment including pain management, functional capacity evaluation for sedentary to light duty work." In his instant report, Dr. An noted that Petitioner continued to treat with Dr. Patel multiple times since his last examination. Nevertheless, her pain persisted without significant improvement.

Dr. An noted that currently Petitioner reported 8/10 neck pain and 5/10 arm pain. Dr. An found tenderness and reduced range of motion. He noted that an MRI showed degenerative disc disease C4-6 with some disc protrusion and foraminal stenosis. Her pain in the shoulder and arm corresponded to her right C5-6 radicular symptoms. He did not find any evidence of symptom magnification or malingering. Dr. An summarized that Petitioner had pre-existing cervical spondylosis and degenerative disc disease, which was aggravated by the work accident and worsened her condition beyond its normal progression. Her subjective complaints corresponded with the objective findings and her current complaints related to the work accident. All treatment she received to date had been reasonable.

Dr. An outlined possible options. The first was to continue pain management and find employment within the restrictions indicated in the FCE, which was around 13 pounds. However, if the pain was significant and worsened a reasonable alternative would be anterior discectomy/fusion C4-5 and C5-6. If she did not have the surgery she was at maximum medical improvement. On January 9, 2018, Dr. An issued an addendum report in which he clarified his prior recommendation was that Petitioner could work with a 13-pound restriction for a full eight-hour workday.

Respondent hired a vocational rehabilitation counselor, Tracy Peterlin. On June 13, 2017, Ms. Peterlin issued her initial evaluation. She noted that the diagnoses were laminectomy/foraminectomy C3-4, C4-5, and C5-6, right shoulder pain/rotator cuff tendonitis, and referred cervical pain. She outlined the FCE results and Dr. Sweeney's restrictions. She indicated that Petitioner had some experience in customer service, clerical work, in data entry, as a cashier, that she had some basic computer knowledge, though she did not have a home computer, and that she had "some college experience." Ms. Peterlin also outlined Petitioner's responsibilities to spend 30-40 hours in the job search, make 15-20 contacts/job applications, and have at least two in-person meetings a week. She explained Petitioner's responsibilities to her.

The 18th and last vocational rehabilitation report was dated March 12, 2018. Ms. Peterlin found Petitioner in overall compliance with her assigned tasks. However, in one report she noted that Petitioner had to be more aggressive in follow up. In one report she noted that Petitioner had two job opportunities but it did not work out because of work hours. Finally, in the 17th and penultimate report, Ms. Peterlin noted that Petitioner was not 100% compliant because "to date she has failed to follow through on three interview opportunities provided by" Ms. Peterlin. She also noted that she postponed an interview until she was able to consult with her lawyer and did not attend a job fair.

Petitioner also employed a vocational rehabilitation counselor, Carl Triebolt. Mr. Triebolt issued his report on April 9, 2018. He noted that Petitioner sustained an injury to her right shoulder and neck which also affected the use of her arms. She last worked on April 3, 2012. He reviewed the FCE, Section 12 reports of Dr. An, and apparently the reports of Respondent's vocational rehabilitation counselor. He noted that the FCE had Petitioner rated at the light physical demand level with additional limitations of a four-hour workday, limitations on duration of siting/standing, use of hands, and neck positioning.

Mr. Triebolt noted that Dr. An opined that Petitioner could work eight-hour workdays with lifting restrictions of 13 pounds. Dr. Sweeney restricted her to four-hour workdays with no lifting over 10 pounds. Petitioner's only relevant work experience was as a correctional officer. Mr. Triebolt also seemed to question the efficacy of the vocational services provided by Respondent's counselor. Mr. Triebolt concluded that based on the FCE, Petitioner's age, education, and work experience, she would be limited to part-time unskilled employment and there was no stable labor market.

Conclusions of Law

In arriving at his award of loss of 275 weeks of permanent partial disability benefits representing loss of the use of 55% the person-as-a-whole for her cervical/shoulder injury, the Arbitrator gave substantial weight to Petitioner's occupation because she was not able to return to her prior job. He gave substantial weight to her age (42) because she would have to live with her disability for a prolonged period of time. He also gave substantial weight to being limited to working four hours a day with a 13-pound restriction which would likely affect her future earning capacity. Finally, the Arbitrator gave great weight to Petitioner's disability corroborated by the records, noting the records of Dr. Sweeney and Dr. Patel as well as the FCE report supported Petitioner's claim of disability. Even though he placed substantial weight in all these aggravating factors, the Arbitrator found that "she was not so injured that she is obviously unemployable" and the vocational evidence did not convince him that she was unemployable under the restrictions imposed by Dr. Sweeney pursuant to the FCE. "Thus, the substantial §8(d)2 is made."

Basically, the Commission agrees with the analysis of the Arbitrator. We agree that Petitioner proved substantial permanent impairment/disability, we agree with the Arbitrator that Petitioner should be restricted to a four-hour workday per the FCE and Dr. Sweeney's restrictions rather than the eight-hour day recommended of Dr. An, and we agree that Petitioner had not sustained her burden of proving that she is odd-lot permanently and totally disabled from working under the criteria established under *National Tea*. On this issue, Ms. Peterlin noted that Petitioner had "some college experience," which we find contributed to the development of some skills transferable to possible employment. Ms. Peterlin also noted that Petitioner had not followed through on three interview opportunities that she had provided. These factors are in conflict with Petitioner's assertion that she was permanently unemployable. Nevertheless, the Commission has a different view than the Arbitrator regarding how the statutory factors affect Petitioner's ultimate degree of disability.

The Arbitrator gave substantial weight to Petitioner's relatively young age (42) and he gave substantial weight to the extent of her restrictions and potential loss of future income. The Commission places greater weight on those factors than did the Arbitrator. In the context of her restrictions and future earning capacity, the Commission notes the failure of Respondent's vocational rehabilitation to find any employment for Petitioner despite nine months of effort and overall compliance by Petitioner in the job-search effort. Based on the statutory factors in §8.1b(b) and the entire record before us, the Commission finds that an award of 375 weeks of permanent partial disability benefits representing loss of the use of 75% of the person-as-a-whole is appropriate in this case and the Commission modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated March 12, 2019 is hereby modified but otherwise affirmed and adopted and attached to this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $10,500.04 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISISON pay Petitioner permanent partial disability benefits of $695.78 for 375 weeks because the injuries sustained the loss of 75% of the use of the person-as-a-whole as provided in §8(d)2

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

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

DATED: OCT 10 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-9/18/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0553

WILLIAMSON, LARISSA
Employee/Petitioner

Case# **15WC011470**

ST OF IL-DEPT OF CORRECTIONS
Employer/Respondent

On 3/12/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
MARTHA A NILES
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAR 12 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Larissa Williamson
Employee/Petitioner
v.
State of Illinois-Dept. of Corrections
Employer/Respondent

Case # 15 WC 011470

An *Application for Adjustment 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 **10/11/2018 and 11/7/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/13/2012**, 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 **$58,860.00**; the average weekly wage was **$1,131.92**.

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

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

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

To date, Respondent has paid **$115,349.00** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of **$115,349.00** for TTD, **$0** for TPD, **$99,613.54** for maintenance, and **$0** for other benefits, for a total credit of **$214,962.54**. The Parties agreed that all TTD and maintenance benefits had been paid through the date of the first hearing.

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 $10,500.04, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78 per week for 275 weeks, because the injuries sustained caused the 55% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner all compensation benefits that have accrued from 4/13/2012 to 11/7/2018 in a lumpsum and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

March 11, 2019
Date

MAR 12 2019

FINDINGS OF FACT

Petitioner, Larissa Williamson, was employed by Respondent as a correctional officer at Respondent's Stateville Correctional Center. She had been so employed since 1996. (PX 8)

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on April 13, 2012. She was escorting an inmate into a van when the inmate tripped and fell, which caused Petitioner to fall also. The inmate was in cuffs and was chained to other inmates, with a lead chain of 3 feet in length hooked to his back. The inmate fell face forward and Petitioner grabbed the lead chan hard. She was jerked almost to the ground. She felt pain in her right shoulder and neck. Petitioner reported her injury to Lt. Cross.

Petitioner first treated with Dr. Wimol Mitrakul, her PCP, who recommended physical therapy. (PX 1) She received steroid injections from Dr. John Hong, a pain specialist. On December 19, 2012, Petitioner presented to Dr. Patrick Sweeney, a spine surgeon. Dr. Sweeney eventually recommended a C3-4 and C4-5 laminotomy with foraminotomy. (PX 3) During this time, Petitioner also complained of right shoulder pain, and underwent a right shoulder and c-spine MRI on August 26, 2013. The shoulder study showed mild subdeltoid bursitis, no rotator cuff tear, and borderline capsular thickening of the acromioclavicular joint. The c-spine MRI showed DDD, worse at C4-5 and C5-6. (PX 3)

Petitioner underwent cervical surgery on January 27, 2014. The procedure also involved C5-6. (PX 3) She had post-surgical complaints of pain and stiffness of the right shoulder, received another injection, and was referred to physical therapy. She did not have a good recovery and continued under Dr. Sweeney's care through October of 2015. (PX 3)

Petitioner had another cervical MRI on October 7, 2014. (PX 4) It showed that right-sided protrusions at C4-5 and C5-6 deform the cord and should impinge on the ventral right C5 and C6 nerve roots. It also showed a right C3-4 protrusion. (PX 4) Petitioner had an EMG on October 10, 2014. (PX 6) It was said to be normal regarding right cervical radiculopathy and right upper extremity neuropathology. (PX 6) On January 2, 2015, Petitioner presented to Dr. Udit Patel, a pain specialist. (PX 7) He prescribed Gabapentin and Norco for her several times over the years, most recently in May 2018. (PX 7)

On June 17, 2015, Petitioner underwent a functional capacity evaluation. (PX 1) The evaluator found that Petitioner could work at a sedentary to light physical demand level. She is limited to occasional lifting of 12.6 lbs., from floor to chair, chair to desk and overhead, working a 4-hour workday, sitting for up to 60 minutes at a time, standing for 15 minutes at a time, and walking 3-4 hours during the workday in frequent, short distances. (PX 1) On October 8, 2015, Dr. Sweeney declared Petitioner to be at MMI with a permanent 10 lbs. lifting restriction and a 4 hour workday. (PX 3)

In June of 2017, Respondent retained Creative Case Management to assist Petitioner in a guided job search. (RX 1) The voc counselor, Tracy Peterlin, MS, CRC, LPC,CCM , applied the restrictions contained in the FCE, described above, and met with Petitioner and her attorney to discuss duties and responsibilities. Petitioner attended 18 vocational sessions with the CCM counselor. The working diagnosis was: S/P cervical laminectomy/foraminotomy, C3-C4, C4-C5 and C5-C6 (1/27/2014), right shoulder pain, rotator cuff tendinitis, referred pain from cervical spine. Petitioner was mostly compliant with the rehabilitation program, however the counselor noted a few times when Petitioner failed to follow through with interviews. In Report #12, Peterlin noted that Petitioner scheduled an interview with Office Team, but cancelled the interview and never rescheduled. Also, in Report #12, It was noted that Help at Home was able to accommodate Petitioner's restrictions and was awaiting her job application, but that Petitioner never applied. Later reports document compliance by Petitioner. The last report was #18, dated March 12, 2018. There was no final report submitted. (RX 1)

On September 15, 2017, Petitioner was seen for an IME by Dr. Howard An, an orthopedic surgeon. (RX 2) He had previously examined Petitioner and had opined that Petitioner's pre-existing cervical DDD condition was aggravated by her work injury. (PX 3) Dr. An opined: "I do recommend that she is able to work at the present time with the same restrictions that was [sic] given by FCE around 13-pounds lifting." (RX 2) Dr. An did not address the workday length restriction until a January 9, 2018 addendum, in which he said Petitioner could work "8 hours per day with no lifting greater than 13 pounds." (RX 2)

As of February 8, 2018 (CCM Report #16), Peterlin began incorporating Dr. An's conclusion that Petitioner could work an 8 hour workday. There is no evidence that Dr. Sweeney was consulted on this issue. (RX 1) On Report #17, the counselor noted that Advanced Physicians was interested in scheduling an interview with Petitioner, but that Petitioner did not follow up. Also on that report, the counselor noted another interview

was set up with Office Team and Petitioner declined to attend. At trial, Petitioner testified that CCM did not arrange any job interviews for her. Petitioner did not develop any interviews on her own. She received no job offers.

On April 9, 2018, Petitioner underwent a vocational evaluation at the request of her attorney with Carl R. Triebold, MS, CRC, LCPC, of Triebold and Associates. (PX 8) The evaluator examined the June 2015 FCE, the IME from Dr. An, and the 18 vocational reports produced by CCM. He opined that Petitioner would only be able to work a sedentary position, and not a sedentary-to-light duty position. He concluded that "a steady labor market is not available for Ms. Williamson." (PX 8)

Petitioner testified that she continues to suffer the effects of the injury. It is hard for her to sit. She has numbness in her hands. She has stiffness. She has difficulty with ADL's and recreational activities that she used to participate in. She takes Gabapentin at night. She takes Norco two times per day and uses 5% lidocaine patches.

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d).

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)

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

Dr. An's opinion that Petitioner can work an 8 hour day, in contradiction to the FCE and the opinion of Dr. Sweeney is found to be not persuasive. The FCE's restrictions, endorsed by Dr. Sweeney, are found to be correct

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS:

The Average Weekly Wage is $1,131.92.

Petitioner claimed an AWW of $1,275.00. Respondent claimed that the AWW is $1,131.92. (ArbX 1)

Neither Party provided a wage audit, setting forth the actual earnings of Petitioner in the employment during the 52 weeks preceding the date of injury, as is required by §10 of the Act.

Petitioner relies on what was identified as PX 4 at the November 7, 2018 hearing, subpoenaed employee records from Stateville, with an "Employer Statement", documenting that Petitioner's monthly salary was $4,969.00 on the last day she worked.

Respondent relies upon RX 4, a "Summary of Disability", which shows that in the year preceding the injury, Petitioner made $4,873.00 per month for the first 8 months and $4,969.00 per month for the remaining 4 months. These numbers yield an AWW of $1,131.92. Respondent's document best complies with the terms of §10 and is relied upon by the Arbitrator in his finding on the issue of AWW.

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:

Petitioner claimed $120,356.55 in bills, per ArbX 1 and her bills exhibit, PX 9.

The bills exhibit contained many paid bills and the same are not awarded. Further, the exhibit contains a bill in the amount of $3,740.00 from Hinsdale Orthopedics for services rendered in September of 2018. There

was no testimony regarding this treatment and there were no supporting medical records submitted. Happily, it does appear that the bills were paid by Respondent.

The awarded bills are as follows: Gateway Spine & Pain Physicians: $5,475.04 (Dos: 8/23/2012 and 9/18/2012). These charges appear to be for injections provided by Dr. Hong and are found to be reasonable and necessary and causally related to the injury.

Pain & Spine Institute of Joliet: $5,025.00 (Dos: 5/18/2018; 4/20/2018; 3/30/2018; 5/13/2015 and 3/11/2015). These charges appear to be causally related to the injury and are found to be reasonable and necessary to cure or relieve the effects of the injury.

Total Amount awarded: $10,500.04

The bills are awarded pursuant to §§8(a) and 8.2 of the Act. Respondent is entitled to a credit fpor all awarded bills that it has paid.

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

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

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a corrections officer at the time of the accident and that she is not able to return to work in his prior capacity as a result of said injury. This factor is given substantial weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. This factor is given substantial weight in determining PPD, as Petitioner will likely have to live a long time with the effects of the injuries.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner's future earnings capacity is severely limited due to her injuries. She is limited in her work time to 4 hour days and limited to weight restrictions of less than 13 pounds. This factor is also given substantial weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner has had a bad result from the surgery that she underwent in an attempt to remedy her injury. Dr. Sweeney's records, the FCE and those of Pain & Spine support Petitioner's claims of disability. This factor is given great weight in determining PPD in this case.

Based on the above factors, and the Record taken as a whole, the Arbitrator finds that, as a result of the injuries sustained, Petitioner suffered permanent partial disability to the extent of 55% loss of use of a person as a whole pursuant to §8(d)2 of the Act.

The Arbitrator declines to find that Petitioner is entitled to a §8(f) PTD award. She is not so injured that she is obviously unemployable. The vocational evidence does not convince the Arbitrator that Petitioner cannot obtain employment within the restrictions of the FCE and as endorsed by Dr. Sweeney. Thus, the substantial §8(d)2 award is made.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRYSTAL PYZDROWSKI,

Petitioner,

19IWCC0554

vs.

NO: 16 WC 30168

SPEEDWAY,

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, causation, temporary total disability, medical, 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 clarifications noted below.

The Arbitrator found "causal connection for Petitioner's neck, right shoulder, right arm and left knee contusion complaints through December 14, 2016. Petitioner's condition thereafter is not causally related to her accident of 9/6/16." We clarify that we find the opinion of Dr. Levin to be persuasive in that, relative to the right shoulder, Petitioner only sustained a contusion, which resolved by December 14, 2016. This is most consistent with the relatively benign MRI findings. We also clarify that, although Petitioner was diagnosed with cervicalgia and cervical radiculopathy, there is no persuasive medical opinion (in light of the cervical MRI showing no compressive lesions) of an anatomical basis to find a cervical cause of Petitioner's symptoms. We find that Petitioner sustained a temporary cervical injury, which resolved by December 14, 2016. Finally, we clarify that Petitioner failed to prove that her continued complaints after that date were causally related to any work-related shoulder or cervical condition because of the benign results of the objective studies along with the nonphysiologic complaints Petitioner had in response to some of Dr. Levin's tests.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 11, 2017, is hereby affirmed and adopted with the clarifications 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.

Bond for the 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 1 1 2019

Maria E. Portela

Thomas J. Tyrrell

L. Elizabeth Coppoletti

SE/
O: 8/27/19
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PYZDROWSKI, CRYSTAL
Employee/Petitioner

Case# **16WC030168**

19IWCC0554

SPEEDWAY
Employer/Respondent

On 10/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW INGOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

- [ ] 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

Crystal Pyzdrowkski
Employee/Petitioner
v.
Speedway
Employer/Respondent

Case # **16 WC 30168**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed out to each party. The matter was heard by the Honorable **Carolyn Doherty** Arbitrator of the Commission, in the city of **Kankakee** on **August 15, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **09/06/16**, 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 her employment.

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

Petitioner's condition of ill-being ***is*** causally related to the accident through December 14, 2016. SEE DECISION.

In the year preceding the injury, Petitioner stipulated average weekly wage was $288.75.

On the date of accident, Petitioner was **31** 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.

ORDERS

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the treatment of her causally related conditions through December 14, 2016 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

Respondent shall pay Petitioner temporary total disability benefits of $288.75/week for 14- 2/7 weeks, commencing September 6, 2016 through December 14, 2016 pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid, if any.

Respondent shall pay Petitioner $288.75 per week for 15 weeks in that Petitioner sustained 3 % loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act. SEE DECISION

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

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

Carolyn M. Doherty
Signature of Arbitrator

10/5/17
Date

OCT 11 2017

FINDINGS OF FACT

At trial, the 31 year old Petitioner testified that she began working for Respondent Speedway in August 2016 as a cook and a customer service representative. Her responsibilities included making break and lunch sandwiches, cleaning the store, making coffee and cashier work. Petitioner testified that she prepared the food in the back room at a prep station using supplies from the freezer and refrigerator following instructions on how to prepare the food. Petitioner worked a shift from 5 am to 1 pm.

On September 6, 2016, Petitioner was at work prepping sandwiches and then carrying trays of sandwiches from the kitchen to the warmer at the front of the store. As such, she was required to leave the kitchen area through a doorway. Petitioner testified that she normally carried the sandwiches in a bin which was 2 to 4 inches deep and 12 inches long by 6 to 8 inches wide. Petitioner testified that while carrying some sandwiches to the front of the store, she slipped and fell on "something slippery on the floor" at the entry door to the back room on September 6, 2016. Petitioner testified that she fell and struck her right shoulder and arm on the security door handle immediately feeling pain in her right shoulder and arm.

RX 1 is a video depicting Petitioner's fall. The parties agree that there are more cameras in the store aside from the camera from which RX 1 was taken. Petitioner asserts the other cameras show different areas of the back stock room toward the outside door as well as the door handle Petitioner alleges that she struck during the fall. Petitioner testified that through her work at the store she is aware there is another security camera that shows a 360 degree view of the whole stock area.

The Arbitrator viewed RX 1 in its entirety. RX 1 depicts a video taken from a camera mounted in what appears to be a back office set behind the kitchen and positioned to view only a portion of the office and mainly at the small doorway between the office and the kitchen area. The camera faces the doorway out into the kitchen. The Arbitrator notes that the video depicts the office door as open with a portion of the door (the hinged area) clearly visible at the lower left side of the video. The door extends out into the kitchen area and the door handle is not visible. The video does not depict a door or doorway from the kitchen to the main part of the store where the warmer is located.

Petitioner is intermittently on camera seen working at a kitchen counter preparing food. The video activity was condensed from approximately 10 minutes down to a little over 1 minute so Petitioner is depicted moving at great speed. At 6:10 am on 9/6/16, Petitioner is depicted holding small items in her left hand while walking around the kitchen counter corner and past the open office door. At that point Petitioner is seen slipping, falling slightly to the right and slightly forward, landing on her knees and then immediately holding her right arm in obvious pain while kneeling on the ground. Petitioner is then seen walking into the back office where she testified she became sick from nausea in the garbage can. At trial, Petitioner testified that the video did not show the door handle she struck because of the location of the camera. The Arbitrator notes that the video depiction of Petitioner's fall is generally consistent with Petitioner's testimony at trial regarding the nature of her fall.

Notice is not in dispute. ARB EX 1. Petitioner testified that her supervisor Kim sent her to Medcore and from there Petitioner was sent to Riverside Hospital. Petitioner testified that her husband was close by so he drove her rather than Petitioner taking an ambulance. Petitioner testified that she was given medication to control the nausea as well as pain medication. Petitioner reported that she slipping at work and striking her right shoulder on a door handle and falling on her knees. She complained of right clavicle pain. She denied head injury, LOC or pain anywhere else. PX 3. Petitioner reported being unable to straighten out her right arm due to pain and

had good sensation to her right hand and fingers. The right shoulder x-ray history indicates that Petitioner fell into a door knob on "right proximal humerus." Right shoulder x-rays were negative Petitioner testified that her pain radiated from her right shoulder up to her neck region and down her forearm to her hand and that she was unable to move her right shoulder. Petitioner testified that she also reported headaches and bruising of the interior of her left knee which she testified hit the floor during the fall. Petitioner was discharged under a diagnosis of right shoulder sprain and was sent home with a sling and ibuprofen. PX 3.

Petitioner presented to her primary care doctor, Dr. Waheed at First Care Family Clinic on September 9, 2016. PX 2. The history noted by Dr. Waheed suggests that Petitioner was involved in a fall at work and that she injured her right shoulder and arm as well as sustained bruising on her knee. Petitioner presented for a follow up per the ER. Dr. Waheed noted her complaints of severe right shoulder and right arm pain and noted soft tissue injury as well. Petitioner denied any other areas of pain. Dr. Waheed noted that the Petitioner was in a right arm sling. He requested that the Petitioner follow up with him after a week under a diagnosis of pain in the right shoulder. He provided Petitioner with medication and opined that the Petitioner is unable to work for 1 week. Petitioner followed up with Dr. Waheed on September 19, 2016 at which time the Petitioner was still experiencing pain and difficulty with range of motion in the right arm. Dr. Waheed during this visit continued to keep Petitioner off of work and recommended that the Petitioner start physical therapy. He indicated he would refer to a specialist if the symptoms did not improve. PX 2.

Petitioner started attending physical therapy at ATI Physical Therapy on 9/22/16. PX 7. Petitioner reported a consistent history of accident, injury and symptoms at ATI. The ATI initial evaluation of September 22, 2016 notes a history that Petitioner is experiencing popping in her shoulder and tingling from her neck down to the finger tips. Petitioner attended physical therapy at ATI on September 23, 2016. At that time it was noted that Petitioner reported worse pain after the visit the day before but "today the swelling and pain are consistent." Petitioner performed poorly at PT on 9/23/16 and reported increased symptoms to her right arm.

Petitioner testified and the medical records reflect that after the physical therapy appointment on September 23, 2016, Petitioner presented to the ER at Riverside Medical Center complaining of neck and right shoulder pain. PX 3. The ER medical records note that the Petitioner's pain is being made worse by physical therapy that extends up to her neck and down in her hands. She is experiencing intermittent tingling and limited range of motion. The Petitioner at the ER denied any new injury. The ER medical records indicate that Petitioner reported, "while at physical therapy today they were maneuvering her neck and right shoulder and felt an electric shooting pain through her neck and down her arm. She states her arm has since gone numb and she's nauseous and dizzy." At the ER the Petitioner was given instructions for cervical radiculopathy and told to follow up with Dr. Waheed.

Petitioner followed up with Dr. Waheed the same day on September 27, 2016 at which point Dr. Waheed noted that the Petitioner was following up from the ER where she complained of pain radiating from her neck to her arm as well as right arm pain and neuropathy. He also noted Petitioner was having headaches. The diagnosis was now right shoulder pain and cervicalgia. He advised Petitioner to get a cervical MRI and an EMG of the right upper arm. He also noted "neurologist as directed." Dr. Waheed once again took the Petitioner off of work.

Petitioner was discharged from physical therapy on September 27, 2016 with the records from that date noting the Dr. Waheed put PT on "hold" pending an MRI and EMG. PX 7. Petitioner followed up with Dr. Waheed on October 3, 2016. At that time Dr. Waheed noted that the Petitioner is scheduled to see a neurologist on Monday. Dr. Waheed continued to recommend an MRI of the Petitioner's cervical spine and an EMG and

continued to keep the Petitioner off of work stating that a "return to work will be determined after the test results and neurologist examination." PX 2.

Petitioner testified and the medical records reveal that at the recommendation of Dr. Waheed, Petitioner saw Dr. Blair Rhode, an orthopedic doctor on 10/7/16. Petitioner testified that Dr. Blair Rhode is a doctor that the Petitioner previously treated with for a right knee injury. The history noted by Dr. Blair Rhode indicates that Petitioner presented for consultation of right shoulder pain and neck pain. The records note that the patient slipped and fell on a slippery floor on September 6, 2016 while she was carrying a tub. She sustained a direct impact to the side of her right shoulder with a jarring to her cervical spine. She states that she developed sudden onset of numbness and tingling to the thumb, index and long finger. Petitioner continued to experience lateral shoulder pain with radiation to the cervical spine. After conducting a physical examination Dr. Rhode diagnosed Petitioner with shoulder pain, neck pain, rotator cuff strain, AC ligament strain and cervical radiculopathy. Dr. Rhode opined that Petitioner sustained a right shoulder and cervical injury secondary to a slip and fall while at work. She sustained a direct blow to her right shoulder as well as cervical injury. Dr. Rhode noted that the Petitioner demonstrated right sided cervical radiculopathy and diffuse shoulder pain. Dr. Rhode recommended that the Petitioner undergo an MRI of her cervical spine and right shoulder and kept Petitioner off of work. PX 5.

Petitioner underwent a cervical spine and right shoulder MRI on 10/19/16. PX 4. The cervical MRI revealed mild disc degeneration without focal disc herniation or significant canal or foraminal encroachment and patent central canal and foramina throughout. The right shoulder MRI revealed no rotator cuff tear, mild rotator cuff tendinitis, and mild ac joint degeneration accompanied by acromial spur and somewhat laterally sloping acromion with supraspinatus abutment. PX 4.

Petitioner presented to Dr. Rhode on October 21, 2016 at which point Dr. Rhode continued to diagnose Petitioner with cervical radiculopathy, rotator cuff strain and AC joint ligament strain. PX 5. Dr. Rhode noted that on physical exam Petitioner continued to demonstrate positive Spurling's sign, positive shoulder impingement and pain with palpation over the AC joint. He ordered continued PT. Petitioner declined an injection on that date and was told to follow up in 4 weeks. Petitioner continued PT at ATI. PX 7.

The Arbitrator notes that at the request of the Respondent Petitioner attended a Section 12 exam with Dr. Jay Levin on November 14, 2016. Dr. Levin opined that Petitioner's medical records are consistent with Petitioner sustaining a contusion to the right shoulder from the occurrence of September 6, 2016 accident. Dr. Levin opined that the Petitioner's condition should have been resolved within 0-21 days post injury. Dr. Levin was of the opinion that the Petitioner does not require any further treatment as a result of the accident of September 6, 2016. Dr. Levin during the physical examination of the Petitioner found a negative AC joint exam and a negative rotator cuff exam. Dr. Levin noted that the Petitioner had a negative drop arm cast, apprehension test and impingement maneuver. He read the October 2016 cervical MRI to show normal age appropriate study with mild degenerative changes and no disc herniations and the right shoulder MRI as showing cuff tendinopathy. RX 2. He noted that Petitioner described "right upper extremity is numb which goes through multiple dermatomes and is not consistent with any referred cervical etiology based upon review of the anatomical findings on MRI of the cervical spine." He further noted that Petitioner's first cervical complaints were 17 days after the accident. RX 2. Dr. Levin noted a right shoulder contusion and no evidence of a cervical injury from the medical records immediately following the accident. He noted some Waddell findings as well on exam. RX 2. No additional treatment was needed in his opinion.

Petitioner next followed up with Dr. Rhode on December 1, 2016 at which point Dr. Rhode injected Petitioner's right sub acromial space with Kenolog and Lidocaine. Dr. Rhode advanced Petitioner to modified duty at this visit. Petitioner was to follow up in 4 weeks. However, Petitioner followed up with Dr. Rhode's physician's assistant on December 14, 2016 who noted that Petitioner "wished to return to duty despite her persisting symptoms. Petitioner was "advanced to full duty" and told to follow up in 4 weeks "for possible MMI."

Petitioner testified that after being off of restrictions, Petitioner worked as a CNA at a place called Aperion in December 2016. However, Petitioner testified that she attempted full duty work at Aperion but was unable to perform work at a full duty capacity.

The Petitioner next followed up with Mark Bordick, Dr. Blair Rhode's PA, on January 11, 2017 at which point Mr. Bordick noted that the Petitioner continued to experience problems noting that "she does not feel capable of continuing full duty due to patient safety." Petitioner was placed back on modified duty. It was further noted that Petitioner was scheduled to attend an IME (although already attended) and that she was to follow up with Dr. Rhode thereafter to review the IME.

Dr. Rhode had the opportunity to review the Independent Medical Evaluation of Dr. Levin. Dr. Rhode after reviewing the Independent Medical Evaluation of Dr. Levin opined on 1/16/17 that in reference to the diagnosis of a shoulder contusion he somewhat finds this to be a vague diagnosis. He noted that "we as orthopedic surgeons typically prefer to isolate the foci of the pathology from single event injury. With reference to the shoulder this typically is an injury to the rotator cuff, AC joint or labral structures. In this patient the patient primarily demonstrates AC and rotator cuff symptomatology. She has been treated conservatively for these conditions. We have attempted modified duty as well as full duty return as typical treatment algorithms would dictate. Unfortunately, we are in a situation where the patient was unable to return to her full unrestricted position secondary to persistent symptomatology. I would appreciate some input from the IME physician as to what our next steps should be. Should we force the patient to continue to work in full unrestricted fashion? Should we continue with our conservative course and place the patient at a modified duty and restart physical therapy? Should we consider a repeat injection? I would emphasize that not all patients fit neatly into treatment algorithms and require some fine-tuning of treatment paradigms. We will await the input from the IME physician and continue to treat the patient." PX 5.

On 1/18/17 Dr. Rhode recommended an EMG of the right upper extremity. The EMG done on 2/14/17. The report indicates that to the extent the study was completed the results were normal and it was noted that "the patient became light headed and sick and therefore EMG study was discontinued at that point." PX 8.

After the EMG, Petitioner followed up with Dr. Rhode on February 24, 2017. Dr. Rhode continued Petitioner's restricted duty. Dr. Rhode noted Petitioner was status post an EMG, with no specific comment on the EMG, and opined Petitioner demonstrated "some findings consistent with thoracic outlet." PX 5. Petitioner next presented to Dr. Blair Rhode's PA, Mark Bordick, on April 7, 2017 at which point Mr. Bordick released Petitioner at full duty. Mark Bordick noted that Petitioner was to follow up with Dr. Blair Rhode in 4 weeks to consider MMI. The Petitioner followed up with Mark Bordick on May 5, 2017 at which point Petitioner reported less pain but continued periodic tingling. Petitoiner was continued on full duty. Petitioner was subsequently seen by Dr. Rhode on June 5, 2017 at which point Dr. Rhode noted that the Petitioner continues to experience numbness from the shoulder to the hand and that the Petitioner has lost grip. Dr Rhode continued to note a positive impingement sign and pain with palpation over the AC joint. Dr. Rhode released the Petitioner full duty at a point of maximum medical improvement with as needed follow up. PX 5.

The evidence deposition of Dr. Levin was taken on March 14, 2017. RX 2. Dr. Levin testified that Petitioner reported taking breakfast sandwiches to the warming location and while holding the sandwiches in her hand she slipped on something on the floor. Petitioner stated that she hit her right side on a metal fire safe door fell to the floor striking her right and left knee on the floor. Petitioner reported immediate bruising and swelling in her right shoulder and pain down her right arm and shoulder. Petitioner reported seeing Dr. Waheed and starting PT. At the time of the Section 12 exam, Petitioner had seen Dr. Rhode and underwent MRI's of the cervical and right shoulder. Petitioner reported numerous complaints of right arm weakness and pain down the right arm with numbness in her fingers. She complained of pain at the base of her neck and into the right trapezial area with constant cervical spine and right shoulder complaints. Dr. Levin performed numerous tests to the cervical region and right shoulder and arm to determine any objective pathology in either area. The tests were negative. However, the Hoover testing for non organic pathologies was positive.

Dr. Levin testified that he reviewed the cervical MRI of October 2016 which he determined showed age appropriate degenerative changes. Minimal tendinits was shown in the shoulder MRI of the same date. Dr. Levin opined that Petitioner had no objective findings to support her subjective complaints. He opined she suffered a right shoulder contusion and no injury to her neck noting that her cervical complaints were not consistent with any cervical etiology based upon the anatomical findings and the cervical MRI. He also noted the first cervical complaints were 17 days after the accident.

On cross exam. Dr. Levin testified with regard to the cervical. "I do not have an anatomical diagnosis based upon any compressive lesion in the cervical spine form the MRI of the cervical spine or any anatomical fining in the MRI of her right shoulder which would support those two areas as being the source of her numbness in isolation to the clinical complaints she's making." RX 2, p. 48. When asked if he could explain the source of Petitioner's pain radiating down her neck into her arm and fingers. Dr. Levin stated, "not from the MRI of her cervical spine. And from historical information. I can't explain the cervical spine injury from the occurrence of September 6, 2016 independent of the MRI findings that was done on the cervical spine based upon the lack of any localizing symptoms to the cervical spine following the trauma." P. 51. He saw no evidence of a compressive change in the neck to which the referred pain could be attributed. He agreed with Dr. Rhode's assessment of rotator cuff sprain as not being unreasonable. P. 55. Tendinosis could be associated with a rotator cuff sprain. However he did not agree with the AC joint ligament strain diagnosis as not supported by the MRI or physical exam findings. P. 56.

Petitioner testified that after being released by Dr. Rhode, Petitioner has not followed up with any doctor. Petitioner testified that she continues to take over the counter medication for pain and for numbness and tingling. As to present physical symptoms, Petitioner testified that she continues to experience pain, numbness and tingling that starts with her neck and radiates all the way to her fingers. Petitioner testified that she feels pain when she is engaged in movements that are below head. Petitioner testified that as soon as she raises her arm overhead she starts having numbness and tingling in her neck all the way into her fingers. Petitioner testified that she is constantly dropping things with her right hand and is having difficulty in grabbing things and lifting weight. Petitioner testified that she is right hand dominant. Petitioner testified that before the accident she was able to engage in all activities but is severely limited after the accident. Petitioner testified that she does not believe that she can go back to being a CNA, the kind of work that she was performing before she was employed at Speedway and before the accident. Petitioner testified that she attempted to work as a CNA at Aperion but was unable to perform work as a CNA. Petitioner testified that she has 3 young children and due to her complaints with regards to her shoulder and neck is unable to engage in activities that she was able to engage in with them before this accident. Petitioner testified that she continues to take over the counter medication ibuprofen and Tylenol.

The Petitioner denied any prior problems with her right shoulder and right neck. Petitioner did acknowledge that she has a partial extensor tendon tear into her right arm that she was treated for 2 or 3 years before the accident. Petitioner testified that she did not have any ongoing treatment with regards to her right arm before the accident.

CONCLUSIONS OF LAW

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

(c) Did an accident occur that arose out of and during the course of Petitioner's employment with the Respondent?

Based on a preponderance of the credible evidence at trial, including the credible testimony of Petitioner buttressed by the accident video and the medical histories provided, the Arbitrator finds that Petitioner sustained and accident arising out of and in the course of her employment with Respondent on 9/6/16. Petitioner testified that she was at work preparing food in the kitchen and had to regularly carry the sandwiches out of the kitchen to the warmer in the front of the store. There is no dispute that the kitchen is not open to the public. The video depicts Petitioner carrying sandwiches in her left hand, walking around a kitchen counter and then suddenly and clearly slipping on the floor of the kitchen. Petitioner testified that she slipped on something on the floor which caused her to fall. Her testimony regarding a substance on the floor is not rebutted. The video further depicts Petitioner falling slightly forward and then immediately holding her right arm in obvious pain. The Arbitrator is not deterred in this finding of accident by the fact that the video does not depict the door handle on which Petitioner testified she struck her arm. The video was taken from a camera that did not have full view of the area and Petitioner's testimony is supported by the initial treating records sufficiently documenting the accident and mechanism of injury. Accordingly, the Arbitrator finds that Petitioner sustained an accident on 9/6/16. Notice of the accident was not in dispute.

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

With regard to causal connection for Petitioner's condition of ill-being, the Arbitrator notes that the medical records repeatedly reflect a consistent history of a work related accident/fall on 9/6/16. Based on a review of those medical records, including all of the diagnostic testing, and considering the opinion of Dr. Levin, the Arbitrator finds that Petitioner's conditions of ill-being in her right shoulder and arm, neck and a left knee contusion are causally related to the accident of 9/6/16. The fact that Petitioner's first neck complaints came at the first physical therapy visit on 9/22/16 is not a sufficient delay on which to base a denial of causal connection for the neck complaints. Petitioner actively and conservatively treated for her neck, right shoulder and right arm symptoms, including a right shoulder injection, from September 2016 through December 14, 2016. Petitioner's treatment was appropriately conservative given the negative cervical MRI and the tendinitis shown on the right shoulder MRI from October 2016. Thereafter, on December 14, 2016, Petitioner asked to return to full duty work, despite her testimony that her symptoms continued. Petitioner was in fact released by Dr. Rhode's office to return to full duty. Although Petitioner returned to Dr. Rhode's office in January 2017, she did not receive any additional treatment for her condition other than a diagnostic EMG which was also negative. Petitioner had no treatment documented for her left knee contusion. Accordingly, the Arbitrator finds causal connection for Petitioner's neck, right shoulder, right arm and left knee contusion complaints through December 14, 2016. Petitioner's condition thereafter is not causally related to her accident of 9/6/16.

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

Respondent's dispute on medical expenses was based on liability. ARB EX 1. Based on the Arbitrator's findings on the issue of causal connection through December 14, 2016, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the care and treatment of her causally related injuries through December 14, 2016 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

(K) What temporary total benefits are in dispute?

Based on the Arbitrator's findings on the issue of causal connection through December 14, 2016, and on the off work or modified duty notes in the treating records through that period, the Arbitrator finds that Respondent shall pay Petitioner TTD for a period of 14-2/7 weeks commencing September 6, 2016 through December 14, 2016 pursuant to Section 8 (b) of the Act at the AWW of $288.75. Respondent shall receive credit for amounts paid.

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

Pursuant to 820 ILCS 305/8.1(b) the Arbitrator finds the following factors in considering the Petitioner's nature and extent of the injury in this case:

1. The reported level of impairment pursuant to an AMA assessment.

The Arbitrator notes that there has been no AMA assessment performed in this case by either party. Therefore, this factor is given no weight.

2. The occupation of the injured employee. 3. The age of the employee at the time of the injury was 31. 4. The employee's future earning capacity.

The Arbitrator notes that the 31 year old Petitioner at the time of the accident was working at Speedway as a clerk. Petitioner testified that she has been working as a CNA for a majority of her life. Petitioner testified that she does not believe that she is able to perform a job as a CNA due to her condition. However, there was no further evidence submitted at trial to support this assertion. The Arbitrator notes that Petitioner is 31 years old and has been released by her treating physician at full duty. There is no evidence to support Petitioner's testimony that she is unable to return to the type of work she did for Respondent or as a CNA. The Arbitrator finds that Petitioner did not sustain any loss of future earning capacity as a result of this accident. These factors are given no weight.

5. The evidence of disability corroborated with the treating physicians' medical records.

The Arbitrator notes that when the Petitioner saw Dr. Rhode's office in December 2016 she received a right shoulder injection. Two weeks later, she continued to have complaints of right shoulder, arm and neck problems and at the time she was returned to work "despite her persisting symptoms." Petitioner testified that she had difficulty returning to work as a CNA and physically performing those duties due to symptoms of pain, numbness and tingling in her neck and down her right arm which she testified continue today. She has no

currently scheduled treatment and is taking over the counter medication as needed. The Arbitrator places greater weight on this factor.

Based on the evidence at trial and on the record as a whole, the Arbitrator finds that Petitioner sustained no permanent partial disability as a result of her left knee contusion and awards no benefits for the left leg. With regard to Petitioner's neck and right shoulder conditions, the Arbitrator finds that Petitioner sustained 3% loss of use of a person as a whole pursuant to Section 8(d)(2) of the Act. The Arbitrator makes no separate right arm award under Section 8(e) of the Act as such an award is not supported by medical records documenting a right arm problem separate from the right shoulder diagnosis or its sequelae.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUDY STAMBAUGH,

Petitioner,

19IWCC0555

vs.

NO: 15 WC 33305

HERTZBERG NEW METHOD, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, and prospective medical care, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident, as explained below, but attaches the Decision of the Arbitrator, which is made a part hereof, for the factual findings with the modifications noted below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

The Commission finds that Petitioner has proven that her bilateral shoulder injuries arose out of and in the course of her employment. We initially address some confusing aspects about the evidence in this case. The first is the timing of Petitioner's bilateral shoulder complaints because some of the records and medical opinions indicate that Petitioner's left shoulder pain started in December 2014. We find that this is not the case. We also note there is some confusion about the right versus left shoulder in the records.

Petitioner testified that her right arm pain began after working on a "huge order" in December 2014. *T.16-18.* When she first saw her primary care physician, Dr. Peterson, on January 20, 2015, her chief complaint was "bil arm pain" but the focus of that record was the right arm, wrist, and shoulder. *Px1.* On examination, Petitioner had tenderness over the lateral epicondyle and biceps tendon groove, right greater than left. This record states Petitioner had pain in her right arm since Christmas and, "The

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last two weeks there has been a special order and the books are heavier and the arm has gotten worse." Dr. Peterson diagnosed "pain, arm" and "epicondylitis, lateral humeral." *Px1*. Physical therapy was prescribed but these records are not in evidence. We note that Petitioner's Application for Adjustment of Claim alleges "right & left shoulder" injuries but does not allege epicondylitis of the elbow and there is no medical causation opinion specifically related to the elbow.

On February 20, 2015, Petitioner underwent an x-ray of the right shoulder, which showed mild degenerative changes. On February 26th, Dr. Karolyn Senica's note indicates a "chief complaint" of *left* shoulder pain but the remainder of the note refers to the *right* shoulder. Dr. Senica's impression was *right* shoulder pain and *right* shoulder impingement for which she could not rule out rotator cuff pathology. She administered an injection in the *right* shoulder. *Px3*. We find that the one reference by Dr. Senica to left shoulder pain on this date was an error. We further find that, at the time of this visit, Petitioner's complaints were to the right shoulder, which is consistent with her testimony.

On April 2, 2015, Dr. Senica wrote that Petitioner's right shoulder was "markedly better" after the corticosteroid injection and that Petitioner's pain was "livable or tolerable at this point." On examination, Petitioner's right shoulder range of motion was "symmetric to her uninvolved, left side, without pain." This reference to the "uninvolved, left side" also supports our finding that Petitioner's left shoulder was not a significant problem at that time. Dr. Senica's impression was "resolved" right shoulder pain and impingement although she could still not rule out a rotator cuff pathology.

We note that Petitioner never had an MRI of the right shoulder and those symptoms resolved after one injection. There is no current recommendation for any further right shoulder treatment. Therefore, we find that Petitioner's right shoulder injury resolved.

Petitioner testified that she continued to perform all of the same work activities between December and May, and when she returned to Dr. Senica on May 12th, her complaints related more to her left shoulder. *T.21*. This is supported by Dr. Senica's note, which indicates a complaint of left shoulder pain for "approximately the past month." Dr. Senica administered a steroid injection in Petitioner's left shoulder since she had good results from the previous right shoulder injection.

The correspondence and some of the testimony of Dr. Barry Werries is confusing because Petitioner's attorney kept referring to Petitioner's *right* shoulder as having the rotator cuff tears and needing surgery. Dr. Werries responded accordingly and continually referenced the "right shoulder." However, Dr. Werries' treating records clearly indicate that he was treating Petitioner's *left* shoulder. This discrepancy was eventually clarified during Dr. Werries' second deposition.

There is also significant confusion throughout the records about the "top shelf" from which Petitioner retrieved boxes of books. Initially, Petitioner's attorney told Dr. Werries that it was 84 inches from the ground, which is impossible because Petitioner is only 4'11" tall. This fact was later corrected to indicate that it was the third shelf (50 ¾ inches off the ground) that was at issue. Dr. Werries indicated that this did not affect his opinion because it was still overhead reaching for Petitioner. This "top shelf" issue is also relevant, however, because Respondent's Job Analysis Report (Rx3) indicates that Petitioner "never to rarely" removes books from the top shelf because it is 73 inches high. Respondent's Section 12 physician, Dr. Luke Choi, relied on this report in formulating his opinion that Petitioner's work activities did not contribute to her rotator cuff tears because she "rarely" performed work at shoulder level or overhead. *Rx2 at 10, 15, 24.*

We next address the Job Analysis Report, which we find does not accurately reflect Petitioner's work activities. Petitioner testified that 50% of her shift involves lifting books off of shelves and that 25% of the lifting was from the top shelf. *T.25-26, 36-37.* Mr. Jim Beavers, Respondent's Shipping Supervisor, testified that 35 to 40% of Petitioner's job involves lifting books off of shelves with 10 to 15%, on average, being lifted from the top shelf; although this could increase to 30% if there was a large order. *T.52-59.* We find that the variations in the percentages between the testimony of Petitioner and Mr. Beavers are minimal and overall are consistent with one another. We find that a large portion of Petitioner's job involves lifting books off of shelves and that a significant amount of the time this is done from the top shelf.

In contrast, the Job Analysis Report indicates that Petitioner, "Never to Rarely obtain[s] trays of books from top storage/staging shelves at 73". Employee is 4'11" tall." *Rx3.* As mentioned above, this "top shelf" issue is important because Petitioner is not claiming that she was obtaining books from the "top shelf" (at 84 inches) but, rather, from the "top shelf" on which books were stored. This shelf was between 50 and 51 inches high. As can be seen in the photos contained in *Px10*, this "top shelf" is higher than Petitioner's shoulder level. The Job Analysis Report also states for "Shoulder Level" reaching, Petitioner "Rarely obtains boxes from boxes to check, moves boxes of books from shelves above waist/chest height." We find that this is simply inaccurate. Petitioner's testimony and that of Mr. Beavers indicate that Petitioner reaches up to remove trays of books from that top shelf between 10 and 30% of the time. Whether it is closer to the 25% that Petitioner stated or the 10 to 15% "on average" that Mr. Beavers claimed, these are both significantly more than the "rarely" that is indicated in the Job Analysis Report.

We are further reluctant to find Respondent's Job Analysis Video (Rx4) persuasive because of Petitioner's testimony that the video does not accurately depict what she does in a typical shift and it does not show her taking any of the boxes off of the top shelf even though Petitioner had demonstrated that activity to the person taking the video. *T.29.* In light of the testimony of Petitioner and Mr. Beavers, along with the clearly inaccurate Job Analysis Report, we find that the video does not accurately reflect Petitioner's job duties. However, even without depicting the particular task of removing books from the top shelf, we find that the video does show Petitioner performing numerous activities involving the conveyer belt with her arms at and above shoulder level since Petitioner is only 4'11" tall.

Focusing on specific aspects of the Decision, the Arbitrator states, "Both Dr. Werries and Dr. Choi agreed that Petitioner's left rotator cuff tears could be explainable based solely on the age of Petitioner and the degenerative process." *Dec. 6.* In fact, Dr. Werries specifically opined that Petitioner's work activities *did* contribute to her rotator cuff tears. On cross-examination, he explained that age "makes you more susceptible to it" because of "the vascularity at that region makes it susceptible to tearing." *Px8 at 25-26.* Later, he agreed that the tears seen on the MRI could be asymptomatic or symptomatic and they can become symptomatic based on the natural progression of the degenerative condition or from activities of daily living. *Id. at 26-27.* However, that was not actually his opinion in Petitioner's case.

In contrast, Dr. Choi's opinion is confusing and not at all persuasive. He is apparently of the opinion that Petitioner's work activities did not contribute to her left shoulder condition because the findings on the MRI were chronic, it was a preexisting condition, there was no specific trauma, and

that people get rotator cuff tears as they age. Specifically, he opined that "repetitive overhead activities will not cause a rotator cuff tendon tear." *Rx2 at 25*. On its face, this is inconsistent with hundreds of previous Commission decisions and case law. Furthermore, he opined that Petitioner would have developed a rotator cuff tear regardless of her overhead work activities. *Id. at 28*. The question, however, is whether Petitioner would have developed a rotator cuff tear at the exact same point in her life? Or, did her work activities hasten that in any way? We find that Petitioner's work activities did hasten that condition of ill-being. Dr. Choi admitted that "theoretically" overhead activities could contribute to a rotator cuff tear "but not any more than what an individual would do from normal activities, such as washing their hair or lifting for things in a refrigerator level or grabbing things overhead." *Id. at 25*.

It appears Dr. Choi believes that theoretical repetitive overhead lifting could contribute to a rotator cuff tear but not in reality, because people also perform overhead activities in their normal daily activities. We find this wholly unpersuasive. If Petitioner's job involves a significant amount of overhead lifting then the mechanism that can "theoretically" cause a rotator cuff tear would likely cause that tear sooner than it would have if Petitioner did not perform that job. In other words, it is a frequency question. We also note that Dr. Choi never fully addressed or disputed Dr. Werries' statement about the microtrauma impingement that is caused by the mechanical irritation of the acromion on the rotator cuff as Petitioner removed the trays from the top shelf. Again, we find Dr. Choi's opinion unpersuasive.

It is axiomatic that Respondent takes Petitioner as it finds her. In this case, she is a 66-year-old, 4'11" tall woman. She has been working at Respondent for 50 years and since 2000 has been performing a job that requires what we find to be significant "at or above" shoulder level work. Perhaps Petitioner is susceptible to rotator cuff tears due to her age and "vascularity" in that region, as stated by Dr. Werries. However, that is the entire point of repetitive trauma injuries. Whether she performed these tasks for 3 months, 5 years, 14 years, or 50 years, the point is that she continued doing so until her physical structure eventually failed, which is the very definition of a repetitive trauma injury and it is compensable under the law. Activities of daily living are exactly that...activities performed regardless of being in a work environment. Any additional overhead or at-shoulder-level activities performed at work are performed *in addition* to those "activities of daily living" and are therefore contributory to Petitioner's rotator cuff tear.

The Arbitrator also gave Dr. Werries' opinion no weight because it was "based on a job description that was not supported by the evidence" because his understanding was that 75-80% of Petitioner's job involved lifting trays but "based on the trial testimony Petitioner spent somewhere around 35% - 50% of her activities lifting trays." *Dec. 7*. The Arbitrator also found that the "majority of this lifting involved the middle shelf where Petitioner would not lift the trays but simply pull them on to a cart. Additionally, the trial testimony estimated that Petitioner lifts between 10% - 25% of the time from the top shelf. Petitioner has the burden of proof and they relied on a flawed causation opinion." *Id.*

The Commission finds the Arbitrator's analysis of Dr. Werries' opinion to be flawed because he testified that a "general description" (and not an exact number of times Petitioner did something) is enough for him to give a causation opinion because there is no "magic number" and everyone is different. *Px8 at 18-19*. He testified that Petitioner's job of moving the boxes off the shelf contributed to her rotator cuff problem because, "Impingement is when someone raises their arm up forward to,

basically when they get to, at the shoulder level or above, the acromion, which is the bone that is above the rotator cuff, can cause mechanical irritation and damage to that rotator cuff and contribute to the tearing." *Id. at 22.* He opined that Petitioner's height puts her in "that impingement range of motion because she is reaching higher to put those books on that shelf." *Id. at 23.* Dr. Werries also opined that the supraspinatus tendon, (which was found to be torn in Petitioner's left shoulder), activates in the range of motion from 60 degrees to about 120 degrees so there would also be some stress on the rotator cuff even at lower levels like the second shelf. *Id.* Therefore, whether Petitioner lifted boxes 75 to 80% of the day versus 35 to 50% of the day is not enough of a difference to find that Dr. Werries' opinion is flawed.

The Arbitrator also wrote:

> One thing that is interesting about the video, however, is how the Petitioner moved the trays. She moved a number of trays from the rollers, raising her arms to just below chest height. Each time she moved a tray, she extended her right up in elevation while keeping her left arm in close to her body. In contrast, in the photograph admitted as PX10, her left arm was elevated at the shoulder while her right arm was in close to her body. *Dec. 7.*

First, focusing on how Petitioner removed the trays from the rollers in the video (chest height) versus how she removed them from the top shelf (as depicted in the photo in *Px10*) is not an appropriate comparison. They are two completely different tasks. Second, the Arbitrator speculated, "While it is likely that she switched the position of her arms, it is also more likely that she would lead with her dominant right arm more often than not. In performing that activity, her left shoulder would not be in an offending position as described by Dr. Werries in his deposition. In other words, the rotator cuff would not be subject to stress. Dr. Werries admitted that the above could have been the scenario during his cross-examination. (PX9 at 16-17)" *Dec. at 7.* However, we find that it was unnecessary for the Arbitrator to speculate about how Petitioner *might* have removed the trays from the top shelf when, at the hearing, *Petitioner actually demonstrated* the technique she used to pull the boxes from the top shelf and the Arb stated:

> She is demonstrating the activity of pulling off the top shelf, her arms are extended straight away from her shoulders, and they are elevated to about the level of her, top of her head, both arms. *T.31.*

In other words, both of her arms were extended and elevated to about the top of her head so there is no need to speculate that Petitioner might not have really placed much stress on her left shoulder. Furthermore, Petitioner's claim is for *bilateral* shoulder problems. If Petitioner took down the heavy boxes in the way the Arbitrator speculated, then this would cause increased "stress" on the right shoulder. Regardless, we find Petitioner's demonstration of how she pulled the trays of books from the top shelf to be credible.

The Arbitrator also dismissed the June 29, 2015 causation opinion of Dr. Senica because her assumption was that Petitioner "lifted trays continuously throughout the day, with many of those trays being at or above shoulder level." *Dec. at 7.* The Arbitrator found that the "evidence showed that only a small portion of the Petitioner's work day involved lifting those trays at that height." *Id.* Again, we find that the exact percentage of time that Petitioner performed these overhead and at-shoulder-height activities is not the issue. The evidence shows that more than just a "small portion" of Petitioner's

work day involved removing boxes from the top shelf, which required her to reach up with both arms. Dr. Senica's use of the word "continuous" may not be 100% accurate but it is clear from that record that Dr. Senica knew that not all of the trays were at or above shoulder level. She specifically noted that "many of the trays are at her shoulder level or above." How many is "many?" It doesn't say "most" or "nearly all" or anything that would indicate that her causation opinion is based on invalid assumptions. And, as a side note, Respondent's own Job Analysis Report does indicate that P does "continuous" (67-100%) moving of boxes at waist level. Accordingly, Dr. Senica's statement that Petitioner continuously moves trays of books would not be that far off base.

Based on the totality of the evidence, Petitioner's work activities were not only "a" contributing factor but, more likely than not, a significant factor in her development of her bilateral shoulder conditions and the Arbitrator's decision is hereby reversed. Petitioner's right shoulder symptoms began in December 2014, after a particularly busy period at work. She continued working full duty and performing the same job duties until her left shoulder became symptomatic around mid-April 2015. Petitioner alleges a June 11, 2015 manifestation date for her repetitive trauma claim, which coincides with the date on which Petitioner first asked Dr. Senica whether her condition could be related to her work activities. This manifestation date is supported by the evidence.

We find that Petitioner's work activities at and above shoulder level were an integral part of her job duties and constitute a risk related to her employment. However, to the extent that a neutral risk analysis should be considered, we find that Petitioner performed work activities at and above shoulder level more frequently and also while lifting heavier weights than the general public.

Based on the above, we find Petitioner is entitled to most of her claimed medical bills submitted in Px11. We award the $230.00 bill of Dr. Peterson. Petitioner's exhibit summary sheet indicates that this is for a date of service of "01/26/15" and the bill itself does list that date at the top of the printout. However, there is no corresponding medical record for that date. Upon closer examination of the bill, it clearly indicates that it is for services on January 20, 2015, which is consistent with Petitioner's documented visit on that date.

We award the Passavant Area Hospital bill in the amount of $3,615.09 for the left upper extremity MRI, performed on June 23, 2015, as it is supported by the medical records. Likewise, the $620.00 in charges by the Orthopedic Center of Illinois are supported by the records and are hereby awarded.

However, we decline to award the Physical Therapists Clinic charges from January 23, 2015 through February 20, 2015, because there are no corresponding treating records in evidence. It also seems as though these physical therapy treatments may have been for right epicondylitis that Dr. Peterson diagnosed on January 20, 2015. However, we find that Petitioner has failed to prove that her epicondylitis is causally related to her work activities. The above notwithstanding, we do award the two physical therapy charges for 6/8/15 and 6/10/15; totaling $232.00. The record for the 6/8/15 visit is in evidence and specifically states that it is for the left shoulder. There does not appear to be a record for 6/10/15 but there is a note in evidence from the therapist addressed to Dr. Senica on that date advising her about suspicion of rotator cuff pathology. Therefore, we find that those charges are supported by the evidence.

We also note that most of the medical bills reflect insurance payments. To the extent that these payments were made by Respondent's group health carrier, we find it is entitled to a credit under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit.

Finally, we hereby award the prospective left shoulder arthroscopy with rotator cuff repair as recommended by Dr. Werries. We note that even Dr. Choi opined that surgery was necessary even though he believed it was not related to Petitioner's work duties.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $4,697.09 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 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 shall pay for the prospective left shoulder arthroscopy with rotator cuff repair as recommended by Dr. Werries, along with post-operative follow up 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 $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 1 1 2019

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Deborah L. Simpson
Deborah L. Simpson

SE/
O: 8/13/19
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STAMBAUGH, JUDY Case# **15WC033305**
Employee/Petitioner

HERTZBERG NEW METHOD INC 19IWCC0555
Employer/Respondent

On 12/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.48% 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:

0352 LaMARCA LAW OFFICE PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
KENNETH BIMA
620 E EDWARD ST PO BOX 335
SPRINGFIELD, IL 62705

19IWCC0555

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Judy Stambaugh
Employee/Petitioner

v.

Hertzberg New Method, Inc.
Employer/Respondent

Case # **15** WC **33305**

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 McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **10/25/17**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **6/11/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**30,888.00**; the average weekly wage was $**594.00**.

On the date of accident, Petitioner was **66** years of age, ***single*** with **0** dependent children.

ORDER

Petitioner failed to meet her burdens on the issues of accident and causal connection. Determination of other disputed issues is moot.

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

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

Signature of Arbitrator

12/12/2017
Date

ICArbDec p. 2

DEC 19 2017

The Arbitrator Finds the Following Facts:

The Employer is a book bindery business. Petitioner has worked for them since 1966. Petitioner has been performing the job duties of a foreperson since 2000. Petitioner testified that as a foreperson she would perform different activities and job tasks throughout her shift. One aspect of her job required her to retrieve trays of books to make sure that the processors have work to do throughout the shift. Petitioner estimated that the trays of books weighed anywhere from 25-50 pounds. Petitioner would then push a cart with trays of books to a processing table. Subsequently, Petitioner would count orders. Petitioner testified that at times she would also work as a processor. Petitioner would also make mylar covers.

Petitioner testified that the trays of books would be stacked on shelves. Petitioner testified that a large order requires books to be placed on the top shelf. Petitioner estimated that the height of the top shelf is between 48'-50". Petitioner testified that she is 4'11". Petitioner testified that when she retrieved trays from the top shelf, her arms would be extended slightly higher than her shoulders. Petitioner testified that if the tray of books is light, she would not lift the tray but place her right hand in the front window of the tray and slide the tray down. See PX10.

Petitioner estimated that 50% of her job involves lifting trays of books. Petitioner estimated that 20%-25% of the trays were on the top shelf.

Petitioner testified that at the end of December of 2014 after working on a large order she started developing tenderness to her right shoulder while lifting trays from the top shelf. Petitioner testified that she did not notice any symptoms when retrieving the trays from the middle or lower shelf as in doing this she would simply pull the trays as opposed to lifting them.

Petitioner first sought medical treatment with her primary care physician, Dr. John Peterson on 1/20/2015. His records note that Petitioner had been experiencing bilateral arm pain the last two weeks as a result of a special order at work with heavier books. Dr. Peterson's physical examination revealed right greater than left elbow pain. He diagnosed Petitioner with left arm pain and epicondylitis. Petitioner underwent an x-ray of her right shoulder on 2/21/2015 which revealed minimal degenerative changes. Petitioner testified that physical therapy only helped a little. As such, Dr. Peterson referred her to Dr. Karolyn Senica for an orthopedic consult (PX1).

Petitioner first saw Dr. Senica on 2/26/2015. The history in Dr. Senica's records state:

> "Ms. Stambaugh is a 66 year old white female, right hand dominant, who presents with complaints of right shoulder pain. She thinks that she has had some trouble over the past couple of months. This has come on gradually. There was not any one specific injury or trauma. Certain motions for her are painful. Reaching away from her body or behind her back is painful. She works at the book binder. She will mark 50 years of service next year. She has to pull trays off of a cart repetitively during the day. She does not really have to do a lot of lifting overhead. She states that while she is working, she does not have too much discomfort." (PX3)

Dr. Senica diagnosed Petitioner with right shoulder impingement with a possible rotator cuff pathology. Dr. Senica elected to inject Petitioner's right shoulder with a steroid on that date. Petitioner returned to Dr. Senica

on 4/02/2015 and reported improvement with her right shoulder. On that date, Dr. Senica noted that Petitioner's impingement had resolved and she was discharging Petitioner from her care (PX3).

Petitioner testified that she returned to Dr. Senica on 5/12/2015 now with left shoulder pain. The history in Dr. Senica's record states:

> "The patient is a 66 year old white female who presents with complaints of left shoulder pain. She is right hand dominant. I initially saw her for right shoulder pain back in February of 2015. She had an injection into the subacromial space and did very well. She has been complaining of some left shoulder pain for approximately the past month. She denies a specific injury or trauma. She has not had any significant overuse." (PX3)

Dr. Senica diagnosed Petitioner with left shoulder impingement and a possible rotator cuff pathology. On that date, Dr. Senica elected to inject Petitioner's left shoulder with an injection (PX3).

Petitioner underwent two sessions of physical therapy in June of 2015 with no relief (PX4).

Petitioner returned to Dr. Senica on 6/11/2015 with continued left shoulder complaints. On that date, a left shoulder MRI was prescribed (PX3).

The MRI proceeded on 6/23/2015 and was interpreted as demonstrating a full thickness rotator cuff tear (PX5).

Petitioner returned to Dr. Senica on 6/29/2015. The history in Dr. Senica's records now states:

> "She works at the book bindery in Jacksonville, she has worked there for 49 years. She has to lift trays of books weighing 30-35 lbs on a regular basis. Some of these are at shoulder level or above. This does aggravate her shoulder. She does this continuously throughout the day." (PX3)

Based on the results of the MRI, Dr. Senica referred Petitioner to her partner, Dr. Barry Werries for a surgical consult (PX3).

Petitioner saw Dr. Werries on 7/10/2015. His record notes that Petitioner stated that she had been experiencing left shoulder pain since December of 2014 without a specific injury. Dr. Werries noted that the MRI revealed a full thickness tear of the supraspinatus and infraspinatus tendons. He recommended an arthroscopic left shoulder rotator cuff repair. Dr. Werries was concerned that the tear would be too large to repair which may necessitate a reverse shoulder replacement in the future. Petitioner has not seen Dr. Werries since the initial visit. On 8/05/2015 Dr. Werries imposed restrictions of no overhead activity with the left upper extremity and no lifting greater than 20 pounds. On 8/26/2015, Dr. Werries increased the restriction to no lifting greater than 10 pounds (PX6).

Petitioner testified that Respondent has been accommodating her work restrictions. Since being on light duty, Petitioner testified that her symptoms have improved. Petitioner testified that she is not taking any pain pills. Petitioner would like to undergo the surgery being recommended by Dr. Werries.

Petitioner testified that a video was secured of her performing her job activities. Petitioner noted that the video does not demonstrate her lifting boxes from the top shelf. Petitioner testified that she attempted to demonstrate this to the person securing the video.

Mr. Jim Beavers testified on behalf of Respondent. Mr. Beavers has worked for Hertzberg New Method for the past 20 years. Mr. Beavers testified that he has been the shipping supervisor and Petitioner's supervisor for all the years that he has worked for Hertzberg New Method.

Mr. Beavers testified that in a typical day, Petitioner would arrive at 7:00 a.m. and would check to see if the processors need work. Petitioner would then pull orders off the shelves for the processors. Petitioner would then go to the line after the processors had completed their work and she would count and check those orders. Mr. Beavers estimated that this would take on average one to one and a half hours to complete. To check the order, Petitioner would count and make sure that the correct number of books were in each tray. While checking the work, if a processor needed additional work, Petitioner would retrieve more trays for the processors. Depending on work flow, Petitioner would also make mylar covers and also perform other work in the picking area. At the end of the shift, Petitioner would perform 15 to 20 minutes of paperwork.

Mr. Beavers testified about the shelves containing the trays of books. He testified that the top shelf is approximately 50 ½" off the ground. The middle shelf is approximately 26 ½" off the ground. Mr. Beavers testified that the middle shelf is the priority. Everything goes on the middle shelf until the middle shelf and a roller area is full. Mr. Beavers estimated that the roller area was approximately 30" off the ground. Mr. Beavers testified that on average, 10-15% of Petitioner's lifting would come from the top shelf. Books on the middle shelf would not require Petitioner to lift at all. Instead, she would pull the trays of books directly on to a cart. Mr. Beavers estimated that in a typical shift, Petitioner will lift 35%-40% of the time. Mr. Beavers testified that Petitioner is not lifting repetitively.

Mr. Beavers testified that Petitioner would ask for help with heavy trays on the top shelf.

Mr. Beavers testified that the job analysis report (RX3) and job video (RX4) is a true and accurate description of Petitioner's job activities. Mr. Beavers agreed that the job video did not show Petitioner lifting off the top shelf.

Dr. Barry Werries testified via an evidence depositions on 11/03/2016 and 6/01/2017. Dr. Werries is a board certified orthopedic surgeon. At the referral of Dr. Senica, Dr. Werries has seen Petitioner on one occasion, on 7/10/2015. On that date, Petitioner reported left shoulder pain since December of 2014. Based on his physical examination and review of the left shoulder MRI, Dr. Werries testified that Petitioner had a full thickness rotator cuff tear that included two of the rotator cuff tendons. Dr. Werries recommended an arthroscopic rotator cuff repair and was concerned that the tear would not be repairable. Dr. Werries currently has Petitioner on work restrictions.

Regarding the issue of causation, Dr. Werries testified that during the 7/10/2015 visit, Petitioner did not advise him of her job activities. On direct examination, Dr. Werries was provided a hypothetical question involving the heights of the shelves where the tray of books were placed. Dr. Werries was asked to assume that 20% - 25% of the boxes that Petitioner lifts during the day were from the top shelf. Dr. Werries was also asked to assume that 75% - 80% of Petitioner's shift involves lifting trays of books. It was Dr. Werries' opinion that Petitioner's activity of moving the trays of books off the shelves contributed to her left rotator cuff problem. Dr. Werries testified that the basis of his opinion was that individuals develop impingement when they raise their arm forward at shoulder level or above. This can cause mechanical irritation and damage to the rotator cuff contributing to tearing.

Dr. Werries did not have the opportunity to review a job video or written job analysis. Dr. Werries did not view the claimant's work station. Dr. Werries did not know how many trays of books that Petitioner would lift from each level of the shelves during an average shift. Dr. Werries agreed that if the hypothetical that was posed to him on direct examination was inaccurate or incorrect, his causation opinion could also be inaccurate or incorrect. Dr. Werries testified that he was aware of the studies between age and the prevalence of rotator cuff tears. He agreed that there is a strong correlation between a rotator cuff tear and age. Dr. Werries agreed with the studies noting that the prevalence of a partial or full thickness rotator cuff tear increases markedly after the age of 50. Dr. Werries agreed that individuals over the age of 70 have a 50% chance of a partial or full thickness rotator cuff tear. Dr. Werries testified that the classic study is a 33% chance of a partial or full thickness rotator cuff tear over the age of 60. Dr. Werries agreed that this chance increases with age. Dr. Werries agreed that it would be reasonable to expect an individual like Petitioner outside of work to have the findings that he saw on the MRI. Dr. Werries agreed that a rotator cuff tear can be symptomatic based on the natural progression of the degenerative condition and by activities of daily living (PX8-9).

Dr. Luke Choi testified via an evidence deposition on 11/09/2016. Dr. Choi is a board certified orthopedic surgeon with a primary focus on shoulder, elbows and knee problems. He performed an independent medical evaluation at Respondent's request on 9/03/2015. Dr. Choi agreed with Dr. Werries in that Petitioner had a full thickness rotator cuff tear to her left shoulder that was in need of surgical repair. Based on Dr. Choi's review of the MRI film, it was his opinion that the tear was chronic in nature based on the amount of fatty infiltration that was seen. Regarding the issue of causation, Dr. Choi testified that based on the history that he secured from Petitioner and his review of the written and video job analysis, there is no relationship between Petitioner's left rotator cuff tear and her job activities. Dr. Choi testified that based on the medical literature, at the age of 60 individuals have between a 40% - 50% chance of having rotator cuff tendon tear. Dr. Choi testified that there is no question in his mind that from a medical standpoint Petitioner's rotator cuff tear was chronic in nature and would have developed regardless of whether Petitioner was performing overhead activities or not. Dr. Choi testified that Petitioner's rotator cuff tear developed as a result of the degenerative process (RX2).

Therefore, the Arbitrator Concludes:

In cases relying on the repetitive trauma theory, petitioners rely on medical testimony establishing a causal connection between the work performed and the disability (See Peoria County Bellwood Nursing Home v. Industrial Commission (1987), 115 Ill 2d 524, 505 NE 2d 1026). Although medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only and not within the common knowledge of lay persons, expert testimony is necessary to show that petitioner's work activities caused the condition complained of. Interlake Steel Company v. Industrial Commission (1985), 136 Ill. App. 3d 740, 483 N.E. 2d 970. Cases involving aggravation of a pre-existing condition primarily concern medical questions and not legal questions. Barry v. Industrial Commission (1984), 99 Ill 2d 401, 459 N.E. 2d 963. This is especially true in repetitive trauma cases. Nunn v. Industrial Commission, 109 Ill. Dec. 634, 510 N.E. 2d 502. The right to recover benefits cannot rest upon speculation or conjecture. County of Cook v. Industrial Commission, 68 Ill. 2d 24, 368 N.E. 2d 1292 (1977).

Consistent with these principals, Petitioner and Respondent elected to secure medical testimony on the issues of accident and causal connection. Both Dr. Werries and Dr. Choi agreed that Petitioner's left rotator cuff tears could be explainable based solely on the age of Petitioner and the degenerative process. On the date of the alleged accident, Petitioner was 66 years old.

Dr. Choi, after securing a detailed history from Petitioner, analyzing the job analysis and video, and analyzing the MRI film, did not believe that Petitioner's job activities for the Respondent contributed to her left shoulder rotator cuff tear. Dr. Choi's reliance on the job video does not lend much credibility to his opinions. The video did not show any examples of the Petitioner removing trays of books from the shelves. It only shows her removing said trays from a roller line, placing them in a shopping cart and pushing them to a work table. The video was taken after the Petitioner's alleged accident and after she was diagnosed with her left rotator cuff tears and likely represented her job duties after she was given work restrictions by Dr. Werries. Dr. Choi also based his opinions in part upon the assumption that the Petitioner has no continuous or frequent overhead or chest level lifting activities on the job. (RX 2; Dep. X 1) The Arbitrator believes the evidence supports this assumption.

One thing that is interesting about the video, however, is how the Petitioner moved the trays. She moved a number of trays from the rollers, raising her arms to just below chest height. Each time she moved a tray, she extended her right up in elevation while keeping her left arm in close to her body. In contrast, in the photograph admitted as PX 10, her left arm was elevated at the shoulder while her right arm was in close to her body. The Petitioner said that she was right hand dominant. Clearly she had to pull these heavy boxes from either the rollers or the shelves. While it is likely that she switched the position of her arms, it is also more likely that she would lead with her dominant right arm more often than not. In performing that activity, her left shoulder would not be in an offending position as described by Dr. Werries in his deposition. In other words, the rotator cuff would not be subject to stress. Dr. Werries admitted that the above could have been the scenario during his cross-examination. (PX 9 at 16-17)

Dr. Werries opined that Petitioner's job activities contributed to her left rotator cuff tear. However, Dr. Werries' opinion is given no weight as his opinion was based on a job description that was not supported by the evidence. It was Dr. Werries' understanding that 75%-80% of Petitioner's job involved lifting trays. The Arbitrator notes that based on the trial testimony Petitioner spent somewhere around 35%-50% of her activities lifting trays. However, the majority of this lifting involved the middle shelf where Petitioner would in fact not lift the trays but simply pull them on to a cart. Additionally, the trial testimony estimated that Petitioner lifts between 10%-25% of the time from the top shelf. Petitioner has the burden of proof and they relied on a flawed causation opinion.

Dr. Senica also opined on causation in her office note of June 29, 2015. She felt the Petitioner's work activities could have contributed to her injuries. However, the doctor based her opinions on the assumption that the Petitioner lifted trays continuously throughout the day, with many of those trays being at or above shoulder level. The evidence showed that only a small portion of the Petitioner's work day involved lifting those trays at that height. Most of the shelf lifting was from the second level, which the photographs illustrate were at the Petitioner's waist or below. (PX 10)

Based on the above, the Arbitrator finds that Petitioner failed to meet her burden on the issues of accident and causal connection regarding her bilateral shoulder conditions. Petitioner's claim for compensation is denied. Determination of other disputed issues is 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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN MACK,

Petitioner,

19IWCC0556

vs. NO: 13 WC 33884

ST. LUCAS ASSOCIATION,

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

The Commission agrees that Petitioner's second accident broke the chain of causation from the first accident. However, after the Arbitrator's decision was issued and after the parties filed their briefs on Review, the Appellate Court issued its decision in *PAR Electric v. IWCC*, 118 N.E.3d 681 (3rd Dist. 2018). The Court clarified that *National Freight Ind. v. IWCC*, 993 N.E.2d 473 (5th Dist. 2013), did not set forth a four-factor intervening cause test but, rather, simply included a summary of the evidence relied upon in that case to support the Commission's decision under a manifest-weight standard of review. Therefore, we clarify that we consider the Arbitrator's reference to *National Freight,* in the case at bar, to be supportive of a finding that

Petitioner's second work accident broke the chain of causation but that the factors enumerated in *National Freight* were not applied as a bright-line test.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 13, 2018, is hereby affirmed and adopted with the changes noted above.

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

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

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

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 1 1 2019

Maria E. Portela

Thomas J. Tyrrell

L. Elizabeth Coppoletti

SE/
O: 8/27/19
49

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

MACK, JOHN
Employee/Petitioner

Case# **13WC033884**
13WC033885

ST LUCAS ASSOCIATION
Employer/Respondent

19IWCC0556

On 2/13/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5238 COLLISON LAW OFFICES LTD
EDGAR K COLLISON
134 N LASALLE ST SUITE 1200
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

John Mack
Employee/Petitioner

Case #13 WC 33884

v.

Consolidated cases: **13 WC 33885**

St. Lucas Association
Employer/Respondent

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

DISPUTED ISSUES

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

FINDINGS 19IWCC0556

On the date of accident, **October 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.

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 $**n/a**; the average weekly wage was $**n/a**.

On the date of accident, Petitioner was **45** 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 $**130,285.17** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**130,285.17**.

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

ORDER

The petitioner's current condition of ill being is causally related to the work accident of October 7, 2013.

The Respondent shall pay reasonable, necessary, and causally connected medical services for treatment after October 7, 2013, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay for vocational rehabilitation from the provider of petitioner's choice.

Respondent shall pay maintenance benefits during petitioner's vocational rehabilitation.

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

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

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

Robert E Luedke
Signature of Arbitrator

February 9, 2018
Date

ICArbDec19(b)

FEB 13 2018

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

The arbitrator finds the petitioner's current condition of ill being is causally related to the work accident of October 7, 2013. The arbitrator bases this decision on the testimony of the petitioner along with the petitioner's treating medical records.

The petitioner's accident of October 7, 2013 is styled as 13 WC 33884. This case is consolidated with the petitioner's accident of July 12, 2012 styled as 13 WC 33885. Parties agree that the petitioner suffered work-related accidents on July 12, 2012 and October 7, 2013.

Petitioner testified he was hired by the respondent as a cemetery maintenance person. He was hired temporarily in April 1997. His duties were to take care of grass and to mix cement. He would lift up stones with crowbars. He would perform maintenance on the mowing machines. He would take the blades off, sharpen them, and then put them back on. He would dig holes for the funerals. On cold days they would use a jackhammer to start the holes for the graves.

When the petitioner started working for the respondent there were four people. At the time of the accident there were only two. The petitioner had to assume those duties. When he went to work for the respondent he was not under any medical restrictions for his back or legs. Petitioner had worked for the respondent about 17 years before he got hurt.

On July 12, 2012 the petitioner had three funerals prior to that day. The petitioner and a coworker were picking boards up when he twisted his right leg causing him to fall onto the board. He noticed he had pain in his back.

After the accident of July 12, 2012 the petitioner continued to work. The first time he received medical treatment was September 22, 2012. The petitioner saw Dr. Sarada Alla. The petitioner complained of pain in his back right side and down his leg. Dr. Alla sent the petitioner for an MRI. The nurse case manager from the insurance company sent the petitioner to Dr. Reese.

The petitioner saw Dr. Reese on October 12, 2012. The petitioner's complaints were low back pain and pain down his right leg along with tingling in his foot.

The petitioner then came under the care of Dr. Butler. The petitioner saw Dr. Butler on or about October 31, 2012. The nurse case manager recommended Dr. Butler. Dr. Butler performed surgery on the petitioner's low back on November 27, 2012 at Lutheran General Hospital.

After surgery the petitioner continued his treatment with Dr. Butler and participated in physical therapy at Flexeon. The petitioner testified that he overexerted himself during physical therapy and his pain increased. Dr. Butler set him for an MRI on January 31, 2013. The petitioner continued with Flexeon Rehabilitation and continue to see Dr. Butler in February, March, and April of 2013. On April 12, 2013 he was released from treatment by Dr. Butler.

The petitioner testified that when he was released he still had back pain. The petitioner returned to work. After a month the petitioner noticed his back pain increased. The petitioner went back to Dr. Butler in May 2013 with complaints of pain. Dr. Butler gave him Celebrex. The petitioner saw Dr. Butler again in July of 2013. The petitioner continued to treat and have back complaints. Between July 25, 2013 and October 7, 2013 the petitioner did not have any medical treatment or see a doctor for his low back.

On October 7, 2013 the petitioner had another injury at work. On that date the petitioner was clearing a spot next to the door where the truck would drop off the shipment of cement. The petitioner was moving wooden pallets from one side of the spot to the other. The petitioner was lifting a pallet up when he twisted and the pain went down both sides of his back and down his leg. The petitioner testified that the pain from his first accident never left him. The pain from his first accident was also down his right leg.

On October 7, 2013 the petitioner returned to see Dr. Butler. Since October 7, 2013 up until the date of the 19b hearing on January 23, 2018 the petitioner has not worked. The petitioner has been under the care of Dr. Butler and Dr. Sokolowski.

On October 9, 2013 the petitioner had another MRI. In October 2013 Dr. Butler sent the petitioner to therapy at Olympia Chiropractic. The petitioner saw Dr. Sokolowski on October 21, 2013. Dr. Sokolowski speaks Polish. The petitioner continued treatment with Olympia Chiropractic in physical therapy in October and November 2013. The chiropractic records mentioned the petitioner's pain increased as he performed his activities.

In December 2013 the petitioner continued his treatment with Dr. Sokolowski and continued treatment with Olympia Chiropractic. In late December 2013 and early January 2014 the petitioner was prescribed lumbar epidural steroids.

The petitioner received a lumbar epidural steroid injection in April 2014. The petitioner saw Dr. Sokolowski in April 2014 the petitioner still continued with Olympia Chiropractic.

The petitioner had his first FCE on August 26, 2014. The petitioner still was not working. The more activity he tried to do the more his pain increased.

In November 2014 the petitioner was given another lumbar MRI. The petitioner was also prescribed surgery by Dr. Sokolowski in 2015. The surgery was performed on November 3, 2015.

Prior to surgery Dr. Sokolowski referred the petitioner to Dr. Patodia for pain management in June 2015. The petitioner wanted to try pain management before he tried surgery.

Dr. Sokolowski has continued to treat the petitioner since November 3, 2015. Dr. Sokolowski referred the petitioner to a Dr. Willoughby because the petitioner was getting depressed.

The petitioner testified his depression was caused by not working, being home, being in pain, and trying to get a job. The petitioner would lie down most of the day. The pain would make him depressed. The petitioner enjoyed working for the respondent. He liked the work.

The petitioner saw Dr. Willoughby and she helped him. The petitioner underwent some physical therapy. The petitioner had a second FCE around November 2, 2016.

In 2017 the petitioner still treated with Dr. Sokolowski. The petitioner treated with Dr. Sokolowski up until September 2017. Dr. Sokolowski asked the petitioner to come back in five months which would be February 2018. The petitioner plans on seeing him again.

In the past few months the petitioner has looked for work. Driving causes the petitioner pain. The petitioner has pain in his low back and right leg when he is driving or sitting in traffic. The petitioner would be in pain when he would go and drive to job interviews or job searches. The petitioner would start feeling pain after about 15 to 20 minutes.

Before the accident the petitioner was the assistant coach for his son's hockey team. The petitioner would go out there with the kids and shoot pucks at them. He and the team would travel. He can't do it now because of the pain. He can't sit for long periods of time. He can't put weight on his right side. He can't bend like he used to. The petitioner used to like to paint. He liked roller skating. He was rollerblading with his son along with playing basketball and baseball in the yard. The petitioner cannot do those activities now because of his pain. His pain is in the center of his back to the left and to the right. It goes down his right leg at the knee or a little below it. He would perform some household activities before the accident. He does very little household activities now. The petitioner will take a walk with his wife after dinner. After a while his back will start aching. He will sit down for a while. The petitioner and his wife will turn around and go home. He cannot go too far.

Respondent's counsel for the accident of July 12, 2012 styled as 13 WC 33885 cross-examined the petitioner. The petitioner had problems with his right leg giving out after the first accident. The problems with the right leg giving out improved after the first surgery with Dr. Butler. The right leg pain improved after the first surgery with Dr. Butler. The low back pain improved after the first surgery with Dr. Butler. The petitioner saw Dr. Butler in May 2013 at which time Dr. Butler changed his prescription. Dr. Butler again released the petitioner to full duty work in May 2013. The petitioner returned to Dr. Butler in July 2013. This would be before the second accident. The petitioner was again released to full duty work. Dr. Butler did not restrict the petitioner in July 2013. This was the last visit before the second accident.

The next time the petitioner saw Dr. Butler would have been after the second accident. He told Dr. Butler he had an injury. He reported to Dr. Butler immediate significant low back pain radiating into his right buttocks because of the second accident. The petitioner reported difficulty walking following the second accident.

The petitioner saw Dr. Butler on October 10, 2013 which is three days after his second accident. Dr. Butler took him off work at that time. The petitioner was not in physical therapy at the time of the second accident. He was working full duty in his normal job at the time of the second accident.

The petitioner saw Dr. Mirkovic at the request of his employer. He saw Dr. Phillips a handful of times. He saw Dr. Mirkovic in April 2014 at Northwestern he told Dr. Mirkovic that he experienced sudden increasing low back pain radiating down both legs to his feet immediately after the second accident.

The petitioner testified that he had low back pain before the second accident. The petitioner also testified that after the second accident the pain went down his legs. He had a little pain in his right side but not all the way down the leg. The petitioner testified that after the second accident everything got worse. It went down both legs. He could barely walk.

Following the first accident but prior to the second accident he was trying to work full duty but he was in pain. After the second accident there was no way he could return to work because of the pain. He could not have gone back to work after the second accident. He couldn't walk.

The petitioner hasn't been out on the ice playing hockey with his son since months before the first injury. He wasn't playing. He was just coaching. He wasn't coaching after the first accident. The hockey coaching was all before the first accident.

After the first accident but before the second accident the petitioner did some household work but not very much. The petitioner's wife did most of the grocery shopping because the petitioner was still in pain. The problems he has today are worse today.

The symptoms the petitioner had before the second accident were manageable with medication. He would have to take a lot of breaks at work and put ice on his back. He was laying on the floor in the office or in the lunchroom. The pain never left after the first injury. The pain was more severe after the second accident. The petitioner feels pain in his left leg after the second accident which he didn't have after the first accident. The petitioner testified that the pain in his right leg was worse after the second accident. After the second accident the weakness in his right leg was worse. After the second injury the numbness in his feet was worse. The petitioner didn't have pain down his left leg after the first accident. The last day that the petitioner worked was the day of the second accident. He was working full duty at that time.

Respondent's counsel for the accident of October 7, 2013 styled as 13 WC 33884 cross-examined the petitioner. Prior to the second accident on October 7, 2013 the petitioner still had pain in his low back. Prior to the second accident on October 7, 2013 the petitioner still had a little bit of pain in his right leg. Even though he returned to full duty work the symptoms were ongoing. Dr. Butler released him to return to full duty work but he still had to take a lot of

breaks. He had to lay down on the floor. His back pain was still bothering him. Prior to the second accident the petitioner could complete a full day of work. He was managing even though he had pains in his back. He was doing his job. He would have breaks and then he would come home and complain. The petitioner does not recall Dr. Butler telling him in February 2013 that he may require spinal fusion in the future.

The petitioner does recall completing some forms in May 2013 when he went to see Dr. Butler about his pain. The petitioner does not recall what he wrote down. The petitioner agrees that in May 2013 he probably would not be able to walk a mile. Petitioner believes he could sit for about 30 to 50 minutes before he would have significant pain. Petitioner had no problem standing prior to the second accident. He would lean against the machinery at work. In June 2013 before the second accident he requested Dr. Butler to prescribe a back brace. The petitioner received a back brace. Dr. Butler told him not to wear too often because it might weaken his back muscles. In July 2013 prior to the second accident the petitioner still had stabbing pain in his low back and right leg. He doesn't recall if he had the numbness in the right foot at that time. Prior to the second accident his prescriptions were Tramadol, Lyrica, and Celebrex. From July 2013 up until the second accident he was taking those medications on a regular basis.

A couple of weeks before the second accident the petitioner was in pain and he called Dr. Butler. Dr. Butler told the petitioner to increase the medication. After the first accident but prior to the second accident he was not able to perform any type of exercise activity. The petitioner just performed his work duties. After the first accident but before the second accident he would have very little pain doing general everyday activities.

After the second accident he had some left leg pain. The left leg pain has now resolved. The left leg pain resolved probably two months after the surgery. After the first accident the petitioner had right leg pain. After the second accident he had pain in both legs. After the surgery of November 2012 his symptoms improved but not to the point where he was back to 100%.

Petitioner was seen by Dr. Butler on October 31, 2012. *P3*. Petitioner gave a history of a July 20, 2012 accident. *Id.* Petitioner gave a history of moving an eight foot board with a coworker over some stones in the cemetery. *Id.* The petitioner tripped over one of the stones, twisted his ankle, and fell to the ground on his knees. *Id.* Petitioner gave a history of not noticing significant back pain at that time. *Id.* Dr. Butler reviewed the MRI which showed a large right lateral disc herniation at L5 S1. *Id.*

Dr. Butler saw the petitioner on October 10, 2013. *Id.* The petitioner gave a history of back pain. *Id.* Petitioner gave a history of sustaining a new work injury occurring on October 7, 2013. *Id.*

He was at work moving skids after he received a shipment of cement. *Id.* When he went to let go of the skid he twisted his back and immediately began to experience significant low back pain. *Id.* Petitioner sustained a previous old work injury which required surgery for right L5-S1 microdiscectomy on November 27, 2012. *Id.* His pain has progressed to the point where he is having difficulty with ambulation. *Id.*

Petitioner appeared at Olympia Chiropractic on October 17, 2013. *P10.* Petitioner gave a history of an October 7, 2013 accident. *Id.* Petitioner was moving a pallet to make room for a shipment of concrete mix. *Id.* As he was moving the pallet he twisted and felt a sharp pain in his low back. *Id.*

The arbitrator has viewed the lumbar MRI of October 9, 2013 taken two days after the second accident. *P9.* There is no indication that this MRI was compared to prior radiographic tests. The MRI mentions minor bulging of the L2 three disc. *Id.* The arbitrator has viewed the MRI of the low back taken on November 26, 2014. *Id.* The MRI shows postsurgical changes from a right him a laminectomy at the L5 S1 level. *Id.* The MRI report also mentions that the findings are unchanged from the previous study October 9, 2013. *Id.*

The arbitrator has viewed the IME report of Dr. Mirkovic dated April 25, 2014. *R2 in 13 WC 33885.* Dr. Mirkovic offered an opinion that the petitioner's present condition of ill-being was causally related to the October 7, 2013 work accident. *Id.*

The arbitrator finds the appellate court's decision in *National Freight Industries v IWCC*, 993 N.E.2d 473, (5th Dist. 2013) applicable to the instant case. In *National Freight* the petitioner suffered a low back accident on November 6, 2006 while working for Fischer Lumber. The petitioner underwent radiographic tests to his low back. The petitioner was eventually released to return to restricted employment. The petitioner obtained new employment with National Freight Industries in 2007. The petitioner continued to have problems with his low back and a microdiscectomy was scheduled for December 5, 2008. The day before the scheduled surgery on December 4, 2008 the petitioner suffered an auto accident in the course of his employment with National Freight Industries. The arbitrator and the IWCC determined that the petitioner suffered an independent intervening accident on December 4, 2008. The petitioner's lost time and medical treatment after December 4, 2008 were determined to be the result of the December 4, 2008 accident with National Freight Industries.

National Freight Industries argued that the petitioner's condition after December 4, 2008 was still the result of the November 6, 2006 accident. The arbitrator determined that the December 4, 2008 accident caused new and increased symptoms. The second accident caused a change in the petitioner's radiographic tests and a different surgical recommendation. The arbitrator in *National Freight Industries* noted that the petitioner's ability to work changed after the second accident. The petitioner was unable to work after the second accident. The respondent for the

second accident in both *National Freight Industries* and in the instant case argues that "but for" the first accident and the surgery resulting from the first accident the petitioner's present condition of ill being would not have occurred. The court in *National Freight Industries* noted that the second accident changed the nature of the petitioner's injury and was not a minor aggravation. In both *National Freight* and in the instant case the petitioner had new and different pain complaints after the second accident. The petitioner in the case at bar was working but is now unable to work after the second accident.

The arbitrator has considered the appellate court's previous decision in *Vogel v IWCC*, 354 Ill.App.3rd 780 (2nd Dist. 2005). The arbitrator finds the appellate court's decision in *Vogel* factually distinguishable. The appellate court in *National Freight Industries* also found the prior *Vogel* decision factually distinguishable.

In *Vogel* the worker sustained injuries while working for the employer. There was no evidence in *Vogel* that the subsequent accidents changed the nature of the injury.

In the instant case there is evidence that the second accident changed the nature of the petitioner's injury. After the second accident the petitioner's pain was not manageable even with medication, the petitioner was unable to return to employment, and the petitioner had increased symptoms to both legs.

The arbitrator is aware of language in the *Vogel* decision that the second accident was not necessarily the sole cause of the petitioner's present problems. Had it not been for the first accident of July 12, 2012 the petitioner's back problems would not have reached the stage they did in such a short period of time. The appellate court dealt with this issue in *National Freight*. The court in *National Freight* commented:

> "In the present case, unlike in *Vogel*, there was evidence from which the Commission could reasonably conclude that the motor-vehicle accident changed the nature of claimant's injury, was the sole cause of his current condition of ill-being, and therefore broke the causal chain from the original accident."

The arbitrator notes that *National Freight* was decided by the same court after their decision in *Vogel*. The arbitrator finds *Vogel* and *National Freight* are consistent but factually dissimilar. The arbitrator finds that the fact situation in *National Freight* is closer to the fact situation in the instant case. Consistent with *National Freight* the arbitrator finds that in the case at bar the character of the petitioner's condition changed after the second accident. Petitioner's present condition of ill being is causally connected to the October 7, 2013 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?

The stipulation sheet in 13 WC 33884 entered as *Arb1* mentions that respondent agrees to pay all bills for medical treatment through January 23, 2018. *Arb1*. Respondent in 13 WC 33884 agreed in court to pay all medical bills for medical treatment through January 23, 2018. *T6*. Arbitrator does note that respondent in 13 WC 33884 checked the "dispute" box for agreement to pay all medical bills through January 23, 2018. *Arb1*.

The arbitrator has viewed the reports of Dr. Phillips. *R2 in 13 WC 33884*. Dr. Phillips examined the petitioner on January 22, 2015. *Id.* Dr. Phillips suggested a repeat MRI to determine if the petitioner had an additional disc herniation from the October 7, 2013 accident. *Id.* Dr. Phillips also determined it was reasonable to proceed with the proposed surgery. *Id.* Dr. Phillips commented that the petitioner's current state of ill-being was the result of the October 2013 injury as well as residual of the July 2012 injury. *Id.* Dr. Phillips commented that the petitioner needs additional medical treatment as a result of both the October 2013 incident and the July 2012 incident. *Id.*

Dr. Phillips issued an addendum dated January 22, 2015. *Id.* Dr. Phillips reviewed the petitioner's March 30, 2015 MRI. *Id.* Dr. Phillips determined that it showed disc degeneration at the L5-S1 level with loss of disc height Dr. Phillips offered an opinion that the petitioners need for revision surgery is causally connected to both accidents. *Id.*

Because of the arbitrator's decision regarding causal connection the Respondent shall pay reasonable, necessary, and causally connected medical services for treatment after October 7, 2013, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent has entered a medical payment history as *R3* and will receive full credit for all medical expenses previously paid whether reflected in *R3* or not.

The arbitrator notes the petitioner received psychological counseling at the Willoughby Center for behavioral health. P 20. The individual was seen on September 7, 2016, September 13, 2016, and October 5, 2016. Id. The arbitrator is aware of Dr. Phillips' opinion that the counseling was not necessary. Regardless of Dr. Phillips opinion the arbitrator finds the counseling sessions by Dr. Willoughby to be reasonable and necessary and causally connected to the petitioner's work accident of October 7, 2013. The petitioner first appeared for counseling with Dr. Willoughby on September 7, 2016 and gave a history of depressive symptoms as a result of chronic pain and

being out of work. Id. The arbitrator finds that the petitioners compensable accident was a factor in his need for psychological counseling.

K. Is Petitioner entitled to any prospective medical care?

Dr. Phillips examined the petitioner on April 12, 2016. *R2 in 13 WC 33884.* Dr. Phillips noted the petitioner was recovering well from his decompressive surgery. *Id.* Dr. Phillips determined the petitioner could return to work with a 30 pound lifting restriction. *Id.* Dr. Phillips determined the petitioner would be at MMI after 4 to 6 weeks of physical therapy. *Id.* At that point the petitioner could return to unrestricted employment. *Id.*

Dr. Phillips reviewed additional records and issued an addendum dated May 18, 2016 *Id.* Dr. Phillips commented that the petitioner had reached maximum medical improvement regarding the October 2013 injury. *Id.* Dr. Phillips opined that the petitioner could currently work at light duty. *Id.* Dr. Phillips offered an opinion that the need for additional physical therapy is related to both the 2012 and 2013 incidents. *Id.* Dr. Phillips wrote that he anticipated the petitioner returning to unrestricted duty. *Id.*

Dr. Phillips reviewed additional records and issued and IME addendum on August 8, 2016. *Id.* Dr. Phillips commented that the additional records do not alter his opinions. *Id.* Dr. Phillips again commented that in May 2016 the petitioner had reached maximum medical improvement regarding October 2013 injury. *Id.*

Dr. Phillips saw the petitioner again on January 17, 2017. *Id.* Dr. Phillips notes that the petitioner underwent a bilateral revision hemi laminectomy at the L5 S1 level. *Id.* Dr. Phillips notes the petitioner underwent an FCE on November 12, 2016. *Id.* The petitioner is capable of working full time at the light physical demand level. *Id.* Petitioner has a 20 pound lifting restriction along with a 10 pound restriction for pushing and pulling and no climbing of ladders. *Id.* Dr. Phillips opined that the petitioner could work at a higher level than the light level defined in the FCE. It. Dr. Phillips believed there was no objective contraindication to the petitioner working with a 30 pound lifting pushing or pulling restriction. *Id.* Dr. Phillips agreed with Dr. Sokolowski that the petitioner had reached maximum medical improvement. *Id.* Dr. Phillips saw no indication for psychological consultation. *Id.*

Respondent has obtained a utilization review report. P3. This report comments that the petitioner's epidural injections were not medically necessary. *Id.* The basis of this opinion is that the petitioner did not have a focal deficit on exam, no significant neural compression indicated in the MRI, and has been determined to have reached maximum medical improvement in different medical exams. *Id.*

The utilization review report also determined that the petitioner's physical therapy after the first 12 sessions were not medically necessary. *Id.* The rationale of the utilization review opinion is that official disability guidelines recommend 12 sessions of physical therapy followed by a home exercise program. *Id.* The report notes that the petitioner has exceeded these recommendations. *Id.* According to the report the petitioner has no deficit that would suggest a home exercise program cannot be performed. *Id.* The report mentions the petitioner has undergone independent medical exams that determine the petitioner has reached maximum medical improvement. *Id.* The report is authored by a Dr. Zarro who represents he is board certified in orthopedic surgery. *Id.*

Dr. Phillips found the petitioner to be at maximum medical improvement on January 17, 2017, August 8, 2016, and May 18, 2016. *P2.*

Dr. Sokolowski's work status report of September 22, 2017 mentions the petitioner has permanent restrictions. P 11. Dr. Sokolowski has a release the petitioner to return to work pursuant to the functional capacity exam. Id. Dr. Sokolowski noted on September 22, 2017 that the petitioners back pain was 3 to 4 on a 10 point scale on his leg pain was one on a 10 point scale. Id. Dr. Sokolowski mentions that the petitioner is at functional maximum medical improvement after revision laminectomy. Id. The arbitrator notes the petitioner's revision laminectomy was in November 2015. This matter was tried more than two years after the petitioner surgery. Dr. Sokolowski saw the petitioner on May 22, 2017 and again mentioned that the petitioner is functionally at maximum medical improvement after his surgery. Id. Dr. Sokolowski saw the petitioner on February 1, 2017 and mentioned that the petitioner was at functional maximum medical improvement. Id. Dr. Sokolowski saw the petitioner on December 14, 2016 and mentioned the petitioner wasn't maximum medical improvement. Id. Dr. Sokolowski saw the petitioner on November 16, 2016 and commented that the petitioner underwent a functional capacity exam dated November 2, 2016. Id. The arbitrator finds it is unlikely that any treating physician would send a patient for a functional capacity exam who was not at or close to maximum medical improvement. Dr. Sokolowski notes that the petitioner is at maximum medical improvement. Id.

Based on the opinions of Dr. Phillips and the utilization review reports the arbitrator finds further physical therapy and injections not reasonable or necessary to relieve the petitioner's condition resulting from his October 7, 2013 accident. The utilization review report does not comment on the petitioner's continued prescription pain medication. Therefore the arbitrator makes no ruling regarding the prescription of future pain medication if any.

No specific future procedure is suggested by Dr. Sokolowski. The arbitrator declines to guess or speculate and therefore makes no ruling regarding the reasonableness and necessity of future medical treatment by Dr. Sokolowski, if any.

L. What temporary benefits are in dispute?

Because of the arbitrator's decisions regarding causal connection and vocational rehabilitation the arbitrator finds that the respondent in 13 WC 33884 shall pay maintenance benefits during the petitioner's vocational rehabilitation.

O. Other: Vocational rehabilitation

Section 8(a) of the Illinois Workers' Compensation Act provides the following:

> *The employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expense incidental thereto.*
>
> *Any vocational rehabilitation counselor who provides services under this Act shall have appropriate certifications which designate the counselor as qualified to render opinions related to vocational rehabilitation. Vocational rehabilitation may include, but is not limited to, counseling for job searches, supervising a job search program and vocational retraining including education at an accredited learning institution. The employer or employee may petition to the Commission to decide disputes relating to vocational rehabilitation and the Commission shall resolve any such dispute including payment of the vocational rehabilitation program by the employer.*
>
> *The maintenance benefits shall not be less than the temporary total disability rate determined for the employee. In addition, maintenance shall include costs and expenses incidental to the vocational rehabilitation program.*

The Illinois Supreme Court, in *National Tea Co. v. Industrial Commission*, 97 Ill. 2d 424 (1983) created a framework of factors to consider in determining whether vocational rehabilitation is appropriate. Factors favoring rehabilitation include:

. The employee has sustained an injury that caused a reduction in earning capacity, and there is evidence that rehabilitation will increase that capacity;
. The employee is likely to lose job security due to the injury; and
. The employee is likely to obtain employment upon completion of rehabilitation training.

The Arbitrator finds that Petitioner is entitled to vocational rehabilitation or job search assistance efforts under a *National Tea* analysis.

The petitioner testified that his past jobs always involved labor-intensive work. He never sold anything and didn't do a great deal of paperwork. He never graduated from high school. He attended high school four years. The petitioner testified he has dyslexia. When he tries to read the words get scrambled. He was in special education in high school. He left high school his senior year.

After the petitioner left high school he did not go to any classes or college. The petitioner still does not have a GED. The petitioner still has problems reading. The petitioner will participate in vocational valuation and training if it is awarded. The petitioner wants to go back to work within his restrictions.

Petitioner obtained a report from Lisa Helma, a certified rehabilitation counselor with Vocomotive. *P19.* The documents from Ms. Helma include a rehabilitation plan. *Id.* Ms. Helma mentions that Dr. Sokolowski has determined the petitioner is at functional maximum medical improvement. *Id.* Ms. Helma suggests vocational testing and job seeking skills instruction. *It.* Rehabilitation goals include evaluate potential for retraining and develop computer proficiency. *It.* Ms. Helma noted the difference in functional abilities noted by Dr. Sokolowski and Dr. Phillips. *It.* Based on Dr. Sokolowski's restrictions Ms. Helma suggested employment as a parking lot attendant, assembler, cashier, or driver. *Id.* Based on Dr. Phillips restrictions Ms. Helma suggested retail clerk, industrial worker, janitor, dishwasher, tool crib attendant, and maintenance worker. *Id.* Ms. Helma projected wages between minimum wage and $11 an hour. *Id.* Ms. Helma commented that based on the petitioner's level of education, previous work experiences, and physical capabilities the petitioner did not have transferable skills. *Id.* Ms. Helma's opinion is that the petitioner is in need of vocational rehabilitation to determine what access he has to a stable labor market and to assist him in returning to work. *Id.* Services would include testing by a certified vocational evaluator, basic computer training, job seeking skill instruction, and placement related activities. *Id.*

Ms. Helma estimated that the cost for the Fast Track to Letter Writing computer curriculum is $100 and the cost for keyboard training is $200. *Id.* Vocational testing would cost between $800 and $1000 on a one-time basis. *It.* Job seeking skills instruction would cost $920. *Id.* Ms. Helma estimated that vocational rehabilitation activities would cost $5,000 per month. *Id.*

Respondent in case number 13 WC 33884 for the accident of October 7, 2013 obtained an initial vocational rehabilitation evaluation report from Ms. Jacqueline Bethel at Medvoc Rehabilitation dated October 5, 2017. *R4.* Ms. Bethel noted that Dr. Phillips and Dr. Sokolowski have different restrictions. *Id.* Dr. Sokolowski opines that the petitioner is capable of lifting up to 25 pounds occasionally and 10 pounds frequently. *Id.* Dr. Sokolowski went on to comment that the petitioner could lift 32.5 pounds occasionally with a bilateral shoulder lift of 20 pounds. *Id.* According to Dr. Phillips the petitioner is capable of returning to work with a 30 pound lifting restriction. *Id.* Ms. Bethel issued a labor market survey dated May 5, 2017. *Id.* The expected entry-level medium wages for both Dr. Phillips restrictions in Dr. Sokolowski's restrictions was $10.45 per hour. *Id.*

The arbitrator finds that the Vocomotive costs for the Fast Track to Letter Writing computer curriculum, keyboard training, vocational testing, and job seeking skills instruction are reasonable. Because of the arbitrator's decision regarding causal connection the arbitrator finds that the respondent in 13 WC 33884 is responsible for the cost of the petitioner's vocational rehabilitation plan. Respondent in 13 WC 33884 shall pay for vocational rehabilitation through the provider of Petitioner's choice. *W. B. Olson v. IWCC,* 981 N.E.2d 25 (1st Dist. 2012). Additionally, Respondent shall pay maintenance benefits during this period.

Ms. Helma estimated that Vocomotive vocational rehabilitation activities would cost $5,000 per month. Id. The arbitrator finds this cost unreasonable and is not awarded.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF KANKAKEE	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACQUELINE WILSON,

Petitioner,

vs. NO: 17 WC 16843

STATE OF ILLINOIS,
ILLINOIS DEPARTMENT OF CORRECTIONS
STATEVILLE,

19IWCC0557

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 6, 2018 is hereby affirmed and adopted.

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

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

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

DATED: OCT 11 2019

Douglas McCarthy

DDM/tdm
O: 10/9/19
052

Stephen Mathis

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

WILSON, JACQUELINE
Employee/Petitioner

Case# **17WC016843**

STATE OF IL DOC STATEVILLE
Employer/Respondent

19IWCC0557

On 12/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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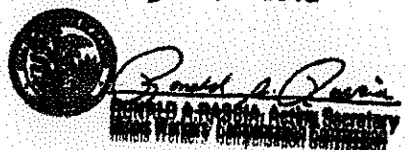
CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

DEC 6 - 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

- [ ] 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)

JACQUELINE WILSON
Employee/Petitioner

v.

STATE OF IL DOC STATEVILLE
Employer/Respondent

Case # 17 WC 16843

Consolidated cases: _____

19IWCC0557

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Kankakee, Illinois**, on **October 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On the date of accident, 11/14/2016, 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 $69,414.28; the average weekly wage was $1,334.89.

On the date of accident, Petitioner was 43 years of age, ***single*** with 1 dependent children.

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $none.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $15,397.30 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $10,891.72 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 the right shoulder surgery as prescribed by Dr. Burra.

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

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

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

Signature of Arbitrator

12/5/18
Date

ICArbDec19(b)

DEC 6 - 2018

Attachment to Arbitrator Decision
(17 WC 16843)

FINDING OF FACTS:

19IWCC0557

Petitioner, a 43-year-old correctional officer, had worked for the State since 1999, starting as a youth supervisor. She was hired as a Correctional Officer at Stateville Correctional Center in 2005. She has worked in the same position as Correctional Officer since that time. Her job was security, contain and control, which would include opening and closing heavy jailhouse doors, some powered and some manual, and transporting inmates on writs for medical treatment or to court, which would entail the use of restraints, including handcuffs, leg irons, and waist chains. Petitioner provided that the power doors would frequently jam, and her duties were upper extremity intensive. She would also turn keys and would generally use her left hand to turn the key, and would pull the jail doors with her right hand. Her job also entails feeding the inmates, where she would use one of two chuckholes in particular in each jail cell door, which had a desk on the other side, for the food tray to land without going to the floor.

Petitioner testified that prior to the accident of November 14, 2016, which is the subject of this claim, she had undergone a one level cervical fusion to the neck. She never had any symptoms or problems with regard to the right shoulder or right wrist. Petitioner testified that on November 14, 2016, at approximately 9:00 a.m., she had gone to the third level of the gallery where it was extremely hot, indicating same felt like 100 degrees. An inmate had already popped the sprinkler for relief, and the chuckhole door was expanded shut and stuck. Petitioner stated that she turned the key to the chuckhole with her left hand, and pulled it with her right. Petitioner stated it didn't open, so she jerked it harder and it still didn't open. Then she jerked with all the force of her right extremity, whereupon she heard a pop in her wrist and it swelled. She testified she "used everything I had" when she felt the pop. She filled out an accident report at noon. According to the report, Petitioner wrote, "While feeding the inmates there is a lock above the chuckhole, I unlocked the chuckhole with my left hand & tried to open it (chuckhole) with my right hand & as I pulled to open it (chuckhole) my right hand popped and there was a sharp pain..." Petitioner testified that she felt the full forces on her entire arm as she tried to pull the chuckhole open, but beyond that did not have any significant symptoms with respect to the shoulder. The overarching pain was from her right hand, which she described on the Accident Report as "swollen & in pain". (Resp. Ex. 1) Petitioner stated that after reporting the incident, she moved on to her next assignment, which was to accompany inmates to medical providers for medical writs. While she worked the remainder of the day, she was unable to bend her right wrist.

The following day, November 15, 2016, Petitioner sought treatment with her family physician, Dr. Diedra Greathouse-Williams. Petitioner presented with complaints of swelling of the hand. She reported that she injured her hand at work yesterday pulling on a handle that would not open, that she had swelling on the top of the hand and in her fingers, was unable to grip a pen, that the hand was in pain, and that she couldn't grip or hold anything, having taken Norco the prior night. The doctor on examination noted decreased flexion of fingers 3 and 4 and edema and tenderness over the dorsal surface of the hand. The doctor assessed right hand pain and ordered an MRI. (Pet's. Ex. 1, pp. 5-6) The MRI when performed on November 28, 2016, was essentially negative. (Pet's. Ex. 1, pp. 9-10) Petitioner testified that she was then referred to Dr. Elliot Nacke, a hand specialist at Hinsdale Orthopedics.

Petitioner presented to Dr. Nacke on December 22, 2016. Petitioner conveyed a history of a work place injury that she was trying to pull open a chuckhole of a cell when she felt a pop in her right hand, with subsequent pain, and that she was right hand dominant, with the pain being 7 out of 10. The doctor noted that Petitioner had difficulty making a claw secondary to pain, assessed her as having right hand extensor tenosynovitis, and referred her to occupational therapy for finger range of motion, grip strengthening and modalities, prescribing a Medrol dose pack and continuing her on full duties. (Pet's. Ex. 2, pp. 8-10) Petitioner

testified that she continued to work, wasn't sure full or light, but that her co-workers would assist her on the job. She advised the doctor that while writing she would have to stop several times, and her hand was weak with minimal lifting. (Pet's. Ex. 2, p. 13 – line 4)

Petitioner returned to Dr. Nacke on February 2, 2017. She reported improvement and increased strength with occupational therapy, but was still sore on the dorsal aspect of the forearm and the dorsal radial aspect of the hand. She reported that her pain was worse with attempted lifting or repetitive use of the hand. Her pain rating was 5 out of 10, with continued swelling and joint pain. Dr. Nacke continued occupational therapy and indicated she should advance her strengthening as tolerated. The doctor kept her at full duty and his diagnosis remained right hand and forearm extensor tenosynovitis. (Pet's. Ex. 2, pp. 17-18)

Petitioner began occupational therapy at ATI Physical Therapy on January 3, 2017. At her initial evaluation, she reported pain, swelling and weakness in her right hand, and inability to use her right hand with light activities. (Pet's. Ex. 3, p. 51) On January 31, 2017, the therapist noted that although Petitioner had made improvement with range of motion, she continued with weakness. Increased pain was noted with repetitive activities "like when is working at the gate." Also noted was Petitioner reporting that heavier lifting was limited at work. (Pet's. Ex. 3, p. 58) On February 21, 2017, it was noted Petitioner was progressing. Her weakness was better and her pain was not hindering her as much. Petitioner did however report mild shoulder discomfort. (Pet's. Ex. 3, p. 22) Petitioner testified that in physical therapy she had been using bands where she would stretch her arms out laterally to the side, and her estimate was that the forces were about 7 pounds when she first noticed shoulder pain. By February 23, 2017, Petitioner reported improvement in her right-hand pain. She also reported right shoulder pain which had been increasing over the last few days. Stimulation and heat was used, and she was educated on icing the shoulder. Also noted was that her shoulder pain was hindering progression. (Pet's. Ex. 3, p. 21) The March 14, 2017 ATI progress notes document Petitioner reporting shoulder pain developed in the last three weeks and appeared to be progressive. As a result, the shoulder mobility was impaired by pain in all directions, limiting Petitioner's ability to perform tasks which included dressing, donning and taking off shirts, coats, and other activities. (Pet's. Ex. 3, p. 14)

Petitioner returned to Dr. Nacke on March 16, 2017. Dr. Nacke documented Petitioner reported an onset of severe pain in the wrist and hand on Monday. Apparently, she had been working the gate for approximately one hour at work. The doctor also noted Petitioner had been experiencing worsening right shoulder pain for the past two weeks. An examination of the shoulder revealed tenderness to palpation over the anterior glenohumeral joint. Active range of motion was less than passive range of motion. Also noted was a positive Hawkins, and 4/5 strength in the supraspinatus limited by pain. Dr. Nacke's assessment was 1.) right carpal tunnel syndrome; and 2.) right shoulder impingement syndrome, rule out a rotator cuff injury. The doctor prescribed a cockup wrist splint and referred her to Dr. Burra for shoulder evaluation. She was also given work restrictions of no repetitive use of the right arm, no pushing, pulling, and no lifting over ten pounds. (Pet's. Ex. 2, pp. 20 – 23)

Petitioner was discharged from occupational therapy on March 16, 2017. The discharge summary notes Petitioner was discharged by physician. Also noted was her "Shoulder mobility is causing pain during day to day tasks. She has to work on the chauk hole which requires extensive manipulation involving both hands. There is some heavier pulling involved with this repetitive tasks…" (Pet's. Ex. 3, p. 8)

Petitioner continued with Dr. Nacke due to her hand and wrist requiring further care. On March 30, 2017, Petitioner reported right hand pain on a 10/10 scale with activity. She also reported that her shoulder pain had decreased due to time off from occupational therapy. Dr. Nacke administered a steroid injection to her right wrist due to ongoing pain. (Pet's. Ex. 2, pp. 24 – 26) By April 27, 2017, Petitioner reported 6/10 intermittent pain which radiated from the 4th webspace along the radial border of the small finger. Her pain was worse with attempted adduction of the small finger. Dr. Nacke recommended a transition to a home program after two (2) weeks of occupational therapy. Her light duty restrictions were continued. (Pet's. Ex. 2, pp. 28 -30)

On May 24, 2017, Petitioner presented to Dr. Giridhar Burra. Dr. Burra documented that Petitioner presented due to a work related injury when "...she was trying to pull open a chuck hold of a cell with her right hand when she felt a pop in her right hand. She attempted to pull the chuck hole with her shoulder going into an extensive movement. She reports that the chuck hole was stuck and she attempted to forcefully open the chuck hole...and was unsuccessful. She developed pain and swelling to her hand immediately after attempting to open the chuck hole..." She additionally reported that while in physical therapy for her hand, she started noticing anterior shoulder pain. She denied any prior injury to the right shoulder. Petitioner described her anterior shoulder pain as sharp and major. She had pain in all planes of movement with increased night time pain when attempting to sleep on the effected shoulder. She also reported a prior spine fusion at C3 in 2002. (Pet's. Ex. 2, p. 31) Dr. Burra on physical exam noted decreased range of motion when compared to the left. Petitioner's Hawkins, Neer, Speed and O'Brien's tests were all positive. X-rays were obtained which the doctor opined demonstrated impingement and AC arthritis. Dr. Burra's impression was right shoulder slap lesion, biceps tendonitis and impingement. Dr. Burra opined that the diagnosis was consistent with the mechanism of injury. He ordered an MR arthrogram and continued her restrictions. (Pet's. Ex. 2, pp. 31-35)

The prescribed arthrogram was completed on June 2, 2017 at Silver Cross Hospital for Hinsdale Orthopedics. The MRI arthrogram revealed a "high-grade bursal surface partial thickness tear of the interior of the anterior supraspinatus tendon from its greater tuberosity foot print. There is up to seven-millimeter retraction of the bursal surface fibers with only a few threads of articular surface fibers remaining intact. This tear is over 80% of the thickness of the footprint anteriorly and centrally. There is no significant supraspinatus atrophy. . ." (Pet's Ex. 2, p. 37)

Additionally, regarding the labrum, the report reflected: "there is some fluid beneath the superior labrum suspicious for a partially graduated Slap-Type Tear." The impression was a high-grade bursal surface partial thickness tearing of the anterior supraspinatus tendon with up to 7 millimeters retraction of the bursal surface fibers with no significant atrophy, and a probable labral detachment extending into the superior aspect of the posterior labrum (Pet's. Ex. 2, p. 37)

Petitioner returned to Dr. Burra on June 5, 2017. She continued to complain of shoulder symptoms noting that she was unable to sleep on the right side. In his progress notes, Dr. Burra commented on his review of the MRI stating:

> "I have reviewed her MRI and clearly there is a near full thickness tear of the anterior portion of the supraspinatus that is confirmed in multiple planes in the coronal as well as the sagittal and to a certain extent in the axial view. This appears to be a bursal-sided involvement. This makes the prognosis a little bit more guarded as opposed to an articular-sided tear. The radiologist had also quantified this as high grade with retraction of about 7 mm. From a degree of involvement, the radiologist has qualified this over 80%, in my opinion, this is for all intents and purposed a near full-thickness tear. Specifically, there is no atrophy. There is no definite evidence of any significant chronicity. . . There is a suggestion of some signal changes in the labrum consistent with a diagnosis of a labral tear. . ."

Dr. Burra noted Petitioner initially presented with wrist and hand issues, but as these worked through, the shoulder came to light. He noted her clinical exam correlated with her MRI findings, and that it was reasonable to consider surgical intervention given that it's a near full thickness tear that has bursal sided involvement and she is symptomatic at rest. The doctor emphasized that "...While defined as a partial-thickness tear this will need to be treated as a full-thickness tear because of the degree of involvement and the bursal-sided involvement..." Petitioner elected to proceed with the recommended surgery. (Pet's. Ex. 2, pp. 39-43)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Kathleen Weber at Midwest Orthopedic on July 17, 2017. In her report dated same, Dr. Weber noted that in addition to performing an examination, she reviewed medical records from both Dr. Nacke and Dr. Burra as well as the therapy records from ATI. The doctor did not view diagnostics but instead relied on the treating doctors records for same. Dr. Weber diagnosed Petitioner with a resolved right-wrist sprain and a mild impingement and biceps tendinitis. Regarding the right wrist, the doctor opined that a causal relationship existed between her right wrist condition of ill-being and the work accident. The doctor however opined that a causal relationship did not exist between Petitioner's right shoulder condition of ill-being and the work accident. The doctor based her opinion on Petitioner not reporting any shoulder discomfort until "at least" three (3) to four (4) months from the incident. She indicated Petitioner clearly had preexisting changes as reported by Dr. Burra's description of the MRI. The doctor indicated that based on Dr. Burra's description of a near full-thickness tear and labral pathology, "I find it hard to believe exercises in physical therapy would have resulted in a tear of the labrum and/or rotator cuff tear. I find no clear mechanism of injury from PT exercises that would result in a labral tear or RTC tear…" Dr. Weber opined that no further treatment was necessary for the right wrist. She indicated that due to Petitioner's complaints of anterior pain and mild impingement, she would recommend a subacromial injection and possible biceps sheath injection. The doctor added that if unsuccessful, surgery would be reasonable. (Resp's. Ex. 5)

On May 15, 2018, Dr. Weber authored an addendum report after reviewing additional medical documentation including but not limited to Petitioner's diagnostics of November 28, 2016 and July 17, 2017. Dr. Weber provided that her opinions remained the same as previously stated in her earlier Section 12 report. The only difference is that she would add four (4) to six (6) weeks of shoulder strengthening therapy to her recommendation. (Resp's. Ex. 6)

Dr. Burra was deposed in this matter on April 6, 2018. Dr. Burra testified that he is an orthopedic surgeon specializing in sports medicine with a particular emphasis on shoulder and upper extremity surgery. Currently his practice is 100% sports medicine and with 80% of it being shoulder related. The doctor provided that he performs thirty-five (35) to forty (40) operations per month with 90% of those being related to the shoulder. (Pet's. Ex. 9 p. 27)

Dr. Burra testified that based on Petitioner's history given and her symptoms, she obviously had an injury when she was trying to pull this hold. He stated that because Dr. Nacke was treating her, there was some amount of restricted activity or lack of full use of the arm. As she started being exposed to activity, she started noticing some symptoms in the shoulder. The doctor explained that for a diagnosis of rotator cuff tear or even a labral tear, symptoms are a reflection depending on the size of the tear or the extent of the tear if it's labral, and symptoms are clearly related also to activity. The doctor provided an example that "…if I have a labral tear and I just sit at the desk and don't do anything, I may not have any symptoms, but I start throwing a ball…, I will start having symptoms. (Pet's. Ex. 9 pp. 13 – 14)

When asked to opine on Petitioner not reporting any shoulder symptoms until she reported same at ATI approximately 3 months following the accident, Dr. Burra stated, "…she had an acute injury. She was incapacitated with time and rest. As she started using that, she noticed shoulder pain… and these didn't get better and they actually were worsening somewhat. Her diagnosis correlates with an objective study. The MRI's, you know, if this something that's been there for five, six seven years and it's pre-existing, the MRI would clearly show atrophy and retraction." The doctor added, "And the fact that this was a full thickness, only involving the anterior portion of the tear would clearly fit her story where it's not very symptomatic but once you're exposed to activity, activity is like a stress test to the shoulder, she started getting pain. And it's a bursal sided tear - bursal sided tears are - have relatively poor prognosis. Bursal sides are the top side tears and they tend to progress. That's why we are very careful about giving steroid injections to these people. And now that she had a small near full thickness tear, when you have a small tear like that, they go in and out of symptoms and the strength deficits. Okay. Somebody with a massive tear and they can't lift their arm, everybody can

make the diagnosis. She has a small near full thickness tear. Unfortunately, its bursal sided. It is near full thickness. And she had the labral tear. That mechanism of injury of pulling is very consistent with it. This is a traction failure. The best way I can describe it as a rubber band being stretched too, and that's where they will fail. The anterior supraspinatus is a risk tear and along with that goes the biceps tendon and SLAP - the superior labral which SLAP lesion." (Pet's. Ex. 9 pp. 14 – 16)

Dr. Burra testified that the mechanism of injury is a traction injury. He stated that "…When you are pulling something, you are contracting your biceps tendon. There is an axial traction along the upper extremity. So, the biceps tendon, your pulling something, you are trying to bend your elbow so to speak, that's contracting the biceps and also there is an axial traction along the line. And what that does, the interior supraspinatus is under strain, the biceps tendon is connected to the labrum and that's how these injuries happen…Same thing with the supraspinatus, so when there is a pressure produced especially when you end up tearing a labrum, the biceps stops contracting, that's the natural inclination. So, all of a sudden, the weight of the body is going backwards and the arm is there, and a momentous injury, it's a fraction of a second, and the rotator cuff sees the strain, especially the interior most portion of the supraspinatus, that's how these injuries happen. It's a quick sequence" (Pet's. Ex. 9 pp. 17-18)

Regarding the need for surgery, Dr. Burra explained that it is widely accepted in literature that surgery I warranted for anything more than 50% involvement, and especially if it's bursal sided, and in her case it's 80 to 90% full thickness and bursal sided. He indicated that there is no controversy about it and surgery is clearly necessary for her. (Pet's. Ex. 9 pp. 18 – 19) Dr. Burra went on to explain that both labral lesions and small rotator cuff tears are notorious for being silent as they require a certain amount of exposure of activity to come to the surface. The doctor provided that they can fail one strand at a time. He noted that the rotator cuff is called one entity, but it has multiple fibers and if you tear enough, then gradually it gets worse and worse and gets bigger and bigger and at some point it becomes symptomatic. (Pet's. Ex. 9 pp. 19 – 20)

Dr. Burra was asked about the role of the AC joint having some mild degenerative changes. Dr. Burra explained it is a pain generator. He did not feel it was playing a significant roll into the overall picture at this point other than being a source of pain. He stated that if Petitioner had months and months of gradually ongoing shoulder pain and had injections, you could say it's an AC joint manifesting, but the problem here was clearly localized primarily to the rotator cuff and the labrum. He added that if there was contribution from the AC joint, you would nibble off a little piece of bone there. Nevertheless, he did not feel this was contributing to her problem. (Pet's. Ex. 9 pp. 20-21)

Dr. Burra was also asked about Dr. Weber's recommendation regarding administering injections. Dr. Burra testified that based on current literature, especially in the last two years, it is obvious that injecting cortisone when there is a rotator cuff tear present carries a significant risk that the tear will become a larger full thickness tear and the quality of the tendon would also degenerate. Dr. Burra stated "This is unequivocally accepted. In fact, Rush's own literature…, they published this, [and] they actually teach it". The doctor continued that within the last 18 months, it is universally accepted that you would not inject cortisone. Similarly, injection into the biceps tendon sheath also carries some risk of rupture of the tendon, especially in a female patient. The only injection he would give is a local anesthetic if there was some question of where the pain was coming from, for diagnosis purposes. (Pet's. Ex. 9 pp. 23-25)

Regarding symptom magnification Dr. Burra testified that Petitioner was quite resolute and gave a great effort. (Pet's. Ex. 9 p. 25)

On cross examination, Dr. Burra was asked, based on his experience with these injuries, is it consistent to be seen by a doctor in November, have numerous physical therapy visits and not have experienced any pain until 3 months later. The doctor replied, "actually very much so and that's actually fairly consistent with what I

see in some of these where more than two body parts are involved." (Pet's. Ex. 9 p. 38) Lastly, when asked whether additional conservative treatment, i.e., additional physical therapy, would be sufficient to return Petitioner back to work, Dr. Burra testified that "…if you got 80% failure, if you try to strengthen that, the remaining 20% are going to fail too and now you got a bigger problem." He added that the "literature clearly says if 50% or more, operate. 50% or less, try to strengthen. (Pet's. Ex. 9 pp. 51 -52)

Dr. Susan Weber also testified via deposition in this matter. Dr. Weber testified that she is Board Certified in internal medicine and sports medicine. She sees 120 to 140 patients a week, for ankle, knee, hip, thigh, back, shoulder the whole muscular skeleton system. (Resp. Ex. 7 pp. 4 – 6) She does not perform orthopedic surgeries, but has assisted in a right shoulder surgery, probably 10 years earlier. The doctor added that if she is actively treating a patient who she deemed a surgical candidate, she refers them to one of her partners. (Resp. Ex. 7 pp. 45 – 47)

Dr. Weber testified that she examined Petitioner at Respondent's request on July 17, 2017. She stated that based on Petitioner's examination and her evaluation of the medical records, Petitioner diagnosis was mild impingement, referencing the rotator cuff, and biceps tendinitis. The doctor testified that she did not believe Petitioner's right shoulder condition of ill-being was causally related to the incident. She testified that if Petitioner injured her shoulder on November 14, 2016, she would have complained of shoulder pain within ten to fourteen days from this date. The doctor stated there was no incident that Petitioner described other than providing "…it happened with the course of therapy, which makes no sense to me." When asked "…have you ever seen in your practice …where somebody has a dormant injury that doesn't manifest itself until some later issue becomes presented," the doctor replied, "Months later, no." (Resp. Ex. 7 pp. 21 – 24) With regard to her IME addendum, Dr. Weber testified that she reviewed the right wrist MRI taken on November 28, 2016 as well as x-rays taken in her office of the right wrist and shoulder on July 17, 2017. The shoulder MRI was not reviewed. (Resp. Ex. 7 p. 30) Referring to Dr. Burra records, Dr. Weber stated Petitioner had preexisting findings on her MRI. Dr. Weber sated that Petitioner's shoulder x-rays revealed degenerative cystic changes at the insertion of the supraspinatus which are also pre-existing. Dr. Weber added that she found no clear mechanism of injury from any of the physical therapy notes. (Resp. Ex. 7 pp. 30 – 31, 56)

Dr. Weber was asked to respond to Dr. Burra's opinion that there was a dormant injury that occurred on the date of accident but that injury did not manifest itself until Petitioner began physical therapy. Dr. Weber responded, "…based on typical treatment for a wrist, I can't see anything that they would have done that would have caused a dormant injury that occurred four months earlier to get bothered…she has degenerative changes on her – she doesn't have a normal shoulder the day she had the injury based on the cystic changes seen just on the x-ray. And so if she would have bothered her shoulder at the time, she would have known it…." (Resp. Ex. 7 p. 35)

On cross-examination, Dr. Weber testified that forceful pulling on a chuck hole would not cause a rotator cuff tear or labral tear. She however indicated that it could potentially aggravate a rotator cuff at the time. (Resp. Ex. 7 p. 62) Dr. Weber testified that a person with a rotator cuff tear in their shoulder would feel pain in their shoulder by doing activities such as reaching overhead or reaching behind a person's back. (Resp. Ex. 7 p. 65) Dr. Weber acknowledged that Petitioner may need surgery if her symptoms persist. However, she felt the surgery would only be appropriate if Petitioner failed extensive conservative management i.e., subacromial injection, possible biceps sheath injection and physical therapy. Dr. Weber stated she was not aware of literature that the injections she recommended were contraindicated. (Resp. Ex. 7 pp. 62-63)

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

It is undisputed that Petitioner's current condition of ill-being with regard to her right wrist is causally related to the November 14, 2016 accident. It is also clear that Petitioner on several attempts was using the full force of her right arm and shoulder to attempt to pull open a chuckhole which was stuck. Petitioner credibly testified that she was attempting to pull the chuckhole door open with all her strength. She heard a popping in her right wrist. Petitioner testified that she felt the full forces on her entire arm as she tried to pull the chuckhole open, but beyond that did not have any significant symptoms with respect to the shoulder. The overarching pain was to her right hand. Thereafter, due to the immediate acute effects and continued treatment and significant symptoms of her hand and wrist, documented by Dr. Nacke, the use of her right upper extremity was limited. Three months later, while only up to seven pounds, using bands in physical therapy, she began noticing symptoms of her shoulder, which progressed from mild to significant in a short period of time, consistent with a progression which was asymptomatic at its inception. The reasonable inference, consistent with Dr. Burra's testimony, is that the tear was small enough, or the activities limited enough, to a point where three months later the tear was larger, activities in physical therapy greater, and symptoms arose and the progression quickly accelerated. Dr. Burra's explanation that a tear can be small enough, or activities limited enough, that a tear doesn't manifest until it progresses, or activities increase, is reasonable.

The Arbitrator is persuaded by Dr. Burra testimony that "...she had an acute injury. She was incapacitated with time and rest. As she started using that, she noticed shoulder pain... and these didn't get better and they actually were worsening somewhat. Her diagnosis correlates with an objective study. The MRI's, you know, if this something that's been there for five, six seven years and it's pre-existing, the MRI would clearly show atrophy and retraction...And the fact that this was a full thickness, only involving the anterior portion of the tear would clearly fit her story where it's not very symptomatic but once you're exposed to activity, activity is like a stress test to the shoulder, she started getting pain. And it's a bursal sided tear - bursal sided tears are - have relatively poor prognosis. Bursal sides are the top side tears and they tend to progress...And now that she had a small near full thickness tear, when you have a small tear like that, they go in and out of symptoms and the strength deficits...She has a small near full thickness tear. Unfortunately, its bursal sided. It is near full thickness. And she had the labral tear. That mechanism of injury of pulling is very consistent with it. This is a traction failure...The anterior supraspinatus is a risk tear and along with that goes the biceps tendon and SLAP - the superior labral which SLAP lesion."

With the exception of a week off initially, Petitioner returned to worked with help from her co-workers throughout this period of time. The medial records document restrictions of very limited use of the hand, which would limit use of the arm. According to Dr. Burra, the MRI arthrogram imaging showed the type of pathology that surgery should be done without injections or therapy, which would be contraindicated. Dr. Burra convincingly explained how a tear can grow with activity. Petitioner having significantly limited use of her right extremity was not because of her shoulder but because of her wrist. It was not until Petitioner began physical therapy that her shoulder symptoms began to manifest.

The Arbitrator finds Dr. Burra's testimony to be clear and convincing, especially as to the mechanism of injury of a less common type tear. The Arbitrator is not persuaded by the opinion of Dr. Weber, especially as to what other etiology might have caused such a tear when Petitioner had limited use of the hand and the symptoms appeared 3 months after the accident while her extremity was limited by reason of the symptomatic wrist. The Arbitrator notes that Dr. Weber did not appear to appreciate the additional risks and poor prognosis of a bursal sided near full thickness tear and her failure to address the lack of chronicity within Dr. Burra's (and the radiologist's) interpretation diminishes the value of her opinions. Also of note is both doctors agree that the accident could cause or as Dr. Weber acknowledged could aggravate, a rotator cuff.

The Arbitrator also notes Respondent has offered no evidence to contest the diagnoses or treatment of Dr. Nacke other than the opinions of Dr. Weber. Dr. Nacke's diagnosis and the chain of events, including immediate and then protracted symptoms and treatment, support the conclusion that this condition was more

than a mild sprain. The Arbitrator adopts the findings and conclusions of Dr. Nacke, who was the only hand specialist to address those issues.

Accordingly, the Arbitrator finds that a causal connection exists between the accident of November 14, 2016, and Petitioner's condition of ill being with respect to her shoulder, as well as to her right wrist.

With respect to J.)Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services; and, K.) Is Petitioner entitled to any prospective medical care, the Arbitrator finds the follow:

Respondent objected to the medical bills submitted only on the basis of liability with regard to causation to the shoulder. Having found in favor of Petitioner on said issue, the Arbitrator awards the submitted bills. The parties stipulated that if found compensable, Respondent shall have credit for any bills paid as well as any bills paid through the group carrier. Having receive such credit, Respondent shall hold Petitioner harmless with respect to such payments pursuant to Section 8(j) of the Act. Respondent may pay any unpaid bills directly to providers.

The next issue for the Arbitrator is whether shoulder surgery be ordered now, or whether to follow Dr. Weber's opinions that injections and therapy should be attempted before surgery. In that regard the Arbitrator finds Dr. Burra persuasive especially in light of testimony that both injections and physical therapy would put Petitioner at greater risk for an increased tear, leading to an even poorer prognosis. Dr. Burra's testimony as to the reasons for not performing epidural injections or physical therapy is convincing.

Accordingly, the Arbitrator awards the shoulder surgery recommended quested by Dr. Burra in his record of March 5, 2017. Respondent shall authorize and perform all acts necessary to effect said surgery as soon as reasonably practical.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICIA TORRES,

Petitioner,

vs. NO: 15 WC 24645

LABOR TEMPS,

Respondent.

19IWCC0558

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical, prospective medical, and temporary total disability (TTD), and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission writes, however, to correct the scrivener's error contained within the Statement of Facts on page 4 of the Arbitrator's Decision. It was noted that the Petitioner returned to Dr. Bayran on April 29, 2015; however, the Petitioner saw Dr. Bayran on April 29, 2016. Therefore, the Commission corrects the date of Petitioner's visit to Dr. Bayran to reflect April 29, 2016, not April 29, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2018 is hereby affirmed and adopted.

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

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

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

DATED: OCT 1 1 2019

DDM/tdm
O: 10/9/19
052

D. Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

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

TORRES, PATRICIA
Employee/Petitioner

Case# **15WC024645**

LABOR TEMPS
Employer/Respondent

19IWCC0558

On 12/12/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.48% 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:

4340 EFTEKHARI LAW OFFICES
EHSAN EFTEKHARI
701 MAIN ST SUITE 203
EVANSTON, IL 60202

5001 GAIDO & FINTZEN
GAIL M BEMBNISTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Patricia Torres
Employee/Petitioner

v.

Labor Temps
Employer/Respondent

Case # **15** WC **24645**

Consolidated cases: **N/A**

19IWCC0558

An *Application for Adjustment 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 **Geneva**, on **October 17, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 15, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 $**16,849.56**; the average weekly wage was $**324.03**.

On the date of accident, Petitioner was **45** years of age, *married* with **2** dependent children.

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

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

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT ON MAY 15, 2015 AND FURTHER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUFFERED ANY CONDITION OF ILL BEING CAUSALLY RELATED TO HER EMPLOYMENT WITH RESPONDENT, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 30, 2018
Date

DEC 12 2018

ICArbDec19(b)

Statement of Facts

Petitioner Patricia Torres testified in Spanish through an interpreter. She testified that on May 15, 2015, she was living with her husband. She was going through a divorce. She had two dependent children under 18 years old. She testified that, on that date, she was employed by Respondent Labor Temps and assigned to Suncast Corp. Her job duties were to assemble plastic parts. She testified that she had been working there for about 3 months. She then agreed she began work on March 23, 2015. Petitioner testified that she worked 8 hours per day, a scheduled 40 hours per week. Respondent offered Petitioner's wage statement as RX 5. The record shows that Petitioner began employment on March 23, 2015, working short weeks varying from 8 to 30 hours per week though April 15, 2015. She then worked 2 weeks of 32 hours and 2 weeks of 40 hours before May 15, 2015.

Petitioner testified that her job required pressing plastic caps with force into the openings at the ends of cylindrical tubes for placement into boxes used for hose reels. The boxes came to her on a conveyor. She had to put two pieces on each box. They came very fast, about one per minute, 100's per shift. She also put on wheels in a different area. This also required her to use her hands to press the wheels on. She testified that she sometimes used a mallet to put the pieces together when she became tired. She testified she is right handed but used both hands to do her job.

Petitioner testified she previously worked for FCA Manufacturing from 2010 to March 2015. Her job duties were to assemble wooden boxes using air guns, staple guns and tack guns. Petitioner testified this work was not as physical as her work at Suncast. Petitioner testified she developed right carpal tunnel syndrome doing this work and had surgery. She did have some left-hand complaints as well. She testified she was placed on light duty and had no further problems. She testified she saw her primary care doctor three times for the left hand. He gave her pain pills and light duty restrictions. She had no further major issues. She was recommended for physical therapy but did not have any. She had no surgical recommendation for the left hand. She testified that when her left hand hurt really bad, it prevented her from doing her work at FCA. Petitioner filed Workers' Compensation claims for the right and left hand against FCA. Petitioner testified that FCA is contesting these claims. Respondent offered the Application for Adjustment of Claim for case 11 WC 44027, claiming injury to the left hand, arm and shoulder as a result of repetitive trauma with a date of accident of 11/10/11 (RX 1). [The Arbitrator has redacted this Exhibit to remove the Petitioner's social security number.] The Commission website reflects that this case is still pending on the Peoria Arbitration Docket.

Petitioner testified that on May 15, 2015, her hand was hurting a lot and she told her supervisor. She testified she was put on light duty. Petitioner testified she first felt pain on May 15, 2015. She did not remember if she reported pain on April 30, 2015. Respondent offered RX 4 which are Respondent's email records of Petitioner's reporting. On June 9, 2015, Julio Benitez noted that Petitioner reported a minor injury on April 30, 2015 to Security Office Wright of slight pain in arms caused by putting the crank and outer tubes on the hose reels with too much force. He followed up on September 14, 2017, noting Petitioner was switched to a different press and no other issues were heard from her (RX 4). Petitioner continued work for Respondent at Suncast through June 9, 2015 (RX 5). Petitioner testified that she did not have a medical restriction or off work recommendation. She left because she could not take the pain.

Petitioner sought treatment at The Pain Centers of Illinois (PX B). She was seen by Dr. Bayran on June 15, 2015 complaining of pain in her left wrist and hand radiating up into her left forearm, elbow, arm and shoulder into the left side of her neck. Petitioner provided a history of pain for about a month. She works making plastic

boxes. She stated that as she was pushing on the sides and cranking to hold it up, she felt pain in her left wrist and hand. She stated the pain has gotten worse and she has not been back to work since last Monday. She denied a history of pain in her left upper extremity prior to this incident. Dr. Bayran assessed carpal tunnel syndrome caused by work injury which happened last month. He recommended 4 weeks of physical therapy. He placed Petitioner on restrictions of 10 pounds lifting and no repetitive forceful hand squeezing on the left side (PX B).

Petitioner underwent physical therapy at ATI from June 17, 2015 through July 16, 2015 (PX D). Petitioner reported slightly decreased pain, but that it still limits her, especially at night. She also reported tingling around the entire left arm (PX D). Petitioner saw Dr. Kao at The Pain Center of Illinois on September 24, 2015. She reported a 30% improvement in her symptoms with physical therapy. She continued to have bothersome pain in her left hand radiating into her left wrist, left forearm, elbow and shoulder with numbness. Dr. Kao recommended an EMG/NCV (PX B). The EMG/NCV performed October 8, 2015 was consistent with left carpal tunnel syndrome. Petitioner was advised to follow up with an orthopedic hand specialist for treatment options and to follow up with Dr. Kao in a month (PX B).

Petitioner was next seen by Dr. Bayran on March 19, 2016. Petitioner reported she continued to work with pain. She complained of weakness in the left hand. Physical examination was unchanged. Dr. Bayran's assessment was cervicalgia and carpal tunnel syndrome left wrist. He stated that the left wrist and hand pain is most likely secondary to carpal tunnel syndrome caused by work injury which happened about a month ago. Petitioner was referred to Dr. Markarian for a surgical evaluation (PX B). Petitioner saw Dr. Markarian on April 12, 2016 (PX F). Petitioner provided a history of doing a lot of repetitive assembly line work about 8 hours a day, picking up small pieces of plastic individually by hand and putting them into boxes. She complained of symptoms of carpal tunnel syndrome on May 15, 2015. She had conservative treatment and it has not improved. Dr. Markarian diagnosed carpal tunnel syndrome and recommended an open carpal tunnel release (PX F).

Petitioner returned to Dr. Bayran on April 29, 2015. She reported working in a new job. Her examination was unchanged. His diagnosis was unchanged. Petitioner was to follow up with Dr. Markarian (PX B). Petitioner saw Dr. Markarian on May 14, 2016. He was waiting for approval of the recommended surgery (PX F).

On July 27, 2017, Respondent obtained a Utilization Review of the medical treatment performed. The treatment was certified with the exception of the physical therapy, where 3 visits of the 14 were certified (RX 2).

Petitioner was evaluated by Dr. Michael Vender at Respondent's request on June 19, 2017. He testified by evidence deposition taken August 14, 2017 (PX 3). Dr. Vender testified that Petitioner provided a history of performing her normal work activities on the assembly line on May 15, 2015 when she felt pain in the left upper extremity. She felt this was related to pushing parts. She did not have a specific injury. She did not give a detailed job description. She stated she handled various things at work. She had been at this job about 3 months. He reviewed her medical records. He also scheduled a new EMG which found carpal tunnel syndrome on the left. His diagnosis was carpal tunnel syndrome. It would be reasonable to proceed with a carpal tunnel release (RX 3).

Dr. Vender opined that Petitioner's work for Respondent was not a causative factor in her diagnosis of carpal tunnel syndrome. He stated that from the job description he reviewed and Petitioner's brief description, there is

no indication that her job activities had any significant forceful exposures or forceful exposures for any duration or repetitiveness. He also stated that even if there was a high-risk job, the employment was only for a limited period of time. It would have to be something exceptional to consider a causal relationship in that short a period of time. He stated that Petitioner has other risk factors including increased body mass, gender and age (RX 3).

Dr. Vender testified that you look for the same risk factors in assessing if the job exacerbated a pre-existing condition. If it does not represent a risk factor for causation, it is not a risk factor for aggravation. Repetition, force and duration can elicit symptoms. Staying away from risk factors lessens the likelihood of developing symptoms. He testified Petitioner's job was not a risk factor. Dr. Vender did not get a detailed job description from Petitioner. He has not seen a job video. If her job was forceful and exertional with duration, that would be a job that he could consider possible a risk factor. In this case we also have the short term of employment. Dr. Vender stated that the carpal tunnel could have been random or idiopathic. Petitioner would have developed it even without having worked for Respondent (RX 3).

Dr. Vender has no opinion with respect to causal connection of Petitioner's carpal tunnel syndrome to her prior employment. He was not asked to give an opinion on prior causation. He was provided no information about her prior employment. If Petitioner had a prior forceful, repetitive, exertional job for a sufficient period of time, that could potentially sway his opinion as to whether the source of her carpal tunnel and the causal relationship to the prior employment. Prior work history is not relevant to his causal connection opinion regarding her work at Respondent (RX 3).

Petitioner testified that she missed about 2 months of work. She returned to work in August 2015. The doctor did not tell her when she could return to work. She has worked various jobs through temporary agencies. She is currently working at a paper envelop company since July 2018. Petitioner testified that she does not work well with the left hand. She has pain when she lifts things. She identified her outstanding medical bills. She would get the carpal tunnel release surgery if it was authorized.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (D) Date of Accident and (F) Causal Connection, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. Petitioner in the present case is alleging that she developed carpal tunnel syndrome in her left hand as a result of the repetitive assembly work she was performing for Respondent at Suncast. An employee who suffers a repetitive trauma injury still may apply for benefits under the Act but must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n, 224 Ill. 2d 53, 64, 862 N.E.2d 918, 924, 308 Ill. Dec. 715 (2006).* In a repetitive trauma case, issues of accident and causation are intertwined. Therefore, a review of the evidence allows both issues to be resolved together. *Boettcher v. Spectrum Property Group and First Merit Venture Realty Group,* 97 W.C. 44539, 991.I.C. 0961.

An employee who alleges injury based on repetitive trauma must show that the injury is work related and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Comm'n, 115 Ill. 2d 524, 530, 505 N.E.2d 1026, 106 Ill. Dec. 235 (1987); Edward Hines Precision Components*

v. Industrial Comm'n, 356 Ill. App. 3d 186, 194, 825 N.E.2d 773, 292 Ill. Dec. 185 (2005). In cases relying on the repetitive-trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. *Williams v. Industrial Comm'n, 244 Ill. App. 3d 204, 209, 614 N.E.2d 177, 180, 185 Ill. Dec. 43 (1993).* Although medical testimony as to causation is not required in every workers' compensation case, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of. *Nunn v. Industrial Comm'n, 157 Ill. App. 3d 440 at 478*; see also *Johnson v. Industrial Comm's, 89 Ill. 2d 438 at 442-43.*

In the present case, the evidence also establishes that Petitioner had complaints in the left hand prior to her employment with Respondent and is also pursuing a claim for the left hand against her former employer FCA, raising a possible aggravation theory. Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions, and this is especially true in repetitive trauma cases. *Nunn v. Industrial Comm'n, 157 Ill. App. 3d 470 at 478.* Thus, repetitive trauma claims involving the alleged aggravation of a preexisting condition cannot succeed unless the claimant presents medical evidence suggesting that (1) the claimant had a preexisting condition that was or could have been aggravated by her repetitive work activities, and (2) her current condition of ill-being was or could have been caused (at least in part) by this work-related trauma and is not simply the result of a normal, degenerative aging process.

Petitioner offered medical records of Dr. Bayran and Dr. Kao at The Pain Center of Illinois and Dr. Markarian. The Arbitrator has carefully reviewed the records. While Dr. Markarian takes a description of Petitioner's work duties as repetitive assembly work about 8 hours per day picking up plastic pieces and putting them in boxes, his records do not include any causation opinion at all. Dr. Bayran notes that Petitioner works assembly making plastic boxes and takes a history of a single incident when she was pushing on the sides of the proximal and cranking to hold up and she felt pain in her left wrist and hand. Petitioner denied any history of pain in her left upper extremity prior to this incident. Dr. Bayran states her carpal tunnel syndrome is likely caused by the work injury which happened about a month ago. Dr. Kao finds Petitioner has left upper limb pain and numbness secondary to her work injury, but his notes have no history of accident or description of any incident or work duties whatsoever. The EMG report simply lists Petitioner's complaints as left upper limb pain and numbness since her work injury of May 2015. The Arbitrator infers that Dr. Kao was basing his statements solely on Dr. Bayran's opinion and statements made by Petitioner.

Respondent offered the deposition testimony of Dr. Vender. Dr. Vender opined that Petitioner's work for Respondent was not a causative factor in her diagnosis of carpal tunnel syndrome. He stated that from the job description he reviewed and Petitioner's brief description, there is no indication that her job activities had any significant forceful exposures or even forceful exposures for any duration or repetitiveness. He also stated that even if there was a high-risk job, the employment was only for a limited period of time. It would have to be something exceptional to consider a causal relationship in that short a period of time. He stated that Petitioner has other risk factors including increased body mass, gender and age

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); Fickas v. Industrial Comm'n, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).* Expert testimony shall be weighed like other evidence with its weight determined by the character,

capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue but may look 'behind' the opinion to examine the underlying facts. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information. See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983).

Having heard the testimony and reviewed the evidence in this matter, the Arbitrator finds the treating causal connection opinions presented are not credible because they are based upon an incomplete and inaccurate history. None of the doctors who saw Petitioner had sufficient evidence regarding her work activities to form a reliable causation opinion. Absent credible evidence, the burden of proof, which is on claimant, is dispositive. *Nelson v. County of De Kalb, 363 Ill. App. 3d 206, 211, 840 N.E.2d 795, 298 Ill. Dec. 682 (2005).*

Petitioner's history is inaccurate on multiple levels. Dr. Bayran takes a history of a specific episode occurring in May 2015, but this is contradicted by the evidence. Petitioner herself testified that she did not have a specific accident. The emails admitted note that she made a complaint on April 30, 2015 and was transferred with no further complaints until she stopped working for Respondent in June. Petitioner testified that she worked 8 hours per day, 5 days per week, but the payroll records show that she worked only short weeks through the onset of symptoms on April 30, 2015, many only 8 hours per week. Most significant, Petitioner denied any prior left upper extremity complaints, when she admitted prior symptoms and treatment for the left hand related to her employment at FCA. While Petitioner stated she only had 3 visits with her family doctor for the left hand, she still has a pending claim against FCA for left hand disability and testified the matter has been denied by the them. She admitted she was placed on light duty for the left hand and recommended for additional physical therapy which she did not have due to the denial of the matter.

Dr. Bayran therefore based his opinion on the false assumptions that Petitioner had a specific episode where she developed pain and that Petitioner had no prior left upper extremity condition. The medical opinion was further based on incomplete information as to the length of time she had been employed by Respondent, the number of hours worked and lacked sufficient detail concerning the nature and frequency of the work. The Commission has determined a claimant fails to prove causation from repetitive trauma when the treating physician testified repetitive motions caused the injuries but failed to detail what repetitive motions the petitioner engaged in and the frequency of the motions. *Gambrel v. Mulay Plastics, 97 IIC 238.* Incomplete or inaccurate history, particularly related to prior medical condition or details of the job duties, has resulted in denial of benefits. See: *Deborah Retkovsky v. Advocate Christ Hospital, 15 IWCC 71, 2015 Ill. work. Comp. LEXIS 71 (citing Sorenson v. Industrial Commission, 666 NE 2d, 713 (4th Dist. 1996); Tracy Riley v. Kraft Foods, 14 IWCC 517, 2014 Ill. Work. Comp. LEXIS 235; Robert Walker v. State of Illinois-Menard, 14 IWCC 519, 2014 Ill. Work. Comp. LEXIS 446; Adam Barker v. Wal-Mart, 16 IWCC 217, 2016 Ill. Work. Comp. LEXIS 135.*

The testimony and opinions of Dr. Vender also suffered from a deficiency as to the details of the job, but his opinions that the duration itself was insufficient, regardless of the nature of the job, is persuasive, particularly

given the prior left-hand symptoms and the minimal time worked before Petitioner's first complaints to Respondent.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of her employment with Respondent on May 15, 2015, and further failed to prove by a preponderance of the evidence that she suffered any condition of ill being causally related to her employment with Respondent.

In support of the Arbitrator's decision with respect to (H) Age and (I) Marital Status and Dependents, the Arbitrator finds as follows:

The medical records confirm that Petitioner's date of birth is March 17, 1970, making her 45 years old on May 15, 2015. Petitioner's unrebutted testimony was that on May 15, 2015, although she was going through a divorce, she was still married. She testified that she had 2 dependent children under 18 years old at that time.

Based upon the record as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that on May 15, 2015, she was 45 years old, married with 2 dependent children under 18 years old.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Prospective Medical, (L) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Medical, Prospective Medical and Temporary Compensation are moot.

Petitioner's claim for benefits is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donald Dettman,

Petitioner,

vs. NO: 11 WC 40908

Streator Engine Parts, Inc.,

Respondent.

19IWCC0559

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator's determination that Petitioner's treatment was within the two-doctor chain of referrals as set forth in §8(a) of the Act, but modifies the rationale for such a finding. Along these lines, the Commission finds that the initial emergency room visit constituted "first aid and emergency treatment", as that term is contemplated by the statute, and did not count as a choice. Instead, Petitioner's first choice of physician was his primary care physician, Dr. Cichon, who in turn referred him to Rezin Orthopedics, where he saw Dr. Ortinau. The Commission finds that Petitioner's second choice of physician was Dr. Burra at Hinsdale Orthopaedics who eventually provided a referral to a specialist for a second opinion in a progress note dated 12/20/11. More to the point, Dr. Burra recorded that "... at this point, if he has residual symptoms, I have asked that he consult a total joint specialist if that is how he wants to address his symptoms." (PX7). He also noted that "I did offer him the choice of a second opinion" and that "[i]t is reasonable to seek an opinion or treatment from a total joint specialist if he is unable to tolerate his symptoms." (PX7). The Commission notes that while this same note

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shows Dr. Burra suggested Dr. Alden for such a second opinion, it was entirely reasonable for Petitioner to visit orthopedic surgeon, Dr. Markarian, for this purpose. As such, the Commission finds that Petitioner's visit to and ensuing treatment with Dr. Markarian was within the second-chain of referrals, and thus compensable.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 10/17/16, with changes, 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 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 15 2019
o: 8/27/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DETTMAN, DONALD
Employee/Petitioner

Case# **11WC040908**

STREATOR ENGINE PARTS INC
Employer/Respondent

19IWCC0559

On 10/7/2016, 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 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4595 WHITESIDE & GOLDBERG LTD
JASON M WHITESIDE
155 N MICHIGAN AVE SUITE 540
CHICAGO, IL 60601

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST PO BOX 1288
ROCKFORD, IL 61105

19IWCC0559

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

DONALD DETTMAN
Employee/Petitioner

Case # 11 WC 40908

v.

Consolidated cases: ______

STREATOR ENGINE PARTS, INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Kankakee**, on **08/17/2016**. 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?
xxx TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. xx Is Respondent due any credit?
O. ☒ Other **Violation of two-doctor rule and permanent total disability**

FINDINGS

On **01/07/2010**, 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 solely in the right knee through October 8, 2013, is causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned $**30,368.00**; the average weekly wage was $**584.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent child.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $**34,493.26** for TTD, $**0.00** for TPD, $**0.00** for maintenance, $**10,514.40** for a PPD advance.

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 $389.35 per week for 137-5/7 weeks for the periods of 4/9/10 through 5/28/10 and 4/9/11 through 10/8/13 pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the causally related right knee injury through October 8, 2013 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner permanent partial disability benefits of $350.40/week for 75.25 weeks, because the injuries sustained caused the 35% loss of the right leg, as provided in Section 8(e) of the Act.

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

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

Carolyn M. Doherty
Signature of Arbitrator

10/5/16
Date

OCT 7 - 2016

FINDINGS OF FACT

Petitioner, Donald Dettman, testified that he began working for the Respondent around March of 2000. (T7) Petitioner's initial position of employment with the Respondent was that of a mechanic, and his job responsibilities included changing oil, sharpening blades, and rebuilding engines. (T8) At some point in 2008, Petitioner was promoted to outside sales, which required him to deliver parts for lawn mowers to different customers. (T9) Petitioner's job in outside sales required him to drive anywhere from 200 to 300 miles per day in order to satisfy his customers' needs. (T9)

On January 7, 2010, Petitioner was working as an outside sales representative for the Respondent when he suffered an undisputed work-related injury. (ARB EX.1) On that date, the Petitioner was involved in a an automobile collision while working as a sales representative. (T10) Petitioner testified that he began his work day on January 7, 2010, at around 7 or 8 am and that it was snowing. (T9-10) Petitioner testified that he was driving his Ford Winstar Van when a driver from the oncoming traffic lane lost control of her vehicle and crashed into him head-on. (T10)

Petitioner described this impact as a big collision and head-on and stated that the van could not be driven. (T10) The police responded to the accident scene as well as an ambulance. (T11) Petitioner testified that he noticed that he had a "six inch road rash" on his left leg and that his left knee "was swelling up." T. 11. He also testified to some pain in his shoulders. Respondent's exhibit 12 indicates that Petitioner completed the Illinois Motorist Report and identified that the crash occurred in Peotone Township, and that Petitioner scraped his left shin and Petitioner's right knee was scratched and swollen. RX 12. Petitioner left the accident scene with the tow truck driver, who towed the Respondent's vehicle and dropped Petitioner off at the nearest truck stop. (T12) Petitioner's boss' wife picked him up from the truck stop and he was taken to Morris Hospital. (T12)

Petitioner reported to the attending physicians at Morris Hospital that both of his knees were hurting, as well as his shoulder. (T12) The Morris Hospital triage records identify that Petitioner ambulated to the emergency room with complaints of bilateral knee pain following a motor vehicle accident. (PX 2, pg. 52) The emergency room physicians identified an abrasion to the left shin and pain in the right knee. PX 2, p. 52. The ER history of accident indicates that Petitioner's vehicle was "t-boned" in the car accident and that Petitioner's vehicle was struck on the driver's side. X-rays were taken of the right knee and no acute pathology was noted. X-rays were taken of the left tibula/fibula and no acute pathology was noted. (PX 2, pg. 53). Petitioner was instructed to follow-up with his primary physician on a final diagnosis of "abrasion, L leg." PX 2, p. 53.

On January 11, 2010, Petitioner reported to his doctor, Dr. Cichon, and provided a history of the subject automobile accident while delivering parts for work on 1/7/10. Petitioner reported left shin abrasion, right knee swelling and popping, left shoulder pain and "a lot" of body stiffness. PX 3. The records also document a "previous right knee surgery on April 9th" but Petitioner denied any prior right knee surgery at trial. T. 32. Dr. Cichon performed a physical examination that revealed some clicking when bending the right knee and tenderness to the upper left tibula area. (PX 3, pg. 5). Petitioner was instructed to remain off-work "till mon" and was told to return to Dr. Cichon in 1-2 weeks "if not 100%". PX 3

Petitioner returned to work on 1/18/10. PX 3. On 1/19/10, he called Dr. Cichon and stated his "knee" was still swollen and sore and requested a refill of Darvocet. He was told to return to Dr. Cichon in one week if he was still having problems. On January 25, 2010, Petitioner returned to Dr. Cichon for a "re-check" and reported that he was not improving. Dr. Cichon noted marked swelling at the MIP joint of the right foot "probable gout" and persistent pain left upper shin area and right knee still popping. He was told to return in one week as necessary. On 2/25/10, Dr. Cichon noted Petitioner's complaints of pain in the left hip after Petitioner was sitting on the

floor refinishing a cabinet. PX 3. Dr. Cichon prescribed an MRI of the right knee, right foot and left hip, which were performed at Morris Hospital on March 5, 2010. The radiologist interpreted the MRI of the right knee to indicate Petitioner had an oblique tear of the posterior horn of the medial meniscus, grade 2 chondromalacia of the medial patellar facet and small ganglion cyst posterior to the medial femoral condyle. (PX 3, pg. 15). Dr. Cichon referred Petitioner to Dr. Rezin at Rezin Orthopedics in Morris, Illinois.

Petitioner reported to Rezin Orthopedics on March 19, 2010, for an initial examination and was told he would be seeing Dr. Ortinau as opposed to Dr. Rezin. (PX 4, pg. 5). Dr. Ortinau reviewed the MRI of the right knee and diagnosed Petitioner with right knee medial meniscus tear and right knee patellofemoral dysplasia, and surgery was recommended. (PX 4, pg. 5). On April 9, 2010, Dr. Ortinau performed surgery on Petitioner which consisted of a right knee arthroscopy with partial medial meniscectomy and patellofemoral as well as medial femoral condyle chondroplasties. Dr. Ortinau noted in his operative report that Petitioner had a large area of grade II chondromalacia changes and grade III chondromalacia changes on the weight-bearing surface. Petitioner was taken off-work and began post-operative physical therapy on April 15, 2010 at Champion Fitness in Dwight, Illinois.

Dr. Ortinau examined Petitioner on April 19, 2010 and removed the sutures, instructed Petitioner to keep attending physical therapy, and to remain off-work for the time being.

At the next appointment, May 3, 2010, Petitioner felt his right knee was doing better. Dr. Ortinau noted, Donald returns today with continued improvement in his knee. He is status post knee arthroscopy. He complains now of left knee pain and left hip pain. He is wondering if this is related to his injury and I told him that he can touch base with the Workman's Compensation Department about this and discuss whether this is something that would be approved or not. The patient is asking for Vicodin and is asking about continuing light duty." PX 4, p. 14. The physical exam of the right knee was normal aside from a lack of some strength and endurance. The plan was to continue PT for two weeks and then return to full duty full time work on 5/17/10. PX 4, p. 14.

In follow-up with Dr. Cichon on 5/05/10, Petitioner also now noted left knee pain. (Petitioner's Exhibit No. 3.) On May 11, 2010, Petitioner underwent an MRI of the left knee at Morris Hospital, ordered by Dr. Cichon, which was interpreted as "unremarkable." Petitioner was noting pain at 0-1 on a 10-point scale in his right knee on 5/14/10 in physical therapy. He advised the physical therapist that he had little to no pain. He was discharged from physical therapy on 5/14/10. (Petitioner's Exhibit No. 5.)

At the physical examination on May 28, 2010, Dr. Ortinau noted the left knee MRI results and stated, "The MRI showed no obvious abnormalities. The patient continues to have some pain in the parapatellar region. He has some abnormal tilt test. Positive patellar apprehension sign." The diagnosis was left knee patellofemoral dysplasia. Petitioner was doing well on the right knee. Petitioner was given a brace for the left knee and told to perform exercises on both knees. (PX 4, pg. 25) Petitioner was continued on full duty work.

Petitioner continued to work full-duty and reported to Dr. Ortinau on July 23, 2010, complaining of pain to both knees. Petitioner described the pain as cramping in both legs. Dr. Ortinau examined Petitioner and diagnosed him with bilateral patellofemoral dysplasia and provided an injection of 1 cc of Kenalog and 9cc of Lidocaine into both knees. Dr. Ortinau attributed the leg cramping to high cholesterol. He continued Petitioner on full duty and told Petitioner to continue home exercises.

Petitioner returned to see Dr. Ortinau on August 20, 2010, and Dr. Ortinau noted "Donald returns today with some subjective complaints of bilateral knee pain. He has patellofemoral dysplasia. He does not have any obvious meniscal signs or symptoms. He is back to work. He had a Cortisone shot about a month ago. He states that it helped on the left, but not much on the right." Physical exam and complained of pain in his

bilateral knees. Dr. Ortinau diagnosed Petitioner with bilateral patellofemoral dysplasia as well as patellofemoral crepitus. Dr. Ortinau instructed Petitioner to return in a month or so, depending upon his pain and problems. On 8/20/10, Dr. Ortinau noted Petitioner was quite careful about moving his knees, which Dr. Ortinau felt was more due to effort than weakness. He also noted breakaway weakness and a lack of endurance. On September 10, 2010, Dr. Ortinau saw Petitioner for the final visit and noted "a little bit of patellofemoral crepitus" in the knees, no pain with full range of motion and 5/5 motor strength. Dr. Ortinau noted conscious guarding more than anything else. He felt Petitioner was objectively doing well in all regards and felt Petitioner needed continued strengthening. Dr. Ortinau ruled out getting an MRI or any further studies and felt more strengthening of the quads and VMO was appropriate for a patient "...presenting like somebody with patellofemoral dysplasia in both knees..." . Dr. Ortinau also felt bracing of the bilateral knees would provide Petitioner some relief. Otherwise, Petitioner was released from Dr. Ortinau's care.

Petitioner testified that he continued to work full-duty through 2010. On his own choice and through a friend's recommendation, Petitioner sought treatment from Dr. Burra at Hinsdale Orthopedics. T. 17. At the initial appointment on January 29, 2011, Dr. Burra took a history of an auto accident while working on January 7, 2010. Petitioner complained of "bilateral right greater than left knee pain." PX 7, p. 3. The Arbitrator notes that for the first time in the medical records Petitioner reported "a dashboard impaction injury with both of the knees." PX 7, p. 3. Dr. Burra noted he had no treatment to the left knee because this was less painful at the time. Dr. Burra noted the right knee surgery and Petitioner's report that since his surgery with Dr. Ortinau his right knee pain never fully subsided. Petitioner described the pain in his right knee as burning, aching, stabbing and sharp pain which did not radiate and was at 6/10 at the worst. Petitioner reported left knee pain over the anterior aspect present since the car accident but no mechanical symptoms. Petitioner's pain in the left knee was 3/10 at the worst. Dr. Burra diagnosed Petitioner with a right knee residual versus recurrent medial meniscal tear and known chondral defect of the patellofemoral and medial femoral condyle, as well as a left knee patellofemoral pain which was originally started as a traumatic dashboard injury. Dr. Burra's initial plan was for a repeat of the right knee MRI, and to undergo a course of therapy for the left knee. Petitioner was ordered to continued full duty work as tolerated and to return after the right knee MRI. PX 7, p. 5.

On March 2, 2011, Petitioner returned to see Dr. Burra for a review of the MRI of the right knee that was performed on February 4, 2011. Dr. Burra noted that Petitioner's right knee "is significantly far more symptomatic with mechanical symptoms of locking and catching as well as persisting anterior knee pain..." PX 7, p. 7. Dr. Burra indicated that the right knee MRI showed a large horizontal cleavage tear and a tear of the posterior horn of the medial meniscus with part of the tear extending down into the capsular rim. Based upon the imaging, Dr. Burra discussed surgical options with Petitioner for the right leg. Dr. Burra felt that the mechanism of injury, whereby Petitioner's bilateral knees struck the dashboard during the auto accident, caused the injuries to both Petitioner's knees, as well as the need for additional surgery. Petitioner was told to continue working full duty as he was able to work as a driver.

On April 4, 2011, Dr. Burra saw Petitioner again and reiterated that the pain in both the right and left knees was caused by a traumatic dashboard injury which occurred in January 2010. Petitioner still complained to Dr. Burra of mechanical symptoms of the right knee. Based upon Dr. Burra's recommendation, the petitioner was scheduled for surgery on his right knee.

On April 7, 2011, Dr. Burra performed an arthroscopy of the right knee, partial medial meniscectomy and microfracture of the medial femoral condyle and microfracture of the trochlea. Dr. Burra instructed Petitioner to remain off-work following this procedure. Dr. Burra recommended physical therapy begin immediately, so Petitioner went to Elite Rehabilitation for physical therapy, beginning on April 11, 2011.

Follow-up appointments showed that Petitioner was compliant with physical therapy and that surgery aided in reducing his pain in his right knee. Petitioner was still complaining of pain and symptoms in the left knee, which were documented at the following visit on May 20, 2011. Petitioner was noted to be compliant with all of physical therapy and had been making great improvements in range of motion. The plan was to watch the left knee. PX 7, 21. Petitioner was kept off work.

At the following appointment on July 5, 2011, Petitioner demonstrated increased range of motion in the right knee but still required additional physical therapy to increase his strength. As for the left knee, Petitioner was still complaining of the same pain, so Dr. Burra recommended physical therapy mixed with a series of Synvisc injections. Petitioner returned to see Dr. Burra on August 2, 2011, and told Dr. Burra that his right knee began swelling again and this was preventing him from continuing on with his physical therapy. Petitioner reported no new injuries and that he was compliant with all therapy. Based upon the complaints, a series of Synvisc injections was ordered for the left knee. Dr. Burra also recommended a repeat MRI of the right knee to gauge the effectiveness of the microfracture repair and see if right knee Synvisc injections would be of benefit. The first Synvisc injection into the left knee was performed at that appointment on August 2, 2011.

Petitioner underwent subsequent Synvisc injections into his bilateral knees on the following dates: Left knee injection 8/17/11; right knee injection 9/2/11, right knee injection on 9/14/11; and a final right knee injection on 9/21/11. Dr. Burra examined the Petitioner again on October 19, 2011, and found that both knees seemed stable and had solid range of motion. However, based upon the previous medical care and Petitioner's injuries, Dr. Burra felt that a functional capacity evaluation should be obtained to determine a permanent release to return to work. Dr. Burra also felt that additional Synvisc injections might be necessary to ward off a total knee replacement in both knees.

Petitioner underwent a functional capacity evaluation on ATI Physical Therapy on November 17, 2011. The test was administered and indicated that Petitioner gave a valid effort and that Petitioner was capable of returning to work in the light physical demand level, with restrictions on Petitioner's ability to squat, kneel, and crawl. ATI records indicate that no job description was provided to ATI and that Petitioner classified his job with the Respondent as Heavy Duty. ATI noted, "his capabilities meet DOT listing of his occupation, however his capabilities fall below the clients description of his job duties." PX 9, p. 2. ATI noted that Petitioner was employed as a salesperson for Respondent which the DOT classified as light duty. PX 9, p. 2.

Petitioner underwent an examination with Dr. Johnson at the request of the Respondent on 11/23/11. (Respondent's Exhibit No. 3.) Respondent also presented Dr. Johnson for his evidence deposition on 3/18/15. (Respondent's Exhibit No. 1.) Petitioner advised Dr. Johnson that he did not recall when his left knee symptoms began but that he did have left knee pain after the accident but that the right knee pain was more severe. Dr. Johnson noted that the Petitioner's left knee MRI findings described a degenerative condition. He diagnosed Petitioner with osteoarthritis in both knees. He did not find the Petitioner's subjective complaints matched the objective findings because Petitioner had significant, diffuse pain over his knee, and the only real objective finding was trace effusion and slight restriction with flexion of one of his knees. He noted Petitioner's left knee showed no focal chondral defects and that the complaints are primarily due to a degenerative condition and significant chondromalacia in the left knee. With regard to the right knee he determined that "based upon the fact that there are some chondral defects, I would feel that the right knee is more likely related to the accident than the left which showed degenerative changes and no focal chondral defects." RX 3. Dr. Johnson determined Petitioner was at MMI as of 11/23/11. RX 3.

Dr. Burra reviewed the FCE with Petitioner on December 20, 2011 and noted that Petitioner would qualify for the light-to-medium job duty status and that his job is classified as a light duty position. Dr. Burra then noted "However, Mr. Dettman subjectively reported this to his work conditioning specialist that his job is a heavy

physical demand level position" and that no official job description was provided. PX 7, p. 61. Dr. Burra determined that Petitioner had a good result from the second surgery and that he could return to work within the FCE restrictions if his job was in fact light demand level. He counseled Petitioner that further complaints should be addressed by a joint specialist if he was unable to tolerate any symptoms. He was given a consult with Dr. Alden, a "total joint specialist". PX 7.

Petitioner next sought treatment from a knee specialist in Dr. Gregory Markarian. Petitioner's first appointment with Dr. Markarian was on January 18, 2012. Dr. Markarian took a history of the auto accident while at work in January 2010, whereby both of Petitioner's knees struck the dashboard during the collision, right worse than left. Petitioner was complaining of pain in his bilateral knees and was ambulating with a cane at this time. Petitioner wanted a second opinion on both knees. Dr. Markarian recommended a review of the MRI's of both knees, as well as a complete medical chart for the follow-up appointment. Petitioner was to remain off-work until the next appointment.

The next appointment with Dr. Markarian was on January 23, 2012. Dr. Markarian reviewed the MRI studies, both prior operative notes, performed a physical examination, and diagnosed Petitioner with bilateral grade 4 chondromalacia and scheduled Petitioner for surgery on both knees.

Dr. Markarian performed surgery on February 16, 2012, which consisted of an arthroscopy of the right knee, lateral retinacular release and open resurfacing of a 6 x 3 femoral component and a 7 x 5 trochlear component. Dr. Markarian also noted a 1A-3A lesion in the knee. Petitioner was thereafter instructed to remain off-work and return to physical therapy at Elite Rehabilitation. On December 10, 2012, Dr. Markarian performed an arthroscopic procedure on Petitioner's left knee, which consisted of a tricompartmental synovectomy, chondroplasty over the trochelear notch and over the medial femoral condyle. PX 10.

Dr. Markarian gave his deposition testimony on October 16, 2012 (prior to the left knee surgery in December 2012). Dr. Markarian indicated that the previous procedure performed on Petitioner's right knee whereby the damaged cartilage was manipulated by drilling is not a very effective way to stimulate the growth of the cartilage. (PX 15, pg. 11). Dr. Markarian felt that another arthroscope of the knee was necessary and that a resurfacing of the right knee would be necessary. (PX 15, pg. 11-12). Dr. Markarian testified that he would extrapolate the arthritis by minimal bone resection and fill in the pothole with a smooth implant. (PX 15, pg. 12) This would preserve the knee and prevent further arthritis. It was Dr. Markarian's plan to do the same procedure on the left knee as well, depending upon what he discovered when he scoped the left knee. (PX 15, pg. 25) It was Dr. Markarian's opinion that the accident of January 7, 2010, aggravated the underlying condition and caused the need for the surgeries to Petitioner's bilateral knees in that Petitioner was asymptomatic prior to the crash and that he struck both knees on the dashboard. (PX 15, pg. 30-31). On cross-exam, Dr. Markarian agreed that his opinions were based primarily on the history of accident provided by Petitioner. PX 15, p. 45-47.

Following surgery, Petitioner continued to undergo physical therapy at Elite Rehabilitation and was eventually instructed by Dr. Markarian to undergo a functional capacity evaluation. On September 13, 2013, Petitioner underwent a functional capacity evaluation at ATI Physical Therapy (PX 14). The assessment was deemed valid and Petitioner was told he was able to work in the light-to-medium duty physical demand level. Again, no job description was supplied. Petitioner noted that although the Department of Labor states his job was a light duty job, he was also required to do deliveries which would be considered medium physical demand level. PX 14.

On October 8, 2013, Dr. Markarian reviewed the FCE and instructed Petitioner to return to work within those restrictions as set forth in the FCE, light to medium level work. RX 11. Dr. Markarian released Petitioner at

MMI for both knees stating that Petitioner's functional abilities met and exceeded his work level. However, Petitioner would not be able to perform deliveries at the medium level. RX 11.

Petitioner testified that after his appointment, he went and visited his supervisor at Streator Engine Parts the next day, October 9, 2013. He spoke to his supervisor, Don Gurnie, who told Petitioner they do not have a position of employment within the restrictions for Petitioner.

Petitioner testified that he started looking for work and submitted several job leads as Petitioners Exhibit 18. (T26) Petitioner's job search was for three weeks from 10/27/13 through 11/16/13. PX 18. He admitted on cross-examination that this was the extent of his job search. He testified he was never offered a job. The majority of the employers were not hiring, according to the exhibit. None of the positions for which he applied was for the position of salesman. He has not worked since his employment with Respondent ended.

On or about March 12, 2014, Dr. Markarian indicated that Petitioner was to discontinue driving due to his bilateral knee problems and recommended that Petitioner apply for permanent disability. (PX 10, pg. 93) Dr. Markarian felt there was no improvement in Petitioner's condition nor would there be any improvement in the future. PX 10.

In order to assist Petitioner in his evaluation of his return to work capabilities, Kari Stafseth from Vocamotive examined Petitioner on March 14, 2014. She determined that Petitioner had no transferable skills; that he has lost his access to his usual and customary job and line of occupation; and that Petitioner does not have access to any viable, stable labor market. Kari Stafseth's opinions and conclusions were based upon a number of factors, including his presentation, age, fairly unskilled work history, geography and restrictions regarding his ability to walk, stand, drive and perform other non-material handling activities.

On July 3, 2014, Kari Stafseth provided her testimony through evidence deposition. Ms. Stafseth reiterated her findings from her report of March 14, 2014, and also reported that Petitioner had difficulty reading and with comprehension as well. PX 16, p. 16. According to Ms. Stafseth, Petitioner would have difficulties in finding gainful employment because he was restricted from driving and he would need to rely on alternative means of transportation to search for work. (PX 16, pg. 25) Petitioner's previous work experience was that of a low-skilled worker and Petitioner had permanent restrictions in the light to medium capabilities, which would severely limit Petitioner's ability to find work. In her opinion, most sedentary work was considered to be skilled or highly skilled employment for which Petitioner was not suited, despite his physical ability to work at a sedentary level. PX 16, p. 43. Thus, it was Ms. Stafseth's opinion that Petitioner had no access to any gainful employment that fell within his physical capacity. PX 16, p. 27,43.

On cross-examination, Kari Stafseth admitted she recommended additional vocational testing but did not perform any on Petitioner. She admitted there was no attempt at vocationally retraining Petitioner, and she never assisted Petitioner with a job search. PX 16, p. 36.

Dr. Johnson examined Petitioner again on 11/12/14. (Respondent's Exhibit No. 2.) Dr. Johnson was deposed on 3/18/15 regarding his 11/12/14 report. (Respondent's Exhibit No. 1.) Dr. Johnson again noted Petitioner's subjective complaints did not match the objective findings during his second examination because his knee examination revealed very stable knees, good and symmetric range of motion, a lack of significant swelling, and a lack of significant focal areas of tenderness. This did not fit with Petitioner's subjective complaints of constant, severe pain and a constant lack of instability. RX 1, p. 21. He agreed with the FCE and that Petitioner could return to work at the light-to-medium physical-demand level. RX 1, p. 22.

Dr. Johnson noted Petitioner was capable of driving, as it related to his alleged bilateral knee conditions. He noted that the reason for the Petitioner's driving restriction was due to Petitioner not being able to feel his feet and decreased sensation in his feet. Dr. Johnson noted that these symptoms would in no way be related to Petitioner's alleged bilateral knee conditions. RX 14, p. 22-23. He did not feel Petitioner required any additional medical treatment for his bilateral knees based on the extensive amount of treatment the Petitioner had already undergone and the fact that Petitioner's subjective complaints did not match objective findings. RX 14, p. 24.

On cross-examination, Dr. Johnson admitted he found causal connection with respect to Petitioner's right knee. RX 14, p. 27. He admitted there is one Morris Hospital emergency note from 1/07/10 that appears to reference the Petitioner's left knee. However, he noted that the majority of the records indicate Petitioner complained of right knee pain and an abrasion to his left shin. Although he noted that hitting a shin on a dashboard could aggravate an underlying degenerative left knee condition, even if there was an aggravation in this claim, this would have only been a temporary aggravation, and the minor degenerative condition noted in the Petitioner's left knee would not require all the treatment Petitioner underwent. RX 14, p. 35-36. He also again noted Petitioner advised Dr. Johnson he was not exactly sure when his left knee pain began. With regard to the left knee condition and surgery Dr. Johnson opined that it was not related to the auto accident stating, "...someone that simply gets an abrasion to a shin, which was the objective findings noted at the time of his initial examination, as well as the exam findings found by myself and Dr. Markarian as well as with the imaging studies showing mild chondromalacia at that time I don't see any focal defect or any problem that would necessitate, ... a significant resurfacing just related to the accident." RX 14, p. 36.

Petitioner testified on cross-examination that he has never looked for work as a salesman since he stopped working for Respondent. He also testified that he was working as a salesman for the Respondent at the time of the accident. He developed the necessary skills to sell products for Respondent. He was trained in sales by Respondent. T. 48. He would attempt to sell additional equipment and parts, was paid on a commission, and received a commission each month. He was required to take and passed a yearly test with the Respondent to stay current with Respondent's parts and services. Petitioner testified he felt he was a good salesman. T. 50. Petitioner testified that he still owns a vehicle, and he has someone who can drive him. He testified on cross-examination that he feels he cannot drive due to decreased feeling in his feet and numbness in his feet. He still holds a valid driver's license.

At the time of trial, Petitioner testified he has pain in both his knees, and they both give out. He utilizes a cane, although it was not prescribed by any physician. He uses the cane in his left hand to support his weight on his left side, according to Petitioner's testimony. He takes Vicodin for medication. Petitioner testified the pain in his left knee did not decrease following his surgeries, contrary to Dr. Markarian's records. Petitioner testified he is able to care for himself, and he is able to perform activities of daily living, for the most part.

Petitioner applied for and is receiving Social Security Disability benefits. PX 17. Petitioner noted he is a high school graduate. He is able to read and write in English and perform basic math. He obtained an HVAC certification. He has experience repairing motor vehicles, lawnmowers, and appliances. He owns and his able to use a computer. Petitioner has no criminal history. He had a number of prior work positions with numerous employers. He obtained all of his employment on his own without professional assistance. T. 45-50.

DC Workfinders performed a Labor Market Survey on 3/27/15 at the request of the Respondent. RX 4. According to the Certified Rehabilitation Counselor Joan Tompsett, Petitioner would be able to return to work as a salesperson even if he was restricted to performing work in the light physical-demand level. Petitioner had numerous positive factors which increase his ability to return to work, including being a high school graduate, having the capability of learning as demonstrated in his previous employment, developing sale skills, and having

transferable skills involving sales. Petitioner qualified for a number of job categories, including, but not limited to, customer service representative, sales representative, order taker, and stationary security guard. Joan Tompsett identified numerous current job openings for which the Petitioner qualified which had an average wage of $474.80, although numerous positions indicated much higher annual wages. RX 4.

Triune performed a Utilization Review at the request of the Respondent on 1/13/15. RX 5. The Utilization Review noncertified physical therapy starting 7/29/14 because Petitioner should be well versed in a home-exercise program. The compound pain cream was noncertified because it is experimental, and no trial of other medications was undertaken. Petitioner's pain management referral was partially certified. The Utilization Review was based on the Official Disability Guidelines.

CONCLUSIONS OF LAW

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

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

The parties stipulated that Petitioner sustained an accident that arose out of and in the course of Petitioner's employment with the Respondent on January 7, 2010. ARB EX 1. Respondent does, however, dispute the accident caused the injuries to Petitioner's left knee, the need for subsequent surgery to the left knee and causal connection for the right knee condition and treatment after 9/10/10.

RIGHT KNEE

With regard to Petitioner's right knee, the Arbitrator notes that Petitioner sustained injury to his right knee in the undisputed accident of 1/7/10. Although there is one reference in the medical records of prior right knee surgery in "April" there is no substantiation of that treatment in any medical record submitted into evidence and Petitioner denied any prior right knee injury or treatment at trial. His testimony was undisputed. Specifically, the Arbitrator notes that Petitioner immediately and consistently complained of right knee pain and swelling after the auto accident as is confirmed by the Illinois Motorist Report, the emergency treatment at Morris Hospital and the records of Drs. Cichon and Ortinau.

Following his discharge from Dr. Ortinau in September 2010, Petitioner worked full duty but testified that his right knee pain never fully resolved. This testimony is buttressed by the records of Dr. Burra who Petitioner saw 4 months later in January 2011 for continued complaints of right knee pain. Dr. Burra confirmed that Petitioner sustained a right knee injury in the auto accident on 1/7/10 and diagnosed Petitioner with a right knee residual versus recurrent medial meniscal tear and known chondral defect of the patellofemoral and medial femoral condyle. Dr. Burra performed a second right knee surgery in April 2011. Thereafter, Petitioner continued to treat for his right knee with physical therapy and injections through October 2011. At that point, Dr. Burra ordered an FCE and in December 2011 released Petitioner from care per the FCE restrictions at the light physical demand level, with restrictions on Petitioner's ability to squat, kneel, and crawl. ATI records indicate that no job description was provided to ATI but that Petitioner was employed as a salesperson for Respondent which the DOT classified as light duty. PX 9, p. 2. He counseled Petitioner that further complaints should be addressed by a joint specialist if he was unable to tolerate any symptoms. He was given a consult with Dr. Alden, a "total joint specialist". PX 7.

One month later, Petitioner sought treatment from a knee specialist in Dr. Gregory Markarian on January 18, 2012. Dr. Markarian took a history of the auto accident while at work in January 2010. Petitioner wanted a

second opinion on both knees. Dr. Markarian recommended a review of the MRI's of both knees. On January 23, 2012. Dr. Markarian reviewed the MRI studies and diagnosed Petitioner with bilateral grade 4 chondromalacia and scheduled Petitioner for surgery on the right knee. On February 16, 2012, Dr. Markarian performed right knee surgery which consisted of an arthroscopy of the right knee, lateral retinacular release and open resurfacing of a 6 x 3 femoral component and a 7 x 5 trochlear component. Dr. Markarian also noted a 1A-3A lesion in the knee. Petitioner was thereafter instructed to remain off-work and return to physical therapy at Elite Rehabilitation. At his deposition on October 16, 2012, Dr. Markarian indicated that the previous procedure performed on Petitioner's right knee whereby the damaged cartilage was manipulated by drilling is not a very effective way to stimulate the growth of the cartilage and that another arthroscope of the knee was necessary and that a resurfacing of the right knee would be necessary. (PX 15, pg. 11-12). It was Dr. Markarian's opinion that the accident of January 7, 2010, aggravated the underlying condition and caused the need for the right knee surgeries in that Petitioner was asymptomatic prior to the crash.

Following surgery, Petitioner continued to undergo physical therapy at Elite Rehabilitation and was eventually instructed by Dr. Markarian to undergo a functional capacity evaluation. On September 13, 2013, Petitioner underwent a functional capacity evaluation at ATI Physical Therapy (PX 14). The assessment was deemed valid and Petitioner was told he was able to work in the light-to-medium duty physical demand level. Again, no job description was supplied. Petitioner noted that although the Department of Labor states his job was a light duty job, he was also required to do deliveries which would be considered medium physical demand level. PX 14. On October 8, 2013, Dr. Markarian reviewed the FCE and instructed Petitioner to return to work within those restrictions as set forth in the FCE, light to medium level work. RX 11. Dr. Markarian released Petitioner at MMI stating that Petitioner's functional abilities met and exceeded his work level. However, Petitioner would not be able to perform deliveries at the medium level. RX 11.

Based on the foregoing, the Arbitrator finds that Petitioner's right knee condition was causally related to the accident on 1/7/10 through October 8, 2013, the date he was placed at MMI by Dr. Markarian for his right knee. It is not lost on the Arbitrator that Petitioner had been released at MMI earlier by Drs. Ortinau and Burra. However, placing credibility on Petitioner's complaints of continued right knee problems prompting him to seek and receive primarily continuous treatment on the right knee through the MMI date provided by Dr. Markarian, the Arbitrator finds causal connection for the right knee condition and treatment through October 8, 2013. Finally, the Arbitrator notes that although Dr. Johnson provided an earlier MMI date of November 2011, he agreed that Petitioner's right knee condition was related to the auto accident.

LEFT KNEE

Based on the record in its entirety, the Arbitrator finds no causal connection between Petitioner's left knee condition or treatment and the accident of 1/7/10. In so finding, the Arbitrator notes that the initial Illinois Motorist Report and the Morris Hospital ER records indicate that Petitioner sustained an abrasion to his left shin. The Arbitrator is not persuaded to find causal connection for the left knee in this matter based on one sole reference to bilateral knee pain contained in one triage ER record as that sole reference is clearly outweighed by the references to the left shin abrasion documented and treated in the remaining records. A finding of causal connection for the left knee is further undermined by the fact that the initial accident report and ER records contain no mention of a "bilateral dashboard injury" as appears in later treating records and that the first mention of left knee pain developing was made to Dr. Ortinau in May 2010 after surgery on the right knee. The Arbitrator further finds that the credible evidence in this matter also fails to support a finding of aggravation to any pre-existing condition of Petitioner's left knee due to the auto accident.

In finding no causal connection for the left knee, the Arbitrator further notes that the causal opinions offered by Petitioner's treating physicians regarding the left knee are based on a history of bilateral dashboard injury at the

time of accident for which no credible objective medical evidentiary support exists in the record. Accordingly, the arbitrator awards no benefits under the Act with respect to Petitioner's left knee.

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

Based upon the Arbitrator's finding that Petitioner's condition of ill-being in his right knee through October 8, 2013, is causally related to the accident of January 7, 2010, the Arbitrator further finds that Respondent is to pay Petitioner all reasonable and necessary medical expenses incurred by Petitioner in the care and treatment of solely his right knee condition through October 8, 2013 pursuant to Sections 8 and 8.2 of the Act. Respondent is entitled to a credit for medical expenses paid.

Based on the finding of no causal connection for the left knee, Petitioner is not entitled to any medical expenses incurred in the care and treatment of the left knee. To the extent Respondent paid any medical expenses related to the left knee or for any other medical conditions other than Petitioner's right knee, Respondent shall receive credit for those amounts paid.

O. Did Petitioner Exhaust his choice of Physicians Under Section 8(a)?

The Arbitrator finds that Petitioner did not exhaust his choice of physicians under Section 8(a) of the Act. In so finding, the Arbitrator notes the foregoing findings on causal connection for the right knee. The Arbitrator further finds that Petitioner's treatment from Drs. Cichon and Ortinau flowed from the ER treatment referring Petitioner to his family doctor who then referred Petitioner to Dr. Ortinau for orthopedic care. Therefore, Drs. Cichon and Ortinau do not constitute Petitioner's first choice.

Petitioner's first choice of physician was Dr. Burra and his second allowable choice was Dr. Markarian. As such, the Arbitrator finds that Petitioner did not exhaust his allowable choices under the Act.

K. Is Petitioner entitled to any temporary benefits/maintenance benefits?

The Arbitrator notes that Petitioner was taken off-work from April 9, 2010 through May 28, 2010, following his surgery with Dr. Ortinau. Petitioner was then taken off-work again by Dr. Burra from the surgery date of April 8, 2011, and did not go back to work for the Respondent thereafter. Based upon the Arbitrator's finding of causal connection and on the medical records of Petitioner's treating physicians, the Arbitrator finds that Petitioner is entitled to receive temporary total disability benefits commencing April 9, 2010 through May 28, 2010; and April 8, 2011 through October 8, 2013, the date Dr. Markarian placed permanent restrictions upon Petitioner's return to work capabilities. Respondent shall receive credit for amounts paid.

The Arbitrator further notes that a preponderance of the credible evidence at trial fails to support Petitioner's assertion that his job for Respondent exceeded his light to medium level work restrictions. Petitioner worked as a driver for Respondent and as documented by two FCE examiners, that job was classified within Petitioner's work restrictions. Further, the Arbitrator notes the finding of causal connection for Petitioner's right knee only in terminating TTD benefits as of October 8, 2013 and in denying maintenance benefits thereafter.

O. Is Petitioner entitled to a finding that he is permanently and totally disabled?

Based upon the Arbitrator's finding of causal connection for the right knee only, the Arbitrator finds that Petitioner is entitled to permanent partial disability for solely the right knee injury. In considering permanent disability in this matter, the Arbitrator notes that the accident preceded the Act's amendment in 2011 and no AMA rating was required or provided by the parties. In determining Petitioner's disability for the causally related right knee injury, the Arbitrator considered other factors including Petitioner's occupation, age, future earning capacity and evidence of disability corroborated by the treating medical records, giving equal weight to all factors.

The Arbitrator notes that based upon the medical evidence submitted at trial, Petitioner sustained a partial medial meniscal tear and underwent three surgeries on his right knee to repair the tear and its attendant conditions. Petitioner's right knee care was extensive. He testified at trial that he has pain in his right knee all of the time and that his right knee gives out. Petitioner testified that he uses a cane for stability but that it was not prescribed by a physician. At the last visit with Dr. Markarian in October 2013, Dr. Markarian released Petitioner at MMI stating that Petitioner's functional abilities met and exceeded his work level for Respondent. In considering Petitioner's disability, the Arbitrator does note that per the most recent FCE, Petitioner is unable to lift at the medium to heavy level as he asserts was required in his job with Respondent as a driver. Petitioner continues to take Vicodin for pain. Although the records indicate that Petitioner is unable to drive, the Arbitrator finds that restriction does not flow solely from Petitioner's causally related right knee condition but rather from a number of conditions found unrelated to this accident.

Based on the foregoing, and on the preponderance of the credible evidence contained in the record in its entirety, the Arbitrator finds that Petitioner sustained 35% loss of use of the right leg pursuant to Section 8(e) of the Act. Finally, based on the Arbitrator's finding of causal connection for the right knee only, the Arbitrator further denies Petitioner's request for permanent total disability under Section 8(f) of the Act. Even assuming causal connection for Petitioner's right and left knee conditions, and considering the light to medium FCE restrictions, Petitioner is not entitled to permanent total disability. Petitioner's most recent FCE noted he was able to perform activities at the light-to-medium physical-demand level. Petitioner's usual and customary employment is as a salesperson. According to the Dictionary of Occupational Titles, as noted in both FCE reports, the position of outside salesperson falls within the light physical-demand level. Petitioner's current capabilities exceed the physical requirements of his usual and customary employment. The Arbitrator notes that Petitioner maintains a valid driver's license and owns a car undermining his assertion that he is unable to drive.
Even assuming the Petitioner could not return to his usual and customary employment, the Arbitrator finds Petitioner is clearly employable. The Petitioner's three-week job search was not a diligent job search necessary to support a finding of permanent and total disability. None of the positions for which he applied were for the position of salesman. In addition, the Arbitrator finds Ms. Staffseth's opinions are sufficiently rebutted by those of Joan Tompsett in Respondent's labor market survey. Petitioner's high school education; reading, writing, and math skills; employment history with transferrable skills; and ability to use a computer lend credibility to Joan Tompsett's opinions that Petitioner is currently employable, even assuming the Petitioner could not return to work as a salesman. Ms. Tompsett concluded that several potential positions offering wages at or near Petitioner's pre-accident wages were available for Petitioner, eliminating a potential for wage differential award under the Act as well.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Reardon,
Petitioner,

vs. No. 15 WC 07081

19IWCC0560

Village of Chicago Ridge Fire Department,
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 causal connection, medical expenses, temporary disability, permanent disability, prospective medical care and §8(a) future medical rights, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On January 5, 2015, Petitioner, a 42-year-old firefighter paramedic, was fighting a fire when he fell forward onto his outstretched right arm. He sustained a right shoulder injury which required arthroscopic surgery by Dr. Michael Terry. On April 14, 2015, Dr. Terry performed a right shoulder Bankart repair, biceps tenodesis, rotator cuff repair and SLAP debridement. Following that, Petitioner underwent physical therapy and work conditioning. Dr. Terry released Petitioner to light duty work on July 7, 2015. Petitioner acknowledged that Respondent was able to accommodate his light duty restrictions. Dr. Terry released Petitioner full duty work on October 21, 2015.

Petitioner's right shoulder problems continued after he was released to full duties. He experienced constant pain and crepitus, and he had difficulty raising his right arm over his head. On April 27, 2016 Petitioner returned to Dr. Terry who, after his examination of Petitioner, found that he had signs of shoulder impingement. Dr. Terry recommended a course of corticosteroid injections, NSAID therapy and home exercises. Petitioner received right shoulder injections on April 27, 2016, May 10, 2017 and September 27, 2017. On September 1, 2017, Petitioner underwent another right shoulder MRI which showed mild to moderate subacromial/subdeltoid bursitis. At Petitioner's last visit at Northwestern Medical Group on September 27, 2017, he was found to be neurovascularly intact and was released to do home exercises and return as needed. Petitioner has not been back to any doctor for medical treatment to his shoulder since that date.

At Respondent's request Petitioner saw Dr. Troy Karlsson for a Section 12 examination on December 3, 2015. Dr. Karlsson opined that Petitioner had reached maximum medical improvement on October 21, 2015, the date he was discharged to full duty by Dr. Terry. Dr. Karlsson opined that Petitioner did not need further medical care to his right shoulder after that date as a result of his work injury. Dr. Karlsson further opined that the shoulder impingement Petitioner developed in 2016 was unrelated to his work accident.

The Arbitrator found that Petitioner proved causal connection of his right shoulder condition only through the date of Dr. Terry's full duty release on October 21, 2015. The Commission views the evidence on this issue differently. Petitioner continued to complain of right shoulder symptoms after that date. He experienced pain and crepitus, and had difficulty performing his job duties. He required three right shoulder injections in 2016 and 2017. Petitioner testified that he did not sustain any subsequent injuries to his right shoulder, and Respondent offered no evidence to contradict that.

Dr. Karlsson attributed Petitioner's post-October 21, 2015 symptoms to a congenital, downward sloping acromion. However, Dr. Karlsson admitted that by definition, impingement is an irritation of the subacromial bursa and rotator cuff. The Commission finds Dr. Karlsson's opinions unpersuasive. His belief that Petitioner worked four months after October 2015 before he developed right shoulder symptoms was contradicted by Petitioner's testimony. The Commission notes that Dr. Terry never reported that the slope of Petitioner's acromion played any role in his right shoulder condition. Dr. Terry documented no congenital right shoulder conditions during the entire period that he treated Petitioner. Petitioner's September 1, 2017 right shoulder MRI report documented no acromioclavicular osteoarthritis, no lateral acromial down sloping, no acromial undersurface hook deformity and no subacromial spurs.

The Arbitrator denied Petitioner's request for medical expenses totaling $1,636.22, for treatment he received after October 21, 2015. The Commission finds those $1,636.22 in expenses to have been reasonable, necessary and causally related to his January 5, 2015 accident. Petitioner did not reach MMI until September 27, 2017. The Commission awards Petitioner the $1,632.22 in medical expenses incurred between October 21, 2015 and September 27, 2017.

With regard to Petitioner's temporary total disability, the Arbitrator found that Petitioner was off work from the April 14, 2015 date of his surgery through July 6, 2015 "and received TTD benefits during this time as indicated by *R1*." The Arbitrator did not specifically award TTD

benefits to Petitioner during this period of time. Notably, Petitioner testified that he received his full salary during the claimed TTD period. The parties stipulated that Respondent had paid $12,404.88 in TTD to Petitioner (Arb. exhibit #1). The Arbitrator awarded Respondent a credit for that amount. The Commission notes that no 8(j) credit was claimed at the time of the arbitration hearing, and no issue was raised on review related to the claimed TTD period or stipulated credit in the amount of $12,404.88 in TTD benefits paid. Thus, the Commission affirms the Arbitrator's finding that Petitioner was off work during the claimed TTD period and the stipulated credit for TTD benefits paid by Respondent, and awards no additional TTD benefits.

With regard to Petitioner's claim for prospective medical care, the Commission finds that the medical records do not reflect any order for prospective medical treatment. Therefore, Petitioner's claim for prospective medical care is denied.

With regard to the nature and extent of Petitioner's injury, the Commission finds the Arbitrator's §8(d)2 award of 10% person as a whole to be appropriate and supported by the evidence. The Commission finds that Petitioner suffered only an injury to his right shoulder as a result of his work accident and was able to return to his prior duties as a firefighter paramedic. While Petitioner asserts that his accident resulted in an injury to both the shoulder and the biceps, entitling him to a permanency award related to separate body parts, the Commission does not find the facts in this case warrant two separate awards. In so concluding, it is notable that the biceps tenodesis which Dr. Terry performed was at the shoulder level and performed during Petitioner's April 14, 2015 surgery as a part of the treatment for his shoulder injury that extended into the biceps. Given the foregoing, the Commission finds that does not warrant a separate award under §8(e)10, and affirms the Arbitrator's §8(d)2 award of 10% person as a whole to encompass the permanent nature of Petitioner's injury at work.

Finally, the Commission provides the following responses to Petitioner's request for four Special Findings on Review, pursuant to Commission Rule 9040.40:

1. In light of the reasoning on claimant's causative burden of *Republic Steel Corp.* and the lack of dispute on causal connection prior to 12/03/2015; given the consistency in the current clinical presentation, the anatomic areas of operative intervention and findings on the post-surgical MRI and unrebutted testimony of symptoms upon return to work is there a preponderance of evidence that could justify severing Petitioner's right to future medical care under Section 8(a) of the Act? If so, kindly explain in your decision.

RESPONSE: The Commission does not acknowledge the conclusions made by Petitioner in the above interrogatory to be its own.

In response to this interrogatory, the Commission states, "This interrogatory seeks an advisory opinion which the Commission lacks authority to issue. The Commission declines to provide a further response."

2. Given that Respondent's only credible medical defense to causal connection after 10/21/2015 is Dr. Karlsson's diagnosis of acromial impingement; a diagnosis contradicted by all treating medical records including an interpretation of the acromion on the 9/1/2017 MRI; is there a preponderance of evidence that could justify severing Petitioner's rights to future medical care under Section 8(a) f *(sic)* the Act? If so, kindly explain in your decision.

19IWCC0560

RESPONSE: The Commission does not acknowledge the conclusions made by Petitioner in the above interrogatory to be its own.

In response to this interrogatory, the Commission answers, "This interrogatory seeks an advisory opinion which the Commission lacks authority to issue. The Commission declines to provide a further response."

3. Given that the evidence in support of an ongoing causal connection and the reasonableness/necessary of this care is there a preponderance of evidence that could preclude an award of the unpaid bills totaling $4,109.66? If so, kindly explain in your decision.

RESPONSE: The Commission does not acknowledge the conclusions made by Petitioner in the above interrogatory to be its own.

In response to this interrogatory, the Commission answers, "Yes." On the Request for Hearing form signed by Petitioner's attorney, Petitioner stipulated that it was only seeking $1,636.22 in unpaid medical expenses. See Arbitrator's Exhibit #1. The Commission has found that Respondent shall pay those expenses pursuant to §8(a) and §8.2 of the Act.

4. Given the anatomic basis of the Appellate Court *(sic)* in *Will County Forest Pres. Dist.* in finding injuries to the shoulder should be awarded under §8(d)(2) and the medical evidence of surgical intervention and residual disability at the bicep tendon and humerus; is there any legal basis or preponderance of medical evidence to deny an award of permanency under §8(d)(2) for the shoulder and §8(e)(10) for the right arm? Is so, kindly explain in your decision.

RESPONSE: The Commission does not acknowledge the conclusions made by Petitioner in the above interrogatory to be its own.

In response to this interrogatory, the Commission answers, "Yes." The Commission finds that the medical evidence in this case shows that Petitioner's injury was to his right shoulder involving a single surgery at the shoulder level including a Bankart repair, biceps tenodesis, rotator cuff repair and SLAP debridement-See Kingston v. Wal-Mart, 2015 Ill. Wrk. Comp. LEXIS 148, 15 IWCC 149; Wright v. AWI Leasing, 2015 Ill. Wrk. Comp. LEXIS 93, 15 IWCC 94.

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

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified. Respondent shall pay Petitioner the sum of $1,636.22 for medical expenses incurred through the date of arbitration, pursuant to §8(a) and §8.2 of the Act. Respondent shall additionally hold Petitioner harmless regarding all payments made by his health insurance.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $735.37 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injury to the right shoulder caused the 10% percent disability to the person as a whole.

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

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

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

DATED: OCT 15 2019

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mp/mcp
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Marc Parker

Barbara N. Flores

CONCURRENCE IN PART AND DISSENT IN PART

I concur in part and dissent in part with the decision of the majority. The Arbitrator found Petitioner's work accident caused a condition of ill-being of his right shoulder. He awarded Petitioner medical expenses up to October 21, 2015, 50 weeks of permanent partial disability benefits ("PPD") representing loss of the use of 10% of person-as-a-whole, denied a separate award for Petitioner's arm, and awarded Respondent credit for overpayment of temporary total disability benefits ("TTD"). The majority modified the Decision of the Arbitrator to award all medical expenses submitted, including the 1,636.22 incurred after October 2015. The majority also affirmed the Arbitrator's PPD award and affirmed the Arbitrator's denial of a separate award for Petitioner's arm.

I would have affirmed and adopted the Decision of the Arbitrator in its entirety. Therefore, I concur with the majority in affirming the Decision of the Arbitrator denying a concurrent award for Petitioner's arm, and in affirming the PPD award. However, I respectfully dissent from the majority finding Respondent liable for medical expenses of $1,636.22 incurred after October 2015 and in awarding temporary total disability benefits.

Petitioner sustained a stipulated accident on January 5, 2015 in which he injured his right shoulder. Petitioner came under the care of Dr. Terry, an orthopedic surgeon. On April 14, 2015, Dr. Terry performed arthroscopic surgery with Bankart repair, biceps tenodesis, rotator cuff repair, and SLAP debridement. Petitioner returned to light duty on July 7, 2015.

By September 9, 2015, Dr. Terry noted that Petitioner reported no pain, independently returned to his weight training program, and he had no abnormalities on examination. Petitioner completed work hardening on October 11, 2015 and was deemed to be able to function at a "very heavy" physical demand level. On October 21, 2015, Dr. Terry declared Petitioner at maximum medical improvement ("MMI") and returned to full-duty work with no restrictions.

Petitioner continued to work at full duty apparently without incident. He returned to Dr. Terry on April 27, 2016. Dr. Terry diagnosed impingement syndrome, prescribed medication, and administered an injection. He continued to work his full-duty job and returned to Dr. Terry on May 10, 2017 reporting some irritation in his shoulder with overhead activities. An MRI taken on September 1, 2017 showed no evidence of recurrent tear of the rotator cuff or labrum and all tendons were intact. The MRI showed nothing except biceps tenodesis. Petitioner was released from treatment *prn* on September 27, 2017.

At Respondent's request, Petitioner saw Dr. Karlsson for a Section 12 medical examination. He testified that when Petitioner was declared at MMI on October 21, 2015 and returned to full-duty work, the condition of ill-being of his shoulder caused by the January 5, 2015 work accident was resolved. His return to Dr. Terry in 2016 and subsequent treatment was the result of a congenital downward sloping Type II acromion and unrelated to his work accident/injury. Interestingly, Dr. Terry did not specifically opine that Petitioner's later complaints and treatment were causally related to his work accident on January 5, 2015. In the absence of a specific medical opinion, I find the opinion of Dr. Karlsson persuasive.

For the reasons, I stated above, I would have affirmed and adopted the Decision of the Arbitrator in its entirety. Therefore, I concur with the majority in affirming the Decision of the Arbitrator denying a concurrent award for Petitioner's arm, and in affirming the PPD award. However, I respectfully dissent from the decision of the majority modifying the medical award of the Arbitrator and finding Respondent liable for medical expenses of $1,636.22 incurred after October 2015.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REARDON, DAVE
Employee/Petitioner

Case# **15WC007081**

VILLAGE OF CHICAGO RIDGE FIRE DEPARTMENT
Employer/Respondent

19IWCC0560

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

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

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

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CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

19IWCC0560

- [ ] 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

David Reardon
Employee/Petitioner

v.

Village of Chicago Ridge Fire Department
Employer/Respondent

Case # **15** WC **7081**

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 **Robert Luedke**, Arbitrator of the Commission, in the city of **Chicago**, on **January 18, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 5, 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 $**$93,489.25**; the average weekly wage was $**1,495.02**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**12,404.88** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**12,404.88**.

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

ORDER

The Arbitrator finds that Respondent is not liable for medical treatment incurred after October 21, 2015 as petitioner had reached MMI.

Respondent awarded a credit for TTD overpayment in the amount of $444.72.

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of MAW pursuant to §8(d)2 of the Act.

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

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

Signature of Arbitrator

2/6/18
Date

FEB 7 - 2018

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

19IWCC0560

The arbitrator finds any right shoulder symptoms or treatment after the MMI date of 10/21/15 is not causally connected to the 1/5/15 accident. Petitioner's treating medical records from Dr. Terry and Ingalls Occupational Health contain a history of the January 5, 2015 work accident and no other nonoccupational cause. Petitioner testified that he had no right shoulder treatment or condition prior to the accident. Petitioner had right shoulder symptoms immediately after the accident. Petitioner has met his burden of proving a causal connection up to the MMI date of October 21, 2015. Petitioner was released from care and determined to be at MMI on October 21, 2015.

Petitioner first sought care with Dr. Terry on February 9, 2015. *P4.* Petitioner previously treated with Dr. Terry for a right elbow injury back in 2010. *Id.* Dr. Terry reviewed petitioner's MRI and documented a tear of the anterior inferior labrum. Petitioner was authorized to continue working light duty. The employer accommodated said light duty.

On April 14, 2015 petitioner underwent a diagnostic arthroscopy of the right shoulder with a Bankart repair, biceps tenodesis, rotator cuff repair and SLAP debridement. *Id.* Petitioner reinitiated physical therapy in June of 2015 and was improving. *P3 and P4.*

After the surgery, petitioner was authorized off work, until he was able to return to light duty on July 7, 2015. *P4.*

Dr. Terry's record of August 3, 2015, documents no complaints of pain or feelings of instability. *Id.* On physical examination, petitioner had full range of motion and was neurovascularly intact. Petitioner was stable and had full forward flexion. Rotator cuff strength was 5/5. *Id.*

Dr. Terry's September 9, 2015 record documents that petitioner denied any pain in the right shoulder. Petitioner was able to return to weight training on his own. Petitioner reported some occasional soreness after his exercises. No abnormalities were noted on physical examination. *Id.*

The medical records document petitioner's completion of his work conditioning program. Petitioner eventually discharged from work conditioning at the "very heavy" physical demand level as of October 11, 2015. *P3.* Based on petitioner's physical capabilities shown in work conditioning, the petitioner was discharged from care as he met all of the physical requirements to return to his job as a firefighter/paramedic. *Id.*

On October 21, 2015, petitioner was discharged from care at MMI from Dr. Terry. Petitioner was released to return to full duty work without restrictions. *P4.* The record indicates that petitioner was doing well and was not taking any anti-inflammatories. His physical examination revealed negative AC tenderness and negative biceps tenderness. *Id.* Petitioner's range of motion was normal and he had a negative apprehension test. Petitioner's strength was 5/5 throughout. *Id.* Petitioner was told to return on an as needed basis. *Id.*

The Arbitrator notes that Petitioner testified at trial that he has been working his full duty job for the Fire Department from October 28, 2015 through the date of trial. Petitioner did acknowledge his promotion to engineer in September of 2016. Petitioner testified that he continues to perform his full duty tasks currently as an engineer. Petitioner denied missing any time from work because of his right shoulder after 10/21/15. Petitioner denied any inability to perform his full duty job after 10/21/15.

The Petitioner did not receive any medical care from the date of his discharge from Dr. Terry on 10/21/15 until he returned for a follow up at Dr. Terry's practice six months later on April 27, 2016. The petitioner testified that he had continued working his full duty job, and did not miss any time from work as a result of right shoulder pain.

When Petitioner was examined on 4/27/16, Petitioner denied any trauma or injury, but complained of some pain. Petitioner gave a history that he only took medications as needed. *P4.* The petitioner was diagnosed with impingement symptoms, and underwent an injection and given medications. Petitioner's physical examination revealed full strength, full range of motion and full symmetry. *Id.* The Arbitrator notes that Petitioner was authorized to continue working full duty.

Petitioner did return on June 29, 2016 following his injection into the subacromial space. The petitioner was again discharged from care and told to return on an "as needed basis". *Id.*

Petitioner did not undergo any medical treatment or therapy for 11 months, when he was next seen on May 10, 2017. During this time 11 month gap, the petitioner continued to work his full duty job. The May 10, 2017 appointment documented some irritation in the right shoulder with overhead activities. *Id.* Petitioner's physical examination at this visit was relatively normal. petitioner was given another subacromial injection and recommended to undergo an MRI if his symptoms persisted. *Id.*

The 9/1/17 MRI showed a biceps tenodesis with the tendons intact without evidence of new or recurrent rotator cuff tear. The postoperative appearance of the labrum was intact with no tear. The only abnormal finding on MRI was a new finding of subacromial/subdeltoid bursitis. *Id.*

The petitioner last visited Northwestern Medical Group on 9/27/17. Petitioner was examined by Dr. Samagh. *Id.* As of 9/27/17, petitioner reported crepitus and issues with forward activities. The 9/27/17 record documents that overhead activity or activities below the waist seem to be "not problematic". *Id.*

The physical examination on 9/27/17 showed full range of motion of the right shoulder with no complaints of pain on range of motion testing. Provocative testing was negative and rotator cuff strength was 5/5. Nothing within said record or physical examination documented any deficits in strength, crepitus or range of motion. *Id.* Dr. Samagh also reviewed petitioner's MRI of the right shoulder which documented bursitis, no other abnormalities. Petitioner was not recommended to undergo any further surgical intervention. The records show that petitioner did not undergo any injections or therapy following the 9/27/17 visit. Petitioner was recommended to perform home exercises and was again told to return on an "as-needed" basis. Petitioner was prescribed with one script of an anti-inflammatory, Duexis. There is nothing in the record that mentions any ongoing care and/or ongoing prescriptions beyond what was given on 9/27/17.

Petitioner testified that he continues to take medications and was told by Dr. Terry that he would have to return every 6 months for the next 3-4 years. As of 9/27/17, petitioner was discharged from care with no recommendations for further treatment or medication.

The Arbitrator notes that respondent does not dispute that Petitioner sustained a compensable accident and underwent necessary and appropriate care. Respondent's examining physician agrees that petitioner sustained a compensable accident and received reasonable and necessary care through October 21, 2015 when he was discharged from care at MMI and authorized to return to full duty work. The objective abnormalities that resulted from the 1/5/15 accident had been cured and had resolved as of October 21, 2015 when he was discharged from care and authorized to return to full duty work. Based on the medical evidence and expert opinions of Dr. Karlsson, any treatment and/or medication management in 2016 and 2017 is not causally related to the injury incurred on 1/5/15. Petitioner's alleged symptoms and bursitis documented in 2016 and 2017 is related to a condition that is unrelated to his 1/5/15 injury. The abnormalities found after 1/5/15 were treated and surgical cured to the point that petitioner was capable of performing at the "very heavy" physical demand level and was able to perform all of his activities of daily living. Any symptoms or treatment needed after 10/21/15 are not causally related to the 1/5/15 accident.

The Arbitrator relies on Dr. Terry's treating records and the expert opinions and testimony of Dr. Karlsson. *P4, R2, and R3.* After review of the original independent medical evaluation and deposition transcript of Dr. Karlsson dated April, 10, 2017, the Arbitrator finds the opinions of Dr. Karlsson persuasive. Dr. Karlsson opined that petitioner's symptoms and diagnosis from 2016 and 2017 were not causally related to his original injury in January of 2015. No causal connection opinion from Dr. Terry regarding the treatment after 10/21/15 was offered by either side.

Dr. Karlsson testified that as of October 21, 2015 and December 3, 2015 the petitioner had a stable shoulder, full symmetry, and normal strength in the right shoulder following his surgical repair and postoperative treatment stemming from the 1/5/15 accident. *R2.* Dr. Karlsson opined that the petitioner's condition resulting from the work accident had been repaired. The petitioner had reached MMI and did not require any further medical treatment as a result of the work related injury.

Dr. Karlsson opined that based on the records in 2016, petitioner's diagnosis and treatment was a separate problem than his prior issues related to the work injury. *R2 at 38-39.* Dr. Karlsson stated that petitioner's pathology in 2016 was different than his prior pathology from his work injury. Dr. Karlsson clearly stated that petitioner's diagnosis of impingement and the subacromial steroid injection is not related to his prior pathology from the work accident, but rather a separate problem. Dr. Karlsson concluded that petitioner's impingement/bursitis was not sequelae of the original work injury, but rather a completely different and separate diagnosis in the same body part. *R2 at 39-40 and 44-45.* Dr. Karlsson does not disagree with the diagnosis made by Northwestern Medical Group in 2016 but comments that petitioner's treatment and symptoms in 2016 have no causal relationship and/or were not caused by any aggravation from the injury in 2015. *R2 at 47-48.* Dr. Karlsson opined that the petitioner's impingement treatment in 2016 was for a separate problem to the shoulder and was unrelated to the 1/5/15 accident.

Dr. Karlsson opined that petitioner's current condition is related to his condition of having a type II acromion, which was documented on the first MRI and in Dr. Terry's first report on 2/9/15. *P4.* Dr. Karlsson further supported his opinions by documenting that petitioner's Type II acromion is not a result of a trauma but the shape of petitioner's acromion. Dr. Karlsson testified that petitioner's current impingement-type symptoms are consistent with a personal condition and any treatment or medication management for said diagnosis is unrelated to his prior rotator cuff repair and labral repair.

The Arbitrator finds that the petitioner sustained a compensable accident on January 5, 2015 which resulted in successful surgery and postoperative care. The Arbitrator finds that the petitioner reached MMI when he was discharged from care and released to return to full duty work as of October 21, 2015. The Arbitrator finds that petitioner's treatment in 2016 and 2017 is not causally connected to the original date of accident pursuant to the treating medical records of Dr. Terry and the opinions of Dr. Karlsson. The Arbitrator finds that Respondent is not liable for any medical costs related to petitioner's visits in 2016 and 2017.

J. Has respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner alleges unpaid medical bills of $1636.22. Petitioner entered *P7* which includes bills from Northwestern Medicine. The Northwestern Medicine bills are as follows:

> May 10 and May 11, 2017 in the amount of $199.13 for the petitioner's epidural steroid injection to the right shoulder
>
> September 1, 2017 in the amount of $88.32 for an MRI of the right upper extremity
>
> September 7, 2017 in the amount of $1096.95 for an MRI of the right shoulder
>
> September 27, 2017 in the amount of $171.43 for the petitioner's epidural steroid injection to the right shoulder.

Based on the arbitrator's decision regarding causal connection the Arbitrator finds that Respondent is not liable for any medical bills or treatment rendered after 10/21/15 when petitioner was discharged from care at MMI and authorized to return to full duty work by Dr. Terry, the treating physician. Respondent is awarded a credit for any medical bills previously paid by the respondent. The unpaid medical bills alleged in *P7* are not causally connected to the work accident and are not awarded.

K. What temporary benefits are in dispute?

The arbitrator has reviewed *R1*. The petitioner received TTD benefits from April 14, 2015 through July 6, 2015. The stipulation sheet between the parties entered as *Arb1* discloses petitioner claims entitlement to TTD benefits commencing on April 10, 2015. Respondent disputes this period of time. The operative report indicates the petitioner underwent arthroscopic surgery to his right shoulder on April 14, 2015. *P4*. The petitioner testified that he was provided light duty employment by the respondent up to the date of surgery. The petitioner was seen by Dr. Terry on March 9, 2015. *Id.* Dr. Terry's note mentions that the petitioner will proceed to surgery. *Id.* There is no indication that the petitioner was removed from employment prior to the surgery date. The arbitrator is aware of a preoperative visit on April 10, 2015. No removal from employment is mentioned in the April 10, 2015 preoperative note. *Id.* The arbitrator finds the petitioner was off work from April 14, 2015 through July 6, 2015 and received TTD benefits during this time as indicated by *R1*.

Parties agreed petitioner's average weekly wage was $1495.02 resulting the TTD rate of $996.68. *Arb1*. Petitioner received 12 weeks of TTD benefits at the two-week rate of $2067.48. The petitioner should have received TTD at the two-week rate of $1993.36. The petitioner received a TTD overpayment of $444.72. Respondent is awarded a credit against any award in the amount of $444.72.

L. What is the nature and extent of the injury?

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of MAW pursuant to §8(d)2 of the Act. The arbitrator bases this decision on the testimony of the petitioner and the petitioner's treating medical records.

Petitioner testified he was employed as a firefighter paramedic for the respondent. On January 5, 2015 petitioner was responding to an apartment fire. Petitioner and his coworkers were bringing a hose into the unit that was on fire. The petitioner is trying to get over a couch inside the apartment unit. The petitioner had his right knee on the couch. The petitioner fell forward and hit the floor. The petitioner testified he felt immediate pain in his right shoulder.

At the time of the accident the petitioner testified he was 6'5" tall and weighed 275 pounds he was wearing all of his firefighter gear. The petitioner estimates that he fell 6 feet from the back of the sofa onto the floor.

Petitioner reported the accident. The accident report was entered into evidence as *P1*. Petitioner testified that other firemen were the author of *P1*. Petitioner testified he fell 4 feet from the top of the couch and put his right arm forward to break his fall.

The petitioner reviewed the accident report two days later. Petitioner didn't seek immediate medical care. He tried ice and anti-inflammatories. When his condition did not resolve he went to Ingalls Memorial Hospital on January 9, 2015. He was placed on restrictions which the employer accommodated.

On January 23, 2015 the petitioner was seen by Dr. Terry at Northwestern. Dr. Terry reviewed an MRI of the petitioner's right shoulder. The petitioner worked at light duty for the respondent and participated in physical therapy at ATI. The petitioner mentioned that during this time his right shoulder would pop out and he would be in pain.

Dr. Terry perform surgery on the petitioner's right shoulder on April 14, 2015. Petitioner was restricted from all work. He received his PEDA and workers compensation benefits.

Petitioner testified his symptoms were helped by the surgery. He returned to light duty employment on July 7, 2015. He was seen by Dr. Terry on August 3, 2015. He participated in physical therapy at ATI during this time. On October 21, 2015 Dr. Terry gave the petitioner a full duty release. Petitioner returned to work on October 28, 2015.

The petitioner recalls being seen by Dr. Karlsson for an independent medical exam at the request of the employer. In 2016 the petitioner noticed pain in his right shoulder. The petitioner testified to a feeling of having gravel in his shoulder. He avoided overhead work. The petitioner is right-handed. Because of the petitioner's shoulder pain he had a steroid injection in his right shoulder on April 27, 2016. He was better for the next 4 to 6 weeks.

On September 16, 2016 the petitioner received a promotion to engineer. He drives the fire truck to the fire. He still handles hoses and ladders. At the present time the petitioner still has some grinding or crepitus in his right shoulder. The petitioner had another injection and another MRI in 2017. The petitioner had a third injection in his right shoulder in 2017.

The petitioner complained of continuing problems at the time of arbitration during work activities. The petitioner saw Dr. Terry in September 2017. The petitioner alleges he has bursitis from the injury. He is approximately 6 to 8 months from the right shoulder injection. The petitioner used to participate in golf, football, and hockey but does not participate in these activities the present time. The petitioner testified he used to coach the hockey team at Brother Rice high school but can no longer do so.

During cross-examination the petitioner agreed that he was seen in 2010 for epicondylitis with Dr. Terry. Petitioner agrees that his final visit with Dr. Terry was on December 27, 2017. There is no recommendation for any additional surgery. The petitioner has no future scheduled appointments. He is presently working at his full duty job.

The petitioner's accident report indicates the petitioner was working in an apartment fire in zero visibility conditions. He was crawling over interior debris and fell forward approximately 4 feet off the top couch. Petitioner attempted to break his fall by putting his right arm forward. He experienced immediate pain in the right shoulder. *P1.*

Petitioner was seen at Ingalls Occupational Health on January 9, 2015. The records were entered as *P2.* The petitioner gave a history of a date of injury of January 5, 2015. *R2.* Petitioner was released to light duty employment with a 5 pound lifting restriction for the right upper extremity *P2.* Petitioner gave a history of being at work in putting out a house fire. *Id.* He fell over a couch

on his right hand to catch himself from hitting the floor and felt sharp pain in his right shoulder. *Id.* There were no fractures indicated by the right shoulder x-ray taken on January 9, 2015. *Id.* Petitioner was referred to an orthopedic surgeon. The petitioner gave a history of having Dr. Michael Terry as his orthopedic surgeon. *Id.*

The ATI physical therapy progress report for October 5, 2015 to October 11, 2015 mentions that the petitioner has progressed to the very heavy level for physical demand. *P3.* The petitioner was able to lift 100 pounds 12 times from floor to chair. He was able to lift 60 pounds 10 times overhead. *Id.* He was able to lift and carry 125 pounds for 100 feet. *Id.* The estimated physical demand level was very heavy. *Id.* The physical therapist wrote that the petitioner's capabilities meet his physical demand level of firefighter. *Id.* Petitioner was discharged from physical therapy. *Id.*

Petitioner appeared at Dr. Terry's office of Northwestern Medical Group for the first time on February 9, 2015. *P5.* Petitioner gave a history of falling while working in an apartment fire on January 5, 2015 resulting in injury to his right shoulder. *Id.*

On February 9, 2015 Dr. Terry saw the petitioner and reviewed the MRI. *Id.* Dr. Terry interpreted the MRI to show a tear of the anterior inferior labrum. *Id.*

The petitioner underwent a diagnostic arthroscopy of the right shoulder, a right shoulder Bankart repair, biceps tenodesis, a rotator cuff repair, and a bridement. *Id.* The procedure was performed by Dr. Terry at Northwestern Memorial Hospital. *Id.* The postoperative diagnosis was right shoulder instability with partial tearing of the rotator cuff with significant Bankart, some articular cartilage wear, biceps tendinitis, and shoulder instability. *Id.*

The petitioner's postoperative recovery was uneventful. The petitioner was seen by Dr. Terry on September 27, 2017. *Id.* Petitioner gave a history of doing well after the surgery until 2016 when he was seen for a series of three steroid injections. *Id.* Petitioner gave a history that the injections did not help. Petitioner's present to discuss the repeat MRI the right shoulder taken in May 2017. *Id.* Petitioner felt there was crepitus in his right shoulder. *Id.* Petitioner gave a history that overhead activity or activity below the waist does not seem to be problematic. *Id.* The repeat MRI indicated the petitioner has no new or recurrent rotator cuff tear. *Id.* Petitioner underwent a fourth epidural steroid injection in the right shoulder. Petitioner will visit on an as-needed basis. *Id.*

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 2 % of the whole person or 3% impairment of the right upper extremity as determined by Dr. Karlsson, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. *Deposition Exhibit 3 contained in transcript of deposition of Dr. Karlsson of April 10, 2017 entered at arbitration as R2.* The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted a full recovery, and the ability to return to unrestricted employment. Because of the objective findings of Dr. Terry and Dr. Karlsson, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a firefighter/paramedic at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes the petitioner has received a full release to return to work. The final progress note from ATI Physical Therapy mentions that the petitioner is capable of working at the heavy physical demand level which is a match for his pre-accident employment. The petitioner has received a promotion to engineer which involves driving the fire trucks to the fire. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the petitioner was able to return to his pre-accident employment. No loss of wages is alleged. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the petitioner underwent right shoulder arthroscopic surgery including a right shoulder Bankart repair, a debridement, a rotator cuff repair, and a biceps tenodesis. The petitioner did eventually have a full release and a discharge from treatment with no further medical visits planned. 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 10% loss of use of MAW pursuant to §8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Benjamin Hester,
Petitioner,

vs. No: 17 WC 12781

Fairview Heights Police Department,
Respondent.

19IWCC0561

DECISION AND OPINION ON REVIEW

Petitions for Review under §19(b), having been timely filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, prospective medical expenses, temporary total disability, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 18, 2018, is hereby affirmed and adopted.

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: **OCT 18 2019**

Marc Parker

mp/wj
10-03-19
68

Barbara N. Flores

SPECIAL CONCURRING OPINION

I agree with the outcome reached by the majority; however, I write separately as I arrive at my decision using a different analysis. The ultimate decision reached rests solely on Petitioner's credibility. While an inference can be drawn from the Arbitrator's decision regarding Petitioner's lack of credibility, it was not specifically stated. I find Petitioner not credible.

Sergeant Schutz testified that on January 20, 2017, he observed Petitioner upon his arrival to work limping. T. 56. Sergeant Schutz inquired of Petitioner as to the cause of the limp, and Petitioner advised he had injured his back. T. 57. This conversation, which is denied by Petitioner, is memorialized in the WC Supervisor Report (RX6) as well as the January 21, 2017 memo- Subject- Officer Hester's report of an off-duty injury to his back. RX4. Moreover, the January 21, 2017 memo further memorializes that Petitioner advised Sergeant Schutz, prior to the CPR incident, regarding a previously scheduled chiropractic appointment for the following Monday [January 23, 2017]. RX4. This pre-scheduled chiropractic appointment is confirmed by Captain Locke.

Captain Locke testified Petitioner presented to his office and advised "his back was hurting, that he had seen a doctor, [*sic*] he was supposed to take it easy over the weekend until he saw the doctor again on Monday." T. 92. Captain Locke subsequently reviewed RX7- an e-mail prepared by himself on January 20, 2017 directed to Lieutenant Beyersdorfer, which helped to refresh his recollection. T. 93-94. Captain Locke then testified as follows: "Ben [Petitioner] came in and was talking, [*sic*] he said he threw his back out previously, was supposed to take it easy over the weekend until he saw his doctor again on Monday. He also mentioned he had been doing CPR on someone on a 1050 [*sic*] that date and that his back was hurting. I mentioned to him if you got that advice you really shouldn't be here at work and then I told him he needed to go home –" T. 94. Captain Locke sent Petitioner home.

Captain Locke identified RX8, which is the same as RX3, an e-mail prepared by himself on January 20, 2017 sent to Sergeant Schutz. Captain Locke advised Sergeant Schutz of his conversation with Petitioner specifically the CPR incident as well as Petitioner's report of prior back treatment and his need to "take it easy" pending his follow-up appointment on Monday, which led Captain Locke to send Petitioner home. RX8. Thereafter, Captain Locke testified as follows: "Q. Okay. If Mr. Hester testified today that he didn't have any such conversation with you would that be accurate? A. That would not be." T. 95.

Lieutenant Krummich testified he spoke with Petitioner on January 21, 2017 and subsequently memorialized their conversation in a memorandum dated February 2, 2017. RX9. Lieutenant Krummich testified Petitioner related he presented to work on January 20, 2017 with back pain, which required him to seek treatment the day prior. T. 108. Petitioner reported he was given the opportunity to leave work but opted to stay after which time he responded to a traffic accident where he performed CPR causing his back to stiffen up. *Id.* Lieutenant Krummich testified if Petitioner's testimony was he did not advise his supervisor that he was experiencing back pain prior to January 20, 2017, such would conflict with his report. T. 109.

Lieutenant Beyersdorfer testified he contacted Petitioner telephonically on January 24, 2017. The purpose of the telephone call was to determine if Petitioner sustained a work-related injury. T. 116. Lieutenant Beyersdorfer testified he directly asked Petitioner if his back was injured at work, and Petitioner stated "No." T. 117. Lieutenant Beyersdorfer stated Petitioner subsequently reported his back injury as work-related on March 23, 2017. T. 22.

Petitioner testified and denied having prior low back problems and, more importantly, denied having the conversations with Sergeant Schutz, Captain Locke, and Lieutenant Krummich wherein he specifically advised of his prior back problems. T. 46-47.

As previously stated, I find Petitioner simply not credible. The testimonies of Sergeant Schutz, Captain Locke, Lieutenant Krummich, and Lieutenant Beyersdorfer are credible and persuasive. Petitioner suffered from back problems prior to January 20, 2017 which is borne out by all the testimony and medical records. Certainly, Petitioner performed CPR on January 20, 2017. Petitioner, though, failed to prove the act of CPR led to an injury which aggravated or accelerated his underlying condition. Petitioner denied having multiple conversations with multiple witnesses regarding his pre-existing back condition. Petitioner denied having multiple conversations with multiple witnesses regarding his previously scheduled follow-up appointment set for January 23, 2017. Moreover, Petitioner arrived at work on January 20, 2017 with an injured back severe enough to cause a noticeable limp which led to an inquiry from his supervisor regarding his fitness to work. More importantly, Petitioner testified after performing CPR he continued to carry out his duties; returned to the police station; and felt no change in his physical condition. T. 18-19. It was only during his shower that he felt a pain in his back. T. 19. Given Petitioner's lack of credibility and the significantly delayed onset of increased back pain, Petitioner failed to prove accident or causal relationship.

Additionally, I would strike the Arbitrator's gratuitous and irrelevant comments regarding Petitioner's attendance or lack thereof during Respondent's case-in-chief and Petitioner's lack of rebuttal testimony. Petitioner and his attorney prosecuted the case, and whatever reasons Petitioner may have for his lack of attendance/rebuttal has no bearing on his credibility. No inference should be drawn, and none is.

For the reasons stated above, I concur with the outcome reached by the majority.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

HESTER, BENJAMIN
Employee/Petitioner

Case# **17WC012781**

FAIRVIEW HEIGHTS POLICE DEPT
Employer/Respondent

19IWCC0561

On 7/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5983 CARAWAY FISHER & BROOMBAUGH PC
JASON R CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

2337 INMAN & FITZGIBBONS LTD
STEPHEN McCLARY
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Benjamin Hester
Employee/Petitioner

Case # 17 WC 12781

v.

Consolidated cases: n/a

Fairview Heights Police Department
Employer/Respondent

19IWCC0561

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 24, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0561

FINDINGS

On the date of accident, January 20, 2017, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $62,443.68; the average weekly wage was $1,200.84.

On the date of accident, Petitioner was 41 years of age, married with 3 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $14,366.94 for other benefits, for a total credit of $14,366.94.

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 5, 2018
Date

JUL 11 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on January 20, 2017. According to the Application, Petitioner was performing CPR on an accident victim and sustained an injury to the low back (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner was hired by Respondent in August, 2007, and worked as a police officer. Prior to working for Respondent, Petitioner was employed as a police officer in Caseyville. Petitioner also served in the military as an MP.

In regard to the accident of January 20, 2017, Petitioner testified that he responded to a vehicular accident at the intersection of St. Clair Avenue and 79th Street. It was a serious accident and bodies of the accident victims were on the street and the intersection was blocked off. Petitioner stated he observed Officer Flynn administering CPR to one of the accident victims, a young black female. Petitioner proceeded to relieve Officer Flynn and performed CPR on the accident victim for approximately four to seven minutes. The victim was unresponsive. Petitioner returned to the police department to shower and change his clothing. Petitioner said that he hurt his low back while performing CPR and that he reported it to his immediate supervisor, Sergeant Schutz, that same day. Petitioner also said that he subsequently talked to Captain Locke and was ordered to go home.

Petitioner identified an Employee Injury Report that he completed and signed. According to the report, Petitioner sustained a low back injury, L3 to L5 with bulging discs as a result of performing CPR on January 20, 2017. It also noted Petitioner reported the accident to Sergeant Schutz. Petitioner could not explain why the report was dated March 24, 2017 (Petitioner's Exhibit 1).

Prior to January 20, 2017, Petitioner was treated for back problems by Dr. Clinton Frye, a chiropractor. Petitioner testified Dr. Frye treated him for middle and upper back problems prior to January 20, 2017. Dr. Frye's records were received into evidence at trial.

Dr. Frye previously saw Petitioner on April 11, 2016, for thoracic and lumbosacral spine symptoms. According to his record of that date, Dr. Frye treated Petitioner's spine at the T5, T10, L3 and L5 levels. When Dr. Frye saw Petitioner on October 24, 2016, he treated Petitioner's spine at the T5, T11, L3 and L5 levels. When Dr. Frye saw Petitioner on January 12, 2017, he treated Petitioner's spine at the T7, T12 and L3 levels (Petitioner's Exhibit 3).

Dr. Frye subsequently saw Petitioner on January 19, 2017 (the day prior to the accident) and noted Petitioner had improved since the last visit. At that time, Dr. Frye treated Petitioner's spine at the T2, T12 and L3 levels. The next time Dr. Frye saw Petitioner was on January 23, 2017 (three days post accident), and he noted Petitioner was in extreme pain because of a work-related injury. At that time, Dr. Frye treated Petitioner's spine at the T8, T11, L3, L4 and L5 levels. He

also ordered x-rays which revealed a mild lumbar spondylosis (Petitioner's Exhibit 3). In regard to Petitioner's appointment with Dr. Frye on January 23, 2017, Petitioner testified at trial that he made the appointment to be seen by Dr. Frye the day following the accident, January 21, 2017.

Dr. Frye again saw Petitioner on January 27, 2017. At that time, he treated Petitioner's spine at the T7, T11, L3, L4 and L5 levels. He also ordered an MRI scan which was performed on February 7, 2017. According to the radiologist, Petitioner had disc bulges at L3-L4, L4-L5 and L5-S1 (Petitioner's Exhibit 3).

Dr. Frye referred Petitioner to Dr. Bruce Vest, an orthopedic surgeon, who initially evaluated Petitioner on February 21, 2017. According to Dr. Vest's record, Petitioner injured his back on January 20, 2017, while performing CPR. Dr. Vest opined Petitioner had sustained an acute lumbar strain and had bulging discs and degenerative disc disease. He prescribed medication and ordered physical therapy (Petitioner's Exhibit 4).

Petitioner received physical therapy from February 23, through April 11, 2017. According to the record of February 23, 2017, Petitioner had an issue with low back pain which was aggravated in January when he performed CPR for 10 minutes (Petitioner's Exhibit 5).

Dr. Frye saw Petitioner on March 22, 2017. At that time, he treated Petitioner's spine at the T9, L1, L3 and L5 levels. He noted Petitioner had been seen by Dr. Vest and had retained an attorney. Dr. Frye subsequently referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 3).

Dr. Gornet saw Petitioner on March 25, 2017, and Petitioner advised him of having injured his back while performing CPR on January 20, 2017. Petitioner advised that while he had been receiving chiropractic care prior to the accident, the pain was much more severe than what it had been previously. Dr. Gornet opined Petitioner's symptoms were consistent with a disc injury in the lumbar spine and were causally connected to the work-related injury (Petitioner's Exhibit 6).

Dr. Gornet subsequently reviewed the MRI and opined it revealed an annular tear at L5-S1. He recommended Petitioner undergo some epidural steroid injections, but if it did not improve his condition, Petitioner should undergo a discogram and L4-L5 and L5-S1 with MRI spectroscopy (Petitioner's Exhibit 6).

Dr. Gornet referred Petitioner to Dr. Helen Blake, a pain management physician. Dr. Blake saw Petitioner on April 18 and May 2, 2017, and administered epidural injections at L5-S1 (Petitioner's Exhibit 7).

The injections did not give Petitioner any long lasting relief and he was again seen by Dr. Gornet on May 26, 2017. Dr. Gornet renewed his recommendation that Petitioner undergo a discogram and MRI spectroscopy. He continued to authorize Petitioner to remain off work (Petitioner's Exhibit 6).

Sergeant Kurt Schutz testified on behalf of Respondent when this case was tried. Schutz stated he had known Petitioner for over 18 years and had also worked with him. He observed Petitioner when he reported for duty on January 20, 2017, and observed Petitioner was limping slightly. He asked Petitioner if he had injured himself and Petitioner responded that he had, but he did not know how. He made the suggestion that Petitioner be careful.

Schutz was also present at the scene of the accident. He did not observe Petitioner performing CPR because he was busy directing traffic. He did note that Petitioner had some blood on him and was concerned about his mental state given the circumstances of the accident. He directed Petitioner to return to the police station and clean up.

Schutz stated that he saw Petitioner later on that same day and again observed Petitioner walking slight limp. He said that Petitioner said nothing about having sustained a work-related injury as a result of performing CPR, but said something to the effect that performing CPR did not do his back any good.

Schutz identified a memo he prepared on January 21, 2017, directed to Lieutenant Hoguet. The memo specifically referenced the fact that Schutz saw Petitioner limping on the morning of January 20, 2017. Further, it noted that Petitioner had advised Schutz that he had already made an appointment with a chiropractor to be seen the following Monday. The memo also noted that Schutz had received a text from Petitioner in which Petitioner stated he was ordered home until he saw a doctor on Monday. The memo indicated "It should be noted that Officer Hester never implied to me or stated that he wished to report an on duty injury relating to any of his police activities during the Duty day of 01-21-17." (Respondent's Exhibit 4).

Schutz also received an e-mail from Captain Christopher Locke on January 20, 2017, in which Captain Locke advised that Petitioner had performed CPR and his back hurt prior to that day, and was told by a doctor to take it easy until Monday when he was to return for another appointment (Respondent's Exhibit 3).

Schutz responded to the e-mail from Locke in an e-mail dated January 21, 2017, in which he stated that Petitioner needed to report that he reinjured his back on duty after injuring it off duty before completing any injury form. Schutz also noted that Petitioner denied having sustained an injury while on the accident scene (Respondent's Exhibit 3).

Schutz subsequently received a telephone call from Petitioner on March 21, 2017. At that time, Petitioner advised Schutz that he had sustained a work-related injury. That was the first time Schutz realized Petitioner was claiming to have sustained a work-related injury. He stated that if Petitioner had previously informed him that he had sustained a work-related injury, he would have prepared a report. On March 21, 2017, Schutz sent a memo regarding his telephone conversation with Petitioner to Lieutenant Beyersdorfer (Respondent's Exhibit 5).

Schutz subsequently prepared a Supervisor Report dated March 27, 2017, regarding Petitioner's work-related accident of January 20, 2017. The report was received into evidence at trial. It was consistent with Schutz's testimony and the other reports/e-mails he prepared (Respondent's Exhibit 6).

Captain Christopher Locke testified on behalf of Respondent when this case was tried. Locke said he had a conversation with Petitioner on January 20, 2017, and that Petitioner informed him that his back was hurting, that he had been seen by a doctor, was supposed to take it easy and was going to see the doctor on Monday.

Locke acknowledged an e-mail dated January 20, 2017, that he sent to Lieutenant Beyersdorfer were in which he advised that Petitioner had thrown out his back the other day and was told to take it easy until he saw the doctor again on Monday. Petitioner did state that he had administered CPR on that date and his back was hurting. He confirmed that he had directed Petitioner to go home (Respondent's Exhibit 7). Locke testified that there was no question in his mind that Petitioner had, in fact, informed him that he had injured his back outside of work.

Lieutenant James Kummerich testified on behalf of Respondent when this case was tried. In January, 2017, Kummerich was a Sergeant, but was subsequently promoted to Lieutenant in March, 2017. Pursuant to a request by Lieutenant Beyersdorfer, Kummerich had a conversation with Petitioner on both January 31 and February 1, 2017, and prepared a memo regarding same on February 2, 2017. According to the memo, Petitioner informed Kummerich that he had been seen by his chiropractor on January 19, 2017, because of back pain. When he reported for duty on January 20, 2017, Petitioner informed his supervisor he was having back pain and was given the option to go home, but declined to do so.

After completing CPR at the accident scene, Petitioner stated his back stiffened up. When he showered, the back pain got worse. When Kummerich spoke to Petitioner on February 1, 2017, Petitioner advised he had been seeing the chiropractor for about three months because of his back symptoms (Respondent's Exhibit 9).

Lieutenant Charles Beyersdorfer testified on behalf of Respondent when this case was tried. At the time of the accident of January 20, 2017, Beyersdorfer was on vacation, but he was Petitioner's patrol Lieutenant. Beyersdorfer said that when he returned to work on either January 24 or 25, he was informed that Petitioner's condition was not work-related.

Beyersdorfer prepared a memo directed to Captain Locke dated March 24, 2017, regarding a conversation he had with Petitioner on March 23, 2017 (Beyersdorfer acknowledged that report was dated 1/23/17, but that this was a typo and should have been 3/23/17). When Beyersdorfer informed Petitioner he had heard that Petitioner was claiming he had sustained a work-related injury, Petitioner responded saying "I don't know how it couldn't be." Beyersdorfer then informed Petitioner that he needed to complete the injury forms (Respondent's Exhibit 10).

Beyersdorfer prepared another memo directed to Captain Locke dated March 28, 2017. In this memo, he stated that he had contacted Petitioner upon his return to duty and Petitioner had informed him that the injury was not duty related. During February/March, Beyersdorfer again talked to Petitioner and Petitioner again did not advise that his condition was work-related (Respondent's Exhibit 11).

At the direction of Respondent, Petitioner was examined by Dr. Kevin Rutz, an orthopedic surgeon, on July 18, 2017. In connection with his examination of Petitioner, Dr. Rutz reviewed medical records and various e-mails/memos. Dr. Rutz opined Petitioner had an annular tear of L5-S1. In regard to causality, Dr. Rutz noted that Petitioner's symptoms were consistent with the medical records. While he noted that performing CPR was an unusual mechanism of injury to the lumbar spine, it appeared to him that it was the cause of Petitioner's disc injury. In regard to the e-mails/memos, Dr. Rutz noted Petitioner's disagreement with the statement in Schutz's memo of January 21, 2017, in which he stated that the appointment for January 23, 2017, was made prior to the accident of January 20, 2017. Dr. Rutz was careful to note that his opinion as to causality was based upon the accuracy of the statements Petitioner had made to him (Respondent's Exhibit 12; Deposition Exhibit 2).

At Respondent's request, Dr. Rutz subsequently reviewed/abstracted the various e-mails and memos and prepared a supplemental report dated August 10, 2017. In that report, Dr. Rutz stated if the information in the e-mails and memos was correct, then Petitioner's low back problems would not be work-related (Respondent's Exhibit 12; Deposition Exhibit 3).

Dr. Gornet was deposed on August 23, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to causality, Dr. Gornet testified Petitioner probably had some pre-existing disc degeneration at L5-S1 and the CPR activity aggravated it (Petitioner's Exhibit 8; p 15).

When cross-examined about the various e-mails and memos, Dr. Gornet stated that they were highly suspicious because they were all prepared after the CPR event took place. Dr. Gornet stated that if they had been prepared prior to the CPR event, then he would have believed them to be valid (Petitioner's Exhibit 8; pp 20-23).

Dr. Frye was deposed on October 13, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Frye's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. He testified that when he saw Petitioner on January 19, 2017, Petitioner was not scheduled to be seen on January 23, 2017, and was to be seen only on an as needed basis. Dr. Frye testified that he thought the treatment he provided to Petitioner on January 23, 2017, was related to the CPR accident.

On cross examination, Dr. Frye testified that he believed Petitioner called his office sometime on the evening of January 20, 2017, and made the appointment for January 23, 2017. Dr. Frye agreed that his records did not contain a description of exactly how Petitioner sustained the work-related injury. Dr. Frye stated he recalled Petitioner having informed him that he injured himself while performing CPR (Petitioner's Exhibit 9; pp 26-30).

Dr. Rutz was deposed on November 3, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Rutz's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. When questioned about why he changed his opinion regarding causality, Dr. Rutz testified that this was a very odd injury and, based primarily upon the medical records, he initially agreed it was likely from the CPR event.

Upon his review of the various e-mails/memos, he stated that if the information contained therein was accurate, then Petitioner's condition would not be related to the CPR event (Respondent's Exhibit 12; pp 14-15, 19).

At trial, Petitioner denied making statements to Schutz, Locke, Krummerich and Beyersdorfer that he had a low back condition prior to the accident of January 20, 2017, and that he reported for duty on January 20, 2017, with a slight limp. After Petitioner finished testifying, he left the courtroom and did not return. Accordingly, Petitioner was not present when Schutz, Locke, Krummerich and Beyersdorfer testified and was not present to offer any testimony in rebuttal.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment by Respondent on January 20, 2017.

In support of this conclusion the Arbitrator notes the following:

There was no question that Petitioner administered CPR to an accident victim on January 20, 2017.

While Petitioner testified that Dr. Frye's treatment prior to January 20, 2017, was for middle/upper back symptoms, it was not supported by Dr. Frye's treatment records. As noted herein, Dr. Frye administered chiropractic treatment to Petitioner's low back at the L3 and L5 levels prior to January 20, 2017.

Sergeant Schutz, Petitioner's immediate supervisor, credibly testified that he observed Petitioner walking with a slight limp when he reported for duty on January 20, 2017, and that Petitioner had injured himself, but did not know how.

Schutz testified that Petitioner informed him that, prior to the accident, he already had an appointment to be seen by his chiropractor. That was also noted in Schutz's memo of January 21, 2017.

Petitioner testified that he made the appointment with Dr. Frye's office the following day, January 21, 2017, but Dr. Frye testified he believed Petitioner made the appointment sometime during the evening of January 20, 2017.

Schutz testified that the only statement Petitioner made to him after performing CPR was that it probably did not do his back any good. He did not know Petitioner was claiming to have sustained a work-related injury until the telephone conversation he had with Petitioner on March 21, 2017.

Captain Locke credibly testified Petitioner had informed him that he had thrown out his back the other day. While Petitioner stated his back was hurting after performing CPR, he did not specifically advise Locke that he had injured himself or reinjured his back while doing so.

Lieutenant Kummerich credibly testified that when he talked to Petitioner on January 31 and February 1, 2017, Petitioner informed him he had been seen by the chiropractor on January 19, 2017, because of back pain.

Lieutenant Beyersdorf credibly testified that when he returned from vacation on either January 24 or January 25, 2017, Petitioner informed him that he had not sustained a work-related accident. It was not until March 23, 2017, that Petitioner informed him that his back condition was work-related.

The Arbitrator notes that the testimony of four witnesses called by Respondent was consistent with one another and the various e-mails and memos prepared by them.

Respondent's Section 12 examiner, Dr. Rutz, initially opined that Petitioner's condition was related to the CPR incident, but did note that it was an unusual mechanism of injury. When he reviewed the various e-mails/memos, Dr. Rutz stated that if the information contained therein was accurate, then Petitioner's low back problems would not be work-related. Dr. Rutz did not attempt to make a judgment as to the credibility of the aforementioned witnesses.

Petitioner's primary treating physician, Dr. Gornet, attempted to make a decision about the credibility of Respondent's witnesses, stating that the e-mails/memos were "suspicious" because they were all prepared after the CPR event. Dr. Gornet was, in effect, making a judgment as to the credibility of Respondent's witnesses. That was not an issue for Dr. Gornet to decide, but rather, it was an issue for the Arbitrator to decide.

When Petitioner testified, he denied having made the appointment for January 23, 2017, prior to the accident, denied having low back issues and treatment prior to January 20, 2017, and that he informed Schutz, Locke, Kummerich and Beyersdorfer that he had a prior low back condition or that he had a slight limp when he reported for duty on January 20, 2017.

As previously stated, it should be noted that Petitioner was not present in the courtroom when Respondent's witnesses testified and he did not give any rebuttal testimony.

In regard to disputed issues (E), (F), (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 issue (C).

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TINA MARSHALL,

Petitioner,

vs. NO: 17 WC 10050

AMERICAN AIRLINES,

Respondent.

19IWCC0562

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical, and temporary total disability (TTD) benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission writes to modify the Decision with respect to the Arbitrator's Finding on causal connection. On Page 2 of the Decision, the Arbitrator indicated that Petitioner's current condition of ill-being was not causally related to the December 4, 2014 work-related accident. In her Conclusions of Law, the Arbitrator additionally indicated that Petitioner had reached maximum medical improvement for her cervical injury on March 8, 2016. The Arbitrator denied prospective treatment and concluded that Respondent was only liable to pay TTD from December 5, 2014 through September 3, 2015.

The Commission agrees with the Arbitrator's ultimate conclusion relative to causal connection, prospective medical, and TTD, but modifies the Decision to indicate that any treatment from February 27, 2017 and onward was not causally related to the December 4, 2014 accident. The evidence establishes that Petitioner last sought treatment on March 8, 2016. At that time, Petitioner was advised to continue her normal activities as tolerated. Thereafter, Petitioner did not seek medical treatment for more than 11 months. When Petitioner finally sought treatment on February 27, 2017, Petitioner reported that she had a sudden onset of shoulder pain as of one week ago. Given the gap in treatment, Petitioner's new and different symptoms and complaints, as well as different MRI findings, the Commission finds that the injuries for which the Petitioner treated on February 27, 2017 forward were not causally related to the December 4, 2014 accident. As such, Petitioner's claim for additional TTD, from April 10, 2017 through October 12, 2018, and for prospective treatment is hereby denied.

With respect to the TTD awarded by the Arbitrator, the Commission corrects the number of weeks listed in the Order section of Page 2 of the Arbitrator's Decision. The correct number of weeks covering December 5, 2014 through September 3, 2015 is 39 weeks, and not 13 3/7th weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 3, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $522.97 per week for 39 weeks, commencing December 5, 2014 through September 3, 2015, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $20,395.83 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for prospective medical is denied.

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

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

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

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

DATED: OCT 2 1 2019

DDM/pm
O: 10-9-19
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

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

MARSHALL, TINA
Employee/Petitioner

Case# **17WC010050**

15WC005994

AMERICAN AIRLINES
Employer/Respondent

19IWCC0562

On 1/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

3998 ROSARIO CIBELLA & ASSOC
ANDREW LUTHER
2561 DIVISION ST SUITE 103
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)

TINA MARSHALL
Employee/Petitioner
v.
AMERICAN AIRLINES
Employer/Respondent

Case # **17 WC 10050**

Consolidated cases: **15 WC 5994**

19IWCC0562

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **OCTOBER 12, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **12/4/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$40,791.92**; the average weekly wage was **$784.46**.

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

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

Respondent shall be given a credit of **$20,395.83** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$20,395.83**. Respondent is entitled to a credit of $ **issue reserved** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$522.97/week** for 13-3/7th weeks, commencing **December 5, 2014** through **September 3, 2015**, as provided in Section 8(b) of the Act. Against this award, Respondent shall be given a credit of **$20,395.83** for temporary total disability benefits that have been paid.

Petitioner's request for prospective medical care 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

1-2-2019
Date

JAN 3 - 2019

FINDINGS OF FACT

Background

Tina Marshall ("Petitioner") alleged injuries arising out of and in the course of her employment with American Airlines ("Respondent") occurring on December 4, 2014. Ax1, Px1-2. By agreement of the parties, case number 15 WC 5994 was dismissed by agreement, *instanter*. On October 12, 2018, the parties proceeded to arbitration on the disputed issues of causal connection, temporary total disability and prospective medical treatment. Ax1. The following is a recitation of the facts adduced at trial. By stipulation, the parties reserved the issue of Respondent's entitlement to credit under Section 8(j).

Testimonial and Other Evidence

Petitioner testified that she worked for Respondent as a flight attendant. Her duties included opening and closing doors, overhead bins, assisting with luggage, pushing and pulling a beverage cart and assisting with landing. It was undisputed that on December 5, 2014, Petitioner worked her usual job as a flight attendant and injured her neck after experiencing turbulence while landing. She immediately reported the incident and sought care.

On December 5, 2014, Petitioner presented to Dr. Patel of Edward Medical Group. Px1, Rx1:20-25. Pain was present on the left and right side, worse on the right side. It was described as aching and shooting in moderate in nature. She was positive for neck pain, negative for numbness, tingling or weakness. She was tender to palpation on the right side. Diagnosis was neck strain. Petitioner was prescribed medications and follow up.

On December 16, 2014, Petitioner again followed up with Dr. Patel. Px1, Rx1:26-31. She was diagnosed with whiplash injury to the neck and the doctor noted the problem had been waxing and waning. On exam, she was positive for neck pain but negative for tingling, weakness, numbness and headaches. There was tenderness bilaterally in the neck along with slight decrease in neck range of motion due to pain. Assessment was whiplash injury to the neck. She was referred for physical therapy.

On December 30, 2014, Petitioner attended physical therapy. Px3. Petitioner related that while working on December 4, she had a hard landing on the flight. She had tender snapping in the right side of her neck. She was off work for two weeks but when she went off of the muscle relaxer, her pain increased. After driving to Wisconsin, she had increased pain. She reported that heavier lifting irritated her neck. She denied numbness or tingling in her arms. Pain was 4/10. Objectively, there was tenderness to palpation at C3-5 centrally, stiffness in the bilateral upper traps, tenderness to palpation in cervical paraspinal surrounding C3-5. Therapists assessed that symptoms were localize around C3-5. Signs and symptoms were consistent with diagnosis.

On January 7, 2015, Petitioner returned for physical therapy. Px3. Subjectively, Petitioner related she had made the mistake of shoveling snow. Therapists noted she had stiffness in the cervical paraspinals around and C3-5. There was decreased flexibility noted. On that same day, Petitioner saw Dr. Patel who noted normal range of motion, but that Petitioner exhibited tenderness. Rx1:32-36. There was mild tenderness bilaterally in the neck, negative Spurling's, normal bilateral arm strength and gross sensation. Assessment was bilateral neck pain. The plan was to continue therapy and ibuprofen as needed. She was to be off work the start of February.

In January 2015, Petitioner attended physical therapy. Px3. She believed she had overdone it with her independent work out. Symptoms seemed to be associated mostly with muscle fatigue and residual soreness as pain was not radicular and occurred after activity. She continued to deny radicular symptoms. Therapists noted Spurling's test was negative.

On January 28, 2015, Petitioner followed up with Dr. Patel. Px3, Rx1:37-38, 40-42. Petitioner reported severely worse neck pain since last Wednesday while in physical therapy. Pain was constant and worse with neck movements and pushing with arms. There was no radiation, numbness, tingling or weakness. X-rays of the cervical spine demonstrated cervical disc spaces well-maintained and end plate spurring at C5-6 and C6-7. Px5, Rx1:93.

On February 5, 2015, MRI of the cervical spine demonstrated mild degenerative disc changes present, without protrusion central canal stenosis, neural foraminal stenosis, cord compression or other cord abnormality. Px6, Rx1:94-95.

On February 9, 2015, Petitioner followed up with Dr. Patel. Px3, Rx1:43-47. Neck pain had been worsening over the last two weeks. There was no numbness, tingling or weakness. Neck pain radiated up the spine and pain was worse with sitting. The doctor reviewed the MRI noting degeneration with osteophyte complexes at multiple levels. While chronic, the doctor noted they can be made worse from the accident. He referred her to a spine specialist and gave her light duty restrictions.

On February 23, 2015, Petitioner followed up with Dr. Patel. Px3, Rx1:48-53. Petitioner had continued complaints of neck pain. On exam there is decreased range of motion to the right as well as positive bilateral neck tenderness. She was negative for weakness and numbness. Assessment was neck injury and strain. The doctor noted slight improvement, but Petitioner still had significant pain with an inability to function at work.

On February 25, 2015, Petitioner was evaluated by Dr. Nicholas Metaragas for the cervical spine. Px4. Petitioner complained of non-radiating neck pain for the last three months after experiencing a rough landing at work. Impression was cervical spine cervicalgia and cervical degenerative disc disease. The doctor informed her that she was not a candidate for epidural steroid injections or surgery. He recommended she be evaluated and treated by chiropractor.

In February 2015, Petitioner continued with physical therapy. Px3. Therapists noted that the MRI indicated cervical degeneration without nerve compression. She continued to have pain with prolonged sitting. Petitioner had no pain with added activities but did report stiffness. When she stopped taking the muscle relaxer over the weekend and noticed an increase in pain. Eventually, the plan was to discharge and transition to a chiropractor for further care.

On March 26, 2015, Petitioner followed up with Dr. Patel. Px3, Rx1:54-59. The doctor noted her problem had been waxing and waning, now improving. There was no numbness, tingling or weakness. She was tender bilaterally. Assessment was whiplash, neck strain and bulge of cervical disc without myelopathy. She was referred out to physical therapy.

On April 22, 2015, Petitioner followed up with Dr. Patel. Px3, Rx1:60-66. She related pain got worse when the physical therapist massaged her neck. She had pain bilaterally, worse on the left. There was no numbness, tingling or weakness. There was mild tenderness in the left mid neck around C6. Spurling's was negative. Whiplash injury and small cervical disc bulge was noted. The plan was to follow up with a spine specialist.

On May 7, 2015, Petitioner first began treating with Dr. Vivek Mohan for a second opinion at the referral of Dr. Patel. Px4:92. He noted the work accident and neck pain without arm pain. She denied numbness in the arms or hands. Impression was cervical strain and whiplash injury. He interpreted the cervical MRI, in relevant part, as showing minimal spondylosis in sub axial spine and mild C5-6 disc degeneration. Impression was whiplash and strain. The doctor recommended trigger point injections, anti-inflammatories for pain control and possible work conditioning. She was to follow up.

On June 4, 2015, Petitioner followed up with Dr. Mohan. Px4. The doctor noted that she was previously recommended for trigger point injections however a Section 12 evaluator recommended facet injections instead. She was currently off work. Pain is 7 out of 10. Impression with cervical strain and whiplash workplace accident. Petitioner was prescribed pain management, anti-inflammatories, facet injection and work conditioning.

On June 10, 2015, Petitioner followed up with Jennifer Brown, PA. Px4. It was noted that recent cervical MRI was reviewed with patient and was essentially unremarkable aside from straightening and degenerate disc disease. She was referred for cervical facet injections. Dr. Syed visited with Petitioner that same day to evaluate and discuss treatment options. That day, Petitioner underwent bilateral cervical facet injections medial branch nerve block via medial branch approach bilaterally from C3-4 and C4-5. Pre- and post-operative diagnosis was cervical spondylosis.

On June 19, 2015, Petitioner underwent cervical facet joint injections from C3-4 to C4-5. Pre and post-operative diagnosis with cervical spondylosis without myelopathy. Px4.

On June 30, 2015, Petitioner followed up the physician assistant. Px4. She reported 50% relief from her last procedure. She reported increase in pain with lifting, bending, household chores, sitting on a hard surface, standing on the floor with her bare feet as well as driving. Pain was 6 out of 10. She was diagnosed with cervical spondylosis and degenerative disc disease. That same day, Petitioner underwent cervical facet joint injections via medial branch approach bilaterally from C3-4 and C4-5. Px4. Pre- and post-operative diagnosis with cervical spinal without myelopathy.

On July 6, 2015, Petitioner followed up with Basma Javaid, PA. Px4. Pain was 4 out of 10. Diagnosis was degenerate disc disease and cervical spondylosis. That same day, Petitioner underwent radio frequency ablation of the bilateral C3 through C5 medial branch nerves. Pre- and post-operative diagnosis with cervical facet syndrome at C3-4, C4-5 and C5-6 bilaterally.

On August 4, 2015, Petitioner saw Kathleen Rogowski, PA. Px4. She reported pain in the left side of the neck and headaches for 2 to 3 weeks following the last procedure. She reported 50% relief from the last procedure. Pain was 2 out of 10. Diagnosis was cervical spondylosis, degenerative disc disease and cervical strain. Impression noted moderate relief following radio frequency ablation. Petitioner did not feel she could return to work. Work hardening was recommended.

On September 2, 2015, Petitioner followed up with Kathleen Ragowski, PA. Px4. Petitioner was status post radio frequency ablation. She had neck pain worse on the right side when pain kicked in. Diagnosis was whiplash, cervical strain, degenerative disc disease and spondylosis of the cervical region without myelopathy or radiculopathy. She completed work hardening and was able to tolerate her 50 pound lifting requirement. She felt she could return to work as a flight attendant. She was placed at ***maximum medical improvement*** and could return to work without any restrictions. She was to follow up as needed.

On October 15, 2015, Petitioner followed up with Dr. Mohan. Px4. She had mild relief following radio frequency ablation. She reported neck pain with turbulence in landings but still no arm pain. She was currently off work due to the work injury. She rated her pain 7 out of 10. Impression was cervical strain, whiplash. The doctor recommended anti-inflammatories for pain control, bio-freeze and was permitted to return to work full time without restrictions.

Three months later, on January 13, 2016, Petitioner followed up with Dr. Shaw. Px4. Pain was 1 out of 10. She was currently working. Petitioner was pain-free in both forward flexion and extension. Under impression, the doctor noted that no diagnosis was found. Petitioner was given trigger point injections to address myofascial pain syndrome.

On February 2, 2016, Petitioner followed up with Dr. Shahbandar for the neck. Px4. She complained of tightness around the cervical paraspinal muscles. Pain was 0 out of 10. Diagnosis with cervical myofascial pain syndrome. There was minimal response noted to trigger point injections. She was prescribed a trial of compound cream and myofascial release in physical therapy. She was to follow up.

On February 27, 2016, Petitioner returned for physical therapy. Px3. She had some increased in stiffness, but the pain did not increase. Her specialist had recently referred her to a chiropractor for her neck. The plan was to continue strengthening.

On March 8, 2016, Petitioner saw Dr. Shahbandar for her neck. Px4. There was 0 out of 10 pains and she was diagnosed with cervical myofascial syndrome and cervical degenerative disc disease. The plan was for therapy, compound cream trial, NSAID trial or Lidoderm patch. Follow up was ordered.

Nearly one year later, on February 27, 2017, Petitioner returned to Edward Medical Group where she saw Jennifer Chludzinksi, NP. Rx1:67-72. Under visit summary, the reason for the visit was shoulder pain times one week. Petitioner presented with shoulder pain with a sudden onset one week ago in the absence of injury. She initially felt the pain in her neck that resolved but developed into shoulder pain that radiates down to her elbow, sometimes in the forearm. The arm felt better when she raised it or lifted her head. Resting her arm and her side is painful. There was a history of cervical ablation with good results and that Petitioner was pain-free before her shoulder pain. On exam there was no tenderness with palpation, there was positive C6-7 and left paraspinal tenderness with palpation, full shoulder range of motion. Diagnosis and assessment was radiculopathy. Petitioner was recommended to consult with orthopedic spine doctor if needed.

At trial, Petitioner testified that she developed a "new" pain down her left arm and that is just came on. She thought she must have slept wrong, that it just appeared and never went away.

On March 6, 2017, Petitioner returned to Edward Medical Group. Rx1:73-79. She reported only mild improvement, rating her pain 7 out of 10. She had tingling down her left arm, forearm to her fingers over the weekend but not at that visit. She was reporting that it was starting to feel like her previous neck pain from years ago. Assessment was cervical radicular pain. Petitioner was referred to Dr. Mohan for further evaluation before physical therapy. X-rays of the cervical spine demonstrated mild postural changes with straightening of the cervical lordosis which is stable. There was very mild anterior C5-6 disc narrowing which was stable compared to previous. The mild anterior C6-7 disc space narrowing appear to be new. *Id.* at 96, Px7. On March 24, 2017, a second MRI of the cervical spine was unremarkable. At C5-6, minimal disc bulge without spinal canal or neuroforaminal stenosis. Px8.

On April 3, 2017, Petitioner followed up with the physician assistant. Px4. It was noted that Petitioner completed physical therapy and was doing very well until six weeks ago when she woke up with symptoms down her left upper extremity. She reported 100% percent relief from her radio frequency ablation for 1-1/2 years. She now rated her pain 7 out of 10. Diagnosis was degenerative disc disease, spondylosis without myelopathy or radiculopathy and cervical radiculitis. Under impression, a 6-week history of neck pain radiating to the left upper extremity with numbness to digits was noted. Following cervical radiofrequency ablation in July 2015 and completion of physical therapy, she was doing very well until six weeks ago when she woke up with new symptoms. The plan was for initial cervical injection with left bias.

On April 3, 2017, Petitioner underwent CESIs. Pre- and post-operative diagnosis with cervical disc disorder at C6-7 with radiculopathy. Px4.

On April 18, 2017, Petitioner followed up the PA, reporting 50% relief from her last injection. Px4. She still had numbness in the left arm. The pain was described as moderate a game that is intermittent. She was able to complete her normal ADLs. Reaching bending and cervical range of motion increased pain. On exam, the cervical spine was unremarkable. The plan was for second cervical injection. That same date, Petitioner underwent a second round of CESIs at C7 through T1. Px4.

On April 27, 2017, Petitioner followed up with Dr. Mohan following injections. Px4. She reported 50% improvement. She was still having neck and left arm pain with numbness in the hands. The MRI was reviewed from 2017 as showing mild degenerative disc disease at C5-6 and C6-7 with protrusion at left C6-7 with mild left foraminal stenosis. Impression was cervical HNP with radiculopathy. The plan was for third CESI at C6-7. The doctor noted radicular pain at C6-7 due to herniation in the lateral recess region. She was to remain off work and follow up.

On May 17, 2017, Petitioner returned to Jennifer Bren, PA. Px4. She complained of neck pain radiating to the left upper extremity with numbness and tingling to all digits of the left-handed. Consideration was given for a third injection and possible surgery. She was to remain off work.

On May 17, 2017, Dr. Sayeed performed a third CESI at C7-T1. Px4. Diagnosis was spondylosis of the cervical spine without myelopathy or radiculopathy and degenerative disc disease. Px4.

On June 1, 2017, Petitioner returned to Dr. Mohan. Px4. She still had numbness and pain in the arm. Impression with cervical disc disorder at C5-6 with radiculopathy. The doctor determined Petitioner had radiculopathy and weakness in the left arm along with progression of her cervical disease from the original work injury as her neck continued to have symptomology. She still had radicular pain from C6-7 due to herniation in the lateral recess region. The plan was for a cervical traction kit for home use. She was to remain off work.

Five months later, on November 9, 2017, Petitioner returned to Dr. Mohan. Px4. Primary diagnosis unchanged. Her pain was not improving, and it was still located in the left side into the scapula radiating down the left arm. Numbness in the hand was better but the pain was back to her original levels. The doctor noted that she originally was seen back in 2015 for cervical pain with radiculopathy following the work injury. She did physical therapy, facet injections and radio frequency ablation and was able to work. However, for the past month she had been having severe pain in her neck radiating down her left arm. She noted numbness and tingling in the left hand. She described decreased range of motion. The doctor noted that imaging studies from 2017 demonstrated mild degenerative disc disease at C5-6 and C6-7 with protrusion at C6-7 with mild left foraminal stenosis. The doctor's impression remained cervical disc disorder at C6-7 with radiculopathy. Under plan, the doctor noted that there was progression of cervical disease from the original injury occurring in

December 2014 as her neck has continued symptomology. He noted her disc herniation at C6-7 had progressed since the past two MRIs. She had mild temporary improvement in symptoms with injections, but the pain returned. She still had radicular pain from C6-7 due to herniation in the lateral recess region. C6-7 disc replacement versus fusion surgery was discussed. She was to remain off work.

On April 27, 2018, the parties took the evidence deposition of Dr. Mohan. Px9. The doctor confirmed he first saw Petitioner in May 2015 and that eventually Petitioner underwent therapy, facet injections at C3-4, C4-5 and ablation at those same levels. In October 2015 he released Petitioner and the next time he saw her was March 2017. When he saw her again, she did not indicate there was any injuries or falls or any events. The doctor testified that most of her symptoms were still the same except that now there were radicular symptoms down the left arm. On exam, there was slight weakness in the biceps, triceps and grip strength. She also had positive Spurling's on the left. His new diagnosis with cervical radiculopathy with weakness of the left arm and some cervical stenosis. He ordered a new MRI and kept her off work. Following the new MRI, the doctor confirmed there appeared to be increased degeneration with disc protrusion on the left side at C6-7 and possibly C5-6 with left foraminal stenosis. The doctor testified that the relief obtained by the injections in 2017 confirmed evidence of radiculopathy. As such, he was recommending surgery. It was his opinion that the need for surgery and treatment plan was due to the incident at work. The doctor based his conclusion on the history she provided, diagnostics and physical examination.

Under cross-examination, Dr. Mohan testified that upon his initial review of the MRI in 2015, there was no disc protrusion, no central canal stenosis, no foraminal stenosis, no cord compression and no abnormalities of the spinal cord. Rather, there was only mild degeneration at C5-6. He testified that the 2015 MRI findings were consistent with age and were non-acute. Further, Dr. Mohan confirmed that there was no diagnosis as to C6-7 at that time. At the time of the October 2015 release, Dr. Mohan agreed there were no findings regarding C6-7. The doctor testified that he had never reviewed the medical note from February 27, 2017 from Edwards Medical Group whereby it was noted that Petitioner had complete resolution of neck pain symptoms prior to being seen on that day. He confirmed that it was being described as a sudden onset. Dr. Mohan testified that in March 2017, Petitioner now had changes on the left side and she was reporting moderate pain on the left side where as before she had full range of motion. The doctor confirmed that this was the first time he was making positive examination findings at C6-7. In addition, the doctor confirmed that there were now positive Spurling's findings whereas before there were none. The doctor went to testify that although she was at maximum medical improvement when he last saw her 2015, she was not pain-free. The doctor explained that there was no other incident that he was aware of. When asked whether it was fair to say that he could not make the opinion to a reasonable degree of medical and surgical certainty that her current condition was related to the incident of 2014 given that she was pain-free, was released from care and did not seek medical care for over 14 months, the doctor replied that it was correct and it was hard to explain why she had a sudden worsening of symptoms. He could not 100% say that her current condition was in fact related to the incident of December 2014.

On redirect examination, Dr. Mohan testified that the incident was a progression of her disease from the initial accident. However, on re-cross, the doctor also stated that it was likely to conclude that either degenerative changes are the cause for her need for surgery or some sort of intervening incident that took place that he was unaware of.

On July 11, 2018, the parties took the evidence deposition of Dr. Daniel Troy. Rx2. When Dr. Troy first evaluated Petitioner on January 26, 2016, she had no radiculopathy. He agreed with the February 2015 MRI radiologist's findings of straightening of the cervical spine, mild degenerative changes, no disc protrusions, no

stenosis, no foraminal narrowing and no cord compression. Dr. Troy noted age appropriate and non-acute changes. He next saw her in July 2016 where his findings were largely unchanged and thus placed Petitioner at maximum medical improvement. He next saw her in March 2018 and he noted reduced motion and positive Spurling's. He interpreted the 2017 MRI as showing age related changes at C5-6 but no herniation at C6-7. He found the two MRIs to be similar. The doctor concluded that her current condition was not related to the original work injury. He did not find Petitioner to be a surgical candidate.

Petitioner testified she still has arm pain she rates 1-2 out of 10 and that her neck pain has always been the same. She experiences symptoms with weather changes and gets headaches. She wishes to undergo the recommendations of Dr. Mohan.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator had an opportunity to observe her demeanor and found her testimony to be credible in her recollection of her work accident, her course of treatment, her subjective complaints and belief as to her current condition of ill-being. Despite finding her credible in the testimony that she did give, the Arbitrator notes that her testimony failed to explain the change her symptoms and the significant the gap in her treatment.

ISSUE (F) ***Is Petitioner's current condition of ill-being causally related to the injury?***
ISSUE (K) ***Is Petitioner entitled to any prospective medical care?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered the entire record, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her work accident. In so concluding, the Arbitrator adopts, relies on and places greater weight on the medical opinions of Dr. Troy over those of Dr. Mohan, noting several inconsistencies in the record as more fully explained below.

In reviewing the record, Petitioner's first phase of treatment lasted thru October 2015, around which time her final assessment was whiplash, cervical strain, degenerative disc disease and spondylosis of the cervical region without myelopathy or radiculopathy. Petitioner testified that following this release, she continued with symptoms to the neck, depending on the airport, aircraft and person flying the aircraft. At trial, Petitioner never indicated ongoing or progressive radiating pain to either arm as part of her ongoing symptoms. Petitioner testified her symptoms were localized to her neck. During this first period of treatment, Petitioner was determined not to be a surgical candidate and Dr. Mohan interpreted her first cervical MRI as showing spondylosis along with degenerative changes, age appropriate and non-acute.

After being released, Petitioner had a near 12-month gap in treatment that was not explained at trial. The Arbitrator finds that this gap alone is sufficient to conclude that Petitioner's current condition of ill-being is not related to her work accident.

When Petitioner returned for treatment in February 2017, a medical note not reviewed by or known to Dr. Mohan until his deposition, she related that she had awoken with pain in the neck and it was going down her left arm. She failed to mention any specific incident or her prior work accident. She noted she was pain free prior to this new visit. At trial, Petitioner offered no explanation as to why the work accident was not mentioned or how it was she simply woke up with pain. For the first time, Petitioner was diagnosed with

radiculopathy. Dr. Mohan would later note that Petitioner had radiculopathy in 2015 however there is no evidence of radiculopathy in any of the medical treatment records dating back to 2015.

Regarding the location of symptoms, following a near year-long gap in treatment, Petitioner's symptoms were predominantly and primarily left sided with radiculopathy and numbness, whereas before, in 2015, they were bilateral without radiculopathy. These key differences are supported by the record and by the testimony of Dr. Mohan, who noted that in March 2017 Petitioner now for the first time had changes on the left side and now had positive Spurling's findings. Petitioner's testimony was that during the first phase of her treatment, her pain was localized to the neck only. (T.25). During this time, she also had no radiating pain. *Id.* Petitioner testified that in February 2017, she had "new" pain to the left arm.

Regarding the assertion that Petitioner's C6-7 herniation had progressed, Dr. Mohan's conclusions are not supported by the record where the first MRI never noted any herniation at C6-7. Further, his testimony essentially agreed with Dr. Troy that C6-7 was never noted or implicated in the first phase of Petitioner's treatment. Dr. Mohan agreed that when he saw Petitioner in March 2017, it was in fact the first time he was making specific findings at C6-7. Further, Dr. Mohan agreed that the 2015 findings were consistent with age and were non-acute.

During his deposition, Dr. Mohan agreed that he could not make his opinion to a reasonable degree of medical and surgical certainty that Petitioner's current condition was related to the work accident given that she was pain-free, released from care and did not seek medical care for over 14 months. The doctor stated that it was hard to explain why she had a sudden worsening of symptoms. Dr. Mohan's later statement on re-direct that the incident was a progression of her disease must be given little weight considering the preponderance of the evidence.

The Arbitrator finds that the opinions of Dr. Mohan are entitled to a little weight given the internal inconsistencies between his testimony and his own medical record and in comparing his testimony against other medical records. Further, he was unaware of Petitioner's February 2017 medical note whereby she indicated that she was pain-free and had simply woke up recently with pain in the neck and on the left side. Thus, Dr. Mohan's opinions were based on a faulty understanding of the chronology, progression and etiology of Petitioner's symptoms.

On the other hand, Dr. Troy persuasively and correctly pointed out that during Petitioner's first phase of treatment, the first MRI never noted C6-7 herniation, that the first MRI was described by Dr. Mohan as age related and non-acute, that radiculopathy was never noted, that there was no progression in light of the negative findings, that Spurling's was negative and that there were no left-sided arm symptoms, only non-radiating bilateral arm symptoms. Following a significant gap in treatment, Dr. Troy pointed out that now Petitioner reported a sudden onset of symptoms with pain radiating to the left side. Petitioner failed to mention any incident or work accident. A new MRI now showed C6-7 pathology and Petitioner now had positive Spurling's. On cross, Dr. Mohan essentially agreed with Dr. Troy's findings and conclusions. Accordingly, the Arbitrator adopts, relies on and places greater weight on the opinions of Dr. Troy over those of Dr. Mohan.

For the foregoing reasons, the Arbitrator concludes that Petitioner's current condition of ill-being is not causally related to her work accident and that she reached maximum medical improvement on March 8, 2016, when Petitioner last treated for her cervical spine with Dr. Shahbandar. Px4:48. Accordingly, Petitioner's request for prospective medical care is denied.

ISSUE (L) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Petitioner sought TTD from December 5, 2014 through September 3, 2015 and from April 10, 2017 through October 12, 2018. Ax1. Respondent claims Petitioner reached MMI on July 11, 2016 and no further TTD or medical care is warranted. Having found that Petitioner's current condition of ill-being is not causally related to her work accident and that she reached maximum medical improvement on March 8, 2016, the Arbitrator concludes that Respondent shall only be liable to pay TTD from December 5, 2014 through September 3, 2015, as requested by Petitioner. Respondent shall be given a credit in the amount of $20,395.83 against this award for temporary total disability benefits paid.

Signature of Arbitrator

1-2-2019
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHELE BRASS,

Petitioner,

vs. NO: 17 WC 9325

MACY'S,

Respondent.

19IWCC0563

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD) benefits, permanent partial disability (PPD) benefits, and penalties and attorney's fees, and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 21, 2018 is hereby affirmed and adopted.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

19IWCC0563

DATED: OCT 2 1 2019

DDM/pm
O: 8/20/19
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michele Brass
Employee/Petitioner
v.
Macy's
Employer/Respondent

Case # 17 WC 09325

Consolidated cases: ______

19IWCC0563

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on August 24, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On March 4, 2017, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $11,143.60; the average weekly wage was $214.30.

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 $3,520.64 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,520.64.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $214.30 per week for 44 3/7 weeks commencing March 5, 2017, through January 9, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $214.30 per week for 220.7 weeks because the injury sustained caused the 15% loss of use of the left arm, 45% loss of use of the left leg, and 40% loss of use of the right leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner Section 19(k) penalties of $3,000.14, Section 19(l) penalties of $10,000.00 and Section 16 Attorneys' Fees of $2,600.03.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

September 19, 2018
Date

SEP 2 1 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on March 4, 2017. According to the Application, Petitioner tripped over the bottom edge of a freight elevator and fell on a concrete floor. As a result of the accident, Petitioner alleged that she sustained injuries to the left elbow, left wrist, left torso, knees, right shin and rib as a result of the accident (Arbitrator's Exhibit 2).

Petitioner sought an order for payment of medical bills, additional temporary total disability benefits and permanency as well as Section 19(k) and 19(l) penalties and Section 16 attorneys' fees. In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits of 44 3/7 weeks, March 5, 2017, through January 9, 2018. Respondent paid Petitioner temporary total disability benefits for 16 3/7 weeks, March 5, 2017, through June 27, 2017. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent at the Alton Square location as a merchandiser. On March 4, 2017 (approximately one week before the store was scheduled to be closed), Petitioner sustained a trip/fall while exiting a service elevator. When she did so, Petitioner fell on a concrete floor landing on her knees, her left elbow and abdominal area. The accident was reported to Respondent that same day and a First Report of Injury was prepared (Petitioner's Exhibit 1).

At trial, Petitioner testified that when she fell she experienced an immediate onset of pain in her knees, left wrist/elbow, right shin and abdomen. Following the accident, Petitioner was seen in the ER of Alton Memorial Hospital. X-rays of the left elbow were taken which revealed a radial neck fracture. Petitioner also complained of left knee and abdominal pain. It was noted Petitioner had undergone left knee surgery approximately three months prior (Petitioner's Exhibit 2).

Petitioner subsequently sought treatment from Dr. Charles Grimshaw, an orthopedic surgeon, who had previously treated Petitioner for the prior left knee condition. Dr. Grimshaw's records for treatment he provided to Petitioner prior to the accident were received into evidence at trial.

Dr. Grimshaw noted in his record of November 1, 2016, that Petitioner had sustained a tibial plateau fracture and a torn medial meniscus. Dr. Grimshaw performed left knee surgery on December 1, 2016, and the procedure consisted of arthroscopic internal fixation of the medial femoral condyle and medial tibial plateau as well as a repair of the medial meniscus (Petitioner's Exhibit 3; Deposition Exhibit 3).

Following the surgery of December 1, 2016, Petitioner continued to be treated by Dr. Grimshaw who ordered physical therapy. When he evaluated Petitioner on January 9, 2017, Petitioner's left knee condition had improved and he released Petitioner to return to work without restrictions at that time. He again saw Petitioner on February 10, 2017, and Petitioner was still experiencing some knee pain. At that time, Dr. Grimshaw administered a cortisone injection (Petitioner's Exhibit 3; Deposition Exhibit 3).

In regard to the treatment Dr. Grimshaw provided to Petitioner subsequent to the accident, Dr. Grimshaw evaluated Petitioner on March 7, 2017. Dr. Grimshaw diagnosed Petitioner with a nondisplaced fracture of the left radial neck and head as well as contusions to the medial femoral condyle of both knees. He immobilized the left elbow with a sling and ordered physical therapy for both the left elbow and bilateral knee injuries (Petitioner's Exhibit 3; Deposition Exhibit 2).

When Dr. Grimshaw saw Petitioner on April 18, 2017, the left radial head fracture was healed. Dr. Grimshaw directed Petitioner to continue with range of motion exercises. However, Petitioner's bilateral knee symptoms had worsened and Dr. Grimshaw administered a steroid injection to both knees (Petitioner's Exhibit 3; Deposition Exhibit 2).

Dr. Grimshaw again saw Petitioner on May 30, 2017, and Petitioner still had persistent pain in both knees. Dr. Grimshaw ordered MRI scans of both knees (Petitioner's Exhibit 3; Deposition Exhibit 2).

MRIs of the left and right knees were performed on June 2, 2017. The radiologist's reports regarding those studies were not tendered into evidence; however, when Dr. Grimshaw saw Petitioner on June 13, 2017, he reviewed the MRIs. In regard to the MRI of the left knee, Dr. Grimshaw noted it revealed advanced patellofemoral chondromalacia as well as chondromalacia of the femoral condyle extension of the medial meniscus. In regard to the MRI of the right knee, Dr. Grimshaw noted it revealed a degenerative medial meniscus tear and chondromalacia of the medial femoral condyle and patella. At that time, Dr. Grimshaw recommended Petitioner undergo bilateral total knee replacement surgeries (Petitioner's Exhibit 3; Deposition Exhibit 2).

Dr. Grimshaw performed left and right total knee arthroplasty surgeries on July 6, 2017, and October 11, 2017, respectively. Following the surgeries, Dr. Grimshaw ordered physical therapy which Petitioner received from November 8, 2017, through January 31, 2018 (Petitioner's Exhibit 3; Deposition Exhibit 2 and Petitioner's Exhibit 4).

When Dr. Grimshaw saw Petitioner on January 9, 2018, he released her from care in regard to the bilateral knee injuries. However, Dr. Grimshaw continued to treat Petitioner for a right shoulder condition which was not work-related (Petitioner's Exhibit 3; pp 22-23).

At the direction of Respondent, Petitioner was examined by Dr. James Vest, an orthopedic surgeon, on August 22, 2017. The exam was previously scheduled to take place on July 18, 2017. In connection with his examination of Petitioner, Dr. Vest reviewed medical records provided to him by Respondent. Dr. Vest noted Petitioner had just undergone a left total knee replacement surgery approximately six weeks prior and was not at MMI. He opined Petitioner was not able to work as a merchandiser, but could perform a sedentary job. Dr. Vest opined Petitioner had sustained a left radial neck fracture as a result of the accident and it had healed. In regard to causality of the bilateral knee conditions, Dr. Vest opined that "The fall at Macy's may have aggravated her underlying knee pain, but I do not think this is the main reason that she required a left total knee replacement, or that she will require a right total knee replacement. I would view her bilateral knee pain as an aggravation of underlying pre-existing primary osteoarthritis of both knees." (Respondent's Exhibit 1).

Dr. Vest was deposed on February 13, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Vest's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to Petitioner's left knee condition, Dr. Vest testified that Petitioner had severe degenerative arthritis that had failed to improve with either the prior surgical treatment or conservative treatment. In regard to Petitioner's right knee condition, Dr. Vest testified that the accident aggravated her right knee pain, but was not the primary cause of knee replacement surgery (Respondent's Exhibit 2; pp 10-12).

On cross-examination, Dr. Vest acknowledged that following the left knee surgery that pre-dated the accident, Petitioner was able to return to work without restrictions. When questioned whether the type of fall Petitioner sustained could cause increased pain to where the treating physician recommended total knee replacement, he responded "I would acknowledge that by her history, she fell, she injured her knees, there was increased pain, and then through her treating physician, she felt there was enough pain to warrant total knee replacement. How much of that pain is from the fall and how much is from the underlying arthritis, I can't really say." (Respondent's Exhibit 2; pp 16-18).

Further, on cross examination, Dr. Vest was asked if he was aware that Dr. Grimshaw had opined that the work injury aggravated and accelerated the need for both knee replacements. Dr. Vest stated that he was unaware of that opinion. Dr. Vest was then asked if Dr. Grimshaw had rendered that opinion, whether he would defer to him because Dr. Grimshaw had the opportunity to see Petitioner before and after the accident. Dr. Vest responded "yes." (Respondent's Exhibit 2; p 19).

Dr. Grimshaw was deposed on June 29, 2018, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner's left elbow and bilateral knee conditions, Dr. Grimshaw's testimony was consistent with his medical records. In regard to causality, Dr. Grimshaw testified that the work-related accident of March 4, 2017, aggravated and permanently accelerated her bilateral knee osteoarthritis and the need for bilateral knee replacement surgeries (Petitioner's Exhibit 3; p 20).

Dr. Grimshaw testified Petitioner was temporarily totally disabled from the first time he saw her shortly after the accident through his visit of January 9, 2018, in regard to her work-related injuries. He also stated Petitioner would have been at MMI in regard to the left elbow injury approximately six to eight weeks following the accident (Petitioner's Exhibit 3; pp 23, 25).

Respondent paid Petitioner temporary total disability benefits from March 5, 2017, through June 27, 2017, 16 3/7 weeks at the rate of $214.30, for a total of $3,520.64. Petitioner claimed she was entitled to payment of temporary total disability benefits from March 5, 2017, through January 9, 2018, 44 3/7 weeks at the rate of $214.30, for a total of $9,520.92.

On September 13, 2017, Petitioner's counsel sent an e-mail to Respondent's counsel demanding reinstatement of temporary total disability benefits retroactive to the date they were terminated and that ongoing medical treatment be authorized. Petitioner's counsel subsequently filed a Petition for Penalties and Attorneys' Fees on October 2, 2017 (Petitioner's Exhibits 7 and 8).

At trial, Petitioner testified she had no prior injuries/symptoms to either her left elbow or right knee. Petitioner acknowledged she underwent left knee surgery in December, 2016, but that she was able to return to work without restrictions in early January, 2017. In regard to her left knee, Petitioner stated that the left knee symptoms were much more intense following the work-related injury than what they had been previously.

Petitioner testified she still has left elbow stiffness and diminished grip strength in her left hand. In regard to her right knee, Petitioner stated she still has stiffness in the right knee and has difficulty going up/down stairs. Petitioner's left knee symptoms are similar to those of the right knee, but just more intense. Petitioner stated she limits her walking and cannot stand any longer than 15 minutes at one time. Petitioner has not returned to work in any capacity. As was noted herein, Petitioner sustained the accident shortly before Respondent closed its store in Alton, Illinois.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of her employment by Respondent on March 4, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that she sustained a trip/fall while exiting a freight elevator landing on a concrete floor. There was no evidence tendered that Petitioner did not sustain such an accident.

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to her left elbow, left knee and right knee are related to the accident of March 4, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner was diagnosed with a fracture of the left radial neck and head. Petitioner's treating physician, Dr. Grimshaw, opined that there was a causal relationship between the accident and the left elbow injury. There was no medical evidence to the contrary.

In regard to Petitioner's left knee and right knee conditions, Dr. Grimshaw testified that the accident of March 4, 2017, aggravated and permanently accelerated Petitioner's bilateral knee osteoarthritis and the need for bilateral total knee replacement surgeries.

Respondent's Section 12 examiner, Dr. Vest, acknowledged that the accident could have caused Petitioner to experience increased knee pain subsequent to same. Further, Dr. Vest agreed that he would defer to Dr. Grimshaw's opinion regarding causality because Dr. Grimshaw had seen Petitioner before and after the accident.

While there was no question Petitioner had a pre-existing arthritic condition and had recently undergone left knee surgery, the law is clear that a pre-existing condition does not preclude recovery if the condition was aggravated or accelerated by the claimant's employment. *Caterpillar Tractor Co. v. Industrial Commission,* 440 N.E.2d 861, 864 (Ill. 1982); *Sisbro v. Industrial Commission*, 797 N.E.2d 665 (Ill. 2003).

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

The evidence clearly supports that all of the medical treatment provided to Petitioner was reasonable and necessary.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 44 3/7 weeks, March 5, 2017, through January 9, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner was under active medical treatment and authorized by Dr. Grimshaw to be off work during the aforestated period of time.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the left arm, 45% loss of use of the left leg and 40% loss of use of the right leg.

In support of this conclusion the Arbitrator notes the following:

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

Petitioner worked for Respondent as a merchandiser. The exact nature of Petitioner's job duties was not stated and, as aforestated, Petitioner's job no longer exists because of the closing of Respondent's store in Alton, Illinois. The Arbitrator gives this factor no weight.

Petitioner was 58 years old at the time she sustained the accident. At the time of trial, Petitioner had not returned to work. Petitioner will have to live with the effects of this injury for the remainder of her working and natural life. The Arbitrator gives this factor moderate weight.

Petitioner's job with Respondent no longer existed and she had not returned to work as of the time of trial. It was not clear whether the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner's medical treatment records noted Petitioner sustained a radial head/neck fracture of the left elbow and injuries to both the left and right knees which ultimately required total knee replacement surgeries. Petitioner testified credibly that she still has complaints referable to the left elbow and both knees which are consistent with the injuries she sustained. The Arbitrator gives this factor significant weight.

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

The Arbitrator concludes Petitioner is entitled to Section 19(k) penalties of $3,000.14, Section 19(l) penalties of $10,000.00 and Section 16 Attorneys' Fees of $2,600.03.

In support of this conclusion the Arbitrator notes the following:

As aforestated, the Petitioner's treating physician, Dr. Grimshaw, and Respondent's Section 12 examiner, Dr. Vest, opined that there was a causal relationship between Petitioner's current condition of ill-being and the accident. When he was deposed, Dr. Vest specifically stated that he would defer to Dr. Grimshaw's opinion as to causality and the need for Petitioner's bilateral total knee replacement surgeries.

The Arbitrator finds Respondent's denial of compensability of this case was both unreasonable and vexations.

Petitioner's counsel tendered his demand for the reinstatement of temporary total disability benefits to Respondent's counsel on September 13, 2017, and filed a Petition for Penalties and Attorneys' Fees on October 2, 2017. Petitioner is entitled to Section 19(l) penalties of $30.00 per day from the time Petitioner's counsel tendered the demand for reinstatement of temporary total disability benefits until the date of trial, 346 days. 346 days at $30.00 per day amounts to $10,380.00. However, in light of the statutory maximum is $10,000.00 and the award is adjusted accordingly.

Respondent paid Petitioner temporary total disability benefits for 16 3/7 weeks at the rate of $214.30, for a total of $3,520.64. The Arbitrator concluded, based upon the testimony of Dr. Grimshaw, that Petitioner is entitled to temporary total disability benefits of 44 3/7 weeks at $214.30, for a total of $9,520.92, which results in an amount of temporary total disability benefits due to Petitioner of $6,000.28. Therefore, Petitioner is entitled to Section 19(k) penalties of 50% of that amount, for a total of $3,000.14.

The total Section 19(k) and Section 19(l) penalties are $13,000.14. Petitioner is entitled to Section 16 Attorneys' Fees of 20% of that amount, for a total of $2,600.03.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEAN BATES-MARTIN,

Petitioner,

vs. NO: 16 WC 24425

DANVILLE MASS TRANSIT,

Respondent.

19IWCC0564

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision and awards prospective medical care in the form of a repeat injection at C3-C4 pursuant to the recommendation of Dr. David Ross, a neurosurgeon who examined Petitioner pursuant to Section 12 at the request of Respondent on March 21, 2017. Dr. Ross also rendered an addendum report on August 21, 2017. Dr. Ross testified by evidence deposition on December 5, 2018 to the opinion that Petitioner needs an additional injection at C3-4. The Commission finds Dr. Ross to be a credible witness and finds his recommendation for prospective conservative treatment to be reasonable and necessary.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 11, 2019 is hereby modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $504.82 per week for a period of 122 2/7 weeks, commencing August 2, 2016 through December 5, 2018, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical services for Petitioner's left shoulder and cervical spine from June 15, 2015 through February 15, 2019 for medical expenses under §8(a) and 8.2 of the Act. Petitioner's claim for medical services for her lumbar spine are denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize prospective medical care in the form of a repeat C3-C4 injection, as recommended by Dr. Ross, in addition to reasonable and necessary medical expenses for the Medrol Dosepak, PPI, Robaxin, and Amiptriptiline, as recommended by Dr. Biswas.

IT IS FURTHER ORDERED that Respondent shall be given a credit for $48,462.72 for temporary total disability benefits that have been paid.

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

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

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

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

DATED: OCT 2 1 2019
o-08/20/19
SM/msb
44

Stephen Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

BATES-MARTIN, JEAN A
Employee/Petitioner

Case# **16WC024425**

DANVILLE MASS TRANSIT
Employer/Respondent

19IWCC0564

On 3/11/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
GARY J STOKES
200 N GILBERT
DANVILLE, IL 61832

0445 RODDY LAW LTD
ROBERT J DOHERTY JR
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

19IWCC0564

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JEAN A. BATES-MARTIN,
Employee/Petitioner

Case # **16** WC **24425**

v.

Consolidated cases: ______

DANVILLE MASS TRANSIT,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Urbana**, on **2/15/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **6/15/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being as it relates to her left shoulder ***is*** causally related to the accident.

Petitioner's current condition of ill-being as it relates to her cervical spine ***is*** causally related to the accident.

Petitioner's current condition of ill-being as it relates to her lumbar spine ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**39,375.96**; the average weekly wage was $**757.23**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

Respondent ***has or shall*** pay all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**48,462.72** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**48,462.72**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $504.82/week for 122-2/7 weeks, commencing 8/2/16 through 12/5/18, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $48,462.72 for temporary total disability benefits that have been paid.

Respondent shall pay all reasonable and necessary medical services for petitioner's left shoulder and cervical spine from 6/15/15 through 2/15/19, as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for medical services for her lumbar spine are denied.

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.

Petitioner's claim for prospective medical care in the form of a repeat C3-C4 injection is denied at this time. However, Respondent shall the pay reasonable and necessary medical expenses for the Medrol dosepak, PPI, Robaxin, and Amitryptiline as recommended by Dr. Biswas', to see if it helps petitioner's symptoms in her cervical spine.

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.

19IWCC0564

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

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

Maureen H. Pulia

Signature of Arbitrator

3/4/19

Date

ICArbDec19(b)

MAR 1 1 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 55 year old city bus driver, sustained an accidental injury that arose out of and in the course of her employment by respondent on 6/15/16. The issues in dispute are casual connection, medical bills, temporary total disability and prospective medical services.

Petitioner testified that on 6/15/16 before she began her route she needed to inspect her bus. Petitioner performed an initial inspection of the outside of her bus and then returned to the bus. Once back inside the bus petitioner noticed that her driver side mirror needed to be adjusted. As petitioner attempted to exit the bus she slipped on a step that was wet from rain. As she began to slip she grabbed the rail on the door with her left hand. Petitioner testified that when she stepped off the bottom bus step to the ground, about 2.5 feet, her feet came out from underneath her and she let go of the rail and struck her back, at about her bra line, on the bottom step and then landed on the left side of her buttock on the ground. She did not hit her head or neck. She testified that she had pain in her back, neck and left shoulder. Petitioner testified that she screamed when she fell, but got up on her own. Some coworkers in the area came to assist her. She stated that it was hard to walk after the fall. A video exists that shows petitioner getting off the bus, a scream is heard, and then she is viewed walking away. The actual fall is not visible on the video.

Petitioner testified that about 20 minutes after the fall, her left arm started hurting. About another 1 ½ to 2 hours later while petitioner was driving the bus, she noticed that when she went to grab the steering wheel she had pain in her left thumb and her arm would not move. By the time petitioner hit her break time she was experiencing pain in her neck, stiffness and numbness, and pain in her buttock. She testified that she could no longer grab the steering wheel with her left arm/hand. Petitioner reported the injury and was sent to Occ Med at Carle.

Later that day petitioner presented to Occ Med at Carle Clinic. She was seen by Steven Jacobs, PA. She gave a history of there being some water on the ground that she slipped on, and her feet went out from underneath her and she landed on her buttocks. Petitioner believed her left arm was out, and she landed more on her left side. She complained of hand and thumb pain, mild wrist pain, forearm pain with burning in the elbow region, and shoulder pain. She also complained of some mid thoracic back pain at approximately the T10 level. Petitioner denied any head injury or loss of consciousness. She also denied any neck pain or any other body part issues. Following an examination, x-rays of her hand, forearm, elbow region and shoulder region were taken. The shoulder x-ray showed some evidence of AC joint arthritis, without any other findings. X-rays of the hand/wrist and elbow looked appropriate. Petitioner

was placed in a thumb spica splint and a sling. She was to take off the sling regularly to do range of motion exercises. An examination of the back was unremarkable. Jacobs assessed left upper extremity FOOSH (fall on outstretched hand) injury. Petitioner was taken off work for 6/15/16, and released to right hand only work on 6/16/16, with mostly sitting and an ability to get up every 20-30 minutes.

On 6/16/16 petitioner was seen again by Jacobs. She asked if her restrictions could be modified since she was not feeling much better. Jacobs did not feel petitioner could drive a bus. Petitioner complained of a lot of shoulder pain, pain and swelling in her hand and wrist, problems with her forearm, and discrete pain in the thoracic area about T10. She reported that the pain in her back region was well localized and not radiating anywhere. She reported that her thumb felt better, and her wrist and forearm were a little sore. She stated that her shoulder was the most problematic. There were signs and symptoms of impingement. Her wrist was still mildly swollen. Jacobs assessed multiple injuries secondary to a fall. He noted that petitioner was unable to drive a bus. He also told the petitioner to continue to wear the forearm splint and sling and do her exercises.

On 6/21/16 petitioner returned to Jacobs. Her injuries were reported as left shoulder pain, numbness down the left arm at times, back pain, upper thoracic and mid back pain, some mild lower back pain, and issues of possible brachial plexopathy. Petitioner's primary complaints that day were mostly shoulder pain, numbness at times down the arm, trapezius strain that radiates towards the neck, and upper back pain on the left. She reported that her wrist, hand and forearm were better. Jacobs continued petitioner's no bus driving restrictions. She was to avoid overhead work, and do mostly right hand work. He also wanted her in physical therapy as quickly as possible.

On 6/28/16 petitioner began a course of physical therapy for her left shoulder strain. Petitioner remained in physical therapy through 7/28/16.

On 7/6/16 petitioner returned to Jacobs for reevaluation of her left shoulder pain. She still had impingement signs in her left shoulder. Her neck was vastly improved. She had minor complaints with full flexion of the neck, but nothing with rotation or extension. She had no radicular symptoms. Her headaches were resolved, and her arm pain was much better. Jacobs noted that petitioner's left shoulder was most problematic, but he believed it would heal with conservative care and therapy. He told petitioner to continue in therapy. He continued her restriction of no bus driving.

On 7/21/16 petitioner followed-up with Jacobs. She complained of some chest wall discomfort, particularly over the pectoralis major. He noted that there had not been any neck issues. Jacobs reported

that he had a note that petitioner had plateaued in physical therapy. He noted that she was not getting better. He noted that the TENS unit was no longer helping her shoulder. Jacobs assessed left shoulder impingement with possible internal derangement, and multiple soft tissue injuries. He restricted petitioner from lifting, pulling or pushing over 2 pounds with the left arm; right hand work mostly; and no overhead work with the left arm. An MRI of the left shoulder was requested.

Petitioner returned to Jacobs on 7/25/16 and reported that she felt a lot better and was wondering if she could drive the bus, but at the same time discussed that over the weekend she had the worst headache of her life where she almost went to the ER. She also had an episode where the left shoulder felt heavy. She reported discrete points where she had pain in the thoracic area and the anterior left shoulder. She reported that the movement in her left arm was a lot better. She also stated that her arm numbness and tingling had dissipated, and she had no headaches. Jacobs told petitioner he did not think she could drive a bus at that time. He sent her for x-rays of her cervical and thoracic areas which showed arthritic changes. By the end of the visit petitioner reported some numbness in her left arm and more back pain and neck pain. He thought an EKG might be necessary. Dr. Jacobs noted that petitioner had a history of migraines. Her pain at the beginning of the visit was 1/10.

On 7/25/16 petitioner underwent x-rays of the cervical spine. The impression was C3-C4 moderate to severe left foraminal stenosis, and additional mild cervical degenerative changes. X-rays of the thoracic spine revealed no acute fracture or malalignment, and minimal lower thoracic levoconvex curvature.

On 7/28/16 petitioner underwent an MRI of the left shoulder. The impression was partial tear of the intra-articular long head biceps tendon, which may extend to the extraarticular biceps tendon in the longitudinal distribution; probable extension to the biceps anchor where there may be degeneration or a component of a SLAP tear; a myotendinous junction and edema at the supraspinatus partial tear, extending to the anterior insertion; and probable hyaline cartilage degenerative edematous signal.

On 8/1/16 petitioner returned to Jacobs. Petitioner reported that her range of motion and strength had improved. Petitioner still had impingement signs, and pain at the inferior border of the scapula on the left. Petitioner also complained of headaches and neck pain. Jacobs noted that radiologic studies of the neck showed some arthritic changes and foraminal stenosis. Although petitioner complained of pain in the left hand, particularly the 1st and 2nd digits, radiologic studies and examination were within normal limits. Jacobs assessed left shoulder hyperextension injury with said findings from the MRI; improved headaches; cervical discomfort with known arthritic change that were stable; and, discrete pain in the left

scapular area, that was most likely a contusion. Jacobs referred petitioner to Dr. Plattner and for additional physical therapy. Petitioner was restricted to 2 to 5 pounds, no driving, and avoiding overhead work with the left arm.

Petitioner testified that she has not worked since 8/2/16.

On 8/17/16 petitioner underwent an EKG following her complaints of chest pain. The EKG came back normal.

On 8/25/16 petitioner presented to Dr. Robert Gurtler. He noted that petitioner was there for her articular surface damage in the left shoulder and the biceps issue in the left shoulder that causes some shoulder pain. He also noted that the pain she was there for was mostly burning pain in the back of her arm and shoulder to her elbow, and then down into her thumb and index finger. Dr. Gurtler was of the opinion that this pain was not clearly from her shoulder, and he believed it needed to be dealt with first. He believed that the foraminal stenosis at C4-C5 was what was giving her the severe pain. He believed that an arthroscopic procedure would be needed in the future. He recommended a cervical MRI.

On 8/29/16 petitioner followed-up with Jacobs for her left shoulder pain; concerns of neck pain with radiation past the elbow; concerns of back pain and numbness and weakness in both legs, which was a rather new finding. Jacobs noted that petitioner had seen Dr. Gurtler who was more worried about her neck and recommended an MRI. Jacobs assessment was cervical strain with possible internal derangement; left shoulder pain with a tear of the intra-articular long head biceps tendon; possible SLAP tear; thoracic back pain; low back pain; leg pain; and left thumb pain. He thought the left hand and thumb pain was possibly related to the neck. He took her off work.

On 8/30/16 an MRI of the cervical spine was performed. The impression was mild motion degradation limits evaluation of the neural foramina; C3-C4 severe left foraminal stenosis and C4-C5 moderate left foraminal stenosis; and no central spinal canal stenosis.

On 9/1/16 petitioner returned to Jacobs after undergoing her cervical MRI. He noted that petitioner's complaints and symptomatology had been somewhat sporadic. Petitioner had no complaints of weakness in her lower extremities. She stated that her area of concern in her back was her thoracic spine. She had no real complaints of any major low back pain or radicular symptoms in her legs. Petitioner was referred to the Spine Center. Jacobs noted that petitioner provided a history of there being some water on the ground and she stepped down, slipped and her feet went out from underneath her and she landed on her buttocks. He was not exactly sure what happened to her left arm, but noted that

petitioner believed that her back and her arm may have hit the steps going down from the bus. He noted that there were times when petitioner stated that her neck was not very problematic, but it was just her shoulder. He continued her off work. Jacobs assessed cervical foraminal stenosis per IME, and thoracic back pain.

On 9/8/16 petitioner presented to Dr. Tipirneni on the referral of Jacobs for her complaints of neck pain. She indicated that most of her pain was probably between the left intra-shoulder blade area between the thoracic area. She also complained of left posterior neck pain that radiates to the left upper extremity. She gave a history of stepping off the bus when her feet went below her and she fell onto her back and buttock area. She further indicated that her left arm was slightly extended and while she was trying to hold on to something she twisted her back. She stated that she fell onto her back and buttock area. Dr. Tipirneni noted that overall, in the majority of her history she talks more about the intra-shoulder, mainly the thoracic area. Later in the history petitioner got to her low back complaints. Dr. Tipirneni found this slightly confusing. She reported that her pain was worsened with any type of prolonged sitting, standing, and bending, and slightly better with rest. Following an examination and radiologic review, Dr. Tipirneni's impression was myofascial pain syndrome, cervical sprain, lumbar sprain/strain, preexisting cervical degenerative disc disease, preexisting cervical spinal stenosis, cervical radiculopathy, and obesity. Dr. Tipirneni felt the majority of petitioner's problems were thoracic, mainly muscular in nature. Additional therapy was recommended. For petitioner's left arm pain a left sided C4-C5 transforaminal injection was recommended. Dr. Tipirneni was of the opinion that her back issues were not related to her work injury on 6/15/16. She saw no reason why she could not return to full duty work. She saw no type of neurological deficits in her exam, but mainly muscle and possibly nerve irritation from the mechanism of injury, as well as lumbar sprain/strain.

On 9/12/16 the petitioner underwent an x-ray of her lumbar spine. The impression was mild L4-L5 grade 1 spondylolisthesis without spondylolysis.

On 9/15/16 petitioner followed-up with Jacobs. Jacobs noted that since the injury she has had neck and shoulder pain, and he thought the shoulder was a bit more problematic and referred petitioner to Dr. Gurtler, who felt the neck should be addressed first. He noted that there were findings for the shoulder that appeared to be heading for surgical intervention. He noted that her neck issues were going to be treated with an epidural. Petitioner reported that recently her back pain was exacerbated and she was experiencing sciatic symptoms, right greater than left. She stated that she was given a muscle relaxer for these complaints. Jacobs noted that he had no way of telling whether or not her back complaints were

from the injury, and that her doctors collaborated the same. Jacobs talked to petitioner about her sciatica, her shoulder, and her neck. Jacobs continued petitioner off work.

On 9/20/16 petitioner underwent a left shoulder injection. Her preoperative and postoperative diagnosis was shoulder capsulitis and shoulder arthritis. This procedure was performed by Dr. Ahmad.

On 9/26/16 petitioner began a course of physical therapy for her cervical spinal stenosis. Petitioner was discharged from therapy on 11/8/16.

On 10/4/16 petitioner followed up with Dr. Tipirneni. Petitioner felt that her thoracic area was getting better. Dr. Tipirneni noted no pain in the nerve root distribution in the thoracic region. Dr. Tipirneni noted that Dr. Ahmad felt that petitioner's left posterior neck pain and left shoulder pain was more shoulder pain rather than neck pain. Petitioner reported 40% improvement from the shoulder injection and stated that the symptoms from her elbow down to her fingers got better. Dr. Tipirneni was of the opinion that the symptom relief from the elbow to the fingers was just a placebo effect because they did not do any neck injection. Dr. Tipirneni's impression was ongoing left shoulder pain, cervical strain/sprain, thoracic sprain, preexisting cervical degenerative disc disease, preexisting cervical spinal stenosis, and obesity. Dr. Tipirneni referred petitioner back to Dr. Gurtler for her shoulder. Dr. Tipirneni recommended additional physical therapy for the thoracic region and neck area. She was also of the opinion that petitioner would be at maximum medical improvement for the thoracic and cervical area after physical therapy as there is no set of other injections or surgery indicated for the neck area. Dr. Tipirneni did not see anything to put petitioner on any type of permanent restrictions for the cervical region or the thoracic region. Dr. Tiprineni released petitioner from her care.

On 10/6/16 petitioner returned to Jacobs. She noted that Dr. Ahmad injected her left shoulder and she reported improvement in the left shoulder. She stated that most of her improvement was in the left upper extremity forearm, and wrist discomfort. She stated that she was improved about 50%. Petitioner reported that therapy was helping her cervical and thoracic spine. Jacobs referred petitioner back to Dr. Gurtler for her shoulder issues. He also referred her back to therapy to work on the myofascial components of the cervical and thoracic area. Petitioner noted that her low back, although still problematic, was better. She also reported that her neck and thoracic areas seemed to be getting better, and the pain going past the elbow was abating. Jacobs examined petitioner and assessed shoulder impingement; myofascial pain in cervical thoracic area that was improved; and low back pain with sciatic symptoms that was improved. Petitioner was continued off work.

On 2/3/17 petitioner underwent a SLAP release with acromioplasty and distal clavicle resection. This procedure was performed by Dr. Gurtler. His postoperative diagnosis was left shoulder biceps tendon tear; rotator cuff impingement; and acromioclavicular joint spurs with impingement. Petitioner followed-up post-operatively with Dr. Gurtler. This treatment included physical therapy from 2/15/17 through 3/17/17.

On 3/21/17 petitioner underwent a Section 12 examination performed by Dr. Matthew Ross, at the request of the respondent. Dr. Ross performed a neurosurgical examination. Petitioner complained of left shoulder and arm pain as well as low back and left leg pain following her injury on 6/15/16. She gave a history of there being rain on the concrete floor of the garage. She stated that as she stepped on to the wet cement, her foot slipped. She stated that she tried to hang on to it to keep from falling, but eventually let go and dropped. She thinks she may have tried to break her fall by extending her left arm. She reported having trouble maintaining a grip with her left thumb. Following an examination and record review, Dr. Ross was of the opinion that petitioner clearly sustained an injury to her left shoulder on 6/15/16, which had been appropriately treated by Dr. Gurtler. He noted that it was difficult to ascertain clinically whether a component of her residual pain was due to a C4 radiculopathy from her C3-C4 foraminal stenosis. He noted that neither the C4 nor C5 nerve roots would cause paresthesias and numbness of the left thumb, index and middle fingers. He stated that this would be the territory of either the C6 or C7 nerve roots or the median nerve. He suspected that petitioner's hand parathesias were probably due to a median neuropathy, possibly at the wrist. He noted that petitioner's sciatic type pain may be due to lumbar disk pathology, but it had not yet been studied. Dr. Ross was of the opinion that petitioner's left shoulder and low back symptoms are causally related to her injury on 6/15/16. Dr. Ross recommended a left C4 selective nerve root block in conjunction with a cervical ESI to identify whether the C3-C4 foraminal stenosis was in fact symptomatic. He also recommended an EMG/NCV of the left arm to assess whether she had median nerve compromise. Lastly, he recommended an MRI of the lumbar spine to determine whether she has pathology that would result in her sciatic symptoms. Dr. Ross was of the opinion that petitioner was unable to work her regular duty job, and had not yet reached MMI. He recommended she undergo an FCE to see whether she was better to meet the physical demands of her job duties, and if so, for her to return to work. If not, then he recommended a repeat C4 selective nerve root block and an ESI, recording what happened.

On 3/9/17 and 4/11/17 petitioner told Dr. Gurtler that she was working with therapy and tolerating it well. She stated that she felt like she was improving. She still had some pain. Dr. Gurtler thought

petitioner may still have some symptoms that might be coming from her neck. He continued her off work.

On 4/12/17 petitioner underwent an MRI of her lumbar spine. The impression was minimal L4-L5 and L5-S1 degenerative changes without any disc bulge or herniation, and no central spinal canal stenosis or foraminal stenosis.

On 5/2/17 the physical therapy noted that petitioner was progressing well with her current treatment plan. Petitioner reported that her husband noticed that she had better left shoulder range of motion. Petitioner reported left shoulder/upper scapula spasms and popping with left shoulder strengthening exercises.

On 5/9/17 petitioner underwent an EMG/NCV that showed minimal left carpal tunnel syndrome. There was no sign of denervation, polyneuropathy or proximal conduction deficits.

On 5/11/17 Dr. Gurtler placed petitioner at maximum medical improvement for her left shoulder. He recommended she follow up with a spine specialist.

On 6/6/17 petitioner underwent a left C3-C4 transforaminal selective nerve root injection. The preoperative and postoperative diagnosis was cervical radiculitis, cervical spinal stenosis and cervical degenerative disc disease. This injection was performed by Dr. Ahmad. On 6/27/17 petitioner returned to Dr. Ahmad and reported that she was definitely better and that she was able to raise her left arm without much pain. She also reported that the pain in her left elbow was better.

On 8/7/17 Dr. Ross drafted an addendum report on petitioner after reviewing the MRI of petitioner's lumbar spine taken 4/12/17, report of the EMG/NCV performed 5/9/17, report of Dr. Gurtler dated 5/11/17, report of Dr. Ahmad dated 6/27/17, and physical therapy records before he saw her. Dr. Ross noted that the MRI of the lumbar spine showed no evidence of disc herniation or nerve impingement at any level; very subtle degenerative spondylolisthesis of L4 on L5; and facet joint arthritis at multiple levels. He noted no pathology on the MRI that would cause sciatic nerve pain. He noted that the EMG/NCV showed mild left carpal tunnel syndrome, but no mention of any cervical radiculopathy. He noted that Dr. Gurtler felt petitioner was at maximum medical improvement for her left shoulder, but believed the remaining pain was originating from her cervical spine. He noted that based on Dr. Ahmad's report petitioner was definitely better after the left C3-C4 transforaminal selective nerve root injection. Dr. Ross was of the opinion that aggravation of facet joint arthritis could cause low back pain that could be managed by physical therapy and/or facet joint injections. He was of the opinion that petitioner's

carpal tunnel syndrome was mild and should be managed conservatively with a trial of wrist splinting, and a possible injection into the carpal tunnel. Dr. Ross was of the opinion that petitioner's low back symptoms, left arm symptoms and cervical symptoms are casually related to the injury on 6/15/16.

On 11/22/17 petitioner presented to Dr. Arundhati Biswas for her neck and back. Following an examination and review of the radiographic images, Dr. Biswas did not think the lumbar spine needed any surgical intervention and that petitioner should continue with conservative measures and physical therapy. He also noted that the cervical spine MRI done in 2016 showed some degenerative changes. A new cervical MRI was ordered to see if there was any progression of her degenerative disc disease. He also prescribed gabapentin/amitriptyline for her nerve pain.

On 12/28/17 petitioner underwent a repeat MRI of the cervical spine. The impression was C3-C4 severe left foraminal stenosis and C4-C5 moderate left foraminal stenosis, and no central spinal canal stenosis.

On 2/1/18 petitioner underwent a cervical C7-T1 interlaminar epidural steroid injection for her diagnosis of cervical degenerative disc disease, cervical radiculopathy, and cervical spinal stenosis. Her chief complaints were neck pain and arm symptoms. Petitioner testified that after this injection she had relief for about 2.5 weeks, but it was not the same relief as she had after the injection in June of 2017.

On 2/23/18 and 3/16/18 petitioner followed-up with Dr. Biswas. He noted that the repeat MRI showed stable findings of the left C3-C4 foraminal stenosis and right C4-C5 foraminal stenosis. Based on these results Dr. Biswas recommended physical therapy for improvement of her shoulder movements on the left side and Robaxin for muscle relaxation. He recommended no surgical intervention at that time.

Petitioner underwent additional physical therapy for her cervical radiculopathy from 3/6/18 through 4/5/18.

On 4/16/18 petitioner presented to Dr. James DeSalvio who was contacted by Nurse Case Manager Heath to review the last physical therapy notes and to provide a comprehensive review of the case and make a determination whether or not the petitioner was at maximum medical improvement. Dr. DeSalvio performed a record review and interviewed petitioner. Petitioner reported that she continues to have symptomatology in multiple body locations. She complained of posterior cervical spine discomfort with radiation to the left scapular region; numbness and tingling that seems to go into the thumb and index fingers; continued pain in her left shoulder; and ongoing cervical pain, even after receiving some

improvement following the injections. Petitioner also complained of low back pain and sciatica-type symptoms in the left leg, and complaints of tightness and tendinitis in both the right and left Achilles tendon. Following his record review and interview with petitioner, Dr. DeSalvio was of the opinion that the one question that needed to be answered is whether the petitioner would benefit from any type of operative procedure on the cervical spine. Dr. DeSalvio was also of the opinion that the back had been worked up properly, and he did not believe that there was anything additional to offer in terms of relieving the symptoms.

On 5/30/18 petitioner underwent a Section 12 examination performed by Dr. Kern Singh, at the request of the respondent. In addition to his examination, Dr. Singh performed a record review. Petitioner complained of neck pain and rated it at a 5-6/10. She also reported entire arm bilateral radiating dysesthesias. She rated her midback pain at 6-7/10. She also reported low back pain that she rated at a 4-5/10. Petitioner complained of entire bilateral leg radiating dysesthesias. She stated that her symptoms were getting worse and she had moderate discomfort predominantly at night. She noted that her pain was sudden and constant in nature. Dr. Singh noted that petitioner had medicolegal representation. Petitioner denied any prior injuries to her neck or low back prior to 6/15/16. She stated that her pain was aggravated by sitting, standing, transitioning, and walking. She stated that she was unable to do housework/chores, make the bed, put on the socks, cough, sneeze, and climb stairs. She also reported that her pain was decreased with standing, sitting, walking, transitioning, and lying on her side. She noted that she could sit 60 minutes at a time, stand 20 minutes at a time, and walk 2 hours at a time. Petitioner reported that physical therapy, heat, ice compresses, and epidural steroid injections provided moderate relief, and the TENS unit provided no relief.

Following his physical examination and record review, Dr. Singh diagnosed cervical muscular strain and degenerative disc disease at C3-C4 and C4-C5. He was of the opinion that petitioner sustained a soft tissue muscular strain to her cervical spine which had resolved. He did not believe her C3-C4 foraminal narrowing was symptomatic since this would result in trapezius pain and not arm pain. He noted no correlating arm distribution of pain for the C4 nerve root, which would be involved in this situation. He was also of the opinion that the EMG further confirms the fact that there is no cervical radiculopathy involved. He noted that petitioner's prognosis was guarded, and she could return to full duty work without restriction. Dr. Singh was of the opinion that the petitioner sustained an aggravation of her underlying degenerative condition, but the EMG confirmed no active cervical radiculopathy. He was unsure as to why recommendations were made for selective nerve root injections into the C3-C4

space as the petitioner never manifested trapezial discomfort, which would correlate with the C4 pathology. Dr. Singh was of the opinion that petitioner did not need any additional treatment and had reached maximum medical improvement.

On 11/19/18 the evidence deposition of Dr. Kern Singh, an orthopedic surgeon, with a subspecialty in spine surgery, was taken on behalf of the respondent. Dr. Singh noted that on examination petitioner had full strength, had normal reflexes in her arms and legs, had normal sensation in her arms and legs, and full range of motion of her cervical and lumbar spine. He was of the opinion she had a normal neurological exam. Dr. Singh noted that petitioner had radiographic evidence of degenerative disc disease at C3-C4 and C4-C5, but had not clinical manifestations of a cervical radiculopathy. Dr. Singh opined that petitioner had a degenerative disc disease diagnosis at C3-C4 and C4-C5, that was aggravated. He further opined that petitioner had no manifestation of a cervical radiculopathy, no deficits in the C4-C5 distribution that would correlate with MRI; no sensory loss, reflex change or strength loss; and an EMG which revealed no evidence of radiculopathy which was consistent with her clinical examination of having a normal clinical and neurological examination. Dr. Singh was of the opinion that it is unusual to have an active radiculopathy with a negative EMG. Dr. Singh did not see any clinical indication for an injection. He believed the injection recommendation was made based upon the MRI findings, but there was no correlating clinical radiculopathy. Dr. Singh was of the opinion that to objectify C4 nerve root compression there would need to be sensory loss above the top of the deltoid, potential loss into the deltoid, and objectionable findings on an EMG of a C4 radiculopathy, none of which were present.

On cross examination Dr. Singh disagreed with Dr. Ross that petitioner's foraminal narrowing in her spine was symptomatic. Dr. Singh was of the opinion that it is anatomically impossible that petitioner's left upper extremity complaints were attributed to an aggravation of degenerative disc disease at C3-C4 and C4-C5. He noted that the nerve root would not provide sensation to the arm, so he could not attribute it to anything anatomic. Dr. Singh was of the opinion that you cannot deny or accept treatment based upon a response to a therapeutic or diagnostic injection. Dr. Singh opined that petitioner's subjective neck complaints are not coming from her cervical spine. Dr. Singh was of the opinion that petitioner's pain complaints are non-anatomic since a C7-T1 injection would have no improvement of symptoms at C3-C4 and C4-C5. Dr. Singh attributed petitioner's trapezial pain to her soft tissue strain. He agreed that trapezial pain can be consistent with pathology at C3-C4.

On redirect examination, Dr. Singh was of the opinion that C3-C4 objectifiable information can lead to trapezial pain, but did not in petitioner's case because petitioner had no correlating sensory change in the trapezial distribution that would correlate with the dysfunction of the C4 nerve root. Dr. Singh was of the opinion that trapezial pain in isolation cannot correlate with C4 nerve root pathology. He noted that you would need an objective finding such as a sensory loss muscle observation, muscle atrophy or weakness, which petitioner did not demonstrate.

On recross examination Dr. Singh was of the opinion that C4 root pathology would manifest as trapezial muscle wasting, and sensory loss in the trapezial distribution over a cape-like pattern in the neck and the shoulder. He also noted that there would be a diminished loss of potential overlap with the bicep and the ability to raise the elbow. Dr. Singh did not believe petitioner's complaints were consistent with the MRI finding of severe stenosis of the C3-C4 foramina.

On 11/30/18 petitioner returned to Dr. Biswas. She reported that she still has neck/back pain that interferes with her activities of daily living. He recommended new MRI's of the lumbar and cervical spine to see if there were any changes. He also prescribed a Medrol dosepak, PPI, Robaxin, and Amitryptiline to see if it helps with her symptoms.

On 12/5/18 the evidence deposition of Dr. Matthew Ross, a neurosurgeon, was taken at the request of petitioner. Dr. Ross was of the opinion that since the cortisone injection into her neck made her better that suggested that some of her symptoms were coming from her neck. He stated that it was possible to see improvement in her symptomatology without a 2nd block at C3-C4 and/or surgery to correct that disc. Dr. Ross was of the opinion that it is not yet known if surgery would be helpful, but noted that with respect to her neck, petitioner was not yet at MMI. He noted that he had recommended an FCE, but petitioner never underwent any FCE.

On cross examination Dr. Ross reiterated that he found no objective abnormality in petitioner's lower back, just subjective complaints of pain. He stated that petitioner's sciatic discomfort was not coming from her low back. He was of the opinion that blunt force to the buttock can affect the sciatic nerve. Since petitioner's lumbar complaints were not documented until 8/29/16, Dr. Ross was of the opinion that he could not definitively state that there was a causal connection between her lumbar spine complaints and the injury on 6/15/16, but then stated that in the absence of any intervening stressor to her back or injury, it's more likely than not that the injury is the cause. Dr. Ross believed that if the symptoms did not occur until six months or a year later then that would be out of the realm of casual connection. Dr. Ross did not think the weakness in her legs she referenced on 9/1/16 was causally related

to the injury. Dr. Ross was of the opinion that petitioner needed no restrictions for her lumbar spine when he examined her. Dr. Ross was of the opinion that if a person receives benefit from a steroid injection for about a year before the symptoms return, then the symptoms would no longer be related to the injury but rather to natural progression of the underlying condition. Dr. Ross was of the opinion that as of 8/2/17, assuming petitioner was as good or better than when he saw her, which is what the records indicate, petitioner could certainly lift between 10-25 pounds.

On 12/21/18 petitioner underwent a repeat MRI of the lumbar spine. The impression was mild degenerative change of the lumbar spine, without significant spinal canal or foraminal compromise.

On 12/21/18 petitioner also underwent a repeat MRI of the cervical spine. The impression was that the exam was limited due to petitioner's motion. What was seen was multilevel degenerative change of the cervical spine, grossly similar to the prior MRI on 12/28/17.

Respondent offered into evidence the job description for City of Danville Bus Driver. The physical demands for walking, standing, turning, sitting, and operating light/heavy equipment is occasional (10-25%); for climbing, kneeling, bending, reaching, pushing, pulling, lifting, and carrying was minimal (less than 10%); and the weight limits for pushing, pulling, lifting, lowering, and carrying were light to moderate (10-25 pounds). Petitioner testified that she lifted more than 25 pounds.

Petitioner's current complaints included pain in her neck, headaches, pain in her left shoulder blade, pain down her arm, and pain in her armpit down to her fingertips. She also reported intermittent numbness and tingling, worse at night. Petitioner testified that she has never been without any neck, left shoulder, or left arm pain. For her pain petitioner takes Tylenol, naproxen, and methocarbamol. Pain at best is a 4/10. Petitioner is unable to tie any specific activity to her pain. Petitioner denied any improvement in her low back and leg since she saw Dr. Ross. She still experiences pain from her buttock to her Achilles heel, and sometimes to the arch of her foot when she walks. This pain is burning and she has numbness. Petitioner testified that her activity since seeing Dr. Ross includes cooking, and cleaning the house, and taking care of her 3 foster children ages 1,2 and 3. She stated that she does not lift the 2 and 3 year old. Petitioner wants the injections recommended by Dr. Ross, and any surgery that is recommended.

Petitioner testified that after her left shoulder surgery the mobility in her left shoulder has improved, but she still has pain. She stated that she can lift her arm above her head and around her back. She stated

that she can still get pain of a 10/10 in her shoulder. She noted that the frequency of her pain has decreased.

Respondent had petitioner examined by Missamore on 11/9/16, and he drafted an addendum report on 11/22/16. Petitioner attempted twice, during the deposition of Dr. Ross, and during the deposition of Dr. Singh, to offer these reports into evidence. Respondent objected to the admission of these reports based on a hearsay objection, and petitioner offered no exception to hearsay during the deposition under which these reports should be admitted. The arbitrator sustained respondent's hearsay objection and Dr. Missamore's reports of 11/9/16 and 11/22/16 were rejected exhibits. No deposition of Dr. Missamore was taken on behalf of either party, and neither party attempted to offer these reports into evidence as exhibits at trial. Given that petitioner cited no exception to the hearsay rule under which these reports would be admissible at the time of the objection, the respondent's hearsay objection was sustained.

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

The parties stipulate that petitioner's current condition of ill-being as it relates to her left shoulder is casually related to the injury she sustained on 6/15/16. Petitioner claims her current condition of ill-being as it relates to her cervical spine and lumbar spine are also causally related to the injury on 6/15/16. Respondent disputes the petitioner's current condition of ill-being as it relates to her cervical spine and lumbar spine are causally related to the injury on 6/15/16.

With respect to petitioner's cervical spine, when petitioner first presented for treatment on 6/15/16 she voiced no complaints regarding her cervical spine. On 6/16/16 petitioner also voiced no complaints regarding her cervical spine. On 6/21/16 she complained of pain radiating towards her neck and upper back, and numbness down her left arm. Then on 7/6/16 she reported that her neck pain was improved and her arm pain was better. On 7/21/16 Jacobs noted many soft tissue injuries. By 7/25/16 petitioner reported that she was feeling a lot better. She reported that her arm tingling and numbness had dissipated. X-rays of the cervical spine revealed moderate to severe left foraminal stenosis at C3-C4 and cervical degenerative changes, and on 8/1/16 petitioner again complained of neck pain.

On 8/25/16 petitioner presented to Dr. Gurtler for her left shoulder and Dr. Gurtler did not believe petitioner's pain was clearly from the shoulder. He believed foraminal stenosis at C4-C5 was causing petitioner's pain. On 8/29/16 Jacobs diagnosed a cervical strain and was of the opinion that there may be a connection between petitioner's left hand, left thumb, and neck. The MRI of the cervical spine performed on 8/30/16 revealed severe left foraminal stenosis at C3-C4, and moderate left foraminal stenosis at C4-C5. On 9/1/16 Jacobs noted that there were times when petitioner stated that her neck was

not very problematic, but it was just her shoulder. She also told Jacobs that her primary area of concern in her back was her thoracic spine.

On 9/8/16 Dr. Tipirneni saw petitioner for her neck pain, but found petitioner's complaints were mostly related to the intra-shoulder area in the thoracic area. She believed petitioner's thoracic problems were mainly muscular in nature. She noted no neurological deficits on examination. Dr. Tipirneni recommended an injection at C4-C5 for her left arm complaints, but Dr. Ahmad performed an injection into her left shoulder because Dr. Ahmad felt that petitioner's left posterior neck pain and left shoulder pain was more shoulder pain than neck pain. Following the shoulder injection petitioner reported that the symptoms from her elbow down to her fingers got better, but Dr. Tipirneni believed this was just a placebo effect because she did not have a neck injection. Petitioner reported 50% improvement in her symptoms. On 10/4/16 petitioner told Dr. Tipirneni that her thoracic area was getting better. She noted no pain in the nerve root distribution in the thoracic region. Dr. Tipirneni recommended only physical therapy for the thoracic and cervical spine and stated that petitioner would be at maximum medical improvement for the cervical spine when done with physical therapy. She stated that there was no other injections or surgery indicated for the thoracic or cervical area.

On 10/6/16 petitioner reported that her neck was better, and the pain past her elbow was abating. Petitioner completed therapy on 11/8/16.

On 3/21/17, after her left shoulder surgery on 2/3/17, Dr. Ross examined petitioner and was not sure if petitioner's residual pain was due to C4 radiculopathy from C3-C4 foraminal stenosis because neither the C4 nor C5 nerve roots would cause paresthesias/numbness of the left thumb, index, and middle fingers. He stated that this would be from C6 or C7, or the median nerve root. He suspected her hand complaints were due to median neuropathy. He recommended a C4 selective nerve root block and cervical ESI to identify whether or not the C3-C4 foraminal stenosis was symptomatic. An EMG/NCV was also recommended. In March and April of 2017 Dr. Gurtler continued to believe that petitioner may have some symptoms coming from her neck. The EMG/NCV showed no sign of denervation, polyneuropathy or proximal conduction deficits, but did show minimal left carpal tunnel syndrome.

After the left C3-C4 transforaminal selective nerve root injection on 6/6/17 petitioner reported to Dr. Ahmad that she was definitely better and was able to raise her left arm without much pain, and noted that the pain in her left elbow was better. On 8/7/17 Dr. Ross noted that the EMG showed no cervical radiculopathy, but was of the opinion that petitioner's cervical symptoms were causally related to the injury on 6/15/16.

Dr. Biswas ordered a repeat MRI of the cervical spine on 11/22/17. It was done on 12/28/17 and was similar to the previous MRI of the cervical spine. Based on these results, in February and March of 2018 he recommended physical therapy, but no surgical intervention. Petitioner underwent the additional physical therapy that was recommended.

On 4/16/18 Dr. DeSalvio, after reviewing petitioner's medical records and interviewing petitioner, said it was yet to be determined whether petitioner would benefit from a surgery to her cervical spine.

On 5/30/18 Dr. Singh diagnosed a cervical muscular strain and degenerative disc disease at C3-C4 and C5-C6. He assessed a soft tissue muscular strain to her cervical spine that had resolved. He did not believe her C3-C4 foraminal narrowing was symptomatic since this would result in trapezius pain, and not arm pain. He noted no correlating arm distribution of pain for the C4 nerve root. He also based his opinion on the fact that the EMG showed no active cervical radiculopathy.

In his deposition Dr. Singh noted that petitioner's neurologic exam was normal, and she had no clinical manifestations of a cervical radiculopathy, despite radiographic evidence of degenerative disc disease at C3-C4, and C4-C5. He was of the opinion that it is anatomically impossible that petitioner's left upper extremity complaints were attributed to an aggravation of degenerative disc disease at C3-C4 and C4-C5, but was also of the opinion that petitioner had a degenerative disc disease diagnosis at C3-C4 and C4-C5, that was aggravated. He agreed that C3-C4 objectifiable information can lead to trapezial pain, but did not in petitioner's case because petitioner had no correlating sensory changes in the trapezial distribution that would correlate with the dysfunction of the C4 nerve root. Dr. Singh did not believe petitioner's complaints were consistent with the MRI finding of severe stenosis of the C3-C4 foramina.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner's current condition of ill-being as it relates to her cervical spine is causally related to the injury on 6/15/16. The arbitrator bases this on the fact that petitioner had no problems with her neck area prior to the injury; since the injury has had ongoing problems with her neck area, that were temporarily improved after she underwent injections; that petitioner's treating physicians have opined a causal connection between petitioner's cervical spine and her injury on 6/15/16; and, that Dr. Singh even testified during his deposition that petitioner had a degenerative disc disease diagnosis at C3-C4 and C4-C5, that was aggravated.

With respect to petitioner's lumbar spine, petitioner made no low back complaints or complaints of radiating pain from her back to her lower extremities on 6/15/16 or 6/16/16. Petitioner reported only

mild low back pain on 6/21/16. It was not until 8/25/16 that Jacobs noted a new finding of numbness and weakness in both legs and diagnosed petitioner with low back pain. However, on 9/1/16 petitioner denied weakness in her lower extremities, and reported no major low back pain or radicular symptoms to the legs. On 9/8/16 Dr. Tipirneni's diagnosis included a lumbar sprain/strain, but she was of the opinion that there was no causal connection between petitioner back issues and the injury on 6/15/16.

On 9/12/16 x-rays of the lumbar spine showed mild L4-L5 Grade 1 spondylolisthesis without spondylolysis. On 9/15/16 petitioner reported that her back pain was exacerbated and she had sciatic symptoms, right greater than left, but Jacobs could not opine a causal connection of petitioner's back complaints to the injury on 6/15/16. On 10/6/16 petitioner reported that her low back was better, but still symptomatic. Jacobs assessed low back pain with sciatic improvement.

On 3/21/17 Dr. Ross noted that petitioner's sciatic type pain may be due to lumbar disk pathology, but needed a study to confirm. Despite this opinion, Dr. Ross was of the opinion that petitioner's low back symptoms were causally related to her injury on 6/15/16. An MRI of the lumbar spine performed 4/12/17 showed minimal L4-L5 and L5-S1 degenerative changes without any disc bulge or herniation, and no central spinal canal stenosis or foraminal stenosis. Based on these findings Dr. Ross saw no pathology on the MRI that would cause sciatic nerve pain. Dr. Ross was of the opinion that an aggravation of facet joint arthritis could cause low back pain that could be managed by physical therapy and/or facet joint injections. Dr. Ross was of the opinion that petitioner's low back symptoms were causally related to the injury on 6/15/16.

On 11/22/17 Dr. Biswas did not think the lumbar spine needed any surgical intervention and petitioner should continue with conservative measures and physical therapy. Petitioner next returned to Dr. Biswas a year later on 11/30/18 and continued to report low back pain that interferes with her activities of daily living. An updated MRI of the lumbar spine was ordered.

At his deposition Dr. Ross was of the opinion that petitioner had no abnormality in her low back, just subjective complaints. He was further of the opinion that her sciatic discomfort was not coming from her low back. Dr. Ross was of the opinion that since petitioner's lumbar complaints were not documented until 8/29/16 that he could not definitively state that there was a causal connection between her lumbar spine complaints and the injury on 6/15/16, but then stated that absent any intervening stressor to her back or injury, that it is more likely than not that the injury is the cause of her lumbar spine complaints. Dr. Ross did not think the weakness in her legs was causally related to the injury.

A repeat MRI of the lumbar spine on 12/21/18 showed mild degenerative changes of the lumbar spine without significant spinal canal or foraminal compromise.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's current condition of ill-being as it relates to her lumbar spine is not causally related to the injury on 6/15/16. The arbitrator bases this finding on the opinions of Dr. Tipirneni and Jacobs. The arbitrator gives no weight to the opinions of Dr. Ross on this issue, given that he has offered opinions both for and against a causal connection between the lumbar spine and the accident on 6/15/16.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found petitioner's current condition of ill-being as it relates to her left shoulder and cervical spine causally related to the injury on 6/15/16, the arbitrator finds all medical services that were provided to petitioner for her left shoulder and cervical spine from 6/15/16 through 2/15/19, reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 6/15/16.

Having found petitioner's current condition of ill-being as it relates to her lumbar spine not causally related to the injury on 6/15/16, the arbitrator finds the medical services provided to petitioner for her lumbar spine from 6/15/16 through 2/15/19 not reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 6/15/16.

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

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having only found the petitioner's current condition of ill-being as it relates to her left shoulder and cervical spine causally related to the injury on 6/15/16, the arbitrator will only address the issue of prospective medical care as it relates to these two body parts.

Petitioner is not requesting any prospective medical expenses as it relates to her left shoulder. With respect to her cervical spine, the petitioner is requesting a repeat C3-C4 injection. However, the arbitrator finds no current recommendation for any further treatment for petitioner's cervical spine in the credible medical record. When Dr. Ross offered his addendum on 8/7/17 he made no treatment recommendations for petitioner's cervical spine. Additionally, in his deposition on 12/5/18 Dr. Ross was of the opinion that it is possible to see improvement in petitioner's symptomatology without a 2nd block at

C3-C4 and/or surgery to correct that disc. Additionally, when petitioner last saw Dr. Biswas on 11/30/18 he also made no treatment recommendations other than a Medrol dosepak, PPI, Robaxin, and Amitryptiline to see if it helps petitioner's symptoms in her cervical spine.

Based on the fact that there is no current recommendation from any doctor for a repeat C3-C4 injection in the credible record, the arbitrator denies petitioner's request for a repeat C3-C4 injection at this time, and only authorizes a Medrol dosepak, PPI, Robaxin, and Amitryptiline to see if it helps petitioner's symptoms in her cervical spine.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Respondent paid temporary total disability benefits from 8/2/16 through 6/4/18. It was terminated at that time based on the opinions of Dr. Singh. Following Dr. Singh's examination on 6/4/18 the only treatment petitioner had was with Dr. Biswas on 11/30/18, and repeat MRIs of the cervical and lumbar spines on 12/21/18. There is no note in Dr. Biswas' records on these dates authorizing petitioner off work. Additionally, the arbitrator finds it significant that on 12/5/18 Dr. Ross, in his deposition was of the opinion that the records indicate that petitioner was as good or better than she was on 8/2/17, and therefore could certainly lift between 10-25 pounds, which is the maximum weight petitioner is required to lift pursuant to the job description for the City of Danville Bus Driver. There is no indication that petitioner ever attempted to return to work.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner is not entitled to any temporary total disability benefits after 12/5/18, the date of Dr. Ross' deposition. Even if Dr. Ross believed petitioner should be off work before this date, on 12/5/18 he opined that she was able to lift up to 25 pounds, which is consistent with her job description. Furthermore, the arbitrator finds the credible record contains no off work authorizations after 12/5/18.

The arbitrator finds the petitioner was temporarily totally disabled from 8/2/16 through 12/5/18, a period of 122-2/7 weeks. Respondent shall be given a credit of $48,462.72 for temporary total disability benefits that have been 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 WILLIAMSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify correct clerical error	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Danuser,

Petitioner,

vs. NO: 11 WC 31420

The Schwan Food Company,

Respondent.

19IWCC0565

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, medical expenses, temporary total disability and permanent disability, and being advised of the facts and law, modifies (correction of clerical error) 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 decision of the Arbitrator delineates the facts in detail relating to causal connection, medical expenses, temporary total disability and permanent disability. However, the Commission notes the Arbitrator's clerical error regarding the temporary total disability benefit dates. The Arbitrator awarded said benefits from November 26, 2017 through December 8, 2017. Based on the record, the Commission finds that the correct dates should be November 26, 2016 through December 8, 2017 (54 weeks).

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2019 is hereby affirmed and adopted with respect to the issues of causal connection, medical expenses and permanent disability.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $651.32 per week for a period of 54 weeks (November 26, 2016 through December 8, 2017), that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 2 1 2019
o: 9/12/19
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DANUSER, MARK
Employee/Petitioner

Case# **11WC031420**

THE SCHWAN FOOD COMPANY
Employer/Respondent

19IWCC0565

On 3/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2904 HENNESSY & ROACH PC
STEPHEN J KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mark Danuser
Employee/Petitioner

v.

The Schwan Food Company
Employer/Respondent

Case # **11** WC **31420**

Consolidated cases: **N/A**

19IWCC0565

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Herrin**, on **December 13, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 30, 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 $**50,802.96**; the average weekly wage was $**976.98**.

On the date of accident, Petitioner was **49** 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**.

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

ORDER

Medical Benefits

Respondent shall pay the following reasonable and necessary medical services, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Provider	Amount
St. Anthony Hospital – Diagnostic	$ 4,711.35
St. Anthony Hospital – Physical Therapy	$ 3,922.25
Dr. David Raskas	$ 90,685.00
WCP Laboratories	$ 230.00
Metro West Anesthesia	$ 4,462.00
Frontenac Surgery & Spine	$171,199.00
Core Medical, LLC	$ 1,890.00
Pain Rehab Products	$ 1,695.00
CT Partners of Chesterfield	$ 8,781.12
Gailcrest Neurological Services	$ 41,650.00
Sunset Labs, LLC	$ 4,600.00
Mission Toxicology	$ 3,662.00
Highline Labs, LLC	$ 1,632.56
Dr. Jeffrey Jensen	$ 175.00

The total medical awarded is: $339,294.82 and per stipulation of the Parties may be paid directly to the providers.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $651.32/week for 54 weeks, commencing 11/26/2017 through 12/08/2017, as provided in Section 8(a) of the Act.

19IWCC0565

Permanent Total Disability

Respondent shall pay Petitioner permanent and total disability benefits of $**651.32**/week for life, commencing **12/09/2017**, as provided in Section 8(f) of the Act.

The awards Petitioner receives are subject to a credit of $68,886.67 of which, the parties stipulate, Respondent is entitled to a credit receive.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

Respondent shall pay Petitioner compensation that has accrued from July 30, 2010 through December 13, 2018, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

3/4/2019
Date

MAR 6 - 2019

Procedural History

A hearing was held on June 3, 2014, pursuant to Section 19(b) of the Act, and a decision rendered on December 19, 2014. The decision was affirmed on July 28, 2015. Petitioner was awarded temporary total disability benefits from October 27, 2010 through May 16, 2012. Temporary total disability benefits terminated because Respondent provided Petitioner a job offer within his restrictions. Respondent paid temporary total disability benefits of $121,731.77 but the award was for $52,845.10 which resulted in a net overpayment to Petitioner of $68,886.67 for which, the parties stipulate, Respondent is entitled to a credit against any subsequent award of benefits. The Decision on Review also affirmed the denial of prospective medical care because, it was found that no specific treatment was recommended or requested.

A second hearing was held on December 13, 2018. The disputed issues involved (1) whether Petitioner's current condition of ill-being is causally connected to his injury, whether Respondent is liable for unpaid medical bills, whether Petitioner is entitled to temporary total disability benefits, and the nature and extend to Petitioner's injury. (Arb. Ex 1).

Findings of Fact

Petitioner testified that between June of 2014 and December 2014 he was experiencing back pain and he noticed that he was leaning forward a lot and walking with a limp. Petitioner testified that his condition worsened so he sought additional medical treatment at the VA Hospital and Clinic. On August 22, 2014, after the June 3, 2014, hearing, Petitioner was examined at the VA Hospital. At that visit, Petitioner reported back pain and right leg pain. Petitioner's reported that his pain level was 5 out of 10. Petitioner requested electrodes for his TENS unit and as advised to continue taking Tramadol. (PX1, pgs.158-161). Petitioner was advised to seek an appointment with his PCP to obtain a narcotic agreement. (PX1, pgs. 163-164).

A note in the VA records dated September 29, 2014 indicated a letter was sent which determined that Petitioner did not meet the criteria to obtain a disabled parking placard. (PX1, p. 150). The VA Hospital notes show that Petitioner attempted to seek a consult at the Marion VA neurology clinic.

Petitioner testified that on January 20, 2015 he contacted the Respondent and requested employment, but no offer of employment was made by Respondent. Petitioner further testified that he had gone to a couple places looking for work but did not receive any employment offers. Petitioner testified that he started receiving Social Security Disability benefits in March of 2015 and did not look for work after receiving Social Security benefits.

Petitioner returned to the VA on March 5, 2015. The records show that Petitioner requested an evaluation for radiculopathy (PX1, pgs. 126-127) and a neurologic consult was recommended. Petitioner returned to the VA on March 25, 2015. Petitioner reported a history of low back pain for four days which started when he placed something in the dishwasher and his back hurt when he stood up. The assessment noted back pain and muscle spasms. At that time, is was noted that the lumbar spine flexion was limited to 30 degrees with lateral flexion, 20 degrees left, 10 degrees right and moderate to severe spasm were noted. Petitioner was recommended to stop using Tramadol and to use hydrocodone. (PX1, pgs. 121-124). Petitioner was referred to Dr. Syed Shah. (PX1, pg.117).

On June 30, 2015, Petitioner returned to the VA and, at that time, an MRI was recommended. (PX1, pg. 109). On July 9, 2015, Petitioner returned to the VA. Petitioner reported that his pain patterns changed approximately two weeks ago and that he was experiencing constant pain in the upper lumbar pain. Petitioner reported his pain level as 6 out of 10. Petitioner was experiencing pain and tingling in the right leg. (PX1, pgs. 99-105).

On August 28, 2015, Petitioner was seen at St. Anthony's Memorial Hospital. The new patient intake form states that Petitioner was complaining of radiating pain down both legs and that his back is "getting worse with time". An MRI was recommended which was performed on September 29, 2015. The MRI showed postoperative changes of disc surgery at L4-L5 and L5-S1 with mild scar tissue, narrowing of the neural foramen of mild degree. At L2-3, The MRI showed a right posterolateral disc protrusion which compromises the right neural foramen with mass effect on the right foraminal L2 nerve root. At L3-L4, the MRI showed a more pronounced central disc protrusion with mild to moderate narrowing of the central canal

and neural foramen bilaterally but more on the right. It was noted the changes at L2-3 and L3-4 "appear different and new in particular the posterolateral disc pathology at L2-3 and narrowing the central canal at L3-4". (PX2). Petitioner was referred to Dr. Ghalambor a spine surgeon. (PX2).

The VA Hospital records dated December 11, 2015, referred Petitioner for a neurosurgical consult for low back, bilateral hip pain, right leg pain and bilateral leg numbness. The records indicate that Petitioner may need surgical intervention for L2-3 right posterolateral disc protrusion that was compromising the right neural foramen with a mild to moderate degree and mass effect on the right foraminal L2 nerve root. The records also recommend that the consult should address the L3-4 central disc protrusion with mild to moderate central canal narrowing and foraminal narrowing. Petitioner was referred to a specialist through the Choice Care program. (PX1, pg. 59).

On April 19, 2016, Petitioner returned to the VA. Petitioner requested additional pain medication while waiting to see Dr. Raskas. Petitioner was provided a handicap placard. (PX1, pgs. 45, 50). Petitioner testified that he was eventually referred to Dr. Raskas through Choice Care at the VA Hospital. Petitioner testified he initially saw Dr. Raskas on July 5, 2016.

Dr. Raskas recommended and performed two surgeries. The first surgery, performed on November 28, 2016, consisted of a L3-4 anterior fusion with a biomechanical spacer and L3-L4 plating and preparation for the second surgery. The second surgery, performed on December 5, 2016, consisted of a L5-S1 decompression and foraminotomy. (PX4). Petitioner testified that after the surgeries his left leg pain resolved but that he continued to experience right leg pain. Petitioner testified the right leg pain did improved after the surgery.

Testimony and Opinions of Dr. Raskas

Dr. Raskas testified that the subsequent surgeries were related to complications from the first surgery and the fusion process. Petitioner developed spinal stenosis above his fusion which occurred more rapidly due to the kyphotic position of the fusion and lack of proper reestablishment of the normal foraminal heights. Dr. Raska testified that a fusion can predispose a patient to develop back pain because of a loss of curvature in the spine due to the fusion and lack of adequate curve between the top of the L4 and S1. The patient develops back pain by constantly trying to straighten up which puts more wear and tear in those segments which

produces ligamentous hypertrophy and spinal stenosis. This happens long-term with fusions but, as in this case, the kyphotic fusion accelerated the process more than what would normally have happened. Dr. Raska testified that his opinion was supported by the myelogram CAT scan dated October 3, 2016. He said the CAT scan shows that Petitioner's posture was titled forward and that would have caused discomfort. Dr. Raskas testified that the nature of the prior fusion surgery created more wear and tear on the segments causing the adjacent segment disease which is well-recognized complication of fusion surgery. (PX4, pgs. 10-11). Dr. Raskas further ropined that the manner in which Petitioner had been fused created a biomechanical problem forcing Petitioner to tilt forward in his posture. (PX4 pgs. 12-14). Dr. Raskas testified the surgeries were necessary was related to complications from the prior fusion performed by Dr. Lange. (PX4, pg. 15). Dr. Raskas testified that at L3-4 he did a large discectomy to remove the disc in its entirety and replaced it with a biomechanical spacer to create a fusion. Dr. Raskas testified that the first surgery consisted of a midline laminectomy at L3-4 where he decompressed the spinal stenosis and performed a posterior fusion. Dr. Raskas testified during the second surgery he decompressed the narrowed neural foramina left over from the prior surgery which was symptomatic at L5-S1. (PX4, pgs. 15-18). Dr. Raskas opined that Petitioner's nerve root at L5-S1 was never completely decompressed during the 2010 surgery based upon Petitioner's rapid improvement after 2016 surgery. (RX4, pg. 20).

In a letter dated September 5, 2018, Dr. Raskas outlined his opinion regarding Petitioner's ability to return to work. Dr. Raskas opined Petitioner should be restricted to sedentary work, no lifting more than 15 to 20 pounds, no repetitive bending or lifting, no repetitive bending, twisting or turning at the waist and a need to frequently change positions to sit to stand and stand to walk. He also opined Petitioner is likely in need of chronic pain management. (PX5).

Testimony and Opinions of the Section 12 Examiner, Dr. DeGrange

On February 9, 2017, Petitioner was examined by Dr. DeGrange pursuant to Section 12 of the Act. Dr. DeGrange testified that he agreed with the need for surgery performed by Dr. Raskas. Dr. DeGrange opined the surgery, performed by Dr. Raskas, was not medically causally related to the incident of 2011 or 2011 surgery. Dr. DeGrange testified that he disagreed with Dr. Raskas' opinion that the need for surgery

was related to an acceleration of degeneration due to the 2011 surgery. Dr. DeGrange opined that the significant gap in time, from 2011 to 2016, shows the need for surgery was the natural progression of the Petitioner's underlying condition and not by the prior surgery. (RX 1, pgs. 10-11). On cross-examination, Petitioner testified the surgery, preformed in 2011, affected the ability of the lumbar spine to flatten out and the 2011 surgery caused trauma to the spine. (RX 1, pg.25). Dr. DeGrange opined the concept of accelerated degeneration is speculative. (RX1, pgs. 10-11). Dr. DeGrange testified that he could not offer any opinions regarding the December 5, 2016 surgery and that he did not review the records for the December 5, 2016 surgery. (RX1, pg. 12)

Dr. DeGrange opined that Petitioner's slip and fall accident only caused a lumbar strain and Petitioner reached maximum medical improvement six weeks after the accident. Dr. DeGrange further opined that the surgery performed, by Dr. Lange, was not related to his work accident. (RX1, pg. 15). Dr. DeGrange testified the surgery performed by Dr. Lange, in 2011, was related to preexisting degenerative disease and not his work injury. (RX1, pgs. 15-16). Dr. DeGrange acknowledged that Petitioner had mild weakness in the right ankle plantar flexion or dorsiflexion which was related to a problem at L5 and S1 as was the finding of decreased leg touch over the dorsum and heal of the right foot. He further noted that the decreased right ankle tendon reflex was in the dermatome pattern of S1. Dr. DeGrange testified that CT film dated February 27, 2012 showed the L4 screw was somewhat low and the L5 screw medially deviated which could cause potential problems at the level of L5. (RX1 @ pp 19-20).

At the hearing, Petitioner testified that after his surgeries he does not walk with as big of a limp. Petitioner testified that he walks straighter now than he did prior to the surgery. He also testified that before the surgical procedure he was bent forward at the waist. Petitioner testified that he takes four Oxycontin per day and does a home exercise program which involves walking. Petitioner testified that he struggles walking down stairs and maintains a sedentary lifestyle.

Petitioner testified that he was evaluated by a vocational counselor, Bob Hammond, on September 24, 2018. Mr. Hammond testified in this matter on December 10, 2018. Mr. Hammond testified he was hired by Petitioner's attorney. Mr. Hammond testified that his vocational analysis starts with the framework of *National Tea v.*

Industrial Commission. (PX7, pgs. 15). Mr. Hammond opined that based on the restrictions imposed by Dr. Raskas, he was unable to complete a *National Tea* analysis. (PX7 @ pp 15-16).

Mr. Hammond testified that in his opinion, based on a reasonable degree of vocational certainty, that no reasonably stable labor market exists for Mr. Danuser. Mr. Hammond testified the restrictions imposed by Dr. Raskas are such that it would not allow Petitioner to work in any occupation, nor would allow an employer to reasonably expect Petitioner to be able to fulfill essential functions of a job. (PX7 pg. 17). On cross-examination, Mr. Hammond admitted it was his opinion Petitioner was not employable full-time, but he did not have an opinion regarding whether Petitioner was employable on a part-time basis. (PX7 pgs. 31-32).

The Arbitrator found the testimony of Petitioner to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992).

With Respect to Issue (F) Whether Petitioner's Current Condition of Ill-Being is Causally Related To The Injury, The Arbitrator Finds As Follows:

An accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 797 N.E.2d 665, 672 (2003). Employers are to take their employees as they find them. *A.C.&S v. Industrial Commission*, 710 N.E.2d 8347 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (1982). If a pre-existing condition is aggravated, exacerbated or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Construction v. Industrial Commission*, 227 N.E.2d 2d 65, 67, 68 (1967), see also *Illinois Valley Irrigation v. Industrial Commission*, 362 N.E.2d 339 (1977). When a pre-existing condition is present, a claimant must show that a work-related accidental injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury. *St. Elizabeth Hospital v. Workers' Compensation Commission*, 864 N.E.2d 266, 272, 273 (5th Dist. 2007). Causal connection between work duties and an injured condition may be established by a claim of

events including claimant's ability to perform duties before the date of an accident and inability to perform same duties following date of accident. *Darling v. Industrial Commission*, 176 Ill.App.3d 186, 530 N.E.2d 1135 (1988). A claimant's prior condition need not be a of good health prior to the accident, if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition, it is the resulting deterioration from whatever the previous condition had been. *Schroeder v. Illinois Worker's Compensation Comm'n*, 4-16-0192WC (Fourth Dist. 2017).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the credible evidence that his surgical procedures performed on November 28, 2016 and December 5, 2016 were necessitated as a consequence of the sequelae of the surgery performed in 2011 and injury of July 30, 2011, as set forth more fully below.

The 2011 surgery was found to be causally related to the work accident after a hearing pursuant to Section 19(b) of the Act. Those findings are considered the law of the case. The Commission previously found Petitioner reached maximum medical improvement on August 22, 2011. At that time, Petitioner had lifting restrictions of 50-pounds.

The Arbitrator finds the opinions of Dr. Raska to be more persuasive than the opinions of Dr. DeGrange. Dr. Raska testified the subsequent surgeries were related to the complications from the first surgery and the fusion process. Petitioner developed a complication related to the first surgery. The spinal stenosis above his fusion occurred more rapidly due to the kyphotic position of the fusion due to improper reestablishment of the normal foraminal heights. Dr. Raska testified that a fusion can predispose a patient to develop back pain because of a loss of curvature in the spine due to the fusion and inadequate curve between the top of the L4 and S1. The patient develops back pain by constantly trying to straighten up which puts more wear and tear in the segments which produces ligamentous hypertrophy and spinal stenosis. Dr. Raska testified that this process happens long-term with fusions but, in this case, Petitioner's kyphotic fusion accelerated the process more than would normally have happened. Dr. Raska testified that his opinion is supported by the myelogram CAT scan of October 3, 2016 which shows Petitioner posture was titled forward. Dr. DeGrange agreed that Petitioner's 2011 surgery affected the ability of the lumbar spine to flatten out. Petitioner testified that after the 2011

surgery he was leaning forward and that he continued to experience back pain which continued to progress.

Dr. DeGrange opined that Petitioner sustained a back sprain and that the 2011 surgery was not related to his work injury of July 30, 2010. Dr. DeGrange's opinions regarding Petitioner's current condition of ill-being were based, in part, upon his upon his belief that Petitioner's initial surgery was not causally related to his work accident. The surgery was found to be causally related to Petitioner's work injury. This decision was affirmed on review. (RX 8). The Arbitrator finds that Dr. DeGrange opinion that Petitioner's condition could be the natural progression of an underlying condition and not related to the Petitioner's prior surgery and injury of July 30, 2010 to be unsupported and speculative. Dr. DeGrange did not review films regarding the need for the L5-S1 surgery nor did her review the 2016 surgical records. The claimant's injury needs not be the sole factor which aggravates a pre-existing condition, so long as it is a factor which contributes to the disability. The Commission may attach greater weight to the opinion of the treating physician than to that of the examining physician. *International Vermiculite Company v. Industrial Commission*, 394 N.E.2d 166, 77 Ill. 2d 1 (1979).

With Respect To Issue (J) Whether The Medical Services Were Reasonable and Necessary and Whether Respondent has Paid Appropriate Charges For All Reasonable and Necessary Medical Services, The Arbitrator Finds as Follows:

Pursuant to Section 8(a) of the Act, the employer shall pay all necessary first aid, medical and surgical services and all necessary medical, surgical and hospital services which are reasonably required to cure or relieve the employee from the effects of the accidental injury. Respondent did not proffer evidence the medical treatment Petitioner received was not reasonable or necessary. For treatment of an employee's workplace injury to be compensable under the workers' compensation laws, Petitioner must establish the treatment is necessitated by the work injury and not some other condition or conditions. *Hansel & Gretel day Care Center v. Industrial Comm'n,* 215 Ill.App.3d 284; 574 N.E.2d 1244 (1991).

Respondent does not dispute the medical treatment Petitioner received was not reasonable or necessary. Respondent disputed liability. Dr. DeGrange agreed that Petitioner needed the surgery. As stated above, the Arbitrator found that Petitioner's current condition of ill-being was causally related to his work-related injury. As such, the Arbitrator further finds that surgeries were reasonably required to cure or relieve the

Petitioner from the effects of his injury. The Arbitrator also finds that Respondent shall pay for the medical expenses outlined in PX 8, pursuant to Sections 8(a) and 8.2 of the Act and subject to the fee schedule. Respondent shall receive a credit for any medical bills that had been paid and Respondent shall hold Petitioner harmless from any claims by any providers for the services for which Respondent is receiving a credit.

With Respect to Issue (K) What Temporary Benefits, If Any, Is Petitioner Entitled, the Arbitrator Finds as Follows:

Petitioner claims to be entitled to temporary total disability benefits from November 26, 2016 through December 8, 2017, representing 54 weeks. (Arb. Ex # 1). Respondent denied these benefits based upon liability. Petitioner is seeking temporary total disability benefits for the time related to the surgical procedures performed by Dr. Raskas. The time period Petitioner was not working is supported by the medical records of Dr. Raskas (PX4) and the testimony of Dr. Raskas (PX7) with the ending date of temporary total disability of December 8, 2017, the date of Petitioner's last visit with Dr. Raskas and the date Petitioner was discharged to his family physician for pain management. (PX4). The Arbitrator finds that Petitioner reached maximum medical improvement as of December 8, 2017.

A claimant is temporarily and totally disabled from the time an injury incapacitates her until such time as she is as far recovered or restored as the permanent character of her injury will permit. *Westin Hotel. V. Industrial Comm'n*, 372 Ill. App. 3d 527 (2007). In determining whether a claimant is no longer entitled to continue receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of return to the workforce. *Interstate Scaffolding, Inc. Illinois Workers' Compensation Comm'n*, 236 Ill. 2d 132 (2010). Once a claimant has reached MMI, her condition has become permanent and she is no longer eligible for TTD benefits. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d. 107 (1990).

Respondent denied these benefits based upon liability. The period of time Petitioner seeks benefits is related to the surgical procedures performed by Dr. Raskas. The Arbitrator finds that the period of time is supported by the medical records of Dr. Raskas (PX4) and the testimony of Dr. Raskas (PX7) with the ending date for temporary total disability of December 8, 2017, the last date Petitioner treated with Dr. Raskas and the date Petitioner was discharged to his family

physician for pain management. (PX4). Having found favorably on the issue of causal relationship regarding the necessity of the surgeries performed by Dr. Raskas and the causal relationship to Petitioner's accidental injury, the Arbitrator finds that Petitioner was temporarily and totally disabled from the effects of his injury from November 26, 2016 through December 8, 2017, representing 54 weeks subject to the overpayment to Petitioner of $68,886.67 for which, the parties stipulate, Respondent is entitled to a credit against any subsequent award of benefits.

With Respect to Issue (L), The Nature and Extent of the Extent of the Injury, The Arbitrator Finds as Follows:

A person is considered totally disabled when he is not able to perform services except those for which there is no reasonably stable labor market. *A.M.T.C. of Illinois v. Industrial Commission*, 77 Ill.2d 482, 397 N.E.2d 804 (1979). If a claimant's physical disability is limited in nature so that he is not obviously unemployable, then the burden of proof is on Petitioner to establish the unavailability of work. Here, Petitioner proffered expert testimony on the issue of whether a reasonably stable labor market exists for his services. This expert testimony was unrebutted.

Given these factors, Petitioner has demonstrated by a preponderance of the evidence that he is permanently and totally disabled based on the "odd-lot" theory of permanent and total disability pursuant to Section 8(f) of the Act. See: *Alano v. Industrial Commission*, 282 Ill.App.3d 351, 668 N.E.2d 71, 217 Ill. Dec. 836 (1996).

At the time of the accidental injury, Petitioner was 49 years of age. The record indicates that he has not worked since October 27, 2010. He is now 58 years of age. Petitioner testified he essentially lives a sedentary lifestyle. He takes narcotic medication for pain, which is managed by the pain management physician. Petitioner has been released to return to work with a restriction of sedentary work, no lifting more than 15-20 pounds, no repetitive bending or lifting, no repetitive bending, twisting or turning at the waist and a need to frequently change positions sit to stand and stand to walk throughout the workday. Petitioner did not testify to an extensive job search, but he did request Respondent reemploy him, albeit prior to his 2016 surgery. Petitioner's testimony that Respondent did not provide him a position is unrebutted.

Petitioner introduced expert testimony from a certified vocational rehabilitation counselor, Bob Hammond, that there is no reasonably stable labor market for his services.

Mr. Hammond testified that Petitioner's current age (58), as well as the work restrictions, evidence no reasonably stable labor market exists for Petitioner's services. Based on the foregoing, I find and conclude that Petitioner is totally and permanently disabled pursuant to Section 8(f) commencing December 9, 2017. No contrary medical evidence nor contrary vocational evidence demonstrates Petitioner's ability to compete in a reasonably stable labor market. The award is subject to a credit for the overpayment of $68,886.67 which Petitioner received and the parties stipulated that Respondent is entitled to a credit against any subsequent award of benefits.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSA ORTIZ,

Petitioner,

vs. NO: 14 WC 33905

ARAMARK,

Respondent.

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DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical, temporary total disability (TTD) benefits, and permanent partial disability (PPD) benefits, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner, Rosa Ortiz sustained an accident that arose out of and in the course of her employment with Respondent on July 31, 2014.

The Commission finds that Petitioner's right shoulder condition is causally related to the July 31, 2014 accident. The Commission further finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the July 31, 2014 accident, as well as TTD benefits from July 31, 2014 through October 2, 2014, and prospective medical treatment.

The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Per the Application for Adjustment of Claim filed October 6, 2014, Petitioner was a 58-year old, single female with no dependents under the age of 18. Petitioner alleged injury to her right shoulder on July 31, 2014 while in the course of her employment. Petitioner filed an Amended Application on June 8, 2018 alleging injury to her right shoulder on July 31, 2014 due to repetitive trauma.

2. At the outset of the arbitration hearing, it was noted that accident was in dispute with respect to a repetitive trauma only. T.6. Respondent objected to the filing of the Amended Application arguing that repetitive trauma was a new theory of recovery as the original Application was for a specific injury. They asked that the Amended Application be stricken as they obtained two Section 12 opinions and depositions relative to specific injury only. T.11. The Arbitrator denied Respondent's objection citing Rule 9020.20, which allows for the filing of an Amended Application prior to hearing. T.12.

3. Petitioner testified that she has been employed as a housekeeper for 14 years and was working without issue prior to the accident. T.19. On July 31, 2014, she was in an elevator with a large container of supplies. As she was exiting the elevator, the container was tilting forward and about to fall. She tried to quickly pick up the container with her right hand as she was holding something in her left hand. T.18. She pulled the container and felt pain in her right shoulder. *Id.* She is right handed. She reported the accident to Brandon Gannon of Human Resources on August 8, 2014. T.19.

4. Petitioner testified that she did not seek medical attention that day as she thought it was nothing serious. T.20. The following day the pain started to get worse, so she went to the ER as she was unable to move her hand. T.20. At the ER, she denied falling but said she was injured at work. She was unable to work for 3 months and then returned to work with restrictions on October 2, 2014.

5. Petitioner presented to Rush University Medical Center on August 2, 2014. The arrival complaint was listed as right shoulder pain. She reported dizziness and a headache for 1 day. She denied any syncopal episodes. She also complained of right upper extremity pain. She denied any falls or injury to her extremity. The onset of her right shoulder symptoms was listed as 1 p.m. yesterday. Her symptoms were aggravated by movement of the right shoulder. She reported prior headaches with her current headache beginning yesterday. She noted that a near syncopal episode occurred yesterday. She felt vertiginous, diaphoretic and almost passed out. PX.1.

   Petitioner's examination was positive for joint pain. Her right shoulder exhibited decreased range of motion, bony tenderness and deformity. She exhibited no swelling, effusion, crepitus, laceration, pain, or spasm. She had normal range of motion in all major joints of the upper and lower extremities. X-ray of the right shoulder revealed minimal to mild inferior displacement of the right humeral head as compared to the glenoid. There was a large focus of amorphous calcification measuring 2.2 x 1.2 cm in the superolateral aspect of the right humeral head, likely representing calcification in the supraspinatus tendon. The impressions were minimal to mild inferior displacement

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of the right humeral head as compared to the glenoid and probable calcific tendinitis involving the right supraspinatus tendon. She also underwent a CT scan that was consistent with a rotator cuff tear. An ultrasound was recommended. She was admitted into the hospital and discharged August 4, 2013. PX.1.

6. Pursuant Dr. Anupama Ananth's record from August 2, 2014, it was noted that Petitioner had a significant past medical history for chronic migraine headaches and vertigo. She presented with 10/10 right shoulder pain and dizziness. Her pain came on suddenly yesterday while she was out working. It started in her right shoulder and radiated to her hand. It felt like her arm was asleep. She denied lifting anything heavy or any trauma. She admitted to lifting something heavy at work on Thursday. She never had this kind of pain before. She had some dizziness with her arm pain but did not feel like the two were related. Examination of the right arm revealed very limited range of motion, 2/2 pain, and abduction of right arm at the shoulder was limited to 30 degrees. She was unable to perform a lift off or empty can test. She had 4/5 grip strength in the right arm. The x-ray was consistent with chronic changes, possible adhesive capsulitis/frozen shoulder v. tendinitis. However, given the acute onset of pain, possible rotator cuff tear was considered. Per the attending attestation, it was noted that Petitioner worked as a housekeeper and noticed acute onset of right shoulder pain after lifting some supplies. She was to follow-up at Midwest Orthopedics at Rush. PX.1.

7. Petitioner underwent an MRI of the right shoulder without contrast on August 2, 2014. The impression was large globular calcification within the subdeltoid bursa overlying the distal supraspinatus tendon, consistent with calcium hydroxyapatite deposition disease. There was moderate subdeltoid bursitis. There was mild tendinosis of the distal supraspinatus and distal subscapularis without a full thickness tear. There was no evidence of fatty atrophy or bulk loss. The labrum and glenohumeral cartilage were intact. PX.1.

8. An Employer's First Report of Injury was completed by Andrew Nurczyk on August 11, 2014. It was noted that Petitioner was pushing a garbage wheeler when it got caught on the elevator floor and tipped. She went to catch it and felt a strain to the right elbow and shoulder. The injury occurred on July 31, 2014 at 8:00 am. PX.2.

9. Petitioner presented to Rush on August 14, 2014 for right arm tendonitis. She was previously in the hospital from August 2, 2014 through August 4, 2014 for pre-syncope issues and shoulder pain. She has been in a sling since being admitted and could barely move her arm secondary to pain. She has been unable to perform her job duties. Examination of the right shoulder revealed minimal passive or active motion due to discomfort in the shoulder along with limited abduction. She was to continue therapy and follow-up with an orthopedic physician. PX.1.

10. Petitioner underwent a shoulder evaluation at Rush Outpatient Physical Therapy on August 21, 2014. She reported an injury occurring on July 31, 2014 when she was carrying a large box of cans in an elevator. The door opened causing a can to flip out of her hands. The door began to close, and she bent over to pick up the can. She raised

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it to her chest and had immediate pain. The MRI was reviewed, and continued therapy was recommended. PX.1.

11. Per the September 12, 2014 physical therapy record, Petitioner reported that she was able to talk to a social worker and work out details of her work injury documentation. It was noted that Petitioner indicated that her ER documentation did not indicate a work injury. Once this was fixed, she was to submit this to her work. PX.1.

12. Per the September 19, 2014 therapy record, it was noted that Petitioner's paperwork has been changed to note that her injury occurred at work. Petitioner reported that she was moving her shoulder more. She felt very stiff and painful in the morning. PX.1.

13. Per the September 30, 2014 therapy record, Petitioner had been feeling pretty good but went to the grocery store on Saturday and lifted a lot of bags at once. She has since had constant shoulder pain. She probably carried 12-pounds, which was the amount she was supposed to carry at work. PX.1.

14. Petitioner was discharged from therapy on October 23, 2014. She had attended 10 out of 10 sessions and was feeling much better and could use her shoulder more. She preferred to use her left shoulder to do chores. She wanted to return to work but did not feel that she was strong enough. PX.1.

15. Petitioner received a right shoulder subacromial bursa corticosteroid injection on October 24, 2014 for her painful shoulder and calcific tendonitis. She was released to return to work on Wednesday, October 29, 2014 and could perform regular duties. Then on October 30, 2014, she was given 10-pound lifting restrictions with limited overhead activities. PX.1.

16. Respondent obtained a Section 12 examination from Dr. Lawrence Lieber of DuPage Medical Group on December 17, 2014. Petitioner reported her injury and that she went to the ER 3 to 4 days later secondary to fainting. She was admitted for 2 days and had a cardiac workup as well as an evaluation of her right shoulder. She had no prior right shoulder issues. She complained of numbness in the right upper extremity as well as stiffness in the shoulder and difficulty with overhead activity. She had restrictions at the extremes secondary to pain. Her testing was positive for AC tenderness, impingement, apprehension, Speed, O'Brien, and Reverse O'Brien. Dr. Lieber's impression was rotator cuff syndrome, partial rotator cuff tear, calcium, calcific bursitis, and AC joint arthritis of the right shoulder. He found significant inconsistencies concerning Petitioner's subjective complaints and the mechanism of injury. There did, however, appear to be a consistent history of an injury on July 31, 2014 as described by Petitioner. He opined that Petitioner had significant pre-existing abnormalities within the right shoulder that were neither caused, aggravated nor associated with the July 31, 2014 event. There was no evidence of any acute injury to the right shoulder on the MRI associated with the event. The significance of her pre-existing condition could have become symptomatic with activities of daily living. There was no evidence of any significant traumatic event to the right shoulder that

could be associated with the July 31, 2014 event. Petitioner did not show evidence of any temporary aggravation of any pre-existing condition. She reached pre-accident baseline as of his examination. There was no evidence of any non work-related systemic condition that caused or contributed to the current condition other than the abnormalities within the right shoulder. Petitioner was at MMI and could work full duty with no restrictions. There was no evidence of permanent disability. RX.1.

17. Dr. Lieber is a board-certified orthopedic surgeon and was deposed October 4, 2017. He found no evidence of an acute injury. RX.1. pg.11. He diagnosed Petitioner with rotator cuff syndrome, partial rotator cuff tear, calcium, calcific bursitis, and AC joint arthritis. RX.1. pg.11. Dr. Liber opined that, from an objective standpoint, Petitioner did not sustain an injury to her shoulder on July 31, 2014. RX.1. pg.12. Subjectively, from her own standpoint, there was an event but objectively there was no evidence of any abnormality. *Id.* Her symptoms were related to the pre-existing abnormalities noted on the MRI. RX.1. pg.13. There was no causal connection between her shoulder and the accident. She had an MRI three days post accident that showed evidence of pre-existing degenerative abnormalities and no evidence of any acute soft tissue or any bony injury that could have been related to the event. Dr. Lieber stated that any injury to the shoulder would have been present on the MRI. RX.1. pg.14. Petitioner's calcific tendinitis was not caused by the injury, rather it was related to chronic wear. The pre-existing bursitis was related to the chronic calcium. Her AC joint arthritis was confirmed by the MRI but was a longstanding degenerative process. The partial rotator cuff tears were degenerative in nature. If they were related to the accident, Dr. Lieber testified that there would have been significant swelling, bleeding and edema about the rotator cuff tear, but there wasn't. RX.1. pg.16. All of her conditions could have become symptomatic through activities of daily living. *Id.* She was at MMI.

18. On cross-examination, Dr. Liber agreed that Petitioner had a work accident on July 31, 2014. However, he stated that there was no objective evidence of any isolated injury to her shoulder. RX.1. pg.23. He noted that there were no prior medical records related to the shoulder and he could not point to anything in the record indicating she had any prior complaints or symptoms related to the pre-existing abnormalities. RX.1. pg.27. Despite all this, he noted that the MRI performed two days later showed no abnormality. The incident was not significant enough to have caused any significant abnormality within the shoulder. He did not think that Petitioner's job duties for over 20 years would cause her condition. RX.1. pg.46.

19. Petitioner followed-up at Rush on January 4, 2015 for right shoulder pain. She noted improvement after the October 24, 2014 injection. She had some improvement with her range of motion. The assessment was right shoulder pain. She was to continue home exercise and remain on modified duty. An MRI was recommended. PX.1.

20. Petitioner presented to Cook County Health on March 9, 2016 for back and right arm pain. Examination of the right shoulder revealed decreased range of motion and some tenderness to palpation over the shoulder joint. The x-ray of the right shoulder was normal. The diagnosis was chronic pain in the shoulder. PX.4.

21. Petitioner followed-up at Cook County Health on September 14, 2016 for continued right shoulder pain. The MRI revealed thickened, likely fibrous distal supraspinatus tendon with some surrounding fluid. This was likely chronic tendinitis with a possible acute component. She was pain free at rest. The diagnosis was rotator cuff impingement syndrome. PX.4.

22. Respondent obtained a records review from Dr. Charles Carroll of Illinois Hand Center on January 17, 2017. He diagnosed Petitioner with impingement, calcific tendinitis and rotator cuff disease, degenerative in nature. Her condition was related to her age and her AC arthritis. Her activities of daily living more likely rendered her condition to become symptomatic as opposed to the alleged injury. Any alleged aggravation of the shoulder or strain would be temporary and would have resolved within 3 to 6 months. There was no permanent aggravation. She had lifting restriction of 20 pounds, but they were not related to any work injury. He agreed with the need for an injection and possible arthroscopic debridement of the calcific tendinitis. An acromioplasty should also be considered. Petitioner's condition was degenerative in nature. The alleged injury would cause nothing more than a strain. He noted there were variable histories and, therefore, there was no clearly defined injury that would cause any of her disease processes. RX.2.

23. Dr. Carroll performed a Section 12 examination on June 12, 2017. He noted that Petitioner provided 3 different histories of accident. The first: Petitioner was carrying a bucket and suffered a strain. The second: Petitioner mentioned pushing and pulling a bucket to prevent her from falling. The third: moving material when the container flipped. She grabbed it with the right arm to prevent it from falling. She then had pain in the shoulder. Dr. Carroll noted Petitioner had resolved calcific bursitis with some mild impingement. She also had acromioclavicular arthritis. She suffered a strain to the right shoulder, at most, that would have resolved in 3 to 6 months. The calcific bursitis, rotator cuff disease and impingement were not related to the injury. She had a degenerative condition and her need for care was related to the degenerative condition. He stated that the injury would not cause her to become symptomatic. RX.2.

24. Dr. Carroll is a board-certified orthopedic surgeon and was deposed September 27, 2017. He opined that the shoulder strain could be related to the alleged injury but would have resolved over a 3 to 6-month period. The other diagnoses were degenerative in nature and not caused or aggravated by the accident. He also performed a Section 12 examination on June 12, 2017. He reviewed the MRI and noted that the findings were degenerative in nature and not related to the incident. RX.2. pg.21. He again opined that Petitioner sustained a strain of the shoulder. The calcific bursitis, rotator cuff disease, and impingement were not related and not aggravated or accelerated by the claimed accident. RX.2. pg.22.

25. On cross-examination, Dr. Carroll noted that Petitioner had a work accident. He noted that she had a degenerative condition and was at the age that a degenerative phenomenon would occur. He did not find that the nature and extent of the injury based on what he reviewed would cause or aggravate a tear. RX.2. pg.32. He noted that

Petitioner was able to work up until the accident. RX.2. pg.33. Depending on the nature of the repetition and the force needed would determine whether her activities crossed the threshold of repetition to cause the injury. RX.2. pg.34.

26. Petitioner testified that her claim was denied after she underwent two Section 12 examinations. T.38. As she did not have any insurance, she began to treat at Cook County where she currently treats. *Id.* She was told that she needs surgery. T.48.

27. Petitioner stated that her shoulder is in a great deal of pain and she cannot perform her work duties. T.54. She has pain when she does strenuous activities. T.56. She takes pain medication 4 to 5 days a week. T.58.

28. On cross-examination, Petitioner testified that the large container of supplies started to lean over as she was exiting the elevator. She injured herself picking it up. T.59. Nothing fell out as she stopped it. The container weighed 60 pounds. She did not report the accident right away as she thought it was nothing serious. T.65.

The Commission disagrees with the Arbitrator's credibility determination and his finding that Petitioner failed to prove an accident arising out of and in the course of her employment with Respondent on July 31, 2014. The Commission, therefore, reverses the Arbitrator's Decision in its entirety.

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n,* 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission disagrees with the Arbitrator's finding that Petitioner was not credible. In support of his credibility determination, the Arbitrator noted that the first two histories Petitioner provided to Dr. Nadim and Nurse Callahan on August 2, 2014 at 12:44 p.m. and 2:23 p.m. were inconsistent with her testimony. In the first history, the Arbitrator noted that Petitioner denied a history of trauma and told Dr. Nadim that the onset of her right shoulder pain was at 1:00 p.m. on August 1, 2014. In the second history, the Arbitrator noted that Petitioner denied to Nurse Callahan an injury to her extremity. The Arbitrator gave great weight to the earliest histories. In further support of his determination, the Arbitrator noted that Petitioner did not give a detailed history of her accident that was consistent with her testimony until October 24, 2014. The Arbitrator also noted that the Petitioner spoke to a social worker to work out the details on her work injury as the emergency room documentation did not indicate a work injury. Because of this, the Arbitrator found the Petitioner not credible.

As stated in *R & D Thiel v. Ill. Workers' Comp. Comm'n*, 398 Ill. App. 3d 858 when the Commission gives its reasons for making credibility findings contrary to those made by the arbitrator, [the reviewing court's] inquiry on review is whether the findings are against the manifest

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weight of the evidence. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980).

While the Arbitrator found the alleged inconsistent histories significant, the Commission finds that the history completed by Dr. Anupama Ananth from the same day, August 2, 2014, supports Petitioner's testimony and undercuts the Arbitrator's credibility determination. Dr. Ananth noted that Petitioner reported lifting something heavy at work on Thursday. The record further indicated that Petitioner related her pre-syncopal symptoms to her shoulder pain. That same day, Dr. Matthew Tetreault noted that Petitioner reported developing shoulder pain after lifting a heavy object. Thereafter, contained within the discharge summary, it was noted that Petitioner notice acute onset of right shoulder pain after lifting supplies at work. The Commission notes that the histories are consistent with Petitioner's testimony. Petitioner testified that she was injured when she tried to pick up the container with her right hand. She further said that her pain was slight on the accident date and that it got worse the following day, causing her to seek treatment. The Commission believes that this testimony was substantially consistent with her history to Dr. Nadim referenced above. Based on the totality of the evidence, the Commission finds that the evidence does not support the Arbitrator's credibility determination. Instead, the above histories, along with the history contained in the accident report filed on August 11, corroborate the Petitioner's testimony.

The Commission has original jurisdiction in cases which come before it. *Caterpillar Tractor Co. v. Indus. Comm'n*, 215 Ill. App. 3d 229, 237 (1991). The Commission also has the authority to consider new theories of recovery even if that theory was never presented to the Arbitrator and the claimant did not amend his application for adjustment of claim to include the new theory, so long as the Commission's consideration of the new theory does not prejudice a party's substantial rights. *Id.* at 238. The Commission's Decision to grant benefits under a new theory of recovery does not prejudice an employer's substantial rights if the employer is aware of evidence supporting the theory before the arbitration. *Id.* at 240; *See also*, *Freeman United Coal Mining Co. v. Indus. Comm'n*, 297 Ill. App. 3d 662, 667 (1998) (wherein the Appellate Court found that the Commission did not err when it found a different date of accident from that alleged in the application. The employer did not establish that it was prejudiced by the Commission's Decision finding a different date for the onset of the employee's injuries. The opinion further found that the Commission did not err in allowing the amendment to conform the application to the proof).

Further, to obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203 (2003). "In the course of employment" refers to the time, place and circumstances surrounding the injury. *Id.* An injury "arises out of" the employment when "the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id.*

While the Petitioner amended her Application to a repetitive trauma injury shortly before trial, the evidence strongly supports that Petitioner sustained a specific injury on July 31, 2014. The medical records along with Petitioner's testimony all establish that she was injured due to a

specific injury occurring on July 31, 2014. Amending the Application back to a specific injury does not prejudice the Respondent's rights as Respondent defended this matter under a specific injury theory prior to Arbitration. Accordingly, the Commission amends the Application for Adjustment of Claim to reflect a singular accident and not a repetitive trauma accident.

According to the Request for Hearing form completed by the parties prior to the June 26, 2018 arbitration hearing, the Respondent disputed accident solely on the basis of a repetitive trauma theory. Having resolved that the Petitioner sustained a singular accident, the Commission finds that no dispute exists as to the occurrence of a singular accident on July 31, 2014. Had Respondent not stipulated to a singular accident, the overwhelming evidence supports that Petitioner sustained an accident arising out of and in the course of her employment on July 31, 2014. The medical records confirm that Petitioner injured her shoulder when she attempted to lift a container of supplies on July 31, 2014. No evidence was offered to rebut Petitioner's theory of accident.

A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). In preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Id.* at 204-205. It is axiomatic that employers take their employees as they find them. *Id.* at 205. Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro Inc.* at 205.

Further, a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982).

The Commission finds no evidence that Petitioner's condition is related to anything but the accident. No evidence was offered to rebut Petitioner's testimony that she had no prior right shoulder issues. The Commission is not persuaded by Respondent's expert opinions suggesting that Petitioner's condition is degenerative in nature and not related to the accident. Their opinion ignores the fact that Petitioner was previously asymptomatic and was working without restriction until the accident. It was not until after the accident that Petitioner's condition became symptomatic resulting in her restrictions and need for treatment.

As Petitioner established that her condition is causally related to her July 31, 2014 accident, the Commission awards Petitioner all reasonable and necessary medical expenses as contained in Arbitrator's exhibit 1. The Commission also awards Petitioner TTD benefits from July 31, 2014 through October 2, 2014, representing 9 weeks.

The Commission further finds that Petitioner is entitled to prospective medical treatment. Respondent's Section 12 examiner, Dr. Carroll, opined that Petitioner needed an injection and

possible arthroscopic debridement. Petitioner is currently treating at Cook County Hospital and surgery has been recommended as she has not yet reached maximum medical improvement. As Petitioner has established accident and causal connection, the Commission hereby orders Respondent to approve and pay for continuing treatment, including surgery, as recommended by her treating physician.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on October 9, 2018, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 9 weeks, from July 31, 2014 through October 2, 2014, that being the period of temporary total incapacity for work under Section 8(b) of the Act, and as provided in Section 19(b) of the Act, this award in no instance shall be a bar to 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 all reasonable and necessary medical expenses as detailed in Arbitrator's exhibit 1, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment, including surgery, as recommended by her treating physician.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $7,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: OCT 22 2019

D. Douglas McCarthy

D. Douglas McCarthy

DDM/tdm

O: 8/28/19
052

Stephen Mathis

SPECIAL CONCURRANCE/DISSENT

I concur with all aspects of the majority's decision other than the award of prospective medical care. I find Petitioner reached maximum medical improvement (MMI) as of October 29, 2014, and her current condition of ill-being is not causally related, which is consistent with the medical records and opinions of Dr. Carroll. No further medical care is indicated nor reasonable and/or necessary. Therefore, I respectfully dissent.

Petitioner injured her right shoulder on July 31, 2014 requiring medical treatment. Following a course of conservative treatment, which included an injection and physical therapy, she was discharged from physical therapy as of October 23, 2014 and released to full duty work as of November 29, 2014. PX4.

As the majority notes, Petitioner was evaluated by both Dr. Lieber and Dr. Carroll, neither of whom are of the opinion that Petitioner's current condition of ill-being is causally related to her accident. Dr. Lieber is of the opinion Petitioner failed to sustain an acute injury to her shoulder and placed her at MMI as of August 2, 2014. RX1, p. 29 & 49. Dr. Carroll is of the opinion Petitioner suffered from an acute strain which resolved within three to six months with a full duty release to return to work as of October 29, 2014. RX2, p.11-12; 23. Dr. Carroll, consistent with Dr. Lieber, is of the opinion Petitioner's current shoulder condition is degenerative in nature and not related to her accident. Id., p. 21.

Petitioner testified she is currently treating at Cook County Hospital with a possible recommendation for surgery. T. 49-50. Petitioner offered no medical records into evidence regarding her current treatment and the proposed surgical recommendation.

Despite this lack of medical documentation, the majority finds Petitioner entitled to prospective medical care purportedly based upon Dr. Carroll's recommendations. Curiously, the majority finds Dr. Carroll's opinion lacking as it relates to causation but apparently persuasive as to the alleged need for ongoing care. Ignoring this dichotomy, Dr. Carroll testified Petitioner's

condition, work-related or not, did not warrant any further medical treatment, injections, surgery or otherwise. Dr. Carroll testified as follows:

> Q. In your report, you do not find any indications for surgery or further care. Yet under your review of the medical records 5 months prior, you indicated an injection and possible surgery. And I quote: She should consider further care regardless of my opinions. Is that correct?
> A. I did state that. And I believe she had an injection subsequent to that report, which she told me was about three times [*sic*] prior to the time I saw her. So she did receive the injection. When I subsequently saw her, it didn't appear after that injection she needed surgery. Surgery was an option at the time 5 months prior. RX2, p. 40.

As Dr. Carroll explained, at one point, he recommended an injection and possible surgery. Since this initial recommendation, Petitioner underwent the injection and based upon Petitioner's physical presentation thereafter, Dr. Carroll is of the opinion no further treatment is warranted. Nonetheless, the majority awards prospective medical care for an unknown type of surgery from an unknown physician without *any* supporting medical documentation. "It is axiomatic that liability under the Act cannot be premised on speculation or conjecture but must be based solely on the facts contained in the record." *Forest City Erectors v. Industrial Commission*, 264 Ill. App. 3d 436, 441, 636 N.E.2d 969 (1994). I find there is no factual basis in the record to award prospective treatment, and the majority's award of the same is speculation.

For the reasons stated above, I respectfully dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

ORTIZ, ROSA
Employee/Petitioner

Case# **14WC033905**

ARAMARK
Employer/Respondent

19IWCC0566

On 10/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
JUNIRA CASTILLO
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
TERRENCE DONOHUE
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
19(b)

Rosa Ortiz
Employee/Petitioner

v.

Aramark
Employer/Respondent

Case # 14 WC 33905

Consolidated cases: N/A

19IWCC0566

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **June 26, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

E. [x] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **July 31, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Petitioner's current condition of ill-being ***is not*** causally related to repetitive trauma from work activities.

In the year preceding the injury, Petitioner earned **$16,476.72**; the average weekly wage was **$316.86**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **0** dependent children.

ORDER

Compensation is hereby denied.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

10/4/2018
Date

ICArbDec19(b)

OCT 9 - 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSA ORTIZ
Employee/Petitioner

19IWCC0566

v. Case # **14** WC **33905**

ARAMARK
Employer/Respondent

FINDINGS OF FACT

Preliminary Matters:

The parties stipulated that the issues in dispute include: accident with respect to the repetitive trauma claim; notice regarding the repetitive trauma claim; causation, TTD, medical bills, prospective care, and if at MMI, nature and extent of the injury. The Arbitrator offered and admitted into evidence as Arbitrator's Exhibit #1, the Request for Hearing, which includes the stipulations and issues in dispute. (AX 1) Although Petitioner's counsel stated she was pursuing this matter as a Section 19(b) hearing over the need for surgery and TTD benefits, the parties agreed that if the Arbitrator finds Petitioner to be at maximum medical improvement, then he may address the issue of nature and extent.

Respondent moved to strike the Amended Application, which indicated a new theory of injury as repetitive trauma. (T. 12) Arbitrator Cronin overruled the objection, and cited Section 9020.20 of the Rules. (T. 12) The Arbitrator entered and admitted into evidence as Arbitrator's Exhibit #2 the original Application, which was filed on October 6, 2014. (T. 13) The Arbitrator offered and admitted into evidence as Arbitrator's Exhibit #3 the Amended Application, which was filed on June 8, 2018. (T. 15)

Trial Testimony:

Petitioner testified that on July 31, 2014, she was in an elevator with a large container of supplies and as she was coming out of the elevator, the container began to

tilt and fall and almost went all the way down, so she quickly tried to pick it up with her right hand and then pulled the container and felt a pain in her right shoulder. (T. 18) Petitioner does housekeeping for Respondent at McCormick Place, and has worked for Respondent for 14 years. (T. 18) Petitioner testified that before that date, she had no prior treatment for, or problems with, her right shoulder, and was able to do her job with no restrictions. (T. 19) Petitioner testified she reported the injury on August 8th to Brandon Gannon in Human Resources. (T. 19) Petitioner testified she did not go to the emergency room the day it occurred because she thought it was nothing serious, but the next day the pain was greater and she was unable to move her hand, so she went to Rush Hospital (T. 20) She testified they performed an MRI, gave her medication, sent her to therapy and referred her to an orthopedic doctor. (T. 20) Petitioner testified that in the emergency room, she provided a history of the work accident. (T. 20) She testified that she went to the emergency room because she had a very strong pain in her shoulder. (T. 22) Petitioner further testified that the specialist to whom she was referred gave her injections, therapy, and medication for the pain, and "that's the way it has been for all this time." (T. 22) She testified that she has not gotten better. (T. 22)

Petitioner testified that she was off work for three months per the doctor's orders, and thereafter, returned to work with light-duty restrictions. (T. 26) Petitioner testified that she saw three doctors at the request of her employer, including Dr. Nicholson. (T. 27) She then testified that she did not recall who arranged for her to see Dr. Nicholson, but that she did see him only once. (T. 28)

At that point, Respondent's counsel made a statement for the record. (T. 28-31)

Petitioner testified that after she was examined by Dr. Nicholson, she saw two IME physicians, Dr. Lieber and Dr. Carroll. These visits were arranged by her employer. (T. 37)

After her case was denied, she began treating at Cook County Hospital. (T. 38) Petitioner testified she did not have insurance so she began treating at Cook County

Hospital, which is where she currently treats. (T. 48) Petitioner testified she underwent therapy and was going to get surgery. (T. 48) She testified that the doctors at Cook County Hospital are recommending surgery and that it is being scheduled. (T. 49) Petitioner testified she did not receive any Worker's Compensation disability benefits during the time she was off work. (T. 50) She testified that when she returned to work, she had restrictions of no lifting more than 10 pounds. (T. 51)

Petitioner testified that, presently, she has a great deal of pain in her shoulder and has difficulty at work and cannot do the jobs they have asked to do and cannot carry and lift things with the affected hand. (T. 54) She testified that she has become used to working with her left arm and that her right arm helps the left arm. (T. 54) Petitioner testified that her work duties include cleaning the offices, the lobby, the bathrooms, the stairs, as well as the glass, with which she has particular trouble. (T. 55) She testified she cleans large glass doors with a squeegee, which is difficult. (T. 55) Petitioner testified she has restrictions and does light-duty work. (T. 55) She has pain in her arm when she does "a strenuous movement," which includes when she gets dressed. (T. 56) She is right-handed. Petitioner testified she works eight hours a day for five days a week. (T. 57) She takes prescribed medication for shoulder pain four or five days per week. (T. 58) Petitioner said that before her accident, she used to do yoga and exercise and do more work. (T. 58) After the accident, she testified, her life changed. She also testified that before the accident, she did not take this prescription medication. (T. 58)

On cross-examination, Petitioner testified that when the accident occurred, nothing fell out of the container. (T. 60) She stated she was not injured from picking something up that had fallen out, but rather from pulling the container so it would not spill over before the elevator door closed. (T. 60) Petitioner testified that she believes all of her pain stems from the specific July 31, 2014 accident, rather than from any work activities over a longer period of time. (T. 63) Petitioner insisted that she reported the accident to a human resources manager on August 8, 2014 rather than on August 11, 2014. (T. 64) Subsequently, she allowed that it maybe it was on the 11th, although she thinks it was the 8th and that he made out the report on the 11th. (T. 65) She reiterated

that she did not report the accident initially because she did not think it was that serious. (T. 65) Petitioner testified that in communicating with her employer and her doctors regarding the reason for her pain, it has always been with regard to a specific event on July 31, 2014, rather than any repetitive trauma over time. (T. 65-66)

Petitioner said she does not recall going to the emergency room on August 2nd and telling them that the onset of her symptoms was at 1:00 PM the day before (August 1st). (T. 67) Petitioner did not acknowledge the history she gave at the emergency room of a headache that had started earlier that same day, and simply responded that she has had migraine headaches for years. (T. 67-68) She testified that the description she gave in the emergency room of having a near syncopal episode yesterday and almost passing out was all because of her shoulder pain. (T. 68) Similarly, she testified that the ER history indicating vertigo or dizziness and that she almost passed out, was all due to her shoulder pain. (T. 69) She acknowledged that when she was in the emergency room on August 2, the staff performed a CT scan of her brain. (T. 70) They also did a mammogram. (T. 71) She agreed that at that time she was also complaining of headaches. (T. 71) Petitioner acknowledged that while treating over the course of her two-night stay at the hospital, she received a diagnosis that included major depressive disorder and anxiety. (T. 71-72) She denied that part of her treatment in the emergency room was for chronic migraine headaches or dizziness. (T. 73) She testified the whole reason she was there and all the treatment she undertook was for her shoulder. (T. 73)

Petitioner testified that in treating at Cook County Hospital she has also been seen for anxiety, headaches, depression, hypothyroidism and GERD. (T. 74)

Regarding her medical bills, Petitioner testified that Public Aid was the only source of payment. (T. 76) She testified that the bills contain treatment for everything, including non-shoulder treatment. (T. 76)

Petitioner testified that she returned to light-duty work after October 2, 2014. (T. 77) She recalled Dr. Hanna issuing a return to work regular duty effective October 29,

2014. (T. 77) Petitioner did not recall there being any discrepancy or confusion regarding the initial history as to how the accident happened. (T. 77) She did not recall speaking to a social worker about how the ER documentation did not indicate that her injury was at work, but that once this is fixed, she will be able to submit it to work. (T. 78) Petitioner reiterated that she does not remember that happening and further, that she did not think she said any of that. (T. 80) Petitioner did not recall undergoing an IME with Dr. Lieber in December 2014, but did recall undergoing an IME with Dr. Carroll in June 2017. (T. 80-81)

On redirect examination, Petitioner testified that at the time of the accident, she was carrying a lunch bag in one hand and only used her right hand on the container at the time of the accident. (T. 82) She testified the container was full of supplies and weighed approximately 60 pounds. (T. 82) Petitioner concluded her testimony by saying the only reason she went to the emergency room was for her shoulder pain, and on that day, she did not get a mammogram. (T. 85)

Treating Medical Records:

On August 2, 2014, Petitioner sought treatment at the emergency room of Rush University Medical Center. The earliest recorded history was taken at 12:44 p.m. Attending Physician Nadim Hafez, M.D., wrote the following:

> "HPI Comments: This 58 year old Hispanic female who presents with weakness. She was interviewed and evaluated with the translator phone (translator # 700796). The weakness is described by the pt. as right arm weakness (in shoulder only). It is located in her right arm at the level of the shoulder. She denied any difficulty below the shoulder joint. Onset of symptoms was 1 p.m. yesterday. The symptoms are Aggravated by movement of right shoulder. Relieved by nothing. Associated symptoms: Pain. Pt. noted 'severe pain' in arm right. Pain is in upper arm at shoulder joint. The shoulder pain radiated to the ipsilateral elbow joint. No hx of trauma. Pain is noted to be sharp and strong. Pain is increased with movement and relieved with rest. The pt. stated she feels weakness

in the shoulder, but not in the ipsilateral (right) elbow, wrist or hand. She is unable to note weather (sic) or not the reason why she feels why she can't move the arm is weakness or pain. The patient denied numbness in any of her extremities. Pt. noted headache that started earlier today. Pt. noted it to be frontal left sided, not first or worst per pt. She noted she has migraines that can present in various ways and that she has had a similar headache before. She believed that this current headache is a mild migraine. She noted her current headache to be very fast in onset. She stated it started over seconds but that all of her headaches have started over seconds. Her migraines come over minutes but take some time to reach maximal intensity they then wax and wayne. (sic) Additionally the pt. noted that near syncopal episode which occurred yesterday. The pt. felt vertiginous (has history of vertigo per pt.), diaphoretic and almost 'passed out.' At this time pt. noted she does not feel dizzy. No chest pain, sob or palpitations noted." (PX 4, P. 10)

Upon examining Petitioner's right shoulder, Dr. Nadim found that she exhibited decreased range of motion, tenderness, bony tenderness and deformity. She also exhibited no swelling, no effusion, no crepitus, no laceration, no pain, no spasm, normal pulse and normal strength. (PX 4, P. 13) Upon examining Petitioner's right hand, Dr. Nadim stated, in pertinent part and in bold type, the following: "**Pt has grossly normal range of motion in all major joints of the upper and lower extremities bilaterally**." (PX 4, P. 14)

X-rays of the right shoulder were interpreted as showing no acute fracture, but minimal to mild inferior displacement of the right humeral head as compared to glenoid. The axillary views were found to be suboptimal. A large focus of amorphous calcification measuring at least 2.2 x 1.2 cm. is noted in the superolateral aspect of the right humeral head, likely representing calcification in the supraspinatus tendon. There are no suspicious osseous lesions and partially visualized right lung is clear. (PX 4, Pp. 15-16)

Dr. Nadim's differential diagnosis was migraine complex, cva, rotator cuff tear, near syncope. (PX 4, P. 14) After reassessing Petitioner that day, Dr. Nadim diagnosed her with "Arm weakness, Arm pain right, Near syncope, Headache Nos." (PX 4, P. 18)

When Lauren Callahan, R.N., of Rush University Medical Center saw Petitioner on August 2, 2014 at 2:23 p.m., she wrote the following:

> "58 yo F, ambulatory to room with steady gait. Patient is Spanish speaking only; translator phone used for eval. Patient reports dizziness and HA x 1 day; denies any syncopal episodes, denies N/V. Patient also has c/o RUE pain, denies falls, denies injury to extremity. No gross deformities seen. PIV established, labs obtained, and sent as ordered. Will continue to monitor."
>
> (PX 4, P. 10)

Then, on August 2, 2014 at 3:35 p.m., in the Dept. of Internal Medicine, Resident History and Physical section, Anupama Ananth, M.D. (Attending Physician) and Lucy Y. Cho, M.D. (Resident – Original Note) indicated the following pertinent section of the History of Present Illness:

> "The patient is a 58 year old female with significant past medical history of chronic migrainous headaches and vertigo who presents with 10/10 shoulder pain and dizziness. Patient states the pain came on suddenly yesterday while she was out walking. It starts in her right shoulder and radiates to her hand. States that it feels like her arm is 'asleep.' Denies numbness/ tingling sensation in her arm/hand. Denies lifting anything heavy or trauma, but admits to lifting something heavy at work on Thursday. She has never had this kind of pain before. With regard to her dizziness, she states it feels similar to her prior episodes of vertigo with a sensation that the room is spinning. She did have some dizziness with her arm pain but does not feel that the two are related. She also states that her headaches have been progressively worsening for the last several years, but stable over the last few days ..."
>
> (PX 4, P. 21)

Examination of her right shoulder showed her right arm was internally rotated with very limited range of motion, and limited abduction of the right arm at the shoulder. (PX 4, P. 23)

Regarding her right shoulder pain, Dr. Ananth discussed with the orthopedic regarding possible etiologies of her pain. X-ray findings were consistent with chronic changes, possible adhesive capsulitis/frozen shoulder vs. tendinitis. Given acute onset of pain must consider rotator cuff tear. An MRI was ordered. (PX 4, P. 25)

Under ATTENDING ATTESTATION, Dr. Ananth stated that she had reviewed and agreed with Dr. Cho's note. Dr. Ananth then wrote her own chart note. She wrote that Petitioner was a housekeeper and noticed acute onset right shoulder pain after lifting some supplies. Dr. Ananth opined Petitioner possibly has rotator cuff injury or possibly has chronic tendinitis given the x-ray findings. However, Petitioner denied prior history of shoulder pain. X-rays were reviewed and discussed with orthopedics who will evaluate patient. MRI ordered. Pain control with Norco. (PX 4, P. 26)

On August 2, 2018 at 7:07 p.m., Resident Matthew Tetreault, M.D. in the Dept. of Orthopedic Surgery provided a consultation. He obtained a history that Petitioner is a 58-year-old right-handed housekeeper who presents with PMH notable for migraines and who p/w complaint of right shoulder pain. Patient states she was cleaning two days ago when she lifted a heavy object and felt some pain in her right shoulder. This pain seemed to dissipate, but she was walking around yesterday when her right shoulder pain returned and increased in severity. She endorsed pain radiating from her shoulder down the lateral aspect of her arm and had difficulty moving her arm. She took some Ibuprofen and her pain and movement improved, albeit temporarily. She then proceeded to the Rush ER for evaluation. Of note, the pain was accompanied by "acute on chronic migraine," and presyncopal symptoms for which she was admitted. Patient denies prior shoulder trauma or pain before lifting episode two days ago. (PX 4, P. 27)

Upon examining Petitioner's right upper extremity, Dr. Tetreault found, in pertinent part, the following:

"Skin cdi, no abrasions, lacerations, swelling
No erythema, no fluctuance
Tenderness to palpation circumferentially over
over glenohumeral joint.
No TTP over AC or SC joints.
Patient refuses to actively forward flex, abduct
or internally rotate shoulder 2/2 to pain.
Will externally rotate at side to 30 deg. Unable
to passively maintain forward flexion or abduction
of arm. Able to passively range shoulder to 175
deg forward flexion, 175 deg abduction, ER at
side to 50 deg, IR at side to L3, ER in abduction
to 90 deg, IR in abduction to 60 deg.
Full painless elbow, wrist, finger ROM.
No pain with short arcs of shoulder ..." (PX 4, P. 29)

Dr. Tetreault's impression was 58-year-old female with right shoulder pain after lifting heavy object, likely 2/2 rotator cuff pathology. No dislocation or fracture on imaging. She was to use a sling for comfort and follow-up with a sport specialist at Midwest Orthopedics at Rush. (PX 4, P. 30) A discharge summary of August 4, 2014 gives a final diagnosis of partial rotator cuff tear, calcific tendinitis, chronic migraine headaches, GERD. (PX 4, Pp. 30-31)

X-rays of the right elbow taken on August 2, 2014 were normal with no acute fracture or dislocations. (PX 4, P. 71)

Petitioner underwent an MRI of the right shoulder on August 3, 2014. The radiologist's impression is as follows: 1) large globular calcification within the subdeltoid

bursa overlying the distal supraspinatus tendon, consistent with calcium hydroxyapatite deposition disease. This is also seen on prior x-ray and appears stable in size. Moderate-sized subdeltoid bursitis. 2) mild tendinosis of distal supraspinatus and distal subscapularis without full thickness tear. No evidence of fatty atrophy or bulk loss; 3) intact labrum and glenohumeral cartilage. (PX 4, P. 33) Within the FINDINGS section of the actual MRI report, the radiologist also notes the following: "There is mild tendinosis of the distal supraspinatus as well as mild tendinosis in the distal subscapularis without evidence of full thickness or partial thickness tear." (PX 4, P. 73)

On August 4, 2014, Dr. Tetreault reviewed this MRI and agreed that there is no evidence of a cuff tear. He diagnosed Type II calcific tendinitis. He recommended rotator cuff strengthening, pain control with anti-inflammatories and outpatient follow-up with Midwest Orthopaedics at Rush. (PX 4, P. 48)

On August 14, 2014, Petitioner followed up at Rush University Medical Center. (PX 4, P. 180) She presented as a 58-year-old Spanish-speaking female with past medical history significant for migraine headaches, anxiety/depression, hypothyroidism, and palpitations who presents for evaluation of her right shoulder. Regarding her shoulder, she has been in a sling since being admitted on August 2 through August 4, 2014, and stated she could barely move her arm secondary to pain. She has been unable to do her job as a housekeeper. She has undergone an MRI of her shoulder, but has also had presyncope workup including CT of the brain that demonstrated an aneurysm, and she was to continue following up with neurology. On examination of her right shoulder, she had discomfort with minimal passive or active motion. The physician, Dr. Abrams, expressed concern for a frozen shoulder. She was given Norco and referred to Dr. Nicholson at Midwest Orthopaedics. (PX 4, P. 183) She was prescribed physical therapy.

On August 20, 2014, Petitioner followed up at Rush. She underwent a shoulder evaluation by Physical Therapist Mizera. (PX 4, P. 200) She presented for physical therapy and a program was outlined of two times per week for six weeks.

Petitioner was seen again at Rush on September 4, 2014. (PX 4, P. 209) This was a physical therapy appointment for her arm and she reported "*the pain is a little better*". (PX 4, P. 215)

Petitioner underwent further physical therapy on September 9, 2014 and reported her shoulder feels "*more better*" and she inquired about returning to work, and noted her work duties included sweeping, mopping, and washing walls. (PX 4, P. 225)

Petitioner underwent further physical therapy on September 12, 2014 and advised that her insurance was not calling her back so she was not able to make a doctor appointment. She wished to return to work. (PX 4, P. 235) The therapist noted difficulties she was having with the exercises and that this might limit her performance at work.

On September 16, 2014, at a physical therapy session, Petitioner related that she was able to talk to a social worker and "*work out details on her work injury documentation. Per patient, in her emergency room documentation, it is not written that her injury was at work. Once this is fixed, she will be able to submit this to her work.*" (PX 4, P. 246)

Petitioner returned for physical therapy on September 19, 2014, and the progress note reads "*patient reports that the paperwork has been changed from the E.D. to note that her injury occurred at work.*" She said her shoulder was moving more but is very stiff and painful in the morning. (PX 4, P. 256)

Petitioner underwent further physical therapy on September 23, 2014 and reported her shoulder is feeling better and does not feel as tight and she can move with less pain. (PX 4, P. 266) The assessment was that she was progressing with strengthening well with no reports of pain during advancing exercises.

Petitioner returned to physical therapy on September 26, 2014, and reported that her shoulder continues to feel better and she only has a little pain in the muscles with certain motions. (PX 4, P. 275)

On September 30, 2014, Petitioner returned to physical therapy and reported that she had been feeling pretty good, but then went to the grocery store on Saturday and lifted a lot of bags at once, and consequently has had pain in the shoulder ever since. (PX 4, P. 285)

Petitioner returned to physical therapy on October 9, 2014 and reported her shoulder in the front is rigid and a little painful. She was advised to make an appointment with an orthopedic doctor to get cleared for return to work. (PX 4, P. 295)

Petitioner returned to physical therapy on October 21, 2014 and reported she could not make an appointment with an orthopedic doctor, and said her shoulder feels good sometimes and other times not. (PX 4, P. 304)

On October 23, 2014, she advised the physical therapist that she was feeling much better and feels like she can use her shoulder much more. She advised she really wants to return to work but does not feel strong enough. She was encouraged to continue with her home exercise program daily. (PX 4, P. 313) The assessment that day indicated that since attending therapy, she has gained significant strength and functional use of her right upper extremity and therefore she was discharged and was to perform a home exercise program on a daily basis. (PX 4, P. 314)

On October 24, 2014, Petitioner saw Michael M. Hanna, M.D., an internist at Rush. He recorded the following HPI:

> "Pt. here with right dominant shoulder pain since an injury at work 7/30/14. She notes she was lifting supplies and her cart started to fall and she jerked her right arm to catch it causing severe pain. She went to the ER due to severe pain and limited ROM, had an MRI showing calcific tendonitis and was discharged with home PT. She notes her pain and ROM have both improved some. Currently, she notes her pain is 6/10, sharp, located anterolaterally, pain is

worse with motions behind her back and above her head, no known dislocation in past or prior shoulder pain. She is using ibuprofen for pain, works in housekeeping and wants to return to work." (PX 4, P. 323)

Dr. Hanna reviewed the MRI report and the lab results and conducted a physical examination of Petitioner. He then formulated an assessment and plan: (1) right shoulder pain consistent with calcific tendonitis (2) discussed options at this point, will proceed with subacromial bursa injection today, post procedure ROM and impingement tests improved (3) discussed possibility of US guided barbotage of calcific tendonitis in future based on response (4) continue home exercise program at least three times weekly, apply ice, and (5) return to clinic in six to eight weeks. (PX 4, P. 325) Dr. Hanna proceeded that day with a subacromial bursa injection. (PX 4, Pp. 325-326)

Dr. Hanna authored a "TO WHOM IT MAY CONCERN" note dated October 24, 2014 in which he indicated that he saw Rosa Ortiz in his office that day and he released her to return to her regular work duties on October 29, 2014. (PX 4, P. 326)

There is a note dated October 30, 2014 that reflects a phone call from Petitioner in which she requests a letter from Dr. Hanna that states she can only do light-duty work, and that she returned to work this week and was not able to do her regular job of mopping and cleaning glass. (PX 4, P. 354) It does not appear that she was seen by Dr. Hanna that day.

Dr. Hanna authored a "TO WHOM IT MAY CONCERN" note dated October 30, 2014 in which he indicates Petitioner was seen on October 24, 2014 and was released to return to work with a 10-pound lifting restriction and limited overhead activities. (PX 4, P. 327)

There then appears another "TO WHOM IT MAY CONCERN" note dated October 30, 2014 and authored by Dr. Hanna in which he stated that he saw Rosa Ortiz in his

office on October 24, 2014. He then stated that she is released to return to work on November 2, 2014 with a 10-pound lifting restriction and limited overhead activities. (PX 4, P. 355)

On October 30, 2014, Petitioner followed up with neurologist Dr. Amin at Rush regarding her headaches. (PX 4, P. 344) She related she still has "*noises in head*" and "*lights*" and feels down and sad about her chronic headache and wants to apply for disability. She reported headaches on 15 out of 30 days a month. Dr. Amin opined her headache control as suboptimal and likely affected by her depression, and he ordered an MRI of her brain.

On November 13, 2014, Petitioner was seen at Cook County (John H. Stroger, Jr.) Hospital. (PX 5, P. 543) There is no indication as to the purpose of the visit.

On November 24, 2014, Petitioner presented again at Rush University Medical Center and was seen by Dr. Goldberg with regard to irregular menses. (PX 4, P. 378)

An MRI of the brain dated November 25, 2014 was interpreted as showing no acute intracranial abnormality and an MR angiogram was found to be unremarkable. (PX 4, P. 395)

On December 3, 2014, Petitioner was seen in the emergency room for post-menopausal bleeding. She followed up on December 16, 2014. (PX 4, P. 459)

Lawrence Lieber, M.D., conducted an IME at the request of Respondent on December 17, 2014. Following a review of records and an examination, Dr. Lieber diagnosed her with rotator cuff syndrome, partial rotator cuff tear, calcific bursitis, AC joint arthritis of the right shoulder. He opined it does appear that an incident occurred on July 31, 2014 to her right shoulder. However, he opined that she has significant pre-existing abnormalities in the right shoulder which were neither caused, aggravated, nor associated with the July 31, 2014 event. These pre-existing conditions include AC joint arthritis,

calcific tendinitis, bursitis, as well as partial rotator cuff tearing. He specifically reviewed the MRI images in coming to this conclusion. He felt her current complaints were related to the pre-existing abnormalities, which could have become symptomatic with activities of daily living. He felt the incident of July 31, 2014 did not represent a significant traumatic event to the right shoulder. Dr. Lieber opined she had reached maximum medical improvement from the July 31, 2014 accident and no further treatment was needed and that she was capable of full-duty employment. He did not feel her admission to Rush Hospital for two days was medically reasonable or related to the July 31, 2014 event.

On January 2, 2015, Petitioner presented to Dr. Hanna for follow-up regarding her right shoulder. (PX 4, P. 465) She reported improvement since her last visit on October 24, 2014 when she underwent the subacromial bursa injection. She reported her pain at rest was 1/10 and with movement or lifting 6/10. She was working modified duty of no lifting more than 10 pounds with the right arm. (PX 4, P. 471) Dr. Hanna assessed her with right shoulder pain improved some after physical therapy, injection and home exercise program, but still symptomatic with activity and unable to complete all of her work duties. He ordered an updated MRI to investigate possible rotator cuff tear. He instructed her to continue with HEP and ice. (PX 4, P. 472) He authored a work status note dated January 2, 2015 in which he gave her a 10-pound lifting restriction and limited overhead activities. (PX 4, P. 473)

On January 21, 2015, Petitioner underwent a gynecological examination to investigate her abnormal uterine bleeding. (PX 4, P. 486)

On February 5, 2015, Petitioner returned to neurology for follow-up regarding her migrainous headaches. She reported a more electric pain in the side of her head that occurs throughout the day. (PX 4, P. 505) The assessment was chronic migrainous headaches, likely affected by depression/anxiety. (PX 4, P. 507)

On February 5, 2015, Petitioner was seen at Cook County psychiatry (PX 5, P. 535)

On April 6, 2015, Petitioner was seen in outpatient psychiatry at Cook County Hospital (PX 5, P. 519) with the discharge diagnosis of major depressive disorder.

On May 11, 2015, Petitioner presented with chest pain with pressure and symptoms of elevated blood pressure for the past three weeks. (PX 4, P. 521) She underwent an EKG that was found to be normal.

On May 17, 2015, Petitioner underwent a mammogram. (PX 4, P. 532)

On June 4, 2015, Petitioner saw Dr. Amin in neurology. (PX 4, P. 541) She reported still having sharp, burning headaches, left sided. The assessment was chronic headaches affected by depression/anxiety.

On June 24, 2015, Petitioner was seen at Cook County Hospital and underwent blood work. (PX 5, P. 514)

On July 6, 2015, Petitioner was seen at Cook County Hospital with complaints of a sore throat. (PX 5, P. 481)

On July 31, 2015, Petitioner was seen at Cook County Hospital and presented with complaints of increased urinary frequency, dysuria, supra pubic pain. (PX 5, P. 462)

On September 4, 2015, Petitioner was seen at Cook County Hospital presenting with lower abdominal pain for one-and-a-half months and increased urinary frequency. (PX 5, P. 441)

On September 28, 2015, Petitioner returned to the neurology department at Rush University Medical Center regarding her headaches. (PX 4, P. 625)

On October 5, 2015, Petitioner was seen at Cook County Hospital and her discharge diagnosis was major depressive disorder (PX 5, P. 433)

On October 26, 2015, Petitioner presented at Cook County Hospital and underwent an ultrasound of the pelvis. (PX 5, P. 403)

On March 9, 2016, Petitioner was seen at Cook County Hospital at which time she stated that she has back pain and pain in her right arm of a chronic nature. (PX 5, P. 374) The diagnosis was chronic pain in shoulder. X-rays of the right shoulder showed no acute osseous abnormalities.

On March 23, 2016, Petitioner was seen at Cook County Hospital by Dr. Mohiuddin (PX 5, P. 355) She presented for follow-up for shoulder pain, indicating she has had pain for about two years after lifting a heavy object. She had therapy two years ago and has had injections with good help. The diagnosis included rotator cuff impingement syndrome and brachial plexopathy.

On April 14, 2016, Petitioner was seen at Cook County Hospital with complaints of abdominal pain. (PX 5, P. 332)

On June 2, 2016, Petitioner was seen by Steven Clar, M.D., at Cook County Hospital. (PX 5, P. 317) He wrote that she presented with a two-year right shoulder pain due to lifting a heavy container at work. She was status post occupational therapy this year without much relief. She said she had an injection at Rush, and that she only has pain with activity, not at rest. X-rays were taken of the right shoulder and no acute osseous abnormalities were identified. The diagnosis was rotator cuff impingement syndrome. Petitioner was to return next week with her previous MRI disc.

On June 8, 2016, Petitioner was seen by Dr. Clar at Cook County Hospital. She presented for an appointment to review the MRI and had brought the disc, but they had trouble loading the disc. (PX 5, P. 304)

On June 10, 2016, Petitioner was seen by Dr. Clar at Cook County Hospital. (PX 5, P. 291) She presented in follow-up for MRI review, but again, the disc of the MRI failed to load.

On June 15, 2016, Petitioner was seen by Dr. Clar at Cook County Hospital. She presented for review of right shoulder MRI. (PX 5, P. 278) Dr. Clar wrote the MRI demonstrated localized, circumscribed, low signal intensity region on T1 and T2 distal supraspinatus tendon-probable fibrous scarring, unlikely calcification as it was not seen on plain film. Patient was feeling better and pain was minimal. She was to continue with physical therapy, home exercise program and return in three months.

On June 22, 2016, Petitioner presented at Cook County Hospital for follow-up of complaints of headache and neck pain. (PX 5, P. 254)

On July 27, 2016, Petitioner was seen by Dr. Chuck and Dr. Warrior at Cook County Hospital for a consultation regarding her headache complaints. (PX 5, P. 238)

On September 14, 2016, Petitioner was seen by Dr. Clar at the Cook County Hospital in follow-up for right shoulder pain. (PX 5, P. 224) He reviewed the MRI to show a thickened likely fibrous distal supraspinatus tendon with some surrounding fluid, likely chronic tendinitis with possible acute component. She was pain free at rest but noted mild discomfort with ABD, or, putting her arm behind her back. Petitioner wished to defer an injection and would continue with the home exercise program. She was to return in two months for re-evaluation.

On October 19, 2016, Petitioner was seen at Cook County Hospital for follow-up regarding her headaches. (PX 5, P. 205)

On October 26, 2016, Petitioner was seen at Cook County Hospital by Dr. Warrior regarding her headaches. (PX 5, P. 186)

On November 16, 2016, Petitioner was seen at Cook County Hospital by Dr. Clar. (PX 5, P. 162) Petitioner underwent an aspiration procedure of her shoulder.

On November 30, 2016, Petitioner was seen of Cook County Hospital with complaints of a cough and chest pain for the past 10 days. (PX 5, P. 140)

On January 11, 2017, Petitioner was seen in the emergency room of Cook County Hospital with complaints of left eye problems. (PX 5, P. 91)

On February 1, 2017, Petitioner presented to Dr. Mohiuddin at Cook County Hospital for follow-up of upper and lower abdominal pain for the past six months. (PX 5, P. 108)

On February 8, 2017, Petitioner was seen at Cook County Hospital. She underwent an EKG that was found to be negative for ischemia. (PX 5, P. 80)

On February 22, 2017, Petitioner presented to Dr. Clar at Cook County Hospital. (PX 5, P. 45) She presented for follow-up of right shoulder impingement. She reported 50% relief with subacromial injection in November. Pain is only with lifting or moving her arm in certain positions and she reported no pain at rest. MRI previously reviewed showing second, likely fibrous distal supraspinatus tendon with some surrounding fluid, likely chronic tendinitis with possible acute component. The diagnosis was acromioclavicular joint pain. She was given a Kenalog injection.

On March 29, 2017, Petitioner was seen at Cook County Hospital by Dr. Warrior. (PX 5, P. 20) She complained of a headache and felt that her headaches have worsened since her last visit.

On May 17, 2017, Petitioner to Cook County Hospital for her right shoulder pain and fibrous/thickened supraspinatus tendon. She was status post subacromial and AC joint injections and status post occupational therapy and home exercise program. She

reported pain at night and feeling weaker. (PX 5, P. 6) The diagnosis was chronic pain in shoulder; she was referred for orthopedic evaluation and was to continue her home exercise program. (PX 5, P. 7)

Testimony of Lawrence Lieber, M.D.:

Dr. Lieber testified on October 4, 2017. He is a board-certified orthopedic surgeon who performs five to fifteen surgeries per week. (RX 1, P. 6)

Dr. Lieber testified to the history Petitioner provided of attempting to keep a cart from falling over at work on July 31, 2014. (RX 1, P. 8) In addition to conducting a physical examination of Petitioner, Dr. Lieber reviewed the MRI films and report, as well as the Rush records for her admission between August 2 and August 4, 2014. (RX 1, P. 11)

Dr. Lieber testified that he noted significant abnormalities of pre-existing AC joint arthritis with calcification in the subdeltoid bursa as well as mild degenerative tearing of the supraspinatus and subscapularis. (RX 1, P. 11) In reviewing the films, he did not see evidence of an acute injury. His diagnosis was rotator cuff syndrome, partial rotator cuff tear, calcific bursitis, AC joint arthritis. (RX 1, P. 12)

Dr. Lieber testified that objectively he did not believe she sustained any injury on July 31, 2014, although subjectively she believes she hurt her shoulder at the time. (RX 1, P. 12) He felt that her symptoms and positive findings were related to the pre-existing abnormalities he could see on the MRI. He did not believe there was a causal connection between her current condition of the shoulder and the accident. (RX 1, P. 13)

He explained that the MRI performed three days after the event showed only pre-existing degenerative abnormalities and no evidence of any acute soft-tissue or bony injury. (RX 1, P. 13) Dr. Lieber explained that calcific bursitis is a degenerative process within the bursa and the rotator cuff tendon in which calcium develops due to chronic wear and the body's reaction to it. (RX 1, P. 14) Dr. Lieber further described the AC joint arthritis he viewed on the films as a degeneration of cartilage that occurs over time and

is a long-standing degenerative process and there was no evidence of acute bone edema or bone injury that may have caused this. (RX 1, P. 15) Dr. Lieber further explained that a partial rotator cuff tear as seen here is a degenerative process over time. He recognized that an acute injury can cause a partial rotator cuff tear, but if that did occur, there should have been significant swelling, bleeding and edema about the rotator cuff tear, which there was not. He only saw isolated rotator cuff tendinitis and degeneration of a chronic nature. (RX 1, P. 16) He opined that her degeneration could become symptomatic with activities of daily living. (RX 1, P. 16)

Not only did he see no evidence that the specific event of July 31, 2014 had any causal relationship to her current condition, but also, he saw no evidence that anything about her employment over time was causally related. (RX 1, P. 18)

Dr. Lieber opined she had reached MMI by the time he saw her and that she was capable full-duty work. (RX 1, P. 18) He felt that, at best, based upon the MRI showing no evidence of any acute event, but still with shoulder complaints, she may have required off work status for two weeks because of her subjective complaints. (RX 1, P. 19) Dr. Lieber specifically opined she did not require the multi-day hospitalization with respect to her shoulder injury. (RX 1, P. 19) He felt that getting the initial MRI was reasonable, and two to four weeks of physical therapy or conservative treatment after the accident. (RX 1, P. 20)

Dr. Lieber reviewed updated records from Dr. Hanna and Cook County Hospital, and stated that they did not change his opinions. (RX 1, P. 21) He also stated that his own diagnosis of a chronic shoulder abnormality with calcific deposition and bursitis tendinitis would be consistent with her seeking intermittent medical treatment as she did. (RX 1, P. 22)

On cross-examination, Dr. Lieber agreed that there was a work accident, but no injury. He further testified that although she had an accident, there is no objective evidence that an isolated injury occurred to her shoulder. (RX 1, P. 23) He testified that

there is nothing he can point to show that pre-existing abnormalities were causing pain prior to the work injury. (RX 1, Pp. 27-28) He agreed with Petitioner's counsel that up until the accident, Petitioner was able to perform her normal work duties without restrictions. (RX 1, P. 28) Dr. Lieber found no objective evidence that the event did anything to her shoulder. (RX 1, P. 31) The objective evidence is degenerative, not acute. (RX 1, P. 31) He did not feel that the injury was significant enough to cause continued symptoms for six months. (RX 1, P. 34) He opined that the MRI of August 2014 shows no evidence of acute injury or abnormality within the shoulder that can be associated with the alleged event. Dr. Lieber pointed out that Dr. Hanna is an internist, whereas Dr. Lieber is an orthopedic surgeon. As such, Dr. Hanna would not have the same training in the musculoskeletal system and its underlying abnormalities and would not have seen anywhere near as many patients as Dr. Lieber has for musculoskeletal problems. (RX 1, P. 48)

On redirect examination, Dr. Lieber testified that given the fact Petitioner underwent conservative care for a brief period of time after the accident, and given that she felt much better, and given she was then carrying groceries and felt greatly increased pain, that that would support his opinion that her condition was such that she was susceptible to injury or aggravation from activities of daily living. (RX 1, P. 50)

On recross examination, Dr. Lieber testified that symptoms can increase and decrease, that sometimes one may feel pain relief and other times the pain gets bad again. (RX 1, P. 53)

Testimony of Charles Carroll, M.D.:

Following his graduation from medical school, Dr. Carroll completed a fellowship in upper extremity orthopedics at Indiana Hand Center. He is board-certified in orthopedic surgery (RX 2, P. 5) and an upper extremity specialist. (RX 2, P. 6) Dr. Carroll performs six to twelve surgeries per week, of which five to ten of those surgeries per month are shoulder surgeries. (RX 2, P. 7)

Dr. Carroll initially conducted a records review and opined in his report that she sustained a strain to her shoulder with degenerative issues with impingement, acromioclavicular arthritis, and calcific bursitis. (RX 2, P. 11) He stated at the time of his records review that he felt her shoulder strain would have resolved over a three-to-six-month period, but that the other diagnoses were degenerative in nature and were not caused or aggravated by the incident. (RX 2, P. 11-12) He testified the fact that she was 61 years old was a risk factor for degenerative conditions, and that the acromioclavicular arthritis can be a source of pain and can be a source of rotator cuff disease as well as calcific bursitis. (RX 2, P. 12)

Dr. Carroll testified that at the time of his records review he felt it was reasonable for her to have some shorter-term restrictions from her strain, but he did not think she would require permanent or long-term restrictions relative to the strain. (RX 2, P. 13) Although he felt an injection that had been suggested for her calcific tendinitis was reasonable, it would not be related to the accident. (RX 2, P. 13-14)

Dr. Carroll then went on to conduct an independent medical examination of Petitioner on June 12, 2017. He testified that she gave three histories of accident. She initially said she was carrying buckets, then she said she was pushing and pulling on buckets to prevent them from falling, and finally she stated that she was moving materials and a container started to flip and she tried to grab it with her right arm. (RX 2, P. 16)

Her pain was more in the superior and posterior of the shoulder rather than the anterior, where you typically see rotator cuff pain. (RX 2, P. 18)

Dr. Carroll explained what calcific tendinitis is and opined that it is degenerative and was not caused or aggravated by the accident which caused her strain. (RX 2, P. 20-21) Dr. Carroll took his own x-rays of Petitioner, which he said revealed acromioclavicular arthritis. (RX 2, P. 21) He did not find evidence of calcific bursitis, which he felt meant the calcific bursitis had resolved by the time of his examination, but found she still had acromioclavicular arthritis and secondary impingement. (RX 2, P. 21)

Dr. Carroll testified that the arthritic changes in the acromioclavicular joint were not related to her accident. (RX 2, P. 21) He testified that she had sustained only a strain to her right shoulder and that the calcific bursitis, rotator cuff disease, and impingement were not related to the work accident. (RX 2, P. 22) He further opined that these conditions were neither aggravated nor accelerated by the accident. He summarized by stating he felt she did have her shoulder pulled, which could have strained her rotator cuff, but would not have caused a rotator cuff tear nor the arthritis. The calcific bursitis was the source of her impingement and not the injury in question, and the injury did not cause the calcific bursitis. (RX 2, P. 22-23) She reached maximum medical improvement for her strain, but did not come to maximum medical benefit for her impingement or arthritis of the acromioclavicular joint. RX 2, P. 23) He felt the calcific bursitis had resolved.

Dr. Carroll testified that he agreed with her full-duty release as of October 29, 2014. (RX 2, P. 23)

Regarding reasonable medical care, Dr. Carroll testified he would relate the physical therapy and injections to the strain, but would not relate the care for her calcific bursitis or for her hospitalization to the injury in question. (RX 2, P. 24)

On cross-examination, Petitioner testified that he can agree with Petitioner's counsel that Petitioner had a work accident. (RX 2, P. 25) Dr. Carroll was aware that Dr. Hanna found that Petitioner's medical condition is a result of her work injury. (RX 2, P. 27) Dr. Carroll believed that Dr. Nicholson examined Petitioner and established a causal connection between Petitioner medical condition and the work injury. (RX 2, P. 29) Dr. Carroll agreed that his own opinion differs and found that Petitioner suffered a strain for which she received treatment. (RX 2, P. 29) Such strain would have resolved over a period of time in and of itself. (RX 2, P. 29)

Dr. Carroll testified that it is not correct to say that a rotator cuff tear is typically related to a traumatic accident and stated that the most common cause of impingement in rotator cuff disease is a degenerative condition. (RX 2, P. 30) Degeneration is from the

wear and tear of life based on blood flow changes in the rotator cuff. Dr. Carroll explained to Petitioner's attorney that impingement is a manifestation of rotator cuff disease and that initially one has discomfort, then there could be partial tearing, and finally there could be a complete tear. (RX 2, P. 31) Partial tearing is more due to degenerative conditions than to a traumatic accident. (RX 2, P. 31)

Dr. Carroll explained that Petitioner had a pre-existing degenerative condition in her acromioclavicular joint and that she is of the age that a degenerative phenomenon would occur. He did not believe that the injury in question would have caused a tear or aggravated a tear. (RX 2, P. 32) He allowed that if she had no arthritis and were not older, his opinion might be different, but given the fact she was 61 and has arthritis, he does not believe the accident caused her rotator cuff disease. (RX 2, P. 33) Dr. Carroll testified the accident would have caused a strain or irritation of the rotator cuff, but not an aggravation. (RX 2, P. 33-34)

Dr. Carroll testified that Petitioner was released to return to work around October 24th, and did return to work by the end of the month, so he felt at that point her strain should be considered resolved. (RX 2, P. 38)

Dr. Carroll testified that Petitioner had undergone an injection five months after his initial records review report, which appeared to eliminate any need for surgery. (RX 2, P. 40)

On redirect examination, Dr. Carroll carefully reviewed the MRI report from August 2014, considered each of the findings and whether they were acute or traumatic, and summarized by stating that the tendinitis is the one thing the MRI shows as well as the calcific bursitis. Also, he noted that the radiologist found tendinosis of the distal supraspinatus, which is consistent with impingement. The radiologist does not find a full thickness tear. The radiologist also comments that there is no evidence of a partial thickness tear of the supraspinatus or the scapularis. So that would indicate more of a tendinitis. It might be consistent with a strain. The radiologist also found that the labrum

and glenohumeral cartilage, which are the suction cup and the cartilage, are normal (RX 2, P. 48)

Medical Bills:

At trial, Petitioner attached to Arbitrator's Exhibit #1 a summary of the unpaid medical bills as referred to in section seven of AX 1. Such attachment reflects the following: Rush University Medical Professional, $220.00 (8/2/14-9/29/15); Rush University Hospital, $2,772.00 (8/2/14-9/28/15); Cook County Hospital, $2,403.68. (4/21/16- 6/23/17) These three amounts add up to $5,395.68. Additional billing statements of various dates from various providers, with no indications of conditions for which she was treated, were also offered into evidence.

CONCLUSIONS OF LAW

In support of his decision with regard to issue (C)"Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator concludes as follows:

Eighteen days before trial, Petitioner filed an Amended Application for Adjustment of Claim in which she alleged that repetitive trauma was the mechanism of the injury to her right shoulder and that July 31, 2014 was the accident, or manifestation, date. Over Respondent's objection, the Arbitrator granted Petitioner's oral motion to amend the Application for Adjustment of Claim.

The Arbitrator notes that an Amended Application for Adjustment of Claim actually *replaces* an Application for Adjustment of Claim.

Despite the Amended Application, Petitioner clearly testified that her right shoulder pain and problems did not stem from her work activities for Respondent over a period of time, but from a single traumatic injury that she claims took place at work on July 31, 2014.

Not one of Petitioner's treating physicians has offered an opinion that Petitioner sustained a repetitive trauma accident or that her right shoulder condition was caused by repetitive trauma due to her employment activities. Petitioner did not offer such opinions by an examining physician. Although Petitioner testified that she worked eight hours a day/five days a week and generally described her duties for Respondent, she did not testify in any detail as to her work activities, for example, the amount of time she spent each workday performing overhead work. Both of Respondent's IMEs opined that Petitioner did not sustain a repetitive trauma injury.

As such, given that Petitioner did not provide a medical opinion that she sustained a repetitive trauma injury to her right shoulder while working for Respondent, and given that Petitioner did not offer more detailed testimony about her work activities, the Arbitrator finds that she failed to prove she sustained a compensable repetitive trauma injury at work that manifested itself on July 31, 2014.

Furthermore, the Arbitrator finds that Petitioner failed to prove that she sustained a single traumatic injury at work on July 31, 2014. The Arbitrator finds that Petitioner is simply not credible.

At trial, Petitioner testified that on July 31, 2014, she felt pain in her right shoulder after she quickly tried to pick up a supply container with her right hand and then pulled on the container.

However, the first two histories Petitioner gave, to Dr. Nadim and Nurse Callahan on August 2, 2014 at 12:44 p.m. and 2:23 p.m., respectively, are inconsistent with Petitioner's testimony. Each took a history with the aid of a Spanish interpreter. In the first history, Petitioner denied a history of trauma and told Dr. Nadim that the onset of her right shoulder pain was at 1:00 p.m. on August 1, 2014. In the second history, Petitioner denied, to Nurse Callahan, an injury to her extremity. The Arbitrator gives great weight to these earliest histories.

In later histories that day, she allegedly reported on August 2, 2014, that she lifted something heavy at work or lifted some supplies. It was not until October 24, 2014 that she gives a detailed history of accident to a doctor that is consistent with her testimony. She told Dr. Hanna that on July 30, 2014, a cart at work was starting to fall and she jerked her right arm to catch it or to lift it.

Through a Spanish interpreter, Petitioner gave three different histories of accident to Dr. Carroll: she initially told him she was carrying buckets, then she told him she was pushing and pulling on buckets to prevent them from falling, and finally she told him that she was moving materials and a container started to flip and she tried to grab it with her right arm.

Although Dr. Carroll testified that there was an accident on July 31, 2014, the Arbitrator notes that Dr. Carroll is not in the best position to determine if an accident occurred. Dr. Carroll has obviously not considered the totality of the evidence.

The Arbitrator notes that Dr. Carroll kept referring to Petitioner as being 61 years of age at the time of accident when she was, in fact, 58 years old at the time. (AX 1)

Dr. Lieber examined Petitioner, reviewed the MRI films and report, and the Rush University Medical Center records for her August 2-4, 2014 admission. Dr. Lieber placed great weight on the MRI films of August 3, 2014, as well as the report, which he found did not show evidence of an acute injury. Dr. Lieber testified that, objectively, he did not believe Petitioner sustained any injury on July 31, 2014, although, subjectively, she believes she hurt her shoulder on that date.

Dr. Lieber agreed that there was a work accident, but no injury. He further testified that although she had an accident, there is no objective evidence that an isolated injury occurred to her shoulder. The Arbitrator notes that Dr. Lieber is not in the best position to determine if an accident occurred as he has obviously not considered the totality of the evidence.

When Dr. Nadim examined Petitioner's right shoulder around 12:44 p.m. on August 2, 2014, he found, *inter alia*, that she had no pain and normal strength. Fewer than three hours later, however, Petitioner complained to Dr. Cho/Dr. Ananth of 10/10 shoulder pain.

The physical therapy record of September 16, 2014 indicates that Petitioner spoke to a social worker to "*work out details on her work injury documentation. Per patient, in her emergency room documentation, it is not written that her injury was at work. Once this is fixed, she will be able to submit this to her work.*"

The physical therapy record of September 19, 2014 indicates: "*patient reports that the paperwork has been changed from the E.D. to note that her injury occurred at work.*"

At trial, with regard to the physical therapy records of September 16 and 19, 2014, Petitioner denied that she made those statements.

Significantly, the Arbitrator finds the fact that Petitioner changed her pleadings with regard to mechanism of injury from a single traumatic event to repetitive trauma 2½ weeks before the trial - - and then denied such claim at trial - - further undercuts her credibility.

The most recent record in PX 5 is dated May 17, 2017. On that date, Petitioner went to Cook County Hospital with right shoulder pain, and a fibrous/thickened supraspinatus tendon. She was status post subacromial and AC joint injections and status post occupational therapy and home exercise program. She reported pain at night and feeling weaker. She was given a diagnosis of chronic pain in shoulder, was referred for an orthopedic evaluation and was to continue her home exercise program.

Petitioner testified that her doctors at Cook County Hospital have prescribed and have scheduled right shoulder surgery, but was unable to produce a treating record or report to support such claim, despite the fact that she was given ample opportunity to do so. On October 24, 2014, Dr. Hanna of Rush University Medical Center discussed and

considered an ultrasound-guided barbotage of her calcific tendinitis. There is no documentary evidence since that time that any physician has prescribed and scheduled surgery for Petitioner's right shoulder.

The Arbitrator finds that Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment by Respondent on July 31, 2014.

Compensation is hereby denied. All other issues have been rendered moot.

Brian T. Cronin
Arbitrator

10-4-2018
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

FRANK RUFFOLO,

Petitioner,

vs.

NO: 11 WC 034882

CITY OF CHICAGO,

19IWCC0567

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, after considering the issues of causal connection, temporary total disability (TTD) benefits, permanent partial disability (PPD) benefits, and nature and extent of disability, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and reinstates the stipulation entered into by the parties at hearing that Petitioner is entitled to TTD benefits commencing August 11, 2011 though May 17, 2013. The Commission further finds that Petitioner is entitled to TTD benefits through June 26, 2013. As to PPD benefits, the Commission awards twenty percent (20%) loss of use of the person as a whole.

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 medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties and reverses the Decision of the Arbitrator for the reasons stated below.

Petitioner began employment with the City of Chicago in 1988 as a stationary fireman. The job description entered into evidence indicates that the job requires lifting up to 80 lbs., the ability to quickly reach out with the arms, the ability to use the hands and arms to grasp and

manipulate objects, and the ability to operate hand tools, power tools and equipment. In addition to his employment with Respondent, Petitioner testified that he owned three restaurants which are managed and operated by his wife, son and a paid employee. Petitioner testified that he did not himself work at the restaurants. There is no evidence that Petitioner did work in the restaurants.

On August 10, 2011 Petitioner was descending a flight of stairs doing his rounds and tripped, falling down a number of stairs, hitting various parts of his body. Petitioner was transported by ambulance to the emergency department at Resurrection Medical Center. A CT scan of the cervical spine was performed showing anterior and posterior osteophytes at C5, C6 and C7. Disc herniations could not be ruled out. A future MRI scan was to be considered "if indicated". The issue of accident was not disputed by Respondent.

Petitioner testified that he had MRIs of his neck and back performed in 2010 but required no continued medical treatment thereafter and was working full duty at the time of the subject work accident. He testified that he had no problems with his neck or back prior to the accident. On August 10, 2010 Petitioner went to MercyWorks, the City's occupational health clinic, and was diagnosed with a contusion and strain of the of the cervical and thoracolumbar spine, left shoulder and right knee. He was taken off work and instructed to return to the clinic on August 17, 2011 for follow up.

On August 12, 2011 Petitioner consulted Dr. Pierro, his primary care physician at Northwestern Medicine. Petitioner reported 8/10 back pain, right side greater than left with radiation to the legs. Petitioner's history reflects displacement of the left C6-7 disc with mild to moderate stenosis based upon a June 2010 cervical MRI. In December 2010 lumbar disc disease was diagnosed with left lateral disc bulge and foraminal stenosis. Dr. Pierro's records describe Petitioner as having had a known history of lumbar spine disease with worsened pain due to a fall. She noted that petitioner was unable to tolerate NSAIDs, having had gastric bypass surgery and prescribed Medrol Dosepak and Tramadol. The plan was for Petitioner to have a repeat MRI if his symptoms were not improved in 6 weeks.

Petitioner attended physical therapy from August 8, 2011 through September 8, 2011. He was seen at Mercyworks on September 8, 2011 and released to return to work full duty by Dr. Sheth. On September 9, 2011 Petitioner returned to Dr. Pierro reporting that his symptoms of cervical and lumbar radiculopathy were not improving. Dr. Pierro ordered repeat MRIs of the cervical and lumbar spine and added Neurontin.

Later in the day on September 9, 2011 Petitioner returned to MercyWorks and was continued off work and directed to return to clinic on September 19, 2011 by Dr. Bartolme. On September 19, 2011 Dr. Bartolme continued Petitioner off work until further notice.

On September 29,2011 Petitioner had repeat lumbar and cervical MRIs performed on order of Dr. Pierro which revealed cervical spondylosis, mild spinal canal stenosis and mild to

moderate foraminal stenosis, greater on the left side due to osteophyte complex at C6-7, bilateral foraminal stenosis at C3-4 and central disc bulge at C4-5 and C5-6 with effacement of the thecal sac. The lumbar MRI revealed moderate left lateral/ foraminal disc bulge and moderate left foraminal stenosis at L4-5. The radiology reports reflected that comparisons were made to the 2010 MRIs and no significant interval changes were noted to either the cervical or lumbar spine studies.

Dr. Pierro referred Petitioner to NWMH Anesthesiology Pain Management where he was evaluated and it was determined that Petitioner's neck and arm symptoms were likely caused by disc extrusion at C6-7. A series of cervical epidural steroid injections were recommended pending work comp approval. Further physical therapy was recommended for management of Petitioner's low back complaints.

On March 1, 2012 Petitioner consulted Dr. Roth, a pain management specialist located in Evergreen Park. Dr. Roth diagnosed left cervical radiculopathy with pain radiating into the left shoulder and arm, weakness of grip, and occasional numbness of the palm. On May 29, 2012 Dr. Roth performed a cervical epidural injection under fluoroscopy. The injection rendered little relief.

Petitioner was examined by Dr. Timothy Smith M.D., a neurologist at Northwestern on November 4, 2012 who recommended Petitioner undergo surgery for his cervical spine issues.

Petitioner continued under the care of Dr. Roth through April 19, 2018. There are no conventional records of treatment with Dr. Ross, rather a series of identical letters written monthly describing a bulging disc at C6-7 with corresponding radiculopathy. Dr. Roth determined that Petitioner was not able to work due to numbness and weakness of grip. Dr. Ross recommended a surgical consultation for decompression of the C6-7 disc. Petitioner did not follow up on the consultation as he did not want surgical treatment.

On October 1, 2012 Dr. Kern Singh performed a Section 12 evaluation on Petitioner at the request of Respondent. Dr. Singh opined that Petitioner sustained a soft tissue injury to his lumbar spine which had resolved. Significantly, he opined that Petitioner's C6-7 disc protrusion had been persistent and continued to cause bilateral C6-7 radiculopathy. Dr. Singh recommended Petitioner undergo an anterior cervical discectomy and fusion. In Dr. Singh's opinion all prior medical treatment was reasonable and necessary. Dr. Singh determined that Petitioner could be released to light duty with less than 10 pounds of lifting and push/pull activities with minimal bending, kneeling, stooping and squatting. These restrictions were outside the work capacity requirements of Petitioner's employment with Respondent.

Petitioner's primary care physician Dr. Pierro referred Petitioner for a neurosurgical consultation with Dr. Joshua Rosenow at Northwestern Medical Center on January 16, 2013. Dr. Rosenow also recommended a foraminotomy or ACDF for significant left foraminal stenosis at C6-7.

Respondent terminated the payment of TTD benefits to Petitioner on May 17, 2013.

Respondent sought an IME Addendum from Dr. Singh on June 24, 2013 which reiterated the prior work restrictions outlined in Dr. Singh's October 2012 report and recommended a Functional Capacity Evaluation followed by work conditioning before Petitioner could be considered to be at MMI.

On May 11, 2015 Respondent sent Petitioner for yet another Section 12 examination. Dr. Sean Salehi, a board certified neurosurgeon, determined the mechanism of injury i.e. fall down stairs was consistent with an exacerbation of Petitioner's *pre-existing* spondylosis at C6-7. This statement demonstrates that Dr. Salehi in fact knew Petitioner had pre-existing cervical pathology which is contrary to the opinion of the Arbitrator that the failure of defense counsel to provide his own Section 12 examiners with necessary medical records kept them in the dark resulting in an evidentiary "near miss" that required the Arbitrator's swift intervention to prevent a miscarriage of justice.

Dr. Salehi noted Petitioner's poor response to conservative treatment and recommended a single level anterior cervical discectomy and fusion at C6-7. Should Petitioner decline surgical treatment Dr. Salehi recommended a two- week Work Conditioning Program followed by a Functional Capacity Evaluation to determine permanent work restrictions. He determined that all prior medical care and treatment was appropriate.

Dr. Salehi performed a second Section 12 evaluation on June 29,2018. Petitioner's complaints of neck pain with radiation, tingling, numbness and hand weakness have continued since the work accident of August 9, 2011. Petitioner has continued to decline surgical intervention given the potential risks and chooses instead to self- limit his activities. At this time Dr. Salehi recommended against a Work Conditioning Program, contrary to his May 11, 2015 plan recognizing the risk of additional aggravation of Petitioner's injury that work conditioning would entail. Instead, Dr. Salehi recommended a Functional Capacity Evaluation only to determine permanent restrictions. Additionally, Dr. Salehi recommended a work-related psychiatric evaluation for Petitioner's report of heightened anxiety. No further work-up or treatment beyond the FCE and psychiatric evaluation is necessary according to Dr. Salehi.

On April 9, 2018 Petitioner met with Lisa Helms of Vocamotive for a vocational evaluation at the request of Petitioner. Ms. Helms met with Petitioner on one occasion and concluded that Petitioner had no transferable skills. In the opinion of Ms. Helms Petitioner is employable in clerical position earning minimum wage to $13.00 per hour and would benefit from vocational rehabilitation. Vocational rehabilitation was not offered by Respondent.

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from

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the evidence." *City of Springfield v. Indus. Comm'n,* 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the **Commission.** *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission disagrees with the Arbitrator's finding that Petitioner failed to prove that he was temporarily totally disabled as a result of the accident of August 9, 2011. Furthermore, prior to hearing the parties stipulated that the Petitioner was entitled to TTD benefits through May 17, 2013. In *Walker v. Industrial Commission,* 345 Ill. App. 3d 1084 (2004) the Court held that the Arbitrator was bound by the parties' stipulations concerning TTD benefits as reflected on the Request for Hearing. It is unclear why the Arbitrator did not adopt the stipulation of the parties.

The Commission reinstates this stipulation which was dispensed with by the Arbitrator. The Commission finds Petitioner was entitled to TTD payments through June 24, 2013 in accordance with addendum Section 12 report by Respondent's Section 12 examiner Dr. Kern Singh.

The Arbitrator was under the misapprehension that Respondent's Section 12 examiners failed to understand and appreciate Petitioner's medical history to the degree he did. Petitioner experienced an exacerbation of a pre-existing spondylosis at C6-7. The pathology in Petitioner's cervical and lumbar spine was evident on the 2010 MRI studies and referenced by Dr. Pierro. The presence of osteophytes in the cervical spine reported in the CT scan at Resurrection Medical Center immediately following the work injury are further evidence of the chronicity of the spine issues.This fact was recognized by every physician who examined Petitioner.

The Arbitrator ignored the medical opinions of Dr. Danielle Pierro, a primary care provider, Dr. Bartolome, an occupational medicine specialist, Dr. Timothy Smith, a neurologist, Dr. David Roth, a pain management specialist, Dr. Joshua Rosenow, a neurosurgeon, Dr. Alan Shepard, a neurologist, Dr. Kern Singh, a spine surgeon retained as a Section 12 examiner by Respondent, and Dr. Sean Salehi, a neurosurgeon retained by Respondent as second Section 12 examiner regarding causation and nature and extent of disability. Instead he laser focused on a single note written on September 8, 2011 by Dr. Sheth Jayant, an occupational medicine physician, who noted Petitioner could return to work full duty on September 12, 2011. The Arbitrator discounted the September 9th order by Dr. Bartolme rescinding the return to work release and taking Petitioner off work indefinitely. The Arbitrator found that Petitioner sustained nothing more than strain of the lumbar and cervical spine that was resolved by September 9, 2011.

The Commission finds that the rulings of the Arbitrator in this case concerning causal connection ,TTD and nature and extent of disability are contrary to the preponderance of the evidence.

The Commission awards TTD benefits to Petitioner from August 11, 2011 through May 17, 2013 pursuant to the stipulation and further awards TTD benefits through June 26, 2013 pursuant to the addendum Section 12 report authored by Dr. Singh.

Petitioner seeks a wage differential award under Section 8(d)1 of the Act. The Commission looks to the recent decisions of the Appellate Court in *Crittenden v. The Illinois Workers' Compensation Commission,* 2017 IL App (1st) 160002WC and *Euclid Beverage v. Illinois Workers' Compensation Commission,* 2019 IL App 2d 180090WC, and finds that Petitioner has failed to prove entitlement to wage differential benefits.

Under Section 8(d)1, an impaired worker is entitled to a wage differential award when she is (1) "partially incapacitated from pursuing his usual and customary line of employment" and (2) there is a "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* (West 2012). The evidence establishes Petitioner is unable to return to his usual and customary line of employment, but Petitioner failed to prove an impairment in his earning capacity.

Petitioner offered into evidence the vocational opinion of Ms. Lisa Helma who establishes an earning potential of Petitioner to be between minimum wage and $13.00 per hour. PX7. The Commission affords no weight to this opinion as Ms. Helma lacked the knowledge or thorough understanding of Petitioner's prior employment history and the skills associated therewith. Ms. Helma rejected the myriad of skills Petitioner possessed due to his significant work-history in the restaurant industry purportedly due to Petitioner's failure to perform such work on a daily basis. Petitioner's use of his skill-set once a day, once a week, or once a year does not negate the existence of such skill-set. Given Ms. Helma's failure to base her expert vocational opinion on Petitioner's true vocational capabilities, her opinion is of little merit and cannot be relied upon to establish Petitioner's earning capacity. Moreover, other than his continued work in the restaurant industry, Petitioner abandoned the job market

As to the issue of nature and extent of the disability the Commission finds that the exacerbation of Petitioner's pre-existing cervical pathology has rendered him disabled to some degree. All of the physicians who have examined Petitioner have recommended cervical spine surgery. If the cervical spine surgery were performed and successful Petitioner's functional status might be improved. Petitioner however, as is his right, has chosen to forego surgical intervention and self-limit his activities.

According to Petitioner's testimony he experiences sharp pain in his left hand, neck pain, back problems and weakness in his left leg. There was no testimony elicited concerning what impact this exacerbation has had on Petitioner's activities of daily living or impairment other than his inability to return to his employment with Respondent. The Commission finds that Petitioner has sustained the loss of use of 20% of the use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 13, 2019, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $789.63 per week for a period of 97 6/7 weeks, from August 11, 2011 through June 26, 2013, that being the period of temporary total disability under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit for amounts paid on behalf of Petitioner on account of said accidental injury under its group health plan pursuant to Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $710.87 per week for a period of 100 weeks, as provided in Section 8(d)2 of the Act for the reason that the injuries sustained caused the loss of twenty percent (20%) loss of use of the person as a whole.

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

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

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 the Circuit Court.

DATED: OCT 22 2019
o-8/28/19
SJM/msb
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUFFOLO, FRANK
Employee/Petitioner

Case# **11WC034882**

CITY OF CHICAGO
Employer/Respondent

19IWCC0567

On 2/13/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

1401 SCOPELITIS GARVIN LIGHT HANSON
GERALD F COOPER
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

19IWCC0567

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

FRANK RUFFOLO
Employee/Petitioner
v.
CITY OF CHICAGO
Employer/Respondent

Case # **11** WC **34882**

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **11-14-18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **08-09-11**, 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 $**62,400.00**; the average weekly wage was $**1,200.00**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**73,005.63** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**73,005.63**.

Respondent is entitled to a credit of $ **73,005.63** under Section 8(j) of the Act.

ORDER

The Petitioner failed to prove that he was temporarily totally disabled because of this claim.

The Petitioner failed to prove that he was entitled to wage differential benefits of $548.27 per week. Therefore, the claim for benefits under Section 8(d-1) is denied.

The Petitioner is entitled to an award of 7.5% whole body disability, or 37.5 weeks at $695.78 (max), or $26,091.75.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

02-21-19
Date

FEB 13 2019

19IWCC0567

STATEMENT OF FACTS

Petitioner was employed as a stationary fireman for the City of Chicago (Dept. of Water Management). At the time of the occurrence, Petitioner was 49 years old, married and had two dependents under the age of eighteen years. He graduated high school from St. Mary of Perpetual Health in 1984 and began working for the City in 1988, after six weeks of training. (PX #7 p.5) (T. 7)

Petitioner's job was to maintain boilers in city buildings. (T. 8) Under supervision, he would maintain high and low-pressure boilers found in heating and ventilation systems, water treatment systems and water pumping stations. (PX #8) Petitioner's job of stationary fireman sometimes required lifting to 80 pounds. (Id.) Petitioner's normal working hours were from 2 pm. to 10 pm. and his job paid $29.62 per hour; it was a full-time job that "generally involved a lot of overtime." (RX #1) (T. 17) It was agreed that the Petitioner earned $61,609.08 in earnings during the year preceding the injury. (Arb. Ex. #1) Remarkably, Petitioner is also the owner of "several" or three local restaurants, but he did not claim to earn any secondary income from these businesses. (PX #7 p.6) (Arb. Ex #3) Petitioner had 22 years of service with the city at the time of the accident. (RX #1)

The Petitioner stated on the day of the injury, August 9, 2011, he was injured going down the stairs, tripping. (T. 10) The accident report states that he tripped on the second step from the top and fell down the stairs while going down to take a reading. (RX #1) The metal stairs were in good operating condition, as they had been painted and sanded prior to the accident. The Petitioner told his supervisor that the plate on the step caused him to trip. (RX #2 p.2) At trial, he stated a plate "sticking up" from the stairs caused him to trip. (T. 10) The ER records state the Petitioner fell 4-5 steps. "Patient believes a piece of metal got caught on his foot or there was oil on the floor that made him fall." (PX #1 p.3) There were no abrasions to the Petitioner's head and he did not lose consciousness. (Id.) Petitioner reported that "He fell

backwards and slid down." (Id.) At trial, he stated that he hit a piece of equipment with his neck. (T. 10) However, the ER body chart clearly indicates abrasions to front of the Petitioner's body including the stomach, chest wall, front knees, and anterior part of the forearm. (PX #1 p.3), but not his neck or head. Despite those inconsistencies, the Arbitrator notes that accident was not disputed by Respondent on this claim. (Arb Ex. #1) (T. 10)

On direct exam, Petitioner testified that before his accident, he had never had any problems involving his neck or low back. (T. 8) (RX #5 p.1) Later, he admitted that he had MRIs on his neck and low back as recently as June 2010 and December 2010. (PX #3 p.2) (T. 9), He stated that those conditions required no medical treatment and no lost time from work. (T. 10) The Arbitrator notes that Petitioner must have forgotten about his prior workers' compensation claim at the Illinois Workers' Compensation Commission 93 WC 006425 involving his neck and back. He was not cross-examined about this prior claim.

An accident report was signed by the Petitioner on the date of loss which states he tripped and went down hitting his <u>left</u> shoulder and injuring his neck and back. (RX #1)

Under oath, Petitioner stated that he tumbled down about 9-10 stairs. (T. 10) He was immediately taken by ambulance to the Emergency Room at Resurrection Medical Center. (T. 10) Petitioner was prescribed valium and ibuprofen for pain. Chest and pelvis x-rays were taken (negative). A CT-Scan were performed (negative) and the Petitioner was discharged with no follow up instructions. He spent about four hours at Resurrection before being discharged. (PX #1)

The next day, the Petitioner went to MercyWorks. (PX #2) (T. 10) That accident history states the Petitioner was coming down the stairs "when he slipped and fell about four steps." (PX #2) Dr. Sheth's clinical exam was negative. (Id.) He was

diagnosed with contusions and strains. Nevertheless, Petitioner was taken off work and given physical therapy until August 17, 2011. (Id.)

On August 12, 2011, Petitioner sought treatment Dr. Danielle Pierro (internist), his primary care physician. He told her that three days earlier, he tripped on the stairs and landed on his back. His primary concern was lumbar pain radiating down the right side, but Dr. Pierro found no leg numbness, tingling or weakness. She noted his pre-existing lumbar pain had worsened, ordered a Medrol dose pack, referred him to physical therapy and ordered a repeat lumbar MRI. (PX #3)

On August 17, 2011, Dr. Sheth at MercyWorks examined the petitioner and found no cervical spasm. No neurovascular deficit over extension. Petitioner's diagnosis was an assortment of strains and sprains. Petitioner was placed off work until September 8, 2011, when he was instructed to follow up with the MercyWorks. Physical therapy was started. (PX #2)

On September 8, 2011, Dr. Sheth reviewed the Petitioner's physical therapy records and performed a clinical exam. He found near full cervical range of motion with no neurovascular deficits. No spasms. Petitioner was diagnosed with cervical thoracic strain and lumbar strain, left shoulder and right knee strain. He instructed the patient to finish physical therapy and return to work with no restrictions on September 12, 2011. (PX #2)

The next day, on September 9, 2011, Petitioner sought treatment with his primary care doctor, Dr. Danielle Pierro (internist) at Northwestern. (PX #3 p.5) She noted that Petitioner's symptoms were not improving, he had worsened right arm and right leg pain. and she ordered a repeat MRI of the cervical and lumbar spine, stating he had symptoms of radiculopathy and could not go back to work. Neurontin was prescribed.

Surprisingly, Petitioner returned to MercyWorks for an unscheduled appointment later that very day. But this time, it appears he may have been examined by Dr. Barolome, instead of Sheth. The progress note shows that the MercyWorks doctor was aware of Petitioner's earlier visit that day with Dr. Pierro and the Petitioner was given an off work note. On exam, the MercyWorks doctor suddenly found neck spasms, decreased right shoulder range of motion and noted that the Petitioner was unable to bend forward and backward to any degree. (PX #2)

Additionally, on this day, Petitioner's application for adjustment of claim ("AAC") was filed with The Illinois Workers' Compensation Commission in Chicago, Illinois. The only body part claimed injured was his low back. (Arb. Ex. #3) It bears repeating that Petitioner's others sprains and strains were not listed as an additional injured body part on his AAC.

In summary, it appears from the record that the Petitioner visited two doctors and one attorney on September 9, 2011.

Petitioner's pre-existing cervical and lumbar condition is significant and contained with Dr. Pierro's records. They state the following in italics:

On June 8, 2010, (14 months prior to the accident) the Petitioner complained of intermittent numbness in the left arm for the last four years, with symptoms recurring several months ago. (PX #3 p.3) A cervical MRI was performed on June 23, 2010. That study showed left C6-7 disc with mild to moderate stenosis. There was cord indentation. (Id.)

In September of 2010, (11 months before the accident) he told her that his left leg had given out on him twice in the last seven weeks. (PX #3 p.3) A lumbar MRI was performed on December 29, 2010 which showed a left lateral disc bulge with moderate left foraminal stenosis. (PX #3) Petitioner told Dr. Pierro of a fall off a ladder in 2005

or 2004. He also injured his low back picking up wood pieces in a gutted building in 2010. (PX #3 p.3) The Petitioner told Dr. Pierro that he was a restaurant owner. (Id.)

On November 11, 2010, (nine months before the accident) the Petitioner told Dr. Pierro that he has had thoracic and low back pain for several years, but it had worsened, especially with sitting. (PX #3 p.3)

On December 14, 2010, Dr. Pierro prescribed new MRIs. Petitioner never followed through. He had recently undergone an Echo stress test (negative). His symptoms resolved, and the patient thought in retrospect they were due to stress and anxiety. (PX #3 p.3) Petitioner's history of panic attacks and lightheadedness go back to 2006. Petitioner told Dr. Pierro his hours as a firefighter were erratic. (PX #3. p.11)

The Petitioner worked until he fell from the stairs at the Mayfair Pumping Station on August 9, 2011. Petitioner is not a Chicago firefighter.

On September 28, 2011, the lumbar MRI prescribed by Dr. Pierro was performed which showed a mild disc bulge 2.5 mm. at L4-5 causing moderate left stenosis. This image was compared to the pre-accident study in December of 2010 and the radiologist specifically found "no significant interval change." (PX #3 p.18)

Likewise, the cervical MRI performed later that day found a 2.7 mm disc bulge causing mild to moderate bilateral stenosis, greater on the left side. It was compared to the pre-accident study taken from June 23, 2010 and the radiologist found "no significant interval change." (PX #3 p.18)

There is no evidence of a follow up appointment with Dr. Pierro after the above MRIs. It appears she referred the Petitioner to Northwestern neurologists.

On October 26, 2011, the Petitioner was examined by Dr. Brooke Vanderby (Northwestern resident). The Petitioner gave a history of falling backwards while going up the stairs. (PX #4 p.2) Dr. Vanderby examined the Petitioner and noted full range of motion of cervical spine 5/5 bilateral upper extremity. Petitioner's neck pain did not radiate up into the arms. Inappropriate pain behaviors were noted, but not clearly articulated by the resident physician. (Id.)

Two days later, the Petitioner was examined by Drs. Mehul Sekhadia (Northwestern neurology) and Vanderby (resident) whom who examined the Petitioner and confirmed Vanderby's earlier findings. Petitioner admitted to drinking 5-6 vodka drinks per day, (which he had denied to Dr. Pierro). (PX #4 p.1) On exam, the doctor found central neck pain complaints, but no radiation to the arms and full cervical range of motion. (PX # 4 p.3) During the lumbar exam, the doctor noted poor effort with left foot EHL (extensor hallicis longus). He found that much of the Petitioner's low back pain was musculoskeletal. (Id.)

On November 28, 2011, an initial physical therapy consultation states that the Petitioner complained of sharp pain in his right lower extremity, neck and down his right arm. (RX #5 p.2) The Arbitrator notes that the actual physical therapy notes are not into evidence.

On December 2, 2011, Dr. Caldwell (Northwestern neurology) examined the Petitioner and reviewed his recent MRIs. Petitioner complained of low back pain, left greater than right. He complained that his lumbar pain was worse than his neck pain. Dr. Caldwell was unimpressed by the lumbar findings, stating that it was "essentially unremarkable" and "relatively normal." Petitioner's neck pain seemed more left sided, but "it was not classic" and there was no numbness or tingling. Dr. Caldwell described the neck bulge as a 4 mm extrusion. (PX #4 p.6) However, this description is in contradiction of the radiologist's report, which described it as a 2 mm disk. However, there was agreement that the stenosis was "mild to moderate." The plan

was to administer an injection prior to surgery. (PX #4 p.10) Instead, of continuing with Northwestern, Petitioner sought a second opinion.

At this point in the medical history, treatment began to focus on the Petitioners cervical spine. Subsequently, no physician was impressed with the Petitioner's lumbar spine injury.

It is unclear how the Petitioner came to treat with Dr. Roth in Evergreen Park. Petitioner testified that Dr. Pierro referred him to Dr. Roth, but there is no evidence of that in the medical records. In fact, Dr. Pierro's notes show that she referred the Petitioner to her colleagues at Northwestern on more than one occasion. As a result, Dr. Roth constitutes Petitioner's second choice of physicians and he became the Petitioner's primary treater.

On March 1, 2012, Dr. David Roth (Evergreen Anesthesia and Pain Management) began treating the Petitioner for his neck. Dr. Roth reviewed the post-accident cervical MRI and stated it showed a disc bulge at C6-7. Injections were prescribed to avoid surgery. Petitioner was taken off work for his weak grip. (PX #5)

On May 29, 2012, Dr. Roth performed an epidural steroid injection to Petitioner's cervical spine (left side). Roth stated that the MRI scan had reveal a herniated disk and Petitioner had history left-sided radiating neck pain and numbness. (PX #5) Petitioner was kept off work because of numbness and limited grip strength. This is the only time in the record where Petitioner's disc condition was characterized as herniated.

Respondent sought a Section 12 Examination with Dr. Kern Singh on October 1, 2012. (RX #3) Dr. Singh did not review any of the Petitioner's pre-accident medical records or MRIs. On exam, he found that the Petitioner was engaged in symptom magnification and cervical and lumbar range of motion was self-limiting. (RX#3 p.2)

Nevertheless, based on the post-accident cervical MRI, he believed conservative measures had failed, Petitioner had radiculopathy and it was appropriate for the Petitioner should undergo a cervical discectomy or fusion. (Id.) Dr. Singh thought the Petitioner's lumbar spine was normal and that he could return to regular work in that regard and had achieved MMI four weeks after the injury. Petitioner didn't want surgery. (TR. 13)

On December 4, 2012, the Petitioner was examined by Dr. Timothy Smith (Northwestern Neurology) who examined the Petitioner and found good neck range of motion, but pain on extension and left rotation. He also found a possible effort limitation of left intrinsics and grip. Nevertheless, he thought the Petitioner should consider surgery. (PX #4 p.12)

On January 16, 2013, Dr. Joshua Rosenow (Northwestern neurology) examined the Petitioner and also wrote "possible effort limitation in left intrinsics and grip." The cervical exam was normal. Nevertheless, he reviewed the cervical MRI from November 2012 and thought the C6-7 disc was a broad disc bulge…left greater than right causing moderate left foraminal stenosis." (PX #4 p.10) Dr. Rosenow discussed a neck injection and surgery was discussed, but not prescribed.

Despite the above exams, Dr. Roth was the primary treater and Petitioner continued to see him monthly for the next six years. On each visit, Dr. Ross kept the Petitioner off work because of left-handed "numbness and weakness in grip." Dr. Ross was recommending a surgical consultation for decompression of the C6-7 disk throughout the next three years. Petitioner never sought out such a consultation as he did not want the surgery yet continued to see Dr. Ross for the off-work notes. Dr. Ross was adamant, "he should not be actively involved in his abilities as a Chicago firefighter." (RX #5) The Petitioner was not a Chicago firefighter.

After the single injection in 2012, Dr. Ross provided no treatment to the Petitioner except for off-work notes. No medication was prescribed. No additional treatment was rendered and according to Dr. Roth, Petitioner's condition improved incrementally with each visit. Further, there is no indication in the Roth's records of a specific clinical exam. (PX #5) Finally, there are no monthly notes from 2014 until April 19, 2018. (PX # 5 & 6)

Perhaps because of the Dr. Roth's poor documentation, on May 17, 2013, Respondent quit paying temporary total disability benefits to the Petitioner. (Arb. Ex. #1)

On June 24, 2013, Dr. Kern Singh authored an addendum report after reviewing the Petitioner's job description as a stationary fireman. (RX #4) He felt the Petitioner could return to work without restriction regarding the lumbar spine, but not the cervical spine. Again, Singh did not review Petitioner's pre-accident medical records. (RX #4) They were never sent to him for review. He was unaware of their existence and there is no record of Petitioner informing him about it. He also opined that Petitioner should have an FCE to determine the Petitioner's work restrictions. In the meantime, he thought the Petitioner should have light duty work, less than 10 pounds lifting, less than 10 pounds of push/pull. Minimal kneeling, bending, stooping and squatting. He repeated that an FCE was necessary for validity purposes. (RX #4 p.1)

Respondent sought another Section 12 Examination on May 11, 2015 with Dr. Sean Salehi who was told by the Petitioner that he had no history of neck pain before the work accident, nor had any prior work-related injuries. (RX #5 p.1) Further, "he used to get some shooting pains down the left arm but this had resolved." An EMG had been performed and carpal tunnel was ruled out. (Id.) Similar to Dr. Singh's earlier exam, no pre-accident records were sent to Salehi to review beforehand. Dr. Salehi reviewed no EMG report nor was it entered into evidence at trial. On exam,

Dr. Salehi found no paraspinal muscle spasms, normal strength in the both upper and lower extremities. Nevertheless, Dr. Salehi thought that the history of the injury was consistent with an exacerbation of a pre-existing spondylosis at C6-7. He prescribed surgery. If Petitioner did not want surgery, then he should undergo an FCE to determine permanent restrictions. For now, light duty (20 lbs. lifting, no push/pull greater than 35 lbs., no overhead lifting) was appropriate. (RX #5 p.3) (T. 14) Petitioner did not tell Dr. Salehi about working in his restaurants. Petitioner did not want the surgery and no FCE was ever performed.

The Petitioner was seen by Dr. Shepherd in 2015 and 2016 for "stroke like symptoms". (T. 14) At trial, Petitioner admitted that he did not have a stroke, but also stated that that the treatment with Dr. Shepherd was partially related to the case. (T. 14) but then later said that the MRI to his brain had nothing to do with his fall down the stairs. (T. 15) Some of Dr. Shepherd's medical records are in evidence. (PX #4)

Petitioner's last cervical MRI occurred at Northwestern Memorial Hospital on February 15, 2017. At C6-7, there was mild to moderate spinal stenosis as well as moderate left and severe right neural foraminal stenosis. (PX #4 p.14) The radiologists stated that the degenerative changes were superimposed on a congenitally slender spinal canal. (Id.)

On March 16, 2017, Dr. Alan Shepherd (Northwestern) reviewed the MRI and examined the Petitioner's neck and found full range of motion and Petitioner's straight leg raise test was negative. Petitioner was able to heel, toe and tandem walk. Petitioner reported some tingling in his hands, but his neck was stable and there was no complaints of neck or back pain. Motor strength was 5/5. In his assessment, Dr. Shepherd suspected MS or multiple sclerosis. He wrote a prescription for an autoimmune panel an eye exam and other tests. Petitioner was not placed off work nor prescribed surgery. (PX #4 p.20)

The above note is the only one in the record. The Arbitrator takes notice that multiple sclerosis affects the central nervous system and is often accompanied tingling or numbness in the arms, legs and fingers.

The Petitioner was seen by a certified vocational rehabilitation counselor, Lisa Helma at Vocamotive at Petitioner's request on April 9, 2018. Petitioner told Helma that he "would need to be careful doing down the stairs. His left leg would go out on him twice a day." It is unclear if her report refers to the Petitioner's lumbar condition before, during or after the accident. (PX #7 p.1) Petitioner told her that he injured his lumbar spine, cervical spine and left arm in the accident (PX #7 p.1)

Petitioner also told Ms. Helma he was treating with Drs. Roth, Shepherd and Pierro. None of them had released him to work. He denied ever having a psychiatric evaluation because of the injury. He stated no FCE had ever been recommended and reported having an ulcer that was caused by anxiety and denied having any problems with anxiety prior to the injury. He admitted to owning several restaurants but only supervised at one of them for about 2.5 hours a day. He told Helma that he owned the restaurants before working for the City of Chicago. (Petitioner graduated high school in 1983 and began working for the City in 1988.)

Throughout the course of the claim, the City of Chicago paid Petitioner $73,005.63 in temporary total disability benefits. (RX #7) He reported that his children were now financially independent. (PX #7 p.6) He denied looking for alternative employment. The Petitioner denied performing the duties of a restaurant manager. (Id. p. 6) Because of his representations, Lisa Helma wrote that Mr. Ruffalo has no transferable employment skills, but might be employable at the maximum rate of $13.00 per hour. (PX # 7 p.8) She did not ask about his income with his restaurant group.

The Petitioner returned to Dr. Salehi for yet another Independent Medical Examination on June 29, 2018. (RX #6) Petitioner told Dr. Salehi that his low back pain is worse and he complained of a stiff and achy neck with tingling down the left arm. (RX #6 p.1) He has anxiety now and that is "now on anxiety medication." Further, that his treating doctor prescribed "lumbar surgery" but he didn't want it, "he is scared to go through surgery." Petitioner told Dr. Salehi that his numbness and weakness of grip preclude his return to work. He reported having difficulty walking, his leg gives out, but he denies falling. Petitioner had positive straight leg raise when lying down, but not sitting. (RX #6 p.3) On cervical exam, Petitioner's Hoffman's sign was negative, but was unable to flex his head forward to any degree. Dr. Salehi stated that since the Petitioner does not want neck surgery, he should undergo an FCE to determine his permanent restrictions. (RX #6 p.4) He thought a psychiatric evaluation was necessary and related to the work accident. (Id.)

Petitioner did not tell Dr. Salehi that he underwent surgeries with Dr. Pierro, including a gastric bypass in 2006. (PX #3 p.2) He did not tell Dr. Salehi that he had symptoms of panic attacks and anxiety in 2006 & 2009 as documented by Dr. Pierro. (PX #3 p.4) He failed to inform Dr. Salehi that he had undergone a cervical MRIs before and after the accident and that there was no interval change. He did not tell Dr. Salehi that he had intermittent radiculopathy before the accident. He did not tell Dr. Salehi that he worked in his restaurants at least 2.5 hours every day. Finally, he did not tell Dr. Salehi that he might have MS.

The Petitioner testified that a fireman under today's contract would make $33.56 per hour. He is currently seeking a wage differential award for remained of his life.

At trial, Petitioner stated that he usually had a "sharp pain in his left hand, and leg weakness." (T. 18) These are both on the left side. He has "some neck pain

and back pain" and "That was it." (T. 18) That was the extent of the Petitioner's current complaints.

On cross-examination admitted that he was an owner or investor of at least three restaurants. Their names are: "Jam 'n Honey" at 958 Webster (Lincoln Park), "Franco's Ristorante" at 300 West 31st Street (Armour Square), and "Franconello's" at 10222 Western Avenue (Beverly). (T. 21) The Petitioner admitted going to the restaurants every day but stated that he didn't "work" a full job. Petitioner testified the restaurants were operated by his wife, his son and another manager. According to the Petitioner, his son (who returned from college) earns over $150,000.00 operating one restaurant. Petitioner's wife makes $75,000.00 to $80,000.00 and the third location, run by manager, makes $68,00.00, plus a bonus. (T. 23-25) There is nothing in the record about Petitioner's income before nor after the accident. Petitioner was not cross examined about this issue.

At trial, no one cross-examined the Petitioner about how he was able to build at least three successful restaurant businesses while working a full-time job with the City of Chicago. Petitioner's normal working hours were allegedly from 2 p.m. to 10 p.m. "with a lot of overtime." (RX #1) (TR. p.17)

Petitioner did not testify to any financial hardship as the result of not receiving any temporary total disability for over five years. It appears from the record that Petitioner was able to pay his home mortgage, car payments, and family living expenses despite not receiving temporary total disability benefits for over five years. Furthermore, throughout the course of the claim, (eight years), (Arb. Ex. #1), petitioner's children have grown. Both were dependents (under 18) at the time of the occurrence and now one manages a restaurant, earning over $150,000 per year. (T. p.20) and the other is financially independent. (PX #7 p.6) As a result, it seems Petitioner was able to put at least one through college despite not receiving any lost time benefits. (Id.)

Petitioner was not cross-examined about the above.

No one bothered to ask how many employees Petitioner's group of restaurants employs or whether any of them have ever filed workers' compensation claims against Petitioner's restaurants.

Petitioner was interviewed by Lisa Helma at Vocamotive on May 4, 2018. There is nothing in the Vocomotive report about Petitioer's restaurant income before or after the accident. Petitioner told Ms. Helma that at the time of accident, he was earning between $43.00 and $46.00 per hour. (PX #7 p.6) He admitted to owning several restaurants but would only go to one for about 2.5 hours per day and simply review inventory. (Id.) Vocomotive made no inquiry about nature and extent of Petitioner's restaurant businesses or Petitioner's activity before the occurrence. (Id.) Petitioner did not exhibit any pain behavior during the evaluation, which took over 2 hours. (PX #7 p.7) He did not exhibit any pain behaviors at trial. Petitioner denied performing any of the duties of a restaurant manager. (Id.) Helma did not believe the Petitioner had any transferable skills, but thought he was employable with the potential of earning $13.00 per hour. Petitioner admitted not seeking additional employment and that vocational rehabilitation services were not offered to the Petitioner by Respondent. Finally, Ms. Helma stated that of "additional discovery may have relevance on her opinions" and "her opinions were based on upon materials provided and reviewed to date." (PX # 7 p.10)

CONCLUSIONS OF LAW

In support of the Arbitrator's decision as to whether Petitioner's current condition of ill-being is causally connected to the accident, the Arbitrator concludes as follows:

Cervical Spine

The Arbitrator finds that Petitioner's current cervical condition is caused by the accident on August 9, 2011, but only to the extent of strain or sprain.

Petitioner's application for adjustment of claim ("AAC") does not claim a neck or cervical injury. Instead, the "part of body affected" states "low back" only. (Arb. Ex. #3) The Arbitrator notes that the AAC was filed on September 9, 2011, a month after the occurrence. Certainly, by that time, Petitioner would have known if his neck had been injured in the fall. It is revelation that the Petitioner did not believe that he injured his neck in the accident and the AAC was never amended.

Further, Dr. Pierro's records show a significant pre-existing history of cervical complaints. On June 8, 2010, (14 months prior to the accident) the Petitioner complained of intermittent numbness in the left arm for the last four years, with symptoms reoccurring several months ago. (PX #3 p.3) A cervical MRI was performed on June 23, 2010. It showed a left C6-7 disc with mild to moderate stenosis. There was cord indentation. (Id.)

Petitioner's pre-accident cervical MRI study matches the post-accident MRI study taken on September 28, 2010. The two images were compared side-by-side by the radiologist who specifically found "no significant interval change." (PX #3 p.18) It is a wonder how this information wasn't sent to Respondent's Section 12 examiners.

Petitioner's current cervical spine condition is identical to his pre-existing one. At best, he currently has a bulging C6-7 disc with intermittent radiculopathy. Evidence of this follows.

It bears repeating that one month after the occurrence, Petitioner filled out an application for adjustment of claim and did not claim to have injured his cervical spine the accident.

Approximately three months after the occurrence, on October 26, 2011, Dr. Brooke Vanderby (Northwestern resident) examined the Petitioner and noted full range of motion of the cervical spine and 5/5 in upper extremities. Petitioner's neck pain did not radiate. (PX #4 p.1-3)

Two days later, Dr. Mehul Sekhadia (Northwestern neurology) examined the Petitioner and found no radiation to the arms and full cervical range of motion.

On December 2, 2011, Dr. Caldwell noted that Petitioner's neck pain was "not classic" and there was no numbness or tingling. (PX #4 p.6) An injection was prescribed based on Petitioner's continued pain complaints despite little objective evidence and inappropriate pain behavior.

Petitioner's treatment with Dr. Roth was not very compelling for the following reasons. First, Roth kept the Petitioner off work for left-sided numbness and diminished grip strength only. (PX #5) The Arbitrator notes that this was same "diminished grip strength" the Northwestern neurologists suspected was self-limiting. Second, Dr. Roth was under the impression that the Petitioner's occupation was a Chicago Firefighter. As a result, Dr. Roth was probably under the impression that Petitioner's occupation was more physically demanding (and perhaps more morally virtuous) than it was. Coincidentally, Dr. Pierro had been under the same false impression (at least for a time). (PX #3 p.4) Third, while it is true that Dr. Roth performed an epidural steroid injection, he really provided no other treatment to the Petitioner for nine years, which is incredible. Petitioner went to see him for his monthly off work slips only. Upon review of Dr. Roth's medical records, one will find that each letter is virtually identical to the other; only the dates were changed. That

Dr. Roth would include a "post-it note" stating "Patient gets a monthly evaluation and letter certification as this, going back to 2012, they are all essentially the same" further diminishes the credibility of Dr. Roth's opinion to the Arbitrator. One would not expect a doctor to carry on such an ineffectual treatment plan for such an extended period. Ironically, on the date Dr. Roth administered the injection, he found that the Petitioner had "occasional numbness and no weakness." (PX #5) Fourth, there is nothing in the record to indicate that Dr. Roth was aware that Petitioner had a pre-existing cervical condition or that the two MRIs had been compared with no interval change. Please recall that Dr. Pierro's records indicate pre-existing intermittent radiculopathy.

While it may be true that Respondent's Section 12 examiners found causal connection in favor of Petitioner neck condition, none of the above troublesome facts were brought to their attention. (RX #3-6) Dr. Kern Singh did not review Our Lady of Resurrection ER records, MercyWorks records or Dr. Pierro's Northwestern medical records which would've included Petitioner's pre-accident MRIs and some observations about self-limiting behavior by Northwestern neurologists. Dr. Singh had no idea that a Northwestern radiologist had already compared the studies and found no interval change. Dr. Singh was unaware that Northwestern neurologists had questioned Petitioner's inappropriate pain behavior in concert with Singh's own positive Waddell findings. Additionally, Dr. Singh was unaware that one month after the occurrence, Petitioner claimed that the only body part affected by the fall was his lower back, not his neck. (Arb. Ex #3) (RX #3) Likewise, Dr. Sean Salehi was in the dark. It is fair to say that no Section 12 examiner had a complete history of Petitioner's cervical or lumbar condition. They never reviewed Dr. Pierro's records (key) nor did they review the ER records nor MercyWorks records. If they had been provided that vital information, it is more than likely that no causal connection opinion would have been given in favor of Petitioner. Instead, they incorrectly believed Petitioner when he falsely told them of no prior work-related injuries or neck pain. (RX #5)

Further, no EMG studies were forwarded to Respondent's Section examiners and no such records are in evidence. Those findings ruled out carpal tunnel syndrome. (Rx #5 p.1) Further, no physical therapy records submitted into evidence. Dr. Salehi states he reviewed a physical therapy note stating Petitioner complained of pain down his right arm and right leg which does not correspond with MRI findings nor other medical records indicating left-sided pathology. (RX #5 p.2)

The Arbitrator acknowledges that this case is rare in that two Section 12 examiner's opinions favoring Petitioner are being rejected. However, if one looks at the entire record and factors in the Petitioner's lack of credibility, it appears that the most compelling medical evidence are the initial treatment with Resurrection ER records and the MercyWorks notes of Dr. Sheth. The Arbitrator agrees with Resurrection ER doctors who diagnosed strains and sprains then discharging the Petitioner with no follow up instructions. Later, Dr. Sheth found that Petitioner suffered strains and sprains and that he was able to return to work with no restrictions on September 12, 2011.

Petitioner's testimony was not credible on either vital nor collateral issues. The record is replete with falsehoods and exaggerations which subsequent doctors based their opinions upon.

Lumbar Spine

Petitioner originally claimed that the only part of his body injured on the date of loss was his lumbar spine. (Arb. Ex. #3) In relation to causation, the Arbitrator finds that the evidence supports a strain or sprain injury.

Immediately after the occurrence, Petitioner was taken to the emergency room at Resurrection Medical, where he was diagnosed with neck/back pain and chest wall contusion. (PX #1 p1) Petitioner's primary complaint was upper back and bilateral

knee pain, not to the lumbar spine. Nevertheless, x-rays of the lumbar spine were taken and found negative. Petitioner was discharged with no follow up instructions. (PX #1 p.3)

Petitioner followed up with Dr. Sheth at MercyWorks on August 10, 2011. Those records state that Petitioner complained of lower back pain, among other body parts. He denied any radiating pain to any extremities. No numbness or tingling. His gait was normal, there was no limp. On exam of the lower back, Petitioner complained of pain during straight leg raise and heel to toe, but he could perform them. Dr. Sheth's diagnosis did not include lumbar strain. (PX #2 p.2)

On August 12, 2011, Dr. Pierro examined the Petitioner complaining of 8/10 back pain with bilateral radiating pain, right greater than left. Dr. Pierro wrote that the Petitioner had known lumbar disc disease from an earlier MRI in December 2010. She notes no leg numbess/tingling/weakness. (PX #3 p.2)

On August 17, 2011, Dr. Sheth examined the lumbar spine and found no paraspinal spasm, full range of motion but was restricted with pain and stiffness. There was no neurovascular deficit. His diagnosis included lumbar spine strain, among other similar injuries. (PX #2 p.3)

On September 8, 2011, Dr. Sheth examined the Petitioner and found that the Petitioner could squat normally, and he was diagnosed with a lumbar strain among other strains and sprains. (PX #2 p.4) Petitioner was scheduled to return to work on the 12th.

On September 9, 2011, Dr. Pierro examined the Petitioner and wrote that despite being off work, Petitioner still complains of persistent pain and could not go back to work. There was no exam and no off-work slip was created.

Later that day, Petitioner returned to MercyWorks for an unscheduled visit and claimed to be unable to bend forward or backward. However, on exam the "flip test" was negative and Dr. Bartolome wrote there was no sciatica. (Id.) Nevertheless, Petitioner was taken off work for other complaints.

Additionally, on this day, Petitioner filed his application for adjustment of claim ("AAC") with The Illinois Workers' Compensation Commission.

Dr. Pierro records show that Petitioner had a pre-existing lumbar spine condition. (PX # 3 p.10) Dr. Pierro's notes state the following:

In September of 2010, Petitioner stated that his left leg had given out on him twice in the last seven weeks. (PX #3. p.3) A lumbar MRI was performed on December 29, 2010 which showed a left lateral disc bulge with moderate left foraminal stenosis (PX #3) Petitioner fell off a ladder in 2005 or 2004. He also injured his low back picking up wood pieces in a gutted building in 2010. (PX #3 p.3)

On November 11, 2010 (nine months before the accident) the Petitioner told Dr. Pierro that he had thoracic and low back pain for several years, but it had worsened, especially with sitting. (PX #3 p.3)

On December 14, 2010, Dr. Pierro prescribed a new lumbar MRI.

The Petitioner did not get the new lumbar MRI until after the fall at the Mayfair Pumping Station on August 9, 2011.

On September 28, 2011, Dr. Pierro re-prescribed a new lumbar spine MRI which showed a mild, approximately 2.5 mm left lateral/foraminal disc bulge....causing moderate left foraminal stenosis. The spinal canal was patent. The

radiologist compared this study with one taken on December 29, 2010 (nine months earlier) and found no significant interval change.

Dr. Pierro referred the Petitioner to other Northwestern neurologists for evaluation. On October 26th & 28th, 2011, the Petitioner was examined by Drs. Mehul Sekhadia and Brooke Vanderby. (PX #4 p.2) Petitioner told the doctors that fell backwards going up the stairs, landing on his low back and right arm. Further, he complained of low back pain located in the center radiating to the waistline as well as the right thigh and calf, but no numbness or tingling. On exam, discordant pain behaviors were noted. (Id.) The doctors wanted to see the MRI results. The diagnosis was low back pain. (Id. p3)

On December 2, 2011, Dr. Caldwell examined the Petitioner at Northwestern, who reviewed the recent lumbar MRI and stated is was "essentially unremarkable" and "relatively normal." (PX #4 p.6) He recommended more physical therapy, which Petitioner did not perform. Dr. Sekhadia (internist) had sent the Petitioner to Dr. Caldwell earlier that day.

Petitioner did not obtain the physical therapy from Northwestern and his low back treatment essentially ended. Another year came and went before Petitioner's lumbar spine was reexamined.

On December 4, 2012, Dr. Timothy Smith examined the Petitioner at Dr. Pierro's request and noted that Petitioner's heel, toe, and tandem walking were normal. He had a normal leg raise, negative spurling's maneuver and l'hermitte's sign. (PX #4 p.12)

On June 24, 2013, Dr. Kern Singh opinion that Petitioner could return to work without restriction regarding his lumbar spine. (RX #4)

Petitioner received no lumbar spine treatment for another five years.

On March 16, 2017, Dr. Alan Shepherd notes stated there was no back pain, straight leg raise test was negative, reflexes were good and Petitioner was able to heel, toe and tandem walk. Dr. Shepherd thought that the Petitioner might have MS or multiple sclerosis. (PX #4 p.18-20) There were no off work notes, nor any recommendation for neck surgery.

On April 9, 2018, the Petitioner told Ms. Helma that "his left leg would go out on him. It would go out on him approximately twice a day" and wrote "that back surgery had been discussed." (PX #7 p.1-2) He reported that he would experience cramping and shooting pain from his back to his left leg. He reported that his left leg would give out while walking. (Id. p.3)

Finally, at trial Petitioner stated that he has "left leg weakness" and "some back pain." (T. 18)

From the information above, there doesn't seem to be strong evidence that the work accident worsened Petitioner's low back condition. The pre-accident and post-accident MRIs are virtually identical. There was no interval change. Petitioner did not seek any significant treatment for his lumbar spine and ostensibly refused the physical therapy that Dr. Caldwell prescribed on November 30, 2011. (PX #4 p.6) No physical therapy records are in evidence and no subsequent medical record refers to it being performed at Northwestern. It was Dr. Caldwell who told Petitioner that his lumbar spine was "essentially normal."

Additionally, there are huge gaps in medical treatment relating to the lumbar spine. Any complaint the Petitioner has presently is too remote in time and place to be related to the work accident in 2011.

In looking at the totality of the treatment records, it appears that Petitioner's current lumbar spine condition is no different than his pre-accident condition. At most, there is a temporary aggravation of a pre-existing condition or a lumbar strain.

In support of whether the Petitioner is entitled to compensation for temporary total disability, the Arbitrator finds the following:

Cervical Spine (neck)

Dr. Jayant Sheth stated that Petitioner could return to work with no restrictions on September 12, 2011. Instead of taking his advice, Petitioner scrambled to obtain a second opinion from Dr. Pierro who did not give him an off-work slip, so he went back to MercyWorks for an unscheduled visit to see either Dr. Sheth or Dr. Bartolome who suddenly found limited range of motion and neck spasms where none had existed a day earlier. Subsequently, Petitioner's cervical MRI on September 28, 2011 showed a 2.0 mm bulge and no significant interval from an earlier study June 2010. Petitioner's next cervical examination came on October 26, 2011 where full range of neck motion was noted and there was no radiation into the arms. (PX #4 p.2) This was confirmed two days later by Dr. Sekhadia at Northwestern (PX #4 p.3)

Most of Petitioner's claim for temporary total disability exists in the medical records of Dr. Roth as he took Petitioner off work for "numbness and weak grip" for the next six or seven years. (PX #5 & 6) Petitioner was repeatedly given off work notes monthly from Dr. Roth, who has no record of performing a clinical exam. (PX #5) Further, Dr. Roth kept the Petitioner off work under the misapprehension that the Petitioner was a Chicago firefighter. (PX #5 - 09-07-12 note) At no time did Dr. Roth prescribe surgery, he simply wanted the Petitioner to have more injections, which Petitioner refused. (PX #5) Additionally, on the date Petitioner received his sole steroid injection, Dr. Roth admitted that there was only occasional numbness and no weakness, which had always been the very basis for keeping off work. (PX #5) In

contrast, Dr. Timothy Smith (Northwestern) examined the Petitioner on December 2, 2012 and noted possible effort limitation of left intrinsics and grip. (PX #4 p.12) This suspicion was corroborated by Dr. Joshua Rosenow on January 16, 2013 who wrote, "possible effort limitation in left intrinsics and grip." Additionally, there is evidence of a negative EMG in the record. (RX #5 p.1) Finally, there are no monthly notes in Dr. Roth's records from October 7, 2014 until April 19, 2018 (PX #5 & 6), a period of 3.5 years. Because of the above, there is little justification for awarding TTD benefits when looking at the entirety of Dr. Roth's treatment records. The Arbitrator has no confidence in them. His repetitive, identical recitations harken to infamous 1911 Triangle Shirtwaist Fire cross-examination of Kate Alterman that most first-year law students study.

It's true that on May 11, 2015, Dr. Sean Salehi wrote that Petitioner should be on light duty of no lifting over 20 lbs, no pushing or pulling over 35 lbs., no overhead work and alternating between sitting and standing every 45 minutes until a work conditioning is performed or a functional capacity exam. (RX #5)

And it's also true that on June 26, 2013, Dr. Kern Singh wrote that Petitioner could work light duty which included only 10 lbs. of lifting, less than 10 lbs. of push/pull. Minimal bending, kneeling, stooping and squatting as it relates to the cervical spine. (RX #4)

However, it is equally true that Respondent's Section 12 examiners were unaware of the Petitioner's pre-existing cervical complaints. In fact, Petitioner told Dr. Salehi that he never had a prior work-related injury nor had a history of neck pain. (RX #5 p.1) Dr. Singh did not ask the Petitioner if he had been injured in the past. (Id.) The doctors were unaware of Petitioner's pre-accident MRIs. Likewise, they were unaware that pre-accident images were identical with post-accident films. There was no significant interval change.

It for the Commission to decide which medical opinion it accepts. International Vermiculite Co. v. Industrial Comm'n., 77 Ill.2d 1, 4 (Ill. 1979) The rules of evidence do not authorize the expert's statements to serve as admissions against interest. Taylor v. Kohli, 162 Ill.2d 91 (1994) The expert's testimony is the mere opinion of a witness assuming the facts given to him are true. Foundry v. Industrial Comm'n., 62 Ill.2d 535, 343 N.E.2d 504 (1976).

The Arbitrator notes that the parties have stipulated that Petitioner was temporarily totally disabled for the period from August 10, 2011 through May 17, 2013. However, this is based on vitally incomplete information of the Petitioner's medical history and the polite fiction that Petitioner earned no secondary income.

The general rule regarding temporary total disability is that an employee must demonstrate not only that he did not work, but also that he was unable to work. There are exceptions to the general rule, however, where the employee has been able to earn occasional wages or perform certain useful services which do not preclude a finding of temporary total disability. The employee's burden in such cases is to prove that the income earned while disabled was only occasional wages and not from employment in the labor market. Dolce v. Industrial Comm'n., 286 Ill.App.3d 117, 221 Ill.Dec. 268, 675 N.E.2d 175 (1st Dist. 1996). In Dolce, the Petitioner was unable to prove that his real estate sales were merely occasional income. Id. In the present case, Petitioner's claim that he only worked 2.5 hours a day in his restaurants is not credible. Petitioner is not a credible witness. Those reasons are cataloged later in this decision.

Occasional work does not preclude Petitioner's from collecting TTD benefits. For instance, J.M. Jones Co. v. Industrial Comm'n., 71 Ill.2d 368, 17 Ill.Dec.22, 375 N.E.2d 1306 (1978) and Firestone Tire & Rubber v. Industrial Comm'n., 76 Ill.2d 197, 28 Ill.Dec. 548, 390 N.E.2d 907 (1979) In these cases, the claimants worked for only a few hours a day and for only part of the period that they were disabled. In the

present case, Petitioner makes a similar claim; but for reasons stated later in this decision, the Arbitrator does not find him credible.

At some point in the legal analysis of the present case, Zenith Co. v. Industrial Comm'n., 76 Ill.2d 197, 28 Ill.Dec. 548, 390 N.E.2d 907 (1979) must be mentioned. In Zenith, the Supreme Court held that a claimant's selling hot dogs from a truck with his family for a few hours a day, six months out of the year did not amount to self-employment barring his TTD benefits. The Arbitrator notes that Petitioner's restaurant group differs from Zenith. They are not hot dog stands and unlike Zenith, they operate twelve months of the year. Petitioner owns "several" or "three" restaurants.

In summary, the Arbitrator rejects the opinions of Dr. Roth and Respondent's Section examiners and instead, finds that the most compelling medical evidence is Dr. Sheth's note stating that the Petitioner can return to work with no restrictions on September 12, 2011. Petitioner was working at his restaurants throughout the course of the claim. No temporary total disability benefits are warranted. Respondent is entitled to credit for overpayment of TTD benefits. Gallianetti v. Industrial Comm'n. 315 Ill.App.3d 721, 734 N.E.2d 482, Ill.Dec.554 (3rd Dist. 2000). Karastamatis v. Industrial Comm'n., 238 Ill.Dec. 915, 713 N.E.2d 161 (1st Dist. 1999).

Lumbar spine

The Arbitrator notes the above and summarizes that the record supports the finding of a lumbar strain or sprain only. The Petitioner's lumbar spine MRIs showed no interval change. At one point, the Petitioner told his doctors that his lumbar spine was worse than his cervical spine. Further, Petitioner's claim of not working at his restaurants during the eight years was not credible. Northwestern neurologists found his lumbar spine to be "essentially normal." Finally, there was a treatment gap of over five years. Respondent has no liability for temporary total disability payments regarding the Petitioner's lumbar spine condition.

In support of the Arbitrator's decision on the nature and extent of the injury, the Arbitrator concludes as follows:

Since the occurrence was before September 1, 2011, Section 8.1(b) does not apply and there are no AMA reports in evidence. Nevertheless, the Arbitrator notes the following:

Petitioner's primary occupation is restaurateur. His secondary occupation was stationary fireman for the City of Chicago.

Petitioner's age at the time of the injury was 49 years old.

The nature and extent of Petitioner's earning capacity is unclear. Petitioner owns several restaurants but did not claim a secondary income at trial. Further, he claimed to earn no income from the restaurants before or after the accident. The Arbitrator finds neither claim to be credible.

The Arbitrator notes that the reported level of impairment by Petitioner is minimal. On direct exam, he stated he has "sharp pain in his left hand and left leg weakness," and "has some neck pain and back pain," and "That's it." (T. 18) the Arbitrator notes that Petitioner had similar complaints prior to the occurrence and he was still able to work full-duty as a stationary fireman for the City of Chicago. The MRIs showed no interval change and there was strong evidence of symptom magnification and exaggeration which was corroborated by more than one doctor. Please compare the Petitioner's own sworn statement with the flawed Section 12 examiners' opinion of significant restrictions.

Despite the age of the case, Petitioner's medical treatment has been minimal. In short, Petitioner has pre-existing unoperated bulging cervical disc that resulted in a single cervical injection. No doctor has characterized the Petitioner's work restrictions as permanent as there has been no FCE. In formulating the permanency award on this case, the Arbitrator specifically rejects the notion of permanent restrictions. No doctor has "permanently restricted" the Petitioner. Respondent's Section 12 examiners stated that he must complete an FCE (functional capacity exam) and WCE (work capacity exam) in order to test validity, achieve MMI, and then determine permanent restrictions. This never occurred. Likewise, the Arbitrator rejects the notion of ongoing restrictions. The Arbitrator rejects Dr. Roth's monthly off work slips as a sham. It seems more likely to the Arbitrator that Petitioner voluntarily left his job as stationary fireman with the City of Chicago because of the growing time demands of his restaurants, which were more lucrative, interesting and family-based. Instead, the Arbitrator adopts the findings of Resurrection Hospital ER and Dr. Sheth at MercyWorks. Petitioner suffered a neck and lumbar strain only with a single injection and awards 7.5% loss of use of a person.

Petitioner's Credibility

It is the province of the Commission to determine whether a claim is supported by a preponderance of the evidence and to judge the credibility of witnesses and resolve conflicts in their testimony.

The Arbitrator does not find the Petitioner credible in many respects. First, one must address the elephant in the room. The Arbitrator does not believe that Petitioner derived no secondary income from his restaurants either before nor after the occurrence. While it is true that Respondent presented no direct evidence to rebut Petitioner's claim of occasional work and no income, the amount of circumstantial evidence against it is compelling for two main reasons.

First, Petitioner's AAC states that at the time of the accident, he was married and had two dependents. (Arb. Ex. #3) Throughout the course of Petitioner's claim, Petitioner's children have aged. Eight years have gone by and presently, at least one child has graduated from college and manages one of the restaurants, earning over $150,000 per year. (T. p.20) The other is financially independent. (PX #7 p.6) As a result, it appears Petitioner was able to pay his home mortgage, car payments, and family living expenses, plus finance <u>at least</u> one college education despite not receiving any lost time benefits since May 17, 2013. Stated another way, the Petitioner has not received any TTD since the Boston Marathon terrorist attack. Upon inspection of the court file, the Arbitrator could find no 19(b) petitions (immediate hearing) enclosed.

In general, claimants can have a 19(b)-immediate hearing before an Arbitrator within thirty days of their request, if properly noticed. 820 ILCS 305/19(b). The Arbitrator notes that there is limited discovery in workers compensation litigation. In short, despite some anecdotal evidence to the contrary, the Illinois workers' compensation system is designed for speed.

In contrast, this claim is over eight years-old and Petitioner has not received TTD benefits for nearly six years. No depositions were taken. There's nothing about this claim to justify an eight-year delay in resolution. Noting this, the Arbitrator observes that virtually no claimant can afford losing their primary income source for such long a time. The likelihood of such an occurrence must be ridiculously small as to be highly improbable. Yet, Petitioner wants the court to believe that he received no secondary income from being a restaurateur either before the accident nor afterwards and that his work was occasional.

Second, there is no good reason to believe the Petitioner about the nature and extent of his restaurant businesses. To wit, Petitioner told the vocational rehabilitation counselor that he owned "several" or three restaurants <u>before</u> his

employment with the City which began in 1988. Yet Petitioner graduated from high school in 1984 and was admittedly a poor student. (PX #7 p.7) As a result, he would have her believe that upon high school graduation, he opened and operated three restaurants from the approximate ages of 18 to 22, which is another highly improbable occurrence. Instead, it is much more likely that the Petitioner opened and operated some of these restaurants during his employment with Respondent, which completely contradicts his statement to Helma, To add a further twist to this narrative, Petitioner testified at trial that one of the restaurants opened eight years ago. (T. 30) As a happy coincidence, the Arbitrator notes that Petitioner's workers' compensation claim is eight years old. How he accomplished this feat while being temporary totally disabled is a wonder and could only have been achieved through hard work and determination.

Meanwhile, Petitioner's credibility suffered further on the issue of causal connection. For instance, he led his treating doctors and Section 12 examiners to believe that he never had a pre-existing low back or neck condition. However, Dr. Pierro's records show that he had lumbar and cervical MRIs as recently as 2010 (PX # 3 p.2) and Petitioner must have overlooked his prior workers' compensation claim (93 WC 006425) involving the same.

There are additional reasons to doubt the Petitioner's credibility, some of the them are on collateral issues, but nevertheless paint the portrait of an unreliable witness. The following is a litany of other factual discrepancies, improbabilities and exaggerations.

Even though accident was not disputed, there were inconsistencies with Petitioner's narrative about the number of stair steps that he fell down and how he landed.

There are discrepancies in the way the Petitioner describes his pain to the doctors. Petitioner's bulging discs are left-sided, but his symptoms migrate back and forth. Petitioner's shoulder injury migrated left and right as well.

On September 9, 2011, Petitioner visited two doctors and filed his AAC with The State of Illinois. He he did not want to return to work for the City on the 12th, as Dr. Sheth had planned, which some might suspect was a form of claim manipulation. Petitioner visited two doctors and one attorney on that day.

Petitioner led some of his treaters to believe that he was a Chicago firefighter which is untrue. Dr. Roth based his off-work opinion, at least in part, on the assumption that this was so. (RX #5)

Petitioner was satisfied with obtaining off-work notes from Dr. Roth for years without obtaining more substantive medical care. He was not prevented from seeking other, more effective medical treatment, as he still had health care coverage under his group plan. (PX #7 p.6) He still had access to excellent medical care at Northwestern.

Petitioner led the court to believe that he had "stroke-like" symptoms with Dr. Alan Shepherd, and intimated it was related to his workers' compensation claim, (T. p.14) but Dr. Shepherd suspected multiple sclerosis, not a stroke. (PX #4 p.20) Petitioner made no attempt to clarify this issue at trial. The words "multiple sclerosis" are not in the court transcript.

Petitioner led vocational counselor, Lisa Helma, to believe that one of his doctors discussed lumbar surgery, but this was untrue. (PX #7 p.2) In fact, no doctor was impressed with his lumbar injury and he has received little lumbar treatment over the last eight years. Compare and contrast this fact with Petitioner telling Helma that "he has difficulty walking, his left leg would give out on him and that his

leg would go out on him approximately twice a day". (PX #7 p.1) Further, Petitioner told Ms. Helma that he had cold feelings in his legs, "as though he was getting into an ice-cold shower," and attributed it to anxiety. (PX #7 p.4) In contrast, the Northwestern doctors were not impressed with the Petitioner's low back condition and considered the post-accident MRI to be an unremarkable study. (PX # 4 p.6) Dr. Caldwell described it as "relatively normal." (Id.) Dr. Shepherd's note on March 16, 2017 shows negative straight leg raise and Petitioner was able to heel, toe and tandem walk. (PX #4 p.18) In short, Petitioner's clinical exam results do match his often bizarre and exaggerated complaints.

Petitioner denied having any anxiety prior to his injury. (PX #3 p.4, 10) (PX #7. p.3) However, Drs. Pierro and Shepherd's records show that Petitioner had issues with anxiety and an "anastomotic ulcer" back in 2006 and 2008 and 2010. (PX#4 p.10, 19) Dr. Pierro's records state this anastomosis (surgical connection) ulcer was the result of his gastic bypass surgery in 2008. (PX #3 p.2)

Note also, that while Dr. Roth kept the Petitioner off work for eight years because of left-sided numbness and diminished grip strength, In contrast, on March 16, 2017, Dr. Shepherd found full cervical range of motion and motor strength 5/5. (PX #4 p.20) As stated earlier, other Northwestern doctors felt the Petitioner's grip was self-limiting.

In reviewing the entirely of the medical records, it appears to the Arbitrator that Petitioner's treatment arc was based on pain complaints and the false representation to his doctors that he had never injured his low back or neck in the past. (PX #2) Petitioner had diagnostic MRIs performed on his neck and low back as recently as June 2010 and December 2010. (PX #3 p.2) (TR. 9) His complaints at that time included intermittent numbness in the left arm for the last four years, with reoccurring symptoms. (PX #3 p.3) Those MRIs showed a left C6-7 disc with mild to moderate stenosis. There was pre-existing cord indentation. (Id.) These are the same

symptoms he had after the accident. The post-accident MRI showed no interval change.

Here, the Arbitrator finds that Petitioner's overall lack of credibility has damaged all aspects of his claim and he failed to prove his claim by a preponderance of the evidence. In summary, it may that Petitioner's symptoms relate to unrelated multiple sclerosis, but it seems more likely that Petitioner's workers' compensation claim is audacious in its entirety.

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

Ana Covarrubias,

Petitioner,

19IWCC0568

vs.

NO. 13WC 38262

Labor Network, Inc. and Cloverhill Bakery,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, prospective medical care, 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 October 17, 2016 is hereby affirmed and adopted.

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

DATED: OCT 22 2019
SJM/sj
o-10/09/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COVARRUBIAS, ANA
Employee/Petitioner

Case# **13WC038262**

LABOR NETWORK INC AND CLOVERHILL BAKERY
Employer/Respondent

19IWCC0568

On 10/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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5001 GAIDO & FINTZEN
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CHICAGO, IL 60602

19IWCC0568

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

Ana Covarrubias Case # **13 WC 38262**
Employee/Petitioner
v.
Labor Network, Inc. and Cloverhill Bakery
Employer/Respondents

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **May 13, 2016, May 23, 2016, June 14, 2016, June 17, 2016, and July 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondents?
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? Have Respondents
paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Chain of Medical Referrals**

FINDINGS

On **March 18, 2013**, Respondents ***were*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this alleged accident ***was*** given to Respondents.

In the year preceding the injury, Petitioner earned $**52,910.00**; the average weekly wage was $**1,017.50**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **no** dependent children.

ORDER

Because Petitioner did not sustain an accident that arose out of her employment, benefits are denied.

The remaining issues are moot.

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

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

Milton Black

Signature of Arbitrator

October 17, 2016
Date

OCT 17 2016

FACTS

Petitioner, Ana Covarrubias, was employed by a temporary help agency, Labor Network, Inc. ("Labor Network") on March 18, 2013. Labor Network had her placed at Cloverhill Bakery ("Cloverhill") on that date. Petitioner worked for Labor Network from 2006 through January 2, 2014 as an office assistant in human resources (Tr. 56).

Petitioner was initially employed as a packer at Cloverhill for two months before she was moved to human resources. Prior to working for Labor Network, she worked for different staffing agencies but had been placed at Cloverhill since 2000 (Tr. 24-26).

Petitioner testified that she began work between 8:30 AM and 9:00 AM (Tr. 29). Petitioner testified that on March 18, 2013, she slipped and fell while going to work at Cloverhill. It was a few minutes before 9:00 AM when she entered the Cloverhill property (Tr. 29). Petitioner testified that she entered at a guard shack (Tr. 27). Petitioner testified that she had logged in at the guard shack and had not yet clocked in for work. (Tr. 59-60). Petitioner testified that she proceeded through the guard shack (Tr. 68) exiting onto a concrete sidewalk (RX 2).

Petitioner testified that rather than walking on the sidewalk she chose to step down off the curb in order to get to the Cloverhill facility (Tr. 61-64). Petitioner further testified:

> There are a lot of people that use the sidewalk stepping off of there to go towards the building, and I am not the only one that does that. A lot of people do that. Not every employee uses the walkway on the ramp. (Tr. 129)

Petitioner testified that when she attempted to step off the curb, she slipped on the bright yellow border (Tr. 128), landed on her lower right side (Tr.31), and fell on the street (Tr. 63-64; RX 2).

Petitioner testified that the curb of the concrete sidewalk was painted bright yellow and was not chipped or structurally defective (Tr. 73). See RX 1-4

Rafael Perez Fierro testified that he was the security supervisor who was working in the guard shack on March 18, 2013 (Tr. 84). Fierro testified that he has worked for Cloverhill for about 15 years (Tr. 83). He testified that there was snow and ice on the curb but that the sidewalk designated for employees was shoveled and salted on March 18, 2013 (Tr. 89-90). He testified that because the sidewalk where employees walk was shoveled and salted, there was ice and snow piled up on the street against on the curb (Tr. 94-95). Fierro testified that the curb is painted bright yellow to prevent employees from stepping off the curb and crossing over to the Cloverhill facility outside of the designated crosswalk (Tr. 95). He testified that he not see Petitioner fall but heard a noise, a loud thump (Tr. 86). He testified that Petitioner fell while trying to take a shortcut from the guard shack to the Cloverhill facility (Tr. 96).

Fierro testified that prior to March 18, 2013, an email was sent to Petitioner and other employees directing employees to go down the sidewalk and use the painted crosswalk (Tr. 99-100, 102-103, 106). Petitioner testified she was copied on that email (Tr. 139). Fierro testified that when employees step off the curb instead of using the designated crosswalk, they are reported and usually receive a write-up (Tr. 107). Petitioner testified she was disciplined for "walking through where the trucks were" (Tr. 138).

ACCIDENT

Petitioner has failed to prove she sustained accidental injuries arising out of her employment with Respondents on March 18, 2013, because she voluntarily undertook an unreasonable or unnecessary risk such that any injury she may have suffered cannot be said to have arisen out of her employment.

Where the injury has resulted from a personal deviation by an employee or where the injury resulted from a risk personal to the employee and not incidental to the employment, the injury is not compensable. Hatfill v. Industrial Commission, 202 Ill.App.3d 547 (4th Dist. 1990). In Hatfill, the employee injured himself when he attempted to jump over an accumulation of water at the base of an incline in the employer's parking lot. There were alternate ways the claimant could have used, and there was no reason for the claimant to jump over the accumulated water onto the incline when other routes were available.

An injury does not arise out of the employment where an employee voluntarily exposes himself to an unnecessary personal danger solely for his own convenience. Dodson v. Industrial Commission, 308 Ill.App.3d 572 (5th Dist. 1999). In Dodson, the employee sustained an injury when she walked across a wet and icy grassy slope to her car in an employee parking lot, rather than using the unobstructed stairs and sidewalk. The accident did not arise out of her employment, despite the claimant's contention that the employer was aware of the

practice and never attempted to stop it. By taking a shortcut, the employee voluntarily exposed herself to unnecessary personal risk solely for her own convenience.

Petitioner chose to take a shortcut and stepped down off of a curb that was wet and icy from snow accumulation. Petitioner did so instead of proceeding down the shoveled and salted sidewalk and crosswalk, both of which the employer provided for employees' ingress and egress. Petitioner made a voluntary decision that unnecessarily exposed her to a danger entirely separate from her employment responsibilities. Petitioner essentially admitted that her choice was personal in nature and to serve her own convenience and not the interests of the employer. Petitioner voluntarily undertook a course of action that unnecessarily increased her risk of injury and was solely for her own benefit.

Based upon the foregoing, the Arbitrator finds that Petitioner has failed to prove that an accident arose of the employment with Respondents.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Altmeyer,

Petitioner,

vs. NO: 14 WC 23916

19IWCC0569

IDOT,

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 all issues, and being advised of the facts and law, modifies the Arbitration Decision Form, and corrects a scrivener's error. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission solely seeks to correct one clerical error. On the Arbitration Decision Form, the Arbitrator mistakenly wrote that Respondent shall pay compensation accrued from October 24, **3013** through March 20, 2019. This is clearly a scrivener's error. The Commission thus modifies the above-referenced sentence to read as follows:

> Respondent shall pay Petitioner compensation that has accrued from **October 24, 2013** through **March 20, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 30, 2019, is modified as stated herein.

DATED: OCT 22 2019
d: 10/8/19
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALTMEYER, ANTHONY L
Employee/Petitioner

Case# **14WC023916**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

19IWCC0569

On 4/30/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1497 MORICI FIGLIOLI & ASSOCIATES
ROBERT BUTZOW
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

6153 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

APR 30 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

19IWCC0569

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

ANTHONY L. ALTMEYER
Employee/Petitioner

Case # **14** WC **23916**

v.

Consolidated cases: ______

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **March 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 24, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,771.00**; the average weekly wage was $**1,418.67**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **4** dependent children.

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

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

To date, Respondent has paid any claimed temporary total disability benefits

Respondent is entitled to a credit for any medical expenses paid for through workers compensation and/or group health coverage under Section 8(j) of the Act.

ORDER

Petitioner's conditions of ill-being in the neck, low back and left shin are causally related to the October 24, 2013 accident.

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66 per week**, the maximum allowable statutory rate, for **2.5 weeks**, because the injuries sustained caused the loss of use of **.5% 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 24, 3013** through **March 20, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

April 29, 2019
Date

APR 3 0 2019

STATEMENT OF FACTS

Petitioner testified he worked for Respondent as a "lead lead" worker. In general, his job duties involved road work, snow plowing and various tasks of highway maintenance. On 10/24/13, he was performing a sewer repair, walking backwards while putting down emulsion to help asphalt stick to the ground. As he did this, he stepped onto another sewer with a broken frame, fell and struck his back on the curb. He testified he also gouged his left shin and snapped his neck when he hit the ground. He developed pain in all of these areas. He notified his supervisor and requested treatment. His supervisor drove him to Northwest Community Occupational Health.

At Northwest Community on 10/24/13, the report notes that Petitioner's injury occurred at work walking backwards while pouring emulsion on a patch of asphalt, in his capacity as a lead worker, and he tripped backward over a broken manhole cover, landing on his back with his leg stuck in the sewer. He injured his back, neck and left shin. He initially complained of pain, non-radiating, in left shin (3/10), lower back (6/10), and neck (3/10). Petitioner had an x-ray of the lower left leg and the pelvis and findings were unremarkable. Lumbar x-ray findings included mild endplate degenerative changes but no instability. Petitioner was diagnosed with lower back pain, neck strain, and a contusion of left leg with an intact skin surface. He was prescribed 600 mg. ibuprofen, Flexeril at night as needed and was given a work status note indicating he could return to work today with no lifting greater than 25 pounds, no bending, walking/standing as tolerated. Petitioner testified he also was given instructions for at home exercise program, which he did at home. Petitioner testified he was not able to work within his restrictions.

On 10/29/13, Petitioner returned for a follow-up, indicating he felt better but that his pain was not totally resolved. His neck, lower back and left leg pain ratings were unchanged. Examination showed some tenderness in left lumbar paraspinal muscles, full range of motion and rotation of the back but discomfort with flexion, full range of motion of the neck and a healing left leg contusion. It was noted he would receive a full duty release on his next visit but remained with restrictions of no lifting greater than 10 pounds, no pushing/pulling greater than 10 pounds, no bending, twisting or stooping. (Px1).

On 10/31/13, Petitioner reported feeling much better and that he was ready to return to work full duty. He reported very minor discomfort and was to take Advil as needed. He was discharged with a full duty return to work as of 11/1/13. (Px1).

Petitioner testified that his condition improved mildly during this time, his leg had healed, and he didn't want to miss a lot of work, so he returned to the clinic on 10/31/13 to obtain a release. Petitioner testified he had no prior back or neck problems. Currently, he indicated he only has pain occasionally pain, such as with strenuous lifting. He continues to work unrestricted duty in the same job with Respondent. He has some ongoing problems with heavy lifting or jackhammering and tries to avoid doing it, though he sometimes cannot such as when he is working with older co-workers. When he develops pain he tries to relax and stretch it out, which helps. He indicated the back pain is a throbbing tightness with some shooting into the right leg. His neck just gets stiff. He

takes Advil maybe a couple of times a week, generally after harder work or prolonged sitting/driving, and takes no prescription medication. He isn't planning to seek further treatment.

Petitioner acknowledged that he had no other injuries besides low back and neck strains and a leg contusion. He did not undergo formal therapy, just home exercises that his doctor advised him to do without weights, and he did not have any injections. He wanted to return to work as soon as possible and did so full duty on 11/1/13. He has not treated since 10/31/13, and on cross-exam denied saying he had minor discomfort. No treatment since 10/31/13 for any of the three body parts. Even if he works as a foreman, he has to perform laboring, including jackhammering in the summertime, which is April to December. He agreed he may have received Vicodin on 10/29/13 for his pain but he didn't take it, indicating he felt better just taking the high dose ibuprofen.

CONCLUSIONS OF LAW

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

The Petitioner has sustained his burden of proof that he injured his left leg, neck and low back on 10/24/13. The injuries were minor, but his testimony was consistent with his medical records, and Respondent produced no evidence which would rebut a causal relationship.

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

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

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party has submitted an AMA permanent partial impairment rating or report into evidence. This factor carries no weight.

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 lead lead worker at the time of the accident, he returned to that job on 11/1/13 and has continued to work regular duty ever since. This factor tends to show the Petitioner's injury has had a minimal impact on his job and that he has been able to return to his prior work capacity. This factor carries reasonable weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 39 years old at the time of the accident. Neither party submitted evidence into the record which tends to show the impact of the Petitioner's age on any causally related permanent disability resulting from the 10/24/13 accident. This factor carries no weight.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner has returned to his regular job for the past five plus years and no evidence was presented indicating his future earning capacity has been impacted by his work injury. This factor carries reasonable weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner sustained what appear to be minor strains to the neck and back and a left shin contusion on 10/24/13. His treatment consisted of a home exercise program and high dose ibuprofen. He missed one week of work. He testified to occasional episodes of pain with heavier parts of his job activities, but he has sought no treatment in over five years and testified he has no plans to do so. His last medical visit indicated he had minimal complaints and was ready to return to his regular job.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of .5% of the person as a whole pursuant to §8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stanley Moore,

Petitioner,

vs. NO: 15 WC 5545

White County Coal, Inc.,

Respondent.

19IWCC0570

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 2, 2018, is hereby affirmed and adopted.

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

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

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 2 2019
TJT:yl
o 10/8/19
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOORE, STANLEY
Employee/Petitioner

Case# **15WC005545**

WHITE COUNTY COAL
Employer/Respondent

19IWCC0570

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

If the Commission reviews this award, interest of 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
BRUCE WISSORE
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0693 FEIRICH MAGER GREEN RYAN
CHERYL L INTRAVAIA
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Stanley Moore
Employee/Petitioner

v.

White County Coal
Employer/Respondent

Case # **15** WC **005545**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 3, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

On this date, Petitioner ***was*** last exposed to coal dust and fumes; however, ***he did*** not sustain an accident or occupational disease arising out of and in the course of employment.

Timely notice of Petitioner's claim of injury ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to his occupational exposure.

On the last date of exposure, Petitioner was **64** years of age, ***married*** with **0** dependent children.

In the year preceding the injury, Petitioner earned $**62,578.94**; the average weekly wage was $**1,203.44**.

Petitioner claims no medical, TTD, TPD, or maintenance benefits.

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

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

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

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

Nancy Lindsay
Signature of Arbitrator

June 27, 2018
Date

ICArbDec p. 2

JUL 2 - 2018

Findings of Fact and Conclusions of Law

The Arbitrator Finds:

Petitioner's full medical records from Carmi Community Health (RX 6), Deaconess Hospital (RX 7), Harrisburg Medical Center (RX 8), along with selected documents from Harrisburg Medical Center (PX 3) and Deaconess Hospital Radiology (PX4) were placed into evidence with the examination reports and deposition testimonies of Dr. Paul (PX1) and Dr. Westerfield (RX and RX4) as well as B-readings and curriculum vitae for Dr. Smith (PX2), Dr. Westerfield (RX 2) and Dr. Meyer (RX 1), and B-readings from NIOSH (RX5).

The NIOSH records revealed films were taken on February 3, 1991, September 28, 1999, September 8, 2003, January 17, 2008 and August 10, 2012. (RX 5 at 3). NIOSH's final classification for all the films was negative for CWP. *Id.* More specifically, the February 3, 1991 film was classified as quality 1 by reviewed by A-reader DEM on February 14, 1991 and was completely negative for CWP. (RX 5 at 19). B-reader, RBH, reviewed the film on April 27, 1991 and found the film was quality 1 and negative for CWP. (RX 5 at 20). The September 28, 1999, film was classified as quality 1 by A-reader HTY on November 29, 1999 and was negative for CWP. (RX 5 at 4). The film was classified as quality 1 by B-reader CS on November 2, 1999 who found the film completely negative for CWP. (RX 5 at 5). The September 8, 2003 film was classified as quality 1 by A-reader HTY on September 9, 2003 and was completely negative for CWP. (RX 5 at 6). B-reader DRI reviewed the film on December 7, 2003 as positive for CWP with a 1/0, s/t classification with findings in the mid and lower zones. (RX 6 at 9). Due to the conflicting readings, B-reader CS, reviewed the film on December 26, 2003 and found the film was quality 1 and negative for CWP. (RX 5 at 7). The January 17, 2008 was reviewed by A-reader, HTY, as quality 1 and negative for CWP. (RX 5 at 11-12). The film was also reviewed by B-reader RTS on February 21, 2008 who found the film quality was 3 and had no evidence of CWP. (RX 5 at 13). The final NIOSH film, dated August 10, 2012, was read by A-reader, HTY, as quality 1 and negative for CWP. (RX 5 at 15). A second review by B-reader, RTS on September 15, 2012 found a quality 2 film with no evidence of CWP. (RX 5 at 17).

The medical records revealed that on July 14, 2006, Petitioner presented to the emergency room following a work injury when was struck in the face with a chain and broke four teeth. (RX 7 at 29-31; PX 4 at 9-11). An October 11, 2006, chest x-ray found some mild scarring in the right middle lobe and otherwise clear lungs. (RX 7 at 27; PX 4 at 7). The final impression found "no acute cardiopulmonary abnormality." *Id.* An EKG taken the same day diagnosed sinus bradycardia on an otherwise normal ECG. (RX 7 at 28; PX3 at 8). On October 29, 2007, Petitioner presented to Carmi Community Health for a laceration on his right ear. (RX 6 at 56). A pre-employment chest x-ray was taken on November 2, 2007 at Harrisburg Medical Center. (RX 6 at 52). The impression found no active disease and the ILO classification was 0/0. *Id.* On November 5, 2007, Petitioner presented for suture removal on his right ear. (RX 6 at 50-51). Petitioner advised of no chest pain, cough and dyspnea. *Id.* His respiratory exam revealed a normal respiratory rate and pattern with no distress. *Id.* The percussion was normal without hyper-resonance or dullness. *Id.* He had normal breath sounds with no rales, rhonchi wheezes or rubs. *Id.* A chest x-ray taken on January 17, 2008 found the lungs clear of infiltrate and had a final impression that found no active disease by noted thoracic scoliosis. (RX 8 at 13). The film was given an ILO classification of 0/0. (RX 8 at 13).

An MRI screen for metallic foreign body taken on June 5, 2009 revealed a speck of metal in Petitioner's right eye. (RX 6 at 42; RX 7 at 24; PX3 at 4). A CT of the chest abdomen and pelvis was taken on June 5, 2009.

(RX 6 at 40-41; RX 7 at 25-26; PX 4 at 5-6). The chest CT scan revealed no angiographic abnormalities with a well demarcated pulmonary arterial tree and no evidence of pulmonary arteriovenous malformation. *Id.* There was a 4 mm, round and well demarcated, noncalcified pulmonary nodule in the left lower lobe. *Id.* There were no other nodular densities seen in the chest. *Id.* There was mild dependent atelectasis in both lung bases. *Id.* The mediastinum and thoracic aorta were normal *Id.* The final summary found a negative CT of the chest, abdomen and pelvis exam except for an apparent incidental finding of a fairly well demarcated soft tissue mass within the pelvis. *Id.* Petitioner presented for his annual exam on June 10, 2009. (RX 6 at 37-38; RX 8 at 18-19). His respiratory exam revealed normal respiratory rate and pattern with no distress. *Id.* Percussion was normal without hyperresonance or dullness. *Id.* He had normal breath sounds with no rales, rhonhi, wheezes or rubs. *Id.*

Petitioner returned on June 18, 2009. (RX 6 at 29-32). He advised of no shortness of breath, wheeze, cough or chest pain. *Id.* His lungs and thorax revealed symmetrical chest rise with no signs of respiratory distress. *Id.* His lung sounds were clear throughout. *Id.* Petitioner was diagnosed with Gilbert's disease. *Id.* A CT scan of the pelvis taken on August 26, 2009 revealed enlargement of the pelvic mass now at 5.8 cm. (RX 6 at 24; RX 7 at 3; PX 4 at 2). An abscess or necrotic tumor were considered. *Id.* Surgery was performed on the pelvic mass and Petitioner's post-operative course was uneventful. (RX 6 at 19).

An EKG taken November 7, 2011 revealed normal sinus rhythm and a probable anteroseptal MI, age indeterminate. (RX 6 at 14). Foot surgery was performed on November 10, 2011. (RX 6 at 12-13). A chest x-ray taken on August 10, 2012 found small bands of atelectasis in both lung bases with no active infiltrates. (RX 8 at 6). Changes of emphysema were present. *Id.* Mild benign bi-apical pleural thickening was noted symmetrically. *Id.* The final impression found emphysema with benign chronic changes as described. *Id.* An ILO form was completed for NIOSH but was not contained within the records. (RX 8). Claimant submitted A-reader, Dr. Youssef's ILO form which found the film was quality 1 and was negative for coal workers' pneumoconiosis. (PX3 at 2).

Petitioner signed his Application for Adjustment of Claim herein on February 5, 2015. (AX 2)

On August 4, 2015, Petitioner obtained a chest x-ray at Dr. Paul's office which Dr. Paul interpreted as having fibrosis in the lower lung fields to a mild degree with some nodules. (PX1, ex. 2 at 2).[1] Dr. Henry Smith read the film as positive for coal workers' pneumoconiosis at a 1/0 classification, p/p, in all the lung zones bilaterally.[2] (PX2 at 1). Dr. Westerfield reviewed the film and found it negative for coal workers' pneumoconiosis.[3] (RX 2 at 2). Dr. Cristopher Meyer read the film as negative for coal workers' pneumoconiosis.[4] (RX1 at 1-2).

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[1] Dr. Paul is board certified in internal medicine, and allergy, asthma and immunology. (PX1 at 41). He is not board certified in pulmonology. (PX1 at 37). He is not a B-reader, a board-certified radiologist or a board-eligible radiologist. (PX1 at 38).

[2] Dr. Smith is a B-reader and board-certified radiologist. (PX2 at 5).

[3] Dr. Westerfield is a B-reader and board certified in internal medicine, pulmonology and sleep medicine. (RX 2 at 4, 7).

[4] Dr. Meyer is a B-reader, board certified radiologist and professor of diagnostic radiology at the University of Wisconsin Hospital and Clinics in Madison, Wisconsin. (RX 1 at 5-6, 22).

Dr. Paul examined Petitioner on August 4, 2015 at the request of Petitioner's attorneys. (PX 1 at exhibit 2, page 1). He noted that Petitioner was 64 years old and had a 30-year history of working in the mines from 1984-2014 mostly working for Respondent. *Id.* All of the employment was underground. *Id.* He worked 4 years at the base but did most of his read dusty when work when he was lime stoning and the rock dust was inhaled to a great degree. *Id.* Petitioner denied any significant wheezing, coughing or shortness of breath. *Id.* Dr. Paul found the CBC was normal, and the pulmonary function studies were "essentially negative with a negative Methacholine stimulation test." (PX1 at exhibit 2, page 2). The PFTs revealed an FEV1 of 3.39 (102% of predicted), an FVC of 4.21 (94% of predicted) and an FEV1/FVC ratio of 81% which was 108% of predicted. (PX1 at ex. 2, page 3). Following review of the film, laboratory testing and exam, Dr. Paul diagnosed simple coal workers' pneumoconiosis. (PX1 at ex. 2, page 2).

On September 14, 2015, Petitioner presented to Carmi Community Health due to a rash that developed after sitting on the ground in a cow pasture he was fencing. (RX 6 at 2-5). He advised that he was retired from White County Coal. *Id.* His physical exam was normal with no acute distress. *Id.* The assessment found tinea cruris, hypercholesterolemia, low trans fat, regular exercise as tolerated and Gilbert's disease. *Id.*

Dr. Westerfield examined Petitioner on March 26, 2016, at the request of Respondent's attorneys. (RX 3). Dr. Westerfield reviewed the reports from Dr. Paul, Dr. Smith and Dr. Meyer as well as Petitioner's medical records from Harrisburg Medical Center, Deaconess Hospital, Carmi Community Heath and NIOSH. (RX 3 at 1). Dr. Westerfield noted that the CT scan taken at Deaconess showed no evidence of coal workers' pneumoconiosis. (RX 3at 2). Dr. Westerfield noted the chest films taken at Harrisburg Medical Center failed to identify any coal workers pneumoconiosis or any active cardiopulmonary disease and that Petitioner was not treated for any respiratory disease at Carmi Community Health and no CWP was present in those records. *Id.* Dr. Westerfield took a chest x-ray as part of his exam and found the film revealed no evidence of CWP. (RX 3 at 12). Dr. Meyer also reviewed this film and found no evidence of CWP. (RX 1 at 3-4).

Dr. Westerfield performed pulmonary function testing that revealed an FEV1 of 3.56 (102% predicted), an FVC of 4.56 (101% predicted) and an FEV1/FVC ratio of 78 which was 100 of predicted. (RX3 at 14). The diffusing capacity was 107% of predicted, the lung volume measurements were 103% (RV) and 101% (TLC) predicted. (RX 3 at 4). The arterial blood gas testing revealed an pCO2 of 44 and pO2 of 95.1. *Id.* After review of his own film, examination, laboratory testing and Petitioner's medical records and reports, Dr. Westerfield found that Petitioner did not have CWP or any other pulmonary disease, respiratory condition, pulmonary impairment or respiratory disability. (RX 3 at 5). Based on the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition, Table 5-4, page 88, Petitioner was Class 0, 0% impairment. (RX 3 at 6).

Dr. Paul was deposed on February 14, 2017. (PX 1). He worked in Springfield for 32 years as the medical director of St. John's Respiratory Therapy and clinical assistant professor of medicine at SIU Medical School where he taught internal medicine and pulmonary until 2016. (PX 1 at 6). Dr. Paul was semi-retired as of mid-2016 and the scope of his practice was now reduced to seeing 12 patients per week. *Id.* He maintained his faculty status as the SIU Medical School. *Id.* He was the senior physician at the Central Illinois Allergy and Respiratory Clinic. (PX 1 at 7). There were six doctors specializing in allergy and pulmonary disease and they took care of patients with respiratory diseases, critical care, allergy diseases and some internal medicine problems. (PX1 at 7). Dr. Paul also wrote a book concerning asthma. *Id.* He had 5,000 patients in his census. *Id.* He performed and read 15-20 chest x-rays a day, 100 a week and maybe 5,000 a year. *Id.* He interpreted pulmonary function testing at the same frequency. (PX 1 at 8). Dr. Paul has been treating coal Petitioners for coal mine induced lung disease back since the 1970s. *Id.*

Dr. Paul examined Petitioner on August 4, 2015 at the request of Petitioner's law firm. (PX 1 at 9). He conducted a patient history, physical exam of the chest, pulmonary function studies, read a chest x-ray and reviewed a B-reading along with that chest x-ray. *Id.* He also did a CBC. (PX 1 at 9-10). Dr. Paul agreed that in order to have pneumoconiosis, you must have, in addition to coal mine dust deposited in your lungs, a tissue reaction to it. (PX 1 at 10-11). He further agreed that the tissue reaction could be called scarring or fibrosis. (PX 1 at 11). He stated the scarring of CWP could not perform the function of normal healthy lung tissue. *Id.* He agreed that you could call the halo around the scarring a focal emphysema. *Id.* Dr. Paul agreed that if you had CWP, you had some impairment in the function of the lung at the site of the scarring whether it could be measured by spirometry or not. *Id.* Spirometry measured global impairment. *Id.* He agreed it was possible to have injury or disease in the lung despite having normal pulmonary function test results. (PX 1 at 12). A person could have shortness of breath despite having pulmonary function tests within the range of normal. *Id.* A person could have a lobe of a lung surgically removed and still have pulmonary function tests within the range of normal. *Id.*

Dr. Paul agreed that when he had pulmonary tests and compared them to a range of normal, the tests did not tell him anything about what the prior position of the specific Petitioner was. (PX 1 at 13). He further agreed that it was reasonable, if he wanted to know whether or not a specific exposure caused impairment of a Petitioner's lungs he would need to have serial pulmonary function tests, pre-tests and post-tests. *Id.* Dr. Paul agreed that pulmonary function testing will tell you the type of abnormality, whether its obstructive or restrictive and how severe it is, but would not tell the etiology of it. (PX 1 at 14). Dr. Paul stated that emphysema, in any of its forms, if significant to cause a measurable defect, would cause an obstructive condition. *Id.* The scarring of pneumoconiosis could be either or both obstructive or restrictive. *Id.*

Dr. Paul agreed that a person with radiologically significant CWP may not have shortness of breath.. (PX 1 at 14-15). He further agreed that a person could have radiographically significant CWP and have normal pulmonary function testing, normal blood gases and normal physical examination of the chest. (PX 1 at 15). Dr. Paul stated that CWP was considered a progressive disease. *Id.* He agreed that with further exposure it could progress to progressive massive fibrosis, complicated pneumoconiosis or cor pulmonale all of which could be life-threatening. *Id.* There was no cure for coal workers' pneumoconiosis. (PX 1 at 15-16). Coal workers' pneumoconiosis could still progress if a coal worker ended his exposure to coal mine dust and had coal workers' pneumoconiosis. (PX 1 at 16). There was no way to stop the progression if the disease was progressing. *Id.* A coal Petitioner with CWP could not have any further exposure to coal mine dust without endangering their health because the coal exposure may increase the progression of the disease. *Id.* Dr. Paul agreed there were exposures in the coal mine environment that could injure the lungs in addition to just coal dust. (PX 1 at 17). He agreed these included silica, diesel fumes, fumes from other petroleum products, smoke and fumes from high sulfer coal fires, smoke and fumes from electrical cable fires, fumes from glues used in the roof bolting process, and welding fumes. *Id.*

Dr. Paul agreed that COPD was an umbrella term for a number of obstructive diseases. (PX 1 at 17-18). He further agreed those diseases included emphysema, chronic bronchitis and asthma. (PX 1 at 18). He further agreed that under the federal black lung program, coal workers' pneumoconiosis could result in a COPD-like condition. *Id.* Dr. Paul agreed the inhalation of coal dust could result in shortness of breath, chronic cough, emphysema, chronic bronchitis and occupational asthma. (PX 1 at 20-21). He further agreed that the exposures that could be found in the environment of a coal mine could aggravate the emphysema, chronic bronchitis and asthma. (PX 1 at 21).

Dr. Paul stated that if an examining doctor got a bunch of treatment records that it would not change what was seen on an x-ray. (PX 1 at 21). He agreed that no matter what would be in the treatment records, they would

not change the results obtained on pulmonary function testing. *Id.* It would not change what you found on physical examination of the man's chest. (PX 1 at 22). It would not change in any way your diagnosis based on your reading of the x-ray, your pulmonary function tests and your physical examination. *Id.*

Dr. Paul agreed that if a person had chronic obstructive pulmonary disease or obstructive lung disease it was the best medical practice to avoid any further Exposure to those agents that could cause or aggravate it. (PX 1 at 22). Dr. Paul agreed that chronic bronchitis was one of the chronic obstructive pulmonary diseases. (PX 1 at 25). He stated you could have chronic bronchitis with normal pulmonary function, normal blood gas testing and normal physical exam of the chest. (PX 1 at 25-26). He testified that if you had further exposure to coal mine dust after you have chronic bronchitis, it could be a progressive disease. (PX 1 at 26). Anything that you inhale that's dusty, such as coal dust, can make a chronic bronchitis worse. *Id.* Dr. Paul further testified that he suspected chronic bronchitis could progress to the point that it begins to develop as a fixed obstructive process, which was what you usually saw in asthma when it was severe and prolonged. *Id.*

Dr. Paul agreed that Petitioner was not a cigarette smoker. (PX 1 at 26). His pulmonary function testing was within the range of normal. (PX 1 at 26-27). The methacholine challenge test was also normal. (PX 1 at 27). Dr. Paul found that Petitioner had coal workers' pneumoconiosis based on his chest x-ray. *Id.* The cause of the CWP was exposure to coal mine and coal mine dust. *Id.* In light of the CWP, Dr. Paul stated that Petitioner could not have any further Exposure to coal mine dust without endangering his health. *Id.* Dr. Paul stated that the some of the coal dust from 30 years of coal mining would remain in the lungs for the rest of the Petitioner's life and the tissue next to the coal dust in the lungs would be exposed to that coal mine dust for the rest of his life. (PX 1 at 28). Dr. Paul stated there were studies that showed that fifty percent of the lung weight could be coal mine dust. *Id.* The lungs themselves had low weight and therefore the coal dust inhalation could increase proportionately. (PX 1 at 28-29). Dr. Paul could not recall the name of the study related to lung weight. (PX 1 at 37).

Dr. Paul stated that the gold standard for diagnosing CWP was pathology. (PX 1 at 29). He stated that a person could have a chest x-ray read as negative for CWP by a competent B-reader or radiologist yet still have CWP. *Id.* He agreed there were studies that showed it was common for long-term Petitioners to have CWP on autopsy that was not diagnosed radiographically. *Id.* An x-ray that was positive for CWP with a sufficient exposure for the disease was sufficient to make a diagnosis of CWP. (PX 1 at 29-30). Dr. Paul believed that a negative interpretation was not sufficient to rule out CWP. (PX 1 at 30). He could not recall the name of the studies or the dates they were issued. (PX 1 at 38).

Dr. Paul did not review any of Petitioner's medical records prior to the exam or before the deposition. (PX 1 at 32). His sole diagnoses from the exam were coal workers' pneumoconiosis and hypercholesterolemia. *Id.* Dr. Paul did not diagnose COPD, bronchitis, emphysema, or asthma. *Id.* He did not find any restrictive impairment either. (PX 1 at 33). He agreed that pneumoconiosis was a permanent and progressive disease which had no cure. *Id.* He stated that if Petitioner had CWP, he would not expect Petitioner's pulmonary function testing would improve; he would expect the values would get worse. *Id.*

Dr. Paul is not a board-certified pulmonologist. (PX 1 at 33-34). He is not a B-reader, a board-certified radiologist or a board eligible radiologist. *Id.* He did not compare Petitioner's chest film with the ILO radiographic films to determine if Petitioner had pneumoconiosis and did not classify the film according to ILO classifications. *Id.* He looks at an x-ray to see if it shows fibronodular lesions; "you either have it or you don't." (PX 1 at 34-35). He could not make the conversion of "mild" to an ILO classification because he did not use them again stating "you either got it or you don't." *Id.* Dr. Paul did not recommend any follow up treatment for Petitioner as a result of the exam. (PX 1 at 35-36). His sole restriction was based on the finding of

pneumoconiosis. (PX 1 at 36). If Petitioner did not have pneumoconiosis, the restriction would not be valid. *Id.* He agreed that Petitioner retained the pulmonary capability to perform his job at the mine. *Id.*

Dr. Westerfield was deposed on April 7, 2017. (RX 4). Dr. Westerfield is a B-reader and is board certified in internal medicine, pulmonary medicine and sleep medicine. (RX 4 at 4). He has been board certified in pulmonary medicine since 1980 and a B-reader since 1991. (RX 4 at 5). Dr. Westerfield's pulmonary practice is limited to occupational lung disease. (RX 4 at 6). He also did sleep disorders but his occupational lung disease practice dealt with independent medical evaluations on behalf of the State of Kentucky, the Federal Black Lung Program, plaintiffs, defendants and insurance companies. *Id.* He was currently the state examiner for Kentucky's black lung program. (RX 4 at 7).

Dr. Westerfield took a work history from Petitioner which revealed he worked 30 years in the coal mines and retired in 2014. (RX 4 at13). He worked underground and had various jobs, including on the belt line and rock dusting. *Id.* The physical examination was normal. (RX 4 at 13). He was a healthy, very pleasant gentleman. *Id.* His chest exam was completely normal. *Id.* There was no evidence of any cardiac or pulmonary disease. *Id.* There were no pulmonary abnormalities. *Id.* Dr. Westerfield also performed an electrocardiogram, a chest x-ray, pulmonary function testing - which included spirometry, lung volume measurements, and diffusing capacity - as well as arterial blood gas testing. (RX 4 at 14). Dr. Westerfield personally reviewed the chest x-ray and, as a B-reader, was required to review the film by comparing it to the standard ILO classification x-rays. (RX 4 at 14-15). Petitioner had a completely normal chest x-ray in terms of his lung findings - his lungs were normal. (RX 4 at 15). Dr. Westerfield explained there was a range for classifying chest films from zero up to three for CWP. *Id.* There were three profusion categories for each of the divisions of zero, one, two and three and the film was graded based on the profusion. *Id.* Petitioner was completely negative. *Id.* Dr. Westerfield also reviewed the August 4, 2015 chest film and it was also negative for any cardiopulmonary disease with no evidence of pneumoconiosis or any other heart or lung problem. (RX 4 at 16).

Dr. Westerfield was aware that Dr. Paul and Dr. Smith both read the August 4, 2015 chest film as positive for CWP and was also aware that their readings differed with Dr. Paul only finding the disease in the lower zones and Dr. Smith finding it in all zones. (RX 4 at 17). He stated this was a significant difference because CWP occurs first in the upper lung fields and then it is seen later in the lower lung fields. *Id.* He explained that lower lung field-only findings were not generally associated with CWP; they were associated with asbestosis. (RX 4 at 18). Dr. Westerfield did not find any abnormalities in the lower lung zones or any of the lung zones. *Id.* There were no abnormalities consistent with a diagnosis of pneumoconiosis on any of the chest films except the finding by Dr. Smith and a 2003 reading. *Id.* The remainder of the interpretations were all negative. *Id.*

Dr. Westerfield stated that both Dr. Paul's testing and his own were valid with full effort. (RX 4 at 22). There was no evidence of any pulmonary impairment on either Dr. Paul's testing or his own. *Id.* If a Petitioner had a pulmonary condition caused by coal dust exposure, the values on spirometry would not improve. (RX 4 at 22-23). If the pulmonary function testing and spirometry improved over time, it would indicate that a person did not have pneumoconiosis. (RX 4 at 23). Dr. Westerfield explained that coal workers' pneumoconiosis was permanent and progressive so it was not going to get better but could worsen over time. *Id.* It may not get much worse but it would not get better and that would not support a diagnosis of pneumoconiosis. *Id.*

Dr. Westerfield stated that Petitioner's diffusion capacity, lung volume measurements and arterial blood gas testing were all excellent and normal. (RX 4 at 24-25). Based on the testing there was no evidence of pulmonary impairment. (RX 4 at 25). Petitioner had normal lung function. *Id.* Dr. Westerfield did not diagnose any pulmonary condition and there was no evidence of emphysema. (RX 4 at 26). After reviewing all the records, reports, chest x-rays, pulmonary function testing, and arterial blood gas testing, Dr. Westerfield

opined that Petitioner did not have coal workers' pneumoconiosis or any other pulmonary disease. *Id.* There was no evidence of either a restrictive or obstructive pulmonary condition. *Id.* Petitioner had the breathing capacity to return to his previous position in coal mine employment or employment with equal energy needs in other industries. *Id.*

Dr. Westerfield further explained that the AMA issued guidelines for evaluation of all impairments for many years. (RX 4 at 27). They were currently up to the Sixth Edition and there was a chapter specifically evaluating respiratory impairment. *Id.* There were tables with subject values and you reviewed the tables to see how a person fits in the table for impairment. *Id.* Based on the testing by both physicians, Petitioner was a class zero, 0% impairment based on the Sixth Edition. *Id.* Dr. Westerfield agreed that both his pulmonary function testing, as well as Dr. Paul's was normal. (RX 4 at 31). If Petitioner had a progressive disease like coal workers' pneumoconiosis, the tests would show worse, not better values. (RX 4 at 31-32).

Petitioner's case proceeded to arbitration on May 3, 2018. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he was 67 years old at the time of the hearing. Following graduation from high school and 1 ½ years of junior college, Petitioner worked approximately 30 years with Respondent (1984 - 2014). He was regularly exposed to coal dust, rock dust, silica dust and diesel fumes and was 64 years old when he left the mine.

Petitioner testified that his first job at the coal mine was as a "general laborer" building brattices which involved fiberglass sealant which released fumes and smoke that required the use of a mask. He worked this job for a couple of years. He then worked at the face for about 3-4 years. His remaining employment was at the outby, which he explained was anywhere but at the face of the mine. For these 20 years he worked as a "waterman" which involved driving a Jeep with a water wagon that used hydraulics to spray water behind the Jeep. He explained that the Jeep was indoors and they had scrubbers on the diesel equipment but if the scrubbers were not up to par, you would breathe the diesel fumes. He stated the fumes were the worst when equipment was moved in or out of the mine. The electricity generators also emitted a lot of fumes. If he had to creep behind the generator he would be exposed to carbon monoxide that would cause him to get light-headed and dizzy. His job also involved rock dusting which was done to keep the level of methane down. Petitioner explained that rock dust was comprised of ground limestone and he would use a mask, but not all the time because it made him feel like he was suffocating. Petitioner worked his last twenty years on the third shift when the mine was idle. He stated that coal production only occurred during the first and second shifts.

Petitioner agreed that he was doing pretty good with his breathing since he left the mine. He never smoked cigarettes and had no health problems. He took Occuvite for his eyes and cholesterol medicine. He was not taking any pulmonary medication. He stated there was a lay off when he first started working at the mine that lasted a couple months. He was off work for a work-related injury stemming from a chain for 3 ½ to 4 months and off a similar length of time for a non-work-related event. Petitioner stated that he left the mine because it was time to go and he was grouchy. He voluntarily resigned from Respondent and did not advise anyone at the mine that he was leaving due to a pulmonary condition. He did not work anywhere else after he left the mine.

<u>The Arbitrator Concludes:</u>

The Occupational Disease Act requires that an employee prove he was disabled within two years of his last date of exposure. 820 ILCS 310/1(f). Disablement is defined under the Act as an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of

becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment. 820 ILCS 310/1(e). Therefore, pursuant to Sections 1(e) and 1(f), the employee must show that he was disabled from an occupational disease prior to May 14, 2016.

1. Coal Workers' Pneumoconiosis

While one of the three readings for the 2003 NIOSH film was positive for pneumoconiosis, all of the final determinations for each of the five NIOSH films were negative for coal workers' pneumoconiosis. (RX 5 at 3). There was one chest CT scan in Petitioner's medical records from June 5, 2009 that contained no diagnosis of coal workers' pneumoconiosis. (RX 6 at 40-41; RX 7 at 25-26; PX 4 at 5-6). There were four chest x-rays in Petitioner's medical records, October 11, 2006, November 2, 2007, January 17, 2008 and August 10, 2012. (RX 7 at 27, RX 6 at 52, RX 8 at 13, 6). None of those films diagnosed coal workers' pneumoconiosis or any other pulmonary disease associated with coal dust exposure. *Id.*

There were two chest films taken as part of the litigation. The first was taken at Dr. Paul's office on August 4, 2015 and was read as having "mild" pneumoconiosis by Dr. Paul. (PX 1, ex. 2 at 2). The film was interpreted by Dr. Smith as positive for pneumoconiosis at a 1/0 ILO classification level. (PX2 at 1). The remaining two B-readers, Dr. Westerfield and Dr. Meyer read the film as negative for the disease. (RX2 at 2; RX1 at 1-2). The most recent film in the record was taken as part of Dr. Westerfield's March 26, 2016 examination. Both B-readers who reviewed the film found it was negative for coal workers' pneumoconiosis. (RX 3 at 12; RX1 at 3-4).

While Dr. Paul opined that Petitioner had coal workers' pneumoconiosis, he conceded that if this was correct, Petitioner's pulmonary function testing would not improve. (PX 1 at 33). Dr. Westerfield agreed that improved pulmonary function testing was evidence that a Petitioner did not have coal workers' pneumoconiosis due to the permanent and progressive nature of the disease. (RX 4 at 23). The pulmonary function testing from Dr. Paul's testing on August 4, 2015 revealed an FEV1 of 3.39 and an FVC of 4.21. (PX 1 at ex. 2, page 3). Seven months later, on March 26, 2016, Dr. Westerfield's pulmonary function testing revealed an FEV1 of 3.56 and an FVC of 4.56. (RX 3 at 14).

None of the radiographic evidence in Petitioner's medical records diagnosed coal workers' pneumoconiosis. NIOSH ultimately found that all the films taken from 1991 to 2012 were negative for pneumoconiosis. Dr. Paul's lack of B-reading credentials undermines reliance on his opinion. Of the qualified B-readers, there was conflict between the three B-readers with one finding pneumoconiosis on the August 2015 film and the other two B-readers finding the film was negative for the disease. There was no conflict between the B-readers for the most recent chest x-ray dated May 2016 with both readers finding the film was negative for pneumoconiosis.

The opinions of Dr. Westerfield and Dr. Meyer were consistent with the radiological chest x-ray interpretations in Petitioner's medical records as well as NIOSH's ultimate findings on the films from 1991 to 2012. Their opinions were also consistent with the medical testimony addressing pulmonary function testing and coal workers' pneumoconiosis. The improved pulmonary function testing values from Dr. Paul's testing in August 2015 and Dr. Westerfield's testing in March 2016 further undermines a finding of coal workers' pneumoconiosis. For these reasons, the arbitrator finds the preponderance of the radiological and medical opinion evidence fails to support a finding of coal workers' pneumoconiosis.

2. Any other occupational disease

Dr. Paul provided lengthy testimony indicating that COPD, emphysema, chronic bronchitis, asthma and restrictive impairments could arise from coal dust exposure. (PX 1 at 14, 15, 17-18, 20-21). However, Dr. Paul conceded that Petitioner did not have any of those medical conditions. (PX 1 at 33). Dr. Westerfield also found that Petitioner did not have any pulmonary disease and had no evidence of any obstructive or restrictive pulmonary condition. (RX 4 at 26). Nothing in the medical records attributed any of Petitioner's diagnoses to his coal mining employment. For these reasons, the Arbitrator finds the preponderance of the evidence fails to support a finding of any other occupational disease stemming from Petitioner's coal mine employment.

3. Conclusion

The preponderance of the evidence fails to support a conclusion that Petitioner has coal workers' pneumoconiosis or was disabled from any occupational disease with two years of his last exposure, May 14, 2014. For these reasons, benefits are denied and all other issues are moot. reasons, benefits are denied and all other issues are moot.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Louis Wager,

Petitioner,

vs. NO: 12 WC 32756

State of Illinois/IYC-Kewanee,

19IWCC0571

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's 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 29, 2018, is hereby affirmed and adopted.

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

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

DATED: OCT 22 2019
TJT:yl
o 10/8/19

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WAGER, LOUIS
Employee/Petitioner

Case# **12WC032756**

SOI/IYC-KEWANEE
Employer/Respondent

19IWCC0571

On 5/29/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
MICHAEL BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

5300 ASSISTANT ATTORNEY GENERAL
CODY KAY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 29 2018

19IWCC0571

STATE OF ILLINOIS)
)SS.
COUNTY OF **Rock Island**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Louis Wager
Employee/Petitioner

v.

SOI/IYC-Kewanee
Employer/Respondent

Case # **12** WC **32756**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **4/4/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/16/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**90,827.88**; the average weekly wage was $**1,746.69**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**41,572.90**, as set forth in Petitioner's exhibit 8, 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.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**712.55**/week for a further period of **87.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **17.5% 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.

Michael K. Nowak, Arbitrator

3/27/18
Date

MAY 2 9 2018

FINDINGS OF FACT

Petitioner was employed with the Illinois Youth Center in Kewanee, Illinois on August 16, 2012 as a supervisor of the guards. This required him to answer any and all emergencies such as altercations. Physically, this required him to run from one end of the prison to the other and also to break up altercations. He described the work as being very physical.

On August 16, 2012, Petitioner was called to break up an altercation. During that altercation, he suffered an injury to his low back. Petitioner candidly testified that he previously had low back pain and had an epidural steroid injection on the right side.

Following this accident, Petitioner went to see his primary care physician at OSF Medical Group He provided a consistent history regarding injuring his low back at work. X-rays of his lumbar area were taken. He returned the next day due to symptoms and pain associated with the injury.

On August 27, 2012, after his visit with this primary care physician, Petitioner went to Kewanee Physical Therapy and Rehab Specialists for physical therapy. At the initial evaluation, he gave a consistent history of breaking up a fight at work on August 16, 2012. Petitioner stated that he continued to have severe significant pain in the lower back going down the left leg.

He followed up with his primary care physician until September 16, 2012. At that time, an MRI of his lumbar spine was ordered. When the MRI was ordered, it was noted in the doctor's records that the Petitioner had pain radiating down to his left leg. He had not had significant improvement since the accident. The MRI took place on September 25, 2012 and showed a multi-level degenerative arthrosis with degenerative disc changes at L5, S1 levels.

Petitioner followed up with his primary care doctor on October 2, 2012. The MRI was reviewed and he was referred to pain management. He came under the care of Dr. Baha with the Illinois Neurological Institute and underwent a series of three epidural steroid injections between November 15, 2012 and January 10, 2013.

Each injection wore off shortly after being given. Because of this, Petitioner was referred to Dr. Fassett, who was also with the Illinois Neurological Institute. He saw Dr. Fassett on February 18, 2013 and gave a consistent history of breaking up a fight at work causing lower extremity pain. Dr. Fassett noted that Petitioner had completed physical therapy and had undergone three epidural steroid injections. Dr. Fassett reviewed the actual film of the MRI and conducted an examination. Dr. Fassett indicated that surgery may not help Petitioner's back pain. Dr. Fassett ordered a bone scan to help him determine the source of the pain and aid him in arriving at treatment options. The bone scan occurred on February 25, 2013 and showed an avid uptake at L5-S1 disc space as well as within the L5-S1 facet. Further, the bone scan indicated severe degeneration at that level. Based on the review of the bone scan, Dr. Fassett testified that he was a little more optimistic that surgery could help the back pain as he believed that he had found the source of the pain. This surgery did not take place at that time as the Respondent scheduled an IME with Dr. Pineda.

On April 15, 2013, Petitioner saw Dr. Pineda. His diagnosis was that the Petitioner's main problem was associated predominantly with the degenerative disc disease at L5, S1. He thought that it was possibly

aggravated by the work accident. It was his opinion that surgery would not fix the problem. Based upon the opinion of Dr. Pineda, the Respondent maintained their denial of the surgery.

On May 14, 2013, Petitioner was involved in a motorcycle accident. The medical records were introduced into evidence. These medical records clearly reflect that he did not injure his back.

Petitioner retired as of August 1, 2013. He indicated that one of the reasons he retired was because he was a first responder and he was not able to run to intervene in altercations nor was he physically capable of breaking up the fights that occur in the facility.

Petitioner indicated that the pain in his low back continued even after he retired. Further, he still had the radicular pain down the left leg. He returned to see Dr. Fassett on July 16, 2015. Dr. Fassett ordered a new MRI. The new MRI showed multi-segment spondylosis, with the most severe area still being of L5-S1 level.

Following the review of the MRI, the Petitioner underwent surgery with Dr. Fassett at OSF St. Francis Medical Center on October 28, 2015. The procedure consisted of a left L5-S1 hemilaminectomy, medial facetectomy, discectomy, and decompression of the S1 nerve. The post-operative diagnosis was L5-S1 disc bulge with lateral recessed stenosis and radiculopathy.

Petitioner followed up one time following the surgery on November 30, 2015 and was released from the doctor's care. Petitioner indicated that he has had a good result from the surgery. He occasionally takes over the counter medication.

CONCLUSIONS

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

The medical records and testimony of the Petitioner indicate that the only problem that he had with the low back prior to the August 16, 2012 accident involved sudden low back and radicular pain going down the right leg. He had an epidural injection and that condition was resolved. The Petitioner testified that he never had symptoms involving the radicular pain going down the left leg until this accident. None of the medical records dispute his complaints. The reason why the surgery was performed by Dr. Fassett was to stop the pain associated with the L5, S1 level as well as the radicular pain going down the left leg. That pain was relieved along with the radiculopathy. Dr. Fassett provided his opinion within a reasonable degree of medical certainty that those conditions were related to the accident of August 16, 2012.

It is not lost on the Arbitrator that there was an approximately 2 year gap in treatment with Dr. Fassett following Respondent's refusal to authorize Petitioner's surgery. However, the evidence indicates that during this period Petitioner continued to suffer unremitting low back pain with radiation down the left leg.

Likewise Petitioner was involved in a motorcycle accident between the initial recommendation for surgery and his return to Dr. Fassett in July of 2015. There, however no evidence of further injury to Petitioner's low back in the accident.

The Arbitrator finds the testimony and opinions of Dr. Fassett more persuasive than those of Dr. Pineda.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds that Petitioner has met his burden of establishing that the condition of ill-being in Petitioner's low back and the surgery performed to treat that condition were causally related to the accident.

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

The only dispute that Respondent had regarding the medical bills was liability. Having found the condition of Petitioner's low back which required surgery was causally related to the accident, the Arbitrator further finds that the surgical procedure of August 28, 2015 and the related treatment were reasonable and necessary. Therefore, Respondent shall pay reasonable and necessary medical services of $41,572.90, as set forth in Petitioner's exhibit 8, as provided in Sections 8(a) and 8.2 of the Act.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was a prison guard as of the date of the accident and Petitioner took an early retirement with one of the factors being his inability to perform his job adequately due to the injuries suffered. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of his injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner took an early retirement due, in part, to his inability to perform his job adequately due to the injuries suffered. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner underwent a series of three epidural injections and eventually underwent surgery as a result of the injuries sustained to his low back. The Petitioner had a good result from the surgery. The Arbitrator therefore gives *some* 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 17.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Elizabeth Brown,
Petitioner,

vs. NO: 09 WC 18312

State of Illinois Department of Human Services,
Respondent.

19IWCC0572

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability 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 December 21, 2018, is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(l) 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 23 2019
o091219
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROWN, MARY ELIZABETH
Employee/Petitioner

Case# **09WC018312**

ST OF IL DEPT OF HUMAN SERVICES
Employer/Respondent

19IWCC0572

On 12/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.48% 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:

5700 RICE LAW OFFICES LTD
PHILIP RICE
110 E LINCOLN ST
BELLEVILLE, IL 62220

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

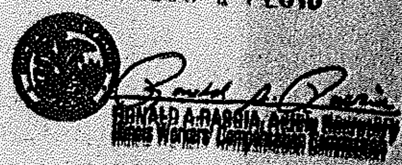
6137 ASSISTANT ATTORNEY GENERAL
CORI STEWART
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

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

DEC 21 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARY ELIZABETH BROWN
Employee/Petitioner

Case # 09 WC 18312

v.

Consolidated cases: N/A

STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES
Employer/Respondent

19IWCC0572

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 25, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0572

FINDINGS

On January 7, 2009, the Respondent, State of Illinois Department of Human Services, ***was*** operating under and subject to the provisions of the Act.

On January 7, 2009, an employee-employer relationship ***did*** exist between the Petitioner and Respondent.

On January 7, 2009, the Petitioner ***did*** sustain injuries that arose out of and in the course of employment.

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

In the year preceding the injury, the Petitioner earned **$15,878.20**; the average weekly wage was **$305.35.**

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

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

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 during the period from **January 7, 2009** through **October 25, 2018**, a period comprising **509 weeks**. Respondent has paid Temporary Total Disability benefits in the amount of **$64,513.23.**

ORDER

Respondent shall pay Petitioner temporary total disability benefits of Petitioner is entitled to Temporary Total Disability benefits of **$237.67/week**, for **509 weeks**, commencing **January 7, 2009 through October 25, 2008**, as provided in Section 8(b) of the Act. Respondent shall receive credit for TTD previously paid in the amount of $64,513.23.

Respondent shall pay Petitioner permanent partial disability benefits of **$237.67 per week** for a period of **200 weeks** because the injuries sustained caused the **40% loss of the person as a whole,** as provided in Section 8(d02 of the Act.

Respondent shall reimburse Petitioner for cash/credit card payments which she directly made to the healthcare providers, as specified below:

Dr. Randy Silverstein

1/9/09	$25.00
2/9/09	$25.00
3/20/09	$25.00
4/3/09	$25.00
7/1/09	$25.00

Washington University Physicians

10/2/09	Dr. Yi	$20.00
7/8/10	Dr. Yi	$40.00
8/9/10	Dr. Yi	$30.00

Rehabilitation Institute of St. Louis

$40.00

Dr. Mary Agne/Illini Family Medicine

9/1/10	$20.00	3/10/11	$20.00
10/13/10	$20.00	4/28/11	$20.00
10/28/10	$20.00	5/31/11	$20.00
12/14/10	$20.00	8/1/11	$20.00
1/17/11	$20.00	9/20/11	$20.00
1/31/11	$20.00		

10/27/11	$25.00	11/5/12	$20.00
11/28/11	$20.00	12/13/12	$20.00
12/8/11	$12.07	1/10/13	$20.00
2/2/12	$20.00	2/14/13	$20.00
5/31/12	$60.00	3/25/13	$20.00
7/24/12	$20.00	4/30/13	$20.00
8/30/12	$20.00		
10/8/12	$20.00		

6/11/13	$20.00	4/30/14	$20.00
8/13/13	$20.00	6/6/14	$10.00
9/10/13	$20.00	7/8/14	$10.00
11/18/13	$20.00	10/6/14	$10.00
1/2/14	$20.00		
2/6/14	$20.00		
3/6/14	$20.00		

Dr. Anwar Khan

12/22/11 $30.00

Barnes-Jewish Hospital Pharmacy

1/13/09	Propoxyphen (hereafter "propox")	$5.60
1/23/09	Cyclobenzaprine (hereafter "cyclo")	$5.67
6/2/09	Propox	$5.60
10/8/09	Lyrica	$45.00
3/22/10	Cyclo	$9.78
3/22/10	Propox	$7.19
3/26/10	Hydrocodone	$10.00
8/12/10	Cyclo	$9.50
9/11/10	Cyclo	$9.50
10/29/10	Propox	$6.60
12/17/10	Tramadol	$4.63
2/10/11	Oxycodone	$5.41
3/14/11	Oxycodone	$5.41
3/17/11	Gabapentin	$8.08
4/30/11	Oxycodone	$5.41
6/1/11	Oxycodone	$5.41
8/4/11	Oxycodone	$10.00
10/28/11	Oxycodone	$10.00

11/29/11	Oxycodone	$10.00
3/1/12	Oxycodone	$9.41
6/7/12	Oxycodone	$10.00
8/31/12	Oxycodone	$10.00
10/9/12	Oxycodone	$10.00
12/17/12	Oxycodone	$10.00
1/10/13	Oxycodone	$10.00
1/10/13	Fentanyl	$10.00
2/19/13	Oxycodone	$10.00
5/2/13	Oxycodone	$10.00

CVS Pharmacy

7/23/13 Oxycodone $10.00

Respondent shall pay balances owed on medical bills identified below as follows, to the extent required under the Illinois Medical Fee Schedule:

DR. RANDY SILVERSTEIN

1/9/09	$81.00	4/24/09	$81.00
1/23/09	$81.00	6/1/09	$81.00
2/6/09	$81.00	7/1/09	$81.00
2/27/09	$81.00	8/5/09	$81.00
3/20/09	$81.00	9/11/09	$81.00
4/3/09	$81.00	12/7/09	$81.00

BARNES-JEWISH HOSPITAL

1/9/09	$254.00
1/30/09	$359.00
3/6/09	$2783.00
10/2/09	$182.00
2/1-10/7/10	$8986.80

WASHINGTON UNIVERSITY PHYSICIANS

1/9/09	$35.00
1/30/09	$67.00
3/6/09	$279.00
10/2/09	$351.00
2/1/10	$1605.00
2/25/10	$1605.00
3/25/10	$127.00
5/7/10	$127.00
7/8/10	$1305.00
8/9/10	$127.00
8/31/10	$1432.00
10/7/10	$700.00
10/7/10	$905.00

REHABILITATION INSTITUTE OF ST. LOUIS

3/9-5/19/09 $840.00

DR. MARY AGNE/ILLINI FAMILY MEDICINE

Date	Amount	Date	Amount
9/1/10	$132.00	2/9/11	$70.00
10/13/10	$70.00	3/10/11	$70.00
10/28/10	$70.00	4/28/11	$70.00
11/18/10	$70.00	5/31/11	$70.00
12/14/10	$103.00	6/21/11	$75.00
1/17/11	$70.00	8/1/11	$75.00
1/31/11	$114.00	9/20/11	$110.00

Date	Amount	Date	Amount
10/27/11	$75.00	8/30/12	$110.00
11/28/11	$75.00	10/8/12	$110.00
12/8/11	$75.00	11/5/12	$75.00
12/29/11	$75.00	12/13/12	$110.00
2/2/12	$75.00	1/10/13	$113.00
4/17/12	$75.00	2/14/13	$113.00
5/31/12	$75.00	3/25/13	$113.00
7/24/12	$110.00	4/30/13	$113.00

Date	Amount	Date	Amount
6/11/13	$113.00	4/30/14	$113.00
8/13/13	$113.00	6/6/14	$201.00
9/10/13	$113.00	7/8/14	$113.00
11/18/13	$113.00	9/8/14	
1/2/14	$149.00	10/6/14	$201.00
2/6/14	$113.00	12/2/14	$77.00
3/6/14	$113.00	3/11/15	$79.00
4/18/14		4/10/15	$79.00

Date	Amount	Date	Amount
5/11/15	$203.00	6/9/16	$206.00
6/8/15	$131.00	7/5/16	$81.00
7/17/15	$115.00	8/4/16	$170.00
8/13/15	$79.00	9/8/16	$118.00
10/12/15	$115.00		
10/12/15	$115.00		
12/7/15	$79.00		
1/4/16	$169.00		
5/12/16	$118.00		

NOTE: FURTHER BILLS LACK DESCRIPTION.

MEMORIAL HOSPITAL

Date	Amount
2/24/11	$3121.00
3/15/11	$138.00
3/28/11	$2943.67
4/15/11	$2943.67
4/29/11	$2943.67
5/12/11	$149.00
6/16/11	$149.00
9/15/11	$149.00
9/22/11	$369.00

DR. ANWAR KHAN

12/22/11 $195.00

BARNES-JEWISH HOSPITAL

(NOTE: Following are listed on Petitioner's Exhibit 27 – bills paid by UMR)

1/28/11 $1276.00
1/28/11 $65.50
1/29/11 $55.00

ADVANCED DIAGNOSTIC IMAGING

(Listed on Petitioner's Exhibit 27)

2/28/11 $264.00

ANESTHESIA ASSOCIATES OF BELLEVILLE

3/15/11 $560.00
3/28/11 $500.00
4/15/11 $500.00
4/15/11 $250.00
4/29/11 $500.00
4/29/11 $250.00
5/12/11 $160.00
6/16/11 $160.00
9/15/11 $160.00

QUEST DIAGNOSTICS

(From Petitioner's Exhibit 27)

4/28/11 $141.00

PAIN REHAB PRODUCTS, INC.

(From Petitioner's Exhibit 27)

9/22/11 $495.00

BJC HOME MEDICAL EQUIPMENT

(From Petitioner's Exhibit 27)

3/9/09 $29.91

BARNES-JEWISH HOSPITAL PHARMACY

1/13/09	Propoxyphen (hereafter "propox")	$5.60
1/23/09	Cyclobenzaprine (hereafter "cyclo")	$5.67
6/2/09	Propox	$5.60

10/8/09	Lyrica	$45.00
3/22/10	Cyclo	$9.78
3/22/10	Propox	$7.19
3/26/10	Hydrocodone	$10.00
8/12/10	Cyclo	$9.50
9/11/10	Cyclo	$9.50
10/29/10	Propox	$6.60
12/17/10	Tramadol	$4.63
2/10/11	Oxycodone	$5.41
3/14/11	Oxycodone	$5.41
3/17/11	Gabapentin	$8.08
4/30/11	Oxycodone	$5.41
6/1/11	Oxycodone	$5.41
8/4/11	Oxycodone	$10.00
10/28/11	Oxycodone	$10.00
11/29/11	Oxycodone	$10.00
3/1/12	Oxycodone	$9.41
6/7/12	Oxycodone	$10.00
8/31/12	Oxycodone	$10.00
10/9/12	Oxycodone	$10.00
12/17/12	Oxycodone	$10.00
1/10/13	Oxycodone	$10.00
1/10/13	Fentanyl	$10.00
2/19/13	Oxycodone	$10.00
5/2/13	Oxycodone	$10.00

WALMART PHARMACY

9/8/14	Oxycodone	$171.91
11/5/14	Oxycodone	$176.91
12/4/14	Oxycodone	$176.91
1/8/15	Oxycodone	$133.49
2/11/15	Oxycodone	$133.49
4/12/15	Oxycodone	$120.24
5/25/15	Oxycodone	$120.24
7/4/15	Oxycodone	$4.83
7/17/15	Oxycodone	$120.24
8/14/15	Oxycodone	$116.98
9/8/15	Oxycodone	$116.98
10/13/15	Oxycodone	$116.98
11/13/15	Oxycodone	$116.98
12/7/15	Oxycodone	$116.98
1/6/16	Oxycodone	$93.00
3/10/16	Oxycodone	$93.00
4/14/16	Oxycodone	$93.00
5/12/16	Oxycodone	$93.00
6/9/16	Oxycodone	$93.00
7/5/16	Oxycodone	$93.00
8/4/16	Oxycodone	$93.00
9/8/16	Oxycodone	$93.00
10/13/16	Oxycodone	$93.00

Respondent shall also satisfy the lien of UMR for payment of medical bills in the amount of $15,943.68 to the satisfaction of UMR and shall hold Petitioner harmless in regard to said lien.

Respondent shall also satisfy the lien of Equian for payment of medical bills in the amount of $2,886.97 to the satisfaction of Equian and shall hold Petitioner harmless in regard to said lien.

Respondent shall pay Petitioner compensation that has accrued between **January 7, 2009** and **October 25, 2018** and shall pay the remainder, if any, in weekly payments.

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

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

Nancy Lindsay
Signature of Arbitrator

12-19-18
Date

DEC 2 1 2018

MARY ELIZABETH BROWN V. STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES, 09- WC -18312

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was employed by Respondent as a caregiver. In that position she goes to the residence of persons with physical difficulties to help take care of the client and the client's household. She had been performing that type of work since 2004 or 2005. Her duties include taking care of the client personally, such as grooming them and cooking meals and taking care of the client's household by such acts as sweeping, dusting, mopping, moving furniture to vacuum and cleaning various rooms.

On January 7, 2009, Petitioner went to the home of client Ms. Quencola McCray. It was snowy outside. At about 8:30 a.m. she started walking up the driveway. She got to a walkway and began walking toward the house entrance. As she did so, both of her feet went up. She landed on her behind. There were red bricks lined up along the side of the walkway. Her lower back hit those bricks.

Petitioner instantly felt pressure and burning in her low back. The client's son heard Petitioner yelling. He came out and helped her into his home. Ms. McCray gave Petitioner a glass of water, sat her on the couch and gave her two Tylenol. Petitioner stayed there about an hour and left to go home. For the rest of the day she laid in bed in pain. She called her family doctor, Dr. Randy Silverstein. She could not see Dr. Silverstein until January 9, 2009.

Dr. Randy Silverstein first saw Petitioner on January 9, 2009. She provided a history that two days previously she had fallen on ice, fell on her back and hurt her back. She complained that the very lower part of her back was hurting; she had tried to use heat and whirlpool and Epson salts had not been successful. He examined her, ordered an x-ray, asked her to use a donut for sitting and gave her Darvocet. The x-ray was performed January 9, 2009 at Barnes-Jewish (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 5-6).

Dr. Silverstein saw Petitioner again on January 23, 2009. Petitioner stated that she continued to have pain in the back, she felt it was worse and she was getting spasms of her lower back with pain going down the left leg. At that time, Dr. Silverstein recommended x-ray, physical therapy, gave her a muscle relaxer and told her to remain off of work. The x-ray was performed January 30, 2009 at Barnes-Jewish. On January 23, 2009, Dr. Silverstein prepared a letter which stated "Mary Brown is a patient of mine. She has been under my care and has been unable to work since January 7th. Her return to work date is unknown at this time." (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 7-8; Deposition Exhibit 1, Letter of January 23, 2009).

Dr. Silverstein saw Petitioner on February 6, 2009. Petitioner stated she continued to have pain in the low back area which continued to go down her left leg. At that time, his assessment was that she continued to have lumbar disk disease, with radiculopathy, low-back pain and coccyx pain. He recommended she remain off work, begin physical therapy and re-check in two weeks. She returned on February 27, 2009. At that time, Dr. Silverstein recommended MRI examination of her lower back, physical therapy and continue home exercise program. The lumbar MRI was performed on March 6, 2009 at Barnes-Jewish Hospital. (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 8-11).

Petitioner underwent physical therapy at Health South Rehabilitation Center at the recommendation of Dr. Silverstein. (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, page 11). Dr. Silverstein continued to see Petitioner through 2009. On July 1, 2009, Dr. Silverstein recommended that Petitioner see Dr. Yi at the pain center. Dr. Silverstein continued to see Petitioner and he continued to recommend that Petitioner see Dr. Yi and his associate Dr. Jones for pain management at the pain clinic at Barnes-Jewish Hospital. (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 15-17).

Dr. Yi and Dr. Jones communicated to Dr. Silverstein that they believed Petitioner suffered an intervertebral disk displacement and muscle spasms of the lower back. Dr. Yi and Dr. Jones recommended that Petitioner begin a course of Gabapentin to help with pain control, continue Darvocet and Flexeril (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 17-18).

Dr. Silverstein last saw Petitioner on December 7, 2009. She continued to have pain in her back. Dr. Silverstein testified that his final diagnosis for Petitioner is lumbar disk displacement. Dr. Silverstein further testified that it is his opinion to a reasonable degree of medical certainty that the back pain is directly related to the accident of January 7, 2009. He further testified to a reasonable degree of medical certainty:

1) That the fall at least contributed to or exacerbated an existing condition, which had not previously bothered her.

2) That the fall accelerated the disk disease.

(Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 19-20)

Dr. Silverstein testified that his billing statements were usual and customary fees for such services in the community and that they were related to treatment provided to Mary Brown to try to alleviate her of the effects of her injury. Finally, Dr. Silverstein testified that as of December 7, 2009, he still had Petitioner on off work status and that as of December 8, 2009 – to a reasonable degree of medical certainty – Petitioner continued to be unable to perform her work duties as a result of the injury. (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 20-21).

Dr. Silverstein testified that at each visit he performed an evaluation of Petitioner as to whether or not she could work and she has consecutively been found to be unable to return to her employment. Dr. Silverstein testified that the type of injury she had would preclude virtually any kind of continuous employment. (Petitioner's Exhibit 1, Deposition of Dr. Silverstein, pages 23-24).

Dr. Yi saw Petitioner on October 2, 2009. At that time, his assessment was Intervertebral disc displacement – lumbar w/o myelopathy and muscle spasm. (Petitioner's Exhibit 4, Medical Records of Barnes-Jewish Hospital, page 21). On February 1, 2010, Dr. Yi performed Lumbar Transforaminal Epidural Steroid Injection (Selective Nerve Root Injection) at L4 and L5. (Petitioner's Exhibit 5, Medical Records of Barnes-Jewish Hospital, page 3). On February 25, 2010, Dr. Yi performed the same injection. The plan on May 7, 2010 was: (1) Increase Lyrica to 75 mg TID; (2) Continue aqua therapy, encourage home exercises; (3) Return to clinic in 2-3 weeks for lumbar epidural steroid injections; (4) Continue hydrocodone/APAP 5/325 mg TID p.m.; (5) Encourage weight loss with diet modification. (Petitioner's Exhibit 5, Medical Records of Barnes-Jewish Hospital, pages 14 and 22).

On July 8, 2010, Dr. Yi performed a Lumbar Epidural Steroid Injection at L5-S1, under fluoroscopy. A second such injection was performed on August 31, 2010. (Petitioner's Exhibit 5, Medical Records of Barnes-Jewish Hospital, pages 36 and 54). On October 7, 2010, Dr. Yi performed a Lumbar Transforaminal Epidural Steroid Injection (Selective Nerve Root Injection) at left L5-S1 and S1-S2. Dr. Yi noted that the pain is mostly in the lower back and radiates down the left leg and into the left foot. Plan on October 7, 2010, in addition to the injection was: Continue Darvocet, Lyrica and other meds and encourage home exercises/stretches. (Petitioner's Exhibit 6, Medical Records of Barnes-Jewish Hospital, pages 3-6).

Dr. Silverstein retired and referred Petitioner to Dr. Mary Agne with Illini Family Medicine. Petitioner first saw Dr. Agne on September 1, 2010. On that date, she saw Dr. Agne for hypertension, diabetes and back pain (PX 8) An examination showed the musculature in her low back was spasmed to palpitation on the right side. She had tenderness and was tearful during the encounter when examining her back. (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 5-6).

Petitioner saw Dr. Kevin Du throughout 2011. History taken on March 15, 2011 provided patient "presents for evaluation of her lower back pain and left leg pain as referred by her Primary Care Physician, Dr. Mary Agne. The patient states she had a fall at work on January 9, 2009. She states since then she has developed lower back pain and left leg pain all the way to her left foot. She states she never had any back pain or leg pain prior to her fall on January 9, 2009. She states her pain is continuous. Her pain level is 7/10 on average. She has difficulty to stand and walk due to the pain." (Petitioner's Exhibit 12, Medical Records of Memorial Hospital, page 6). On March 28, 2011, Dr. Du performed left L5-S1 transforaminal epidural steroid injection and left S1 selective nerve root block with fluoroscopic guidance. Similar injections were performed on April 15, 2011. (Petitioner's Exhibit 12, Medical Records of Memorial Hospital, pages 17 and 23). On April 29, 2011, Dr. Du performed left L4-5 and left L5-S1 transforaminal epidural steroid injection with fluoroscopic guidance. (Petitioner's Exhibit 12, Medical Records of Memorial Hospital, page 30).

Records of Dr. Du for September 15, 2011 indicate that the impression of Dr. Du for Petitioner was: (1) L4-5 and L5-S1 disk protrusion; (2) Lumbar radiculopathy; (3) Morbid obesity with body weight 263 pounds; (4) Lower back pain and leg pain. (Petitioner's Exhibit 13, Medical Records of Memorial Hospital, page 1 of 2).

Dr. Agne testified that when she saw Petitioner on October 28, 2010, her diagnosis was "chronic back pain as well as other diagnoses." (Petitioner's Exhibit 29, Deposition of Dr. Agne, page 7). Dr. Agne's assessment on January 17, 2011 was "chronic low back pain for two years with pain control being an issue and some side effects from the pain medication causing sedation." (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 8-9).

On January 31, 2011, Dr. Agne gave Petitioner an injection of Toradol. On February 9, 2011, Petitioner told Dr. Agne that she continued to be very uncomfortable and complained of increasing pain in the low back. (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 11-12). On April 28, 2011, Petitioner reported she had a decrease in her activity levels because of the pain. On August 1, 2011, she told Dr. Agne that pain was radiating down her left leg from her hip and she was again experiencing tearfulness and hopelessness with pain at that time. On October 27, 2011, Petitioner told Dr. Agne her pain was increasing; she was tearful and stated she stays home a great deal due to increasing pain. (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 12-13).

On December 9, 2011, Dr. Agne noted that Petitioner has been experiencing low back pain radiating down her left leg since an injury in January 2009 and she has failed to respond to pain management, physical therapy, epidural injections and medications since the fall sustained in January 2009. In December 2011, it was the

opinion of Dr. Agne – to a reasonable degree of medical certainty – that Petitioner will likely have permanent low back pain radiating to her leg and that the patient is probably disabled from the pain. Further, that Petitioner will chronically experience back pain which is disabling. Further, that Petitioner is "unlikely to return to her old job or any full-time job for which she can become gainfully employed due to the chronic pain, the use of chronic pain medications and the side effects of these medications." (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 14-17).

Dr. Agne testified that she still sees Petitioner on a monthly basis and a great deal is related to her low back. For her low back, Dr. Agne recommended aquatic therapy. She has provided different combinations of pain medications which have increased in strength and amount and to which Petitioner has had very little response. Dr. Agne testified she has provided Toradol injections. She has provided a quad care because "her gait was unsteady and she was further aggravating her back by listing when she was ambulatory." (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 17-19). When she last saw Petitioner on September 6, 2018, Petitioner "required an injection of Kenalog and Toradol at that time and of course a refill of her pain medication, and her back pain had not improved." (Petitioner's Exhibit 29, Deposition of Dr. Agne, page 20).

Dr. Agne testified the following opinions to a reasonable degree of medical certainty:

- That Petitioner will likely have permanent low back pain radiating to her leg.
- That Petitioner is permanently disabled from the pain.
- That Petitioner will chronically experience back pain which is disabling.
- That Petitioner is unlikely to return to her old job or any full-time job which she can become gainfully employed due to the chronic pain, use of chronic pain medications and the side effects of those medications.
- That the fall on the ice on January 7, 2009 was the proximate cause of the injuries for which Dr. Agne treated her.
- That the fall on the ice on January 7, 2009 is the proximate cause of her current complaints of low back pain and related leg pain.

As to prognosis, Dr. Agne opined that "the remainder of her life will be dealing with this pain." (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 20-25).

Dr. Agne testified that an x-ray of January 9, 2009 showed Petitioner had osteopenia which is a chronic problem. Further, that her notes of October 13, 2010 indicated that Petitioner had chronic pain with degenerative joint disease which is an arthritic condition that can cause back pain; further, that on November 18, 2010, Dr. Agne saw Petitioner for pain related to gout which she believed was in the right hand and again for gout in the toe on September 20, 2011. Dr. Agne also testified that, at one point, Petitioner was treated for fibromyalgia and diabetes. (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 26-29).

Dr. Agne testified that the osteopenia and degenerative joint disease would have been years in the making. Further, that as far as any other condition Petitioner had Dr. Agne does not have any knowledge of Petitioner not being able to perform her work duties as a result of said conditions at any time before January 7, 2009. Finally, Dr. Agne testified that – to a reasonable degree of medical certainty – if Petitioner was working without any problems up through and until January 7, 2009 and then since January 7, 2009, when the fall occurred, she has not returned to work, the likely reason she is unable to return to work is because of the incident of January 7, 2009. (Petitioner's Exhibit 29, Deposition of Dr. Agne, pages 30-32).

Petitioner's case proceeded to arbitration on October 25, 2018. At the time of hearing the disputed issues were causal connection, medical bills, TTD, and the nature and extent of Petitioner's injury. Petitioner was the sole witness testifying at the hearing. Respondent tendered no exhibits.

Petitioner testified that in January of 2009 she was employed by Respondent as a caregiver. She would go to the residence of a person with physical difficulties to help take care of the client and the client's household. She had been performing that type of work since 2004 or 2005. Her duties include taking care of the client personally, such as grooming them and cooking meals and taking care of the client's household by such acts as sweeping, dusting, mopping, moving furniture to vacuum and cleaning various rooms.

Petitioner testified that on January 7, 2009, she went to the home of her client, Ms. Quencola McCray. It was snowy outside. At about 8:30 a.m. she started walking up the driveway. She got to a walkway and began walking toward the house entrance. As she did so, both of her feet went up. She landed on her behind. There were red bricks lined up along the side of the walkway. Her lower back hit those bricks.

Petitioner testified that she instantly felt pressure and burning in her low back. The client's son heard Petitioner yelling. He came out and helped her into his home. Ms. McCray gave Petitioner a glass of water, sat her on the couch and gave her two Tylenol. Petitioner stayed there about an hour and left to go home. For the rest of the day she laid in bed in pain. She called her family doctor, Dr. Randy Silverstein. She could not see Dr. Silverstein until January 9, 2009.

Petitioner testified that she treated with Dr. Silverstein through December 9, 2009 when he retired. During that time her back was hurting and she was experiencing stinging, burning, "drilling," and pressure in her back, especially her lower back. Her tailbone also hurt and she described tingling, numbness, and spasms in her left leg. Petitioner testified that Dr. Silverstein referred her for therapy at HealthSouth which she attempted. He also had her engage in a home exercise program. Dr. Silverstein, according to Petitioner, never released her to return to work. She further testified that no doctor has released her to return to work.

Petitioner further testified that Dr. Silverstein referred her to Dr. Yi and she saw him approximately 13 times between August 17, 2009 and October 7, 2010. Dr. Yi furnished her with pain medication and recommended aqua therapy. During this time she continued to experience burning in her left leg and her tailbone and low back hurt.

Petitioner testified that she began seeing Dr. Agne at Illini Family Medicine around September 1, 2010. She continues to treat with her at this time. Dr. Silverstein referred Petitioner to Dr. Agne. Petitioner testified that Dr. Agne has prescribed pain medication and a cane as well as aqua therapy and has referred her for an MRI and for treatment with Dr. Du and Dr. Khan. She also provides injections.

Petitioner testified that Dr. Du has also performed injections and nerve root blocks which only lasted for about four to five days. Dr. Khan and she did not get along.

Petitioner testified that she saw Dr. Agne last month. Petitioner further testified that Dr. Agne provides injections in her right hip and left hip every two months. She still takes cyclobenzaprine and hydrocodone. She testified that she saw the Work Comp doctor – Dr. Robson – two times, once in 2010 and once in 2012.

Petitioner testified that she received TTD or maintenance for quite a period of time and it just stopped in August of 2014. She has not received any TTD since August 2014. No doctor has released her to return to work and she has not returned to work. Petitioner testified that her job was physically demanding, including helping a client in and out of a tub if she wanted a bath, moving furniture and cleaning and vacuuming rooms, changing

and cleaning a bed, cleaning windows, dusting, cleaning the fireplace and kitchen, washing dishes and sweeping, mopping and waxing floors. Petitioner testified she had worked this job since 2004 or 2005; she was able to do the work and had no problems physically doing the job before January 7, 2009. She has not been able to do that kind of work since January 7, 2009. Petitioner testified that prior to January 7, 2009 she had no problems with her low back or left leg area and did not have any treatment to the low back or left leg area.

Petitioner acknowledged that she has been on social security disability since February of 2014.

Petitioner testified to her current condition. She has pain all the time in her low back that goes across her back from hip to hip and her leg does not raise as much as it should. A lot of times she cannot get out of bed. She has not been able to do household chores. She no longer attends church like she used to. She no longer goes on vacations or road trips because she cannot sit in a car for very long. These activities require sitting for a period of time which causes pain. Her daughter is her caretaker. She helps groom Petitioner and cooks for her. She no longer has relations with her husband. She uses a shower chair. She can no longer do activities with her grandchildren as she used to, such as going to the zoo or the park. Her activities are greatly limited. She used to attend/work at fundraisers every weekend but no longer can. Petitioner testified that she falls and stumbles and still experiences spasms in her left leg. Petitioner also has a motorized scooter that Dr. Agne ordered for her. Due to her husband's own illness, it is difficult for her to utilize the scooter. She has to utilize a motorized cart if she is in a store.

Petitioner acknowledged that she can drive. She hadn't done so, however, for about three to four weeks prior to arbitration. Her husband is unable to drive at the present due to "spells" so she has to drive now and then. She does it but probably shouldn't.

On cross-examination Petitioner acknowledged that Dr. Silverstein was her family doctor. Petitioner testified that Dr. Silverstein has also treated her for sinus infections and problems with dairy products. Petitioner testified that Dr. Agne also treated her for sinusitis, allergies, asthma, bronchitis, general arthritis in her left foot and ankle, gout, fibromyalgia, joint degeneration and diabetes. She was unaware that she had osteopenia. She takes medicine for her fibromyalgia and it helps with the "hurt" she experiences from it. She believed she was diagnosed with diabetes about a year before Dr. Silverstein retired. She denied that it caused any numbness in her extremities indicating that the doctor told her she was in perfect health with her diabetes.

Petitioner acknowledged that she has never been referred for surgery. She also testified that the physical therapy hurt really bad but the aqua therapy helped for a while. She doesn't do the aqua therapy in the winter because she'll catch a bad cold.

Petitioner testified that prior to working as a personal assistant for Respondent she worked as a personal assistant at St. Louis University Hospital for about two years. She's essentially been a caregiver during her work life.

The only expert she met with about whether there were other jobs she could do with her back pain was the work comp doctor, Dr. Robson. She has not seen a vocational expert.

Petitioner testified that she has incurred numerous medical bills which are related to the injury of January 7, 2009. Those medical bills are identified in the attachment to this Decision labeled "Mary Brown Related Bills". Some medical bills were paid by UMR (health insurance coverage through Petitioner's husband's employment). UMR has asserted a lien in the amount of $15,943.68. Some medical bills were paid by Equian (Medicare/Medicaid). Equian has asserted a lien in the amount of $2,886.97. (Petitioner's Exhibits 26 & 27).

Petitioner testified that she has made some personal payments on these medical bills either through cash or charge payments.

The Arbitrator Concludes:

Issue (F) Causal Connection.

Petitioner's current condition of ill-being in her low back and left leg is causally related to her work accident of January 7, 2009. This determination is based upon Petitioner's credible testimony, the persuasive testimony and records of her treating doctors, and a chain of events.

The mere fact that an employee may suffer from a pre-existing condition does not preclude recover under the Act. Compensation will be awarded if the employee can show that the preexisting illness was aggravated or accelerated by the employment. Palmer House v. Industrial Commission, 146 Ill.Dec. 322, 326, 558 N.E.2d 285, 289 (1st Dist. 1990). The employee need not prove employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor in the resulting injury. Williams v. Industrial Commission, 51 Ill.Dec. 685, 687, 421 N.E.2d 193, 195, 85 Ill.2d 117 (Ill. 1981).

A non-employment related factor which is a contributory cause with the compensable injury in an ensuing injury or disability does not constitute an intervening cause sufficient to break the causal connection between the employment and claimant's condition of ill-being. Mendota Township High School v. Industrial Commission, 183 Ill.Dec. 820, 822, 612 N.E.2d 77, 79, 243 Ill.App.3d 834 (4th Dist. 1993).

A causal connection between a candidate of ill-being and a work-related accident can be established by showing a chain of events wherein an employee has a history of prior good health, and, following a work-related accident, the employee is unable to carry out his duties because of a physical or mental condition. BMS Catastrophe v. Industrial Commission, 185 Ill.Dec. 339, 343, 614 N.E.2d 473, 477, 245 Ill.App.3d 359 (4th Dist. 1993).

Petitioner's testimony was credible and unrebutted. While Petitioner has had other medical issues, both before and after her accident herein, she was working full duty without any restrictions prior to her undisputed accident herein and no evidence of prior medical treatment to her low back was presented. The fact that Petitioner may suffer from other physical conditions does not negate a finding of causation as the accident herein has remained a cause of her condition of ill-being and as long as the accident remained "a" cause of a claimant's condition, causation under current Illinois law, exists.

Issue (J) Medical Expenses.

The Arbitrator finds that Petitioner has incurred medical bills related to her injury, as set forth in the attachment hereto, designated "Mary Brown Related Bills".

Respondent is responsible for payment of these bills subject to prior payment made by employer and medical bill fee schedule. Respondent to hold Petitioner harmless as to said bills.

Petitioner has made cash or charge payments toward some of these medical bills, itemized as follows:

Dr. Randy Silverstein

1/9/09 $25.00
2/9/09 $25.00
3/20/09 $25.00
4/3/09 $25.00
7/1/09 $25.00

Washington University Physicians

10/2/09 Dr. Yi $20.00
7/8/10 Dr. Yi $40.00
8/9/10 Dr. Yi $30.00

Rehabilitation Institute of St. Louis

$40.00

Dr. Mary Agne/Illini Family Medicine

9/1/10	$20.00	3/10/11	$20.00
10/13/10	$20.00	4/28/11	$20.00
10/28/10	$20.00	5/31/11	$20.00
12/14/10	$20.00	8/1/11	$20.00
1/17/11	$20.00	9/20/11	$20.00
1/31/11	$20.00		

10/27/11	$25.00	11/5/12	$20.00
11/28/11	$20.00	12/13/12	$20.00
12/8/11	$12.07	1/10/13	$20.00
2/2/12	$20.00	2/14/13	$20.00
5/31/12	$60.00	3/25/13	$20.00
7/24/12	$20.00	4/30/13	$20.00
8/30/12	$20.00		
10/8/12	$20.00		

6/11/13	$20.00	4/30/14	$20.00
8/13/13	$20.00	6/6/14	$10.00
9/10/13	$20.00	7/8/14	$10.00
11/18/13	$20.00	10/6/14	$10.00
1/2/14	$20.00		
2/6/14	$20.00		
3/6/14	$20.00		

Dr. Anwar Khan

12/22/11 $30.00

Barnes-Jewish Hospital Pharmacy

1/13/09	Propoxyphen (hereafter "propox")	$5.60
1/23/09	Cyclobenzaprine (hereafter "cyclo")	$5.67
6/2/09	Propox	$5.60
10/8/09	Lyrica	$45.00

3/22/10	Cyclo	$9.78
3/22/10	Propox	$7.19
3/26/10	Hydrocodone	$10.00
8/12/10	Cyclo	$9.50
9/11/10	Cyclo	$9.50
10/29/10	Propox	$6.60
12/17/10	Tramadol	$4.63
2/10/11	Oxycodone	$5.41
3/14/11	Oxycodone	$5.41
3/17/11	Gabapentin	$8.08
4/30/11	Oxycodone	$5.41
6/1/11	Oxycodone	$5.41
8/4/11	Oxycodone.	$10.00
10/28/11	Oxycodone	$10.00
11/29/11	Oxycodone	$10.00
3/1/12	Oxycodone	$9.41
6/7/12	Oxycodone	$10.00
8/31/12	Oxycodone	$10.00
10/9/12	Oxycodone	$10.00
12/17/12	Oxycodone	$10.00
1/10/13	Oxycodone	$10.00
1/10/13	Fentanyl	$10.00
2/19/13	Oxycodone	$10.00
5/2/13	Oxycodone	$10.00

CVS Pharmacy

7/23/13 Oxycodone $10.00

Respondent shall reimburse Petitioner for said payments.

The Arbitrator finds that some related medical bills have been paid by UMR in the amount of $15,943.68 and that UMR has asserted a lien for reimbursement.

The Arbitrator finds that some related medical bills have been paid by Medicare/Medicaid in the amount of $2,886.97 and that Equian has asserted a lien for reimbursement.

Respondent is responsible for the foregoing medical bills and shall satisfy the lien to the satisfaction of UMR and Equian and shall hold Petitioner harmless in regard to said liens.

While Respondent took exception to some of the bills from Dr. Agne, the Arbitrator notes that Dr. Agne testified that, at virtually all times when Petitioner came to see her, there has been some component of the exam addressing Petitioner's low back. (PX 29, p. 25)

Issue (K) What Temporary benefits are in dispute (TTD)?

Petitioner was temporarily totally disabled during the period from January 7, 2009 through October 25, 2018. Respondent shall receive credit for any Temporary Total Disability benefits it has paid (see AX 1).

To prove a claim for temporary total disability, the employee must show not only that he did not work, but also that he was unable to work. Palmer House v. Industrial Commission, 146 Ill. Dec. 322, 326, 558 N.E.2d

285, 289, 200 Ill.App.3d 558 (1st Dist. 1990). Petitioner has met her burden of proof as she testified, and the records confirm, that she has not been released to return to her pre-accident job since her accident. Respondent provided no explanation for why it terminated TTD benefits in August of 2014.

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

Petitioner's accident pre-dates September 1, 2011 and therefore consideration of the five factors under the Act need not be considered in assessing permanent partial disability. The Arbitrator notes, however, that Petitioner has never undergone surgery and has been treated with injections, medications, and forms of therapy. She has chronic low back and left leg pain for which she requires pain medication. She has never been released to return to her job as a care giver which appears to be a very physically demanding job. Petitioner, at the time of arbitration, was 51 years old. She is, and has been, receiving Social Security Disability benefits. She also suffers from other medical conditions and the medical records reflect ongoing complaints and symptoms associated with those conditions. While Respondent had Petitioner examined by Dr. Robson on two occasions, Respondent did not introduce Dr. Robson's reports into evidence. Respondent did not have Petitioner recently examined. Finally, Respondent has tendered no evidence rebutting Petitioner's credible testimony regarding the nature and extent of her injuries. The Arbitrator finds that Petitioner has sustained 40% loss of a person as a whole as a result of her accident herein.

****

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

Renee L. Thompson,
Petitioner,

vs. NO: 11 WC 41506

State of Illinois, Sheridan Correctional Center,
Respondent.

19IWCC0573

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, 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 December 4, 2018, is hereby affirmed and adopted.

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

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

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 23 2019
o091219
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMPSON, RENEE L Case# **11WC041506**
Employee/Petitioner

SOI SHERIDAN CORRECTIONAL CENTER
Employer/Respondent

19IWCC0573

On 12/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN LLP
JIM M VAINIKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

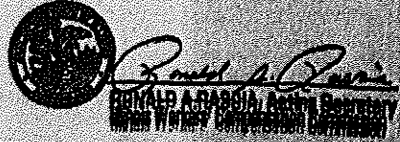
6197 ASSISTANT ATTORNEY GENERAL
COURTNEY L SCHOCH
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

DEC 4 - 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF LA SALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Renee L. Thompson
Employee/Petitioner

Case # **11** WC **41506**

v.

State of Illinois, Sheridan Correctional Center
Employer/Respondent

19IWCC0573

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Ottawa**, on **October 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 30, 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 $**46,748.00**; the average weekly wage was $**899.00**.

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

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$599.33**/week for **22 6/7** weeks, commencing **February 27, 2012** through **August 6, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$80,269.26**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$539.40**/week for **75.25** weeks, because the injuries sustained caused the **35% loss of the left leg**, as provided in Section 8(e) of the Act.

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

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

Arbitrator Anthony C. Erbacci

November 27, 2018
Date

DEC 4 - 2018

FACTS:

On August 30, 2011, Petitioner was an employee for the State of Illinois as an office coordinator. Her hire date was April 26, 1995. Her shift was from 8:00am to 4:00pm. Her office is in the State prison, Sheridan Correctional Center. The prison is surrounded by a barbed wire fence. The Petitioner parks her car in an employee designated parking lot. Visitors to the prison are directed to a visitor parking lot. Petitioner testified that she carries only her keys and badge to her office from the parking lot. She leaves her purse in the car for safety reasons as she works in the prison.

On August 30, 2011, Petitioner testified credibly that she had a conversation with her supervisor during her shift where the supervisor asked to borrow some money from Petitioner. Petitioner told the supervisor that she would have to wait until the end of the shift. The Petitioner and the Supervisor, Darlene Bridge left work at 4:00pm. They locked their office door and proceeded through the employee parking lot towards Petitioner's car. The path Petitioner took to her car was the same path that she would have taken whether she was getting in her car to go home, or give her supervisor money just before Petitioner would go home. The Petitioner reached her vehicle first and opened the driver's side door. She reached into the car to get the money out of her purse. When Petitioner turned to hand the money to the supervisor, Petitioner's left foot stepped into a 3 foot round and 3 inch deep pothole. It caused Petitioner to twist her left knee.

Petitioner never completed the transaction of giving the money before stepping into the pothole. Petitioner yelled out in pain. She noticed throbbing pain in her left knee. She did drive her vehicle to her daughter's volleyball game. While sitting in the bleachers, she continued to notice the pain. She placed ice on her knee the rest of the night. She treated at the Health Care Unit at her facility the next day.

On September 15, 2011, Dr. Paul Perona at Family Orthopedic Center began treating Petitioner for her injury. He x-rayed her left knee and on September 20, 2011, he gave her a cortisone injection into the knee. The injection did not help relieve Petitioner's pain. On November 11, 2011, an MRI was taken of her left knee and it showed a tear of the medial meniscus and anterior cruciate ligament plus tricompartmental osteoarthritis. Surgery to her left knee was performed on November 23, 2011. The procedure performed was a partial medial meniscectomy and chondroplasty of the medial compartment. After a few follow up visits, five weeks post-op, on December 29, 2011, Petitioner was still having pain and popping in her left knee. On January 27, 2012, Dr. Perona was prescribing a left total knee arthroplasty. The knee replacement was performed at St. Margaret's Hospital on February 27, 2012. Petitioner had physical therapy starting March 22, 2012 through July 12, 2012. Petitioner was returned to work full duty on August 6, 2012.

Petitioner's surgeon, Dr. Perona, has provided a causation opinion clearly indicating that Petitioner had a history of left knee problems but the last treatment to her left knee was in June 2008. That is over 3 years before her work related injury in August 2011. Dr. Perona opined that Petitioner did have degenerative joint disease to her left knee that was tolerable until she tore her meniscus in her work injury. He stated that it was this injury that has caused her to need the surgery.

Dr. Primus was the Section 12 doctor for the Respondent. He admitted during his deposition that the mechanism of injury, the twisting of the knee in the pothole, could have caused the meniscus tear and the ACL tear. He also opined that the arthritis from the knee surgery could have worsened the knee to the point of requiring a knee replacement.

Petitioner was prescribed to be off work only from February 27, 2012 through August 6, 2012 during the time she treated for her left knee replacement. She testified that she never received any TTD benefits. The medical bills are unpaid.

Petitioner testified that she is constantly concerned about damaging her left knee replacement. She favors her left leg and becomes very anxious when she has to kneel. She walks up gymnasium bleachers by stepping up with her right leg and then bringing her left leg up to her right leg before proceeding onto the next step. She also testified that she needs to take antibiotics prior to any dental procedures to prevent any infection in her knee replacement.

CONCLUSIONS:

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

The Arbitrator finds that Petitioner incurred an accident arising out of and in the course of her employment. The Petitioner stepped into a pothole on the premises of the Respondent immediately after leaving her office to go home. The parking lot was owned and maintained by the Respondent and was exclusive to the employees of the prison. The condition of the parking lot increased the risk of accident and caused the injury to occur. Thus, her injury was in the course of her employment. Petitioner testified that she never carries her purse into the prison due to safety reasons. When she fell in the parking lot, she was where she would have been and at the same time she would have been there regardless of whether she was retrieving money or not from her car. The fact that she was taking money out of her purse when she would be going to her car anyway was so inconsequential that it in no way increased her risk of injury as the pothole was an existing risk. In addition, the Arbitrator finds that Petitioner was proceeding to her car without detour or frolic. The Arbitrator finds Petitioner's accident arose out of her employment.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to her injury. The Petitioner did have treatment to her left knee prior to August 30, 2011. But the last time she treated was in June of 2008. Dr. Perona's medical opinion was credible that Petitioner's meniscus tear, meniscectomy, and subsequent knee replacement were all related to her injury. In fact, the Section 12 physician, Dr. Primus, also agreed that the meniscectomy was related to her injury. He went on to explain that the arthritis from the surgery could have accelerated the need for a knee replacement.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator, having found in favor of Petitioner for accident and causation, also finds that Respondent is liable for all the medical bills related to Petitioner's treatment including the left knee replacement totaling $80,269.26 per the Fee Schedule.

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

The Arbitrator, having found in favor of Petitioner for accident and causation, also finds that Respondent is liable to pay temporary total disability benefits to Petitioner from February 27, 2012 through August 6, 2012 covering the time period that Petitioner was off work after her left knee replacement.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

In the instant case, the Petitioner suffered a meniscus tear in her left knee which was treated with a meniscectomy, and subsequent knee replacement. The Petitioner testified that she currently continues to be concerned about damaging her left knee replacement and she favors her left leg and becomes anxious when she has to kneel. Because the Petitioner's work accident occurred after September 1, 2011, Section 8.1(b) of the Act requires consideration of the following criteria in determining the level of permanent partial disability:

* The reported level of impairment based upon the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment;
* the occupation of the injured employee;
* the age of the employee at the time of the injury;
* the employee's future earning capacity; and
* evidence of disability corroborated by the treating medical records.

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 an office coordinator at the time of the accident and that she is able to return to work in his prior capacity as a result of said injury. The Arbitrator therefore gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Because of this young age, 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 did not lose any future earnings capacity. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner testified that she is constantly concerned about damaging her left knee replacement, and she favors her left leg and becomes anxious when she has to kneel. She walks up gymnasium bleachers by stepping up with her right leg and then bringing her left leg up to her right leg before proceeding onto the next step. She also testified that she needs to take antibiotics prior to any dental procedures to prevent any infection to her knee replacement. 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 left leg pursuant to §8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CURTIS LINEN,

Petitioner,

vs. NO: 16 WC 15216

MARTEN TRANSPORTATION,

Respondent.

19IWCC0574

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b)/8(a) of the Act having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, and temporary total disability (TTD) benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

19IWCC0574

The Commission modifies the Arbitrator's Decision and finds that Petitioner's post-traumatic stress disorder (PTSD) is causally related to the April 25, 2016 work-related accident. The Commission does not disturb the Arbitrator's findings or conclusions with respect to the right shoulder.

The Commission finds significant Petitioner's testimony regarding observing the driver of the truck that had rear-ended him in the April 25, 2016 collision, "hanging out the window." (T.8). Petitioner testified that he was highly upset about seeing the driver who died in the accident. "I never want to see that again. Just shocked really. I was – I didn't know – to this day I just don't know what to think about it." (T.9). Following the accident, the medical evidence documented Petitioner's complaints of possible depression and emotional concerns within a couple of weeks of the April 25, 2016 collision. (PX7). The Commission notes that Respondent did not dispute on review the seriousness of the accident. Further, by its Brief, Respondent made no argument pertaining to the issue of causal connection and Petitioner's PTSD.

The Commission further notes that although the Arbitrator made an adverse finding as to Petitioner's credibility, the crux of that conclusion was in relation to Petitioner's right shoulder condition. The Arbitrator in fact found it reasonable that "anyone who was involved in an accident in which the other party died, could suffer PTSD." The Arbitrator also did not find Dr. Manal Elmusa credible; however, the Commission finds that Dr. Elmusa was simply Petitioner's treating chiropractor who had referred Petitioner to Dr. Daniel Kelley, a licensed clinical psychologist at Integrated Behavioral Medicine. The Arbitrator made no credibility findings relative to Dr. Kelley.

Dr. Kelley conducted a psychological examination that included various tests. Dr. Kelley indicated that Petitioner was tearful during the interview, reported symptoms of dysphoria, sweats, anxiety, hyperarousal, headaches, nightmares, flashbacks of the April 25, 2016 accident, excessive worry/ruminations, and avoidant/socially isolative behaviors. Petitioner also reported having anxiety while driving his personal car. Following Dr. Kelley's evaluation, he diagnosed Petitioner with PTSD as a result of the April 25, 2016 collision. (PX8). There was no evidence to rebut Dr. Kelley's diagnosis of PTSD or his opinion on causal connection. Petitioner treated with Dr. Kelley from May 31, 2016 through October 31, 2016. (PX8).

Based on the Commission's finding of causal connection of Petitioner's PTSD, the Commission awards all reasonable and necessary medical expenses related to the PTSD and awards TTD benefits from April 26, 2016 through October 2, 2016. Petitioner testified that he returned to work on October 3, 2016. (T.16). All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed November 13, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary medical bills related to Petitioner's post-traumatic stress disorder (PTSD).

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $536.80 per week for 22 6/7 weeks, commencing April 26, 2016 through October 2, 2016, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of 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 $12,400.00. 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 the Circuit Court.

D. Douglas McCarthy

Stephen Mathis

DISSENT

I respectfully dissent. I would affirm and adopt the decision of the Arbitrator finding Petitioner failed to prove a causal connection between the work accident and his alleged Post-Traumatic Stress Disorder.

Initially, I do not agree with the majority's assertion that the Arbitrator's adverse credibility assessment was limited to Petitioner's right shoulder condition. To the contrary, prior to analyzing the specific disputed issues, the Arbitrator issued a rather detailed indictment of Petitioner's credibility:

> The Arbitrator finds petitioner is, at best, not credible. He had very selective memory of injuries suffered in the previous automobile accident from January, 2016. He claimed he could not remember what injuries, if any at all, he suffered in the January

22, 2016 accident; he was only certain he had not injured his right shoulder in the January 22, 2016 accident. In fact, he testified his wife was the only one who made a claim to State Farm for injuries from the January 22, 2016 accident. He also lied on his applications with Jerry's Towing [SIC] and Trans Am regarding his use of cocaine and failed to include his employment with respondent.

Moreover, Petitioner himself provided conflicting testimony as to what he, in fact, witnessed on the date of accident. On direct examination, Petitioner testified he went to the rear of his vehicle and observed the deceased driver. Thereafter, Petitioner contradicted himself during cross-examination stating:

Q. Do you know what type of vehicle struck you?

A. No, I don't.

Q. Was it large vehicle, small vehicle? You went out and looked at it, right?

A. I didn't actually - - no, I didn't. T. 29.

Therefore, I believe the majority's reliance on, and assignment of significant weight to, only a portion of Petitioner's inconsistent testimony is misplaced.

I similarly disagree with the majority's attempt to diminish DC Elmusa's role in Petitioner's claim for Post-Traumatic Stress Disorder. To be clear, it was DC Elmusa's referral, which was the impetus for Dr. Kelley's involvement. Petitioner was evaluated by DC Elmusa on May 11, 2016. Notably, DC Elmusa authored two reports concerning that single evaluation: Version 1, the report she generated to send to Respondent's workers' compensation carrier, and Version 2, the report she generated to send to State Farm. Despite having two opportunities to do so, in neither of those records does DC Elmusa mention Petitioner manifesting any signs of emotional distress or being "despondent and dispirited" as she described him in the May 13, 2016 "To Whom It May Concern" letter, *i.e.*, Version 3 of the May 11, 2016 encounter.

The majority chooses to overlook Petitioner's repeated instances of malfeasance, and without providing the requisite explanation for its reversal of the Arbitrator's adverse credibility finding, awards benefits to a dishonest person for a subjective condition which is primarily predicated on an individual's self-reported symptoms. Like the Arbitrator, I find Petitioner has no credibility. I further find Petitioner's dishonesty coupled with Dr. Elmusa's duplicitous conduct and internally inconsistent records render Petitioner's claim for PTSD incredible.

Finally, even assuming, *arguendo*, Petitioner proved he developed PTSD as a consequence of the accidental injury, I do not believe Petitioner proved entitlement to the Temporary Total

19IWCC0574

Disability benefits awarded. My review of the record reveals Dr. Kelley first authorized Petitioner off work on May 31, 2016. Prior to that, work restrictions were imposed by the physicians treating Petitioner's right shoulder. Given the majority concurs Petitioner's right shoulder condition is not causally related to his work accident, the award of TTD benefits from April 26, 2016 through May 30, 2016 is not supported by the record.

Therefore, I respectfully dissent.

DATED: OCT 24 2019

L. Elizabeth Coppoletti

LEC/DDM/pm
O: 8-28-18
043

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

LINEN, CURTIS
Employee/Petitioner

Case# **16WC015216**

MARTEN TRANSPORTATION
Employer/Respondent

19IWCC0574

On 11/13/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
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) 8(a)

Curtis Linen
Employee/Petitione
v.
Marten Transportation
Employer/Respondent

Case # 16 WC 15216

19IWCC0574

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Wheaton**, on **February 16, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of claimed accident **April 25, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Petitioner's average weekly wage was **$805.20**

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

Respondent ***does not owe*** for any medical services.

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

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

ORDER

Medical Benefits

Respondent shall pay Edward Hospital in the amount of $12,756.00 subject to the fee schedule, §8 and §8.2 of the Act, with credit to be given for any payments made directly by respondent of pursuant to §8j.

Temporary Total Disability Benefits

The claim for temporary total disability benefits is denied

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

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

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

Christine M. Ory
Signature of Arbitrator

November 9, 2018
Date

NOV 13 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Curtis Linen	)
Petitioner,	)
vs.	) **No. 16 WC 15216**
Marten Transportation	)
Respondent.	)
	)

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

This matter proceeded to hearing in Wheaton on February 16, 2018 under §19b/§8a of the Act. The parties agreed that on April 25, 2016, Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agreed Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They agreed petitioner earned $4,831.20 in the six-week petitioner had worked for respondent before the accident; and that petitioner's average weekly wage, calculated under the provisions of §10, was $805.20.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment with respondent;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury;
3. Whether respondent is liable for the unpaid medical bills;
4. Whether petitioner is entitled to payment for prospective medical treatment; and
5. Whether petitioner is due temporary total disability.

STATEMENT OF FACTS

Petitioner testified he was driving a tractor/trailer for respondent on April 25, 2016. He was on I-88 in Lisle, Illinois and traffic was stopped. He was stopped for 30 seconds to a minute when he felt a large jolt. He was pushed back and forth. He exited the vehicle and saw damage to the other truck and the other driver hanging out the window.

He testified he had pain in his right shoulder, lower back and neck; he was upset. He was taken via ambulance to Edward Hospital. That night, at about 10 or 11 P.M., as he was very upset from the accident, he used cocaine for the first time in years. The next day another sample of blood was taken. He as not sure at what time that was done.

He sought treatment at Illinois Ortho Network where he saw Dr. Giannoulias on May 9, 2016. He was seen again by Dr. Giannoulias on June 15, 2016. He was referred to Mid-City Rehabilitation by Dr. Giannoulias where he received treatment from May 11, 2016 through August 23, 2016. He received physical therapy to his neck, back and right shoulder. On October 26, 2016, Dr. Giannoulias recommended shoulder surgery. He was also seen by Dr. Kelly for psychological treatment.

Petitioner testified he was a passenger in a vehicle involved in a motor vehicle accident on January 22, 2016. He was not sure where his pain was located from this accident, but he was sure

his right shoulder was not hurt. He testified his right shoulder felt fine before the April 25, 2016 accident.

He claimed to be off from April 25, 2016 to October 3, 2016. He worked for Jerry's trucking on October 3, 2016 to November 17, 2016. He claimed he could not perform the job, which is why he left this job. He claimed his right shoulder, neck and back hurt when he worked.

He worked for Trans Am Trucking for only one day; October 12, 2017. He claimed he was fired as he had not put all the previous employers on the application; he was fired for not being truthful on the application. He had passed the DOT physical.

On November 22, 2017, Dr. Giannoulias again recommended surgery. He testified he testified he continues to have pain in right shoulder, neck and excruciating pain in the lower back. He was prescribed pain medication, but doesn't like to take them. He still wants to have shoulder surgery.

He reiterated that the only time he used cocaine in many years was on the night of the accident and has not used it since.

On cross-examination, petitioner was not sure how long he had worked for respondent; maybe one or two months. On his application to Jerry's Trucking and Trans Am he listed all previous employers; except for respondent.

He testified he vaguely remembered the automobile accident in January, 2016. He alleged that only his wife made a claim to State Farm for her injuries.

He testified he received treatment at Mid-City for this accident [April 25, 2016 accident] only. He did some stretching and rotating therapy. He denied he told Mid-City to send bills to State Farm. He denied he had problems shifting or getting in and out of truck after the January, 2016 accident.

Petitioner testified that on May 11, 2016 he was examined by Dr. Elmusa. He did not give facts of the January, 2016 accident and denied telling him of problems since the January, 2016 accident.

He was examined by Dr. Gleason on September 19, 2017 at respondent's request.

Respondent's vehicle he was driving was a Freightliner Cascading 53 feet in length with air suspension. He was stopped in traffic. Petitioner did not look at the vehicle that struck his vehicle. He reiterated he was jolted back and forth. He had his hands on the steering wheel and stick shift. His hands were below his shoulder.

He confirmed he worked for Trans Am and did not drive; he was only in orientation. He drove for Jerry's Trucking after passing the DOT physical.

Illinois Orthopedic Network Bills (PX.1)

$1580.50 bill PA Brittany Macleod for services rendered on May 9, 2016.
$375.49 bill from Dr. Chunduri on June 30, 2016

Premium Health Care Solutions (PX.2)

$4,705.00 for services rendered on May 25, 2016.

Metro Anesthesia Consultants Bill (PX.3)

$1,316.00 for services rendered on June 30, 2016.

IWP Bill (PX.4)

$38.80 for Clonazepam on July 13, 2016.

Edward Hospital Records (PX.5)

Petitioner arrived via ambulance to the emergency room on April 25, 2016. The history provided was that he was a restrained driver involved in an automobile accident driving a semi that was rendered by a car. The other driver was killed. He had complaints of headaches, neck pain, lower back and right hip pain. He received a cervical and brain CT scan, as well as X rays of chest, lumbar spine, and pelvis; all were negative. The test for alcohol was negative. Petitioner was discharged with a contusion of scalp, cervical strain and multiple contusions.

The records also include $12,766.00 bill for services rendered on April 25 2016

Origin Diagnosis Record (PX.6)

The drug panel test done at Work Right in Countryside on April 26, 2016 was positive for cocaine.

Illinois Orthopedic Network Records (PX.7)

Petitioner was initially seen by Dr. Chunduri on May 9, 2016. Petitioner reported he was injured when his semi had been rear-ended by another semi [on April 25, 2016]. He reported he felt acute pain in his neck and right shoulder which had gradually worsened. Dr. Chunduri's assessment was right shoulder and neck pain. An MRI of the right shoulder and neck were ordered. He was prescribed Mobic, Protonix, Flexeril and Tramadol. He denied use of illicit drugs.

On May 13, 2016, Dr. Elmusa wrote that petitioner was despondent and dispirited after being involved in a motor vehicle accident on April 25, 2016 and the other driver died in the accident. A week later he was terminated from his job. Dr. Elmusa believed petitioner would benefit from psychological counseling.

The May 25, 2016, cervical MRI showed diffused disc bulging at C3-4 through C7-T1. The May 25, 2016, right shoulder MRI showed a full thickness tear of the supraspinatus tendon with disruption of tendon fibers and acromioclavicular joint arthropathy.

On June 8, 2016, Dr. Krishna Chunduri referred petitioner for an orthopedic evaluation. On June 15, 2015, orthopedic surgeon, Dr. Christos Giannoulias recommended surgical repair of the right rotator cuff tear. On June 16, 2016, petitioner was seen again by Dr. Chunduri with complaints of right shoulder pain and rotator cuff tear, as well as lumbago and cervicalgia. A lumbar MRI was ordered.

Integrated Behavioral Medicine, Ltd. Records (PX.8)

Petitioner was evaluated by clinical psychologist, Dr. Daniel Kelly on May 31, 2016 and June 24, 2016. In his June 30, 2016 evaluation report he determined petitioner was suffering emotional distress from the automobile accident of April 25, 2016 and recommended therapy and referral to a psychiatrist for medication. He received psychological counseling until October 31, 2016 when it was terminated for financial reasons. Diagnosis was post-traumatic stress disorder.

Mid-City Rehabilitation Ltd. Records (PX.9)

According the records, petitioner was first seen by Manal Elmusa on May 11, 2016. These records contain a report entitled: "Orthopedic Evaluation Number 1 dated May 11, 2016". In this evaluation report, petitioner had complaints centered on the neck; he also mentioned his right shoulder was bothering him. He denied any previous injury to that same area. The records reportedly were for treatment to the cervical spine and right shoulder; with an onset date of April 25, 2016. According to these records, petitioner received treatment on: May 12, 2016, May 13,

2016, May 18, 2016, May 18, 2016, May 20, 2016, May 25, 2016, May 26, 2016, May 27, 2016, June 1, 2016, June 2, 2016, June 3, 2016, June 8, 2016, June 9, 2016, June 10, 2016, June 16, 2016, June 22, 2016, June 24, 2016, June 28, 2016, July 5, 2016, July 7, 2016, July 11, 2016, July 13, 2016, July 14, 2016, July 15, 2016, July 19, 2016, July 21, 2016, July 26, 2016, July 17, 2016, July 28, 2016, July 29, 2016, August 2, 2016, August 3, 2016, August 4, 2016, August 9, 2016, August 22, 2016 and August 23, 2016.

Core Medical Bill (PX.10)

$1,298.99 for nerve stimulator and electrodes as a referral from Dr. Elmusa.

Dr. Jerrold Leikin March 1, 2017 Deposition (PX.11)

Dr. Leikin, board certified in internal medicine, emergency medicine, medical toxicology and medical review officer, testified via deposition in behalf of petitioner. Dr. Leikin reviewed the medical records from Edward Hospital, where petitioner was taken after the accident and determined from these records that petitioner did not show any manifestation of intoxication, which included cocaine (7). The only conclusion that Dr. Leikin could make from reviewing report from Origin Diagnostic from the urine collection of April 26, 2016 was that petitioner had ingested a significant amount of cocaine within a week of the accident of April 25, 2015 (10-11). Dr. Leikin could not say whether the level of cocaine, whenever ingested, was the sole and proximate cause of the accident (13).

Dr. Jerrold B. Leikin December 12, 2016 Report (PX.12)

Dr. Leikin opined that "due to the lack of information regarding the quantitative value of the cocaine metabolite in [petitioner's] urine [collected on April 26, 2016], no determination as to the acute cocaine intoxication at the time of the accident can be made".

Illinois Traffic Crash Report (PX.13)

The State Police report of the vehicular accident to which petitioner was involved on April 25, 2016. Petitioner's vehicle was rear-ended by a truck driven by Daniel Garcia who died in the accident.

Petitioner's Employment Records from Jerry's Trucking (PX.14)

Patrick Nolan, president of Jerry's Trucking, Inc., confirmed petitioner worked as a driver for Jerry's Trucking from October 3, 2016 to November 17, 2016. Petitioner reported on his employment application for Jerry's Towing that he was employed by: IMG Trucking from October 2014 to May, 2016, and also indicated from October, 2014 to September, 2016; Doru Trucking from January, 2009 to April, 2014; and George Global Trucking from January, 2009 to April, 2016, and also indicated from October, 1995 to December 2008.

Petitioner signed a drug statement on September 30, 2016 that he had not tested positive on a pre-employment drug test.

Trans Am Trucking Employment Records (PX.15)

The records show petitioner was paid for a week period in October, 2017. Petitioner signed a statement on October 11, 2017 that he had never tested positive on an IDOT drug test.

Origin Diagnostic Records (RX.1)

These records are the same as Petitioner's Exhibit 6.

Illinois Bone & Joint/Dr. Thomas Gleason September 19, 2017 Report (RX.2)

Petitioner was examined by board certified orthopedic surgeon, Dr. Thomas Gleason, pursuant to §12 on September 19, 2017. Dr. Gleason also reviewed all of the medical records (including the set of records that were part of the State Farm's records for the automobile accident of January 22, 2016). These records included those from Edward Hospital, Dr. Chunduri, Dr. Giannoulias, Dr. Elmusa, and Dr. Kelly.

Based upon his exam and the review of the medical records, Dr. Gleason concluded that although petitioner did have problems with his right shoulder, the condition was unrelated to the work accident of April 25, 2016.

May 11, 2016 Mid-City Rehabilitation Record [This record is part of the State Farm Records introduced a Respondent's Exhibit 6] (RX.3)

In this record by Dr. Elmusa, petitioner recited a history that on January 22, 2016 he sitting in a right front passenger seat in a vehicle that was stopped and rear-ended. He reportedly felt fine after the accident and went home. He stated a day or two later he returned to work and was experiencing pain in his right shoulder. He stated he was having difficulty shifting and getting in and out of the truck at work. He did not seek medical treatment.

Petitioner reported he was having lower back problems since the accident [of January 22, 2016] and that he had sought treatment from an orthopedist.

The examination report identified in these records also as Orthopedic Examination No. 1, and dated May 11, 2016, included only discussions of the lumbar spine exam.

Trans Am October 11, 2017 DOT Drug Statement (PX.4)

This report was included in Petitioner's Exhibit 15.

Dr. Christos Giannoulias November 22, 2017 Record (RX.5)

Petitioner was seen again by Dr. Giannoulias on November 22, 2017, after undergoing an independent medical exam on September 19, 2017. Petitioner denied to Dr. Giannoulias that he had problems with his right shoulder prior to April 25, 2016. Based upon petitioner's denial of previous problems, Dr. Giannoulias stood by his opinion that petitioner's right shoulder problem was related to the work accident.

State Farm Fire and Casualty Company Records (RX.6)

These records are in regard to the January 22, 2016 automobile accident in which petitioner was a passenger in one of the vehicles involved in the accident. Contained in these records were medical records from Mid-City Rehabilitation. The records reflect treatment to petitioner's lower back with an onset of January 22, 2016. Treatment dates include: May 11, 2016, May 12, 2016, May 13, 2016, May 18, 2016, May 19, 2016, May 20, 2016, May 25, 2016, May 26, 2016, May 27, 2016, June 1, 2016, June 2, 2016, June 3, 2016, June 8, 2016, June 9, 2016, June 16, 2016, June 22, 2016, June 24, 2016 June 28, 2016, July 5, 2016, July 7, 2016, July 11, 2016, July 13, 2016, July 14, 2016, August 4, 2016. Also included was a June 10, 2016 record for treatment of the shoulder and neck with onset date of April 25, 2016.

CONCLUSIONS OF LAW

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

The Arbitrator finds petitioner is, at best, not credible. He had very selective memory of injuries suffered in the previous automobile accident from January, 2016. He claimed he could not remember what injuries, if any at all, he suffered in the January 22, 2016 accident; he was only certain he had not injured his right shoulder in the January 22, 2016 accident. In fact, he testified his wife was the only one who made a claim to State Farm for injuries from the January 22, 2016 accident. He also lied on his applications with Jerry's Towing and Trans Am regarding his use of cocaine and failed to include his employment with respondent.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

Although petitioner tested positive for cocaine the day after the accident, petitioner's expert, Dr. Leikin testified he could not determine petitioner was intoxicated at the time of the accident. Petitioner was stopped when rear-ended. According to Dr. Leikin's testimony, the medical records from Edward Hospital emergency room after the occurrence, petitioner did not show signs of intoxication. Petitioner admitted he had ingested cocaine the night after the accident.

Based upon a preponderance of the evidence, the Arbitrator finds petitioner was involved in an accident that arose out of and in the course of his employment with respondent on April 25, 2016.

F. With respect to the issue of whether petitioner's condition of ill-being is causally related to the claimed accidental injuries, the Arbitrator makes the following conclusions of law:

Petitioner cannot be believed. Therefore, his claim that he injured his right shoulder condition, that is not supported by the medical evidence, cannot be believed.

According to the Edward Hospital records, where petitioner was taken immediately after the April 25, 2016 accident, petitioner had no complaints of right shoulder problems; his right shoulder was not X-rayed. According to the Mid-City Rehabilitation records, that were contained in the State Farm file regarding the January 22, 2016, petitioner felt fine after the January 22, 2016 accident. However, the next day or two later he returned to work and was experiencing pain in his right shoulder. He was having difficulty shifting and getting in and out of his truck at work.

After reviewing Dr. Gleason's report of September 19, 2017, Dr. Giannoulias stood by his opinion that petitioner's right shoulder problem was related to the work accident of April 25, 2016 as petitioner was adamant that he had no problems with the right shoulder before the April 25, 2016. The Arbitrator finds Dr. Giannoulias' opinion lacks credibility as he relied upon the false statement by petitioner that he had no problems with his right shoulder before the April 25, 2016 accident in reaching his conclusions that the right shoulder was related to the April 25, 2016 work accident.

The Arbitrator finds Dr. Gleason, who reviewed all the medical records, including those related to the January 11, 2016 accident, to be credible. Accordingly, the Arbitrator relies on Dr. Gleason's opinion in finding that, although petitioner has right shoulder problems for which he needs treatment, the right shoulder problems were not caused by the work accident of April 25, 2016.

The Arbitrator also considered petitioner's claim for the PTSD condition. In some circumstances, it would be reasonable to consider that anyone who was involved in an accident in which the other party died, could suffer PTSD. However, in petitioner's case, as he has no credibility, and Dr. Elmusa, who created separate sets of records for petitioner in order to apparently double dip in petitioner's behalf, has no credibility. For these reasons, the Arbitrator finds petitioner's claim for PTSD is without merit.

J. With respect to the issue regarding medical bills incurred, the Arbitrator makes the following conclusions of law:

As the Arbitrator determined petitioner's right shoulder condition, and the claimed PTSD, were not caused by the work accident of April 25, 2016, the claim for medical expenses incurred for both conditions is denied.

The Arbitrator awards the bill from Edward Hospital in the amount of $12,756.00 subject to the fee schedule, §8 and §8.2 of the Act, with credit to be given for any payments made directly by respondent of pursuant to §8j

K. With respect to the issue regarding the need for prospective medical treatment, the Arbitrator makes the following conclusions of law:

As the Arbitrator determined petitioner's right shoulder condition was not caused by the work accident of April 25, 2016, the claim for prospective medical treatment is denied.

L. With respect to the issue regarding TTD, the Arbitrator makes the following conclusions of law:

As the Arbitrator determined petitioner's right shoulder condition and the claimed PTSD conditions were not caused by the work accident of April 25, 2016, the claim for temporary total disability 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELAINE GOLDIE,

Petitioner,

vs. NO: 16 WC 11878

THE DANA HOTEL & SPA,

Respondent.

19IWCC0575

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 10, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that pursuant to Section 8(a) and subject to Section 8.2 of the Act, Respondent shall pay Petitioner an amount equal to the unpaid medical bill of $2,700.00 for the reasonable, necessary and related medical services rendered to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability of $376.13/week for 32-5/7 weeks, which represents the period commencing 4/11/6 through 11/15/16, in accordance with Section 8(b) of the Act. Respondent shall receive a credit in the amount of $12,218.19 for TTD benefits they have previously paid Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for the L4-L5 microdiscectomy surgery that treating neurosurgeon P.D. Ackerman, M.D., has prescribed, pursuant to Section 8(a) and subject to Section 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 $2900.00. 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 24 2019
LEC/bsd
O09/10/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Barbara Flores

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)

Elaine Goldie
Employee/Petitioner

v.

The Dana Hotel & Spa
Employer/Respondent

Case # **16** WC **11878**

Consolidated cases: **None**

19IWCC0575

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **9/29/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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, **3/31/16**, 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 $**29,337.88**; the average weekly wage was $**564.19**.

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 is entitled to a credit of $**12,218.19** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**12,218.19**.

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

ORDER

Pursuant to Section 8(a) and subject to Section 8.2 of the Act, Respondent shall pay Petitioner an amount equal to the unpaid medical bill of $**2,700.00** for the reasonable, necessary, and related medical services rendered to Petitioner.

Respondent shall pay Petitioner temporary total disability benefits of $**376.13**/week for **32-5/7** weeks, which represents the period commencing **4/1/16** through **11/15/16**, in accordance with Section 8(b) of the Act. Respondent shall receive a credit in the amount of $**12,218.19** for TTD benefits they have previously paid Petitioner.

Respondent shall authorize and pay for the L4-L5 microdiscectomy surgery that treating neurosurgeon P.D. Ackerman, M.D., has prescribed, pursuant to Section 8(a) and subject to Section 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

5/10/2018
Date

MAY 10 2018

ICArbDec19(b)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Elaine Goldie
Employee/Petitioner

v. Case # 16 WC 11878

The Dana Hotel & Spa
Employer/Respondent

19IWCC0575

FINDINGS OF FACT

Petitioner testified in open hearing before the Arbitrator who had opportunity to observe her demeanor under direct examination and cross-examination.

Petitioner testified she is 5'4" inches tall and weighs 165 pounds. On the accident date, she weighed 167 pounds. She worked for Respondent for 5 years before the accident date. Her job title was "Turndown." She started working for Respondent in March 2011. She worked the first 3 years for Respondent on the morning shift as a "Housekeeper." She then was promoted to the second shift, which was Turndown. The second shift was from 2:00 PM to 10:00 PM and then was changed to 1:30 PM 10:00 PM. At the time of the accident, she worked the shift from 1:30 PM to 10:00 PM. Respondent's business is that of a boutique hotel. When Petitioner worked the first shift, she was responsible for cleaning the rooms, which entailed stripping the beds, removing all bottles, moving all garbage, cleaning the bathroom, deep cleaning the toilet areas, cleaning the showers, making the bed, dusting, vacuuming, and mopping. Sometimes she would move furniture out to dust and then push it back. She was responsible for totally cleaning the room. Respondent had 216 rooms. Petitioner would be responsible for cleaning 11-13 rooms on the first shift. She did that 5 days a week and sometimes 10 days in a row. Petitioner was then promoted and started to work on the second shift in the position of Turndown.

Petitioner testified that the second shift Turndown job started at 1:30 PM. The job duties included cleaning the rooms if a guest checked out late. She would clean 1-2 rooms, and sometimes up to 8 rooms. She would have to help the Houseman with the dirty linen: sort it, put it in bins, remove the bins, which weighed up to 600 pounds each, move and push the bins to the area where dirty linen was stored, clean the lobby and all the common areas, clean the toilets, vacuum, mop, sweep up the outside, clean the entrances, wipe down the glass in the lobby, wipe

down the glass doors, and do whatever else needed to be done. Toward the evening, she would have to enter a room if a guest asked for a turndown. She might have to fix his beds, change his linen if the bed needed to be changed, give him fresh towels, wipe up the excess water from the shower or sink, replace his water glasses, replace his coffee, give him buckets of ice, or pull down the shades. If she received a call from a specific room, she would have to go up and make a sofa bed, deliver a shower cap, earplugs, shaving kit, and other amenities that a guest may request.

On March 31, 2015, Petitioner started work at Respondent at 1:30 PM. She was working the second shift as a Turndown. Between 8:30 PM and 9:00 PM, the guest from room 1301 called. She wanted her sofa bed pulled out. There were two cocktail tables in the room, each of which was about 2 feet high. There was an area rug where the cocktail tables were and there was a slab of granite on each table. The granite was not stuck to the table and moves from the table. The table is too heavy to lift and she could not push it because of the rug. So, she had to bend over, hold the granite, and then maneuver it from side-to-side so as to move it little by little from the rug to the wooden floor. Once she placed each table on the wooden floor, she could push it more easily.

The Arbitrator notes that the activity Petitioner demonstrated was as though she was "walking" the table on its legs.

Petitioner testified that as she was maneuvering one of the tables off the rug and onto the wooden floor, she felt a pop in her back with a lot of pain. There was a guest in the room so she shrugged it off. She opened up the sofa bed, and put sheets and pillows on the bed. After the guest indicated that she needed nothing else, she left the room. T. 19-20. She then took the stairs because she does not like to tie up the elevators. When she got to the stairs, she tried to put her foot down on a step, but neither one of her feet would go down the stairs. Petitioner described her reaction as "What's going on?" She went to the elevator and went down the elevator to the break room. She sat down and took off her support hose. As soon as she took the hose off, pain shot from her back, down to her buttocks, down her leg, across her knee, and straight down to her big toe. T 20. It was approximately 9:00 PM or 9:10 PM. She was leaving at 10:00 PM. She sat there for a good 20 minutes until it subsided. There was nobody there to tell. Security was there. Her husband picked her up at work and she went home. She took a couple of Aleve and then went to sleep.

When Petitioner got out of bed the next morning, she took 2-3 steps and fell down. When she went down there was no leverage in her leg; it was like someone took away her leg and she was walking with one leg. She got up. He did not know what was going on and what happened.

She walked to the kitchen and tried to make it to the sink, but went down again. After that, she was scared. She called her husband and started screaming for him to come to her. He came into the kitchen and asked what's wrong. She said she didn't know but she couldn't walk and didn't know what was going on. Her husband lifted her up and she went to the kitchen sink. He asked her if she was okay. She said she was okay but she didn't know what was going on; she was walking didn't know what was going on with her leg. He stayed with her in the kitchen and watched her. Petitioner testified she went to throw something into the garbage, and she fell down again. Petitioner testified "that's when I lost it." She asked her husband to call work because she wanted to go to the Emergency Room. She was scared because she couldn't walk. She didn't know why this kept happening. She went to the Emergency Room.

Petitioner testified she was taken to the Community First Medical Center. The medical records of Community First Medical Center were admitted in evidence as Petitioner's Exhibit 1. These records reveal:

On April 1, 2016, Petitioner presented to the Community First Medical Center and gave a history of back pain after lifting objects at work PX 1, p 15; her pain score was a 10 on scale of 0/10. PX 1, p. 13; she left without being seen. PX 1, p. 16.

Petitioner testified that she was really frightened and it was taking too long to be seen at the Community First Medical Center so she left. Her husband took her to Presence Resurrection Medical Center Emergency Room.

The medical records of Presence Resurrection Medical Center were admitted in evidence as Petitioner's Exhibit 2. Such records reveal:

On April 1, 2016, Petitioner was treated at Presence Resurrection Medical Center Emergency Room. History indicates: patient arrived at ED with husband; at work last night about 2000 when she had to lift a heavy object by herself; patient states that after moving the object she had sudden onset of pain into her lower left side of her back; patient states that throughout the night she had intermittent "charlie horses" in her legs; she fell to the ground several times; has tingling sensation in her fingertips. PX 2, p 10. After an examination, a diagnosis was made of acute low back pain with sciatica. PX 2, p 9. She was given Ibuprofen and Valium. PX 2, p. 9. Cyclobenzaprine/Flexeril and Ibuprofen were ordered for her home use. PX 2, p. 9. She was ordered to return to the Emergency Room if symptoms worsen and follow up with her primary care physician. PX 2, p. 9. She was ordered off work until April 4, 2016. PX 2, p. 19.

Petitioner testified that she stayed off work as a result of the order from the doctors at the Presence Resurrection Medical Center Emergency Room.

Petitioner testified she went home after she left the Emergency Room at Presence Resurrection. Petitioner continued to have problems over the next 5 days with her back and leg. She also began to have swelling in her neck and started bleeding in a way that was similar to menstruation even though she had been through menopause. She started to develop shoulder pain. The shoulder pain, neck pain, and bleeding started after the fall that she suffered at home. She did not experience those symptoms at the time of the accident. She fell at home on a Friday morning. On Friday evening into Saturday morning, she noticed that it was hard for her to sleep and hard to put her head down.

On April 5, 2016, Petitioner was treated at Physicians Immediate Care. The medical records of Physicians Immediate Care were admitted in evidence as Petitioner's Exhibit 3. These records reveal:

On April 5, 2016, Petitioner gave history of constant back pain of the lower back since Thursday, March 31, 2016; severe pain; it was a result of an injury that occurred on March 31, 2016, which was work-related with sudden onset; no similar problems in the past; not the result of motor vehicle accident; denies that any non-work-related event or illness possibly contributed to or is related to development of symptoms; pain radiates to the right shoulder, right hand, left thigh, left knee and left lower leg; onset is associated with an injury; on March 31, 2016, she tried to move heavy table when she felt a pain in her back; left and tried to walk downstairs but felt like her feet wouldn't work; went home and went to bed; woke up in the morning, she was having worsening back pain and kept falling; went to ER on 4/1 diagnosed with muscle spasms given Ibuprofen and Flexeril; now the pain keeps worsening; feeling it in the left low back to the buttock and it shoots down to her knee, her right leg and foot feel numb; having right neck pain and stiffness; states her right arm and hand feel numb; can't sit due to the pain; not able to walk without assistance. PX 3, p. 6. An injection of Toradol and medication were administered. She left the room with difficulty. Diagnosis was low back pain, cervicalgia, radiculopathy. She was ordered to return to the clinic on April 7th for a re-check; she was ordered off work until re-evaluation on April 7, 2016, and was ordered to go to Presence ER. PX 3, p. 9.

Petitioner testified that on April 6, 2016, she returned to Presence Resurrection Medical Center Emergency Room.

On April 6, 2016, Petitioner was seen at the Presence Resurrection Emergency Room. History indicates: she complained back pain; was in ER with back pain that started a few days ago; was here in ER on April 1 with acute back pain after moving a table; patient now has increasing pain as well as numbness to her anterior thigh; pain continues to be on the left side; shooting pain down her leg from her left back; no incontinence; having a difficult time walking; feels that her leg is going to give out when she tries to put pressure on it; no alleviating symptoms; sent here by Urgent Care for MRI; patient states that over the last few days has had vaginal bleeding and was post-menopausal as of age 48 and has not bled since then; patient now has some bleeding. PX 2, p. 37. After examination diagnosis was disc disease in lumbar spine. Petitioner was referred to Dr. Yapor and prescribed Medrol Dosepak. PX 2, p. 40. An MRI was ordered. PX 2, p. 41

On April 6, 2016, MR images of the lumbar spine without contrast were taken at the Presence Resurrection Medical Center and were interpreted as showing the following: mild degenerative disc disease from the L1 through the L5 levels; at L3-4 broad-based central posterior disc protrusion mild disc encroachment on the inferior edge of the right neural foramen; at L4-5 annular tear along the left posterior lateral margin of the disc with minimal encroachment on the left inferior aspect of the left neural foramen. PX 2, p. 49. Work restrictions were ordered and she was referred to Dr. Yapor. PX 2, p. 62.

On April 7, 2016, Petitioner was examined by Wesley Y. Yapor, M.D., at Northwestern Neurological Associates. Medical records of Wesley Y. Yapor, M.D. and P.D. Ackerman, M.D., of Northwestern Neurological Associates were admitted in evidence as Petitioner's Exhibit 4. History given: female states she was perfectly well until March 31, 2016; was at work moving tables and furniture; begin having pain in the low back by the next day she was in terrible pain; low back pain with pain radiating to the left foot and toe; also, has been having severe neck pain with numbness of the hands and severely limited cervical ROM. PX 4, p 23. Dr. Yapor reviewed the MRI, which showed a left L4-5 foraminal herniation; this would explain her left foot and back complaints. PX 4, p. 24. Assessment was: lumbar herniated discs; neck pain. MRI of the cervical spine was ordered and Medrol Dosepak was ordered. PX 4, pp. 24-25.

On April 11, 2016, MR images of the cervical spine without contrast were taken at Bright Light Radiology. The images were interpreted as showing multilevel spondylosis, degenerative disc disease, and uncovertebral joint arthropathy in the cervical spine resulting in multiple areas of stenosis. Notably there is moderate bilateral foraminal stenosis at C5-6, and C 6-7 moderate

right and moderate to severe left foraminal stenosis. PX 5. The unpaid bill for the cervical MRI is in the amount of $2,700.00. PX 5.

On April 12, 2016, Petitioner returned to Dr. Yapor. History on that date indicates: female who was known to have a left L4-5 extruded disc with the left foot drop; patient also has severe neck pain; Medrol helped the pain a lot but now the pain is returning; left partial foot drop has not improved; cervical ROM has improved. PX 4, p. 20. MRI of the cervical spine shows C3-7 disc disease with contact of the anterior cervical cord but no cord compression. PX 4, p. 21. Assessment was: left foot drop; lumbar herniated disc; herniated cervical disc. Plan was: left L4-5 microdiscectomy. PX 4, p. 22.

Petitioner testified that she agreed to proceed with the surgery that Dr. Yapor had ordered. T. 33.

On April 21, 2016, Petitioner returned to Dr. Yapor. History indicates: 52-year-old female who was known to have an extruded lumbar disc with a partial foot drop on the left; patient states that she is doing poorly with severe pain and worsening left foot strength. Petitioner was continuing to take hydrocodone. Assessment: lumbar herniated disc. Plan: scheduled to see a second opinion ASAP to satisfy her insurance company. PX 4, pp. 18-19.

On April 30, 2016, Petitioner was treated at the Community First Medical Center for shortness of breath. History indicates: 52-year-old female with history of tobacco abuse switched to E cigarettes over the last two weeks, chronic low back pain that requires her to walk with a cane presents with shortness of breath. PX 1, p. 22.

On May 12, 2016, Petitioner was examined by Carl N. Graf, M.D., Respondent's Section 12 examining physician.

On June 12, 2016, Petitioner was seen at Community First Medical Center. History indicates: states that she has had back and abdominal pain since April 1st and is on workers' compensation and has had MRIs and needs back surgery. Now the pain is worse in her abdomen and back. PX 1, p. 77. Medication for abdominal pain was ordered. PX 1, p. 74.

On June 13, 2016, Petitioner was seen at the Emergency Room of presence Resurrection Medical Center. History indicates: 52-year-old female, medical history significant, presents to the emergency department for evaluation of abdominal pain; states pain has been present for 2 months; patient with accident and resulting disc herniations, laminectomy pending; associated with 5/10 central abdominal pain, nausea, denies vomiting, admits to constipation since starting pain meds;

no exacerbating or relieving factors. PX 2, p. 85. After examination, impression was: umbilical hernia, otalgia. She was ordered to follow up with PCP; medication was prescribed. PX 1, p. 87.

On June 28, 2016, Petitioner returned to Dr. Yapor. History indicates: 52-year-old female who is known to have lumbar disc disease and a partial left foot drop. Patient and I went over the IME report and she was upset about the things he stated and the fact that he was implying she was faking her pain and weakness. PX 4, p 16. After examination the assessment was: lumbar herniated discs; neck pain. Dr. Yapor wrote: "The IME makes no mention of her partial foot drop on his exam. I find this unusual." The plan was to have an EMG to confirm the left foot drop and PT. PX 4, p. 17.

On July 12, 2016, Petitioner underwent an EMG at Presence Resurrection Medical Center. PX 2, pp. 122-136. The EMG was interpreted as revealing an abnormal study; there is a electrodiagnostic evidence of a sensory predominant axonal peripheral polyneuropathy affecting the lower extremities; there is no electrodiagnostic evidence on the study for a left lumbosacral radiculopathy; it should be noted that a lumbosacral radiculopathy affecting sensory nerve roots only, while sparing motor nerve roots, can produce a normal electrodiagnostic study. Clinical correlation is advised. PX 4, p. 56

On July 13, 2016, Petitioner was treated at Athletico Physical Therapy (Petitioner Exhibit 8 admitted in evidence) on the referral from Dr. Yapor. PX 8, pp. 3-15. Pain was reported as 7/10 current, 7/10 best, 10/10 worst. Patient reports symptoms are progressively worse. PX 8, p. 17. Examination revealed patient demonstrates fear avoidance behavior with movement; patient sits with left lower extremity extended and unloads the left side; patient is unable to place back against the chair; range of motion demonstrated severe restrictions; special tests lumbar special test findings as follows positive straight-leg raising test and positive slump test. PX 8, p. 18. She participated in physical therapy. PX 8, p. 15.

The July 15, 2016 Athletico Physical Therapy note documents: patient reports that her leg pain has significantly decreased however back pain has increased; using ice and laying on her stomach as instructed which she feels has helped; continues to present with antalgic gait pattern with decreased stance time through her left lower extremity; physical therapy was administered and it was noted that patient was able to demonstrate improved tolerance to exercises today as compared to initial evaluation and was able to walk into clinic with improved posture; patient

symptoms continue to be highly irritable and slow progression with exercise should be taken. PX 8, p. 13.

The July 19, 2016 Athletico Physical Therapy note documents: patient reports that she continues to have elevated pain levels to low back; states that her left lower extremity feels mostly numb; antalgic pattern noted upon arriving at clinic throughout the duration of session; treatment was administered. PX 8, p. 12.

The July 20, 2016 Athletico Physical Therapy note documents: patient reports that her foot hurts today; patient is unable to lay supine for many exercises; physical therapy was administered; improved LS extension; responding well to extension-based exercises with a decrease in leg pain however continues to be unable to lay supine or perform any exercises in that position. PX 8, p. 10.

The July 25, 2016 Athletico Physical Therapy note documents: patient reports she felt a relief in symptoms following last visit; however, symptoms returned the following day; states that she did not perform POE at home over the weekend; patient encouraged to be more compliant; physical therapy continued. PX 8, p. 9.

The July 27, 2016 Athletico Physical Therapy note documents: patient states that her leg pain has improved, however, has more back pain; patient able to stand with an upright posture and is no longer forward bend at the hips; patient continues to demonstrate centralization of leg symptoms however is unable to progress to prone on extended elbow press-ups secondary to fear and pain; physical therapy continued. PX 8, p. 8.

On August 16, 2016, Petitioner returned to Dr. Yapor. History indicates: 52-year-old female who is status post a back injury and was found to have an L3-4 and L4-5 disc disease on MRI; patient was found to have a partial foot drop on the left. MRI with a radiologist and she agrees that the L3-4 disc is more prominent on the left but report does not state this. She will amend the report to reflect the findings. EMG was interpreted to suggest she has peripheral neuropathy and not a radiculopathy. Assessment was: lumbar herniated disc; left foot drop. Plan was Medrol Dosepak, Neurontin, will stop PT because she states they are causing increased pain. Is still in need of surgery: lumbar discectomies. PX 4, pp. 14-15. PX 8, p. 7.

On August 25, 2016, Petitioner returned to Dr. Yapor. History indicates: 52-year-old female known to have cervical disc disease; has neck pain and muscle spasms but no arm weakness; back pain is severe and the left foot is no better and still weak; has left L3-L4 and L4-

L5 disc protrusions. PX 4, p. 10. Notes: diagnosis lumbar herniated discs; left foot drop; neck pain. PX 4, pp. 11-12. Order: may not return to work. Surgery was ordered left L3-4 and L4-5 discectomies to be scheduled on September 14, 2016 at Resurrection. PX 4, p. 13.

On September 1, 2016, Petitioner was seen by her PCP, Maria L. Banaad-Omiotek, M.D., for her annual checkup. The records of Dr. Banaad-Omiotek were admitted in evidence as Petitioner's Exhibit 7. Among the diagnoses were essential hypertension, hyperglycemia, low back pain, hypercholesterolemia. PX 7, p. 10.

On September 15, 2016, Petitioner returned to Dr. Banaad-Omiotek for treatment of her hypertension, diabetes, and hypercholesterolemia. PX 7, p. 13.

On October 4, 2016, Petitioner returned to Dr. Yapor. History indicates: 52-year-old female who is known to have a left partial foot drop and left-sided disc disease at L3-4 and L4-5. The patient has seen an IME who disagrees with her foot drop and her MRI findings. The head of the radiology department, who was a neuroradiologist, amended her report after reviewing it again and agreed that there is a left-sided herniation. PX 4, p. 7. The assessment was: lumbar herniated discs; left foot drop. The plan: in view of the present situation, I recommended a pain clinic and have the patient return to the IME with the amended report. PX 4, p. 9. It is noted that in this office visit note of Dr. Yapor an addendum by Diana O. Iwanik, M.D., July 28, 2016 states: review of the MRI study demonstrates a broad-based posterior disc protrusion at the L3-4 level; there is mild to moderate encroachment on the ventral aspect of the thecal sac by the disc protrusion; in addition there is a diffuse disc bulging with disc encroachment noted on the inferior aspect of the neural foraminal bilaterally; sagittal views show similar degree of encroachment on the edges of the neural foraminal bilaterally, however, on the axial views the encroachment appears to be minimally more pronounced along the inferior adage of the left neural foramen where the disc contour is minimally lobulated consistent with focal disc protrusion. Findings were discussed with Dr. Yapor. Signed by Diana O. Iwanik, M.D. 7/28/2016. PX 4, p. 9.

On October 13, 2016, Petitioner was seen by Randolph Chang, M.D., of Health Benefits Physicians on referral from Dr. Yapor. These records were admitted in evidence as Petitioner's Exhibit 6. History was: 52-year-old female complains of low back pain radiating to the left lower extremity began from a work-related injury in March 2016, patient has seen multiple doctors including Dr. Yapor who recommended surgery and then after seeing an IME doctor. She was recommended to have an epidural injection which is the reason why she is here today. Pain is

worse with ambulation and with lying down and there's a question about a foot drop initially but it appears that she had improved, although today she reports that her foot is weak again. Imaging study: MRI of the lumbar spine from April 6, 2016 was interpreted to reveal disc protrusion at L3-4 and L4-L5 with encroachment on the neural foramen. EMG done in July show she has some peripheral neuropathy but no lumbar radiculopathy. Diagnosis: low back pain with radiculopathy to the left lower extremity with lumbar disc herniation, stenosis and degeneration. Plan: transforaminal epidural steroid injection at L4-L5 left and L5-S1 level and increase medication. PX 6, pp. 2-3. A bill in the amount of $307.00 was issued. PX 6, p. 4.

On October 24, 2016, Petitioner was again examined by Respondent's Section 12 physician, Dr. Graf. RX4.

Petitioner testified that the transforaminal epidural steroid injection that Dr. Yapor prescribed was not administered because Respondent would not authorize it. T. 44.

On January 16, 2017, Petitioner returned to Dr. Banaad-Omiotek. Her diagnoses were hypertension, low back pain, and hypercholesterolemia. PX 7, pp. 19-20.

On February 9, 2017, Dr. Banaad-Omiotek noted that Petitioner would be seeing Dr. Ackerman for follow-up. PX 7, p. 21. The treatment that she ordered for Petitioner's low back pain included alternating cold packs with moist heat and massage. Petitioner was to schedule a follow-up visit. PX 7, p. 23.

Petitioner testified that Dr. Yapor died and that his practice was continued by his associate, Paul ("P.D.") Ackerman, M.D. T. 51

On February 20, 2017, P.D. Ackerman, M.D., of Northwestern Neurological Associates, examined Petitioner. History states: 52-year-old female with known partial left foot drop; previously seen last in October 2016 by my partner, Dr. Yapor who recommended L3-L4 and L4-L5 MCD; by report the patient underwent IME who disagreed with her foot drop and her MRI findings and was cleared to return to work; the patient is known to have left partial foot drop and left-sided disc disease at L3-L4 and L4-L5 – radiology amended the lumbar MRI report. Patient works as a housekeeper at the Dana Hotel downtown; initial trauma was related to converting a sofa into a bad; pain was initially in her back, but then developed a severe L L5 radiculopathy; her EMG however did not demonstrate evidence of lumbar radiculopathy. PX 4, p. 3. After review of the diagnostic testing and the examination Dr. Ackerman noted: I reviewed the patient's MRI with her and her husband in clinic this afternoon; despite a normal EMG with a partial L foot drop and

a classic L L5 radiculopathy the radiographic correlate (a L paracentral/foraminal disc herniation), I agree with Dr. Yapor that the patient would benefit from a lumbar microdiscectomy; I explained that I thought the symptomatic level was L4-L5 and I would recommend L L4-L5 MIS MCD; I am also concerned that because the weakness in her foot has been present for several months, even with a technically successful operation, the patient may not recover full function of her distal LLE. PX 4, pp. 5-6.

On March 4, 2017 through March 6, 2017, Petitioner was treated at Presence Resurrection Medical Center for complaints of chest pain. PX 2, pp. 137-264.

On March 13, 2017, Petitioner saw Dr. Banaad-Omiotek, who noted a decreased range of motion with back extension and lateral flexion, and pain with back extension and lateral flexion. PX 7, p. 27.

On May 8, 2017, Dr. Banaad-Omiotek noted a decreased range of motion with back extension and lateral flexion and pain with back extension and lateral flexion. PX 7, p. 31.

Petitioner testified that she returned to work in November 2016, after Thanksgiving, because Respondent cut off her workers compensation benefits. Her husband was not working. She was the only one working. She did not want to be homeless and there was nothing else for her to do. So, she sucked it up, went back to work and that is where she has been ever since. T. 44-46. She has been working for Respondent up to the date of the hearing on the second shift Turndown. T. 46. She performs the job differently now. T 46. Supervisors now are letting her check rooms after they are cleaned; she checks for amenities, the closets, and the glasses to make sure they're clean and everything is right and there are two robes and slippers and luggage rack. He still helps with the linen by sorting and all of her coworkers are aware of her back and remind her to watch her back. T. 47. If she does too much, her leg will start up and if she stands too much, she has to go to the break room and sit down. She doesn't like doing that because she is supposed to be working. T. 47-48. She has to sit down because her leg gets weak where it feels like if she doesn't sit down, she's going to fall. She needs to work; she's the only one making money. T. 48. She sits for 15 to 20 minutes and then gets back up; she does that throughout the day. T. 48. She is tired of having to live like this, having to keep sitting down and worrying about if her leg is going to give out again, but she does what she has to do. T. 48-49.

On her days off, Petitioner testified, she lays in bed. T. 49. She no longer picks up her grandchildren. T. 49. She does not want this problem with her leg and wants to be able to walk

into the store, do grocery shopping, and do some walking. She loves to walk. T. 49. She can walk to the corner store and may carry a gallon of milk but by the time she gets home, she's limping. T. 49-50.

Petitioner testified that the last time she saw Dr. Ackerman was in February 2017.

Petitioner testified that the leg pain she had a year or two prior to the accident was in her calves. T. 56. She also had pain and numbness in her hands at that time. T. 56. Dr. Sawlani, who was treating her at that time, ordered an ultrasound of her calves. T. 57. The pain was in her calves. T. 57. She was not having any numbness in her legs, just pain. T. 57. Petitioner has been diagnosed with Type II diabetes. T. 59-60. She did not initially sustain an injury to her cervical spine or neck on March 31st. T. 60.

Denise Gonzalez was called as a witness by Respondent. She has worked for Respondent as Human Resources Manager and was in that position for 4 years. She was in that position on the accident date of March 31, 2016. Her job responsibilities were employee relations, recruitment, payroll processing, terminations, benefit administration, overall dealing with the employees. She was familiar with various positions of employees in the company. She was generally tasked with managing all of the employees at Respondent. She knows Petitioner as an employee of Respondent in the position of Turndown Attendant. She sees Petitioner 3 to 4 times a week. Petitioner is one of the employees she oversees, but not directly. She was aware that Petitioner suffered an accident on March 31, 2016 and was out of work and returned to work in November 2016. She returned to work full duty. There's nothing different about her job duties before and after the return to work and she had the same responsibilities. She worked full time. She received her full wage. Petitioner received one raise of 3% in 2017. She sees Petitioner on a regular basis and speaks to her and is friendly with her. The witness testified that Petitioner's job performance has been excellent since her return to work. Petitioner has not described any problem with completing her job tasks. Petitioner has not reported any problems with lifting or carrying or moving around generally. Petitioner is not in any sort of light-duty position. She is required to complete her full job duties. The witness reported that Petitioner has never complained of any pain. The witness testified that she has seen Petitioner walking around and would say that she was walking normally. Petitioner is very active and walks back and forth from Housekeeping to break room area. The witness has not observed any problem with her walking. The witness has not seen Petitioner trip over anything. The witness has not observed Petitioner limping. The witness testified that she is not Petitioner's

direct supervisor. She does not supervise Petitioner's day-to-day activities as Petitioner works on the second shift as a Turndown person. The witness testified that Petitioner has been a diligent employee for the years the witness has known her. The witness agreed that she has never had occasion to question Petitioner's honesty and hard work. The witness testified she has an office in which she works as Human Resources Manager. Every week, she has observed Petitioner walking.

Paul D. Ackerman, M.D., testified via evidence deposition. The deposition transcript was admitted in evidence as Petitioner's Exhibit 9. Dr. Ackerman is a physician licensed to practice medicine in the State of Illinois and specializes in neurosurgery. PX 9, p. 5. He was graduated from Princeton University and Loyola University School of Medicine, where he did an additional 7 years as a neurosurgical resident. He was graduated in June 2016 at which time he joined the practice of Northwestern Neurological Associates. PX 9, pp. 5-6. Dr. Wesley Yapor was senior partner when Dr. Ackerman joined the practice.

Dr. Ackerman testified that Dr. Yapor initially treated Petitioner. Dr. Yapor died in January 2017 and Dr. Ackerman took over the care and treatment of Petitioner. He is on the staff of Resurrection Medical Center with full surgical privileges, and also has surgical privileges at Swedish Covenant Hospital, Community First Medical Center, and Presence St. Mary and Elizabeth Medical Center.

Dr. Ackerman reviewed the entire chart of the treatment of Elaine Goldie, including the treatment given by Dr. Yapor. Dr. Ackerman examined her on February 20, 2017. He took a history of the mechanism of injury and of Petitioner's initial complaints. He reviewed the first office visit note of Dr. Yapor, dated April 7, 2016. PX 9, p. 10. He reviewed the testing that had been done. PX 9, p. 10. Dr. Ackerman noted that the patient had demonstrated 3/5 motor strength of a myotome or muscle group, specifically the left anterior tibialis and the left exterior hallucis longus. PX 9, p. 11. These were the findings of Dr. Yapor. Such findings indicated that the patient had weakness to the point that she cannot dorsiflex her left foot or her left great toe against gravity. This was found to be profound weakness. PX 9, pp. 11-12. Dr. Ackerman noted that Dr. Yapor, based upon his examinations and the MR images, assessed Petitioner with a lumbar disc herniation and neck pain. PX 9, pp. 12-13. Dr. Yapor ordered an MRI of the cervical spine and prescribed a Medrol Dosepak. This is an oral, systemic, tapered steroid pack that is typically given to patients with acute inflammatory processes or suspected radiculopathy or for a neurologic deficit, or compression of the neural elements. PX 9, p. 13.

Dr. Yapor's notes indicate that the patient reported the Medrol Dosepak helped the pain a lot, but that the pain returned. Her cervical range of motion was improving. PX 9, p. 14. There was no improvement in her left partial foot drop. Dr. Ackerman testified that a partial foot drop would be given a motor strength designation of between 1 and 4 on the previously described 0 to 5 scale; 5 being full strength, 0 being complete flaccid paralysis. A partial foot drop would imply a motor score of 1, 2, 3, or 4. PX 9, p. 15.

Dr. Ackerman noted an inconsistency in the office visit note of Dr. Yapor dated April 21, 2016 with the prior office visit note of April 7, 2016. The April 21, 2016 note indicates that the patient described persistent, severe pain and worsening of her left foot strength. However, the motor exam on that day demonstrated 5/5 for the left anterior tibialis and 5/5 for the left exterior hallucis longus, which are different than the results Dr. Yapor had previously found. PX 9, pp. 16-17.

Dr. Ackerman testified that a foot drop is an urgent situation because it is a neurological deficit caused by compression, or irritation of a nerve root or spinal cord. The longer the deficit has been present, the less likely it is that even with a technically successful operation in which the area of stenosis or compression is fully decompressed, the less likely it is that the patient will fully recover from that deficit. PX 9, pp. 19-20.

On June 28, 2016, Dr. Ackerman testified, Dr. Yapor noted that the left anterior tibialis and left extensor hallucis longus was back to 3/5 consistent with diagnosis of a partial left foot drop. PX 9, pp. 20-21. Dr. Ackerman testified that he reviewed the Section 12 report including the summary of the medical treatment rendered to Petitioner prior to Dr. Yapor's first examination. PX 9, p. 22. There was nothing in the examination of June 28, 2016 to suggest to Dr. Ackerman that the patient was improving. PX 9, pp. 22-23.

Dr. Ackerman testified that cervical complaints were noted on the initial examination, but in subsequent examinations, no cervical complaints were documented. So, it appears that her cervical complaints resolved with time. PX 9, p. 25.

Dr. Ackerman testified that Dr. Yapor, in an addendum dated August 16, 2016, documents a partial drop foot and continuing left foot problems. However, upon examination, he finds that the strength of left anterior tibialis and left extensor hallucis longus is 5/5, which is inconsistent with a drop foot. Dr. Ackerman testified in reviewing of all of the records and his own examination of the patient, that would be inconsistent with Dr. Yapor's findings. PX 9, p 26. Dr. Ackerman

testified the diagnosis was not changed in that note and Medrol Dosepak and Neurontin were ordered with physical therapy to stop because it increased the pain. PX 9, p. 27. Dr. Yapor was still recommending surgery: lumbar discectomy. PX 9, p. 27.

At the deposition, Dr. Ackerman's staff produced an office visit note dated July 28, 2016. This was marked as Deposition Exhibit 2. PX 9, pp. 27-28. In the July 28, 2016 note, the plan was "Medrol Dosepak, Neurontin. Will stop PT because she states they're causing increased pain." In the addendum note of August 16, 2016, Dr. Yapor added the last line: "She is still in need of surgery for lumbar discectomies." PX 9, p. 28. Dr. Ackerman testified that there was nothing in the note to suggest that the partial drop foot had improved or that there was a change in the course of treatment. PX 9, p. 29.

Dr. Ackerman testified that the note of August 25, 2016 documents complaints to the left foot with no improvement. On this date, she was complaining of neck pain but no arm weakness. Back pain was described as severe. PX 9, pp. 29-30. Motor exam showed 4/5 left anterior tibialis and 4/5 left exterior hallucis longus. PX 9, p. 30. That is consistent with a partial foot drop. PX 9, p. 31. The doctor's diagnosis was not changed. He was still recommending L3-L4 and L4-L5 discectomy. PX 9, p. 31. Dr. Ackerman testified that Petitioner had negative straight leg testing that is documented throughout the records. PX 9, pp. 31-32. Dr. Ackerman opined that a negative straight-leg raising test is not a particularly reliable, sensitive, or specific test. It can occasionally help confirm a clinical diagnosis but he does not rely upon it heavily. PX 9, p. 32. His overall clinical impression takes into account the patient's history, examination, and ancillary radiographic investigations that have been undertaken to formulate clinical treatment. PX 9, pp. 32-33.

Dr. Ackerman testified that the October 4, 2016 office visit note does not document any improvement. PX 9, p. 33.

Dr. Ackerman reviewed the MRI report and the amended report. PX 9, pp. 33-34.

He testified that Dr. Yapor, in the October 4, 2016 note, documents 4/5 left anterior tibialis and a 4/5 left extensor hallucis longus. That is consistent with a diagnosis of a partial drop foot. PX 9, pp. 33-34.

Dr. Ackerman testified that an EMG is an electro-myelogram, which is a study in which, basically, a neurologist will connect electrodes, small needles to a patient and record the stimulation of the spinal cord or nerve roots. PX 9, p. 34. It is used most commonly in situations in which you are not entirely sure if a disc herniation may be causing the patient's symptoms. He

opined that it is rarely used, at least by surgeons, as a diagnostic tool. It can be included in part of the overall clinical picture or clinical diagnostic decision-making. PX 9, pp. 34-35. Dr. Ackerman testified that an EMG is not a definitive test in determining whether a patient has either a foot drop or radiculopathy. PX 9, p. 35. Dr. Ackerman reviewed the EMG report dated July 12, 2016. He noted that the findings were: "This is an abnormal study. There's electrodiagnostic evidence of a sensory predominant axonal peripheral polyneuropathy affecting the lower extremities. There is no electrodiagnostic evidence on this study for a left lumbosacral radiculopathy." PX 9, p. 36.

Dr. Ackerman examined the patient on February 20, 2017. He took a history, which is reflected in the note of that date. PX 9, pp. 37-39. After he took a history, he performed a review of systems that included documentation of the medication she was taking. PX 9, pp. 38-39. Dr. Ackerman noted that one of the medications she was taking was Metformin, which is used to treat Type II. PX 9, p. 39. Dr. Ackerman testified he was aware that the patient had Type II diabetes and explained that Type I diabetes is juvenile diabetes. PX 9, pp. 39-40. He conducted a physical exam in which she had 4 - out of 5 for the left anterior tibialis motor strength and 3 out of 5 for the left extensor hallucis longus motor strength. The doctor testified that the significance of this is that his objective examination was consistent with the partial foot drop. Dr. Ackerman found that she had symmetric lower extremity reflexes; no clonus or Babinski's; straight-leg raising test was negative bilaterally; no midline or lumbar tenderness; grossly intact sensation to light touch but when he stimulated the L5 dermatome, particularly distally, it prompted an abnormally uncomfortable noxious sensation. The significance of that is that it can be a sign that there is irritation of a lumbar nerve root. PX 9, pp. 40-42.

Dr. Ackerman testified that in addition to reading the MRI report and the addendum to the July 28, 2016 note, he actually looked at the films. It is his practice as an operating neurosurgeon to always view the films to make a diagnosis. PX 9, p. 42.

Dr. Ackerman testified that his conclusion after reviewing the MRI report was that the images demonstrated disc bulges at L3-L4 and L4-L5 worse on the left, worse more significantly and symptomatically on the left at lumbar L4-L5. PX 9, p. 43. Dr. Ackerman testified that his clinical diagnosis after reviewing the MRI films, Dr. Yapor's medical records, the Section 12 reports, and his February 20, 2017 examination results for Petitioner, was left L5 radiculopathy caused by a left-sided L4-L5 disc herniation. PX 9, p. 33. He opined that after reviewing all the medical records available to him and hearing Petitioner's history, it seemed reasonable to him that

the patient had an injury at work. PX 9, pp. 43-44. Dr. Ackerman testified that he had no indication that the patient had any complaints or problems with her left foot, her left leg or back prior to the work accident. PX 9, p. 44.

Dr. Ackerman testified that the diagnosis of left foot drop is a clinical diagnosis. PX 9, pp. 44-45. To diagnose the foot drop, he relied on his clinical examination. PX 8, p. 45. He had no reason to suspect that she was not giving her full effort. PX 9, pp. 45-46. As far as the lumbar radiculopathy, he took everything into account. Her history seemed consistent; it didn't change. He took into consideration his own personal interpretation the MRI findings, the interpretation of the MRI by the neuroradiologist, and the interpretation of the MRI by his partner, Dr. Yapor. Dr. Ackerman testified that he took everything into account. PX 9, p. 46.

In his practice, Dr. Ackerman has found patients to have lumbar radiculopathy in light of a negative EMG. PX 9, p. 46. Dr. Ackerman opined that the foot drop and lumbar radiculopathy that he diagnosed should be treated with a lumbar microdiscectomy on the left at lumbar L4-L5. The surgical goal of that procedure is to partially remove the offending lumbar disc herniation and insure that the nerve root, in this case the left L5 nerve root, is free from any kind of compression. The goal is to alleviate her left leg pain. PX 9, p. 47. Dr. Ackerman testified that the foot drop related to ongoing compression of the primary motor root that goes to the anterior tibialis and extensor hallucis longus. The surgical goal would be to remove that pressure and then, hopefully, with physical therapy and rehabilitation, the patient meet may be able to regain some or all of that myotomal strength. PX 9, p. 47.

Dr. Ackerman testified that, as a physician, he was trained to identify inconsistencies and consistencies. In this particular case, if he had suspected that there was something that was inconsistent or that the patient was not being forthright or giving her best effort on his examination, he would have subtly documented that in his note. PX 9, p. 48. He testified that the foot drop could impair the patient's ability to walk. PX 9, p. 48. Dr. Ackerman reviewed the summary that the IME made of the first and second medical providers to Petitioner after the date of the accident. PX 9, p. 49.

On cross-examination, Dr. Ackerman testified that his recommendation is for a one-level microdiscectomy at lumbar L4-L5. PX 9, p. 50. Anytime he receives an MRI of someone in their 50s, particularly an MRI of the lumbar spine, he would find it unusual not to see anything that would be considered degenerative. PX 9, p. 51. Dr. Ackerman thought the foot drop was caused

by the L4-L5 disc herniation that is compressing on the L5 nerve root on the left. PX 9, pp. 51-52. His diagnosis of partial foot drop is based only on his physical examination of Petitioner; that would be the motor examination. PX 9, p. 52. Dr. Ackerman testified that the motor function test is conducted with the patient sitting on an examination table. The doctor then asks the patient to provide as much resistance as she possibly can. Systematically, he goes through the tests of the myotomes. PX 9, p. 53. It is the only objective reporting that a doctor can really give; something subjective, he would consider, is what the patient would report to him. PX 9, p. 53. He compares one side with the other. PX 9, p. 53. If the patient actually had 5/5 motor strength, he would say that she did not actually have a foot drop. PX 9, p. 54.

Dr. Ackerman testified he would order an EMG if he were suspicious as to what was causing this finding of a foot drop. PX 9, p. 55. He finds that an EMG is, occasionally, a useful diagnostic tool. PX 9, p. 55. He has found that an EMG is a bit inconsistent, which is why he does not order it routinely. PX 9, pp. 55-56.

Dr. Ackerman testified that peripheral neuropathy would not be related to any lumbar spine condition. Peripheral neuropathy can be the result of uncontrolled diabetes. PX 9, p 56. Peripheral neuropathy can present itself as pain, numbness or weakness. PX 9, p. 57.

He reviewed the April 6, 2016 MRI of the lumbar spine and believed the symptomatic level was at L4-L5. PX 9, p. 57. The radiologist's impression was consistent with what he found on reviewing the MRI. PX 9, p. 58.

Dr. Ackerman testified that in his practice, when he is seeing a patient, he tries to correlate something that is abnormal to determine whether that may be pathology that is symptomatic. So, in certain circumstances, he will see what does not appear to be severe or huge, and yet the patient is symptomatic. In other cases, he will see a patient with a maybe a more impressive disc, who does not have a whole lot of symptoms. So, it is his job to correlate the MRI findings with what the actual patient is complaining of. PX 9, p. 59.

Dr. Ackerman testified that his opinion is that there is radiculopathy is not based solely on the MRI, but on the whole clinical picture: the patient's history, his examination, and the MRI. It's not strictly a radiographic diagnosis. PX 9, p. 59. It's a clinical diagnosis. PX 9, p. 60. Straight leg testing can add to the clinical picture. PX 9, p. 60. Dr. Ackerman testified he would expect clonus and Babinski's to be negative in a patient with radiculopathy, as was the case here. PX 9, p. 60. He finds that the straight leg test is not consistent enough for him to say he would expect it to be

positive; he finds it to be pretty variable. It can help confirm. PX 9, pp. 60-61. A change of motor strength from 3/5 to 5/5 would be significant improvement. PX 9, p. 62.

Dr. Ackerman testified that in Dr. Yapor's July 28, 2016 note, he finds a 5/5 motor strength for the anterior tibialis and extensor hallucis and that Dr. Yapor amended that note, but did not change his motor findings. PX 9, p. 64.

Dr. Ackerman testified in regard to Dr. Graf's Section 12 report dated September 12, 2016. He reviewed Dr. Graf's report. Dr. Graf documented physical therapy notes of July 13, 2016 in which the therapist records a positive straight leg raise test and positive slump test. Dr. Ackerman testified that that was one situation in which a straight leg was found to be positive despite occasions when he and Dr. Yapor tested and found them to be negative. PX 9, p. 66. Dr. Ackerman testified that the Section 12 report documents and summarizes the physical therapist's note of July 15, 2016: "... an observation of her gait remains antalgic and she demonstrates decreased stance time to the left lower extremity." PX 9, pp. 66-67. Dr. Ackerman testified that the Section 12 report reflects the physical therapy note of July 19, 2016 that indicates Ms. Goldie reported continued low back pain, numbness of the left lower extremity and an antalgic gait. PX 9, p. 67. Dr. Ackerman testified that these notes reinforce the fact that the patient had inconsistent left lower extremity pain. PX 9, pp. 67-68. He did not review physical therapy notes in rendering his opinion. PX 9, pp. 68.

Admitted into evidence as Respondent's Exhibit 1 is the curriculum vitae of Carl N. Graf, M.D. Dr. Graf is certified by the American Board of Orthopedic Surgery, American Board of Independent Medical Examiners, Fellow of the American Academy of Orthopedic Surgeons and ABIME board certified. He is affiliated with Alexian Brothers Medical Center, St. Alexis Medical Center, Centegra Memorial Medical Center. He was graduated from Augustana College and Loyola University Stritch School of Medicine. He did a five-year orthopedic residency at University of Illinois at Chicago, and a one-year combined orthopedic and neurological spine surgery fellowship at Indiana Orthopedic Hospital. RX 1

Admitted into evidence as Respondent's Exhibit 2 is the Section 12 report of Dr. Graf dated May 12, 2016. The report indicates that Dr. Graf took history of the patient. Patient is currently taking Norco. He reviewed systems and conducted a physical examination the cervical spine, shoulder, thoracic lumbar sacral spine. He found that the overall spinal alignment is neutral; no paraspinal muscle spasm present; pain to palpation is present to light, one finger touch in the right

side of the low back. He tested motor strength and found that for the left and the right lower extremity Ms. Goldie demonstrates the inability to break the strength of my single index finger in any motor group. He conducted neurological examination of both the left and right lower extremity. In testing sensation, he wrote that Ms. Goldie noted decreased sensation in the left anterior aspect of the shin, the left lateral aspect of the shin, the right posterior aspect of the calf; she states she has no sensation in the bilateral lateral position of the foot. There is decreased sensation in the sole of the left foot. He noted sitting straight leg raising negative in the distracted and informed scenario; supine straight leg raise is negative bilaterally. He noted that Petitioner demonstrates 9 non-organic pain signs on evaluation. He noted that Petitioner filled out a pain disability questionnaire which placed her in a self-rated category of extreme disability. The report further indicates he reviewed Presence Resurrection Medical Center records of 4/1/16 and 4/6/16, and Dr. Wesley Yapor's/Neurosurgical Consultation's note of 4/7/16, 4/12/16, and 4/21/16. RX2

Dr. Graf comments that in the note of 4/7/16, Dr. Yapor documents left anterior tibialis and EHL strength of 3/5. Dr. Graf comments that in the note of 4/21/16 of Dr. Yapor documents left anterior tibialis and EHL strength is 5/5; straight leg raise test is negative bilaterally; needs lumbar surgery ASAP. Dr. Graf reviewed radiologic studies of MRI lumbar spine without contrast 4/6/16. He personally reviewed an MRI scan of the lumbar spine of 4/6/16 which he interpreted to reveal small annular tear in the foraminal region of the left at L4-L5; there is no notable nerve root compression; there is a small central disc bulge at L3-L4 which is central and the effaces the thecal sac. He reviewed an MRI of the cervical spine without contrast dated 4/11/16. He personally reviewed the MRI scan of the cervical spine of 4/11/16. He interpreted that MRI as demonstrating a disc bulge at C4-C5 on the right; no notable nerve root compression; degenerative changes from C3 to C7; at C5-C6 there is a central bulge with no nerve root compression; there is a tiny left paracentral disc bulge at C6-C7, though no nerve root compression. RX2

In his Summary and Opinion, Dr. Graf stated that Petitioner is a 52-year-old female who claims injury on March 31, 2015; initially presented to emergency department and subsequently followed up with Dr. Yapor. He diagnosed a partial foot drop and recommended a microdiscectomy; she subsequently followed up where Dr. Yapor, and he noted that the strength had returned to 5/5. Dr. Graf stated that on examination, Ms. Goldie demonstrates a rather bizarre evaluation; she has subjective complaints of pain including her neck, upper extremities, and bilateral lower extremities; she demonstrates multiple inconsistencies and non-organic pain signs;

she demonstrates giveaway weakness throughout the bilateral upper and lower extremities in all motor groups. Dr. Graf states that imaging studies demonstrate a small annular tear within the foraminal region of L4-L5; he did not appreciate any nerve root encroachment, the reading radiologist notes "minimal encroachment" on the left inferior aspect of the neural foreman; regardless this would not substantiate Ms. Goldie's diffuse subjective complaints. In regard to the cervical spine, Dr. Graf stated that Petitioner has severe complaints of neck pain, giveaway weakness of the bilateral upper extremities with non-anatomic distribution of numbness, and imaging studies that demonstrate multilevel cervical spondylosis with no notable nerve root compression. RX2

Dr. Graf opined that he is unable to substantiate Ms. Elaine Goldie subjective complaints given the lack of objective findings and that the requested surgery would not be considered reasonable. Ms. Goldie was initially diagnosed with a partial foot drop by Dr. Yapor and subsequent follow-up notes document left anterior tibialis and EHL strength has returned to 5/5; Ms. Goldie denies any radiating leg pain, solely numbness. Dr. Graf stated that a course of physical therapy (2-3 times a week by a licensed certified physical therapist) would be considered reasonable and that a lumbar epidural steroid injection would further be considered reasonable, necessary and causally related to the claimed injury in question. Dr. Graf stated this despite Ms. Goldie's myriad complaints. Dr. Graf opined Petitioner can return to the light physical demand level and he is hopeful these restrictions can be reduced as time goes by. Dr. Graf opined Ms. Goldie's lumbar condition would be considered causally related to the claimed injury in question. With regard to her cervical condition, given there were no initial complaints of neck or arm pain and given Ms. Goldie has subjective complaints that lack an objective basis, he opined her cervical condition is not related to the claimed injury in question and should be considered outside of this claim. RX2

Dr. Graf's diagnosis: Ms. Goldie has a myriad of complaints; she does though have an annular tear and bulge on the left side at L4-L5; this does account for a small amount of her subjective complaints; thus, I would consider amongst her numerous diagnoses to include left radiating leg pain. RX2

Dr. Graf opined Ms. Goldie's back pain and leg pain would be considered causally related to the claimed injury in question; regarding the cervical spine, he was unable to causally connect such symptoms as again she had no initial complaints of neck pain. RX2

Dr. Graf opined that lesion on her cervix with mild bleeding would not be a cause of her foot drop. RX2

Dr. Graf opined that cervical spine intervention is not warranted at this time. RX2

Dr. Graf opined that Ms. Goldie can return to work in the light physical demand level at this time. RX2

Admitted into evidence as Respondent's Exhibit 3 is the supplemental Section 12 report of Dr. Graf, dated September 12, 2016. No additional physical examination was conducted of Petitioner as part of this report. Report indicates that the doctor was provided with additional medical records and was asked to prepare an addendum report. Additional medical records reviewed were Dr. Yapor office notes 6/28/16, 7/28/16, 8/25/16; Athletico Physical Therapy notes 7/13/16, 7/15/16, 7/19/16, 7/20/16, 7/22/16, 7/25/16, 7/27/16. In the Summary and Opinions of the report, Dr. Graf states: at the time of the previous exam Ms. Goldie had a physical examination of complete loss of strength encompassing her bilateral upper and lower extremities in addition to a myriad of inconsistencies and nonorganic pain signs. Ms. Goldie returned to see Dr. Yapor who noted that I did not comment on her foot drop in my IME report; it should be clearly noted that when Dr. Yapor initially evaluated Ms. Goldie, she had a documented strength of 3/5; this is considered extremely weak and not able to lift her foot up against gravity; she then returned to see Dr. Yapor in April and demonstrates 5/5 full strength, though he states that "she needs surgery ASAP "; this apparent need for urgent surgery is questioned, given the apparent recovery of her strength.

Dr. Graf stated: I have further reviewed Ms. Goldie's imaging studies once again; there's a small bulge at L3/4 which effaces the thecal sac and there is no nerve root compression at either the L3/4 or L4/5 levels; further, the EMG demonstrates no evidence of lumbar radiculopathy; despite this, there is a recommendation for two level lumbar decompression; it continues to be my opinion that the requested surgery would not be considered reasonable or medically necessary. RX3

Dr. Graf stated that the requested surgery would not be considered reasonable or medically necessary. RX3

Dr. Graf stated, with regard to the MMI, that it is apparent Ms. Goldie continues to have significant subjective complaints; I would need to see her back for follow-up evaluation to determine if she is at MMI. RX3

Dr. Graf stated, with regard to work restrictions that apply to the March 31, 2016 accident, that he previously opined she can return to light physical demand level and that he would need to re-evaluate her, given the amount of time that has elapsed. RX3

Admitted into evidence as Respondent's Exhibit 4 is the Section 12 report of Dr. Graf dated October 24, 2016. A second physical examination was conducted and additional medical records were supplied to the doctor. Dr. Graf reported a history from Petitioner: since her last Section 12 exam, she has undergone physical therapy using local modalities with massage on the left side and cold packs; she is not having right-sided low back pain; Ms. Goldie states that a lumbar epidural injection is scheduled for this week on Thursday; she claims pain in the left side with radiation to the left buttock and left foot; she notes that she is a diabetic and has pain and numbness in the sole and dorsum of the left foot which is chronic; she is tripping over a great deal of things with her left foot; this is more noticeable of recent; her doctor recommended an injection and had discussed a fusion surgery for her; she is not currently working; neck pain resolved after taking steroid oral medication. Physical Examination was reported as: overweight; demonstrates antalgic gait; no difficulty with stepping up on her tip toes or up onto her heels; no difficulty with squatting and raising from a squatting position though notes low back pain to her buttock with performing such; cervical spine evaluation deferred secondary to no complaints; overall spinal alignment is neutral; a list is not present and there is no paraspinal muscle spasm present: pain to palpation is present to light, one finger touch on the left side of the low back; forward bending and extension is deferred. Dr. Graf tested her motor strength: in the left lower extremity, Ms. Goldie demonstrates the inability to break the strength of my single index finger in any motor group; in the right lower extremity, Ms. Goldie demonstrates giveaway weakness in all motor group distributions of 4/5. Neurologic examination of the lower extremities was performed with a finding of sensation decreased and the sole of the left foot and sensation is normal in the right lower extremity. Sitting straight-leg raise is negative bilaterally in the distracted and informed scenario; supine straight-leg is negative bilaterally though Ms. Goldie complains of buttock pain on the right, no pain reported on the left. Left hip and right range of motion was full. Dr. Graf noted six nonorganic pain signs. Pain disability questionnaire completed by Ms. Goldie places her into severe disability self-rated category. RX4.

Dr. Graf reviewed additional medical records: Dr. Wesley Yapor's office visit note of 10/4/16 in which she demonstrates 5/5 motor strength throughout with the exception of 4/5 left anterior tibialis and left EHL with negative bilateral straight leg raising. RX4.

In his Summary and Opinions Dr. Graf states: his opinions remain unchanged as stated in the two previous reports; he diagnoses Petitioner with "low back pain with non-verifiable radiating pain." He is unable to substantiate Ms. Goldie's subjective complaints of pain given the lack of objective findings: she continues to demonstrate numerous inconsistencies on evaluation which do not correlate to any specific nerve root distribution; it should again be noted that Ms. Goldie on examination demonstrates a small disc bulge at L3-L4 and L4-L5, no disc herniation, no nerve root encroachment or otherwise; she demonstrates no evidence of lumbar radiculopathy on her EMG. Dr. Graf opined that the requested surgery is neither reasonable nor medically necessary. Dr. Graf stated that there is no objective reason why Ms. Goldie cannot return to her full-duty level job as described. RX4.

Dr. Graf considered Petitioner's back injury to be soft tissue in nature with non-verifiable radicular complaints. He determined that the grade modifier was 0. Accordingly, Dr. Graf determined that Petitioner has an AMA impairment rating of 1%, whole person impairment. RX4.

Admitted into evidence as Respondent's Exhibit 5 is the supplemental Section 12 report of Dr. Graf, dated August 16, 2017. No additional examination of Petitioner was made as part of this report. Dr. Graf reviewed one additional medical record: the consultation note of P.D. Ackerman, M.D., dated February 20, 2017. Dr. Graf also reviewed the deposition of Paul D. Ackerman, M.D., dated July 13, 2017. RX5.

Dr. Graf opined that it continues to be his opinion that the requested surgery would not be considered reasonable nor medically necessary. RX5.

Dr. Graf opined that there is no notable nerve root compression at the L4/5 level on MRI and a negative EMG. Given such results, he opined that surgery is neither reasonable nor medically necessary regardless of causation. RX5.

Dr. Graf opined that Ms. Goldie has long been at MMI. RX5.

Dr. Graf also wrote: "In my opinion, no work restrictions are reasonable nor related to the claimed work injury in question." RX5.

Admitted into evidence as Respondent's Exhibit 6 is a document entitled Payment Detail. It shows all the indemnity amounts and medical bills that Respondent has paid in this case. RX6.

Admitted into evidence as Respondent's Exhibit 7 is a statement of Petitioner's wages from November 16, 2016 through July 31, 2017. RX7.

Admitted into evidence as Respondent's Exhibit 8 are the records of Central Primary Care. These records reveal that on November 8, 2013, Petitioner was seen by Haresh B. Sawlani, M.D., for a follow-up visit on ultrasound of her bilateral legs that was taken on November 6, 2013. She complained of sharp pain in her right knee and right pelvic area as well as heaviness of lower extremities and bilateral arms that started today. The musculoskeletal exam was reported as normal; gait normal; motor strength normal upper and lower extremities; no rigidity, no tremor, normal strength tone and reflexes, sensory exam intact. Podiatric exam was normal bilaterally. Assessment was peripheral vascular disease, chest pain, neuropathy. On November 4, 2013, Petitioner was seen by Dr. Sawlani with complaints of B/L leg pain and numbness on hands; per patient they feel heavy going on for about a year; has taken Aleve, Ibuprofen with no relief. Musculoskeletal exam was reported as normal. Neurological exam was reported as gait normal, motor strength normal, upper and lower extremities, no rigidity, no tremor, normal strength, tone and reflexes, sensory exam intact. Podiatric exam was normal bilaterally. Assessment was peripheral neuropathy, Diagnostic Imaging Ultrasound: Artery Doppler Low Extension Bilat. On February 1, 2013, Petitioner was seen by Neelima Sunkara, M.D. She was there for a check-up, test results from her mammogram, complained of pain in the right side of her hip, took Aleve and did not help the pain. Podiatric exam indicated: ankle swelling: denies, difficulty walking: denies, foot numbness: denies, sole pain: denies. Musculoskeletal exam: normal. Extremities were reported have no edema. Back was reported to be: normal full range of motion spine nontender to palpation. Neurologic examination was reported to be: gait normal, motor strength: normal, upper and lower extremities: no rigidity, no tremor, normal strength, tone and reflexes, sensory exam: intact. On November 6, 2013, Petitioner underwent a bilateral arterial Doppler test of her lower extremity. These were interpreted as revealing suspected stenotic/occlusive changes, bulging the arteries of the right lower leg and the left posterior tibial artery. On November 13, 2013, Petitioner underwent a CT angiogram of the lower extremities. These were interpreted as revealing minimal plaque formation without evidence of hemodynamically significant abnormality involving the arteries of the bilateral lower extremities. RX8.

Admitted into evidence as Respondent's Exhibit 9, this is the original report of Dr. Yapor, dated July 28, 2016 and identified in the deposition of Dr. Ackerman. RX9.

CONCLUSIONS OF LAW

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator concludes as follows:

Petitioner offered into evidence an unpaid bill from Bright Light Radiology in the amount of $2,700.00. Such bill was for an MRI of Petitioner's cervical spine, which Dr. Yapor had ordered on April 7, 2016. PX 5.

Petitioner claims that such bill was for reasonable, necessary, and related medical care. Respondent claims that such bill was for care unrelated to the March 31, 2016 accident.

On April 1, 2016, at 12:09 p.m., Petitioner first sought treatment after the accident at Community First Hospital Emergency Room. She reported to the triage nurse that she had acute, 10/10 back pain after lifting objects at work. Petitioner left the Emergency Room before she received treatment. At 1:29 p.m., when a nurse at that hospital called out Petitioner's name 3 times, she received no response. PX1, pp. 15-16.

That same day, at 4:53 p.m., Petitioner presented to a nurse in the Emergency Room at Presence Resurrection Medical Center. The nurse took the following history:

> "Pt. arrived to ED with husband. Pt. states that she was at work last night, about 2000, when she had to move a heavy object by herself. Pt. states that after moving the object, she had sudden onset of pain to the lower left side of her back. Pt. states that throughout the night, she had intermittent "charlie horses" in her legs, and fell to the ground several times. Pt. states she now has tingling sensation to her finger-tips. Sensation is intact bilaterally to LE. Pt. is A&Ox4. Skin is pink, warm, dry."
>
> PX2, p. 10.

The physician examined Petitioner and found, *inter alia*, a positive straight-leg raising test of the left, and a negative test on the right. PX2, p. 6. The physician diagnosed Petitioner with acute low back pain with sciatica. PX2, p. 7.

At Physicians Immediate Care, on April 5, 2016, in addition to back pain and leg pain, Petitioner complained of pain radiating to her right shoulder and hand, right neck pain and stiffness, and right arm and hand numbness. PX3.

On April 6, 2016, Petitioner returned to the Emergency Room at Presence Resurrection Medical Center. At 3:45 p.m., a nurse took the following history:

> "Patient, AxOx3, admitted to ED with complaints of severe lower back pain that radiates down her left leg due to moving a heavy object at work on 3/31/16. Complains that her right shoulder and neck started feeling sore afterwards. Patient states that she is unable to move because of the pain but denies any incontinence. Patient states that she is menopausal but has been bleeding since the incident. Patient states that she has stopped taking her muscle relaxants and ibuprofen because they make her "sick." Was referred to ED by PCP for an MRI. Denies any N/V/SOB. Patient standing at bedside, unable to sit down. Will continue to monitor patient.". PX2, p. 40.

Petitioner first saw Dr. Yapor on April 7, 2016. Dr. Yapor recorded Petitioner's complaints that included low back pain radiating into the left foot and toe and severe neck pain with numbness of the hands and severely limited cervical ROM. Dr. Yapor examined Petitioner and ordered an MRI of the cervical spine. PX4.

The Arbitrator finds, given Petitioner's presentation to him, that it was reasonable and necessary for Dr. Yapor to order an MRI of the cervical spine to rule out cervical pathology as the cause of her complaints. Furthermore, given Petitioner's earlier complaints to the nurses at Community First and Presence Resurrection Hospitals, the Arbitrator finds the need for such test to be causally related to the accident.

The evidence in the record demonstrates that Petitioner's neck and right shoulder/arm symptoms did, in fact, resolve.

Based on the foregoing, the Arbitrator finds the bill for this diagnostic test to rule out cervical pathology was reasonable, necessary, and related, and orders Respondent to pay this bill, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator concludes as follows:

By a preponderance of the evidence, the Arbitrator finds that Petitioner has proven that her current condition of ill-being of herniated L4-L5 disc with radiculopathy is causally related to the accident of March 31, 2016.

The evidence indicates that Petitioner had no complaints of low back pain or pain radiating into her legs prior to the accident of March 31, 2016.

On November 4, 2013, Petitioner gave a history to Dr. Sawlani at Central Primary Care of pain in her legs and numbness in her hands. Dr. Sawlani recorded the following: "they feel heavy; going on for about 1 year; has taken Aleve and Ibuprofen, but no relief." Dr. Sawlani's physical examination indicated normal back (full range of motion, spine non-tender to palpation), normal musculoskeletal, and normal neurologic findings. The doctor assessed Petitioner with, in pertinent part, peripheral neuropathy. He ordered diagnostic imaging in the form of an ultrasound ("Artery Doppler Low Ext. Bilat."). (RX8)

On November 8, 2013, Petitioner returned to Dr. Sawlani for follow up of the ultrasound taken of her bilateral legs on November 6, 2013. At this visit, Petitioner reported the following complaints: sharp pain in her right knee and right pelvic area, heaviness of her lower extremities and bilateral arms ("started today"), "palpations A/W chest pain today while she was washing dishes." Once again, Dr. Sawlani's physical examination revealed normal back (full range of motion, spine non-tender to palpation), normal musculoskeletal, and normal neurologic findings. This doctor found that she had peripheral vascular disease, chest pain and neuropathy. He ordered a CT angiogram of the bilateral lower extremities along with thoracic aorta, a thalium stress test, and an EMG/NCV of her bilateral upper extremities. (RX8)

Petitioner testified that in all the time she worked for Respondent prior to the date of the accident, she had no problem with her back or legs as far as pain, and had no difficulty doing her job because of back or leg pain. Petitioner testified that she *did* have numbness and burning in her calves for which she underwent an ultrasound. She testified that she was diagnosed with blockages in her veins and received blood thinners, which made her feel better. She had a pinched nerve in her shoulder blade for which she took medication. She also had a problem with a vein in the front of her left leg. Petitioner further testified that the doctor recommended tight-fitting medical stockings, and after that, everything was fine.

In the medical records of Petitioner's initial treating neurosurgeon, Dr. Yapor, he suggests that her back and leg complaints were caused by the work accident of March 31, 2016. After Dr. Yapor's death, Petitioner began treating with Dr. Yapor's partner, Paul D. Ackerman, M.D., who is a board-certified neurosurgeon. Dr. Ackerman diagnosed Petitioner with left L5 radiculopathy caused by a left-sided L4-L5 herniation that was caused by an injury at work on March 31, 2016. He opined that Petitioner's left foot drop is related to ongoing compression caused by the offending disc herniation.

Dr. Ackerman recognized that both he and Dr. Yapor found no clonus and no Babinski's, and a negative straight leg raising test. On July 13, 2016, however, while participating in physical therapy at Athletico, Petitioner was found to have a positive straight-leg raising test and a positive slump test.

With regard to the straight-leg raising test, Dr. Ackerman testified that he has not found this test to be particularly reliable, sensitive, or specific. He performs the test as it was part of his training. He finds that this test can occasionally help confirm a clinical diagnosis, but he does not heavily rely on it.

Dr. Ackerman recognized that the EMG test was positive for neuropathy, but not for radiculopathy. He testified that an EMG is not a definitive test for determining whether a patient has either a foot drop or radiculopathy.

Dr. Ackerman based his causation opinion on his physical examination of Petitioner on February 20, 2017, which revealed a left foot drop [PX9, p. 47] as well as dysesthesias along the left L5 distribution, particularly distally, PX9, pp. 41-42, his review of the April 6, 2016 lumbar MRI films, which revealed left-sided disc bulges at L3-L4 and L4-L5, significantly worse at L4-L5, PX9, pp. 42-44, the history of the accidental injury, as told to him by Petitioner, PX9, p. 44, and a review of all the medical records. PX9, p. 44.

As to whether peripheral neuropathy is a risk factor for a foot drop, Dr. Ackerman testified that it can be a result of uncontrolled diabetes and can present itself as pain, numbness and/or weakness in an extremity. However, the Arbitrator notes that there is no evidence that Petitioner has had uncontrolled diabetes. Rather, the evidence in the record indicates that Petitioner was taking the medication Metformin to treat her diabetes.

The Arbitrator notes that on July 28, 2016, at the request of Dr. Yapor, radiologist Diana O. Iwanik, M.D., amended her interpretation of the April 6, 2016 lumbar MRI. However, this

radiologist only amended her interpretation of the film at the L3-L4 level. Her impression of the L4-L5 level remained the same: "... there is an annular tear along the left posterior margin of the disc with minimal encroachment on the left inferior aspect of the left neural foramen."

Respondent relies on the opinions of their Section 12 examining physician, Carl N. Graf, M.D., a board-certified orthopedic surgeon, who examined Petitioner on 2 occasions (May 12, 2016 and October 24, 2016) and provided 2 additional Section 12 addendums (September 12, 2016 and August 16, 2017) based on additional records. RX2, RX4, RX3, RX5, respectively.

In his September 12, 2016 report, Dr. Graf points out that when Dr. Yapor first evaluated Petitioner, he found 3/5 motor strength in the left lower extremity and diagnosed a foot drop. Yet, when he performed this test later that same month, he found 5/5 motor strength in the left lower extremity. RX3. The Arbitrator notes that in his July 28, 2016 note, Dr. Yapor also found 5/5 motor strength in the left lower extremity. RX9. Dr. Ackerman testified that an increase in motor strength from 3/5 to 5/5 would be significant. He testified that he would not diagnose a foot drop if a person had normal strength. PX9, p. 54.

In both of Dr. Graf's examinations, Dr. Graf found that Petitioner displayed a "bizarre" constellation of symptoms including multiple inconsistencies and non-organic pain. He found that she demonstrated break away weakness in all motor groups tested in the bilateral upper and lower extremities and was unable to resist even Dr. Graf's single finger. When distracted, Dr. Graf wrote, Petitioner's motor function improved.

In his October 24, 2016 Section 12 report, Dr. Graf noted that Petitioner stated that she is a diabetic and has pain and numbness in the sole and dorsum of the left foot, which is chronic. He also wrote that Petitioner noted that she is tripping over a great deal of things with her, which has recently become more noticeable. RX4. Dr. Graf was unable to substantiate Petitioner's myriad complaints based on her negative MRI, her EMG that was negative for radiculopathy, and her physical examination. He also found that Petitioner demonstrated negative straight-leg raising tests while in the sitting and supine positions. RX2, RX4. He concluded that Petitioner's condition had resolved and that she could return to full work duties. RX4.

Dr. Graf reviewed Petitioner's MRI of her lumbar spine from April 6, 2016 on several occasions and concluded that the MRI showed no notable nerve root compression. He opined that there were small bulges at L3-4 and L4-5, but nothing that explained her alleged symptoms. RX2, RX3, RX4, RX5.

Yet, in his May 12, 2016 report, Dr. Graf opined that Petitioner's condition of her "back pain and leg pain would be considered causally related to the claimed injury in question." RX 2. Dr. Graf, in that same report, described the diagnosis as a "myriad of complaints ... She does though have an annular tear and bulge on the left side at L4-L5. This does account for a small amount of her subjective complaints. Thus, I would consider amongst her numerous diagnoses to include left radiating leg pain." RX 2. In that same report Dr. Graf, while opining that a surgery is not reasonable or necessary to address Petitioner's condition, states that in addition to physical therapy "in my opinion a lumbar epidural steroid injection would further be considered reasonable, necessary and causally related to the claimed injury in question. I state this despite Ms. Goldie's myriad of complaints." RX 2.

In his October 24, 2016 report, however, in formulating his impairment rating, Dr. Graf considered Petitioner's back injury to be soft tissue or non-specific condition.

The Arbitrator finds the opinions of Dr. Ackerman to be more persuasive than those of Dr. Graf.

Dr. Ackerman testified that in his own examination of Petitioner, he tested motor strength and found it to be indicative of a partial drop foot that required surgery. Dr. Ackerman explained that a partial drop foot is a clinical diagnosis. He testified credibly that a patient can have radiculopathy with a negative EMG and a negative straight leg rise. He testified that the MRI was indicative of a pathology that explained Petitioner's back and left leg complaints.

Dr. Ackerman testified that, as a physician, he was trained to identify inconsistencies and consistencies. In this particular case, if he had suspected that there was something that was inconsistent or that the patient was not being forthright or giving her best effort on his examination, he would have subtly documented that in his chart note. He did not.

The Arbitrator finds that Petitioner's current condition of ill-being, which is that of a left partial foot drop and left-sided LE radiculopathy, is causally related to the work accident of March 31, 2016.

With regard to Petitioner's cervical condition, the Arbitrator finds that Petitioner's *current* condition of ill-being of her cervical spine is not causally related to the March 31, 2016 accident. The evidence indicates that Petitioner's neck and cervical radicular symptoms resolved.

In support of his decision with regard to issue (L) "What temporary benefits are in dispute? TTD", the Arbitrator concludes as follows:

The Arbitrator has found that Petitioner's current condition of ill-being is causally related to the accident. Petitioner was ordered off work by her first medical provider and the off-work order continued through her treatment with Dr. Yapor. It was only after Dr. Graf, Respondent's Section 12 physician, opined that Petitioner could return to full-duty work that Respondent cut off her TTD benefits. Respondent stopped paying such benefits on November 15, 2016.

Petitioner testified that she continued to have pain and weakness in her back and leg, but because she was the only wage earner in the family, she had to return to work. She testified that her co-workers assist her with her duties so that she does not have to do all of the heavy work she previously did in the position of Turndown.

Respondent's witness, Denise Gonzalez, testified that as HR manager, she would see Petitioner walking in the hotel. She did not observe Petitioner limping or walking with difficulty. However, on cross-examination she testified that she is not Petitioner's direct supervisor and would only see her in her capacity as HR director when Gonzalez would leave her office. Moreover, Ms. Gonzalez agreed with Petitioner's Counsel that Petitioner is a very hardworking person, and that she has no reason to question Petitioner's honesty or diligence.

Based on the foregoing, the Arbitrator finds that Petitioner was temporarily totally disabled as a result of the March 31, 2016 accident from April 1, 2016 through November 15, 2016, which represents 32-5/7 weeks. The Arbitrator orders Respondent to pay TTD benefits to Petitioner for such period. Respondent shall receive a credit for TTD paid in the amount of $12,218.19.

In support of his decision with regard to issue (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator concludes as follows:

The Arbitrator has found that Petitioner's current condition of ill-being of left partial drop foot with radiculopathy is causally related to the March 31, 2016 accident of. Dr. Ackerman opined that treatment for such condition would be a one-level discectomy. Dr. Ackerman testified that the surgical goal of this procedure would be to partially remove the offending lumbar disc herniation and insure that the nerve root, in this case the left L5 nerve root, was free from any kind of compression in order to alleviate her left leg pain and weakness. PX9, PX4.

The Arbitrator finds that such procedure is reasonably required to cure or relieve her from the effects of the accidental injury and therefore orders Respondent to authorize and pay for such procedure, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Brian T. Cronin
Arbitrator

5-10-2018
Date

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ 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

TOMMIE JONES,

Petitioner,

vs. NO: 08 WC 53784

STATE OF ILLINOIS, DEPARTMENT OF JUVENILE JUSTICE,

Respondent.

19IWCC0576

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 benefit rates and the nature and extent of the 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 10, 2018 is hereby affirmed and adopted.

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

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

19IWCC0576

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review.

DATED: OCT 24 2019
LEC/bsd
O08/27/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
SECOND CORRECTED

JONES, TOMMIE
Employee/Petitioner

Case# **08WC053784**

ST OF IL DEPT OF JUVENILE JUSTICE
Employer/Respondent

19IWCC0576

On 8/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0924 BLOCK KLUKAS & MANZELLA PC
MICHAEL D BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

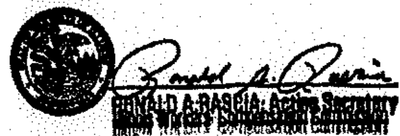
4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

AUG 10 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
2ND CORRECTED ARBITRATION DECISION

Tommie Jones
Employee/Petitioner

Case # **08** WC **53784**

v.

State of Illinois, Department of Juvenile Justice
Employer/Respondent

19IWCC0576

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **June 6, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 16, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**54,660.00**; the average weekly wage was $**1,051.15**.

On the date of accident, Petitioner was **35** years of age, ***single*** 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 $**146,852.00** for TTD, $**0** for TPD, $**89,497.23** for maintenance, and $**36,440.04** for other benefits, for a total credit of $**272,789.27**.

ORDER

Respondent shall pay Petitioner maintenance benefits of $**700.77** for **67 6/7** weeks, commencing **01/12/2016** through **04/30/2017**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**700.77**/week for **360 5/7** weeks, commencing **11/17/2008** through **01/11/2016, a total period of 373 1/7 weeks less 12 6/7 weeks**, as provided in Section 8(b) of the Act.

Respondent shall pay all reasonable and necessary medical services as provided in Section's 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all 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 providers direct.

Respondent shall pay Petitioner permanent partial disability benefits, commencing **May 8, 2017**, of $**806.54**/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.

Arbitrator Anthony C. Erbacci

August 10, 2018
Date

AUG 10 2018

FACTS:

On November 16, 2008, Petitioner, a 35-year-old, 10-year employee of the Respondent, sustained an undisputed accidental injury arising out of and in the course of his employment when he responded to a staff assault, and physically picked up and restrained an inmate. Immediately following the incident, the Petitioner was sent to the nurse's station, and the nurse noticed that his wrist, hand and fingers were swollen like a softball. The same day he went to Presence St. Joseph Medical Center with a history of right hand injury and he was splinted. He also reported that he had a prior ligament surgery to the thumb.

November 17, 2008, Petitioner saw his primary doctor at Advocate Health Centers with a history that he sprained his right hand yesterday at work and developed swelling, as well as a history of the prior thumb surgery. The assessment was a sprain of the right hand. He returned again November 25, 2008, where the doctor noted limited mobility in flexion opposition, assessed right hand pain, and recommended he see an orthopedist.

On December 5, 2008, Petitioner saw a specialist, Dr. Jack Gelman of Plastic Surgery Specialists, with a history of the altercation with a juvenile resident. The doctor noted pain in the wrist as well as the thumb and index finger and began him on conservative care. Following conservative care, Petitioner went on to have a right wrist arthroscopy with TFCC debridement and reconstruction of the radial collateral ligament of the right wrist, with an interposition tendon graft, a harvest of the palmaris long tendon, and an excision of a volar ganglion, right wrist mid-carpal joint. The post-operative diagnosis was right wrist TFCC injury, right wrist radial collateral ligament tear, and volar ganglion right wrist, mid-carpal joint.

Approximately 11 months after the surgery, with significant symptoms, an EMG was performed which was abnormal. Dr. Gelman referred Petitioner to Dr. Roderick Birnie at University of Chicago. Dr. Birnie noted that the Petitioner may have a superficial branch of the radial nerve neuroma. He continued Petitioner with the restrictions of no pushing, pulling or lifting with that arm. Petitioner returned to Dr. Birnie on January 4, 2011, and the doctor noting a positive EMG confirming the clinical diagnosis, and pain such that it was difficult to continue activities of daily living as well as work. He prescribed surgery for the Petitioner.

Petitioner testified he was notified on March 11, 2011, that surgery was authorized, and promptly appeared at Dr. Birnie's office March 15, 2011 (Id., p. 9). Petitioner testified that the doctor had thought that the surgery was approved in January, which it was not, and the record reflects the doctor noting that the work adjuster was contacted and she would be able to give authorization, which did not happen until approximately March 11th. The doctor told Petitioner that with the delay in treatment, he did not feel comfortable taking Petitioner on as a patient, although he continued the restrictions of no pushing, pulling or lifting with patient to follow up with another hand surgeon.

The testimony was that no authorization for another hand surgeon was forthcoming, so on August 29, 2011, Petitioner saw Dr. Daniel Mass, also at the University of Chicago Physicians Group. The doctor noted there were two problems related to his work-related injury, the first being that he still had wrist pain and the second being a postoperative neuroma of a branch of the radial nerve. He felt it appropriate that he have another MRI and possibly rescope the wrist to figure out what was causing the wrist pain, which was also causing weakness of grip. Dr. Mass noted both of these conditions

needed to be addressed before the Petitioner could return to work. He also noted an unexplained problem of popping and clicking at the IP Joint of the thumb.

On January 4, 2012, Petitioner underwent surgery with Dr. Mass. During the surgery, the doctor noted dynamic scapholunate instability. He was not prepared to do a flap and a capsular shift and screw fixation of this joint, as he had not spoken to the patient about it. He stopped the surgery and indicated that he would need to do a further surgery. On February 20, 2012, Dr. Mass performed another surgery for right wrist instability. Right wrist pain and swelling continued, so Dr. Mass prescribed a right wrist radial styloidectomy which he performed February 20, 2013.

Prior to the surgery performed by Dr. Mass, Petitioner was examined by Dr. Michael Vender on January 3, 2013, at the request of the Respondent. Dr. Vender's impression was status post right wrist injury with multiple subsequent surgical procedures. He noted that the findings were consistent with Petitioner's complaints. He also noted the screw across the scaphoid into the lunate was loose, and that there was erosion around both ends of the screw. He prescribed a procedure known as a "salvage procedure." He also limited Petitioner to sedentary to light activities utilizing the right hand.

Petitioner's next visit to Dr. Mass was October 15, 2013, eight months status post the last surgery, with pain from 5 to 10 at rest to 8/10 with any attempted activities and significant hypersensitivity to the wrist. He had continued to use a home TENS unit every day. Dr. Mass found that he should continue to use the TENS unit and the only thing surgically he could offer was a partial wrist fusion which Petitioner did not wish to pursue. He was to be seen back PRN should he wish surgery. Dr. Mass also found that the Petitioner was unable to work at that time.

Petitioner returned to Dr. Vender for a second Examination on August 29, 2014. Dr. Vender noted that Petitioner continued to have residual symptoms after undergoing various surgeries. He stated the screw across the scapholunate joint, along with continued instability, was suspected of leading to his ongoing complaints and findings and was due to the injury in question. Dr. Vender found the Petitioner to be at MMI, noted that the Petitioner should utilize a wrist splint, and recommended only sedentary to light activities related to the right hand. Dr. Vender noted the need for restrictions was based on the residuals of the Petitoner's work injury, and would be indefinite.

In November, 2014, Dr. Mass referred Petitioner for pain management and he treated at Health Benefits Pain Management until they closed, and then at Pain and Spine Institute of Joliet. Petitioner currently remains on Norco, Gabapentin and a prescription for sleep. The Petitioner testified to continuing significant symptoms and limitations.

Petitioner testified that he had a high school diploma and one semester at Chicago State Junior College. He had ten years in the Army Reserve and his highest rank was E-4. He worked at Kennedy King College where he taught GED level students basic Word and Excel, but he had not kept up to date. His work at Chicago State involved heavy lifting of boxes of books, warehouse type work. He had also worked years ago as a shoe salesman at Payless Shoes. He was right hand dominant.

On his own initiative, from the fall of 2014 through July of 2016, Petitioner took a two year on line course at Kaplan University to obtain an associate's degree in accounting. The school wanted him to continue and get additional certificates, but as the classes got harder his grades had dropped,

and the medication he was taking was having an adverse effect on his ability to continue. The Petitioner also testified to his networking efforts and his conducting of a job search on his own.

On October 20, 2014 the Petitioner met with the Respondent's Certified Rehabilitation Consultant, Charlotte Bishop. Ms. Bishop concluded that Petitioner "would have difficulty replacing the full salary he earned at the time of injury" and that Petitioner "has sustained a significant reduction in his earning capacity." Ms. Bishop noted Petitioner's documented work history, his interest in returning to work, ability to assume responsibility and leadership and readiness to explore training programs in accounting as positive factors regarding Petitioners return to employment.

The Petitioner then started vocational counseling sessions with Tracy Peterlin on December 11, 2015. Ms. Peterline noted that she was in contact with Petitioner' clinical psychologist, Dr. Daniel Kelley and that due to Petitioner's anger, hostility and poor frustration tolerance, he was not yet an appropriate candidate for competitive work or vocational rehab at that time. Dr. Kelly was concerned that Petitioner would "lose his cool in any vocational or employment setting in his current state." The file was placed on hold until Dr. Kelley cleared Petitioner for vocational rehab on January 11, 2016.

The Petitioner again began vocational counseling with Tracy Peterlin starting February 17, 2016. Ms. Peterlin noted at that visit that due to the Petitioner's ongoing issues with pain, the need to take medication on a regular basis and his anger and frustration issues, her prognosis was guarded with regard to a successful vocational outcome. On April 26, 2016 Petitioner's psychologist Dr. Kelley cleared Petitioner to initiate contacts with employers and actively engage in a guided job search. Thereafter the Petitioner participated in a vocational rehabilitation program through January 11, 2017. Although the Petitioner did continue to attend meetings with the vocational consultant, his compliance with the program was noted to be less than optimal.

In January 2017 the Petitioner got an interview with Guide Right Organization, or GRO, which is a community-based organization in Roseland. He found this job through a lodge brother. On February 14, 2017 Petitioner notified Tracy Peterlin that he was offered a position at Guide Right Corporation as a Community Support Specialist.

On approximately February 1, 2017 the Petitioner was hired by Guide Right Organization for $16.00/hr. for 20 hours per week, subject to a background check. The job was for 9 months during the school year, but for the 3 months of the summer he was allowed to work a different job at the same rate of pay, $16.00/hr. for 25 ½ hours per week doing re-entry programs with youths. His job during the school year was essentially one of a truant officer, where he would be encouraging students and parents to regularly attend school when their attendance was poor or non-existent. Before he took the job, he checked with the State's Vocational Councelor, Tracey Peterlin, who agreed that he should take it.

On May 5, 2017 Tracy Peterlin met with Petitioner to discuss further vocational services since Petitioner's employment with Guide Right had yet to start due to a delay in their lengthy background and fingerprinting cross-check process. Petitioner started training at Guide Right for his new position on May 4 and began working on May 8, 2017 as a truancy officer. Petitioner would work until June 20 and resume work again in August when school begins again. At trial, Petitioner stated that he works approximately 25 hours per week during the summer months with slightly different duties.

On March 5, 2018 Petitioner met telephonically with Petitioner's vocational expert Edward F. Pagella. At deposition, Pagella opined that while Petitioner is making $16 per hour now while working part time, he would only make about $9 per hour if he were working full time. Pagella indicated that the $16/hour rate is higher than what would be expected for full time work as it takes into consideration the part time aspect of the job.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner sustained and undisputed accidental injury arising out of and in the course of his employment when he responded to a staff assault, and physically picked up and restrained an inmate. Immediately following the incident, the Petitioner was sent to the nurse's station, and the nurse noticed that his wrist, hand and fingers were swollen like a softball. The same day he went to Presence St. Joseph Medical Center with a history of right hand injury and he was splinted. Thereafter, the Petitioner commenced a continuing course of medical treatment for those injuries with his family doctor and then specialists, resulting in four surgeries. He was never able to return to full duties thereafter, and only was able to return to light duties for the 90-day period allowed by the State.

Dr. Mass for Petitioner and Vender for Respondent, agreed that the conditions for which he underwent the four surgeries were causally related to the incident. Accordingly, the Arbitrator finds causal connection between the assault of November 16, 2008, and Petitioner's current condition of ill being in his right upper extremity.

In addition to the severe hand injury, the chain of events and medical evidence also supports that the Petitioner suffered psychiatric and psychological sequelae from his accident. Petitioner's Exhibit 17 is the office note of Dr. Joseph Beck, a psychiatrist, that he had a pain disorder from a work-related injury, lack of sleep the most prominent symptom, with the chief complaint of depression. Dr. Beck referred Petitioner to Dr. Daniel Kelly of Integrated Behavioral Medicine, a psychologist, and the treatment records were admitted into the record.

The records of Dr. Kelly, document the Petitioner's symptoms, and Dr. Kelly noted that Petitioner was referred by both the pain doctor and psychiatrist to address mood and sleep disturbance, as well as coping skills for dealing with chronic pain following the work accident of November 16, 2008 where he injured his right wrist. The diagnosis was of a pain disorder associated both with psychological factors and a medical condition, as well an anxiety disorder. Dr. Kelly treated the Petitioner from June 17, 2015, thru July 21, 2016. He consulted with the vocational manager, Tracey Peterlin regarding the issues at that time releasing the Petitioner to light duty for vocational rehabilitation effective January 11, 2016. Prior to then he had restricted Petitioner from work or vocational rehabilitation.

Based upon the testimony of the Petitioner, the ongoing course of treatment which commenced immediately following the Petitioner's undisputed injury, the opinions of Dr. Mass, Dr.

Vender and Dr. Kelly, and the temporal sequence of events surrounding the Petitioner's injury, treatment, and rehabilitation, the Arbitrator finds that a causal relationship does exist between the Petitioner's work injury of November 16, 2008 and his current condition of ill-being.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Evidence of the bills for medical treatment incurred by the Petitioner as a result of his injury were admitted into evidence without objection, subject to the dispute as to the issue of causal connection, with the further stipulation in Arbitrator's Exhibit 1 that the Respondent may pay the bills directly to the providers.

The Arbitrator has found that the Petitioner's condition of ill-being is causally related to the work injury and, therefore, finds that the medical expenses incurred in this case as evidenced by the bills admitted into the record were reasonable and necessary and causally related to the Petitioner's work injury. Petitioner shall receive credit for all expenses already paid and may pay any outstanding medical expenses directly to the providers pursuant to the medical fee schedule or the negotiated rate under section 8(a) of the Act.

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

The parties have stipulated to the period of TTD and period of maintenance to which the Petitioner is entitled and the credits to be given the state. Respondent is liable to the petitioner for TTD at a rate of 700.77 week for the period of November 24, 2008 through January 11, 2016 representing 372 3/7 weeks, less 12 6/7 weeks for the period of time Petitioner worked light duty during that time period between April 11, 2010 and July 10, 2010.

Respondent is also liable to Petitioner for 67 and 6/7 weeks of maintenance from January 12, 2016 to April 30 2017, as a stipulated payment period of maintenance. Respondent shall receive credit for $36,440.04 representing the first year's payments of TTD, with the parties having stipulated that Petitioner was paid full salary pursuant to the Public Employee's Disability act for that one year period. Since the amount awarded is at the Worker's Compensation TTD rate, likewise the credit would be at the TTD rate as well. In addition to that sum, Respondent shall have a credit for $146,852 in TTD and $89,497.23 in maintenance, all pursuant to stipulation.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

Petitioner was restricted by Respondent's Section 12 doctor, Dr. Vender, to sedentary or occasional light work. At the time he was released PRN, Dr. Mass restricted Petitioner from work totally, from which it could be inferred that, due to the medications and nature of the severe injury to the right wrist of a right-handed person, the doctor was finding total disability or, alternatively, due to

the nature of Petitioner's inability to use his right hand, as he testified, the doctor was restricting Petitioner from any use of the right arm in any return to work. Respondent's vocational consultant noted that the Petitioner's position as a juvenile justice specialist, as described by the State of Illinois, was classified as "medium", and was not within his current physical restrictions. The same conclusion was reached by Tracey Peterlin, the second vocational consultant hired by the Respondent. The Petitioner vocational consultant, Edward Pagella, also found that the Petitioner would not be able to return back to his previous occupation as a Juvenile Justice Specialist. No evidence has been adduced by either party suggesting that Petitioner could return to his duties in his prior position. Accordingly, the Arbitrator finds that the evidence overwhelmingly proves that Petitioner sustained a partial incapacity that prevents him from pursing his usual and customary line of employment.

By Petitioner's testimony, and Petitioner's Exhibit 38, he was making $58,813.46 annually at the time of his injury. His average earnings for the year preceding are likewise consistent, being $54,660.00. The parties stipulated in Arbitrator's Ex. 1 that the amount of earnings of Petitioner in the full performance of his duties in his former occupation as a Juvenile Justice Specialist for the years 2017 and 2018 would be $80,694.20, or $1,551.81 per week. Mr. Pagella opined that Petitioner's position as a truancy officer was comparable to and in the field of security, where current earnings were $8.25 to $10.00 per hour, with an experienced supervisor at a major security company making $24,000.00 annually, or $12.00 per hour.

In the Labor Market Surveys conducted in this matter, jobs suitable for the Petitioner were identified ranging from $9.00 to $20.00 per hour. No jobs listed by either of the Respondent's vocational consultants in the labor market surveys approached Petitioner's earnings at the time of injury of $58,813.46, nor the stipulated sum he could be making currently in excess of $80,000.00 annually. Accordingly, it is clear that the Petitioner has suffered an impairment of earning capacity.

The evidence demonstrates that Petitioner conducted a job search using two methods, the first of which was his own networking, and the second of which was performing homework and following up on job leads after applying for jobs, including attempts at personal contacts and attending job fairs. There was also evidence that the Petitioner was somewhat less than fully cooperative with the Respondent's employment assistance program, although it was noted that his cooperation had improved during the course of the job search. Mr. Pagilla, Petitioner's rehabilitation counselor, opined that the Petitioner was cooperative and motivated, having gone to school and having found employment on his own. The job Petitioner ultimately obtained was through his networking, and for nine months it paid $16.00/hr. for 20 hours per week, and for 3 months paid it $16.00/hr. for 25½ hours per week. He was essentially a Truant Officer for nine months, and spent the other three months, working with students during the summer to encourage them to return to school. No licenses or certifications were required. Training was two days, and all that was otherwise needed was a good background check. Mr. Pagella described the job as unskilled or semi-skilled. For those nine months of the school year, the Petitioner would earn $320.00 per week for 39 weeks, for a total of $12,480.00. For the other three months the Petitioner would earn $408.00 per week for 13 weeks, for a total of $5,304.00, for an annual total of $17,784.00, or $342.00 per week. At $9.00 per hour, which was the wage of one of the jobs listed in Respondent's initial Vocational Rehabilitation Labor Market Survey, the weekly wage would have been $360.00 per week. Thus, Petitioner's current wages are close to one of the acceptable jobs identified by Respondent's initial vocational consultant.

Also significant is once the position for $16.00 per hour, 20.00 hours per week, was identified and offered to Petitioner, the Respondent ceased its vocational assistance efforts because the Petitioner had obtained employment. Thus, the employment Petitioner obtained, at a wage slightly less than one of the jobs listed on the Labor Market Survey, was apparently acceptable to the Respondent. The Respondent was free to continue vocational rehabilitation efforts if it felt the job was not suitable yet choose to cancel further attempts to find a higher paying job. Respondent did reinstitute meetings when it took a period of time for the background check to come through, yet once it did, the same cessation of vocational rehabilitation efforts occurred. Looking at the Respondent's Vocational Rehabilitation Plan, the job fell within the category of Security Consultant or Youth Worker/Counselor, both of which were listed in the plan. Thus, it would appear that the Respondent, at least indirectly, agreed that the Petitioner's new job was suitable employment, since both the vocational counselor and the State approved the job and ceased vocational rehabilitation.

The Arbitrator has reviewed the Evidence Deposition of Edward Pagella, and finds his testimony credible. Mr. Pagella testified that even though the Petitioner is being paid on a 1099 and called an independent contractor, he's getting paid a wage for tasks he is performing, which is employment. Mr. Pagella testified that a job at five hours a day would be optimal for Petitioner as Petitioner was taking Norco, and it would start having cognitive effects after 4 to 5 hours. Mr. Pagella also testified that the job Petitioner obtained was a viable job for long term employment. He considered this job in the nature of a security guard and opined the job was suitable and viable. He felt with respect to many of the other jobs, the Petitioner's wrist condition, which caused him to be slow in typing, keyboarding or even writing, would inhibit his ability to find and keep a long-term job.

In finding that the Petitioner's employment is suitable, the Arbitrator also notes that Dr. Vender was clear that Petitioner's subjective complaints were supported by his objective findings, and that Petitioner would be required to wear a wrist brace. Petitioner was slow in writing to the extent he attempted to teach himself to write left-handed.

Accordingly, with Petitioner having obtained the job at GRO, which Mr. Pagella opined to be suitable and which was apparently considered to be suitable by both Respondent and its Vocational Case Manager, the Arbitrator finds that all the evidence supports a finding that the Petitioner's current employment is "suitable employment" for purposes of Section 8(d)1. The Petitioner's part-time wages of $342.00 per week is within the $8.25 to $10.00 per hour range Mr. Pagella testified to and they are also close to the $9.00 per hour ($360.00 per week) job identified by Respondent's vocational consultant.

With the stipulation that Petitioner would have earned the sum of $80,694.20/year or $1,551.81/week in the full performance of his previous employment, and further the finding that in his current suitable employment he earns $342.00/week on the average, there is a loss of earnings per week of $1,209.81. Two-Thirds of that sum is $806.54/week, (within the then State maximum of $912.56) which Respondent shall pay commencing May 8, 2017, the date he began employment with GRO, for the duration of the disability because the injuries caused a loss of earnings, as provided in Section 8(d)(1) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gerald Brinner,
Petitioner,

vs. No: 12 WC 38523

19IWCC0577

State of Illinois,
Illinois Department of Transportation,
Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner, a 58-year-old laborer, injured his right Achilles tendon while exiting a truck at work. The Arbitrator found Petitioner proved accident and causation of his condition of ill-being, and awarded Petitioner: (1) 64 weeks of temporary total disability benefits, for the period October 20, 2012 through January 13, 2014, as provided in §8(b) of the Act (minus a credit of $11,989.08 for non-occupational indemnity disability benefits paid by Respondent), and (2) 41.75 weeks of permanent partial disability benefits as provided in §8(e) of the Act, for the 25% loss of use of the right foot.

In affirming and adopting the Arbitrator's award, and specifically, the level of Petitioner's permanent partial disability, the Commission expresses the relevance of the five factors enumerated in §8.1b(b) of the Act, and assigns the following weights to them:

(i) Disability impairment rating: *no weight,* because neither party offered an AMA Impairment Rating into evidence.

(ii) Employee's occupation: *significant weight,* because as a laborer, Petitioner regularly engages in physical activities in his position in order to maintain roads, bridges and streets.

(iii) Employee's age: *some weight,* because at his age of 58, Petitioner's Achilles tendon is more susceptible to reinjury than if he were younger.

(iv) Future earning capacity: *no weight,* because Petitioner was allowed to and did return to his usual position without restrictions. In addition, no evidence was offered into evidence to show a reduction in earning capacity.

(v) Evidence of disability corroborated by the treating records: *significant weight,* because Petitioner was found to have suffered a complete rupture of his right Achilles tendon, for which he underwent two procedures, a right Achilles tendon repair with augmentation graft on December 7, 2012 and a Topaz procedure of the right Achilles tendon and a fasciotomy on June 20, 2013. Petitioner's injury rendered him unable to work for almost 15 months, and he testified that on occasion, he still experiences pain and swelling in his foot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 8, 2018, is hereby affirmed and adopted.

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

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 24 2019

Marc Parker

mp/wj
o-10/17/19
68

Barbara N. Flores

DISSENT

I respectfully dissent from the decision of the majority, which affirmed and adopted the Decision of the Arbitrator with explanation. I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving that he sustained a work-related accident, and denied compensation.

19IWCC0577

Petitioner testified he suffered an Achilles tendon injury while getting out of a truck at work on September 14, 2012. He also testified that he explained exactly how he injured his Achilles tendon to all of his medical providers. He acknowledged that he had prior such injury in 2001, but testified he had no continuing issues since until the alleged accident.

Petitioner first sought medical treatment after the alleged 2012 injury on September 17, 2012. The treatment note from that visit indicated that Petitioner reported left-knee pain and that his left ankle was "hurting again." There was no mention of the etiology of his pain or that his condition was in any way work related. In fact, the medical records never indicate that Petitioner ever reported that he injured his Achilles getting out of a truck at work while there were references to his feeling pain while getting out of a car. In addition, at deposition, Petitioner's treating doctor testified he could not recall Petitioner ever reporting that he injured his ankle while getting out of a truck while at work. There is also an August 16, 2012 treatment note, which obviously pre-dates the alleged accident in September of 2012, which indicates that Petitioner had had no problem since his 2001 Achilles injury "until now" and that he had experienced ankle pain for a couple of weeks without any recent injury. Finally, Petitioner did not file an accident report even though he had filed one for a prior work-related accident earlier in the same year, he passed his medical bills through his group insurance rather than through workers compensation, and he took FMLA leave for time off related to the Achilles condition rather than seeking TTD benefits. He took these actions even though there was no evidence that any workers' compensation claim had been denied.

The Arbitrator cited cases in which a claimant's unrebutted testimony alone was deemed sufficient to prove accident. However, here it is not that the medical records do not directly corroborate Petitioner's testimony, rather the medical records actually directly contradict Petitioner's testimony. There is nothing to substantiate Petitioner's claim other than his uncorroborated testimony. Because the medical records are at odds with his testimony, I find Petitioner's testimony to be completely noncredible. Therefore, I do not believe Petitioner sustained his burden of proving he sustained a compensable accident on September 14, 2012.

For the reasons stated above, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving that he sustained a work-related accident, and denied compensation. Therefore, I respectfully dissent from the decision of the majority.

Deborah L. Simpson
Deborah L. Simpson

dls/dw
o-09/18/19

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRINNER, GERALD Case# **12WC038523**
Employee/Petitioner

ILLINOIS DEPT OF TRANSPORTATION **19IWCC0577**
Employer/Respondent

On 1/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5314 DEAN J CARAS & ASSOCIATES
320 W ILLINOIS ST
SUITE 2216
CHICAGO, IL 60654

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JAN 8 - 2018

STATE OF ILLINOIS)

COUNTY OF **Cook**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gerald Brinner
Employee/Petitioner

v.

Illinois Dept. of Transportation
Employer/Respondent

Case # **12** WC **38523**

Consolidated cases: ____

19IWCC0577

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Charles Watts** Arbitrator of the Commission, in the city of **Chicago**, on **11/02/2017**. 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 **Sept. 14, 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 $**69,271.00**; the average weekly wage was $**1,332.13**.

On the date of accident, Petitioner was **58** years of age, *married* with **2** dependent children.

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

Petitioner's group insurance *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, **$11,989.08** in nonoccupational indemnity disability benefits, and $**0.00** for other benefits, for a total credit of $**0.00**.

Respondent is entitled to a credit of $**49,672.62** under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY **$44,848.46** IN TEMPORARY TOTAL DISABILITY BENEFITS - $888.08 PER WEEK FOR 64 WEEKS, COMMENCING OCTOBER 20, 2012 THROUGH JANUARY 13, 2014, AS PROVIDED IN SECTION 8(B) OF THE ACT, MINUS A CREDIT OF $11,989.08 FOR NON-OCCUPATIONAL INDEMNITY DISABILITY BENEFITS PAID BY RESPONDENT.

RESPONDENT SHALL PAY **$29,048.82** IN PERMANENT PARTIAL DISABILITY BENEFITS - $695.78 PER WEEK FOR 41.75 WEEKS – BECAUSE THE INJURIES SUSTAINED CAUSED THE 25% LOSS OF THE RIGHT FOOT, AS PROVIDED IN SECTION 8(E) OF THE ACT.

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

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

Signature of Arbitrator

December 29, 2017
Date

JAN 8 - 2018

FINDINGS OF FACT

OCCURRENCE **19IWCC0577**

On September 14, 2012, Petitioner, Gerald Brinner, was an employee of the Illinois Department of Transportation, in Harvey, Illinois for 20 years. He was a Highway Maintainer who maintained the roads, bridges, sewers and streets. His mode of transportation was an international dump truck. The passenger compartment of dump truck was elevated with steps and a running board used to get in and out of the passenger compartment of the dump truck. Petitioner reported to work on September 14, 2012 at 6:30am at Respondent's yard located in Harvey, Illinois, and built a sewer on that day. Petitioner returned to the yard at approximately 2:00pm. When exiting the dump truck, Petitioner testified, "when he stepped down on that running board, my foot slipped . . . my foot just kind of turned; and I heard a pop, and I felt a pain in my (right) Achilles." (Transcript of the Proceeding, page 17). Getting in and out of the truck was the only way he was able to perform his job duties that day, and that only he and his co-worker were allowed to get in the truck. Petitioner testified that the running board "was bent and sort of twisted and that the condition of the running board "caused my foot to turn when I stepped on it. Just, like, it slipped". (Transcript at 30). After his foot slipped, he felt a pop and then he felt pain. (Id.).

The Respondent offered no evidence to refute the Petitioner's testimony other than alleging that Petitioner did not file a written accident report on the day of the incident.

Additionally, Dr. Diel testified that he believed the Petitioner came to his office for a September 14, 2012. (See Evidence Deposition of Dr. Fredrick Diel, page 4). Dr. Diel testified that he knows that the Petitioner had the injury stepping out of a vehicle. (Id).

NOTICE

Petitioner telephoned his supervisor, Frank Romanski, on September 17, 2012, and reported that on September 14, 2012, when he had stepped down from the truck to unload the equipment, he "stepped down on the running board and hurt my ankle, that I felt a pop and I told them exactly what had happened". (Transcript at 20). Petitioner told Mr. Romanski he was not coming to work and instead was going to see a doctor. (Transcript at 21). On September 18, 2012, he gave Frank Romanski a note from the doctor that he could not

work. (Id.). On that same date, Petitioner advised his immediate supervisor, Kevin Reynolds, of his work injury. Petitioner testified that neither Mr. Romanski or Mr. Reynolds required the Petitioner to fill out any paperwork. (Transcript at21 and 22). When questioned, Petitioner testified that he did not recall whether he completed any paperwork or forms to report his injury. (Transcript at 43). Neither Mr. Romanski nor Mr. Reynolds testified.

The parties agree that Respondent has paid $49,672.62 in medical bills through its group medical plan for the injury to his right Achilles tendon. The medical treatment began on September 17, 2012 and ran through January 27, 2014. Respondent's witness, Laura Siano, a payroll supervisor testified that Petitioner was placed on non-occupational disability on October 22, 2012. (Transcript at 62). An application for adjustment of claim was filed in this matter on November 7, 2012.

Respondent's witness, Laura Siano, a payroll supervisor, testified that no workers' compensation file was found for Petitioner. (Transcript at 69). She was not aware that the Petitioner had filed an Application for Adjustment of Claim for the September 14, 2012 accident on November 7, 2012. (Transcript at 64). When asked if she was advised by the Respondent's workers' compensation department that Petitioner had made a compensation claim on November 7, 2012, she testified, "if they received it, no. I've asked my workers' comp people four times in the last year they say they have nothing." (Id.). She testified that "employees can report those injuries to their supervisors orally." (Transcript at. at 67).

CAUSATION, NATURE and EXTENT

Petitioner testified that he had a previous injury to his right Achilles tendon in 2001, but that from 2001 to September 14, 2012, that he had not had any other injury to his right Achilles tendon. (Transcript at 13). An x-ray of the right ankle was performed on August 16, 2012 and the result was negative with respect to the petitioner's right Achilles tendon. (PX 1 and RX 3).

On September 17, 2012, the Petitioner went to the Franciscan Hammond Clinic Specialty Center and he gave a history to the nurse practitioner, Jane Taggart, and testified that he told Ms. Taggert that he hurt his ankle at work stepping out of a truck. (Transcript at 19). The medical record indicates that the Petitioner's right ankle

was hurting again and was swollen. (PX 1). The assessment was ankle joint pain. (Id.) Petitioner was to follow-up in one week and he was prescribed Naproxen. (Id.)

Petitioner next sought medical attention from Dr. Jondelle Jenkins on September 24, 2012 and gave the following history:

> Patient presents with tendonitis of the right Achilles tendon. Patient describes the area as aching. The condition has existed for several days and began suddenly. The course is worsening. The affected area is made worse by ambulating, climbing, driving a car. Past treatments include casting. He originally injured area in 2001 and was casted. He aggravated it two years ago with a motorcycle accident. A few days ago he heard it pop when getting out of car and felt that again yesterday.
> (PX 1)

Petitioner testified that he told Dr. Jenkins that he hurt his ankle at work getting out of a truck. (Transcript at 26).

On October 2, 2012, Petitioner reported back to the Franciscan Hammond Clinic Specialty Center and saw Joselito Navarro, a nurse practitioner, and advised her that when he got out of his truck and stepped down on a running board, his ankle popped. (Transcript at 27-28).

On October 8, 2012, Petitioner reported to Dr. Fred Diel, gave the history of injuring the right Achilles when getting out of the truck at the yard and that he felt his ankle pop. (Transcript at 29-30). An MRI exam was conducted on October 11, 2012 at the Franciscan Hammond Clinic Specialty Center showed a high grade partial tear of the right Achilles tendon. (RX 3 at 54). On October 15, 2012, Dr. Diel advised the Petitioner of the results to stay off of work. (Id. at 59). Dr. Diel found it necessary to take the Petitioner completely off work because of the risk of full rupture. (Evidence Deposition of Dr. Diel at 7).

On October 24, 2012, the Petitioner presented to Dr. Diel at the Franciscan Hammond Clinic for a PRP injection of the right Achilles tendon; Petitioner had been off work and on non-steroidal anti-inflammatories for two weeks. (PX 1). On November 14, 2012, the Petitioner returned to Dr. Diel at the Franciscan Hammond Clinic for follow-up after the PRP injection to the right Achilles. (RX 3 at 65). Dr. Diel testified that Petitioner was experiencing less pain post-injection. (Evidence Deposition of Dr. Diel at 7).

Petitioner returned to see Dr. Diel on November 20, 2012. (RX 3 at 67). The record indicates:

> Pt returns for new onset pain and swelling right achilles. Pt was stepping

out of car and felt sharp pain. Pain rated 7/10 right. (Id.)

Dr. Diel's assessment was a rupture of the Achilles tendon and he ordered a second MRI. (Id. at 68). The December 3, 2012 MRI now showed a complete rupture of the Petitioner's right Achilles tendon which required immediate surgery. (Evidence Deposition of Dr. Diel at 8; RX 3 at 69). It is Dr. Diel's opinion, to a reasonable degree of medical certainty, that the complete rupture was probably caused or aggravated by the Petitioner's work accident on September 14, 2012. (Evidence Deposition of Dr. Diel at 9). Dr. Diel's initial treatment for the partial initial tear was immobilization and PRP (Id. at 25). Dr. Diel opined that the complete rupture discovered on the December 3, 2012 MRI most likely arose out of the partial tear that was initially sustained on September 14, 2012. (Id. at 26).

The surgery to repair the now complete rupture of petitioner's right Achilles tendon was performed by Dr. Diel on December 7, 2012 at Franciscan Physicians Hospital. (Id. at 8). The Operative Report indicates Dr. Diel found a bulbous area and nice good healthy tissue along with a complete rupture of the posterior aspect of the Achilles tendon. (PX 3). The description of procedure indicated that the proximal portion of the Achilles tendon was tubularized to bring the longitudinal split together, a crackow was then performed of the distal aspect of the tendon in both proximal and distal, Achilles tendon was tied down in this position. (Id.). Then an artelon graft was used to wrap the Achilles tendon at the sight that had ruptured, and the surgical area was closed. (Id.). The Petitioner presently has the graft in place and a 3 ½ inch long scar with about a 3/8 inch keloid (Transcript at 34).

Post-surgery through June 2013, Petitioner was directed by Dr. Diel to remain off of work and in a cam-walker so that the Achilles tendon could heal properly. (Evidence Deposition of Dr. Diel at 9-10). A May 29, 2013 MRI showed post-operative changes of the right Achilles tendon with increased signal intensity along the post-operative site with thickening of the tendon. (RX 3 at 107). As a result, Dr. Diel performed a second surgery on June 20, 2013 which was a radio-ablation Topaz therapy to break-up the tendinosis on the right Achilles tendon. (Evidence Deposition of Dr. Diel at 10-11). Subsequent to the Topaz procedure, the petitioner remained off of work and followed-up with Dr. Diel all the way through January 27, 2014. (Evidence Deposition of Dr. Diel at 11). Dr. Diel testified he had him off of work continuously during that period of time

because of the scarring and tendinosis and that any increased motion on the tendon would have exacerbated the problem. (Evidence Deposition of Dr. Diel at 12). It was Dr. Diel's opinion to a reasonable degree of medical certainty that all of the care and treatment that he rendered from October 8, 2012 through January 27, 2014, was reasonable and necessary in light of the injury the Petitioner sustained at work on September 14, 2012. (Id.)

Respondent offered no evidence to refute the Petitioner's claims regarding causation or the necessity of any of the medical care.

PAYMENT OF TEMPORARY TOTOAL DISABILITY

Petitioner was kept off work continuously from October 8, 2012 until January 13, 2014 by Dr. Diehl. (Evidence Deposition of Dr. Diel at 26-27). Petitioner testified that he remained off work and he continued to give his off work slips to the respondent and that the respondent did not pay Temporary Total Disability during the entire time he was off work. (Transcript at 35). Petitioner filed an Application for Adjustment of Claim on November 7, 2012.

Petitioner did not receive any TTD benefits nor STD benefits. The Petitioner did receive $11,989.08 in non-occupational indemnity benefits for which a credit is allowed under Section 8(j) of the Act. The time-period Petitioner was taken off work by Dr. Diel, October 8, 2012 until January 13, 2014, is 64 weeks. Petitioner's TTD rate during that period was $888.08 multiplied by 64 weeks equals $54,837.54 minus the credit of $11,989.08, for a total owed TTD of $44,848.46.

CONCLUSIONS OF LAW

As to C, whether the petitioner sustained an accident which arose out of and in the course of the petitioner's employment with the respondent, the Arbitrator concludes as follows:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment, 820 ILCS 305/2 (West 2000). Both elements must be present at the time of claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989).

Arising out of the employment refers to the origin or cause of a claimant's injury. As the Supreme Court held in Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989):

> For an injury to "arise out of" the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Typically, an injury arises out of one's employment if, at any time of the occurrence, the employee was performing acts he was instructed to perform by his employer or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties.

In addition, an injury arises out of the employment if the claimant was exposed to a risk of harm beyond that to which the general public is exposed. Brady v. L. Rufollo & Sons Construction Co., 143 Ill.2d 542, 548, 578 N.E.2d 921, 161 Ill. Dec. 275 (1991).

A claimant's testimony standing alone may be sufficient to support an award of benefits under the Act. Seiber v. Industrial Comm'n, 82 Ill.2d 87, 97, 411 N.E.2d 249, 44 Ill. Dec. 280 (1980). [***14]. Medical testimony is not essential to support the conclusion that an accident caused a claimant's condition of ill-being. International Harvester v. Industrial Comm'n, 93 Ill.2d 59, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982). Circumstantial evidence can be sufficient to prove a causal nexus between an accident and the claimant's injury. Gano Electric Contracting v. Industrial Comm'n, 260 Ill. App.3d 92, 96-97, 631 N.E.2d 724, 197 Ill. Dec. 502 (1994).

On September 14, 2012, Petitioner did sustain an accident that arose out of and in the course of employment. The Petitioner, a 20-year employee of the Respondent, testified credibly how on September 14, 2012, when exiting his work dump truck to unload tools on a damaged running board that was bent and crinkled, his right foot turned and he heard a pop and felt pain in his right Achilles tendon. He indicated getting in and out of that dump truck was the only way he would be able to do his job duties on that day and that he sought medical attention for the right Achilles tendon injury on September 17, 2012. In terms of credibility, Petitioner's lengthy tenure with Respondent weighs in his favor. No symptom magnification or inconsistencies were reported in the medical records, and petitioner resumed working as a laborer for respondent when released

to work in January of 2014. Petitioner was still employed by the Respondent in the same capacity up to the time of the hearing.

The petitioner stated he did not have any other injury to his right Achilles tendon between 2001 to September 14, 2012, and he had an x-ray one month before the accident that did not show any tears in his right Achilles Tendon. The petitioner was exposed to a defective truck running board that arose distinctly out of his employment and in the scope. When viewed as a whole, the timeline of events, medical evidence, and testimony support the finding that petitioner's Achilles tendon injury is causally related to his work accident of September 14, 2012.

As to D, the date of accident was September 14, 2012, the Arbitrator concludes as follows:

The Petitioner sustained a right Achilles tendon tear as a result of his injury on September 14, 2012. The Petitioner heard a pop and experienced pain and swelling after stepping out of his work truck. Based on the fact that the petitioner noticed pain and swelling in his right Achilles tendon on September 14, 2012, when exiting his work dump truck, the arbitrator concludes the date of accident was September 14, 2012.

As to E, whether the petitioner gave timely notice to the respondent, the Arbitrator concludes as follows:

Under 820 ILCS 305/6 (c), an injured employee must give notice to the employer as soon as practicable, but not later than 45 days after sustaining an accidental injury arising from the employment. A notice of an accident must give the approximate date and place of the accident, if known, and may be given orally or in writing.

In *Ferrin Cooperative Equity Exchange v. Industrial Commission*, 64 Ill.2d 445, 356 N.E.2d 559, 1 Ill.Dec. 371 (1976), the claimant alleged that he told the foreman of the accident the same day it happened. The foreman, when called as a witness, said he did not recall any such conversation and, if an accident had been reported, he would have called and notified the insurance agent immediately. It was held there was valid notice.

The question of oral notice came up in *Crow's Hybrid Corn Co. v. Industrial Commision*, 72 Ill.2d 168, 380 NE.2d 777, 20 Ill. Dec. 568 (1978), in which the employee's wife made a phone call to the company advising the employer of her husband's injury. The Supreme Court held that it was sufficient notice as the

Compensation Act does provide for oral notification. The *Crow's* case is also notable as it discussed the extension of notice time when payments are made from group insurance.

In *Tolbert v. Ill. Workers' Comp. Comm'm*, 2014 IL App (4th) 130523WC, the Petitioner filled out a "Voluntary Leave Questionnaire" and left his job due to respiratory problems he had. At the time of his leaving, he did not specifically report that the respiratory problems were work-related; however, later on it was determined that the respiratory problems was actually histioplasmosis that was caused from inhaling fungus and/or bird feces while on the job. In finding that notice was properly given, the Court held that the Respondent was aware of the Petitioner's illness with the prescribed 45-day period and that it did not matter that the Respondent was not told at that precise time that the illness was work-related. Therefore, while the notice may have been defective or inaccurate at the time it was given, the notice was sufficient and without a showing from the Respondent that it was prejudiced in some way, proper notice was found. *Id.* at 78.

Petitioner testified credibly that he orally gave notice of the accident to his supervisor, Frank Romanski, on September 18, 2012 and his immediate supervisor, Kevin Reynolds, on September 18, 2012, and that neither Mr. Romanski nor Mr. Reynolds required the petitioner to fill out any paperwork. Neither Mr. Romanski nor Mr. Reynolds testified to refute any of Petitioner's testimony. The Respondent offered no evidence to refute the Petitioner's testimony other than alleging that Petitioner did not file a written accident report on the day of the incident and that no file on the matter had been found. Importantly, Respondent's witness, Laura Siano, a payroll supervisor, testified that "employees can report those injuries to their supervisors orally." (Transcript at. at 67).

The parties agree that all medical bills incurred by the Petitioner for this injury were paid through respondent's group medical plan for medical treatment that began from September 17, 2012 and ran through January 27, 2014. Moreover, all parties agree that an application for adjustment of claim was filed in this matter on November 7, 2012, well before the termination of said group's medical payments were made. Finally, Respondent's witness, Laura Siano, a payroll supervisor, testified that Petitioner was placed on non-occupational disability on October 22, 2012. (Transcript at 62).

Therefore, timely notice of this accident was given to Respondent.

As to F, whether the petitioner's condition of ill-being is causally related to the injury, the Arbitrator concludes as follows:

"Medical evidence is not an essential ingredient to support [***14] the conclusion of the Commission that an industrial accident caused the [claimant's] disability." *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63, 442 N.E.2d 908, 911, 66 Ill.Dec. 347 (19820; see also *Pulliam Masonry v. Industrial Comm'n*, 77 Ill.2d 469, 471, 397 N.E.2d 834, 835, 34 Ill. Dec. 162 (1979) ("It is not necessary to establish a **causal connection** by medical testimony."). "A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester*, 93 Ill.2d at 63-64, 442 N.E.2d at 911.

A claimant may be entitled to benefits under the Act even though he suffers from a preexisting condition of ill-being. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203, 797 N.E. 2d 665, 671, 278 Ill. Dec. 70 (2003). "[I]n preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *Id.* at 204-05, 797 N.E.2d at 674. "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being." (Emphasis on original.) *Id.* At 205, 797 N.E.2d at 673.

Petitioner gave uncontradicted testimony. Petitioner testified he had no prior problems with his right Achilles for 13 years before the accident, sought medical treatment within three days of his injury, and gave a history that he hurt his ankle at work stepping out of a vehicle. After three weeks of conservative care and no improvement, Petitioner was seen by Dr. Fredrick Diel, and gave a history of injuring his right Achilles tendon from getting out of a vehicle. An MRI conducted less than one month after the accident showed a high grade partial tear of the right Achilles tendon. After further conservative treatment failed, a second MRI in December of 2012 showed a complete rupture of the Petitioner's Achilles tendon, which required immediate surgery. Dr.

Diel testified credibly that it was his opinion to a reasonable degree of medical certainty, that the initial partial rupture was caused on September 14, 2012, when Petitioner heard the pop exiting his vehicle and that the complete tear was also caused or aggravated by the petitioner's work accident on September 14, 2012. Respondent offered no evidence to refute Petitioner's evidence.

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

As to L, the nature and extent of the injury, the Arbitrator concludes as follows:

Petitioner sustained the complete tear injury to his right Achilles tendon ultimately requiring surgical repair occurring on December 7, 2012. Because the 63-year-old Petitioner's occupation is that of a laborer building roads and bridges and his job involves being on his feet all day, his injury will affect his work to a greater extent than it would to the average injured employee. Petitioner testified clearly and convincingly that his right Achilles tendon injury causes him pain and has affected him up to the hearing on November 2, 2017. After the initial surgery, the Petitioner had an additional Topaz surgery to remove scar tissue on June 20, 2013. Petitioner was off work for a total of 64 weeks and subsequently returned to his fully duty position as a highway maintainer at the Illinois Department of Transportation.

Therefore, Respondent shall pay Petitioner permanent partial disability benefits of $695.78 per week for 41.75 weeks, because the torn right Achilles tendon injury, sustained as a result of his September 14, 2012 work accident, caused the 25% loss of the right foot, as provided in Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Brooks,

Petitioner,

vs. NO: 11 WC 12905

Regional Elite Airline Services, LLC

Respondent.

19IWCC0578

DECISION AND OPINION ON REMAND

This matter now comes before the Commission on remand from the Appellate Court. The Commission, in relevant part, affirmed the Arbitrator's denial of causal connection as it pertained to Petitioner's right elbow. The Circuit Court of Champaign County affirmed the Commission's ruling. On appeal, the Appellate Court reversed the Circuit Court's order affirming the Commission's decision. The Appellate Court found the Commission's affirmance of the Arbitrator's decision to be against the manifest weight of the evidence and remanded the matter for further consideration consistent with its opinion.

The Commission hereby incorporates by reference the findings of fact contained in the arbitration decision to the extent it does not conflict with the Appellate Court's order dated May 23, 2019. The Commission further incorporates by reference the Appellate Court's order, which delineates the relevant facts and analysis, 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).

19IWCC0578

I. Right Elbow

The Appellate Court found that Petitioner had established a causal connection between her elbow condition and accident. *Brooks v. Illinois Workers' Compensation Comm'n*, 2019 IL App (4th) 180438WC-U. In its analysis, the Court noted that the record showed that Petitioner's prior cubital tunnel release surgery in 2006 had little to no effect on the onset of her elbow problem following her November 2011 and June 2012 shoulder surgeries. *Id.* ¶ 46. Given the lack of evidence of ulnar issues between 2006 and this testing, and Petitioner's ability to work after the 2006 surgery until her November 2011 rotator-cuff surgery, the Court found that the EMG results "clearly showed (as interpreted by Dr. Li and corroborated by Dr. Riskin) the onset of what was soon to become right ulnar neuropathy." *Id.* ¶ 49. The Court also disagreed that the formal diagnosis of right ulnar neuropathy after the June 2012 shoulder surgery negated the existence of right ulnar neuropathy symptoms prior to June 2012. *Id.* ¶ 50. In so concluding, the Court noted that Dr. Fletcher examined Petitioner on November 9, 2011 following her first shoulder surgery at which time she had an abnormal neurological examination and positive Tinel's sign in the right elbow. *Id.* Finally, the Court noted that none of the doctors opining about the onset of Petitioner's "elbow problems disagreed with Dr. Li's suggestion that the positioning of Petitioner's right arm during and after her rotator-cuff surgery aggravated her ulnar nerve causing her elbow problems." *Id.* ¶ 51.

Thus, the Court concluded, in pertinent part, that:

> The record adequately and clearly demonstrates that claimant's elbow problem was the result of her reasonable and necessary shoulder surgery. Her May 2010 work-related accident caused an injury to her shoulder. The manifest weight of the evidence, taking the combined opinions and supporting medical documentation as set forth above, demonstrates that the required surgery to repair claimant's shoulder "was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Sisbro*[*, Inc. v. Industrial Comm'n*], 207 Ill. 2d [193,] 205 [(2003)].

Id. ¶ 53. Accordingly, in compliance with the Appellate Court's order, the Commission finds that Petitioner's reasonable and necessary right shoulder surgery was a causative factor in her resulting right elbow condition. Although not specifically ordered by the Appellate Court, the Commission, in keeping with the Court's order, also finds that Respondent shall be liable for medical expenses related to Petitioner's elbow condition and finds that the causally related elbow condition warrants award of the prospective right ulnar nerve surgery prescribed by Dr. Li.

II. Neck Pain

Having found that Petitioner's right elbow condition was causally related to the accident at work, the Court turned its attention to Petitioner's alleged neck pain. *Brooks*, 2019 IL App (4th) 180438WC-U. The Court noted the Arbitrator's finding that Petitioner did not seek treatment for the head and neck pain until after March 2013 was not borne out in the records. *Id.* ¶ 56. From April 2013 until March 2014, Petitioner sought treatment from Dr. Madden, her primary care physician, who noted her ongoing complaints of chronic headache and neck/back pain as well as symptoms about the occiput with radiating pain down the spine, for example. *Id.* The Court also

disagreed with the finding that a non-occupational fall prompting an emergency room visit on March 8, 2014 was not significant as well as the finding that Petitioner did not report a history of ongoing headaches, neck pain, or right shoulder pain related to her work accident. *Id.* ¶¶ 57-58. The Court highlighted that both propositions were repudiated by the emergency room records. *Id.* Finally, the Court found that the Arbitrator's summary of Dr. Sweeney's testimony was inaccurate based on the totality of the medical reports in the record demonstrating that Petitioner had not completely recovered, and that reliance on Dr. VanFleet was misplaced as he did not review the emergency room records. *Id.* ¶¶ 59-60. The Court concluded that Dr. VanFleet's opinion was based on an inaccurate overview of the pertinent circumstances. *Id.*

Accordingly, in compliance with the Appellate Court's order, the Commission finds that the record supports the conclusion that Petitioner's neck pain condition is causally related to her accident at work. The Commission further finds the opinions of Dr. Sweeney that Petitioner's back, neck, and shoulder injuries were caused by the work-related accident to be more persuasive than those of Dr. VanFleet and accords no weight to Dr. VanFleet's opinions. Although not specifically ordered by the Appellate Court, the Commission, in keeping with the Court's order, also finds that Respondent shall be liable for medical expenses related to Petitioner's neck condition and finds that the causally related neck condition warrants award of the prospective occipital neuralgia injections to treat her cervicogenic headaches, suboccipital neuritis, and cervical facet syndrome as prescribed by Drs. Fletcher and Sweeney.

III. Penalties and Fees

In compliance with the Appellate Court's order, the Commission denies Petitioner's claim for penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner has proven causal connection between her work accident and her conditions of ill-being in the back, neck, shoulders and right elbow.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $190.00 per week for a period of 82 weeks (March 11, 2013 to April 21, 2014 and October 4, 2015 to April 12, 2016), that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner any and all medical expenses related to her neck, back, shoulder(s) and right elbow pursuant to §8(a) and §8.2 of the Act. These expenses total $21,576.82.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded prospective right ulnar nerve surgery.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded prospective occipital neuralgia injections.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $41,100.00. 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 24 2019
d: 10/17/19
BNF/wde
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AMOS BLACK,

Petitioner,

19IWCC0579

vs.

NO: 11 WC 19057

LORIG CONSTRUCTION COMPANY,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes to the Commission on remand from the Circuit Court of Cook County. The claim was arbitrated on October 27, 2015. On May 16, 2016, an arbitration decision was issued in which the Arbitrator awarded Petitioner 70 weeks of temporary total disability benefits, medical expenses related to treatment of his cervical and thoracic spine, denied medical expenses associated with treatment of his shoulders and right hip, and awarded 175 weeks of Permanent Partial Disability benefits representing loss of 35% of the person-as-a-whole. In his decision, the Arbitrator found that Petitioner was not obviously unemployable and noted that a vocational rehabilitation counselor hired by Respondent testified that Petitioner was capable of obtaining employment in which he could earn \$10.00 to \$15.00 an hour. On October 27, 2017, the Commission affirmed and adopted the Decision of the Arbitrator.

Petitioner appealed the decision of the Commission to the Circuit Court of Cook County. The Circuit Court confirmed the Decision of the Commission regarding medical expenses and temporary total disability benefits, but reversed the Decision of the Commission regarding the permanency award. The Circuit Court found that Petitioner had not specifically waived a right to a wage differential award under §8(d)(1) of the Act and that because he could not return to work at his previous job paying \$35.00 and was likely not able to obtain employment at that pay rate, he had established that he was eligible for a wage differential award.

In addition, the Circuit Court found that even though Petitioner did not conduct a job search, he sustained his burden of proving that he was permanently and totally disabled from gainful employment under the odd-lot theory due to his age, minimal education, and employment history in manual labor. The Circuit Court concluded that "the Commission clearly erred in its decision that Plaintiff is ineligible for wage differential benefits pursuant to section 8(d)(1) of the Act, and clearly erred its (*sic*) conclusion that Plaintiff is not entitled to odd lot permanent total disability benefits." Therefore it reversed the Decision of the Commission and remanded the decision "in order for the Commission to properly calculate Plaintiff's award."

The Commission notes that although the Circuit Court held that Petitioner was eligible for both a wage differential award under §8(d)(1) of the Act and a permanent and total disability award under §8(f) of the Act, the court did not direct that the Commission award benefits under both sections concurrently. Rather, the court remanded the matter to the "Commission to properly calculate" the award.

The Commission recognizes that in *Chlada v. IWCC*, 2016 Ill App. 150122 (1st Dist. WC div.) the Appellate Court found the claimant there should receive both a wage differential and permanent and total disability award simultaneously. However, the court specifically held that those awards compensated the claimant for two separate and distinct injuries and the that separate awards were necessary to fairly compensate the claimant for each of those injuries. In the case now before the Commission, there was only a single injury for which Petitioner must be compensated. In addition, the Commission finds neither statutory authority nor Appellate Court precedent under which the Commission is empowered to award both a wage differential and permanent and total disability award concurrently for a single injury.

The Commission opts to award Petitioner benefits for permanent and total disability under §8(f). First, claimants generally have the option of seeking permanency awards under either permanent partial disability or wage differential. In this matter we presume that Petitioner would elect to receive the higher benefits afforded under §8(f). Second, Petitioner was never offered employment to establish earning capacity to differentiate from his prior earnings and calculate the wage differential. Third, the decision of the Circuit Court that Petitioner is permanently and totally disabled implies that he cannot obtain gainful employment, therefore his current earning potential is zero, and therefore, again, there is no basis upon which to award a wage differential.

The Commission notes that because the Circuit Court confirmed the aspects of the Decision of the Commission other than permanency, the Commission awards permanent and total benefits as of September 10, 2012, when the Arbitrator and Commission found Petitioner to be at maximum medical improvement and terminated temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $850.11 per week for a period of 70 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

19IWCC0579

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses submitted into evidence for treatment rendered to relieve Petitioner's conditions of ill-being of his cervical and thoracic spine under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2.

IT IS FUTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $850.11 per week for life commencing on September 10, 2012 as provided in §8(f) because the injuries rendered Petitioner permanently and totally disabled from gainful employment.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is eligible for cost-of-living adjustments from the Rate Adjustment Fund commencing on the second July 15th after entry of this award.

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 24 2019

Deborah L. Simpson

Thomas J. Tyrrell

Maria E. Portela

DLS/dw
46

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

MOISES VALLE,

Petitioner,

vs. NO: 16 WC 38681

UNIFIRST,

Respondent.

19IWCC0580

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 causal connection, medical expenses, and permanent partial disability (PPD) benefits, and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This claim was consolidated with claim number 17 WC 5552 for purposes of hearing and a separate Decision was issued for 17 WC 5552.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2018 is hereby affirmed and adopted.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 the Circuit Court.

DATED: OCT 25 2019

DDM/pm
O: 8/28/19
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VALLE, MOISES
Employee/Petitioner

Case# **16WC038681**

17WC005552

UNIFIRST
Employer/Respondent

19IWCC0580

On 12/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1120 BRADY CONNOLLY & MASUDA PC
DANIEL J CODY
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Moises Valle
Employee/Petitioner

v.

UniFirst
Employer/Respondent

Case # **16** WC **038681**

Consolidated cases: **17 WC 05552**

19IWCC0580

An *Application for Adjustment 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 **8/7/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/1/16**, 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, in part,* causally related to the accident.

In the year preceding the injury, Petitioner earned **$21,179.95**; the average weekly wage was **$847.20**.

On the date of accident, Petitioner was **30** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. There was no compensable lost time as a result of this claim.

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 $6,739.40, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

The award for PPD associated with this claim is made in Case No. 17 WC 05552.

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

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

Signature of Arbitrator

December 3, 2018
Date

ICArbDec p. 2

DEC 4 - 2018

FINDINGS OF FACT

At the beginning of the trial, Petitioner made a motion to amend the Application for Adjustment of Claim, changing the date of accident from 12/2/2016 to 12/1/2016. There was no objection and the motion was granted. The Amended Application was admitted as Arbitrator's Exhibit 2.

Petitioner was employed by Respondent as a working supervisor. In this job, Petitioner would do office work and route work for absent employees. The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 1, 2016. He bent over to lift some heavy clothes off the floor and he experienced pain in his lower back. Petitioner's testimony was that he had sharp lower right back pain down his right leg to his right foot and toes at that time.

Petitioner was sent for treatment by Respondent to U.S. Healthworks (USHW), where he had a course of physical therapy from December 1, 2016 to December 12, 2016. Work restrictions were in place through December 12, 2016. The physician notes from USHW document right low back pain only on 12/1/2016. The pain complaints were described as low back pain without radiculopathy and without sciatica on 12/5/2016. On 12/7/2016, decreased right lower extremity strength was noted and there was said to be right thigh and leg pain. On 12/19/2016, it was noted that Petitioner had begun treatment with a physician of his choice and he was "discharge". (PX 1, RX 4)

Petitioner testified that as of December 12, 2016, he was still experiencing a lot of lower back and right leg pain and sought treatment at the Illinois Orthopedic Network (ION), coming under the care of Dr. Murtaza on December 14, 2016. Dr. Murtaza documented Petitioner's symptoms and history of accident and released Petitioner to continue working with restrictions and ordered an MRI. Petitioner had the MRI on January 9, 2017, which showed at L2-3, a 1 mm disc protrusion with effacement of the thecal sac, and at L4-5, a 2-3 mm disc protrusion effacing the thecal sac and causing bilateral stenosis and encroaching the left exiting nerve roots. (PX 2, RX 5) Petitioner was referred for a course of physical therapy at ATI, which he underwent from January 19, 2017 to February 9, 2017. (PX 3) Dr. Murtaza opined that Petitioner's condition and need for treatment was causally related to the December 1, 2016 accident. Dr. Murtaza prescribed prescription medications, which Petitioner testified provided some relief. (PX 2&3) Petitioner testified the therapy had provided some relief. Petitioner testified that he remained in treatment and was working with restrictions when he had another injury

to his back, sustained while working for Respondent, on February 16, 2017 (see Decision of Arbitrator in 17 WC 005552). Petitioner testified that he had no prior injuries to his back before the December 1, 2016 accident.

CONCLUSIONS OF LAW

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

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

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

F – CAUSAL CONNECTION

Based on the opinions of Petitioner's treating physician, Dr. Murtaza, and Petitioner's testimony, the Arbitrator finds Petitioner's low back condition of ill-being and the need for treatment following the December 1, 2016 accident, until his re-injury on February 16, 2017, is causally related to the December 1, 2016 accident.

J MEDICAL EXPENSES

Based on the Arbitrator's finding regarding Causal Connection and the opinion of Dr. Hsu, the Arbitrator awards the following bills, which are for medical services found to be reasonable and necessary to cure or relieve the effects of the injury:

PX 2	Illinois Orthopedic Network (DOS: 12/14/2016; 1/13/2017):	$ 265.58
PX 3	ATI (DOS: 1/19/2017 – 2/9/2017):	$3,074.14

PX 5	Premium Healthcare Solutions LLC (DOS: 1/9/2017):	$2,486.00
PX 6	Metro Health Solutions (DOS: 1/9/2017):	$ 913.65
	TOTAL:	**$6,739.40**

This award of medical expenses is made pursuant to Sections 8(a) and 8.2 of the Act; Respondent to pay the lesser of the actual charges, the Fee Schedule, or the negotiated rate. Respondent is entitled to a credit for all awarded bills that it has paid.

L – NATURE AND EXTENT

The award for PPD regarding this injury is made in Case No. 17 WC 05552, filed concurrently with this decision.

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

MOISES VALLE,

Petitioner,

vs. NO: 17 WC 5552

UNIFIRST,

Respondent.

19IWCC0581

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 causal connection, medical expenses, temporary total disability (TTD) benefits, and permanent partial disability (PPD) benefits, and being advised of the facts and applicable law, modifies the Arbitrator's Decision as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator had previously found that Petitioner's low back condition was causally related to the December 1, 2016 work accident [Claim No. 16 WC 38681] up until Petitioner's re-injury on February 16, 2017 [Claim No. 17 WC 5552]. This claim was consolidated with claim number 16 WC 38681 for purposes of hearing and a separate Decision was issued for 16 WC 38681.

In this claim, 17 WC 5552, the Arbitrator found that Petitioner's low back condition was causally related to the February 16, 2017 work accident, but only up to May 24, 2017 – the date of Petitioner's Section 12 examination with Dr. Hsu.

Based on the evidence in its entirety, the Commission modifies the Arbitrator's Decision in 17 WC 5552, and finds that Petitioner's current condition of ill-being is causally related to the February 16, 2017 accident, and that Petitioner reached maximum medical improvement (MMI) on August 3, 2017. Following the first accident to Petitioner's low back on December 1, 2016, Petitioner was actively treating until he sustained his second work injury on February 16, 2017.

By the date of Dr. Hsu's May 24, 2017 Section 12 examination, Petitioner was in physical therapy and he reported continued low back pain that radiated down his right leg. His functional limitations as of May 23, 2017 included disturbed sleep, difficulty in maintaining a sitting or standing position, and difficulty walking and lifting heavy weights. (PX4). More notable is that Dr. Hsu's causation opinion is only based on Petitioner's first injury of December 1, 2016. Dr. Hsu offered no opinion relative to the February 16, 2017 injury, other than stating that although Petitioner reported a second injury, "this is not necessarily supported by the evidence given to me in the medical records. There is no documentation of this second incident in the records that I reviewed." (RX3). Every opinion provided by Dr. Hsu related to the December 1, 2016 injury, which he believed to be a lumbar strain. Thus, by the time Dr. Hsu evaluated Petitioner on May 24, 2017, he believed that Petitioner had reached MMI for his lumbar strain. He further opined that Petitioner's treatment to date, including the injections, had been reasonable and necessary.

The Commission further finds Dr. Murtaza more reliable than Dr. Hsu as Dr. Murtaza had evaluated Petitioner from the beginning – since the first injury. Dr. Murtaza was informed of Petitioner's work-related injuries in December 2016 and February 2017. He noted that Petitioner had no prior injury to his low back or right lower extremity. Dr. Murtaza evaluated and treated Petitioner following the first and second injury. As the treatment progressed from medication, a back support, physical therapy, and injections, Dr. Murtaza continuously and consistently assessed Petitioner's recovery through repeat MRIs and eventually a functional capacity evaluation (FCE). Dr. Murtaza diagnosed Petitioner with an L4-5 disc protrusion and left-sided foraminal stenosis. While Petitioner's complaints were mostly right-sided, the MRIs evidenced bilateral findings in the lumbar spine. Dr. Murtaza further believed Petitioner reached MMI on August 3, 2017, and discharged him with permanent restrictions per the FCE. The Commission finds Dr. Murtaza more persuasive than Dr. Hsu, and further finds that Petitioner reached MMI on August 3, 2017 – not May 24, 2017.

The Commission having found continuing causal connection, next addresses Petitioner's claim for medical bills and TTD. The Arbitrator had awarded medical benefits up to the date of Dr. Hsu's Section 12 examination, or May 24, 2017. The Arbitrator also denied payment for an office visit charge for the May 16, 2017 MRI. The Arbitrator noted that the actual MRI bill was separately awarded and there were no supporting record for the office visit that allegedly took place on the same date as the MRI. By its Brief, Respondent indicates that the Arbitrator erroneously awarded a bill past the MMI date of May 24, 2017. Specifically, Respondent disputes the medical charge from ION that was incurred on August 3, 2017.

The Commission finds that Petitioner is entitled to all reasonable, necessary, and causally related medical bills through August 3, 2017, including the radiologist charge for the May 16, 2017 MRI that the Arbitrator did not award. (PX11). Notwithstanding causation, Respondent's Section 12 examiner, Dr. Hsu, had opined as of May 24, 2017 that the treatment to date had been appropriate. Additionally, the Arbitrator found no evidence of a rhizotomy on April 27, 2017, and did not award this bill. A rhizotomy is a form of facet procedure which is documented in the ION medical records. The Commission finds this medical bill reasonable, necessary, and causally related to the February 16, 2017 accident. (PX2).

With respect to TTD, the Arbitrator awarded benefits from February 22, 2017 through May 24, 2017. Having found Dr. Murtaza more persuasive than Dr. Hsu, and having found that Petitioner reached MMI on August 3, 2017, and not May 24, 2017, the Commission modifies the Arbitrator's TTD award to February 22, 2017 through August 3, 2017.

The Commission next finds that although the Arbitrator properly considered the five factors under Section 8.1b of the Act, the Arbitrator did not provide the appropriate weight to the fifth factor. The Commission affords greater weight to the fifth factor as evidence of disability as corroborated by the medical records demonstrate that Petitioner suffered more than a lumbar strain. Petitioner's treatment not only comprised of medication, a back support, physical therapy, and injections, but Dr. Murtaza also discharged him with permanent restrictions per the FCE. The FCE had classified Petitioner in the medium physical demand level. Having found Dr. Murtaza more persuasive than Dr. Hsu, and having determined that Petitioner's current condition of ill-being as to his low back is causally related to the February 16, 2017 work accident, the Commission finds that Petitioner's PPD benefits should be increased to 10% MAW.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed December 4, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable, necessary, and causally related medical bills through August 3, 2017.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $564.80 per week for 23 2/7 weeks, commencing February

22, 2017 through August 3, 2017, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $8,152.57 for temporary disability benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $508.32 per week for a period of 50 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 10% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: OCT 25 2019

D. Douglas McCarthy

DDM/pm
O: 8/28/19
052

Stephen Mathis

DISSENT

I respectfully dissent from the Majority's opinion modifying the Arbitrator's Decision. I find the Arbitrator's Decision to be thorough and well-reasoned. I rely on the Arbitrator's detailed findings and would affirm and adopt this Decision.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VALLE, MOISES
Employee/Petitioner

Case# **17WC005552**

16WC038681

UNIFIRST
Employer/Respondent

19IWCC0581

On 12/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1120 BRADY CONNOLLY & MASUDA PC
DANIEL J CODY
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Moises Valle
Employee/Petitioner

v.

UniFirst
Employer/Respondent

Case # 17 WC 05552

Consolidated cases: 16WC038681

19IWCC0581

An *Application for Adjustment 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 **8/7/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/16/17**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,179.95**; the average weekly wage was **$847.20**.

On the date of accident, Petitioner was **49** 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 **$0** for TTD, **$8,152.57** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,152.57**.

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 $13,812.54, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner temporary total disability benefits of $564.80/week for 13 -1/7 weeks, commencing 2/22/17 to 5/24/17 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $508.32/week for 20 weeks, because the injuries sustained caused the 4% loss of use of a person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner all compensation that has accrued from 2/16/2017 to 8/7/2018 in a lump sum and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

December 3, 2018
Date

DEC 4 - 2018

FINDINGS OF FACT

This matter was tried with a companion case, No. 16 WC 038681. The Findings of Fact therein are adopted herein.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on February 16, 2017. Petitioner testified that despite restrictions as a result of the December 1, 2016 accident that he was working with, on February 16, 2017, he was pushing and pulling a 300 pound bin out of a door, twisting his body, when he experienced increased pain in his lower back and down both his right and left legs, to his feet and toes. Petitioner testified the pain was greatly aggravated and was now down both legs, as opposed to only the right leg after the December 1, 2016, accident.

Petitioner testified he was sent by Respondent to USHW on February 16, 2017. (PX 1) He then continued in treatment at ION with Dr. Murtaza. Petitioner had previously been referred to ION by his attorneys. (PX 2)

Petitioner was seen at ION on February 22, 2017, where Dr. Murtaza documented Petitioner's new accident and increased symptomatology. As a result, Dr. Murtaza placed Petitioner on a total work restriction, ordered a new MRI and an EMG, and prescribed a lumbar epidural injection. Dr. Murtaza opined that Petitioner's condition, increased symptoms, need for treatment and inability to work were as a result of the February 16, 2017 accident. Dr. Murtaza referred Petitioner for therapy at a facility closer to his home, at Premier Therapy. (PX 2) Petitioner had a course of therapy there from February 24, 2017 to July 10, 2017. (PX 4) Petitioner testified the therapy provided some relief. Dr. Murtaza again prescribed pain medications, which Petitioner testified provided some relief. Petitioner had the EMG on March 2, 2017, which was abnormal, showing radiculopathy at L4-L5. (PX 2 & 8) Petitioner underwent a lumbar transforaminal epidural steroid injection on March 9, 2017, which he testified provided temporary relief. As a result, Dr. Murtaza ordered facet injections at L4-5, L5-S1, which Petitioner had on April 27, 2017. Petitioner testified this also provided some relief. (PX 2) Petitioner had another MRI on May 16, 2017, which also showed a 1 mm diffuse disc protrusion at L4-5, effacing the thecal sac to the left, with narrowing of the left neuroforamen effacing the left L4 exiting nerve root. (PX 11) On May 26, 2017, Dr. Murtaza opined that the May 16, 2017 MRI showed that Petitioner's disc pathology had regressed. On June 16, 2017, Dr. Murtaza commented on the May 24, 2017 IME report of Dr. Hsu, placing Petitioner at MMI. Dr. Murtaza noted Petitioner's continuing symptoms after the February 16, 2017 accident, opined he was not at MMI, released him with restrictions and prescribed a work conditioning program. On July 13, 2017, Dr. Murtaza ordered an FCE to determine any permanent work restrictions. On

July 19, 2017, Petitioner had the FCE at Premier Therapy, which was deemed to be valid and placed permanent medium capacity work restrictions. On August 3, 2017, Dr. Murtaza released Petitioner to return to work as of August 7, 2017 within the permanent restrictions of the FCE, and discharged Petitioner as having reached MMI. (PX 2 &4)

Petitioner was seen by Dr. Wellington Hsu, an orthopedic surgeon, for a Section 12 examination on May 24, 2017. (RX 3) Petitioner provided a history that he sustained injury on December 1, 2016, lifting heavy and dirty clothes. He claimed after doing that repetitive lifting he experienced the onset of low back pain as well as right lower extremity radiating pain. Petitioner also gave a history of a second incident on February 16, 2017, when he was moving a 300 pound tub and noted acute onset of low back pain again. On physical examination, Dr. Hsu noted that Petitioner had negative straight leg raise testing and displayed positive Waddell signs with axial compression and hip rotation 2/4. Dr. Hsu reviewed Petitioner's lumbar spine MRIs from January 9, 2017 and May 16, 2017. He noted the initial MRI revealed age appropriate spondylitic changes with no evidence of herniation or stenosis. He opined that Petitioner's May 16, 2017 MRI demonstrated no significant change from the previous MRI. (RX 3)

Dr. Hsu assessed Petitioner with a resolved lumbar strain and lumbar spondylosis. He opined that Petitioner's December 1, 2016 incident caused him to have a lumbar strain and he only suffered a soft tissue injury to the lumbar spine. He did not believe Petitioner sustained any structural injuries secondary to his viewing of the imaging ordered in January 2017. He did not believe that Petitioner sustained a second work related injury in February of 2017, from his review of the medical records. He believed Petitioner's lumbar spondylosis condition was an age-related, genetic condition which was not related to his work activity. Overall, he did not believe Petitioner sustained any structural injuries secondary to the work incident/exposure and no pre-existing condition was aggravated. Dr. Hsu opined that Petitioner had appropriate treatment to the date of his examination in the form of physical therapy, epidural injections, and medications. He opined that no additional treatment would be required or related to the work injury. He opined Petitioner had reached maximum medical improvement as of May 24, 2017. As Petitioner demonstrated a normal physical examination with no significant structural pathology seen on lumbar MRI. He noted the Petitioner had no functional disability seen on physical examination and no work restrictions were required for Petitioner. (RX 3)

On May 26, 2017, Petitioner met again with Dr. Murtaza. The chief complaint was low back pain with intermittent bilateral lower extremity pain and right hip pain. Dr. Murtaza reviewed the new MRI and charted that the new MRI actually showed the previous disc herniations had regressed. Dr. Murtaza noted that Petitioner had a 1mm disc bulge at L5-S1 without any central or minimal neural foraminal stenosis. Petitioner was to continue physical therapy. No further injections were recommended. (PX 2; RX 5)

On June 16, 2017, Petitioner met with Dr. Murtaza and reported that physical therapy had been helpful -- while he had low back pain, his hip and lower extremity pain had resolved. Dr. Murtaza thought that Petitioner was capable of light duty work and recommended a work conditioning program. (PX2; RX5)

On June 20, 2017, Petitioner began attending work conditioning sessions with Premier Physical Therapy Petitioner reported that he did not experience any numbness or tingling in lower extremities. Petitioner completed approximately 11 work conditioning sessions. (PX 4; RX 7)

On July 13, 2017, Petitioner followed up with Dr. Murtaza after two weeks of work conditioning. Petitioner reported work conditioning had not helped significantly with his pain. He did note his radiating pain had improved, but he had continued lumbar pain bilaterally with sitting for long periods of time, lifting or bending. Dr. Murtaza released Petitioner to return to work with restrictions as of July 17, 2017 and recommended that Petitioner undergo a functional capacity evaluation to determine permanent restrictions. (PX 2; RX 5)

On July 19, 2017, Petitioner underwent a functional capacity evaluation with Premier Physical Therapy. The results of his test were considered valid. In the history provided to the examiner, Petitioner said that he sustained an injury on December 20, 2016 while trying to lift a heavy bag of clothes weighing about 40 pounds. He claimed he sustained a second injury on February 16, 2017. Petitioner displayed a positive objective Waddell sign of simulated trunk rotation. He was currently complaining of less pain at the lower back and indicated his pain did not radiate to the lower extremities. Petitioner displayed the ability to lift 40 pounds from shoulder to overhead, 45 pounds from waist to shoulder, 50 pounds from floor to waist, and carry 55 pounds for 20 feet. He was able to push and pull 120 pounds for 20 feet. (PX 4; RX 7)

On August 3, 2017, Petitioner was seen by Dr. Murtaza for the final time. Petitioner had undergone a valid FCE which placed him at the medium physical demand level. He reported his pain level to be 4-5/10. He was taking ibuprofen and pantoprazole. He denied any significant radiating pain at that time. Petitioner was assessed with L4-L5 disk protrusion with left preponderance causing left-sided foraminal stenosis. Dr. Murtaza released Petitioner to return to work with permanent restrictions per the FCE, as of August 7, 2017. He was discharged at MMI. (PX2; RX6) Petitioner testified he has not returned to see Dr. Murtaza since this date and has not seen any other medical professional regarding his conditions.

Petitioner submitted into evidence medical records and outstanding medical bills from Illinois Orthopedic Network. Although drug screen testing were ordered and charged on March 9, 2017, the results were not contained in the records adduced. The medical bills contain a $1,700.00 charge for the drug screen. The medical bills also revealed a charge for $20,000.00 for rhizotomy procedure on April 27, 2017. The medical records provided do not include any support that a rhizotomy procedure was performed. Furthermore, the ION

medical bills also reflect a charge from May 26, 2017 for a new patient consultation for $246.36 after Petitioner had been treating with ION and Dr. Murtaza since December 14, 2016. (PX 2)

Petitioner testified that he was off of work from February 22, 2017 through his effective date of release to return to work with permanent restrictions of August 7, 2017, having never returned to work for Respondent. Petitioner testified that following August 7, 2017 he received unemployment benefits, until finding work at his current employer, Chicago Extruded Metals, performing office work in a lighter capacity as of February 28, 2018. Petitioner testified that he has had no other accidents other than the December 1, 2016 and February 16, 2017 work accidents. Petitioner testified that he continues to experience pain in his back and down both legs, which do vary in intensity from day to day. Petitioner testified the pain is worse when walking, bending, sitting and lying down. Petitioner testified he does not lift objects over 30 pounds due to this pain, and he continues to take both non-prescription and the prescribed medications, which provide some pain relief.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Statement of Facts in support of the Conclusions of Law set forth below.

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

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

F – CAUSAL CONNECTION

The Arbitrator finds that Petitioner's current condition of ill-being regarding his low back is, in part, causally related to the injury (to wit: resolved lumbar strain with degenerative spondylosis). The Arbitrator finds the opinions of Dr. Hsu to be persuasive on this issue. The treating medical records and Petitioner's testimony do not persuade the Arbitrator that Petitioner suffered any permanent aggravation or acceleration of the spondylosis condition of his spine as a result of the injuries.

J MEDICAL EXPENSES

Based on the Arbitrator's finding regarding causal connection and the persuasive opinions of Dr. Hsu, the Arbitrator awards the following medical bills:

PX 2	Illinois Orthopedic Network	$4,060.06 -*
PX 4	Premier Physical Therapy	$1,669.53 -*
PX 7	IWP	$ 212.66-*
PX 8	Suburban Pain Care Center	$2,009.00
PX 9	Midwest Specialty Pharmacy	$1,237.51-*
PX 10	Metro Anesthesia Consultants	$2,137.78
PX 11	Molecular Imaging	$2,486.00-*
	TOTAL:	**$13,812.54 -***

The award of medical expenses is made pursuant to Sections 8(a) and 8.2 of the Act; Respondent to pay the lesser of the actual charges, the Fee Schedule or the negotiated rate amount. Respondent is entitled to a credit for all awarded bills that it has paid.

*—The explanation for a reduction in the amounts claimed by Petitioner regarding medical expenses is as follows.

ION—Patient visit 2/22/2017 ($80.86) added. Drug screen 3/9/2017 ($1,700.00) subtracted (No supporting documentation of any drug screen on 3/9 and no supporting medical opinion). Rhizotomy 4/27/2017 ($20,000.00) subtracted (No evidence of Rhizotomy being performed on 4/27/2017, or any other date. The Arbitrator declines to speculate what the charges would be for the Lumbar intra-articular facet injections at L4-L5 and L5-S1 on the right with fluoroscopic needle localization and epidurogram procedure that was apparently performed). Shame on ION for their sloppy billing. New patient consult 5/26/2017 ($240.36) subtracted. (No basis for this charge in a patient that has been seen by this entity for 6 months, and per Dr. Hsu MMI/no further treatment opinion) Patient visits, 6/16/2017 ($80.86) and 7/13/2017 ($119.37) subtracted. (Per Dr. Hsu MMI/no further treatment opinion)

Premier—Awarded charges are for PT through 5/24/2017 Dr. Hsu IME date ($1,480.00), plus charges for 3/23/2017 PT ($9.53) and Re-evals on 3/20/2017 ($60.00), 4/10/2017 ($60.00) and 5/5/2017 ($60.00).

IWP—Reduction for charge of 6/19/2017 ($54.22) (After Dr. Hsu exam).

Midwest Specialty Pharmacy—Awarded charges are incurred prior to 5/24/2017 Dr. Hsu exam.

Molecular Imaging—Office visit charge for MRI 5/16/2017 subtracted. (No supporting records other than MRI, which was awarded)

K – T.T.D.

Based on the Arbitrator's finding regarding causal connection and the opinion of Dr. Hsu, the Arbitrator awards 13-1/7 weeks T.T.D., from February 22, 2017 through May 24, 2017.

L – NATURE AND EXTENT

When making the determination of permanent partial disability as related to Petitioner's injuries, the Arbitrator is to address five factors, pursuant to Section 8.1b(b) of the Workers' Compensation Act: "(i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records."

With regard to subsection (i) of Section 8.lb(b), the reported level of impairment pursuant to Section 8.1b(a), the Arbitrator notes that neither Party entered into evidence an impairment rating. Therefore, the Arbitrator gives no weight to this factor in determining PPD.

With regard to subsection (ii) of Section 8.lb(b), the occupation of the injured employee, Petitioner testified that he currently works for Chicago Extruded Metal doing less physical office work. The Arbitrator gives some weight to this factor in determining PPD.

With regard to subsection (iii) of Section 8.1b(b), the age of the employee at the time of the injury, Petitioner was 30 years old at the time of his work injury. Petitioner therefore has more work years in which he may experience the lingering effects of his injury than an older employee. The Arbitrator gives moderate weight to this factor in determining PPD.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, Petitioner testified that he was able to obtain new employment. Dr. Hsu released Petitioner to full duty work. Dr. Murtaza

released Petitioner with medium duty restrictions. No evidence was presented that Petitioner's future earnings capacity was diminished due to his work injury. The Arbitrator gives moderate weight to this factor in determining PPD.

With regard to subsection (v) of Section 8.lb(b), evidence of disability corroborated by the treating medical records, Petitioner testified that he experiences pain walking, bending, sitting and laying as he goes through his activities of daily living. He has decreased ability to lift. He experiences pain down both legs to his feet. He takes Advil and Ibuprofen for his pain complaints. The ION records of 8/3/2017 mildly support this testimony. The Arbitrator gives appropriate weight to this factor in determining PPD.

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 and after considering all of the evidence adduced, the Arbitrator finds that, as a result of the injuries sustained, Petitioner suffered permanent partial disability to the person as a whole to the extent of 4% loss of use thereof, pursuant to Section 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Baldock,
Petitioner,

vs. No. 16 WC 011597

Vandalia Correctional Center,
Respondent.

19IWCC0582

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that Petitioner failed to prove that he had suffered an accident that arose out of his employment and denied all benefits. The Commission majority affirms this finding but modifies the Arbitrator's Decision to reflect its conclusion that Petitioner's pre-existing knee condition was relevant to, but not dispositive of, the issue of whether Petitioner had proved that his alleged accident arose out of his employment with Respondent.

In this case, Petitioner failed to prove either an employment-related or increased neutral risk, and the Arbitrator properly concluded that the risk which caused Petitioner's injury was personal and non-compensable.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, finding that Petitioner failed to prove that his accident arose out of his employment with Respondent, filed April 6, 2018, is hereby affirmed with the above change.

19IWCC0582

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 25 2019

o-09/12/19
mp/dak
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Barbara N. Flores

Deborah L. Simpson

DISSENT

I respectfully dissent from the decision of the majority. I would have reversed the decision of the Arbitrator and found that Petitioner's injury arose out of his employment and resulted from an employment-related risk.

Pursuant to *McAllister v. Illinois Workers' Comp. Comm'n*, 2019 IL App (1st) 162747WC, and *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (1989), injuries from employment-related risks are compensable under the Act. Risks are employment-related when the employer instructs the employee to perform the task, when the employee has a common law or statutory duty to perform the act, or when the task is something the employee might reasonably be expected to perform incident to his assigned duties. *Id.* In this case, Petitioner was assigned to inspect the gym for contraband after the inmates had left. At the time of his injury he was inspecting the workout area of the gym while walking on a rubber mat and moving between various pieces of equipment. Petitioner testified that he was injured while taking a "side-step" to avoid a "heavy bag." The Arbitrator found Petitioner, a fifteen-year employee, "lacked veracity" because his incident reports and initial treatment records, while mentioning that he was injured when he took a "step," failed to mention the direction of his step was to the "side" and taken to avoid the "heavy bag." I disagree with the Arbitrator's finding. The fact that Petitioner's initial reports of injury were not as complete as later descriptions of the accident, is not, in my view, evidence of a lack of credibility. The various reports were not inconsistent. See *Posecion v. Sherman Hosp.*, 2009 Ill. Wrk. Comp. LEXIS 1203 and *Sinskis v. Southwest Airlines*, 2015 Ill. Wrk. Comp. LEXIS 1711. I would have found Petitioner's injury to have resulted from an employment-related risk. Under the facts of this case, I would have reversed the decision of the Arbitrator.

Therefore, I respectfully dissent from the decision of the majority.

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BALDOCK, JOHN
Employee/Petitioner

Case# **16WC011597**

SOI/VANDALIA CORRECTIONAL CENTER
Employer/Respondent

19IWCC0582

On 4/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.90% 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:

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

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

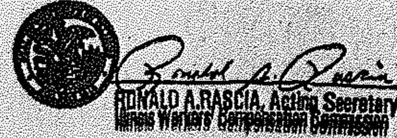
0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 6 - 2018



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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOHN BALDOCK
Employee/Petitioner

Case # **16** WC **11597**

v.

Consolidated cases: ______

STATE OF ILLINOIS/VANDALIA CORRECTIONAL CENTER
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **June 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 30, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**88,751.52**; the average weekly wage was $**1,706.76**.

On the date of accident, Petitioner was **45** 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 AND ALL** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment on January 30, 2016. All benefits are denied.

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

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

Signature of Arbitrator

April 5, 2018
Date

APR 6 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOHN BALDOCK
Employee/Petitioner

19IWCC0582

v. Case #: **16 WC 11597**

STATE OF ILLINOIS/VANDALIA CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On January 30, 2016, Petitioner was 45 years old, married, and had no dependent children. He testified he was employed by Respondent as a Correctional Lieutenant at Respondent's Vandalia facility and had been so employed since January 1, 2011. He has worked for Respondent at various correctional facilities since 1993. His primary job duties are to inspect all buildings and dormitories, supervise inmate movement, and oversee correctional staff. He testified that inspection of buildings required him to walk through and visually inspect every structure in the facility, including equipment, furniture, and fixtures, to ensure the safety of the staff and inmates. He primarily looked for things that had been tampered with or things that could be used as weapons. He walked through and inspected 13 buildings, which included prisoner dorms, the gym, and administration buildings. He testified that he would spend a total of three to four hours a day walking and about two hours a day standing while supervising the inmates and staff.

Petitioner testified that on the day of the accident, January 30, 2016, he arrived at work around 6:30 a.m. to start work at 7:00 a.m. He stated that his right knee felt fine that morning and he walked into work without a limp or any pain. His first task was to conduct roll call, which was a meeting with the correctional staff about inmate issues and scheduling. He then proceeded to a dorm, where he and other correctional officers transferred a group of inmates to the gym. While at the gym, Petitioner supervised the inmates for one hour. He then walked the group of inmates back to their dorm.

Petitioner testified that his next assigned duty was to walk back to the gym and visually inspect the building for anything missing or unusual. The path he took to the gym was the same general path he normally used. He entered through the sally port and turned left to go inspect the employee gym, the bathroom, and then the workout area of the building. The workout room floor was covered with rubber interlocking gym mats and filled with various lifting and workout equipment, as well as a heavy punching bag.

Petitioner testified that he stayed on the right wall, carefully looking for irregularities. He inspected this area very carefully and had to pay particular attention to the workout equipment or anything metal, as pieces could be used as weapons. He testified that he turned left at the back wall and walked towards the hanging heavy bag. As he approached the heavy bag, he was looking at the universal machine to his left and then went to his right to step around the heavy bag and go through about a three-foot space between the bag and the wall. As he planted his right foot, his right knee felt like it dislocated or buckled. He felt immediate pain and started to limp. He testified that he then turned to leave the gym and on the way out his knee gave out two more times—once while walking on the rubber flooring, and again when he was stepping off the rubber flooring onto the concrete floor. He then went back to the administration building to get off his knee, and did end up working the rest of his shift.

Petitioner testified that he had substantial difficulty walking after the incident and that several co-workers made comments to him about having to carry him to his car. He testified that he did not report the incident that day, as he hoped it would get better since he was off work the next two days. The next morning he could not walk on his right knee and used crutches he borrowed from his mother. The next day (Monday) he saw his primary care physician, Dr. Goggin, who obtained an MRI and eventually referred him to Dr. Rick Wright. Dr. Wright ultimately diagnosed an ACL tear and a medial meniscus tear, and performed surgery on February 23, 2016. Following surgery, Petitioner underwent physical therapy and was off work until April 6, 2016.

Petitioner candidly testified that he had prior injuries to his right knee. His original injury was in the 1990's when he was in the military. After he got out of the military he had his first surgery, by Dr. Bonutti, for an ACL deburring and a medial meniscectomy. In 2004, he had his second surgery, by Dr. Penn, for a medial meniscectomy. In addition, in 2012 he had two Kenalog injections by Dr. Goggin, and a third Kenalog injection in 2013. He believed his diagnosis in 2012-2013 was arthritis in the knee. His symptoms during that time were stiffness and swelling with prolonged standing or overstressing of the knee. Petitioner testified that, although the record from Dr. Goggin states he was being referred to an orthopedic surgeon in 2015, he did not see a specialist at that time.

Petitioner testified that the symptoms he experienced in the past were different from the symptoms he experienced following the incidents at work on January 30, 2016. Following the incidents, he could not walk, and the stiffness and swelling greatly increased. In addition, he testified that he had never had the dislocating type sensation he experienced that day. He testified that since his surgery in 2016 he feels better. He still has "some of the arthritic type stuff" but the ACL is better and he is able to walk. He still has stiffness and swelling after he has been on his feet for a prolonged period or has overstressed his knee.

Petitioner testified that he attended an IME with Dr. James Williams, and discussed with him his prior knee injuries and surgeries. He acknowledged that he did not advise Dr. Williams of his prior injections, but testified he was not attempting to hide the information. He acknowledged that he told Dr. Williams he had not had any significant knee injuries, but testified that he was referring to any incident in which he was completely incapable of walking.

On cross-examination, Petitioner reviewed Respondent's Exhibit 1, page 1 (Employee's Notice of Injury) and acknowledged that he had completed the form on February 1, 2016. He agreed that as to the question of how the injury occurred, he wrote "while walking thru gym". He also agreed that as to the question of describing the injury, he wrote "Rt. Knee buckled/twisted". Petitioner reviewed Respondent's Exhibit 9, Incident Report, and acknowledged that he completed the form on Monday, February 1, 2016. He agreed that he stated he "was touring the gym area and took a step and felt my knee buckle". Petitioner conceded that on neither report did he mention anything about the heavy gym bag or doing a side step around any object.

Petitioner was asked about the history recorded by Dr. Goggins on February 1, 2016, *to wit*, "He was standing at work and his knee turning and appeared to pop out of place then went back into place. After that he started to have a lot of pain and swelling." Petitioner denied that he told Dr. Goggins that he was just standing and his knee popped out.

Petitioner was asked about the history recorded by Dr. Wright that he "acutely injured his right knee on January 30 when he was walking" and felt the knee buckle. Petitioner conceded that he did not mention anything about the heavy bag or doing a side step.

Petitioner was asked to review Arbitrator's Exhibit 2, the Application for Adjustment of Claim signed April 5, 2016. He acknowledged that the history of the accident on the Application was, "walking in gym, side stepping heavy bag".

Petitioner testified that on the date of the incident he took his normal route, there was nothing out of the ordinary, and there was no defect in the gym floor. He noted that he goes past the heavy bag every time he is in the gym, but did not necessarily always take a step to the right or the left around the bag.

Petitioner acknowledged he had an arthritic right knee and that it would flare up occasionally. He agreed he had treated with Dr. Penn in the past. He did not dispute Dr. Penn's note from June 2006 (PX3), wherein Dr. Penn stated he had talked to Petitioner "at length in the past and again about the likelihood of him needing a knee replacement on down the road", as well as viscosupplementation injections.

Pre-Accident Medical

Regarding his prior right knee issues, Petitioner testified he first hurt his knee in the military in the early 1990's and had to have a medial meniscectomy and ACL debridement in about 1994 by Dr. Bonutti. On November 19, 2003, he presented to Dr. Timothy Penn and reported he had struck the outer portion of the right knee one month prior while participating in martial arts, and had experienced swelling since that time. MRI showed moderate degeneration and tear of the medial meniscus. PX3. After an injection and several follow up appointments, Petitioner underwent surgery by Dr. Penn on June 3, 2004. Surgery consisted of arthroscopy, partial medial meniscectomy, and anterior compartment patellar chondroplasty. Postoperative diagnosis was medial meniscal tear with patellofemoral degenerative arthritis. PX7.

Petitioner returned to Dr. Penn on June 8, 2006, and reported he had persistent pain in his knee since the time of his second surgery. Dr. Penn noted there were arthritic issues in his knee. He also noted, "I have talked to him at length in the past and again about the likelihood of him needing a knee replacement on down the road, which may not have occurred had he not had the initial injury 14 or 15 years ago." He recommended anti-inflammatory medications and glucosamine/chondroitin sulfate and stated, "At some point down the road, he may wish to try Viscoat supplementation." PX3.

Dr. Goggin's records span from February 5, 2009, through March 11, 2016. On February 5, 2009, Petitioner's main complaint was sinus problems, but he also reported chronic right knee pain, for which the doctor diagnosed him with arthritis. On April 5, 2012, Petitioner presented for an immunization shot and also reported right knee pain. On April 19, 2012, Petitioner's chief complaint was dizziness, but he also received a Kenalog injection into the right knee. On September 19, 2012, Petitioner's chief complaint was right knee pain. He was given a second Kenalog injection. He returned to Dr. Goggin on November 12, 2012, and received a third Kenalog injection. The diagnosis was again arthritis. On May 6, 2013, Petitioner once again received a Kenalog shot in the right knee. On January 5, 2015, Petitioner presented to Dr. Goggin with right knee pain, which he stated had been getting worse over the last two years. An x-ray was taken and he was referred to an orthopedic doctor. Petitioner testified that he did not see an orthopedic doctor at that time, because he was experiencing mainly swelling and pain with overactivity. Petitioner felt this was just his arthritis acting up and it was something he could live with. PX1, RX4. The Arbitrator notes this is the final treatment record from Dr. Goggin until February 1, 2016, two days after the incident at work.

Post-Accident Medical

On February 1, 2016, Petitioner completed an Employee's Notice of Injury. He noted he had not reported the incident when it occurred on January 30 because he "thought it was just a simple twist" of the knee. As to the duty he was performing at the time of injury he stated, "touring the inmate gym area". He indicated that the injury occurred "while walking thru gym" and his description of injury was "right knee buckled/twisted". Petitioner also completed an Incident Report that day and stated he was "touring the gym area and took a step and felt my right knee buckle". RX1. **The Arbitrator notes there is no reference to the presence of a heavy bag or sidestepping around such bag in relation to the onset of Petitioner's symptoms.**

On February 2, 2016, Shift Supervisor Joseph Pruett completed a Witness Report and indicated that on January 30 he observed Petitioner stumble in the gym and thereafter began limping as he was walking. He asked Petitioner if he needed to go to the Health Care Unit, but he declined and advised the would just sit down for a few minutes. Mr. Pruett saw Petitioner towards the end of the shift and again asked if he was alright, and he advised he was off for the next two days and would just rest. That same day, David Simmons completed a Witness Report and indicated that on January 30 he observed Petitioner "walking in the gym when it appeared that his right knee buckled" and thereafter he limped out of the gym. RX1. **The Arbitrator notes that neither co-worker made any reference to the presence of a heavy bag or Petitioner sidestepping around such bag in relation to the onset of his symptoms.**

Following the incident at work, Petitioner presented to Dr. Andrew Goggins, his primary care physician, on February 1, 2016. The reported history is as follows: "He was standing at work and his knee turning and appeared to pop out of place then went back into place. After that he started to have a lot of pain and swelling. He has been using crutches to take the weight off of it." On examination, there was right knee swelling, decreased range of motion, and positive anterior drawer test. Impression was right knee injury and possible acute ACL tear. Dr. Goggins noted, "History consistent with workplace injury." He recommended an MRI, an orthopedic referral, and continued non-weightbearing. PX1, RX4. **The Arbitrator notes there is no reference to the presence of a heavy bag or sidestepping around such bag in relation to the onset of Petitioner's symptoms.**

On February 2, 2016, Petitioner underwent a right knee MRI. It revealed: (1) large joint effusion; (2) small popliteal cyst; (3) "chronic" ACL tear; (4) "chronic" medial meniscus tear; and (5) degenerative joint disease. PX5.

On February 8, 2016, Petitioner returned to Dr. Goggin, who noted that the MRI showed a chronic ACL tear and other areas of damage. He recommended Petitioner keep his appointment with Dr. Ungata, and deferred to him regarding the knee. PX1, RX4. The Arbitrator notes that Petitioner testified he never saw Dr. Ungata.

On February 17, 2016, Petitioner presented to Dr. Rick Wright at Washington University, upon referral by Dr. Goggin. He completed a patient intake/orthopedic history form and indicated he was being seen for recent right knee injury and chronic knee pain. As to what started the pain or problem, Petitioner wrote "knee (rt) buckled twice while taking a step". Dr. Wright took a history from Petitioner and noted, "45-year old male who acutely injured his right knee on January 30 when he was walking. He felt the knee buckle and had immediate swelling and pain. Was atraumatic." Dr. Wright further noted Petitioner's long-standing history of knee pain, his three surgeries, and his injections in 2014 which reportedly did not help. Examination showed effusion, reduced range of motion, positive Lachman's, guarded pivot shift test, and medial joint line tenderness. X-rays showed mild medial compartment osteoarthritis. Impression was chronic ACL tear and acute medial meniscus tear with displacement into the intercondylar notch. Dr. Wright recommended arthroscopic partial medial meniscectomy and ACL reconstruction with bone patella tendon bone autograft. PX2, PX6. **The Arbitrator notes that neither Dr. Wright's history nor, more telling, Petitioner's history on the intake form contain any reference to the presence of a heavy bag or sidestepping around such bag in relation to the onset of Petitioner's symptoms.**

On February 23, 2016, Petitioner underwent arthroscopic surgery by Dr. Wright. Surgery consisted of: (1) partial medial meniscectomy; (2) patellar chondroplasty; and (3) anterior cruciate ligament reconstruction using autologous bone-patella-tendon-bone autograft with two screws. Postoperative diagnosis was ACL tear, medial meniscus tear, and patellar chondral injury. PX8.

On February 25, 2016, Petitioner presented to Phoenix Physical Therapy for an initial evaluation. The history recorded was that he had an injury to his right knee on January 30, 2016, when "the knee buckled twice while walking at work". **The Arbitrator notes there is no**

reference to the presence of a heavy bag or sidestepping around such bag in relation to the onset of Petitioner's symptoms. Petitioner underwent physical therapy on a consistent basis through May 23, 2016. PX9.

Petitioner followed up postoperatively with Dr. Wright on March 7, April 4, and May 5, and had an uneventful postoperative recovery. He was last seen by Dr. Wright on August 15, 2016, and it was noted that he was doing well with no complaints. He was instructed to continue to ice and elevate his knee to control swelling. He was released to unrestricted sport and work activities and released from care at that time. PX2.

On April 5, 2016, Petitioner signed the Application for Adjustment of Claim. As to how the accident occurred, he stated, "walking in gym, side stepping heavy bag". AX2. **The Arbitrator notes this is the first reference to the presence of a heavy bag or sidestepping around such bag in relation to the onset of Petitioner's symptoms.**

On February 27, 2017, Petitioner was evaluated by Dr. James Williams, Respondent's Section 12 examiner. Dr. Williams indicated the following history, as provided by Petitioner: "He was walking through the gymnasium and as he stepped to the right to avoid a hanging heavy bag, he felt a shift in his right knee that was obviously not normal. He did not fall to the floor, but could tell that his knee moved in a way that was unusual. It wasn't particularly painful, so he continued to walk on, but within about a minute he experienced a similar shifting in his knee when he stepped from one surface to another in the gymnasium." RX7.

In addition to obtaining a history, Dr. Williams conducted a thorough physical examination, reviewed current and past medical records, and reviewed injury and witness reports provided by Respondent. Dr. Williams opined that Petitioner sustained a new right medial meniscus tear as a result of the incident at work on January 30, 2016, and that he had a chronic ACL tear that likely contributed to the meniscal tear but which was not causally related to the incident at work. He noted that the lack of an intact ACL explained why Petitioner's medial meniscus could tear by simply walking at work. Dr. Williams opined that Petitioner reached maximum medical improvement on August 15, 2016. He assessed a 0% AMA rating, noting that the current injury resulted in a 2% impairment rating, but that Petitioner had already sustained a 2% rating from his prior injuries and that apportionment was appropriate in this case given his two prior meniscus tears. RX7.

Dr. Williams testified by way of deposition on May 11, 2017. He is Board Certified in Physical Medicine and Rehabilitation. He testified consistent with his report. Dr. Williams testified that immediately prior to the incident at work, Petitioner had an already abnormal medial meniscus and ACL, by virtue of his prior injuries and surgeries and arthritis. Specifically, his meniscus was not as thick or smooth as would be a normal meniscus, and he had more arthritis than was normal for someone of his age. Further, his ACL was likely either completely torn or almost completely torn, given the MRI findings and the radiologist's characterization of a "chronic ACL tear". RX8.

Dr. Williams testified that the "knee shifting" that Petitioner described was either the tear of the meniscus itself or the torn meniscus irritating his knee and then causing swelling. He noted

that walking with an incompetent ACL could cause a meniscus tear simply from a relatively minor force on the knee from the way in which Petitioner was walking, which he described as minor physical activity of normal walking. Dr. Williams testified that Petitioner described that he was simply walking normally and did not do anything in particular. He noted, "[T]he comment about walking around the heavy bag was almost like an offhand comment or, you know, he says as if he was trying to find some reason to explain why it happened at that moment. He said, 'I was just— just walking around it'. It wasn't anything that was violent or sudden or anything that—that he was doing that was out of the ordinary. He was just simply walking." RX8.

On cross-examination, Dr. Williams agreed that it was "reasonable to say" that in 2006 Petitioner did not necessarily have ACL insufficiency. With regard to the AMA impairment rating, Dr. Williams explained the process in detail as to how he arrived at the rating, and then how he arrived at the apportionment, to yield a final rating of 0%. RX8.

CONCLUSIONS OF LAW

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

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

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483 (1989).

There is no dispute that Petitioner's injury occurred in the course of his employment. He was performing his job duties of walking through the gymnasium when his knee buckled. The issue is whether his injury arose out of his employment.

An injury "arises out of" one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work or that he or she is exposed to the risk of injury to a greater degree than the general public. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 45 (1987). There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill.App.3d 149, 162 (1st Dist. 2000).

Petitioner attempted to establish that his injuries were the result of an employment related risk, *to wit*, having to sidestep around a heavy bag that was in his path in the gymnasium. In this endeavor, however, Petitioner failed. The Arbitrator finds significant and dispositive that the record is completely void of any mention of sidestepping around this bag until Petitioner filed his Application for Adjustment of Claim, more than two months after the incident. He filled out two injury reports two days after the incident and made no mention of the bag. Neither of the witness reports mentioned the bag. Petitioner provided a history of injury to all of his medical providers, including Dr. Goggins, Dr. Wright, and Phoenix Physical Therapy, and made no mention to any of them of sidestepping around the bag when his knee buckled. Given the critical void in the record, the Arbitrator finds Petitioner's assertion that his knee buckled as a result of sidestepping around the heavy bag to be lacking in veracity.

The Arbitrator finds that Petitioner's injuries were not the result of an employment related risk, nor a neutral risk. Rather, his injuries were the result of a personal risk. The record clearly established that Petitioner had extensive pre-existing problems with his right knee. Further, the record clearly established that his knee buckled as he was simply walking through the gymnasium of Respondent's facility. There was no evidence of any defect in the gym floor or anything out of the ordinary. Dr. Williams testified that the "knee shifting" that Petitioner described was either the tear of the meniscus itself or the torn meniscus irritating his knee and then causing swelling. He noted that walking with an incompetent ACL could cause a meniscus tear simply from a relatively minor force on the knee from the way in which Petitioner was walking, which he described as minor physical activity of normal walking. Although Dr. Williams referenced Petitioner sidestepping around the heavy bag, such reference was premised upon the accuracy of the history that such activity occurred, and the Arbitrator has found that it did not.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident on January 30, 2016, that arose out of and in the course of his employment with Respondent. All other issues are rendered moot and the Arbitrator makes no findings regarding same. All benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Soule Jojo Njonkou-Sany,

Petitioner,

vs. NO: 15 WC 24406

Gate Gourmet, Inc.,

Respondent.

19IWCC0583

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice provided to all parties, the Commission after considering the issues of causal relationship, medical expenses and permanent partial disability benefits and being advised of the facts and the law modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Maximum Medical Improvement

The Commission notes, "The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized. [citations omitted]." *Mechanical Devices v. Industrial Commission (Johnson)*, 344 Ill. App. 3d 752, 760, 800 N.E.2d 819 (2003). The Commission affirms the Arbitrator's finding Petitioner reached maximum medical improvement on August 14, 2015. Dr. Sisson released Petitioner to return to work without restrictions on that date. RX4. Petitioner testified he returned to work for Respondent working light-duty for one week with a return to his regular job duties, thereafter. T. 41. Petitioner testified he continued working his regular job duties until the time of the arbitration. T. 42. On May 4, 2016, Dr. Wehner evaluated Petitioner pursuant to Section 12 of the Act and opined Petitioner reached maximum medical improvement on August 14, 2015. RX6.

Medical Expenses

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981).

The Commission finds Respondent is liable for the following medical bills:

-PX2: City of Chicago ambulance bill D/S 8-9-15: $1,002.00 charged.
-PX4: Presence Resurrection Medical Center ER D/S 8-9-15: $2,417.00 charged.
-PX4: Midwest Imaging D/S 8-9-15 x-ray readings: $97.00 charged.
-RX7: US Health Works D/S 8-10-15: $272.11 charged; 8-14-15: $97.84 charged.

The above medical bills total $3,885.95. The Commission awards the bills pursuant to Sections 8(a) and 8.2 of the Act. Respondent is entitled to a Section 8(j) credit in the amount of $1,697.41. The Commission affirms the Arbitrator's finding that medical services after August 14, 2015 were neither reasonable nor necessary and affirms the denial of medical expenses for Advanced Physical Medicine (Dr. Goldvekht) and Pain Specialists (Dr. Glasser), based on the opinions of Dr. Wehner. RX6.

Nature and Extent of Permanent Disability

Pursuant to Section 8.1b of the Act, the Commission weighs the following five factors accordingly (*820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101):

Section 8.1b(b)(i) – level of impairment

Although Dr. Wehner opined that according to AMA guidelines there is a zero percent (0%) impairment rating for these soft tissue injuries, the Arbitrator found she failed to include the evaluation required by Section 8.1b(a) and, therefore gave no weight to this factor. The Commission affirms the Arbitrator's finding and assigns no weight to this factor.

Section 8.1b(b)(ii) – occupation of the injured employee

The record evidences Petitioner's occupation at the time of his August 9, 2015 accident was Ramp Agent for Respondent. After working light duty for a week following his accident, Petitioner returned to his usual and customary position. The Arbitrator gave this no weight. The Commission finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 53 years-old at the time of his August 9, 2015 injury. The Arbitrator gave this factor no weight. The Commission observes Petitioner has a lesser work life expectancy which will require him to manage the effects of his injury for some period of time. The Commission finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner returned to work in the same position and earning the same or more than prior to the injury. The Arbitrator noted there is no evidence that his future earning capacity was impacted as a result of his injury. The Commission affirms the Arbitrator's finding and assigns no weight to this factor.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

According to the medical records, an ambulance arrived immediately after the August 9, 2015 accident. The Chicago Fire Department ambulance report evidences Petitioner reported that after the jet blast, he hit his right cheek and left hand and complained of face/right cheek pain and left wrist pain. Petitioner denied any neck or back pain. Petitioner reported his left wrist hurt, but he was able to move it. He was transported to Resurrection Hospital ER. PX1.

The medical records of Presence Resurrection Medical Center evidence Petitioner was seen in the ER on August 9, 2015 by Dr. Bordo. The following history was noted: "He was on the jet way restocking the plane when another passing jet delivered a jet blast which caused him to fall forward onto the jet door and onto the ground. He did not fall down a significant height. Struck his left wrist against the door and his right chest against the ground. He did not have any significant head trauma. He did not pass out. He does not complain of headaches, nausea or vomiting. He has no difficulty breathing. He has no numbness, tingling or weakness." On examination, Dr. Bordo found Petitioner's head without obvious abnormality; his neck was supple and there was no goiter; his cervical spine was without tenderness, step-off or deformity to palpation; his back had no CVA tenderness; there was no tenderness or deformity of the chest wall; the extremities were normal, atraumatic with no cyanosis or edema. Left wrist x-rays evidenced no gross left wrist acute bony trauma or obvious focal bony abnormalities. Chest x-rays evidenced both lungs were clear without signs of active intrathoracic disease. After reviewing the x-rays, Dr. Bordo's assessment was fall, left wrist and chest wall contusion. Dr. Bordo released Petitioner to return to work the following day with restrictions of no or limited use of the left hand. Petitioner was discharged with a diagnosis of contusion of the chest wall and contusion of the left wrist and instructed to use ice and heat. Petitioner was to call orthopedic specialist, Dr. Mahr, for an appointment. PX3.

The medical records of US Health Works evidence Petitioner was evaluated on August 10, 2015 by Dr. Sisson. The following history was noted: "He states that he was standing in an aircraft doorway servicing that aircraft when a jet blast from another aircraft blew him over slamming his chest into the door frame and his left hand into a bulkhead at 9:43 AM, on August 9, 2015." There was no mention of hitting his head or face. Dr. Sisson noted the ER visit and x-ray results. The following was noted: "He now complains of pain in his left wrist and bilateral chest wall. He denies any type of head injury. There was no neck pain nor loss of consciousness involved." On examination, Dr. Sisson found chest wall tenderness over the bilateral ribs at the levels of T8 to T10; normal chest wall excursion; lungs were clear bilaterally; there was no external evidence of trauma to the chest wall. Cardiovascular examination was normal. Petitioner's left wrist had full range of motion with minimal complaints of discomfort at the extremes of flexion and extension; ulnar ward and radial ward deviation were without discomfort; there was some tenderness to palpation over the extensor retinaculum; there were no gross nerve, vessel, nor tendon deficits detected. Dr. Sisson's impression was 1) Left wrist strain; 2) Contusion of the chest wall. Dr. Sisson opined Petitioner was able to perform his regular duties. Dr. Sisson instructed Petitioner to use ice and heat for 20 minutes each four times a day and provided him a hot/cold pack. Petitioner was given a wrist wrap and instructed to use it at all times except to sleep and bathe. Ibuprofen was prescribed. Dr. Sisson opined these injuries should not represent long-term disabilities. Dr. Sisson released Petitioner to return to work that day with no restrictions. In an Employee Work Status Report dated August 14, 2015, Dr. Sisson noted Petitioner may return to work that day with no restrictions. Petitioner was to continue ice and heat, Ibuprofen as directed and use the wrist wrap. No follow-up appointment was scheduled. RX4.

The Commission finds the above weighs in favor of an increased permanence.

Based on the above factors and the record in its entirety, the Commission finds Petitioner sustained permanent disability of the person as a whole to the extent of 2.5% pursuant to Section 8(d)2 of the Act.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's April 2, 2018 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $3,885.95 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 Respondent shall be given credit in the amount of $1,697.41 and Respondent shall hold Petitioner harmless from any claims

from any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner claim for medical expenses for Advanced Physical Medicine (Dr. Goldvekht) and Pain Specialists (Dr. Glasser) is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $355.15 per week for a period of 12.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 2.5%.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,700.00. 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:
LEC/maw
o08/28/19
43

L. Elizabeth Coppoletti

Stephen J. Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NJONKOU-SANY, SOULE JOJO Case# **15WC024406**
Employee/Petitioner

GATE GOURMET INC
Employer/Respondent

19IWCC0583

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5094 SKLARE LAW GROUP
MICHAEL TRYBALSKI
20 N CLARK ST SUITE 1450
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
GLENN A BLACKMON
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Soule Jojo Njonkou-Sany
Employee/Petitioner

v.

Gate Gourmet, Inc.
Employer/Respondent

Case # **15** WC **024406**

Consolidated cases: ____

19IWCC0583

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **January 24, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 9, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**30,779.63**; the average weekly wage was $**591.91**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services, to which he is entitled.

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 $**1697.41** under Section 8(j) of the Act.

ORDER

CREDITS: Respondent shall be given a credit of $1697.41 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8 (j) of the Act.

MEDICAL BENEFITS: Respondent shall pay for all reasonable and necessary medical services, pursuant to the fee schedule, for all medical services provided by the Chicago Fire Department, Resurrection Hospital, and U.S. Health Works incurred by Petitioner prior to August 15, 2015, if any remain unpaid. All other medical services and their respective charges are denied as not causally related.

TEMPORARY TOTAL DISABILITY: Because there was no time after the injury that Petitioner was totally incapacitated and unable to return to work, temporary total disability is denied.

PERMANENT PARTIAL DISABILITY:

With regard to subsection (i) of Section 8.1b(b), this Arbitrator notes the record contains an impairment rating of 0% as determined by Dr. Julie Wehner. This Arbitrator notes she failed to include the evaluation required by Section 8.1b(a). Because of this, this Arbitrator gives no weight to this factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the record reveals petitioner was employed as a Ramp Agent at the time of the accident and he was able to return to work immediately in his prior capacity as a result of said injury. This Arbitrator gives no weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), this Arbitrator notes that Petitioner was 53 years old at the time of the accident, because he had full range of motion of his left wrist and minimal complaints of discomfort and was moving freely without pain, this Arbitrator gives no weight to this factor.

With regards to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, this Arbitrator notes there is no evidence Petitioner suffered a diminishment in earnings capacity due to the accident. Because of that, this Arbitrator gives no weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, there is none. Because of this, this Arbitrator gives no weight to this factor.

Based on the above factors, and the record taken as a whole, this Arbitrator finds Petitioner sustained no permanent partial disability as a result of the accident of August 9, 2015.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 29, 2018
Date

APR 2 - 2018

Soule Jojo Njonkou-Sany v. Gate Gourmet, Inc., No. 15 WC 024406

Findings of Fact

Soule Jojo Njonkou-Sany (Petitioner), a 53 year old male, was working for Gate Gourmet, Inc. (Respondent) as a Ramp Agent at Chicago O'Hare Airport on August 9, 2015. A Ramp Agent caters an airplane, restocking food and beverages, and related supplies from and to aircraft parked at the gates. This is a fairly labor intensive job, lifting up to 75 pounds, standing or walking most of the day, and operating in hot and cold environments. That day, Petitioner was servicing an airplane at Gate G-18. Petitioner was walking to the aircraft when a jet blast from another airplane at the adjacent Gate, G-20, that was turning to leave the gate, hit him. Petitioner testified he was knocked into the airplane door, and dropped inside the door falling on his left hand. Soule Jojo Njonkou-Sany, No. 15 WC 024406 Transcript of Proceedings on Arbitration at 8-10, 12, 13, 33, 85; Petitioner's Exhibit 1 (unpaginated); Petitioner's Exhibit 11 (unpaginated).

Petitioner, at various times, and to various medical personnel, said he hit his right cheek and left hand on the plane; struck his left wrist against the door and right chest on the ground; slammed his chest into a door frame and left hand into a bulkhead; struck the door and struck the ground; and was knocked forward into the aircraft. Petitioner's Exhibit 1; Petitioner's Exhibit 3 at 11 (pages 5, 11, 13, 14, 23, and 26 are improperly accentuated in yellow highlighter and such are ignored by the Arbitrator); Petitioner's Exhibit 4 (unpaginated); Petitioner's Exhibit 5 at 4; Respondent's Exhibit 5 at 1.

Chicago Fire Department responded to the scene at 9:51 a.m. They found Petitioner walking around. Petitioner told them he had not lost consciousness and did not have neck or back pain. He said his left wrist hurt and had face pain. He was taken to Resurrection Hospital. Petitioner testified he was questioned in the ambulance on the way to the hospital, and gave an account of his injury. Petitioner's Exhibit 1; Petitioner's Exhibit 3 at 5, 23; Sany at 18, 36-37.

Petitioner was admitted to Resurrection Hospital at 10:30 a.m. He testified he had no problem communicating and answered questions the doctor asked him. There is no documentation in the hospital records of complaints made by Petitioner, nor anything in the notes of his general appearance, except a notation there was aching pain in his left wrist of 3/10. X-rays of Petitioner's chest and left wrist were negative. Petitioner was diagnosed with contusion of the chest wall, contusion of the wrist, and unspecified essential hypertension. He was given no medication and told to follow up as needed. A Treatment and Work Status Report indicated he could return to work August 10, 2015, with "No/Limited" use of the left hand. He was told to use ice/heat and there diagnosed with a left wrist contusion. He was referred to a Dr. Mahr, an ortho specialist, and instructed to call for an appointment as needed. Petitioner was discharged home at 12:12 p.m. Petitioner testified he went home and went to work the next day. Sany at 20, 37; Petitioner's Exhibit 3 at 5, 10, 14-16, 26, 34.

Petitioner completed an Employee Incident Investigation form, but the detailed description of the incident is indecipherable. Petitioner's Exhibit 11; Respondent's Exhibit 1.

That next day, August 10, 2015, Petitioner testified his employer sent him to U.S. Health Works, where he saw Dr. Alan Sisson. Petitioner complained of pain in his left wrist and chest wall. There was no neck pain or external evidence of trauma to the chest wall. Petitioner had full range of motion to his left wrist and minimal complaints of discomfort. Dr. Sisson's impression was a strain of his left wrist and contusion to the chest wall. Sisson said Petitioner could perform his regular duties, was to use a hot/cold pack four times a day, use a wrist wrap, and to come back for a follow up in two weeks. Petitioner was given 40, 200mg ibuprofen tablets. At the follow up visit Petitioner was returned to work without restrictions and told to continue the use of the wrist wrap and ibuprofen. Sany at 20, 39; Respondent's Exhibit 4 (unpaginated). There was no referral by U.S. Health Works to any other medical provider.

Petitioner has a personal physician, Dr. Anderson Amber, but has never seen him regarding the accident. Petitioner testified he has never missed work because of the accident. He said he worked light duty inside a warehouse for a week, then went back to servicing aircraft. At trial he testified he works the same job, same hours, and overtime when requested. Brian Rosel, a supervisor of Petitioner, testified that after the accident, nothing changed about Petitioner's duties, he worked the same job, same hours, and was paid the same wage. He said Petitioner is now making more in his hourly wage. Sany at 27, 41-42, 59, 62, 87, 90.

Despite the physicians at Resurrection Hospital and U.S. Health Works indicating Petitioner could return to work; Petitioner's return to work; the absence of any diagnosis other than a strain and a contusion; the lack of prescription medication; the lack of referral to any other medical provider by U.S. Health Works; and the lack of follow up with Dr. Mahr, Petitioner testified he began treating at Advanced Physical Medicine 11 days after the accident. It is of note that the Petitioner did not testify why he sought this treatment, or if he had complaints of pain or other medical conditions at the time. He did not even know what kind of a doctor the doctor who treated him at Advanced Physical Medicine was. Petitioner said someone told him to go there but he can't remember who. He denied it was his attorney. However, the records of Advanced Physical Medicine show the bills were not sent to Petitioner's home address, but to a post office box with a different zip code. Moreover, the bills from Preferred Open MRI indicate on an information sheet "RonSklare/Working." Also, when the Petitioner submitted to an independent medical examination, he told that physician his attorney referred him to Dr. Goldvekht. Sany at 20-21, 47, 55-56; Petitioner's Exhibit 6 (unpaginated); Petitioner's Exhibit 9 (unpaginated); Respondent's Exhibit 5 at 1. It would not be unreasonable to be skeptical that the subsequent medical treatment was reasonable and necessary.

Petitioner began treating at Advanced Physical Medicine with Dr. Aleksander Goldvekht. There is nothing in the record that speaks to the qualifications or expertise of Dr. Goldvekht. The records of Goldvekht have several inconsistencies, referring to Petitioner as "she," and notations that the patient is "heling." In the initial evaluation of Petitioner, on August 20, 2015, Goldvekht noted Petitioner was prescribed medication at Resurrection. That is not true, no medication was provided Petitioner. He noted Petitioner was experiencing pain in his neck, mid

and lower back, rib cage, left wrist and face. This was a vast expansion of symptoms from Petitioner's treatment at Resurrection and U.S. Health Works. Goldvekht assessed Petitioner with: cervical discogenic pain; lumbar discogenic pain; sprain strain thoracic spine, rib cage contusion, and left wrist sprain. Even though, by that time, Petitioner was back to work at full duty, Goldvekht said Petitioner's condition still remained guarded at that time. That is not a medical term and is undefined. Sany at 41; Petitioner's Exhibit 3 at 7; Petitioner's Exhibit 5 at 4, 6, 7.

Goldvekht's plan was medication, physical therapy, and an MRI. Petitioner saw Goldvekht four times between August 20, 2015, and October 29, 2015. The assessment and plan remained the same. Goldvekht said Petitioner should remain off work, even though he was working full duty, and referred Petitioner for pain management. Petitioner's Exhibit 5 at 4-7. The MRI, referred by Dr. Goldvekht, was performed at Preferred Open MRI on October 22, 2015. The impression of the unknown radiologist was: multilevel spondylosis causing neural foraminial narrowing; multilevel disc bulges causing mild to moderate stenosis from L3-S1; disc bulges narrowing the bilateral neural foraminial and impinging the exiting nerve roots at all levels; heterogeneous signal in the vertebral bodies suggest osteoporotic changes; disc herniations as outlined above, which likely impinges the exiting nerve roots; minimal straightening as mentioned above; no evidence of fracture or dislocation; and Schmori's node formation in the T 12 vertebral body, with 50% loss of height. The results were noted in Dr. Goldvekht's records, but they were not completely reflected as made by the radiologist. Petitioner's Exhibit 5 at 7; Petitioner's Exhibit 9 (unpaginated). As a result of an independent medical examination of Petitioner by Dr. Julie Wehner, who reviewed the MRI, she concluded the MRI was grossly overread and should not have any medical weight. She said there was no disc herniation and minimal degenerative changes. Wehner said the MRI showed a long standing mild degenerative process, the other levels were normal with no bulging discs, and other findings suggest osteo porotic changes. She found the MRI completely normal for Petitioner's age and the radiologist misrepresented the findings. Respondent's Exhibit 6 at 2, 3.

Petitioner had two visits with Dr. Scott Glasser at Pain Specialists of Greater Chicago, on November 3, 2015, and November 24, 2015. Glasser, apparently without explanation, on his own gave Petitioner a disability score of 49/100, assessing him with: cervical radiculopathy, facet synd w/o myelop, cervical facet synd w/o myelop, thoracic, facet synd w/o myelop, lumbar, and lumbar radiculopathy. In an entry which indicates Glasser's foray into advocacy, and seemingly runs afoul of Section 16, he noted, "We discussed the interventional treatment of the spinal joints injured in the work accident which caused the acute disc injuries seen on the MRI." Glasser performed bilateral facet joint injections on Petitioner. By then Petitioner had been back to full duty nearly three months. Petitioner's Exhibit 5 at 15, 17, 19.

Petitioner also took part in 17 physical therapy visits between August 27, 2015, and April 2, 2016. He was assessed by the physical therapist with traumatic soft tissue injuries, loss of function, ROM and strength, muscle tone, and poor endurance. Petitioner was working full duty at the time. The treatment provided consisted of manual therapy, therapy exercises, EMS, US, heat/cold, mobility, strength, transfers, posture, and HEP. When Petitioner was asked by Dr.

Wehner why he needed physical therapy, he said he was not sure why. Petitioner's Exhibit 5 at 8, 10-14; Respondent's Exhibit 6 at 3. There appears to be no documentation of progress or resolution of Petitioner's condition.

Petitioner testified his last visit to a doctor was November 24, 2015, his last treatment was two weeks after his injection of November 10, 2015. He said after that last visit he was not feeling much better, with pain when he turned his head, he takes it easy and goes slow. Sany at 23, 25, 26.

About nine months post accident, on May 4, 2016, Petitioner submitted to an independent medical evaluation by Dr. Julie Marie Wehner, Board Certified in Orthopaedic Surgery. At that examination, Wehner took a history from Petitioner, reviewed his medical records from Resurrection Hospital, U.S. Health Works, and Advanced Physical Medicine, reviewed the MRI and disc, and conducted a physical examination. Petitioner told Wehner he continued to work full duty, sometimes a double shift. He appeared in no distress, and moved freely without pain. Petitioner freely moved his head and neck. Petitioner could turn his head, during examination, without difficulty. Wehner said the diagnosis of the injury of August 9, 2015, would have been right chest wall contusion and left wrist sprain. Petitioner, said Wehner, required no further medical treatment and should have reached MMI by August 10th or 14th when sent back to work and discharged by U.S. Health Works without restrictions. Wehner found no reason why Petitioner could not return to work after his ER visit and no reason why Dr. Goldvekht recommended taking Petitioner off work. Goldvekht's treatment of Petitioner, said Wehner, was not medically necessary or reasonable for treatment of the accident, nor were the injections, or MRI. She was especially critical of the inconsistent locations of pain throughout Petitioner's medical records and noted the recorded complaints were not verifiable. There was no documentation, said Wehner, of neck, thoracic, or lower back pain until Goldvekht started treating Petitioner. Respondent's Exhibit 6 at 1-4; Respondent's Exhibit 5.

In the independent examination of Petitioner by Dr. Wehner, she remarked Petitioner "...is at maximum medical improvement and according to the AMA Guides to Evaluation of Permanent Impairment, Sixth Edition, there is zero percent (0%) impairment rating for these [right chest wall contusion and left wrist sprain] soft tissue injuries." At hearing, counsel for Petitioner objected to admission of the AMA portion of Wehner's report on grounds there was none of the supporting documentation for this impairment rating. Sany at 100. Wehner does not address the measures of impairment specified in Section 8.1b(a), nor indicated why that is not required or necessary in this case.

At the hearing, Petitioner testified on direct examination in a direct manner. This Arbitrator had no problem understanding his answers. However, on cross examination, Petitioner dodged and deflected questions posed to him regarding when his Application for Adjustment had been filed, how often he saw Dr. Sisson, additional treatment recommended by Sisson, who referred him to Advanced Physical Medicine, what kind of doctor Goldvekht was, and when he last sought therapy. Sany at 49-59. Petitioner's refusal to give a straight direct answer during most of his cross examination makes Petitioner's credibility suspect.

Conclusions of Law

As to disputed issue **F**, is Petitioner's current condition of ill-being causally related to the injury, this Arbitrator makes the following conclusion of law: Petitioner's current condition of ill-being, as stated by Petitioner, pain when he turns his head, on the left side of his neck and head, and right shoulder, not causally related to the injury sustained in the accident of August 9, 2015.

In support of this conclusion, I note and rely on the contents of the records from the Chicago Fire Department, Resurrection Hospital, and U.S. Health Works, indicating a left wrist and chest wall injury of minor and limited duration. Petitioner's Exhibit 1; Petitioner's Exhibit 3; Respondent's Exhibit 4.

I further rely on the examination of Petitioner by Dr. Wehner who found the injury caused by the accident to be a right chest wall contusion and left wrist sprain. She also noted, well prior to the hearing, Petitioner could turn his head without difficulty. Respondent's Exhibit 6 at 3, 4.

As to disputed issue **G**, what were Petitioner's earnings, this Arbitrator makes the following conclusion of law: Petitioner's average weekly wage should include overtime hours.

In support of this conclusion, I rely on the testimony of Petitioner that overtime was mandatory, and on the schedule. He said you would have to explain if you could not do it and could trade the time with coworkers. I find the testimony of Brian Rosel, given the explanation of the schedule of work, that "sometimes" overtime was not mandatory, not credible. I also rely on Respondent's wage records that indicate overtime woven into the entire payment history. Sany at 28-29, 46, 89-90; Respondent's Exhibit 8.

As to disputed 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, this Arbitrator finds that MMI occurred August 14, 2015, with Petitioner's ability to return to work without restrictions, and all medical services after that date are neither reasonable nor necessary and are denied. All charges by the Chicago Fire Department, Resurrection Hospital, and U.S. Health Works, if unpaid, are to be paid by Respondent.

In support of this conclusion, I rely on the examination of Petitioner by Dr. Wehner and her assessment of the injuries sustained on August 9, 2015, and the medical treatment necessary for them. Respondent's Exhibit 6 at 4. I also rely on the records from both Resurrection Hospital and U.S. Health Works. Petitioner's Exhibit 3 at 26; Respondent's Exhibit 4.

As to disputed issue **K**, what temporary benefits are in dispute, TTD, this Arbitrator makes the following conclusion of law: because there was no time after the injury that Petitioner was totally incapacitated, and unable to return to work, Petitioner is not entitled to temporary total disability.

In support of this conclusion I rely on the testimony of Petitioner that he did not miss any work and returned to his regular duties. Sany at 27, 41.

As to disputed issue **L**, what is the nature and extent of the injury, this Arbitrator makes the following conclusion of law: I conclude Petitioner sustained, as a result of the accident, a left wrist contusion/strain, and a contusion of the chest wall.

In support of this conclusion, I rely on the records of Resurrection Hospital and U.S. Health Works and their diagnosis and impressions. I also rely on the examination of Petitioner by Dr. Wehner and her diagnosis of chest wall contusion and left wrist strain. Petitioner's Exhibit 3 at 5; Respondent's Exhibit 4; Respondent's Exhibit 6 at 4.

As to permanent partial disability, I consider the factors found in Section 8.1b(b) of the Act.

As to the reported level of impairment pursuant to subsection (a), Dr. Wehner found a 0% impairment rating for Petitioner's soft tissue injuries according to AMA Guides to Evaluation of Permanent Impairment, Sixth Edition. However, she failed to include an evaluation of medically defined and professionally appropriate measures of impairment required in Section 8.1b(a), or say why in this case such was not required or could not be made, and so seems to lack the foundation required by the Act. Respondent's Exhibit 6 at 4. I give no weight to this factor.

As to the occupation of the injured employee, he was and is, a Ramp Agent for Respondent, a fairly labor intensive job. Petitioner returned to work missing no time. He testified he works the same job, same hours. He told Dr. Wehner he sometimes works a double shift. Sany at 9, 42, 85; Respondent's Exhibit 6 at 1. I give no weight to this factor.

As to the age of the employee at the time of the injury, Petitioner was 53 years old. While at that age, the healing process can take longer, the day after the accident, U.S. Health Works reflected he had full ROM of his left wrist and minimal complaints of discomfort. Dr. Wehner, in examining Petitioner found him in no distress and moving freely without pain. Respondent's Exhibit 4; Respondent's Exhibit 6 at 1. I give no weight to this factor.

As to the employee's future earning capacity, there is no evidence Petitioner sustained a diminishment in earnings capacity due to the accident. Brian Rosel, one of his supervisors testified his hourly salary had actually increased. Sany at 90. I give no weight to this factor.

As to evidence of disability corroborated by the treating medical records, there is none. At trial Petitioner testified and described the condition of the left side of his body, his left wrist, as "I cannot turn. I take it easy, same with my hand and here." He did not directly answer whether he feels any pain. There are no treating medical records to corroborate the testimony, however the examination of Petitioner by Dr. Wehner found Petitioner freely moved his head and neck, and moved freely without pain appearing in no distress, misrepresenting that he could not turn his head. Sany at 26; Respondent's Exhibit 6 at 3. I give no weight to this factor.

While no single factor solely determines disability, based on a consideration of these factors, and the record and testimony taken as a whole, I find no factor favors a determination of

permanent partial disability, and Petitioner sustained no permanent partial disability as a result of the accident of August 9, 2015.

As to disputed issue **N**, is Respondent due any credit, this Arbitrator finds respondent is due credit for payments made to U.S. Health Works of $369.95; Midwest Image of $74.38; and Presence Healthcare of $1253.08. Respondent's Exhibit 7. Payments made to Eqmd Inc. are not credited as there is no indication in the record that entity is related to the accident or injury. They are not referenced in the evidence at all.

Arbitrator

3/29/2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KAREN ANDERSON, widow of Alec Anderson and mother of Sierra Anderson, a minor,

Petitioner,

vs. NO: 13 WC 39081

HOMEWOOD FLOSSMOOR HIGH SCHOOL,

Respondent.

19IWCC0584

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 and causation and being advised of the facts and law, provides supplemental analysis but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator concluded Decedent's death fell under the Section 11 exclusion of the Act. Under Section 11, "[a]ccidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties[,] and picnics do not arise out of and in the course of the employment even though the employer pays some or all of the cost thereof." *820 ILCS 305/11* (West 2010). However, "[t]his exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program." *Id.*

On Review, Petitioner argues the application of Section 11 was error as a matter of law. Petitioner posits Section 11 specifically requires the voluntary recreational activity must be part of a "program," and there is no evidence Decedent's treadmill workout was part of a program. The Commission declines to adopt the narrow interpretation of "program" Petitioner advances.

The Commission initially observes Petitioner provides no authority for this interpretation

of Section 11. Moreover, we conclude Petitioner's interpretation of "program" is inconsistent with the provision's specific inclusion of picnics and parties as examples of "voluntary recreational programs." Finally, "[u]nder basic rules of statutory construction, where the same words appear in different parts of the same statute, they should be given the same meaning unless something in the context indicates that the legislature intended otherwise." *McMahan v. Industrial Commission*, 183 Ill 2d 499, 514, 702 N.E.2d 545 (1998). The Commission finds it significant that the term "program" has not been so narrowly interpreted when utilized in other sections of the Act; for instance, an employee's self-directed job search may constitute a "vocational-rehabilitative program" under Section 8(a). *Roper Contracting v. Industrial Commission*, 349 Ill. App. 3d 500, 506, 812 N.E.2d 65 (2004).

Petitioner further argues Decedent was not engaged in recreation. Citing *Elmhurst Park District v. Illinois Workers' Compensation Commission*, wherein the Appellate Court defined "recreation" as "the act of recreating with a state of being recreated: refreshment of the strength and spirits after toil: DIVERSION; PLAY" (395 Ill. App. 3d 404, 409, 917 N.E.2d 1052 (2009)), Petitioner posits "working out on a treadmill by yourself is primarily, if not solely, strenuous exercise performed to increase fitness and not for fun or recreation." The Commission finds this assertion is inconsistent with Cook's unrebutted testimony. Cook spoke to Decedent after he exited the weight room, and "we sat down on a set of bleachers for about - - I don't know - - two, maybe four minutes. And he stated that, you know, it's been a while since he lifted any weights, and he was happy to lift weights; and he was about to go and run right before we had a meeting later on that night." T. 45-46. This testimony evidences Decedent was exercising for "refreshment of [his] strength and spirits." Further, the Commission observes Section 11 expressly includes "athletic events" as one of the general examples of activities which may be considered "recreational." The term "athletics" is defined as "<u>exercises</u>, sports, or games engaged in by athletes." Merriam-Webster's Collegiate Dictionary 72 (10th ed. 2000) (Emphasis added). Compare *William Darin v. City of East Peoria*, 13 IWCC 855, affirmed by the Appellate Court in *Darin v. Illinois Workers' Compensation Commission*, 2015 IL App (3d) 140536WC-U ("Claimant's exercise activities fall within the definition of the term 'athletics' and the Act expressly includes 'athletic events' as an example of a 'recreational activity' for which compensation is precluded.")

The Commission finds Decedent was engaged in a recreational activity. We observe much of the questioning at trial was directed at whether it would be reasonable or incidental to Decedent's duties for him to participate in one of the practices for the 32 sports he oversaw. The Commission finds this focus misplaced given the fact Decedent was not engaged in such an activity when he suffered the fatal cardiac event. To be clear, he was not supervising a practice or joining a student activity to build rapport and/or set a positive example; rather, he was working out on his own. Therefore, the only way in which Petitioner avoids the Section 11 bar is by offering evidence that Decedent was required to be physically fit. Petitioner failed to present such evidence.

In arguing Decedent was required to be physically fit, Petitioner highlights the following contract provision: "The Director shall conform to, comply with, and be subject to all lawful rules, regulations and orders, heretofore or hereafter adopted by the Board relating to professional growth, physical fitness, temporary illness and temporary incapacity, and to all

other lawful rules, regulations, and orders heretofore or hereafter adopted by the Board." RX2. The Commission emphasizes, however, there is no credible evidence in the record demonstrating the Board had, in fact, adopted any rules, regulations, or orders relating to physical fitness. To the contrary, Bryant asserted there were none; the only fitness requirement was the passing of a pre-employment physical, a requirement applicable to all hirees. Bryant's testimony was corroborated by Cook, who testified he had never seen such a requirement in any contract or heard it discussed in any meetings. T. 48. And while Wilcox felt it was important for the athletic director to set a good fitness example for the students, he explained that was his opinion only and not a requirement set by his school district. T. 33-34. The Commission concludes Decedent was engaged in a voluntary recreational activity.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 2018, as modified above, 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.

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 28 2019

LEC/mck

O: 8/28/19

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

ANDERSON, KAREN WIDOW OF ANDERSON, ALEC AND MOTHER OF ANDERSON, SIERRA A MINOR
Employee/Petitioner

Case# **13WC039081**

19IWCC0584

HOMEWOOD FLOSMOOR HIGH SCHOOL
Employer/Respondent

On 1/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

0863 ANCEL GLINK
BRITTON W ISALY
140 S DEARBORN ST SUITE 600
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Karen Anderson, Widow of Alec Anderson and Mother of Sierra Anderson, a minor
Employee/Petitioner
v.

Case # **13 WC 39081**

Consolidated cases: ______

Homewood Flossmoor High School
Employer/Respondent

19IWCC0584

An *Application for Adjustment 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 **October 4, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Decedent'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 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. [x] 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?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ____

19IWCC0584

FINDINGS

On **August 7, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Decedent Alec Anderson ***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, Decedent Alec Anderson earned $**118,294.80**; the average weekly wage was $**2,274.90**.

On the date of accident, Decedent Alec Anderson was **54** years of age, ***married*** with **1** dependent child.

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

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

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

The Arbitrator finds that Decedent Alec Anderson died on **August 7, 2013**, leaving **2** survivors, as provided in §7(a) of the Act, including **a wife and a minor child**.

ORDER

The Arbitrator finds that because decedent Alec Anderson's activity of exercising after his job responsibilities had ended on August 7, 2013 was a voluntary recreational activity his death did not arise out of and in the course of his employment. In accord with §11 of the Act, benefits are denied.

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

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

Signature of Arbitrator

January 15, 2018
Date

JAN 17 2018

Karen Anderson, widow of Alec Anderson and mother of Sierra Anderson, a minor, v. Homewood Flossmoor High School
13 WC 39081

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of the deceased Alec Anderson's employment by Respondent?; ***F:*** Was the death of Alec Anderson causally related to the accident on August 7, 2013?; ***J:*** Were the medical services that were provided to the deceased Alec Anderson reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

STATEMENT OF FACTS

This matter involves a death claim from August 7, 2013, relating to the death of Alex Anderson, brought by his widow, Petitioner Karen Anderson. Petitioner testified she and Mr. Anderson were married July 18, 1998 (PX #1). Petitioner was still married to Mr. Anderson at the time of his death on August 7, 2013 (PX #3). They had a daughter Sierra Anderson, born May 18, 2001 (PX #2). Mr. Anderson had no other children.

Petitioner testified about Alec Anderson's education and background as an Athletic Director for Respondent Homewood Flossmoor High School. Mr. Anderson graduated from SIU–Carbondale, majoring in history and physical education. He first worked at Kankakee School District in 1985 as a history and physical education teacher for 13 years. He later got his Masters Degree from Governor's State while working there in their Administration. He was employed by Urbana High School as Athletic Director and Assistant Principal for 6-8 years. Mr. Anderson then worked at Evanston High School as Athletic Director for one year. Next, he was employed at Bolingbrook High School for 8 years as an Assistant Principal and Athletic Director.

In August 2012 Mr. Anderson was hired by Respondent as Athletic Director. Petitioner believed that as Athletic Director for the Respondent, Mr. Anderson supervised all sporting events, attending home and away athletic events. On the date of his death, August 7, 2013, Mr. Anderson was required to be at Freshmen Orientation later that night. Petitioner testified that Mr. Anderson often kept hours from 7:00 A.M. until 10:00 P.M., depending on what game was going on, and whether the athletic events were at home or away.

Petitioner testified that Mr. Anderson was muscular and not overweight. He worked out regularly at the school, but did not have any personal goals he was hoping to accomplish with his fitness activity. He would bring workout clothes with him to school just about every day. Petitioner believed that although her husband's regular work day would be by 4:00 or 4:30 P.M., there was always some additional thing, such as a game or a meeting that he needed to attend. On the morning of August 7, 2013, when she last saw Mr. Anderson, he exhibited no signs of ill health.

Petitioner believed that the day he passed away, August 7, 2013, Mr. Anderson was required to be at Freshmen Orientation, so that his work day did not end until after that event. She believed that his workday was not over until that event was done. Petitioner testified that she would not be surprised that there were other people that day, on August 7, 2013, playing basketball. She agreed that it was not part of their job duties to play basketball between the times of 4:00 P.M. and 7:00 P.M.

Ronald Edward Wilcox testified for Petitioner. Mr. Wilcox is Athletic Director of Kankakee High School. He has been working 18 years in education, and has been employed as a teacher, a basketball coach, an Assistant Athletic Director, and Athletic Director for the last 3 years. He belongs to the Illinois Athletic Directors Association and the NIAAA, the national organization for athletic associations.

During meetings and conversations with other athletic directors at these associations, Mr. Wilson discussed expectations and duties of athletic directors. In his opinion, it is important for an athletic director to maintain a high level of fitness. He believes an athletic director should "practice what you preach" when working with student athletes. In his own practice, it is not uncommon to participate in certain practices, and involve himself in open gyms. Mr. Wilcox is also aware of other athletic directors, including himself, who workout on a school's exercise equipment.

Mr. Wilcox admitted that his contract with Kankakee High School does not require that he keep a certain level of physical fitness. He also admitted that his job description does not require that he maintain a level of physical fitness. When he started employment as Athletic Director, he had a physical examination, but not since. He is not aware of Homewood Flossmoor's standards for its Athletic Director, so he could not testify about whether the Respondent requires a certain level of physical fitness for its athletic director. He testified that he is

"pretty hands-on" with working with his students, but that is not aware of the level of interaction which Alec Anderson had with his students at Homewood Flossmoor.

Homewood Flossmoor Associate Principal Dr. Lawrence Cook testified for Respondent. Dr. Cook knew Alec Anderson personally as the school's Athletic Director. Dr. Cook agreed that he was present at the high school when Mr. Anderson passed away of August 7, 2013. Dr. Cook had been playing basketball when he spoke with Mr. Anderson on the evening of August 7, 2013, around 4:30 P.M. Mr. Anderson was coming from the weight room. Mr. Anderson said that it had been a while since he had lifted weights and that he was happy to lift them and was next going to run before attending Freshman Orientation. Dr. Cook assumed Alec went to the cardio-vascular room.

Dr. Cook testified that administrators are obligated to be at school from 7:30 A.M. until 4:00 P.M. He believed it was the same for Mr. Anderson as well. Freshman Orientation was scheduled for 7:00 or 7:30 P.M. Although employees were not required to stay in between 4:00 P.M. and 7:00 P.M., Dr. Cook testified that he was waiting at the school until the start of orientation. Dr. Cook agreed that the basketball games that he was playing were voluntary and recreational and something he personally chose to do that day but were not part of his job duties. Dr. Cook did not believe that Mr. Anderson was required to lift weights or go on the treadmill, because he has never seen that in any contract or heard it at any meetings that they are required to engage in physical activities in order to maintain or keep their jobs.

At the freshmen orientation meeting, just before 7:00 P.M. on August 7, 2013, the Principal asked if anyone knew of Mr. Anderson's whereabouts. Dr. Cook said that he had seen him about 2 hours ago. Because Mr. Anderson lived 30 to 40 minutes from the school, Dr. Cook thought that it did not make any sense for him to go home and then come back later for Freshmen Orientation meeting. Dr. Cook volunteered to look for Mr. Anderson. He found Mr. Anderson unresponsive lying on the treadmill, at the end of the belt, face down about 7:15 or 7:30. Mr. Anderson was wearing workout clothes.

Dr. Cook testified that it is reasonable for school employees to use the fitness center during school hours, such as during lunch but not during regular work hours. When he uses the fitness equipment, it is something he believes to be completely voluntary and recreational. When he saw Mr. Anderson on the day

he passed away, it was already after school hours. The cardiovascular room is off limits to the general public and would only be used for staff or faculty.

Jodi Marie Bryant, Director of Human Resources and Public Relations for Respondent, also testified for the Respondent. Her job duties include managing all employees, participating in all the hiring, enforcement of school policies, making sure people are aware of policies and maintaining the personal files, among many other things. She is the custodian of the personnel files and records. Ms. Bryant participated in hiring Alec Anderson as Athletic Director. On August 7, 2013, Ms. Bryant was at the school, but did not speak at Freshman Orientation. Rather, she got the materials ready for the meeting and was present as an administrator of the school. That day, after the school day ended, and because she lives in Lisle, she chose not to drive home because of the distance. Instead, she stayed at her desk until the freshman orientation began.

Ms. Bryant confirmed that typical administrative work days during the school year are from 7:30 A.M. until 4:00 P.M. During the summer, the hours are from 7:30 A.M. to P.M. On the night of August 7, 2013, because there was a work event at 7:00 p.m., she was duty free from 3:30 P.M. until 7:00 P.M. Also, Ms. Bryant agreed that all the employees who needed to attend the freshman meeting at 7:00 p.m., were "duty free" between 3:30 P.M. and 7:00 P.M. Mr. Anderson had the same summer work hours as did all other 12-month employees. Mr. Anderson would not have been required to stay at work beyond 3:30 P.M. except for attending the 7:00 P.M. meeting. Ms. Bryant saw Mr. Anderson that morning and he did not look out of the ordinary.

Ms. Bryant brought Mr. Anderson's personnel file to the hearing (RX #1). The personnel file contained the job duty description for Director of Athletics and Student Activities. This job duty description was in place at the time of Mr. Anderson's death. Ms. Bryant is familiar with this job duty description because when she hired the person for the position, they go over these duties to make sure that the new hire understands the requirements of the job. She testified that Mr. Anderson's job duty description did not require the Director of Athletics and Student Activities to maintain a certain level of physical fitness. Additionally, the Director of Athletics, he did not teach students. Instead, he was responsible for the 32 sports, 75 teams, and 80 clubs and activities, which involve administrative scheduling, evaluation form completion, ordering equipment, and reviewing budgets.

Ms. Bryant testified that every employee, when hired by the School District, needs to have a physical done in order to be hired. Mr. Anderson's physical exam on April 30, 2012, he was normal, showing that he had a TB test and was physically fit for the employment and the position (RX #5). Mr. Anderson also passed a physical fitness test demonstrating that he was able to walk distances, sit for the correct length of time required, and frequently lift 10 lbs. The personnel file had a Contract for Director of Athletics, Intramurals, and Student Activities, dated July 1, 2012 through June 30, 2017 (RX # 2). Ms. Bryant reviewed these contracts and authenticated their accuracy. There was nothing in Mr. Anderson's contract that required him to maintain a certain level of physical fitness. None of the School District contracts require any employee to maintain a certain level of fitness. There are no other agreements between the School District and Amr. Anderson.

Ms. Bryant testified that most of the school's administrators and a lot of the teachers work out at the school, but are only allowed to work out outside of work hours. That includes all staff members, including physical education staff. The locations around the school where they can work out include the track, working in the weight room, in the fitness room, or in the field house in the north building. These athletic facilities are benefits available to both administrators and staff. There have been instances when she has had to tell employees that they cannot work out during school hours. The use of the school exercise equipment is something that is totally voluntary on the part of the employee. She further testified that for activities that occurred after the regular school day end but before an activity like the orientation in this case, administration and faculty members were allowed to use the exercise equipment, but they do so outside of the scope of their employment.

Ms. Bryant was not Mr. Anderson's direct supervisor. She never provided guidance or suggestions to Mr. Anderson regarding how he performed his job. Mr. Anderson had from time to time assisted in coaching the football team. Ms. Bryant emphasized that his responsibilities were administrative, not coaching. She described Mr. Anderson as the "coach of the coaches." Assisting in athlete instruction, assisting in coaching, or refereeing an intramural game were outside his job responsibilities.

Petitioner's Exhibit # 5 is the Flossmoor Fire Department EMS report for the events at Homewood Flossmoor on August 7, 2013. The report indicates that a call was received at 19:32 hours from the men's locker room at Homewood Flossmoor High School indicating the Athletic Director had passed out. The EMS crew was taken to the second floor of the high school gymnasium where Mr.

Anderson was having CPR done to him. A heart monitor was placed but no pulse was noted. Mr. Anderson was noted to be in asystole. It was noted he had been running on the treadmill next to his body and had cuts/burns to his face and neck from the machine. He was transported to South Suburban Hospital.

The records of South Suburban Hospital were admitted evidence as Petitioner's Exhibit #6. Mr. Anderson arrived by EMS at 20:00 hours. Mr. Anderson was unresponsive and in asystolic arrest on arrival. His pupils were fixed and dilated. The physical exam noted lividity and coolness of his body. Heroic efforts to resuscitate were unsuccessful. He was pronounced dead at 20:06 hours. The diagnosis was cardiac arrest – asystole. It was noted as an ME (Medical Examiner) case.

Petitioner's Exhibit # 7 is the report of postmortem examination performed on August 8, 2013, by Latanja M. Watkins, M.D. of the Cook County Medical Examiner's Office. Dr. Watkins noted coronary artery disease due to arteriosclerotic cardiovascular disease. There was 90% occlusion of the left anterior descending coronary artery, 75% occlusion of left circumflex coronary artery, and 50% occlusion of the right coronary artery. Abrasions to the head and neck with a contusion to the right arm were also noted. It was Dr. Watkins' opinion that Mr. Anderson died of sudden cardiac death due to severe coronary artery disease due to arteriosclerotic cardiovascular disease.

Petitioner's Exhibit #4, records of Dr. Rajasekhar Kolla, Mr. Anderson's primary care physician, was admitted over Respondent's objection. Dr. Kolla's records covered a period from April 30, 2012 through August 2, 2013. Dr. Kolla noted that Mr. Anderson was a "well adult."

Petitioner's Exhibit #8 was December 15, 2016 report from Dr. Bruce Leavitt, Professor of Surgery, Division of Cardiothoracic Surgery at the University of Vermont Medical Center. He reviewed the Cook County Medical Examiner's report, records have South Suburban Hospital, the South Cook County EMS report, and organ tissue donor forms. Dr. Levitt summarized his review on those records. It was his opinion that Mr. Anderson died from sudden cardiac death secondary to pre-existing structural heart disease while exercising on a treadmill. Dr. Leavitt noted that Mr. Anderson's heart disease included three-vessel coronary artery disease (blockages of over 50%), as well as evidence of an old heart attack.

Dr. Leavitt concluded that demand ischemia (lack of blood flow to the heart muscle) was causative in the development of the dysrhythmia that caused Mr. Anderson's death. The doctor opined that while exercising on the treadmill he placed an increased demand on his heart for oxygen required for that intense

level of exercise. The blocked arteries could not deliver the amount of oxygen needed for his heart muscle to perform adequately. Ischemia developed in his heart muscle which in turn led to an arrhythmia which eventually led to death.

Respondent's Exhibit #3 is the undated report of Dan J. Fintel, M.D., Professor of Medicine, Department of Cardiology at the Feinberg School of Medicine at Northwestern University. Dr. Fintel made to the be so EMS report, records of South Suburban Hospital, records of Dr. Kolla, and the Medical Examiner's report. Dr. Fintel noted Mr. Anderson's diagnosis was sudden cardiac death secondary to malignant ventricular arrhythmia with underlying three-vessel coronary artery disease. Dr. Fintel noted Mr. Anderson had severe underlying premature coronary artery disease.

Dr. Fintel noted that when Mr. Anderson exercised prior to sudden death he increased his myocardial oxygen demand and experienced ischemia in his left ventricle. This placed him at risk of developing the malignant arrhythmias of ventricular tachycardia or ventricular fibrillation which was likely led to his cardiopulmonary arrest. Dr. Fintel also noted that even absent exertional activity Mr. Anderson was at significant risk of suffering myocardial infarction and sudden cardiac death. He further noted that without medical treatment for the underlying severe coronary disease he believed it was highly likely Mr. Anderson would suffer a myocardial infarction or cardiac death. Dr. Fintel noted that significant ischemia would predispose Mr. Anderson to an arrhythmia at rest or due to increase in myocardial oxygen demand by exerting himself, such as may have happened on August 7, 2013.

Respondent's Exhibit #1, Director of Athletics and Student Activities job description included in the definition of the position a statement that the Athletic Director: "Provides the leadership to ensure that the extracurricular program is designed and conducted so that students will have optimum opportunities for mental, social and physical development." Major policy responsibilities are listed as well as key functions which include the, "authority/responsibility – supervise all athletics, intramural and student activities." Personnel functions included: "recommend and evaluate all staff in the co-curricular areas." Section C of the job description included: "Provide leadership and supervision in all areas relating to the students in activities."

Respondent's Exhibit #2 is the employment contract between Mr. Anderson and the Board of Education of Homewood Flossmoor High School. That contract was dated December 20, 2012. The contract included a provision stating:

"The Director shall conform to, comply with, and be subject to all lawful rules, regulations and orders heretofore and hereafter adopted by the Board relating to professional growth, physical fitness, temporary illness and temporary incapacity and all other lawful rules, regulations and orders heretofore or hereafter adopted by the Board."

CONCLUSIONS OF LAW

C: Did an accident occur that arose out of and in the course of the deceased Alec Anderson's employment by Respondent?

The Arbitration finds that Petitioner failed to prove that the death of Alec Anderson arose out of and in the course of his employment by Respondent.

An injury is compensable under the Act only if the claimant can prove by a preponderance of the evidence that it arose out of and in the course of his or her employment. An injury arises out of one's employment if its origin is in some risk connected with, or incidental to, the employment so that there is a causal connection between the employment and the accident injury. An injury is in the course of employment when it occurs within the period of employment at a place where the employee can reasonably be expected to be in the performance of his or her duties and while he or she is performing these duties or a task incidental thereto. However, purely voluntary recreational activities are not compensable under the Illinois Workers' Compensation Act. §11 of the Act states in pertinent part:

"Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of the employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program."

Here the question is whether the activities engaged in by decedent Alec Anderson were voluntary recreation or an activity expected within the scope of his employment as Athletic Director. If the activity was purely recreational Petitioner's claim would not be compensable under §11. On the other hand, if the activity was ordered or directed by the employer, an activity from which the employer derived some benefit, then the claim may be compensable.

Petitioner presented the testimony of Ronald Wilcox, Athletic Director of Kankakee High School. Mr. Wilcox testified that a high school athletic director

should be physically fit as an example to students. Wilcox is a member of two professional athletic director organizations. He did not offer evidence that either professional organization recommendations or guidelines that high school athletic directors should be a certain level of physical fitness in order to appropriately perform their jobs. It is clear that Mr. Wilcox offered his personal opinion rather than citing to professional recommendations or guidelines or even accepted custom and practice within the community of high school athletic directors. As such, the Arbitrator does not find Mr. Wilcox's opinions persuasive.

Respondent presented evidence that neither the job description for Athletic Director nor Mr. Anderson's employment contract required that certain level this is a requirement of employment. There was nothing within Mr. Anderson's employment contract or job description which directed or implied that he maintain a certain level of physical fitness as an example for students.

The evidence showed that the administrative duties of Mr. Anderson ceased at 4:00 P.M. and were not to resume until 7:00 P.M. at Freshman Orientation. The time Mr. Anderson spent exercising was voluntary recreation within the purview of §11 of the Act. Mr. Anderson was engaged in an exercise activity that was for his personal benefit during hours when he had no job-related duties or responsibilities. He was clearly engaged in voluntary recreation.

In light of all the evidence, the Arbitrator finds that Petitioner failed to prove that Alec Anderson's death arose out of and in the course of his employment by Respondent.

F: Was the death of Alec Anderson causally related to the accident on August 7, 2013?

In light of the Arbitrator's finding above that Mr. Anderson's accidental death did not arise out of and in the course of his employment, this issue is moot.

The Arbitrator does note that Mr. Anderson had significant three-vessel coronary artery disease. The physician opinions presented by both Petitioner and Respondent inferred that Mr. Anderson's heart disease made him prone to cardiac ischemia and infarction, whether exercising or not. The Arbitrator does note that Dr. Leavitt, Petitioner's expert, is a board certified thoracic surgeon, while Dr. Fintel, Respondent's expert, is aboard certified cardiologist. Had their

opinions differed in any substantial way, the Arbitrator would have deferred to Dr. Fintel's opinions.

However, due to the unfortunate event involved here being the result of voluntary recreation Petitioner failed to prove that Mr. Anderson's death was causally related to any work activity.

J: Were the medical services that were provided to the deceased Alec Anderson reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

In light of the Arbitrator's finding above that Mr. Anderson's accidental death did not arise out of and in the course of his employment, this issue is moot.

The Arbitrator does note that the emergency paramedic and medical services provided to Mr. Anderson were in fact reasonable and necessary. However, due to the unfortunate event involved here being the result of voluntary recreation Petitioner failed to prove that those medical services and the related charges were causally related to any work activity.

L: What is the nature and extent of the injury?

In light of the Arbitrator's finding above that Mr. Anderson's accidental death did not arise out of and in the course of his employment, this issue is moot.

This fatal injury was the result of voluntary recreational activity under §11 of the Act, and therefore Mr. Anderson's death did not arise out of and in the course of his employment and no benefits can be awarded as a result.

Steven J. Fruth, Arbitrator

January 15, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ADAM LECZYCKI,

Petitioner,

vs. NO: 14 WC 29047

MPD CONSTRUCTION GROUP, INC.,

Respondent.

19IWCC0585

DECISION AND OPINION ON REVIEW

Petitioner timely filed a Petition for Review of the Arbitrator's January 25, 2018 decision. Therein, the Arbitrator found Petitioner failed to prove the existence of an employer-employee relationship. The matter was assigned a May 18, 2018 Return Date on Review. The authenticated transcript was not filed by the Return Date, and a Rule to Show Cause hearing was held before Commissioner Coppoletti on June 21, 2018. At that time, Respondent made an oral motion to dismiss Petitioner's review because it had not been perfected; specifically, Respondent argued 1) the Petition for Review was timely but unsigned, and 2) the authenticated transcript was not timely filed. Highlighting the Petition for Review comported with the express requirements of Rule 9040.10, as well as the discretionary language in Section 19(b) ("The Commission, or any member thereof, may grant further time not exceeding 30 days, in which to file such agreed statement or transcript of evidence." *820 ILCS 305/19(b)*), Commissioner Coppoletti denied the motion with respect to both grounds. The matter was continued to June 27, 2018, on which date the parties would appear and authenticate the transcript. On that date, Respondent's Counsel signed the authentication "without waiving our standing objection as to the argument of jurisdiction or statute of limitations." Respondent did not pursue either argument in its brief or at oral argument.

Notice given to all parties, the Commission, after considering the issue of employer-employee relationship and being advised of the facts and law, corrects and supplements the decision as set forth below but otherwise affirms and adopts the Decision of the Arbitrator,

which is attached hereto and made a part hereof.

Evidentiary Rulings

When the parties offered their documentary evidence, objections were made to several exhibits:

Petitioner's Exhibit 4 (Dr. Szyfer) – Respondent objected on the basis the exhibit contained only a bill and no accompanying medical records and therefore there was no foundation for the treatment;

Petitioner's Exhibit 7 (Prescription Partners Bills) – Respondent's objection is based on lack of certification or subpoena;

Petitioner's Exhibit 9 (text messages between Peter and Petitioner) – Respondent objected on multiple grounds: 1) it is not subpoenaed/certified; 2) the texts are in Polish which implicates due process; and 3) lack of probative value;

Petitioner's Exhibit 10 (MPD Payment ledger) – Respondent's objection is based on no subpoena/certification; and

Respondent's Exhibit 7 (Dr. Bernstein's May 19, 2015 Addendum Report) – Petitioner's objection is predicated on the report never being provided to him.

The Commission observes the Arbitrator indicated a ruling on each objection would be made in the decision, however said rulings were omitted. The Commission corrects this inadvertent error and formally sustains each of the above objections.

Employer-Employee Relationship

Whether an employment relationship exists is a threshold question in a workers' compensation claim (*Keating v. 68th & Paxton, LLC*, 401 Ill. App. 3d 456, 467, 936 N.E.2d 1050 (2010)), and absent such a relationship, there can be no liability under the Act (*Roberson v. Industrial Commission*, 225 Ill. 2d 159, 174, 866 N.E.2d 191 (2007)). The Commission, like the Arbitrator, finds Petitioner failed to prove the existence of an employer-employee relationship. The Commission writes separately to address Section 1(a)3 of the Act.

Section 1(a)3 provides as follows:

> Any one engaging in any business or enterprise referred to in subsections 1 and 2 of Section 3 of this Act who undertakes to do any work enumerated therein, is liable to pay compensation to his own immediate employees in accordance with the provisions of this Act, and in addition thereto if he directly or indirectly engages any contractor whether principal or sub-contractor to do any such work, he is liable to pay compensation to the employees of any such contractor or sub-contractor unless such contractor or sub-contractor has insured, in any company or association

19IWCC0585

> authorized under the laws of this State to insure the liability to pay compensation under this Act, or guaranteed his liability to pay such compensation. *820 ILCS 305/1(a)3* (West 2010).

Matyjas credibly explained he requires his subcontractors, without exception, to provide a certificate of insurance; this stems from a prior instance where one of his contractors suffered a work injury and filed a claim against him. T. 120. In response, his attorney advised him to require all subcontractors to provide a certificate of insurance, thereby availing himself of the exemption set forth in Section 1(a)3. The Commission wishes to make clear Section 1(a)3 is inapplicable to the injury herein by virtue of Petitioner being the owner of Adam Construction. Section 1(a)3 states any person hiring a contractor, where the contractor fails to have his or her own insurance, "is liable to pay compensation to the employees of any such contractor." *820 ILCS 305/1(a)(3)* (Emphasis added). In other words, absent Adam Construction having insurance, Section 1(a)3 would theoretically require Matyjas to pay compensation to "the employees" of Adam Construction. However, the record before us demonstrates Adam Construction has no employees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 25, 2018, as modified above, 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.

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 28 2019

L. Elizabeth Coppoletti

LEC/mck

O: 8/28/19

Stephen Mathis

43

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision in its entirety. After considering the totality of the evidence, I believe Petitioner met his burden of proving by a preponderance of the evidence the existence of an employer – employee relationship on August 5, 2014.

Petitioner was a 43-year-old construction worker on the date of accident. He is a Polish immigrant and testified through an interpreter. Petitioner testified that he worked for Respondent for approximately two years prior to the work accident. He worked primarily as a carpenter but also performed duties such as demolition before remodeling the interiors of the buildings. On the date of accident, the crew was preparing a kitchen for a complete remodel. Ziggy Matyjas was his boss and Peter was Petitioner's direct supervisor.

This case is particularly troubling because it involves the growing trend of construction businesses taking advantage of immigrant workers while attempting to abandon their responsibilities pursuant to the Act. Respondent admits that it requires all its subcontractors to incorporate and obtain workers' compensation insurance. In this way, Respondent attempts to skirt its clear responsibility to obtain appropriate workers' compensation insurance for its workers. In fact, Ziggy testified that following a 2006 incident in which a worker sued for workers' compensation benefits pursuant to the Act, he required each subcontractor incorporate and obtain its own workers' compensation policy. Respondent would not hire any subcontractor unless or until it met those two requirements. Furthermore, Respondent would only pay Petitioner through Petitioner's company. As further evidence that Respondent used this scheme to avoid its statutory responsibilities, Ziggy readily admitted that he did not even look at the submitted policies or ensure that the policies covered the workers. Respondent only wanted its workers to go through the motions of getting an insurance policy to further insulate the company from its obligations. The result is immigrants such as Petitioner purchase purported workers' compensation insurance policies that provide no coverage because the policies exclude officers. Unfortunately, Respondent is not the only construction company engaging in this ruse. Petitioner readily admits that he created Adam Construction before he began working for Respondent because a different construction company would only pay Petitioner through a shell company. A few other companies also required Petitioner receive his pay through Adam Construction. However, Respondent was the first employer that required Petitioner to provide proof of workers' compensation insurance coverage.

It is undisputed that navigating the nuances of each employment relationship to determine whether an employer – employee relationship existed on the date of accident is difficult and fact-specific. The Illinois Supreme Court has identified several factors to consider when determining the employment relationship between the parties. These factors include, but are not limited to:

> "1) whether the employer controls the manner in which the worker performs the work; 2) whether the employer dictates the worker's schedule; 3) whether the employer compensates the worker on an hourly basis; 4) whether the employer withholds income and social security taxes from the worker's taxes; 5) whether the employer can

> discharge the worker at will; and, 6) whether the employer supplies the worker with materials and equipment."

Steel & Mach. Transp., Inc. v. Ill. Workers' Comp. Comm'n, 2015 IL App (1st) 133985WC at ¶ 31. Illinois courts also consider the nature of the work performed by the employee in relation to the employer's general business. *Id.* While no one factor is determinative of the outcome, the right to control the work and the nature of the work are the two most important factors. The Appellate Court determined in an analogous situation that an employee's incorporation for tax purposes and purchase of occupational accident insurance are at best weak indicators of an independent contractor relationship, particularly when these actions were taken at the employer's insistence. *See Ware v. Indus. Comm'n*, 318 Ill. App. 3d 1117, 1127 (2000).

I strongly disagree with the majority's denial of benefits. The credible evidence supports a finding that an employer – employee relationship existed between Petitioner and Respondent on the date of accident. For example, Petitioner had set work hours and could not leave a job site without first informing either Ziggy or Peter. The company paid Petitioner by check and Petitioner was paid $19.00 an hour. Every Monday Petitioner had to call into the office and report his hours and the addresses of the job sites where he worked the previous week. Petitioner rarely worked at the same job site more than one day. Each day one of his supervisors would tell him that day's work site. Petitioner sometimes worked at more than one site in a single day and Respondent controlled the order of the jobs Petitioner completed each day. Petitioner did not have direct contact with Respondent's clients; instead, Ziggy or Peter would tell Petitioner each day which projects Petitioner had to complete. Ziggy or Peter would also provide guidance regarding the way Petitioner performed his assigned tasks. While Petitioner brought a few basic personal tools to each work site, Respondent owned and maintained the heavy and specialty tools. Respondent stored these specialty tools in its warehouse and transported them to the relevant job sites. Occasionally some workers would have to go directly to the warehouse to gather the necessary tools and transport the tools to the job site.

Petitioner testified that usually Ziggy or Peter would purchase supplies with a credit card; however, occasionally Petitioner would go to Home Depot to get the supplies and someone at the company would pay via credit card over the phone. Petitioner credibly testified that Respondent provided a uniform for him to wear that included a hat, several shirts, and several sweatshirts. Petitioner provided his own work boots, winter jackets, and pants. Petitioner credibly testified that he was not able to work for other companies while working for Respondent. His supervisors also exercised control over the way he performed the demolition and rehab projects. The construction crew even had a set time for lunch. Finally, Petitioner's work was intimately related to Respondent's business. These factors clearly support a finding that an employer – employee relationship existed between Petitioner and Respondent on the date of accident.

For the forgoing reasons, I would reverse the Arbitrator's Decision in its entirety and find Petitioner met his burden of proving that he was engaged in an employer – employee relationship with Respondent on the date of accident.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LECZYCKI, ADAM Case# **14WC029047**
Employee/Petitioner

MPD CONSTRUCTION GROUP INC
Employer/Respondent

19IWCC0585

On 1/25/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5626 URSULA BABICZ & ASSOC
1 S 660 MIDWEST RD
SUITE 200
OAK BROOK TERR, IL 60646

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Adam Leczycki
Employee/Petitioner
v.
MPD Construction Group Inc
Employer/Respondent

Case # **14** WC **29047**

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 **Robert Luedke**, Arbitrator of the Commission, in the city of **Chicago**, on **January 17, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/5/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**n/a**; the average weekly wage was $**n/a**.

On the date of accident, Petitioner was **43** 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, $ 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

Because an employee-employer relationship did not exist, benefits are denied. All other issues moot.

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

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

Robert E. Luedke 1/25/18

Signature of Arbitrator Date

JAN 25 2018

B. Was there an employee-employer relationship?

The arbitrator finds the petitioner did not meet his burden of proving an employee-employer relationship. The arbitrator bases this decision on the testimony of the petitioner, the testimony of Mr. Matyjas, president of the respondent, and the documents entered by the parties.

Fact summary

The petitioner testified that he earned $19 an hour and that his supervisors were "Ziggy and Peter." The petitioner testified that he worked from 7 AM to 5 PM that his duties included remodeling. On the date of accident the petitioner testified that Peter told him to travel to a town home that they were remodeling. After the petitioner suffered his accident he told Peter and Ziggy. Petitioner did not return to work with the respondent.

The petitioner testified that he has been working for other employers since September 3, 2015. The petitioner testified that he was paid by check from the respondent. The petitioner testified that he was paid on a per hour basis and that he reported his hours. He didn't work at the same location every day. According to the petitioner Peter told him where to work. Sometimes Ziggy told the petitioner where to work. The petitioner testified that both Peter and Ziggy told the petitioner what to do. The petitioner testified that a majority of the tools were owned by the respondent. The petitioner testified that Peter brought tools to the job site. The respondent had a warehouse and office on Grand Avenue. The materials used in construction were purchased by the respondent. According to the petitioner Peter bought the materials with a company credit card. Occasionally the petitioner was sent to Home Depot to purchase materials with the respondent's credit card. The petitioner never used his own credit card to purchase materials for the respondent. The petitioner testified he would be notified by phone or text message by Peter or Ziggy regarding when or where the next job would be.

The petitioner testified he had a company called Adam Construction. The petitioner did not have a Social Security number but Adam Construction had a tax ID number.

During cross-examination the petitioner agreed that R1 was an insurance certificate Adam Construction provided to the respondent to show that Adam Construction had workers' compensation insurance on the petitioner. Petitioner admitted that he had to prove that he was covered by workers compensation insurance provided by Adam Construction before he could work for the respondent. The petitioner testified he purchased the policy and paid the premium. The policy was later cancelled for nonpayment of premium. *R4.*

The petitioner testified he had a prior work injury in 2010 with Top Line Construction. The petitioner did not give Top Line Construction a certificate of workers compensation insurance. The petitioner did not give a certificate of workers compensation insurance to any other companies.

The petitioner is president of Adam Construction. The petitioner is the only officer. The petitioner testified he is not excluded from workers compensation coverage under the Adam Construction policy. However the arbitrator notes R4 discloses the petitioner signed a form excluding him from worker's compensation coverage.

Petitioner agreed that R2 is a 1099 form for the year 2013 provided to the petitioner by the respondent. The arbitrator notes the recipient's name on the 1099 is "Adam Leczycki dba/Adam Construction."

Petitioner agreed that R5 is a transaction list indicating the checks the respondent wrote to Adam Construction in 2014. The arbitrator has reviewed R5 and notes that the transaction list mentions the checks are made out to Adam Construction. The checks are in varied amounts.

The petitioner testified that Peter and Ziggy were not at the job site all the time. The petitioner testified that Peter and Ziggy were not there every morning. The arbitrator finds this testimony significant. The respondent never told the petitioner when he could take a break. The petitioner could take a lunch break whenever he wanted. The petitioner testified he could not leave the job site. The petitioner agreed that he did projects for the respondent in 2014. He supplied his own truck. The petitioner testified that most of the tools were supplied by the respondent. The petitioner testified he had personal tools in his toolbox. He would be responsible for replacing his personal tools.

Petitioner agreed that his tax return for 2014 indicates he took a deduction of $3413 for replacement of his personal tools. The petitioner testified the respondent had a warehouse which housed special tools. The petitioner did not use the special tools all of the time. The petitioner testified that approximately 2 to 5 times a month he went to the respondent's warehouse to get a tool.

During cross-examination the petitioner testified that he chose the tools to use. The respondent did not provide training. The respondent did not have the petitioner sign any employee handbooks. The petitioner testified he wore hats and a sweatshirt that had the respondent's name on it. The petitioner supplied his own boots. The petitioner testified that his supervisor brought him gloves. The petitioner paid for his own parking when he was at the job site. The petitioner testified that Peter and Ziggy told the petitioner how to do the demolition. The petitioner testified he couldn't perform the demolition his way.

Mr. Zbigniew Matyjas testified on behalf of the respondent. Mr. Matyjas testified he is the president of MPD Construction. Mr. Matyjas testified that MPD Construction is a general contractor. The respondent's business is 80% commercial and 20% residential. When the respondent performs remodeling Mr. Matyjas sets up the order of the particular building trades. The project may start out with demolition and then move on to carpentry and the other specific trades. The respondent uses different vendors. Mr. Matyjas testified the respondent has approximately seven employees. Mr. Matyjas personally does not do any of the construction work. The seven employees of the respondent consist of a secretary, a supervisor, a tile man, a painter, and electrician. The respondent uses independent contractors. At the time of arbitration the respondent had approximately 15 to 20 independent contractors currently out on jobs. The respondent doesn't use all of the specific independent contractors all at one time. Mr. Matyjas testified that the respondent may have 12 to 15 projects going on any given day.

Mr. Matyjas testified that he first met the petitioner when he was hiring new subcontractors. He hired Adam Construction to do demolition work. Mr. Matyjas testified he had a verbal agreement with Adam Construction. He insisted on a certificate of insurance for proof of workers' compensation insurance from Adam Construction. Adam Construction provided the certificate of insurance entered as R1. Mr. Matyjas testified that the petitioner is covered by his own workers' compensation insurance. The respondent gets a certificate for workers compensation insurance from every independent contractor. He doesn't need a certificate of workers compensation insurance from his seven employees.

When Mr. Matyjas is discussing a potential remodeling job with an owner Mr. Matyjas will first walk through the premises with the customer. If the respondent is hired than work will proceed. Different vendors are used for different projects. Adam Construction is generally used for demolition.

Mr. Matyjas testified that Adam Construction can decline a job. Adam Construction can perform other jobs with other general contractors while he is working with the respondent. The respondent never told Adam Construction or the petitioner when to take a break, whether or not they could leave early, where to park, or that they couldn't work for other general contractors. The respondent has some heavy specialized tools for use by subcontractors on different jobs. The petitioner has access to the respondent's tool warehouse. The petitioner has his own hand tools. The subcontractors have their own work truck. The subcontractors also have their own phone. The respondent has no written policies or handbook regarding the subcontractors. The respondent provides no training to the petitioner or to the other subcontractors. The respondent does show the designs or blueprints to the subcontractors. The respondent does not tell the subcontractors or the petitioner how to perform the individual jobs.

The respondent paid Adam Construction Company for their services. Mr. Matyjas testified that R5 is a printout of the check amounts paid to Adam Construction. The checks are paid based on the address of where the job was performed. The hours the petitioner worked are close to the amount paid. Adam Construction received a 1099 entered as R2. The petitioner did not get a W-2 because he was not an employee. The employees of the respondent received a W-2.

If one of the respondent's employees is injured then the employee fills out an employee accident reporting form. The petitioner never filled out an employee accident reporting form.

During cross-examination Mr. Matyjas testified that the respondent has an employee handbook for employees. An employee handbook was not provided to the petitioner. The agreement Mr. Matyjas had with the petitioner the was that the petitioner would perform demolition and carpentry work for $190 a day. Mr. Matyjas doesn't remember if the petitioner was asked to work five days or six days.

Mr. Matyjas testified that the petitioner is a subcontractor. The respondent's employees get paid vacations, overtime, and a 401(k) plan. The petitioner did not receive any of these benefits. The respondent has workers compensation insurance for the respondent's seven employees. Mr. Matyjas does not tell the subcontractors how to do their job. Mr. Matyjas testified he doesn't have the knowledge to tell the subcontractors in the different specialties how to do their job.

The arbitrator has reviewed R1 which the petitioner testified is a certificate of workers' compensation insurance for Adam Construction. The arbitrator has also reviewed R2 which is a 1099 tax form for 2013 with the recipient being Adam Leczycki d/b/a Adam Construction.

The schedule C tax return for 2013 for Adam Construction was entered as R3. The petitioner is listed as the name of the proprietor. The petitioner deducted $18,251 for car and truck expenses and $12,821 in supplies. The petitioner's net profit from Adam Construction was $10,373. The petitioner indicated on the tax return that he used his vehicle for 32,052 miles for business purposes. Petitioner alleged business expenses of $5446 for small tools, cell phone, uniforms and laundry, boots and gloves, and parking.

The schedule C tax return for 2014 is also included in R3. Petitioner alleged in 2014 that he was a sole proprietor for Adam Construction. Petitioner alleged on the tax return gross receipts of $32,710 along with $28,438 in total business expenses. Petitioner alleged a net profit of $4272. In 2014 petitioner alleged business expenses of $5761 for cell phone, uniforms and laundry, boots and gloves, small tools, and parking.

The schedule C tax return for 2015 is also included in R3. Petitioner alleged gross receipts of $20,767. For 2013, 2014, and 2015 petitioner did not check the box indicating income reflected on a W-2 form. Petitioner alleged business expenses of $14,141. Petitioner alleged a net profit of $6626. Petitioner alleged that he used his vehicle for business purposes for 10,317 miles. Petitioner alleged additional business expenses for cell phone, uniforms and laundry, boots and gloves, and small tools.
The workers compensation insurance policy for Adam Leczycki d/b/a Adam Construction was entered as R4. This policy was canceled effective October 1, 2014 for nonpayment of premium. *R4.* An Illinois workers compensation coverage selection form is signed by the petitioner and dated March 27, 2014. *Id.* The petitioner elected not to be covered under the Illinois Worker's Compensation Act. *Id.* The exclusion endorsement excludes the petitioner Adam Leczycki from payments under the policy. *Id.* The name of the insured is Adam Construction. *Id.*
Arbitrator notes the petitioner did not enter into evidence any W-2 forms, employee contracts, employee handbook, or copies of paychecks to the petitioner from the respondent.

Case law

There is no inflexible rule for determining whether an individual is an employee or an independent contractor. *Wenholdt v. Industrial Comm'n,* 95 Ill. 2d 76 (1983). The determination of whether a claimant is an independent contractor or an employee is crucial for it is the initial decision of the employment status of a claimant which determines whether he is entitled to compensation benefits. *Alexander v. Industrial Comm'n (1978), 72 Ill. 2d 444, 381 N.E.2d 669.* Some of the factors which must be considered in making this determination include the following: the right to control the manner in which the work is done; the method of payment; the right to discharge; the skill required in the work to be done; who provides tools, materials, or equipment; whether the workman's occupation is related to that of the alleged employer; and whether the alleged employer deducted for withholding tax. The right to control the manner in which the work is done is the most important factor in determining the relationship. Nonetheless, in determining whether an individual is an independent contractor or an employee, no one factor is determinative. *Wenholdt Id.*

Respondent did not deduct for withholding tax or for social security. The failure to withhold taxes or provide fringe benefits is not decisive. *Kirkwood Brothers Construction v. Industrial Comm'n,* 72 Ill. 2d 454. (1978).

The respondent required the petitioner to produce proof of workers compensation insurance which would clearly indicate that the parties contemplated an independent contractor relationship. Although this understanding is a factor to consider in determining claimant's status, it does not establish such status as a matter of law, *Wenholdt, Id.* Since many jobs contain elements of each, there is no clear line of demarcation between the status of employee and independent contractor. *Kirkwood, Id.*

Mr. Matyjas testified that petitioner was paid per day and not by the hour. There was no evidence that claimant performed any work pursuant to respondent's specific instructions or in a manner

directed by respondent. There was no evidence that respondent either helped claimant himself or brought in someone else to help claimant. It is undisputed that claimant used his own truck to travel to the job site or to haul materials purchased by respondent. After reviewing this evidence, the arbitrator finds that respondent did not exert a significant degree of control over the means by which claimant accomplished his work.

The arbitrator finds the appellate court's decision in *Esquinca v. Ill. Workers' Comp. Comm'n,* 2016 IL App (1st) 150706WC instructive in the instant case. In *Esquinca* the petitioner was a truck driver who owned his own truck. He delivered loads for the respondent. In *Esquinca* the parties signed a written agreement indicating the petitioner was an independent contractor. The petitioner in *Esquinca* was required to obtain workers compensation insurance for himself and was responsible for expenses in the operation of his truck. He could choose the routes necessary for the transportation of the loads. The petitioner had the respondent's logo on his truck. The petitioner paid for his own liability insurance for his truck. The president of the respondent testified that the petitioner was contacted and told that a load was available. The petitioner was told when and where the load needed to be delivered. He was not told which route to take. The petitioner was free to accept the load or turn it down. The petitioner was not told how to maintain his truck. The petitioner was paid a percentage of revenue for each load he delivered. The petitioner was paid by a 1099. In *Esquinca* the arbitrator found the respondent had minimal control over the manner in which the petitioner performed his job duties. The arbitrator noted the petitioner was free to accept or decline a delivery assignment. The arbitrator noted the respondent was only interested in the end result. The petitioner was free to drive for other companies.

Applying *Esquinca* to the instant case, the evidence shows that the employer did not have the right to control the claimant's work performance or work-related activities to any notable degree. In both cases the petitioner was paid by a 1099 and required to obtain workers compensation insurance. In both cases the petitioner was not told specifically how to obtain the acceptable end result.

Compensation

The petitioner testified that he earned $19 an hour. The petitioner testified that he was paid by check from the respondent. The petitioner testified that he was paid on a per hour basis and that he reported his hours. The petitioner's compensation was indicated by a 1099 form. The petitioner never received a W2. The recipient's name on the 1099 is "Adam Leczycki dba/Adam Construction." The transaction list mentions the checks are made out to Adam Construction. The checks are in varied amounts. The respondent paid Adam Construction Company for their services and not the petitioner. Mr. Matyjas testified that R5 is a printout of the checks paid to Adam Construction. The checks are paid based on the address of where the job was performed. The agreement Mr. Matyjas had with the petitioner was that the petitioner would perform demolition and carpentry work for $190 a day. Mr. Matyjas testified that the respondent's employees get paid vacations, overtime, and a 401(k) plan. The petitioner did not receive any of these benefits.

The arbitrator finds it significant that the petitioner was paid by checks payable to Adam Construction Company based on the address of the construction site in varied amounts. The

arbitrator also finds it significant that the petitioner received no payroll check with insurance or deductions taken out. The petitioner received a 1099. The arbitrator finds that the method of compensation between the parties would indicate an independent contractor relationship.

Workers Compensation Insurance

Mr. Matyjas testified that he insisted upon a certificate of workers compensation insurance from the petitioner before the petitioner could start work for the respondent. Petitioner testified that he provided a certificate of workers compensation insurance for Adam Construction to the respondent. Petitioner testified that he paid the premiums for this insurance and that he is covered by his workers compensation insurance policy. This testimony is contradicted by R4 which indicates the petitioner voluntarily chose to exclude himself from workers compensation coverage through Adam Construction when the petitioner signed the workers compensation coverage selection form on March 27, 2014. *R4.* The Adam Construction workers' compensation policy was later canceled for nonpayment of premiums. *Id.* Petitioner provided a workers' compensation policy to the respondent which would indicate the petitioner was aware that the parties contemplated an independent contractor relationship and that the petitioner was responsible for his own workers' compensation coverage. The evidence regarding workers' compensation insurance would indicate an independent contractor relationship.

The right to control the manner in which the work is done

Petitioner testified he received his job assignments from the respondent by phone call or text. Mr. Matyjas testified that he hired the petitioner as a subcontractor to perform carpentry and demolition services. Mr. Matyjas testified that he is not a carpenter and would not have the expertise to tell the petitioner how to perform carpentry or demolition. The petitioner provided no evidence of any specific circumstance where the respondent told the petitioner how to perform carpentry or demolition. Petitioner provided no evidence of any instance where the respondent corrected the petitioner's work methods. Petitioner testified that occasionally Peter or Ziggy would be at the job site which the arbitrator finds would be reasonable for any general contractor. The petitioner testified that the respondent was not at the job site every day. The arbitrator finds it significant that on the date of injury the respondent was not at the job site. On the date of injury the petitioner was simply performing demolition services as he saw fit. Petitioner did not call Peter or any other witness to testify to facts supporting the conclusion that the respondent controlled the manner in which carpentry or demolition services were performed. The arbitrator finds that the petitioner did not meet his burden of showing that the respondent controlled the manner in which the carpentry or demolition services were performed. The lack of control indicates an independent contractor relationship.

Conclusion

The arbitrator finds the petitioner did not meet his burden of proving an employee-employer relationship. All other issues are moot. Compensation denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Grisham,

Petitioner,

vs. NO: 17 WC 21622

19IWCC0586

State of Illinois – Centralia 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, causation, medical expenses and nature and extent, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects a clerical error in the decision of the Arbitrator at p.2 of the form decision to show that Petitioner alleged a date of accident of April 24, 2017, not April 24, 2018.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 6/27/18, with corrections, 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.

19IWCC0586

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 29 2019
o: 10/8/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRISHAM, JOHN
Employee/Petitioner

Case# **17WC021622**

SOI-CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

19IWCC0586

On 6/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
SHANNON D RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
RISK MANAGEMENT SERVICES
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 27 2018

19IWCC0586

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Grisham
Employee/Petitioner

Case # 17 WC 021622

v.

Consolidated cases: ______

State of Illinois-Centralia Correctional Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ed Lee**, Arbitrator of the Commission, in the city of **Mount Vernon**, on **04/04/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **04/24/2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**79,020.00**; the average weekly wage was $**1,519.62**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**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 $**if any** under Section 8(j) of the Act.

ORDER

The Arbitrator finds Petitioner has failed to meet his burden of proof in this matter. Petitioner's claim for permanency is hereby denied.

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

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

Carol Lee 6/25/18

Signature of Arbitrator Date

JUN 27 2018

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOHN GRISHAM,
Employee/Petitioner,

v. Case No. 17 WC 021622

STATE OF ILLINOIS – CENTRALIA CORRECTIONAL CENTER,
Employer/Respondent.

STATEMENT OF FACTS

On April 24, 2017, Petitioner was employed as a correctional officer at Centralia Correctional Center when he allegedly sustained a work-related injury to his left wrist due to the repetitive nature of his job duties. This claim came before Arbitrator Lee for trial at the Mount Vernon docket on April 4, 2018. The issues in dispute include accident, notice, causal connection, responsibility for medical bills, TTD, and nature and extent of the injury.

On April 24, 2017, Benjamin Scott Smith, FSPM, completed a Supervisor's Report of Injury or Illness outlining the reported accident as described by Petitioner to have been caused by the continuous use of keys and opening doors. (RX3).

On April 25, 2017, Petitioner completed an Illinois Form 45: Employer's First Report of Injury listing an accident date of April 24, 2017 as a result of turning keys and opening locks of the doors. (RX1).

On April 26, 2017, Petitioner completed a Workers' Compensation Employee's Notice of Injury reporting an accident date of April 24, 2017 as a result of writing logs and reports with repetitive key turning in locks. (RX2).

On April 27, 2017, Petitioner completed an Illinois Department of Corrections Incident Report indicating he initiated treatment for his left wrist with Dr. Mary Agnes on January 5, 2017 as a result of repetitive turning of keys, writing in logs, and performing other job duties requiting the repetitive twisting of his left wrist. (RX4). Petitioner met with Dr. Bruce Kraemer by referral on April 24, 2017 at which time he recommended surgery. (RX4).

On October 8, 2017, Petitioner completed a Detailed Job Description at the direction of his attorney. (PX11). Petitioner indicated he moves groceries, doors, pallets weighing up to one hundred pounds. (PX11). He did not indicate the frequency or duration of these activities. He did not describe the types of movements involved. (PX11). Petitioner also indicated he locks

and unlocks locks and doors daily on an hourly basis. (PX11). He did not indicate how many locks he uses or the frequency or duration of these activities. (PX11).

MEDICAL HISTORY

On February 21, 2017, Petitioner presented to Dr. Mary Agne at the Southern Illinois Healthcare Foundation for left handed joint pain. (PX3). The onset of Petitioner's symptoms was noted to be that same day. (PX3). Petitioner was told to wear a wrist splint at night and use his right hand more if feasible. (PX3). He was prescribed Prednisone. (PX3). X-rays and a nerve conduction study were ordered. (PX3).

On March 7, 2017, Petitioner returned to Dr. Agne for hypertension. (PX3). Petitioner's prescription of Bupropin was increased at his request. (PX3).

On March 27, 2017, Petitioner underwent an EKG/NCS at Memorial Hospital of Belleville for intermittent pain, numbness, and tingling in his left hand and fingers for more than six weeks. (PX4). He noted no significant hand weakness. (PX4). Petitioner had normal manual motor strength and sensory examination in his left upper extremity with a positive Tinel's test at the wrist and elbow. (PX4). The report suggested evidence of severe left median motor-sensory focal distal neuropathy at the wrist. (PX4).

On March 29, 2017, Petitioner underwent an x-ray of his left hand at Elite Imaging which was negative. (PX5).

On March 31, 2017, Petitioner was referred to SLU Anheuser-Busch Institute for carpal tunnel syndrome of his left upper limb. (PX3).

On April 21, 2017, Petitioner presented to Dr. Bruce Kraemer at SLU Care for left wrist pain. (PX6). A two month history of symptoms was noted. (PX6). Dr. Kraemer also indicated Petitioner had prior cervical complaints that affected his right hand. (PX6). A open carpal tunnel release was recommended. (PX6).

On May 25, 2017, Petitioner called Dr. Kraemer's office in anticipation of his surgery to address carpal tunnel syndrome in his left wrist. (PX6). Petitioner indicated he planned to go on vacation on June 17, 2017 and inquired as to what his restrictions would be. (PX6).

On June 29, 2017, Petitioner presented to SLH St. Louis University Hospital for a left carpal tunnel release through a longitudinal palmar incision which was completed by Dr. Kramer without issue. (PX7).

On July 3, 2017, Petitioner returned to Dr. Kraemer following his left carpal tunnel release. (PX6). He reported reoccurring fingertip numbness in his thumb, index and middle fingers, but said he was sleeping well and had no pain. (PX6).

On July 17, 2017, Petitioner returned to Dr. Kraemer for follow up. (PX6). Petitioner indicated he needed additional time off as he was employed as a prison guard, requiring full

heavy active duty. (PX6). Petitioner was released to return to work effective July 31, 2017. (PX6).

On August 21, 2017, Petitioner returned to Dr. Kraemer for follow up. (PX6). Petitioner's hand was 90% improved and he was very pleased with his progress. (PX6). He had resumed all of his normal work activities. (PX6). Petitioner was to continue with his hand exercises but was released from care and told to follow up as needed. (PX6).

On October 5, 2017, Petitioner underwent an Independent Medical Examination by Dr. Anthony Sudekum at the Missouri Hand Center. (RX5). Dr. Sudekum has the added qualification of surgery for the hand (CAQSH). (RX5). The doctor opined that Petitioner's left sided carpal tunnel syndrome was not caused by his work duties at Centralia Correctional Center. (PX5). He felt the surgical release Petitioner underwent in June of 2017 was appropriate to address his condition, but was not related to his alleged work accident. (RX5).

TESTIMONY

Dr. Bruce Kraemer, M.D. via deposition on November 28, 2017

On direct examination, Dr. Kraemer testified Petitioner brought what he believed were his only nerve conduction studies with him to the doctor's office. He said the studies showed that there was no sensory response of the median nerve which usually means the individual has severe carpal tunnel syndrome, which correlated with his clinical examination. As Petitioner had tried to treat his condition conservatively, Dr. Kraemer recommended a surgical release which took place June 29, 2017. Dr. Kraemer said Petitioner has done well since surgery with 90% improvement resulting in his being overall very leaved with his ability to resume all prior work activities. He noted Petitioner was a "very muscular, strong guy" and so needed to be careful. Dr. Kraemer noted Petitioner also had a biceps tendon rupture and other issues on his right side from his cervical problem.

Dr. Kraemer testified he did not initially take an in-depth evaluation of Petitioner's job duties but knew he was a prison guard. Later, the doctor received more information from Petitioner and a work job description which told him Petitioner was a food service supervisor II. Dr. Kraemer was aware of the use of small Folgers Adams keys and opined that the key grip was most likely not causing Petitioner's carpal tunnel syndrome. Instead, he believed it was the heavy nature of what was being done and noted Petitioner was a particularly muscular guy though he did not work out a lot. Dr. Kraemer explained that the gripping and using keys was not important, but rather the fact that he may be using his hand as a hammer to bang things, lifting fifty to one hundred pounds repeatedly, lifting things over his head, all activities in which you have to not only lift but rotate your wrist to do so. In summary, the doctor said it's not just the use but the heavy use of his wrist upon which he based his opinion. Dr. Kraemer stated Petitioner was right hand dominant but did a lot of activities with his left hand due to issues with his right side. Dr. Kraemer indicated Petitioner's work was a contributing factor in his development of left sided carpal tunnel syndrome.

Dr. Kraemer testified he did not know what a neurometrics test was but preferred "the old-fashioned nerve conduction studies." The doctor stated Petitioner's BMI was 34.56 and, again, noted he was very muscular. Dr. Kraemer testified the only non-work factor Petitioner had for the development of carpal tunnel syndrome was cervical radiculopathy with a bulging disc on the right. The doctor explained that the disc couldn't be the cause of Petitioner's issues on his left side since he's had such a nice recovery following his surgical release.

When asked on cross examination if he felt Petitioner's would have developed these symptoms without his job duties, Dr. Kraemer replied, "Well, it's a very hard thing to say." It appears Dr. Kraemer based his opinion on Petitioner's reports that his symptoms were worse at work and were only on the left side. The doctor believed Petitioner was doing "heavy job activities" and felt relief on the weekends when he wasn't at work, resulting in what he called a strong correlation. Dr. Kraemer again brought up that Petitioner was a muscular man who took testosterone. He said people do not take testosterone and get to be that large without some type of activity and work. This was despite Petitioner's claims that he does not work out. Dr. Kraemer said you could equally blame Petitioner's work duties and his overcompensation for his right sided cervical issue for his development of carpal tunnel syndrome in his left wrist.

Dr. Kraemer testified to additional risk factors he did not include in his direct examination. He said Petitioner's age was somewhat of a factor, though it would be worse if he was fifty or sixty. The doctor said his weight would be a factor but not as much since it was muscular weight. He supported his position by stating since Petitioner "got really well" it proved his was not really obese. Dr. Kraemer said hypertension would only be a risk factor for the elderly population. He stated taking Cypionate or testosterone could be a risk factor, but likely wasn't for Petitioner since his condition was one-sided. Dr. Kraemer admitted he could not recall Petitioner having an EMG done on his right side for comparison. He admitted he did not review Dr. Agne's records in detail to discover whether Petitioner had similar right sided problems. Dr. Kraemer assumed that the lifting injury noted by Dr. Agne on January 11, 2016 was the biceps rupture on Petitioner's previously suffered. Dr. Kraemer did not have Dr. Agne's record of August 21, 2017 wherein Petitioner requested a cortisone injection for left shoulder pain.

Dr. Kraemer testified he was supplied the additional duty information he discussed on direct examination by Petitioner's attorney. The doctor admitted he did not know how many keys Petitioner turned per day. He indicated that wouldn't really matter as his decision was based more so on the heavier use and the positions of the wrists, especially with overhead lifting, and, for example, the pushing or slamming of big doors. Dr. Kraemer said Petitioner's condition not be caused by fine manipulations such as the turning of Folgers Adams or master lock style keys unless it was fifty to one hundred locks an hour, repetitively. Dr. Kraemer dismissed Petitioner's writing as playing a role in his condition as it he right-handed and developed the carpal tunnel syndrome in his left. Dr. Kraemer admitted he assumed Petitioner was lifting heavy items above his head since he was "the big boy on the block".

Dr. Kraemer testified Petitioner should have fairly normal range of motion and he was not aware of any limitations Petitioner was experiencing. Dr. Kraemer said he did not note any tenderness at his last visit with Petitioner. He said Petitioner may have had a little pain if you

pushed hard enough, but that was resolving. Dr. Kraemer stated Petitioner could have had some sensory issues since he had last seen him only a few months following his surgery, but he did not document an impairment. The doctor said a better measurement could be had at twelve months because the nerves need time to heal.

Dr. Anthony Sudekum, IME Physician, via deposition on February 6, 2018

On direct examination, Dr. Sudekum testified he performed an Independent Medical Examination of Petitioner on October 5, 2017 following his carpal tunnel release performed by Dr. Kraemer in June of 2017. At the time he met with Petitioner, he was still having numbness in his fingertips and thumb tip though his nighttime symptoms had resolved. Dr. Sudekum reviewed Petitioner's job duties with him verbally and also reviewed a written job description as it relates to Petitioner's position as correctional food services supervisor II at Centralia Correctional Center. Dr. Sudekum agreed with Petitioner's diagnosis of left carpal tunnel syndrome which was adequately treated with surgery. Dr. Sudekum did not feel that Petitioner's left carpal tunnel syndrome was caused or aggravated by his job duties at the correctional center. The doctor's opinion was primarily based on his knowledge of Petitioner's job duties. Dr. Sudekum personally visited Centralia Correctional Center to do a walk-though and evaluation of the facility as it might relate to the causation of upper extremity conditions like carpal tunnel syndrome. The doctor observed correctional services supervisors carrying out their daily duties and characterized their manual activities as mild to moderate. The activities included handling of keys, opening doors and cabinets, some writing and logging of inventory, and light manual activity of lifting and carrying though the inmates did the vast majority of the that activity. Dr. Sudekum estimated a person in Petitioner's position would key 50 to 100 times per day which was supported by Petitioner's own statements at the time of the exam.

Dr. Sudekum noted the number of risk factors and comorbid conditions had by Petitioner that could have led to the development of carpal tunnel syndrome. Petitioner is over 47 years old, has a history of hypertension, is in the moderately obese category with a BMI of 34, was a former motorcycle rider for a long period of time, and said he worked out quite a bit. Dr. Sudekum vehemently disagreed with Dr. Kraemer that muscular weight is not a factor in the development of carpal tunnel syndrome. He explained that obesity causes the body to compress the nerve and compromise blood flow. This is even truer of more muscular body types as the density of muscle seems to cause more issues. The doctor also noted Petitioner's history of cervical disc disease which caused radicular symptoms in his right hand, which he characterized as a high risk for the development of carpal tunnel syndrome. Petitioner informed Dr. Sudekum he was right hand dominant and did not elaborate as to what he later claimed was his extensive use of his left hand to overcompensate for his cervical issues affecting his right side.

On cross examination, Dr. Sudekum testified that the duties of a food service supervisor are not virtually identical, the same, or just similar to those at Pinckneyville, Menard, Centralia, and Vienna Correctional Centers. Dr. Sudekum agreed that Petitioner stopped riding his motorcycle in 2015 after an accident, but believed the riding could be a contributing factor as it could have caused or contributed to compression neuropathies if he was feeling symptoms at the time he was still riding. Dr. Sudekum echoed Dr. Khariton's conclusion in his nerve condition

study that Petitioner had no sensory response which he agreed was relatively severe for carpal tunnel syndrome. Dr. Sudekum noted he was not studied on the right side.

Dr. Sudekum testified that though gripping, grasping, exposure to vibratory tools and hand use can cause carpal tunnel syndrome, but they are also normal activities people do every day and are not themselves provocative of carpal tunnel syndrome. Dr. Sudekum noted Petitioner's right hand was significantly stronger than his left, supporting Petitioner's statement to the doctor that he was right hand dominant. Dr. Sudekum termed activities such as opening doors and turning locks as benign activities. He opined that Dr. Kraemer would not be in a better position to diagnose causal connection because of his knowledge of Petitioner's inclination to do those types of activities with his left hand. Dr. Sudekum said Petitioner made a pretty good recovery following surgery and suggested that his neck be evaluated to attempt to address his remaining symptoms and determine if his cervical radiculopathy could be bilateral in nature. Dr. Sudekum agreed he did not have all of Petitioner's records for his cervical radiculopathy. The doctor was aware of Petitioner's prior military service and did not believe he had other assignments in his duties at the correctional center. Dr. Sudekum stated he prefers to do open surgical releases rather than arthroscopic but has completed both. Dr. Sudekum reiterated that he believed Petitioner would have developed carpal tunnel syndrome absent his job at Centralia Correctional Center.

John Grisham, Petitioner

On direct examination, Petitioner testified that he is employed by the Illinois Department of Corrections as a food service supervisor II and has been so employed for a little more than twenty-two years. Prior to starting his employment with the State of Illinois at age twenty-six, Petitioner was employed by the Georgia Department of Corrections and served in the United States Army as a fuel specialist with the primary task of dispensing fuel.

Petitioner testified he noticed issues with his hands beginning in 2015 and 2016, which gradually worsened overtime. His symptoms included numbness in his left three fingers, numbness in his hand, and pain in his wrist. Petitioner is right hand dominant, but claimed he uses his left hand more at work due to a herniated disc which causes pain in his right hand and occurred in 2015.

Petitioner testified his job duties included putting away and shelving groceries by instructing the inmates how to put food away, how to stack it, and where to stack it. At times, Petitioner physically picks up the food to show the inmates what is to be done. Petitioner said he participates in or helps with putting the groceries away with the inmates to make sure it gets done quickly and correctly. Petitioner also opens cabinets using grip and force. Petitioner uses his hands to search for contraband such as "hooch" and weapons. Petitioner also works in cold temperatures when he places items in the cooler by opening a steel door and putting the items on a shelf. Petitioner said he instructs the inmates as to how to put and stack canned goods away. Petitioner did not testify he moves groceries from the warehouse by hand, but instead he uses a dolly and a jack. Petitioner explained that there are many locks in the food service area which he must lock and unlock to allow the inmates to use any utensils. Petitioner stated there are fourteen locks on the dishwasher, twelve of which are opened twice at breakfast and twice at

lunch. Petitioner described the keys he uses as small Folgers Adams keys, bigger than an average size house key. Petitioner said the locks are not always functional and can be full of soap or chemicals. Petitioner claimed he uses his left hand to unlock the locks.

Petitioner testified he does not currently have any hobbies which would involve the repetitive use of his hands, but he used to and has since given those up. Petitioner no longer rides his motorcycle and stopped in 2015 after a wreck. Petitioner stated he does not have gout, rheumatoid arthritis, or any other factors associated with compression neuropathy or carpal tunnel syndrome. Petitioner admitted he has hypertension for which he takes medication. Petitioner ultimately sought treatment from his primary care physician in 2017, Dr. Mary Agne. After a nerve conduction study, Petitioner was referred by Dr. Agne to Dr. Bruce Kraemer, an orthopedic surgeon at Washington University. Dr. Kraemer began treating Petitioner on April 24, 2017 and diagnosed Petitioner with severe left sided carpal tunnel syndrome. Petitioner agreed he was much less detailed in the incident report he completed at that time than he was in Petitioner's Exhibit 11. Dr. Kraemer performed surgery which Petitioner said has helped. Petitioner described his numbness as being 98% gone and his strength as being 70% less than what it was, though he still has pain in his wrist with range of motion. Petitioner claimed he is more likely to use his right hand, even though it is painful, due to the pain in his left hand. Petitioner clarified there is no claim of injury to his right hand. Petitioner said the only medication he takes is over the counter Tylenol on a daily basis. Petitioner indicated he is now unable to work out, but admitted that is also the result of a torn bicep tendon and other problems.

On cross examination, Petitioner testified he knew his work duties were causing his problems in his left hand in 2015 or 2016. He was having the same issues at that time, though he thought they were milder at the time. Petitioner said his job duties were the same as they are now prior to 2017. Petitioner stated that pretty much all of his job duties gave him issues prior to his surgery including opening and unlocking locks and helping the inmates to get their tasks done faster. Petitioner claimed he is right hand dominant but now uses his left hand more than the right. However, for example, Petitioner said he would use his right hand to write a letter. Petitioner claimed he began using his left hand more than his right following his carpal tunnel release as prior to that, his left was more painful than the right so he used his right hand more. After prompting by his attorney, Petitioner added that, prior to 2017, he started using his left hand more than his right due to a herniated disc in his back causing pain in his right. Petitioner explained that he has no idea what caused his herniated disc but it resulted in pain and numbness in his right side. Petitioner stated his right hand caused him more pain prior to 2015. But from 2015 to 2017, he believed his left hand was causing him more pain than his right. Following his surgery in 2017, Petitioner said his right side is more painful which causes him to use his left side more.

Petitioner testified that once the shows the inmates how to do something, they are able to take over that activity from him. Petitioner has to show the inmates how to do tasks up to three or four times. Petitioner must show the inmates how to do their assigned tasks daily as they are moved out of the department quickly and replaced by new inmates. Petitioner agreed the inmates do the majority of the work in the food services department. Petitioner admitted the inmates do all of the activities he listed in detail on direct examination, with the exception of opening locks and doors. Petitioner stated he puts grocery items away through each workday, but specifically

mentioned Monday, Wednesday, and Thursday. Petitioner acknowledged that the quantity of items to be put away varies from day to day. Petitioner was uncertain as to how heavy the small Folgers Adams key he described would be.

Petitioner testified he no longer lifts weights as he experiences instability in holding the weights which causes pain. He claims he is unable to lift weights at any level currently. Petitioner said he now does cardio at the gym he attends. Petitioner stated he is six feet and one inch tall and weighs approximately two hundred fifty pounds which is a consistent weight for him. Petitioner is forty-eight years old. He was diagnosed with hypertension in March of 2017 and began taking medication at that time. Petitioner claimed he had no symptoms of hypertension prior to his diagnosis.

Petitioner testified he experiences pain in the middle of his wrist with range of motion, side to side, and up and down during any time when his wrist is in use. Petitioner admitted he did not tell his doctor about his pain. Petitioner is not experiencing the same pain in his right wrist, but he has some pain with range of motion.

Petitioner testified he went on vacation to Panama City Beach, Florida in June of 2017 as is outlined in his medical records.

Petitioner testified he has received a performance evaluation since returning to work following his surgery. He stated the results were "Exceeds in all areas."

On redirect, Petitioner clarified that the inmates do not do any of the locking or unlocking.

Benjamin Scott Smith, Food Services Program Manager

Mr. Smith testified he agreed with Petitioner's testimony and described him as a good, loyal worker. Mr. Smith indicated there are a lot of locks but he is not sure whether that's a problem or not. He said he does not key as much as the food supervisors but must use the keys a lot during the day. Mr. Smith agreed with Petitioner's description of the small Folgers Adams keys and described them as three inches long. He noted there is also another key that is closer to a house key, of which they have several. Mr. Smith described the dishwasher locks as having chemicals and lime in them so it is a constant job to keep them clean. He agreed that makes them hard to turn.

CONCLUSIONS OF LAW

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

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

Petitioner failed to meet his burden of proof by demonstrating that an accident occurred which arose out of and in the course of his employment with Respondent and that his current condition of ill-being is causally related to the alleged injury.

Petitioner claimed he was aware that the duties of his employment were causing his symptoms in his left hand dating back to 2015. Petitioner's initial notices of his alleged injury attributed his development of left sided carpal tunnel syndrome to his continuous use of keys, opening of doors, and writing of logs and reports at Centralia Correctional Center as evidenced by the reports contained in Respondent's Exhibits 1, 2, 3, and 4. Despite Petitioner's own beliefs about the origin of his condition, Dr. Kraemer and Dr. Sudekum both opined that Petitioner's keying and gripping were not the cause of his development of carpal tunnel syndrome. For this reason, Dr. Kraemer said it did not matter that he was unaware of how many keys Petitioner turned each day. Instead, Dr. Kraemer connected Petitioner's condition on the heavy nature of his job duties such as using his hand as a hammer to pound things, repeatedly lifting 50 to 100 pounds, lifting items overhead, and other activities requiring the lifting and turning of his wrist. The doctor specifically said Petitioner's condition would not have been caused by fine hand manipulations such the turning of Folgers Adams keys unless he was doing so 50 to 100 times each hour rather than just daily. According to Petitioner's testimony at trial and his statements to Dr. Sudekum, he was only turning 50 to 100 keys per day, not her hour. Dr. Kraemer confessed it would be very difficult for him to say that Petitioner would not have developed his condition absent his employment at Centralia Correctional Center. He thought you could equally blame Petitioner's cervical issues and his employment duties for his development of the carpal tunnel syndrome. He indicated his causation opinion was based on Petitioner's reports that his symptoms were worse at work and subsided on the weekends when he was off work. Dr. Kraemer also noted 5 times during his deposition Petitioner was quite muscular. That fact was apparently important to the doctor as he assumed Petitioner was constantly lifting heavy items because he was a large, muscular male. Despite this, Dr. Kraemer testified Petitioner's BMI placing him the in moderately obese category was not a comorbid factor. Dr. Kraemer ignored Petitioner's obviously muscular build and the compression that would cause in his upper extremities. In light of Petitioner's physical appearance and his use of testosterone, the doctor was vague in whether he believed Petitioner's contention he no longer worked out. Dr. Kraemer pointed out that an individual does not become as muscular as Petitioner while using testosterone without some level of exercise or weight lifting. Rather than delve into that potential risk factor, and many others quickly dismissed by the doctor, the focus was instead placed on the assumption that since Petitioner had a nice recovery following surgery, his condition must have been carpal tunnel brought about by his work duties. This is a rather large assumption and fails to consider the many other reasonable issues put forth by Dr. Sudekum.

Dr. Sudekum personally visited Centralia Correctional Center and observed food service supervisors completing their daily employment duties while Dr. Kraemer has not. Dr. Sudekum believed Petitioner keyed 50 to 100 times each day, which would have been insufficient to cause carpal tunnel syndrome. The frequency of the keying was supported by Petitioner's own testimony. The IME doctor called attention to the fact that the inmates do most of the manual labor in the food services department. This was confirmed by Petitioner through his testimony at hearing. Petitioner confessed he only shows the inmates how to do the numerous activities he described in his direct examination and Petitioner's Exhibit 11 up to 3 or 4 times each day.

Unlike Dr. Kraemer, Dr. Sudekum did not believe Petitioner did a great deal of heavy activities. The lack of frequent, heavy activities was supported by Petitioner's Exhibit 11 and Respondent's Exhibits 1, 2, 3, and 4. Petitioner's testimony also supported Dr. Sudekum's belief. Petitioner listed his job duties in his testimony and Respondent's Exhibit 11, but failed to indicate the frequency or duration of those activities. Instead, Dr. Sudekum offered a more in depth analysis of Petitioner's potential comorbid factors including hypertension, age, moderate obesity and muscular build, prior motorcycle riding, and cervical radiculopathy. Dr. Sudekum noted Petitioner stopped riding a motorcycle in 2015, which happens to be the same year in which his symptoms began. Petitioner asked for an increase in his medicine meant to control his hypertension in March of 2017, only weeks after he presented to Dr. Agne for left handed joint pain. Petitioner continued to have numbness and tingling in his left hand after his carpal tunnel release, despite Dr. Kraemer's reliance on Petitioner's successful recovery in rendering his causation opinion. For that reason, Dr. Sudekum suggested Petitioner's cervical radiculopathy may be playing a larger role than Dr. Kraemer expected. Both doctors confirmed Petitioner never underwent a nerve conduction study on his right side. He had a history of complaints on the right and the left, which prompted him to request a cortisone injection into his left shoulder for pain. Petitioner's other issues calls the origin of his symptoms into question. The evidence presented does not support that Petitioner's allegations that keying, opening doors, and writing caused his development of carpal tunnel syndrome as alleged in his initial documentation of the injury. Petitioner changed his testimony at trial to focus more intently on his other job duties in light of the opinions of Dr. Sudekum and Dr. Kraemer. This inconsistency has not gone unnoticed by the Arbitrator.

Petitioner and his physician placed great emphasis on his preference for using his left hand over his right for daily activities, despite being right hand dominant. Dr. Kraemer assumed that since Petitioner only developed the condition in his left hand, he must be using it more. This assumption was disproved by Dr. Sudekum who noted Petitioner's strength was greater in his right than his left. Petitioner also failed to tell Dr. Sudekum he believed he was using his left hand more than his right, which calls Petitioner's veracity into question. As noted above, there was no EMG/NCS on the right hand for comparison purposes. In his testimony, Petitioner initially stated that prior to his surgical release, his left side was more painful than the right. This sensation spanned 2015 to 2017 and caused him to use his right more than left at that time. This is contradictory to the statements of Petitioner and Dr. Kraemer that he used his left hand more than his right at work which brought about his development of carpal tunnel syndrome on the left side only. After prompting from his attorney, Petitioner clarified his testimony to say he used his left more than his right prior to 2017. It is unclear when or how Petitioner used each of his hands in his daily job duties based on his testimony. The Arbitrator must instead rely on the undisputed testimony from both doctors and Petitioner that he was right handed as supported by the medical evidence that Petitioner's right side was stronger. This does not correlate with Petitioner's allegation that his job duties caused his development of carpal tunnel syndrome on his non dominant, left side.

As the Arbitrator has determined Petitioner has failed to meet his burden of proof, the claim is denied and all other issues are moot.

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

Issue (K): What temporary benefits are in dispute (TTD)?

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

Based on the foregoing, paragraphs (J), (K), and (L) 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 COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ENDILISIA MUNOZ,

Petitioner,

vs. NO: 01 WC 004569

CITY OF CHICAGO,

19IWCC0587

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 causal relationship, medical expenses, and permanent disability and being advised of the facts and law, provides further analysis of 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.

Causal Connection

The Commission finds Petitioner failed to prove her low back condition is causally related to her injury of November 10, 1999 to her right knee. Initially, the Commission notes Petitioner failed to provide any testimony at trial (October 6, 2016) regarding any current or prior complaints of low back pain. This failure of testimony regarding low back complaints is also noted in the initial 19(b) hearing of July 13, 2004.

Even assuming such testimony was presented, the medical evidence fails to establish a causal relationship between Petitioner's current condition of ill-being in her low back and her November 10, 1999 injury. On March 10, 2016, Dr. Buvanendran evaluated Petitioner who complained of low back pain for a one-month duration. PX1. Petitioner provides no history regarding the cause of her back pain nor is there any indication in the medical record memorializing Petitioner's alleged altered gait. On August 7, 2006, Dr. Singh evaluated

19IWCC0587

Petitioner who provided a history of a gradual onset of low back pain. Dr. Singh diagnosed degenerative disc disease consistent with the MRI performed on March 22, 2006. PX1. Again, Petitioner provides no history regarding the cause of her back pain nor is there any indication in the medical record memorializing Petitioner's alleged altered gait.

On August 10, 2006, Dr. Fetzer evaluated Petitioner who provides a history of "insidious onset of right sided axial low back pain." For the first time, an altered gait is noted, which Dr. Fetzer finds to be the cause of Petitioner's low back pain. Dr. Fetzer recommends physical therapy, but there is no evidence Petitioner followed such recommendation. PX2.

On November 21, 2004, Dr. Sheinkop authors a letter noting, "this patient has lumbosacral spine disease, the latter resulting in referred pain to her lower extremity. The patient's current diagnosis is that of a remote right total knee replacement, complex, with reflex sympathetic dystrophy and deep venous thrombosis." PX2. Again, there is no mention of an altered gait. Moreover, Dr. Sheinkop fails to even provide a diagnosis regarding Petitioner's low back condition.

On April 12, 2013, Dr. Konowitz evaluated Petitioner pursuant to Section 12 of the Act at Respondent's request. Petitioner provided a history of intermittent low back pain. Dr. Konowitz opined Petitioner suffers from chronic back pain which is unrelated to her knee injury. Dr. Konowitz noted Petitioner's use of a cane but found no relationship between such usage and Petitioner's development of back pain. RX1.

The Commission affords greater weight to the opinions of Dr. Konowitz over those of Dr. Fetzer. Dr. Konowitz had the benefit of reviewing all of Petitioner's prior medical records whereas Dr. Fetzer did not. Moreover, the medical records evidence Petitioner's low back pain developed gradually over time with no specific cause. This is consistent with the MRI findings of degenerative disc disease as well as the opinion of Dr. Singh.

Medical Expenses

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). As Petitioner failed to prove her condition of ill-being as it relates to her low is causally related to her injury of November 10, 1999, the Commission finds the medical treatment also unrelated and denies payment of the expenses.

Permanent Disability

A. Permanent Total Disability

The Commission finds Petitioner failed to prove entitlement to permanent total disability benefits.

We have held on numerous occasions that "an employee is totally and permanently disabled for the purposes of workmen's compensation benefits when he is unable to make some

contribution to industry sufficient to justify payment to him of wages." [citation omitted]. However, this does not require that the injured party be reduced to a state of total physical or mental incapacity or helplessness. [citation omitted]. A person is totally disabled when he cannot perform services expect those that are so limited in quantity, dependability or quality that there is no reasonably stable market for them. [citations omitted]. Therefore, if an employee can take up some form of employment without seriously endangering his health or life he is not entitled to total and permanent disability compensation. [citations omitted]. *A.M.T.C. of Illinois, Inc. v. Industrial Commission*, 77 Ill. 2d 482, 487-88, 397 N.E.2d 804 (1979).

Petitioner testified her symptoms have persisted since her last evaluation by Dr. Mitchell Sheinkop in 2004. Petitioner provided numerous examples of what she claimed were her physical limitations, but she presented no medical opinion contemporaneous with the date of the arbitration hearing that would corroborate her claim. The most recent medical records Petitioner tendered into evidence memorialize treatment in 2006, almost ten years prior to the October 6, 2016 arbitration hearing, and those records concerned Petitioner's low back, a body part found unaffected by Petitioner's November 10, 1999 accident.

The medical records more recent than 2006 indicate little or no residual impairment from Petitioner's November 10, 1999 accident. Petitioner came under the care of Dr. Verma on February 22, 2008 after being involved in a motor vehicle accident on December 5, 2007. Dr. Verma, after examining Petitioner's right knee, was left with the impression that Petitioner's right knee had been reasonably well since her surgery in 2003. Dr. Verma's subsequent records indicate Petitioner's left knee was the sole focus of his attention. RX2.

Dr. Konowitz was the most recent medical professional to examine Petitioner as of April 12, 2013. At that time, Petitioner complained of significant pain in her thoracic spine pain, lumbar spine pain, left ankle pain, right leg pain, left leg pain. The physical examination, though, resulted in no findings of any tenderness to palpation to any part of her body except that portion of her skin that was the site of a skin graft harvesting. The range of motion testing of Petitioner's hips and knees resulted in no complaints or findings of pain. RX1.

Dr. Konowitz' examination was also remarkable in that, save for the active flexion in Petitioner's right knee, her lower extremities demonstrated full range of motion, the ability for her to squat normally, the ability for her to walk normally on her toes and heels, and 5+/5 strength. Dr. Konowitz determined Petitioner's disability involved only her gait and released Petitioner to return to work with sedentary restrictions. RX1.

The Commission affords greater weight to the opinions of Dr. Konowitz over those of Dr. Sheinkop. The Commission notes Petitioner's condition seems to have improved since Dr. Sheinkop authored his letter of November 21, 2004. Among the enumerated activities Dr. Sheinkop indicated Petitioner was unable to perform were walking any distance, using stairs, squatting, and carrying items. Dr. Singh, in his August 7, 2006 letter to Dr. Buvanendran, indicates Petitioner engaged in walking recreationally and was able to walk for 30 minutes. PX1. Petitioner's testimony also indicates she can negotiate stairs and carry items, albeit not without taking certain precautions. T. 24; 28. Dr. Konowitz found Petitioner capable of returning to work at a sedentary capacity, but for, Petitioner's voluntary retirement, she is

capable of returning to work. As such, the Commission finds Petitioner failed to prove entitlement to permanent total disability benefits.

B. Permanent Disability Benefits pursuant to Section 8(d)1 and 8(d)2

Where a claimant's attempt to establish permanent total disability is unsuccessful, it is incumbent upon the Commission to alternatively consider the claimant's entitlement to wage differential benefits. See *Lenhart v. Illinois Workers' Compensation Commission*, 2015 IL App (3d) 130743WC, ¶52, 29 N.E.3d 648:

> In cases where a claimant unsuccessfully seeks PTD benefits and does not make an alternative request for PPD benefits, the claimant is still entitled to PPD benefits when the evidence supports such an award. Likewise, in such cases, we believe that the Commission is obligated to consider a wage differential award when there is evidence in the record that could support a wage differential award (regardless of which party presented the evidence), and when nothing in the record suggests that the claimant elected to waive his right to recover such an award.

Under Section 8(d)1, an impaired worker is entitled to a wage differential award when (1) she is "partially incapacitated from pursuing [her] usual and customary line of employment" and (2) there is a "difference between the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which [she] was engaged at the time of the accident and the average amount which [she] is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1* (West 2012). Petitioner failed to present evidence of an inability to return to her usual and customary line of employment or an impairment of earning capacity.

Petitioner testified she voluntarily retired in 2004 and never contacted Respondent regarding a return to work. T. 46. Dr. Konowitz opined Petitioner was able to return to work at a sedentary capacity. Petitioner testified her job responsibilities required her to operate a Xerox machine in making pamphlets and booklets. Joint Exhibit, p. 7. Given the duties, Petitioner is able to return to work but for her voluntary retirement. As for an impaired earning capacity, Petitioner testified she has sought no employment since retiring. T. 35-37. There is no evidence vocational or otherwise as to Petitioner's earning capacity. The Commission finds Petitioner failed to prove her entitlement to benefits pursuant to Section 8(d)1.

Under Section 8(d)2, an impaired worker is entitled to benefits "if such injuries partially incapacitate [her] from pursuing the duties of [her] usual and customary line of employment but do not result in an impairment of earning capacity…" *820 ILCS 305/8(d)2* (West 2012). As previously stated, Petitioner failed to prove she is incapacitated from performing her usual and customary line of employment. As such, the Commission finds Petitioner failed to prove her entitlement to benefits pursuant to Section 8(d)2.

C. Benefits pursuant to Section 8(e)

The Commission finds Petitioner proved entitlement to benefits pursuant to Section 8(e)

of the Act. Petitioner's injury to her right knee required multiple surgeries with the most recent being May 9, 2003. Petitioner last consulted with Dr. Sheinkop on March 22, 2004 at which time he noted Petitioner's surgical outcome to be reasonable. PX2. Thereafter, Petitioner underwent pain management with her final visit regarding her right knee occurring on March 10, 2006. PX1. Petitioner testified other than Tylenol 3, she takes no other medications for her knee. T. 28. As such, the Commission finds Petitioner is disabled to the extent of 50% loss of use of her right leg pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 27, 2017 is hereby affirmed and adopted as modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove a causal relationship between her low back condition and her accident of November 10, 1999.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove entitlement to medical expenses, pursuant to Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the sum of $345.03 per week for a period of 100 weeks, as provided in Section 8(e)12 of the Act, for the reasons that the injuries sustained caused the 50% loss of use of the left leg.

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.

Pursuant to Section 19(f)(2) of the Act no bond is required. 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 29 2019
LEC/mav
O: 08/27/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MUNOZ, ENDLILISIA
Employee/Petitioner

Case# **01WC004569**

CITY OF CHICAGO
Employer/Respondent

19IWCC0587

On 11/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOHN POWERS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0113 CITY OF CHICAGO
NICHOLAS PERRONE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Endilisia Munoz
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **01** WC **4569**

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 **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **October 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **11/10/1999**, 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 **3/10/2011** injury, Petitioner earned $**29,984.75**; the average weekly wage was $**575.05**.

On the date of **11/10/1999** accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of $**909.00** under Section 8(j) of the Act.

ORDER-CORRECTED WEEKS TO 100

This Arbitrator finds that Petitioner's back condition is not casually related to the work accident, and, therefore, all bills related to the back are denied.

In regards to the right knee injury, Respondent shall pay Petitioner permanent partial disability benefits of $345.03/week for **100** weeks, because the injuries sustained caused a 50% loss of the right LEG , as provided in section 8 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.

#01 Arb. George J. Andros

Signature of Arbitrator

November 21, 2017

Date **CORRECTED**

NOV 27 2017

Endilisia Munoz vs. City of Chicago
01 WC 4569

FINDINGS OF FACT

On July 13, 2004, the parties proceeded as a 19(b) hearing, with disputed issues as to accident, notice, causation, medical services, and temporary total disability. The Arbitrator found that Petitioner did sustain injuries to her right knee that arose out of and in the course of employment; timely notice of the accident was given to Respondent, necessary medical services have not been provided by Respondent, and Respondent owed Petitioner TTD from December 23, 1999 through February 29, 2004. On July 17, 2007, the decision of the Arbitrator was affirmed by the Illinois Workers' Compensation Commission.

The parties proceeded to hearing on October 6, 2016, with disputed issues as to medical bills and the nature and extent of the injuries. Petitioner retired on February 29, 2004, and so no additional TTD was claimed.

The medical records presented at the 19(b) hearing indicate that Petitioner sustained an ACL tear, soft tissue damage, and a linear peripheral ear involving the peripheral aspect of the posterior medial meniscus on the right knee. She underwent a total right knee arthroplasty on December 23, 1999. On February 1, 2000, after she presented with right knee swelling and instability, she underwent a second right knee surgery. On May 11, 2000, Petitioner underwent a right knee open lysis for adhesions for arthrofibrosis, and on May 9, 2003, following an infection she underwent an irrigation and debridement of the right total knee replacement, a medical gastrocnemius pedicle flap from right leg to cover right anterior knee wound, and a split thickness skin graft right thigh to right muscle pedicle flap. (Ax 2 & 3).

Petitioner testified that the last time she treated for her right knee was when she saw Dr. Shienkop in March 2004. On November 21, 2004, Dr. Sheinkop authored a letter to the Petitioner's attorney and opined that, "This patient is incapable of returning to any type of work-related activity because of her functional limitation and her complex pain pattern necessitating ongoing treatment. This patient has reached maximum medical improvement but that situation is consistent with total disability and inability to walk any distance, walk unassisted, use stairs, stand for prolonged periods of time, squat, kneel, crawl, lift, and carry as well as climb." Dr. Shienkop also notes the last time he saw Petitioner was on March 22, 2004. (Px 2, p 2).

On July 13, 2004, the parties proceeded with a 19(b) hearing. Petitioner made no complaints of back pain at that time.

In February 2004, Petitioner began treating with Dr. Buvanendran for right knee pain. On March 10, 2006, Petitioner reported lumbar back pain and on March 22, 2006, Petitioner underwent a lumber MRI. Following the MRI she returned to Dr. Buvanendran who diagnosed her with a L3-L4 disc herniation and lumbar radiculopathy. She then had a total of four epidural steroid injections.

On August 7, 2006, she began treating with Dr. Kern Sigh for her low back pain. At that time, Dr. Sigh reported that "she is able to sit for 15 minutes, stand for 20 minutes and walk for 30 minutes." (Px 2, p 4). Dr. Sigh reviewed the March 22, 2006, MRI and noted there is a decrease in disc height at L3-L4 and L5-S1 and that there are modic signal changes consistent with degenerative disc disease at L3-L4.

On August 10, 2006, Petitioner was seen by Dr. April Fetzer. Dr. Fetzer opined that the right axial low back pain was "likely the result of hip and sacral compensation from an altered gait pattern secondary to the previous knee injury." (Px 2, p 7). Petitioner testified that she has not treated for her right knee or back since 2006.

Petitioner testified that on December 5, 2007, she was involved in a car accident, in which the car was totaled. She testified that she was in the front passenger seat, and her niece was driving. She stated that her left knee was injured in that accident. As a result of the injuries sustained in that car accident, in February 2008, the Petitioner began treating with Dr. Nikhil Verma. Following a left knee MRI, on March 6, 2008, Dr. Verma diagnosed her with a left knee medial meniscus tear. On March 17, 2009, Petitioner saw Dr. Henry Danko, her internist, in preparation for her left knee surgery. Dr. Danko reported that "In December 2007 she injured both knees in an MVA" (Rx 1). Petitioner testified at trial that she has had no other injuries to her right knee since the November 10, 1999, accident.

As a result of the car accident, on March 27, 2009, Petitioner underwent a left knee arthroscopy with Dr. Verma to repair a left knee small medial and lateral mensical tears. (Rx 3). On July 6, 2009, Petitioner had a follow-up appointment with Dr. Verma, at which time he reported that she "is undergoing physical therapy for her left knee, as well as her right knee." (Rx 2). At trial, Petitioner reported that she only injured her left knee in the 2007 car accident and that she does not recall telling her doctor that she injured both knees.

Petitioner underwent an Independent Medical Examination with Dr. Howard Konowitz on April 12, 2013. (Rx 1). At that time, Petitioner had subjective complaints of bilateral weakness of the knees and did not meet the criteria for complex regional pain syndrome.

Both knees appeared swollen and heavy. He also diagnosed Petitioner with chronic back pain, noting nonsymptomatic findings on a 2002 MRI, and opined the back pain is unrelated to the work injury. Dr. Konowitz found that Petitioner was at MMI and she was able to work in sedentary duty job.

Petitioner is currently 70 years old. Petitioner testified that she completed her sophomore year in high school, and prior to working for the City, she worked in a grocery store. She also testified that she currently does not have a driver's license. Petitioner retired in February 2004 before she was at MMI. She testified that she has not applied for any jobs or made any attempts to seek employment since that time.

Petitioner testified at trial that she has pain and stiffness in the morning and it takes her awhile to get out of bed. She keeps a cane next to her bed and uses handrails in the bathroom. She testified that currently she does not leave the house alone and often relies on her nieces and nephews or other relatives to take her to the grocery store or other locations, however in 2004, she could go to the grocery store by herself if she did not need to carry anything. She testified that she can walk with her cane approximately 100 feet or can walk down her block for approximately five houses. She feels stiffer with the cold weather or when it is raining, and she avoids going outside when it is snowing. She testified that her left knee also makes it difficult for her to walk, as it cramps up from time to time. She testified that she can only go up 2 or 3 stairs, but later stated that her house has 4 steps that she goes up and down every time she leaves the house. She lives with her older sister and is able to sit down and do some household chores such as dusted and folding laundry. She currently has no doctor appointments scheduled for her right knee or lower back.

Petitioner further testified to taking Tylenol 3 approximately 3 times a day, but that some days she does not take it if she does not feel like it is needed. The prescription is provided by Dr. Danko, who she also sees for other medical problems.

CONCLUSIONS OF LAW

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

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and a finding of fact that Petitioner's right knee condition, prior to the car accident on December 5, 2007, is causally related to the injury.

In summary, the testimony of Petitioner and the medical records support the causal relationship, however, the car accident caused further injury that is not related to the work accident. The Arbitrator further finds as a finding of fact and as a matter of law that Petitioner's current lumbar back condition is not causally related to the November 10, 1999, accident.

Petitioner's reliability as the witness on her own behalf was sub par plus suspect as she seemed confused throughout her testimony and the contemporaneous medical histories conflicted with and failed to corroborate her testimony. Thus, this Arbitrator relies on the medical records admitted in evidence. Petitioner testified that she only injured her left knee in her 2007 car accident. The contemporaneous medical records conflict with this. Two doctors, Dr. Verma and Dr. Danko made reference to her right knee in 2009, reporting that she injured both knees in the 2007 car accident and was in physical therapy for both knees. Therefore, the car accident caused further injury to Petitioner's right knee that is not related to this claim.

Petitioner had no complaints of back pain at the 2007 19(b) hearing. An MRI from 2002 showed non-symptomatic findings, and she did not start treating for her low back until 2004, five years following the accident. Additionally, Dr. Konowitz's IME opined Petitioner's back pain is not related to the work accident from 1999. Therefore, Petitioner has failed to meet her burden to prove her low back complaints are causally related to the work incident of November 10, 1999.

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

The Arbitrator finds as a matter of fact that the medical bills were related to the treatment of Petitioner's back. The Arbitrator found as a matter of fact and law that Petitioner's back problems are not casually related to the November 10, 1999 accident;
Therefore, as a matter of law in the case at bar this Arbitrator holds that Respondent is not liable for the medical expenses herein under the Workers Compensation Act. Thus, the bills are not awarded.

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

In summary, Petitioner was a 53 year-old technician for the City of Chicago at the time of her November 10, 1999, accident. She continued to work following the accident until December 23, 1999. The medical records indicate that the Petitioner underwent four surgeries on her right knee as a result of the injury sustained on November 10, 1999. Petitioner then retired in February 2004 before reaching maximum medical improvement.

Petitioner presented Dr. Sheinkop's note from November 2004, which stated that she is incapable of returning to any type of work-related activity.

However, Dr. Sheinkop's letter was directed to the Petitioner's attorney, and Dr. Shiekop had not seen Petitioner since March 2004, which was 8 months prior to authoring his letter. Additionally, none of the subsequent medical records indicate restrictions that would prevent Petitioner from working in a sedentary capacity. Many of Petitioner's current complaints can be attributed to the intervening car accident in 2007. According to the contemporaneous medical reports, she injured both knees in the car accident and had surgery on her left knee, which contributes to her difficulty walking. She also needed physical therapy on both knees following the accident. Despite the injuries sustained in the 2007 car accident, the 2013 Respondent section 12 expert, Dr. Howard Konowitz specifically states that she is able to work a sedentary job. In this particular case the Arbitrator adopts the opinion in the case at bar of Dr. Konowitz.

Therefore, the Arbitrator finds that Dr. Sheinkop's opinion that Petitioner cannot work is not supported by any of the other medical records and is not adopted by a preponderance of the evidence.. Nonetheless, this Arbitrator recognizes that Petitioner's related right knee treatment and resulting surgeries from the 1999 work accident resulted in complaints of pain and soreness.

The Arbitrator finds that as a result of the injury sustained on the above date, Petitioner is to have and receive from Respondent 50% loss of the right leg under section 8.

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

Miguel Ojeda,

Petitioner,

19IWCC0588

vs.

NO: 16 WC 6700

The Steel Supply Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b) and 8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, medical, benefit rate and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2018, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 29 2019
o10/17/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

19IWCC0588

OJEDA, MIGUEL Case# **16WC006700**
Employee/Petitioner

THE STEEL SUPPLY COMPANY
Employer/Respondent

On 12/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4069 LAW OFFICE OF JONATHAN SCHLACK
CHRISTOPHER BASSMAJI
200 N LASALLE ST SUITE 2830
CHICAGO, IL 60601

2097 KRAKER FANNING & OLSEN
DANIEL K SWANSON
300 S RIVERSIDE PLZ SUITE 2050
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)/8(A)

Miguel Ojeda
Employee/Petitioner

Case # **16** WC **6700**

v.

Consolidated cases: **D/N/A**

The Steel Supply 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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **October 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **January 6, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

The parties agree Petitioner established causation as to the need for the lumbar surgery Dr. Chioffe performed in April 2016. For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation, as well as reasonableness and necessity, as to the additional lumbar spine treatment Dr. Erickson provided or prescribed from November 2, 2016 through April 12, 2017 but did not establish causation, reasonableness or necessity as to the lumbar fusion Dr. Erickson recommended.

The Arbitrator finds Petitioner's average weekly wage to be $420.00, based on Respondent's binding stipulation. Arb Exh 1.

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

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

The parties agree Petitioner was temporarily totally disabled from February 22, 2016 through October 31, 2016. They further agree Respondent is entitled to credit for $10,296 in temporary total disability benefits it paid prior to trial. Arb Exh 1.

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

ORDER

The Arbitrator finds that, in addition to the stipulated period [see above], Petitioner was temporarily totally disabled from November 1, 2016 through April 12, 2017.

The Arbitrator awards Petitioner the following medical expenses, subject to the fee schedule: American Center for Spine (Dr. Erickson), 11/2/16 – 4/12/17, $1,100.00 (PX 8, pp. 2-4); Lake County Neuromonitoring, 11/8/16, $1,500.00 (PX 9); Lakeshore Center Surgery Facility, 3/10/17, lumbar discogram, $3,159.15 and $9,477.45 (PX 10); Lakeshore Open MRI, 3/10/17, post-discogram lumbar CT scan, $1,046.00 (PX 11); River North Pain Management, 3/10/17, lumbar discogram, $28,350.00 (PX 13); and Western Touhy Anesthesiology, 3/10/17, $840.00 (PX 14). See the attached decision for further details.

The Arbitrator awards Petitioner the expenses ($216.00, $458.10, $291.00 and $291.00) associated with the medication Dr. Erickson prescribed on April 12, 2017, with Respondent receiving credit for the payments reflected on the Delaware Physicians, LLC bill (PX 15).

The Arbitrator declines to award prospective care in the form of the lumbar fusion recommended by Dr. Erickson. The Arbitrator awards prospective care in the form of a functional capacity evaluation, with validity profiling, that Dr. Erickson recommended at his deposition.

This Arbitrator declines to find Respondent liable for penalties or fees.

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

12/4/18
Date

ICArbDec19(b)

DEC 4 - 2018

Miguel Ojeda v. The Steel Supply Company
16 WC 6700

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on January 6, 2016, while working for Respondent. They also agree the accident resulted in a back injury requiring a revision microdiscectomy performed in April 2016. Respondent paid temporary total disability benefits from February 22, 2016 through October 31, 2016. The disputed issues include causal connection, earnings, medical expenses relating to treatment rendered after October 31, 2016, additional temporary total disability through the hearing of October 16, 2018, penalties/fees and prospective care, in the form of a lumbar fusion recommended by Dr. Erickson.

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter.

Petitioner testified he underwent a lumbar microdiscectomy, at L4-L5, in 2006. T. 44, 51. Petitioner testified he recovered fully from this surgery and was not subject to any restrictions during the ten-year interval preceding the accident of January 6, 2016. T. 52.

Petitioner testified he began working as a packer for Respondent in 2014. T. 15. Respondent fabricates metal bars. Petitioner testified his job involved lifting heavy items, including metal bars and tubes, and packing them in boxes that were then shipped to customers. T. 16.

Petitioner testified he believes he was paid at the rate of $12.50 per hour in 2015 but he "didn't quite recall." He worked ten hours per day but his schedule varied, depending on his assigned hours. T. 16-17.

Petitioner testified that, on January 6, 2016, he left his post and went to another area to get a metal coil weighing 60 to 80 pounds. When he tried to lift the coil from the floor, he felt a sharp jolt, as if someone had struck him in the spine. He went to his knees and could not get to his feet. A co-worker came by and asked him what happened. He alerted Petitioner's supervisor, Salvador Castillo. Petitioner testified he reported the injury to Castillo. T. 17-18.

Petitioner testified he went to Alexian Brothers on the date of the accident. T. 19. Records in PX 1 reflect Petitioner went to Amita Health Medical Group on that date and saw Alina Volodka, PA-C [hereafter "Volodka"]. Volodka recorded a history of the work accident and 2006 back surgery. She noted that Petitioner denied having any back issues following that surgery. She noted complaints of low back pain with persistent numbness and pain radiating down both legs to the calf area.

Volodka described Petitioner's gait as antalgic. On examination, she noted the scar from the prior surgery, tenderness to palpation from L3-L5, palpable spasm of the left paraspinals and pain with straight leg raising bilaterally to 70 degrees. She described Waddell signs as positive for axial loading and simulated rotation. She indicated that lumbar spine X-rays showed no acute abnormalities.

Volodka diagnosed a lumbar strain. She prescribed Toradol, Ibuprofen, Cyclobenzaprine and physical therapy. She released Petitioner to restricted duty with no lifting, pushing or pulling over 10

pounds, no bending and alternating sitting, standing and walking. She directed Petitioner to return on January 11, 2016. PX 1, pp. 4-5.

Petitioner next saw Volodka on January 11, 2016. She indicated Petitioner denied improvement and again complained of lower back pain radiating to both legs, left worse than right. She again described Petitioner's gait as antalgic. She noted positive straight leg raising bilaterally. She directed Petitioner to continue the medication, "start PT ASAP" and return on January 20, 2016. PX 1, pp. 24-26. She continued the previous work restrictions and added a "no climbing" restriction. PX 1, p. 30.

Petitioner underwent an initial physical therapy evaluation at Athletico on January 14, 2016. The evaluating therapist, Brianne Lopez, P.T., recorded a history of the 2006 surgery, the recent work accident and the post-accident care. She described Petitioner's job as heavy, noting he described having to lift up to 100 pounds on occasion. She indicated that, according to Petitioner, Respondent was assigning him to tasks beyond his restrictions. She noted significant bilateral lower extremity weakness, more pronounced on the left. PX 2, pp. 5-11.

Petitioner continued attending therapy thereafter. PX 2.

On January 20, 2016, Volodka started Petitioner on a tapering dose of Prednisone and continued the previous restrictions. PX 1, p. 40. She directed Petitioner to continue attending therapy, noting his first session was scheduled for that day. She noted that Petitioner was "asking for disability." PX 1, p. 27.

Petitioner returned to the facility on January 27, 2016, and saw a physician, Dr. Sellers. The doctor noted persistent low back and radiating left leg complaints, aggravated by prolonged sitting and bending. He indicated Petitioner denied improvement. A handwritten entry indicates Petitioner stated he was not able to work due to pain and requested "full disability." The entry goes on to state that Petitioner made the same request at the previous visits. PX 1, p. 48. The doctor described Petitioner's gait as limping. He noted minimal flexion, to about 10 degrees, extension to 0 degrees and positive straight leg raising on the left. He described Petitioner as "actively resist[ing] SLR." PX 1, p. 49. He referred Petitioner to Dr. Chebes, who is described as a "back pain specialist." PX 1, pp. 47, 50, 55. He continued the previous work restrictions. PX 1, p. 55. There is no evidence indicating Petitioner saw Dr. Chebes.

A therapy note dated February 5, 2016 reflects Petitioner reported deriving only transient relief from the therapy sessions. PX 1, p. 27.

Petitioner testified that, following the accident, he continued working for Respondent until February 22, 2016, at which point he and some of his co-workers were laid off.

The last facility note is dated February 23, 2016. It appears Petitioner saw Dr. Sellers on that date. The doctor noted persistent back pain and left leg numbness. He also noted that Petitioner reported having been fired the previous day and requested disability "again." The doctor directed Petitioner to continue taking Naproxen and attending therapy. He prescribed a lumbar spine MRI, continued the previous restrictions and directed Petitioner to return in one week. PX 1, pp. 57-61.

The lumbar spine MRI, performed without contrast on February 24, 2016, showed a central herniation at L1-L2, disc bulging at L3-L4 narrowing the foramina, a left herniation and/or granulation at

L4-L5, with the radiologist indicating a contrast study could be performed for further characterization, given the prior surgery, and a central herniation at L5-S1 with underlying bulging narrowing the foramina. PX 3, pp. 3-4.

Petitioner continued attending therapy at Athletico through February 29, 2016. PX 2, pp. 46-47.

On March 2, 2016, Petitioner began a course of care at Elite Total Rehab. On that date, Dr. Owen, a chiropractor, recorded a history of the work accident and subsequent care. He noted that Petitioner reported undergoing lumbar spine surgery nine or ten years earlier but had worked for Respondent for the last three years "with no significant symptoms." He indicated that Petitioner complained of constant low back pain radiating into his left leg. On initial examination, Dr. Owen noted positive straight leg raising on the left at 45 degrees and decreased sensation for the L4-S1 dermatome. He diagnosed lumbar radiculopathy, lumbar disc displacement, lumbar discitis and left hip pain. He recommended treatment and noted Petitioner might need to see an orthopedic surgeon. He described Petitioner's prognosis as "fair to poor." PX 4, pp. 10-11.

On March 9, 2016, Dr. Owen noted no relief of Petitioner's symptoms. He indicated that Petitioner was scheduled to see an orthopedic specialist the following day. He wrote to Dr. Chioffe the same day, asking him to evaluate Petitioner. PX 4, pp. 15, 17.

Petitioner saw Dr. Chioffe of Spine Consultants on March 10, 2016. In his note of that date, the doctor documented a referral from Dr. Owen. He recorded a history of the work accident and subsequent care. He indicated that Petitioner complained of back pain, left posterior leg pain to the bottom of his foot and anterior thigh numbness. He also noted a history of a microdiscectomy in 2006. He indicated that Petitioner complained of difficulty walking.

On initial examination, Dr. Chioffe noted positive straight leg raising on the left, 5/5 lower extremity strength and intact sensation. He described Waddell's testing as negative.

Dr. Chioffe described Petitioner as having a "small disc herniation at L4-L5 on the left." He prescribed a Medrol DosePak followed by Mobic. He referred Petitioner to Premier Pain for a left L4-L5 transforaminal injection. He directed Petitioner to take one week off therapy and then resume seeing Dr. Owen. PX 5, pp. 8-12.

Petitioner saw Dr. Patel of Premier Pain & Spine on April 4, 2016. The doctor recorded a history of the 2006 back surgery and the January 6, 2016 work accident. He noted that Petitioner denied improvement secondary to therapy and complained of developing a rash after taking an oral steroid pack. He noted complaints of 10/10 pain in the low back and left leg as well as bilateral leg weakness. He administered a left L4-L5 transforaminal epidural steroid injection. PX 6.

Petitioner returned to Dr. Chioffe on April 7, 2016. The doctor noted that Petitioner described the injection as having caused his pain to worsen. He described Petitioner's radiculopathy as "fairly severe." He noted that Petitioner exhibited dorsiflexion weakness "that correlates with the level of his disc herniation." He described Waddell's testing as negative. He started Petitioner on Norco and recommended a microdiscectomy at L4-L5, based on the lack of response to therapy, medication and the injection. PX 5, pp. 14-15.

Dr. Chioffe performed the recommended L4-L5 microdiscectomy on April 26, 2016, with Dr. Butler acting as his assistant. PX 7, pp. 65-66.

Petitioner testified the surgery did not help. T. 26.

Petitioner returned to Dr. Chioffe on May 11, 2016. The doctor noted persistent complaints of left leg pain and numbness "as well as bilateral dorsal foot numbness." He indicated that Petitioner denied right leg pain. He continued the Norco and directed Petitioner to return in one month. PX 5, pp. 17-18.

The next Spine Consultants note, dated June 16, 2016, identifies Dr. Butler as the provider but bears the electronic signature of Dr. Chioffe. PX 5, pp. 21-22. RX 4. The note reflects that Petitioner denied improvement, complained of 7-9/10 pain in his lower back and left leg and foot and was using a walker. The examining physician noted positive straight leg raising on the left at 45 degrees, negative reverse straight leg raising and several positive Waddell's signs. He described Petitioner's clinical presentation as "abnormal for a revision microdiscectomy surgery," adding: "I cannot explain the symptoms [Petitioner] is reporting such as itching in the back, bilateral leg heaviness and necessity for a walker when he has near full strength in bilateral legs." He indicated that Petitioner "may have some symptom magnification" but that he felt compelled to rule out any worsening or concerning pathology before restarting therapy. He prescribed a repeat lumbar spine MRI. PX 5, pp. 21-22.

Petitioner underwent the repeat MRI on June 27, 2016. The interpreting radiologist, Dr. Strimling, compared the images with those taken preoperatively, on February 24, 2016. His impression was "multi-level disc degeneration spondylosis with multi-level disc bulging" along with "small superimposed disc protrusions at the levels of L4-L5 and L5-S1" and "post-operative changes from prior discectomy at the level of L4-L5." PX 7, p. 233.

On July 1, 2016, Petitioner returned to Dr. Chioffe and complained of constant 6-10/10 pain in his left lower back, left thigh, left foot and right lower back. The doctor also noted new complaints of pain in the neck and left arm.

The doctor indicated the repeat MRI showed no recurrent disc herniation, no foraminal stenosis, no fluid collection and no nerve compression. He described straight leg raising and reverse straight leg raising as negative. He noted positive Waddell's signs of non-anatomic sensory changes and overreaction. He indicated that Petitioner's worsening symptoms could not be explained. He noted that Petitioner declined an injection. He prescribed a Medrol DosePak and referred Petitioner to Dr. Owen for six weeks of range of motion and core strengthening exercises. PX 5, pp. 25-26.

Petitioner resumed seeing Dr. Owen of Elite Total Rehab on July 11, 2016. The doctor noted complaints of pain in the neck and left arm as well as the lower back and left leg. He felt Petitioner might benefit from an EMG to evaluate the left leg symptoms. PX 4, p. 32. Petitioner continued seeing Dr. Owen thereafter through August 10, 2016. In his note of that date, the doctor indicated he spoke with Dr. Chioffe's assistant and again suggested an EMG. He described the assistant as telling him that Dr. Chioffe "may potentially refer [Petitioner] to a neurologist for a second opinion." PX 4, pp. 50-51.

On August 12, 2016, Petitioner returned to Dr. Chioffe and denied improvement. On re-examination, the doctor described straight leg raising, reverse straight leg raising and Waddell's signs as negative. He recommended that Petitioner discontinue therapy, continue taking anti-inflammatories as

needed and obtain a second opinion. He indicated he wanted to continue following Petitioner closely in case his symptoms changed. PX 5, pp. 30-31.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Levin, an orthopedic surgeon, on September 21, 2016. In his report of that date, Dr. Levin indicated an interpreter, Jose Sosa, and Petitioner's son were present during the examination.

Dr. Levin described Petitioner's past medical history as significant for a work-related back injury in 2006 for which he underwent surgery by Dr. Graf. He indicated that Petitioner reported being off work "for approximately 8 years" following this surgery. He stated that Petitioner denied having any back or left leg symptoms throughout the year 2015.

Dr. Levin recorded a consistent account of the January 6, 2016 work accident and subsequent care. He noted that Petitioner began seeing Dr. Owen, a chiropractor, after consulting an attorney and went on to see Dr. Chioffe, who performed another lumbar spine surgery in April 2016. He noted that Petitioner denied any improvement following this surgery. He documented complaints of constant low back pain radiating down the left leg into the foot, numbness in the lower left leg and right leg numbness to the knee. He noted that Petitioner reported experiencing difficulty with many routine activities, including prolonged sitting, walking, driving and getting in and out of a car. He indicated Petitioner was taking Norco for pain.

Dr. Levin described Petitioner's gait as reciprocal with a slight antalgic component on the left side. He indicated that Petitioner exhibited weakness of ankle dorsiflexion on the left when attempting to walk in a heel/heel fashion. He noted that straight leg raising was negative on the right and elicited leg pain down to the knee on the left.

Dr. Levin indicated he reviewed the images of the post-operative June 27, 2016 lumbar spine MRI. He interpreted the images as showing degenerative disc changes at L1-L2, no abnormalities at L2-L3, bilateral facet arthritis creating foraminal stenosis on a degenerative basis at L3-L4, post-operative changes and a left disc protrusion at L4-L5 and bilateral facet arthritis at L5-S1 with a central annular bulge and degenerative disc changes. Dr. Levin also reviewed lumbar spine X-rays with flexion-extension views. He noted some degenerative and sclerotic changes at various levels and minimal translation of L4-L5 with flexion which reduces in extension.

Dr. Levin indicated he needed to review the images of the pre-operative lumbar spine MRI performed on February 24, 2016 before he could express his opinions. RX 2.

On September 22, 2016, Dr. Chioffe noted that Petitioner was following up after an independent medical examination. He also noted new complaints of right leg and testicular pain. On re-examination, he noted positive straight leg raising and several positive Waddell's signs. He prescribed Tramadol and indicated he was awaiting the independent medical examiner's report. He did not recommend any further surgery, again noting that the repeat MRI did not show any recurrent disc herniation or residual stenosis. He indicated that Petitioner "has failed to progress but exhibits illness behavior and out of proportion pain on exam and in the office." He directed Petitioner to return in three or four weeks. He anticipated that Petitioner would reach maximum medical improvement at six months postoperatively. PX 5, pp. 34-35. RX 5.

On October 20, 2016, Dr. Levin issued another report, after reviewing a Form 45, the post-operative lumbar spine MRI and additional medical records. He interpreted the post-operative MRI as showing post-operative changes. He characterized the treatment to date as reasonable and necessary. He saw no need for additional surgery and did not recommend additional conservative care. He found Petitioner to be at maximum medical improvement. In reliance on various ODG guidelines, he opined that Petitioner would have been capable of resuming full duty as of October 20, 2016. Levin Dep Exh 3.

On October 27, 2016, Dr. Chioffe issued a note stating that Petitioner "may not return to work at this time pending the results of his IME." He indicated he wanted to see Petitioner again to re-evaluate his work status once the IME results were available. PX 5, p. 38. RX 6.

Petitioner testified he continued receiving temporary total disability benefits through October 31, 2016. T. 30.

On November 1, 2016, Dr. Levin issued a letter attaching an AMA Guides impairment rating. In the letter, he indicated that, based on his September 21, 2016 examination, Petitioner's impairment rating was 13% of the whole person. RX 3.

Petitioner saw Dr. Erickson, a neurosurgeon, on November 2, 2016. The doctor recorded a history of the 2006 surgery, the January 6, 2016 work accident and the post-accident care. He noted that Petitioner did not improve following the April 2016 surgery and that, despite an "acute exacerbation" in September 2016, his surgeon was not recommending additional care. He noted complaints of low back pain radiating down the left leg, with associated paresthesia of the first and fifth toes. He described straight leg raising as positive on the left at 30 degrees.

Dr. Erickson interpreted the post-operative MRI as showing "continuing foraminal stenosis relative to a central disc herniation at L5-S1." He suspected Petitioner's pain was emanating from L5-S1 rather than L4-L5. He described Petitioner's symptoms as "more compatible with an S1 radiculopathy." He recommended a lumbar discogram and post-discogram CT scan, indicating these studies would show whether there was "an organic basis for [the] lack of response to surgery." He directed Petitioner to under SSEP testing and remain off work. PX 8, pp. 9-11.

Petitioner returned to Dr. Erickson on January 29, 2017, with the doctor again recommending a CT discogram. PX 8, pp. 12-13.

Dr. Vargas performed a discogram at L2-L3, L3-L4, L4-L5 and L5-S1 on March 10, 2017. In his report, he described Petitioner as "blinded at the outset of level disc injection." He described Petitioner as cooperative and his responses as valid. He concluded that Petitioner has "unequivocal concordant discogenic pain at L4-L5 and L5-S1, with controls at the L2-L3 and L3-L4 levels." PX 10, pp. 3-8. A post-discogram lumbar CT scan, as read by Dr. Kuritza, demonstrated a large, left-sided herniation with an extruded nucleus pulposus at L4-L5 and a 4-5 mm posterior central herniation, also with an extruded nucleus pulposus, at L5-S1. PX 11, p. 3.

On April 12, 2017, Dr. Erickson noted that SSEP testing performed in November "showed moderate delays present on the left side at L5-S1." He also noted that the discogram showed "positive production at both L4-L5 and L5-S1." He documented ongoing low back and radicular complaints, indicating it was difficult for Petitioner to sit for more than thirty minutes at a time. He recommended a minimally invasive hemilaminectomy and decompression accompanied by a fusion from L4 through S1.

He indicated this "would be a re-operation," noting concern that he would not achieve total reversal of Petitioner's problem "without instrumented fusion at this point in light of the prior surgical approach." He described Petitioner as an "excellent surgical candidate." He directed Petitioner to remain off work. PX 8, pp. 14-16.

According to Dr. Erickson's records (PX 8, p. 17), Petitioner saw Dr. Kranzler on June 16, 2017. No note authored by Dr. Kranzler is in evidence.

Petitioner returned to Dr. Erickson on August 16, 2017. The doctor noted that Petitioner had seen Dr. Kranzler on June 16th and that the doctor had agreed with his surgical recommendation.

Dr. Erickson also noted "complaints of neck pain and stiffness which has been present intermittently since the summer of 2016." He also noted a complaint of tingling radiating to the second through fifth fingers of the left hand. He described the relationship between these complaints and the work injury as "unclear." He recommended that Petitioner undergo a cervical spine MRI prior to the lumbar fusion. He continued to keep Petitioner off work. PX 8, pp. 17-18.

A cervical spine MRI, performed without contrast on August 31, 2017, showed 2-3 millimeter posterior mostly central disc protrusions indenting the ventral surface of the thecal sac at these levels. PX 11, p. 4.

Dr. Erickson testified by way of evidence deposition on September 5, 2017. PX 16. Dr. Erickson testified he is a board certified neurosurgeon in private practice. He attended medical school at Northwestern and did his residency and internship at the University of Chicago. PX 16, p. 7. He typically sees 30 to 40 patients during a normal office day. Of those patients, 4 or 5 will be surgical candidates. PX 16, p. 8.

Dr. Erickson testified he does not independently recall Petitioner. His records show he first examined Petitioner on November 2, 2016. Petitioner reported injuring his back at work on January 6, 2016 and continuing to work thereafter through February 22, 2016. PX 16, p. 10. Petitioner complained of pain radiating from his back into his left leg. PX 16, p. 10.

Dr. Erickson testified that, on initial examination, he noted positive straight leg raising on the left at 30 degrees. He was able to determine that the sacroiliac joint and hips were not sources of pain. His neurological examination was normal. PX 16, p. 11. The positive straight leg raising suggests that the nerve was either compressed or tethered. PX 16, p. 11.

Dr. Erickson testified he interpreted the February 25, 2016 lumbar spine MRI as showing post-surgical changes, namely a left-sided laminectomy at L4-L5, and a central disc herniation at L5-S1 accompanied by some nerve outlet narrowing on both sides. PX 16, p. 12. He believed the disc herniation at L5-S1 might be significant, given Petitioner's lack of response to the surgery. He felt it was possible that there was "tethering of the nerve" at the operated L4-L5 level. He viewed Petitioner's symptoms as "more compatible with an S1 radicular pattern." He ordered SSEP testing, which allows testing of one nerve at a time, unlike an EMG. PX 16, p. 13. He also recommended diagnostic discography to help determine the sources of pain. He believed Petitioner's symptoms stemmed from the work accident, based on his history and the diagnostic studies. PX 16, p. 13. His initial note does not address work status but Petitioner was probably off work as of that time. PX 16, p. 14.

Dr. Erickson testified he next saw Petitioner on April 12, 2017. On that date, Petitioner's symptoms were "similar although not identical." Petitioner still had leg pain but his toe pain had changed, in terms of the involved toes. PX 16, p. 14. Petitioner had undergone a discogram, which documented pain at the L4-L5 and L5-S1 levels. A discogram separates two discs from one another by independent injections and prioritizes disc abnormality based on the intensity of the pain when the disc is pressurized. PX 16, pp. 15-16. A discogram also can be used to determine whether a patient's pain is real, based on the patient's response. A CT scan is typically performed after a discogram, while the dye is still within the discs. This scan shows more about structural problems in the discs than a conventional CT or MRI. PX 16, pp. 15-16. A discogram is both subjective and objective. The patient's description of pain is subjective while the assessment of the pain by the discographer is both subjective and objective. The CT scan is "the most objective part of the examination." It is typically interpreted by a radiologist who is independent from the examination of the problem. The radiologist is "blinded in a way." PX 16, pp. 16-17.

Dr. Erickson opined that Petitioner's pain complaints correlated with the discogram. The discogram and post-discogram CT "seemed to show problems more at [L4-L5 and L5-S1] than the other levels that were injected." He discussed surgical options with Petitioner. A person who has nerve velocity abnormalities like Petitioner would be offered "minimally invasive hemilaminectomy without fusion, with the idea being that the leg pain would be changed by operating and exploring the area" around the involved nerve roots. He also discussed a fusion, given that Petitioner had already undergone surgery. He was worried that a simple decompression would only partially relieve Petitioner's difficulty with extended sitting. Sitting is usually comfortable for a person who has a pure nerve compression. PX 16, pp. 17-19.

Dr. Erickson testified he would have kept Petitioner off work as of April 2017. PX 16, p. 19.

Dr. Erickson testified he next saw Petitioner on August 16, 2017. Sitting was still painful for Petitioner as of that date. Petitioner was "bent toward the right side." His examination still showed good strength and sensation. He wanted Petitioner to seriously consider a fusion as opposed to a re-operation, minimally invasive hemilaminectomy. He continued to keep Petitioner off work. PX 16, p. 20.

Dr. Erickson testified he believes he saw the images of the post-operative lumbar spine MRI. PX 16, p. 21.

Dr. Erickson testified he views Petitioner as an excellent surgical candidate. Petitioner has two abnormal discs. The MRI and nerve testing showed that those discs are the most likely sources of Petitioner's pain. The discogram confirmed that each of those discs was a competent source of pain. PX 16, pp. 21-22.

Dr. Erickson testified he "can't speak for all of [Petitioner's] complaints" but his notes document complaints consistent with mechanical back syndrome at L4-L5 and L5-S1. He does not rely on Waddell's signs as a useful tool. It makes sense to perform Waddell's testing in a setting where a person is giving inconsistent responses to requests during an examination. He would not take a patient to surgery if he felt the patient was falsifying or clinically depressed. PX 16, pp. 22-23.

Dr. Erickson testified he both agrees and disagrees with Dr. Levin. Specifically, he agrees with Dr. Levin's opinion that "there is no large recurrent disc herniation at L4-L5." He sees no such recurrent

herniation either, although Petitioner "has a residual disc protrusion, which is probably a herniation." PX 16, p. 24. He cannot say whether this is recurrent or it remains after surgery. PX 16, p. 24. He does not attach much significance to Dr. Levin's Waddell's findings. "A lot of people are surprised and act dramatically when you touch them superficially." PX 16, pp. 24-25. It is notable that Petitioner was using a walker as of the examination "but people with mechanical back pain often do use a walker to stand for prolonged periods." PX 16, p. 25. We cannot say in every case that because a surgery was uncomplicated it was successful. In Petitioner's case, it could be that the diagnosis was not fully determined before the surgery. Petitioner may have had problems at L5-S1 all along yet only L4-L5 was addressed surgically. Petitioner also may have had mechanical back pain all along. The surgery addressed only a relatively minor nerve compression and not the structural weakness of the discs or the pain from loading the discs. A person who does not respond well to surgery is not necessarily a bad patient. PX 16, p. 26.

Dr. Erickson testified he disagrees with Dr. Levin's conclusion that Petitioner is at maximum medical improvement. He believes Petitioner is a candidate for surgery and that the surgery has a great chance of significant improvement. PX 16, p. 26. He also disagrees with Dr. Levin's opinion that Petitioner can resume full duty. He would predict that Petitioner would fail at work because of his inability to sit or stand very long. He would not, however, disagree with a functional capacity evaluation being done. It is not dangerous for Petitioner to undergo such an evaluation. If the evaluation showed Petitioner to be capable of light duty, it would not be dangerous for Petitioner to attempt such duty. However, Petitioner has been off work for an extended period and it is thus unlikely he would look like a person who is capable of exertion. PX 16, p. 28. He agrees that Petitioner does not have a lot of neurological deficits. Petitioner's neurological examination is good but he has pain and restriction based on the discal injury. PX 16, p. 28. With respect to diagnosis, it was not unreasonable for Dr. Chioffe to rely on the MRI alone and not do SSEP testing. At the same time, an MRI sometimes does not show the whole problem. PX 16, p. 29. He views the treatment Petitioner underwent prior to his initial visit as reasonable and necessary. The therapy and surgery were reasonable. Petitioner is "reasonably motivated and wants to get better." PX 16, p. 30. The treatment he is recommending, i.e., a two-level fusion, is reasonable and necessary, as well as related to the work accident. PX 16, p. 31.

Under cross-examination, Dr. Erickson acknowledged he has no records showing whether Petitioner underwent injections before the initial visit. He does not know how Petitioner came to see him in November 2016. Petitioner could have been referred to him by a pain management physician. He does not know whether Dr. Chioffe made the referral. He is aware of Dr. Butler. It is always possible Dr. Butler made the referral but "that would be an unusual chain of referral." PX 16, p. 33.

Dr. Erickson testified that, at the initial visit, Petitioner was neurologically intact with abnormal sensations in a dermatome or two dermatomes. Petitioner had full strength in both legs. Petitioner did not complain to him of back itchiness. Petitioner apparently voiced this complaint to Dr. Levin. PX 16, p. 34. He has no explanation for this complaint but some nerve problems can be described by a patient as itching or burning. PX 16, p. 35. He has not reviewed any notes authored by Dr. Butler. PX 16, p. 35. If Dr. Butler noted back itchiness and indicated Petitioner was using a walker despite full leg strength, it would be reasonable to be suspicious of this. However, he sees patients who are quite straightforward who are leaning on walkers to avoid back pain. Some people do not go shopping unless they can lean over a grocery cart. You have to "look at the whole picture" and not simply assume a person using a cane or walker is overly demonstrative. PX 16, p. 36.

Dr. Erickson testified it is possible he saw Dr. Chioffe's operative report but not his office records. He does not know whether Dr. Chioffe was the last doctor to see Petitioner before he saw Petitioner on November 2, 2016. PX 16, p. 37. He does not believe he is aware that Dr. Chioffe documented disproportionate pain. PX 16, p. 38. There are "excellent actors" in the patient population but he sees very few true malingerers. PX 16, p. 38. He sees people who are anxious or trying to impress him as to their pain level but he sees very few people who are faking. PX 16, p. 39. In Petitioner's case, the positive discogram shows involvement of two discs. Most people who are faking will show you how weak they are yet Petitioner demonstrated good strength and sensation. PX 16, pp. 39-40. He cannot rule out symptom magnification, in general. Symptom magnification is "quite common in situations involving disability and anxiety." If he sees it, he makes a note of it. PX 16, p. 41. He cannot rule out secondary gain, either for financial or familial reasons, in any particular case but the objective studies back up Petitioner's complaints. PX 16, p. 41.

Dr. Erickson testified he is not qualified to perform AMA Guides impairment ratings. He will not comment on Dr. Levin's rating. PX 16, p. 42.

Dr. Erickson testified that, based on the toe and foot complaints Petitioner voiced at the initial visit, he felt Petitioner might have problems at both levels, not just L4-L5.

Dr. Erickson testified a discogram is "blind" in that the radiologist reading the post-discogram CT scan is not aware of the patient's complaints. PX 16, p. 43. There are false positives with discograms and they should not be used in isolation. A discogram is "just another piece of information." PX 16, p. 44. He agrees that it would be reasonable for Petitioner to undergo a functional capacity evaluation. PX 16, p. 44. A functional capacity evaluation is another way to judge effort and symptom magnification. He "would never hesitate to order an FCE for a person." PX 16, p. 45. He does not know when Petitioner began using a walker or who prescribed it. PX 16, p. 45. He usually prescribes walkers for older individuals who are risk of falling. PX 16, p. 46. Walkers are cheaper than braces and certain types of canes. He does not prescribe them much. PX 16, p. 46. Dr. Erickson acknowledged he might have had "very little clinical information" concerning the care Petitioner underwent early on, following the injury. PX 16, p. 47.

On redirect, Dr. Erickson testified many doctors use injections for patients who are hoping to avoid surgery. The doctor who saw Petitioner on August 12, 2016 recommended a second opinion. It is possible that Petitioner came to him for the purpose of getting a second opinion. PX 16, p. 48.

Under re-cross, Dr. Erickson acknowledged that the recommendation of a second opinion did not constitute a referral to him. His notes do not reflect how Petitioner came to see him. PX 16, p. 49.

Dr. Levin testified by way of evidence deposition on September 26, 2017. RX 1. Dr. Levin testified he did his residency in orthopedic surgery and underwent fellowship training in orthopedic spinal surgery. He obtained board certification in orthopedic surgery and has been recertified. RX 1, pp. 5-7.

Dr. Levin testified he has no independent recollection of examining Petitioner on September 21, 2016. RX 1, p. 8. His examination report sets forth a history of a lifting-related work accident. The report reflects that FABER's testing was negative. This means that Petitioner did not complain of pain when he flexed Petitioner's hip up to 90 degrees. FABER's testing is performed to check for localized hip pathology. RX 1, p. 13. Petitioner "demonstrated slight loss of strength when asked to do the extensor

hallucis longus between the left and right." This testing involves having a patient actively plantarflex his foot. Petitioner's anterior tibialis strength "was somewhat different between the right and left." Whenever Petitioner exhibited weakness, the weakness was left-sided. It would not be fair to say that Petitioner was neurologically intact, "if you take intact to [mean] absolutely identical on both sides." He objectively recorded Petitioner's motor deficits but those recordings were "subject to subjective input." RX 1, p. 16. Petitioner exhibited left-sided weakness of the EHL, plantar flexor and anterior tibialis. RX 1, p. 16.

Dr. Levin testified he reviewed the post-operative lumbar spine MRI in connection with his September 21, 2016 examination. Following that examination, he received and reviewed additional materials, including an employer's first report of injury, a January 6, 2016 note from Amita Health Medical Group, records from Alexian Brothers Medical Center, therapy records from Athletico, some chiropractic records, Dr. Patel's note of April 4, 2016, some notes from Dr. Chioffe, through July 1, 2016, and the April 2016 operative report. Dr. Levin testified he issued an additional report on October 20, 2016, after reviewing these materials. He did not re-examine Petitioner on October 20, 2016. RX 1, pp. 17-18. His diagnosis as of October 20, 2016, referable to the January 6, 2016 work accident and in reliance on the history Petitioner provided, was "recurrent L4-L5 herniated nucleus pulposus." RX 1, pp. 19-20.

Dr. Levin testified he agrees with Dr. Chioffe's interpretation of the post-operative lumbar spine MRI, i.e., that this study shows post-operative changes. RX 1, p. 20.

Based in part on the history Petitioner provided, Dr. Levin opined that the work accident of January 6, 2016, caused the recurrent disc herniation at L4-L5 and brought about the need for the April 27, 2016 surgery. RX 1, pp. 21, 23-24. If in fact Petitioner had no injury on January 6, 2016, his opinion could change. Recurrent disc herniations can occur absent trauma. RX 1, p. 24. Dr. Levin further opined that the treatment Petitioner underwent prior to September 21, 2016 was reasonable and necessary. RX 1, p. 20. Petitioner's MRIs showed he had prior surgery to the L4-L5 area. The clinical complaints recorded on January 6, 2016, after the accident, were consistent with a recurrent disc herniation at that level. RX 1, p. 21.

Dr. Levin further opined that Petitioner's post-operative complaints did not correlate with the objective findings. Dr. Chioffe described the April 27, 2016 surgery as "uneventful" and the post-operative lumbar spine MRI showed no evidence of a recurrent herniation. Moreover, Dr. Chioffe noted positive Waddell's testing postoperatively. RX 1, pp. 21-23.

Dr. Levin further opined that, based on ODG guidelines, Petitioner could have returned to clerical work 42 days post-injury, manual work 56 days post-injury and heavy manual work as of October 20, 2016. RX 1, p. 25. He believes Petitioner has reached maximum medical improvement. RX 1, p. 26. He further believes Petitioner's illness behavior as of September 22, 2016 was disproportionate, based both on Dr. Chioffe's comments and the post-operative MRI. RX 1, p. 26. He believes there was "some element of nonorganic etiology" in Petitioner's post-operative complaints. Those complaints were not consistent with the surgery, which did not result in complications, or the post-operative imaging. He believes the term "malingering" to be a psychiatric diagnosis. Since he is not a psychiatrist, he cannot say Petitioner was "malingering." As an orthopedic surgeon, however, he can say there were "some physical findings that [were] just not supported by known medical fact." RX 1, p. 27. If the term "symptom magnification" is given an anatomic, rather than psychiatric, definition, he can say that

Petitioner's post-operative symptoms made no anatomical sense. He cannot rule out secondary gain. RX 1, pp. 28-29.

Dr. Levin testified that Petitioner did not present with a walker to the September 21, 2016 examination. He made no recommendations as of that examination. RX 1, p. 29.

Dr. Levin testified he has undergone training in performing impairment ratings. He attended one course in 2012 and another in 2014. He received certifications following both courses. He is scheduled to attend another course in October or November 2017. RX 1, pp. 29-30. Based on his examination of September 21, 2016 and the PDQ form Petitioner completed on that date, he rates Petitioner's impairment at 13% of the whole person. His report of November 1, 2016 sets forth that rating. RX 1, pp. 30-31. In arriving at that rating, he used the AMA's lumbar spine regional grid and then determined a class. He believes Petitioner's class is "2", based on his diagnosis "for motion segment lesions" and other factors. There are three grade modifiers within that class. A 12% whole body rating would be the "middle." When he summed up the modifiers for Petitioner, he moved one to the right, to 13%. Since Petitioner's impairment involves his lumbar spine, the impairment is to the whole person. RX 1, p. 32.

Under cross-examination, Dr. Levin testified he performs approximately 250 independent medical examinations per year. RX 1, pp. 33-34. Most of the examinations he performs are requested by respondents. RX 1, p. 34. He reviewed the images of the February 2016 lumbar spine MRI. He does not consider the abnormality at L5-S1 to be a herniation. He views it as degenerative annular bulging. RX 1, pp. 35-36. To him, the term "protrusion" means a bulge. With a protrusion, the nuclear materal is not going through the annulus in a herniated fashion. RX 1, p. 37. When he saw the digital images concerning the post-operative MRI, he described bilateral facet arthritis with a central annular bulge and degenerative disc changes at L5-S1. He believes this interpretation is correct but recognizes that another physician could disagree with him. RX 1, p. 39. It is possible Petitioner was suffering from mechanical back pain all along but he does not think so. Otherwise, he would not have recommended surgery at the L4-L5 level. He agrees with Dr. Chioffe that the post-operative MRI did not show a recurrent herniation. RX 1, p. 43. He did not review the discogram. RX 1, p. 44. He seldom orders discograms for his own patients. RX 1, p. 44. He might order one for a patient who is experiencing discogenic pain above or below a previously fused level. A discogram is "certainly subjective" because it involves the patient's input. RX 1, p. 45. The objective part of the study is the post-discogram CT scan. RX 1, p. 46. He views the surgery Dr. Chioffe performed as successful because the post-operative MRI does not show any recurrent herniation and suggests that the anatomical change was dealt with. RX 1, p. 47. He is not aware whether non-physicians can be certified to perform AMA impairment ratings. RX 1, p. 48.

Petitioner returned to Dr. Erickson on September 27, 2017. The doctor indicated that the cervical spine MRI performed on August 31, 2017 showed small herniations from C3 through C7, with the most prominent being a small central herniation at C6-C7. He noted complaints of left-sided neck and trapezius pain. He indicated that Petitioner recalled his neck pain beginning several weeks after the work accident. He noted that this was not documented in the records and therefore he did not view the neck condition as directly related to the accident. He indicated that, since the cervical spine MRI did not show any severe central stenosis, it was safe for Petitioner to proceed with the previously recommended lumbar spine surgery. He continued to keep Petitioner off work. PX 8, pp. 19-21.

Petitioner testified he last saw Dr. Erickson in June 2018. Dr. Erickson recommended a fusion at L4-L5. Petitioner testified he intends to proceed with this surgery. T. 24-25.

Dr. Erickson's last note of June 20, 2018 reflects complaints relative to the low back, left ankle, third, fourth and fifth toes of the left foot, neck and left shoulder. On lumbar spine re-examination, the doctor noted positive straight leg raising on the left at 40 degrees and mild light touch difference over the lateral calf. The doctor again recommended a transforaminal lumbar interbody fusion from L4 through S1 with a left-sided approach. He continued to keep Petitioner off work. PX 8, pp. 22-24.

Petitioner filed a petition for penalties and fees, along with Section 8(a) and 19(b) petitions, on July 20, 2018. Arb Exh 2.

Petitioner testified he continues to experience back pain and left leg numbness. T. 26. He has difficulty interacting with family members because his pain problem causes him to feel very anxious and moody. He last worked for Respondent in February 2016 and has not worked anywhere else since. At some points he was subject to a 5-pound lifting restriction. He was not able to find work within that restriction. Dr. Erickson has found him not capable of working. He has not sustained any new accidents since January 6, 2016. T. 26-27, 31.

Under cross-examination, Petitioner testified that Dr. Chioffe recommended he obtain a second opinion but did not specifically refer him to another doctor. Dr. Chioffe did not refer him to Dr. Erickson. T. 33-34. It was his attorney who referred him to Dr. Erickson, following the independent medical examination. He cannot recall seeing Dr. Butler, Dr. Chioffe's associate, in May 2016. T. 36. He cannot recall whether he saw Dr. Chioffe or Dr. Butler in June 2016. T. 40. Regardless of which doctor he saw at that time, he complained of back itchiness and heaviness in his legs. He was using a walker at that time. Dr. Chioffe did not prescribe a walker. The nurses at the hospital gave him a walker after his back surgery. No one prescribed a walker prior to the surgery. T. 43. He underwent an examination by Dr. Levin on September 21, 2016 and returned to Dr. Chioffe the following day. He did not return to Dr. Chioffe after September 22, 2016. T. 44-45. He was not happy with the comments Dr. Chioffe made on that date. T. 47. Dr. Chioffe did not speak clearly with him concerning his situation. Dr. Chioffe spoke of a hernia, not of his discs. T. 49. When he told Dr. Chioffe that he had a disc problem, the doctor said, "who told you that?" He related he had heard this from his chiropractor. He first saw Dr. Erickson on November 2, 2016. Dr. Erickson did not prescribe a walker. He last saw Dr. Erickson in June 2018. Before that visit, he had last seen Dr. Erickson in August 2017. T. 49. He has not looked for any kind of work since February 22, 2016. T. 48. Respondent laid off other employees, in addition to him, on February 22, 2016. T. 42.

On redirect, Petitioner testified he saw a doctor at Spine Consultants on June 16, 2016 but honestly cannot recall which doctor he saw. T. 50. Following the surgery, he used a walker for seven to ten months. He no longer uses a walker. He did not bring a walker to the hearing. T. 50-51. He felt "perfectly fine" following the 2006 back surgery. After that surgery, ten years went by with nothing bothering him. T. 52. During that time, he worked at two companies. He was not subject to any restrictions as of the January 6, 2016 accident. T. 52. He views Dr. Erickson as the second opinion that Dr. Chioffe recommended. T. 53. He never returned to Dr. Chioffe or Dr. Butler after he started seeing Dr. Erickson. T. 53.

Under re-cross, Petitioner reiterated that he was given a walker following his back surgery. T. 55.

Arbitrator's Credibility Assessment

The Arbitrator finds credible Petitioner's testimony that he recovered from his 2006 back surgery and was not subject to restrictions as of the 2016 accident. Respondent did not introduce any evidence contradicting Petitioner's description of the heavy lifting he performed prior to this accident.

Several of the providers who saw Petitioner after the accident expressed concern about his presentation.

The physician's assistant who treated Petitioner during the first few weeks following the accident noted positive Waddell's signs. She described Petitioner as consistently asking to be taken off work. Under cross-examination, Petitioner acknowledged making these requests. T. 41.

Dr. Chioffe, Petitioner's back surgeon, did not note any positive Waddell's signs until after the April 2016 surgery. On June 16, 2016, he noted some unusual symptoms and indicated Petitioner "may have some symptom magnification." Nevertheless, he ordered a repeat lumbar spine MRI, which did not show any recurrent herniation. On July 1, 2016, Dr. Chioffe noted new complaints relative to the neck and left arm. When he last saw Petitioner, on September 22, 2016, he noted new right leg complaints as well as disproportionate pain behavior. He directed Petitioner to return to him in three or four weeks, so that he could read the IME report and address work status. Petitioner opted not to return.

During the hearing, Respondent's counsel pressed Petitioner on the issue of whether he saw Dr. Butler, Dr. Chioffe's partner. Petitioner recalled Dr. Chioffe suggesting he obtain a second opinion but could not recall seeing Dr. Butler. The Arbitrator finds Petitioner credible on this point. The itemized Spine Consultants bills in PX 5 list Dr. Butler as a provider on only one date, namely the date of surgery. This is consistent with Dr. Chioffe's operative report, which describes Dr. Butler as assisting with the surgery. PX 7, p. 65. All of the office visit notes in PX 5 bear the electronic signature of Dr. Chioffe, not Dr. Butler. It is clear to the Arbitrator that Petitioner elected to see Dr. Erickson (at his attorney's recommendation) after discontinuing care with Dr. Chioffe but there is no evidence suggesting Petitioner exceeded the choices afforded by Section 8(a).

Dr. Erickson did not document any positive Waddell's signs but, in August 2017, noted neck and trapezius complaints which, ultimately, he could not link to the work accident. At his deposition, he acknowledged he could not explain all of Petitioner's symptoms but nevertheless described Petitioner as a good candidate for a lumbar fusion. He admitted, however, that Petitioner's use of a walker, as documented in earlier records, would be "suspicious," given his full leg strength.

Dr. Levin, Respondent's examiner, did not note any positive Waddell's signs or symptom magnification in his September 21, 2016 examination report. He documented some left-sided weakness. At his subsequent deposition, he testified there was "some element of nonorganic etiology" in Petitioner's post-operative complaints, based in part on the repeat June 27, 2016 lumbar spine MRI.

While the Arbitrator agrees with Dr. Levin's opinion that further lumbar spine surgery is not warranted, the doctor's conclusion that Petitioner was capable of "heavy manual work" as of October 2016 is at odds with his impairment rating. It is also potentially at odds with the March 10, 2017 CT discogram, which Dr. Levin never reviewed.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection?

Respondent agrees Petitioner established causation as to a recurrent L4-L5 herniation warranting the April 2016 microdiscectomy but disputes causation insofar as Petitioner's post-operative complaints and Dr. Erickson's fusion recommendation are concerned.

The Arbitrator, having considered the treatment records and deposition testimony, finds that Petitioner established causation, as well as reasonableness and necessity, as to his consultation with Dr. Erickson. Although Dr. Chioffe felt Petitioner might be magnifying his symptoms as of June 16, 2016, he nevertheless recommended repeat lumbar spine imaging. Following this imaging, he continued to recommend care, in the form of medication and additional therapy, despite positive Waddell's. On August 12, 2016, he recommended a second opinion and indicated he wanted to follow Petitioner closely. On September 22, 2016, he prescribed Tramadol and a return visit, despite noting "illness behavior." RX 5. He never released Petitioner to work. The Arbitrator further finds that Petitioner established causation as to the lumbar spine care Dr. Erickson rendered from November 2, 2016 through April 12, 2017. The Arbitrator finds it reasonable for Petitioner to have consulted Dr. Erickson, given Dr. Chioffe's August 2016 recommendation that he obtain a second opinion. The Arbitrator uses April 12, 2017 as a "cut-off" point in terms of the lumbar spine care because it was after this date that Petitioner began to focus on his neck and upper extremity complaints, prompting Dr. Erickson to order a cervical spine MRI. Dr. Erickson was ultimately unable to link Petitioner's neck and radicular arm complaints to the work accident.

While the Arbitrator does not subscribe to Dr. Levin's opinion that Petitioner was capable of resuming "heavy manual work" as of October 2016, she is persuaded by his opinion that Petitioner does not require a lumbar fusion. This opinion is consistent with the repeat lumbar spine MRI, Dr. Chioffe's post-discectomy Waddell's findings, the fact that Petitioner's clinical picture includes neck and left arm complaints that no one links to the accident and Dr. Erickson's concession that a functional capacity evaluation could help determine the validity of Petitioner's lumbar spine complaints.

What is Petitioner's average weekly wage?

At the hearing, Petitioner claimed earnings of $23,114.00 and an average weekly wage of $444.50. Respondent claimed an average weekly wage of $420.00. Arb Exh 1.

Neither party offered any wage-related documents into evidence.

Petitioner testified he typically worked ten hours per day but acknowledged his schedule varied, depending on the hours he was assigned. He believed he was paid at the rate of $12.50 per hour in 2015, the year before the accident, but was not sure. T. 16-17.

The Arbitrator finds that Petitioner failed to meet his burden of proof on the issue of wages. He had some recollection of earning $12.50 per hour in 2015 but did not establish what his typical work week consisted of during that year.

The Arbitrator finds an average weekly wage of $420.00, based on Respondent's binding stipulation. Walker v. Industrial Commission, 345 Ill.App.3d 1084 (4th Dist. 2004).

Is Petitioner entitled to temporary total disability from November 1, 2016 through the hearing of October 16, 2018?

Respondent agrees Petitioner was temporarily totally disabled from February 22, 2016 through October 31, 2016 (Arb Exh 1). Respondent relies on its Section 12 examiner, Dr. Levin, in arguing that Petitioner reached maximum medical improvement and was capable of full duty as of October 31, 2016. Citing Dr. Erickson's surgical recommendation and the fact Dr. Chioffe never released him to work, Petitioner claims he remained disabled through the hearing of October 16, 2018.

Based on the foregoing credibility- and causation-related findings, the Arbitrator views Petitioner as reaching maximum medical improvement on April 12, 2017. As noted earlier, it was after April 12, 2017 that Petitioner's non-accident-related neck and upper extremity complaints began to dominate his clinical picture. The Arbitrator finds that, in addition to the stipulated period, Petitioner was temporarily totally disabled from November 1, 2016, through April 12, 2017.

The Arbitrator has previously found Petitioner's average weekly wage to be $420.00. The parties stipulated Petitioner was married and had one dependent child as of the accident. Arb Exh 1. The Arbitrator finds Petitioner's temporary total disability rate to be $286.00, the applicable minimum.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims a number of unpaid medical bills, including a bill relating to a cervical spine MRI performed in August 2017. PX 17.

The Arbitrator has previously found that Petitioner established causation, as well as reasonableness and necessity, as to the lumbar spine care Dr. Erickson rendered from November 2, 2016 through April 12, 2017. Dr. Erickson's itemized bill reflects charges of $500, $400 and $200 (PX 8, pp. 2-4) for Petitioner's three office visits during this interval. The Arbitrator awards Petitioner these charges, subject to the fee schedule. The Arbitrator also awards Petitioner the $1,500.00 charges, subject to the fee schedule, for the SSEP monitoring performed, at Dr. Erickson's direction, on November 8, 2016. PX 9. The Arbitrator also awards Petitioner the $3,159.15 and $9,477.45 charges, subject to the fee schedule, associated with the lumbar discogram Dr. Vargas performed on March 10, 2017. The Arbitrator declines to award the $275.00 non-emergency transportation charges of the same date. PX 10. Petitioner failed to establish the need for non-emergency transportation. The Arbitrator also awards Petitioner the $1,046.00 charges, subject to the fee schedule, associated with the post-discogram lumbar spine CT scan performed on March 10, 2017. PX 11. The Arbitrator declines to award the $325.00 charges [Lakeshore Surgery Center] associated with an office visit of March 10, 2017 since these charges are not well-explained and appear to overlap with the charges set forth in PX 13 for services performed the same day. The Arbitrator awards Petitioner the $28,350.00 charges, subject to the fee schedule, of River North Pain Management Consultants, S.C. for the services performed on March 10, 2017. PX 13. The Arbitrator also awards Petitioner the $840.00 charges [Western Touhy Anesthesiology], subject to the fee schedule, associated with the anesthesia administered on March 10, 2017. PX 14. Finally, the Arbitrator awards Petitioner the charges of $216.00, $458.00, $291.00 and $291.00 [Delaware Physicians LLC] associated with the medication Dr. Erickson prescribed on April 12, 2017, with Respondent receiving credit for the payments reflected on the bill. PX 15.

In awarding the charges associated with the March 10, 2017 lumbar spine discogram and post-discogram CT scan, the Arbitrator has considered the opinions expressed by Dr. Levin, Respondent's examiner. Dr. Levin acknowledged he did not review Petitioner's discogram results. He did not describe discograms as inherently unreasonable. He acknowledged prescribing them occasionally and agreed that a post-discogram CT scan is an objective study. RX 1, pp. 44-46. The Arbitrator further notes that Respondent offered no utilization review evidence.

Is Petitioner entitled to prospective care?

Based on the foregoing credibility and causation analyses, the Arbitrator declines to award the lumbar fusion recommended by Dr. Erickson. As of Petitioner's last visit to Dr. Erickson, in June 2018, he was continuing to complain of upper extremity symptoms that the doctor could not link to the accident. On direct examination, Dr. Erickson acknowledged he "could not speak for all of [Petitioner's] symptoms." He also acknowledged he could not rule out symptom magnification, although he felt the objective examination findings supported Petitioner's lower extremity complaints. He agreed that a functional capacity evaluation would determine whether Petitioner was magnifying his symptoms.

The Arbitrator awards prospective care in the form of a functional capacity evaluation, with validity studies.

Is Respondent liable for penalties and fees?

Petitioner filed a petition for penalties and fees on July 20, 2018. Arb Exh 2. Petitioner claims various medical bills but did not offer any evidence indicating he made a "demand for payment" of these bills, as required by Section 19(l) of the Act.

The Arbitrator declines to find Respondent liable for penalties and fees, based on both the procedural deficiencies and the evidence. Respondent relied primarily on its examiner, Dr. Levin, in terminating the payment of benefits as of October 31, 2016. Although the Arbitrator has awarded additional benefits beyond that date, she is unable to find that Respondent acted in an objectively unreasonable manner in discontinuing payment as of October 31st, under all of the existing circumstances. Dr. Erickson began recording neck and upper extremity complaints in August 2017. He could not link these complaints to the accident. Although he continued to recommend a lumbar fusion, he subsequently testified he agreed with Dr. Levin's MRI interpretation. He also conceded that a functional capacity evaluation would be useful and that it would be safe for Petitioner to attempt light duty if the evaluation demonstrated this. Upon review of treatment records he had not previously seen, he acknowledged it was "suspicious" that Petitioner was using a walker in June 2016, despite having "near full" strength in his legs. RX 4. PX 16, p. 36.

On this record, the Arbitrator is unable to find that Respondent acted vexatiously and unreasonably in terminating the payment of benefits.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lynne Murphy,
Petitioner,

19IWCC0589

vs.

NO: 12 WC 39909

JP Morgan Chase Bank,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 2, 2018, is hereby affirmed and adopted.

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

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

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 29 2019
o10/17/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0589

MURPHY, LYNNE
Employee/Petitioner

Case# **12WC039909**

JP MORGAN CHASE BANK
Employer/Respondent

On 8/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0787 MEYERS & FLOWERS LLC
JOHN N HARP III
3 N SECOND ST SUITE 300
ST CHARLES, IL 60174

2461 NYHAN BAMBRICK KINZIE & LOWRY
INGRID M LULICH
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LYNNE MURPHY,
Employee/Petitioner

Case #**12 WC 39909**

v.

Consolidated cases:

JP MORGAN CHASE BANK,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **KETKI STEFFEN**, Arbitrator of the Commission, in the city of **ELGIN/WHEATON II**, on **June 12, 2018 and July 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/26/2010**, 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 $**26,000.00**; the average weekly wage was $**500.00**.

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

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

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

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

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

ORDER

Denial of benefits

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.

KSSteffen — July 28, 2018

Signature of Arbitrator — Date

STATE OF ILLINOIS)
) ss.
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LYNNE MURPHY

Petitioner,

v.

JP MORGAN CHASE BANK

Respondent.

COURT NO. 12 WC 39909

FACTUAL HISTORY

Testimony of Lynne Murphy:

Lynne Murphy testified at trial that she resides in South Elgin, Illinois. In 2010, she worked for JP Morgan Chase at the call center located on Randall Road in Elgin, Illinois. Her job duties included making calls to customers and taking calls from customers about bills.

On May 26, 2010, Ms. Murphy testified she worked her regular shift. Around 10:30 p.m., she spoke with a customer on the phone for a long period of time. At that time, about 9 people were still working in the office. People had been cleaning the cubicles around her for approximately 2 weeks. She stated her eyes itched due to the cleaning solutions around her. While on the call, Ms. Murphy sat in her cubicle behind a partition that was 3 to 3 ½ feet high. A girl cleaning the cubicles came by her and "hosed" her face with spray. The spray got into her eyes and her face burned. Ms. Murphy testified she abruptly ended her call. She stated her employer wrote her up for ending the call so quickly. She testified she went to get air and wrote down what happened. Ms. Murphy stated she told her supervisor, Gwen Baldwin, what happened. Ms. Baldwin was in her office and Ms. Murphy stood at the doorway of Ms. Baldwin's office for the remainder of her shift, approximately 10-15 minutes. After telling her supervisor, Ms. Murphy testified she went home. When asked whether she washed her face, Ms. Murphy stated she did not wash her face.

Ms. Murphy testified she completed a written statement, but her employer did not complete an accident report initially. She stated that she gave a copy of her statement to the security officer and asked that he acknowledge receipt of her statement by signing it. Ms. Murphy testified she went to the doctor because her eyes were puffy, her nose hurt inside, she had issues swallowing, and she had problems with different smells. Her main problem was her eyes.

Ms. Murphy testified she first sought treatment with her primary care physician, Dr. Maida. She did not tell him at that time that she was sprayed in the face at work. Ms. Murphy testified Dr. Maida wanted to check her for allergies as her eyes were running. She stated that she repeatedly asked her employer what the substance was that was sprayed on her, but she did not find out the name of it until a year later. At that time, she also received a copy of the Material Safety Data Sheet for the spray.

Ms. Murphy identified Petitioner's Exhibit 9/Respondent's Exhibit 1 as an incident report she previously reviewed. This is the report that she stated was not completed by her employer until a year after her alleged incident. Ms. Murphy did agree the date on the report was June 4, 2010. (PX9, RX1).

When asked about her medical treatment, Ms. Murphy testified she continued to see Dr. Maida on many occasions for her sinuses and her eyes. She also sought treatment with a variety of specialists including an ENT, an ophthalmologist, a dermatologist, and an allergist.

Ms. Murphy testified she saw Dr. Bryan Kemker on September 16, 2011, but she could not recall if he was an allergist or an ophthalmologist. She agreed he could be an ENT. She stated he diagnosed her with rhinitis and may have prescribed nasal spray. She was not sure about the prescription from him as she had so many medications. She subsequently saw Dr. Smart, an allergist, in October, 2011. She testified he did not diagnose her with allergies. She later sought treatment with Dr. Kadlec, an ophthalmologist, for some issues with her eyelids. A small growth was removed off the top of her eyelid. Dr. White also evaluated her and prescribed Bactrim and cortisone. She continued to seek treatment with Dr. Maida as she never got better.

Ms. Murphy testified at one point a tow truck brought a car by her and she could not breathe due to the fumes. She did not explain when or where this incident occurred. Ms. Murphy testified she went to see Dr. Maida after that incident. She stated her nose is always dry and she is sensitive to perfumes and other smells. Ms. Murphy testified she had the same issues while at work.

In 2017, she sought treatment with Dr. Perdigon in Florida. He prescribed antibiotics. Ms. Murphy stated she took antibiotics to clear her fungal infections. Her issues started in her eyes and she also had problems in her head, nose, and down her

throat. Ms. Murphy testified there is part of her ear doctors cannot see and she had issues with pus, blood, and white stuff down her throat.

When asked if a doctor has authorized her off work, Ms. Murphy testified a doctor does not have to tell her she is unable to work as she cannot breathe when she walks into a place. She stated that she does not work as she cannot work.

In terms of her daily life, Ms. Murphy mentioned she cannot go into certain places or stores. She is unable to walk by a tire department due to the smell of the tires. If there is asphalt on the road, she cannot go by that area due to the smell. She also has issues with gas pumps and any perfumes or odors. She testified that she tries to eat organic foods, take vitamins, and use natural things. She does not like to take medications. Ms. Murphy testified she is not currently employed.

On cross-examination, Ms. Murphy stated that the female who sprayed her got scared and ran away after she sprayed her. She did not have a conversation with her. The girl had a twin sister and she did not know their names. She sprayed her with a clear bottle, but Ms. Murphy was not sure if the cleaning solution was diluted as recommended by the Material Safety Data Sheet. Ms. Murphy stated she did not wash her face or eyes after she was sprayed.

Ms. Murphy agreed the first time she sought medical treatment after the incident was on June 4, 2010. She stated that she has reviewed the records of her treatment with Dr. Maida. Ms. Murphy testified that she saw Dr. Maida on May 19, 2010, a week before the alleged incident at work. She agreed that she was on multiple medications before the incident at work. When asked if she had a MRSA infection in the past, Ms. Murphy stated she thought she had a bacterial infection in her nose and tested positive for MRSA, but she believes it was later determined that she did not have MRSA.

Ms. Murphy testified she did not tell Dr. Maida she was sprayed in the face at work until she learned the name of the spray a year after the incident. When asked if she first mentioned this incident at work to Dr. Maida at a visit on March 27, 2012, Ms. Murphy stated that may have been the date she told him, but she needed to check her records as she had the exact date written down.

Ms. Murphy testified she used to live in a townhouse, but she sold her townhouse a few weeks ago. She has cats, but her cats are in Florida, where she moved. Ms. Murphy stated she currently lives with a person in Illinois since her townhome sold. Ms. Murphy mentioned that she used to burn candles, but she cannot burn candles anymore after this incident. She also has issues if anyone uses bleach nearby. When asked if she has any issues with the eye makeup she wears, Ms. Murphy stated she does not have any issues. She testified she has to leave areas all of the time due to her sensitivity to different smells. When asked if she takes any prescription

medications, Ms. Murphy confirmed she takes thyroid and blood pressure medications. Her medications have been the same since before the date of the alleged incident.

Ms. Murphy agreed that she asked Dr. Maida to write down what had happened to her at work, but she could not recall if she asked him to say her problems were due to the incident at work.

Ms. Murphy stated that she saw Dr. Terrance Moisan for a Section 12 exam at the request of her employer on March 13, 2014. She stated Dr. Moisan could see her issues as she had welts on her eyes.

Ms. Murphy testified she has had no other jobs since she left her employment with JP Morgan Chase in 2012. She admitted no doctor currently has authorized her off work. When asked if she is retired, Ms. Murphy stated she would like to work. She testified that she worked for La Z Boy prior to working at JP Morgan. She did go shopping to a La Z Boy store with a friend after the incident at work and she had to leave due to odors. Her current sources of income include Social Security benefits and assistance from her children. She last lived in her townhouse 3 years ago and then rented it out as she could not afford to live there. Ms. Murphy stated she sold her townhouse a few weeks earlier. When asked if she sold it herself, Ms. Murphy testified a broker named Ed from Magnum Realty sold her house. She could not recall how to spell his last name.

Ms. Murphy admitted she has a valid real estate broker's license in Illinois. She did not believe she sold any homes since 2010 and only helped family when they sold their homes. She then was unable to recall if she listed any homes and thought she might have sold a home in Bartlett. Ms. Murphy stated she had no reported income in Illinois and she did not take fees from any real estate transactions.

Ms. Murphy was asked to review Respondent's Exhibits 6 and 7, which included a list of home sales where Ms. Murphy was either the list agent or the selling agent. She testified she could not recall all of these transactions, but she had no reason to dispute that these were accurate lists. Ms. Murphy agreed some of these sales occurred after 2012, but she did not believe she received money from these sales. When presented with Respondent's Exhibit 8, the MLS listing for her townhouse that recently sold, Ms. Murphy agreed her name was on page two of the listing as the co-listing agent. She stated her managing broker put her on the listing as he did not want to show the townhome. She claimed she did not get any fees or money from the sale.

On re-direct examination, Ms. Murphy testified her application for Social Security Disability benefits was denied because the nature of her condition was not clear. She also applied for short-term disability benefits and her application was denied. She receives regular Medicare benefits and she is a Medicare beneficiary.

After the parties finished questioning Ms. Murphy, the Arbitrator asked Ms. Murphy whether she had access to water, a water fountain, or a bathroom. Ms. Murphy agreed that she did have access to water, a water fountain, and a bathroom. The Arbitrator then asked Ms. Murphy whether it was true that she did not wash her face or eyes after she stated she was sprayed in the face by the cleaning lady. Ms. Murphy testified that she did not wash her face or eyes and explained that her employer would not let her leave to go wash her face or eyes and made her stand in the doorway of her office for 10-15 minutes. When asked if she had to ask permission to go to the bathroom, Ms. Murphy stated she had to sign out on a sheet if she left to go to the bathroom.

Medical Treatment:

Ms. Murphy presented to Dr. Gerald Maida on May 19, 2010. (RX 9). She reported an infection a couple years earlier in her left tooth with possible radiation up the sinus or bone. She now has recurrent pain and swelling over the left cheek and eye. Upon examination, Dr. Maida noted shallow excoriation around the lower part of each nostril. The records document a possible MRSA infection as she had a friend with MRSA. Dr. Maida diagnosed her with cellulitis of the nose and left cheek or sinus issues. He prescribed Bactroban twice a day for 10 days and Bactrim DS twice a day for 10 days. Dr. Maida recommended bloodwork.

Ms. Murphy returned to Dr. Maida on June 4, 2010 for a physical exam. (PX 1). Her past medical history was significant for nasal cellulitis, high blood pressure, and hypothyroidism. She complained of discomfort in her left leg radiating down, itching in her nose, and discomfort around her left eye with some blurred vision. Dr. Maida diagnosed her with cellulitis of the nares with Klebsiella and Proteus, resolved. He also diagnosed her with pruritus of the nose, probably related to Bactroban. He recommended she concentrate on exercise, weight control and referred her to ophthalmology due to blurred vision.

She returned to Dr. Maida on June 18, 2010 for a gynecological exam and a nasal culture. Dr. Maida took a culture of the anterior nares to determine if there was any abnormal colonization. He commented that her nasal ulcerations and inflammation seem to be healed, although there was some erythema of the hairy area of the nares with no evidence of infection. As she complained of significant itching of the nose and eyes, Dr. Maida recommended she see an ophthalmologist.

On August 6, 2010, Dr. Maida noted Ms. Murphy had sinus discomfort in her nose and head. She had a resolving tooth abscess and active treatment with a dentist. Ms. Murphy was convinced she had a persistent infection. Dr. Maida noted that her last nasal culture was negative for MRSA. He diagnosed her with a possible head and neck

infection. Prior to undergoing an extensive workup, he prescribed a trial of Augmentin and noted she should undergo blood work with CRP, CBC, and sedimentation rate.

On September 24, 2010, Ms. Murphy reported nasal itching and a rash. She also had itching along the right eye. Dr. Maida diagnosed her with pruritic skin and a facial rash. He referred her to a dermatologist and instructed her to keep the area dry with no scented creams or ointments.

On October 1, 2010, Ms. Murphy presented to Dr. Chanachai Memark, a dermatologist. (PX 13). She reported a skin rash and red scaly patches under her nose. He diagnosed her with dermatitis with possible seborrheic dermatitis. At a follow-up visit on November 1, 2010, Dr. Memark diagnosed her with eczema in her upper eyelids and noted she had seborrheic keratosis in her right breast.

Dr. Maida saw her on November 12, 2010. She had complaints of abdominal pain. Her mouth and throat were normal. She reported anxiety and was referred for counseling. Dr. Maida authorized her off work until November 30, 2010 due to an acute grief reaction and spastic colitis.

Dr. Maida reevaluated her on July 13, 2011. She reported sinus issues and denied any known allergies. He diagnosed her with sinusitis, blepharitis, high blood pressure and hypothyroid. He recommended an exercise program and weight control.

Dr. Bryan Kemker, an ENT, evaluated Ms. Murphy pursuant to a referral by Dr. Maida on September 17, 2011. (PX 3). He reviewed her allergies and noted she had no known allergies. She had sinus and nose problems, facial pain and dental problems for years. In the past, allergy testing did not reveal any known allergies. She reported pressure in her ears, but noted her hearing was fine. Dr. Kemker performed a nasal endoscopy with evidence of nasal congestion noted. Dr. Kemker diagnosed her with chronic sinusitis, facial pain, and allergic rhinitis. He recommended a CT scan of her sinuses and an allergy consultation.

On October 3, 2011, Dr. Maida documented in his notes that the CT scan of her paranasal sinuses revealed mild leftward bowing of the nasal septum, but her paranasal sinuses were clear.

Dr. Bryan Smart, an allergist, evaluated Ms. Murphy on October 3, 2011. (PX 4). She mentioned a leaking crown which led to a root canal 8 years earlier. She started a new job 2 years ago and seems to sneeze more in this building. Her eyes are red and itchy. Steroid cream at the end of her nose helped. Ms. Murphy stated her sister has allergy problems and Ms. Murphy owns four cats. Dr. Smart diagnosed her with nonallergic rhinitis. Her allergy testing was negative with a good response to positive

control. He prescribed Azelastine and told her to sit away from any irritants at her workplace.

Dr. Sada Kadlec evaluated Ms. Murphy's eyes on October 9, 2011. (PX 5). She reported multiple episodes of upper eyelid swelling and dermatitis. She reported she was told she had allergies in the past, but denies seasonal allergies. She recently used steroid and Patanol to her right upper lid and believes this made it worse. Upon examination, multiple erythematous plaque-like areas are present on her eyelids. Dr. Kadlec diagnosed her with dermatitis of the right eyelid and noted a lesion of the right lid which could be squamous papilloma.

On December 9, 2011, Dr. Maida noted her aerobic bacteria culture revealed heavy growth of staphylococcus aureus with multiple negative rods present. She did not mention any ongoing nasal or respiratory issues. On December 13, 2011, Dr. Maida noted Ms. Murphy had a staph infection and recommended she use Bactroban ointment twice a day for 10 days in the interior part of both nostrils.

Dr. Memark reevaluated her on December 16, 2011 and she reported eczema on her eyelid and a staph infection in her nose.

On December 30, 2011, Dr. Maida recommended additional bloodwork to check her thyroid. One of her diagnoses included MRSA (methicillin resistant staph aureus) with positive culture.

On March 27, 2012, Dr. Maida's records reflect that Ms. Murphy presented with nasal and facial itching after exposure to cleaning chemical. She stated a cleaner sprayed her face with chemical cleaner on May 26, 2010 at work. She reported irritation with smoke and other things since 2010. Her nose and throat were worse over the last 2 weeks with her eyes itching, swollen and tearing. Dr. Maida diagnosed her with airborne allergy and allergic rhinitis. He recommended an antihistamine for both allergic rhinitis and airborne allergy.

On March 31, 2012, Dr. Maida noted she has staph infection and prescribed an oral antibiotic due to her systemic symptoms. He instructed her to make sure that no one near her, such as a family member or friend, is the likely source of her infection as this would be a person who is diabetic or chronically ill or has been in a nursing home. He recommended that she thoroughly wash her hands and use an antibacterial soap once daily.

On April 2, 2012, Dr. Maida's records include a note from Claire Shelton documenting that Ms. Murphy needed Dr. Maida to prepare a letter. The notes mention: "The letter for her job needs to state that this all started after she was sprayed in the face with those chemicals from the cleaning crew. It should also state that she was

cleared of the Staph infection 2 weeks ago and after cleaning of her office again she was infected again by Staph." (PX1).

Ms. Murphy continued to seek treatment with Dr. Maida in 2012 and 2013. She reported ongoing issues with her eyes, nose and cheeks. Ms. Murphy reported that her symptoms improved while she was at home versus at work.

On December 3, 2012, Dr. Maida noted she had hoarseness and chest discomfort which Ms. Murphy related to being sprayed at work in the face with a cleaning solution in May, 2010. She reported hypersensitivity syndrome to various odors and irritants which caused reddening, irritated eyes and nose, shortness of breath, hoarseness and chest discomfort. Her symptoms improve when she is off work. Dr. Maida diagnosed her with rhinitis, chest discomfort, and dyspnea. He explained her symptoms are allergy-like even though her testing was negative. He noted some allergy medications work to reduce symptoms even though specific allergies are not found. He recommended Singulair.

On January 21, 2013, Dr. Maida issued a letter "to whom it may concern". He noted Ms. Murphy's symptoms first began in May, 2010 when she was sprayed in the face with cleaning solution. She subsequently experienced a number of symptoms with allergy like reactions, asthma like reactions, nasal irritation, chest discomfort, headaches, shortness of breath, fatigue, and recurrent nasal staph infections. He documented that none of these symptoms had been present prior to the May, 2010 episode. Her recurrent staph infections were a special concern as topical and oral antibiotics have not cleared the infection and she was entering a carrier state. Dr. Maida stated these seem to be exacerbated when exposed to any type of odors or atmospheric irritants and her symptoms become progressive and she is unable to function at work due to exposure to perfumes and colognes. Her symptoms outside of work vary in intensity, but are more severe at work. Dr. Maida concluded she is unable to work in her job due to exacerbation of symptoms.

On February 19, 2013, Ms. Murphy reported her symptoms worsened. Ms. Murphy continued to treat with Dr. Maida throughout 2013. She presented to Dr. Wesley White on December 10, 2013. (PX 6). She reported a long history of symptoms since being sprayed in the face at work and reported sensitivity to chemicals and perfumes. He prescribed Mupirocin to eradicate the carrier state.

On March 13, 2014, Ms. Murphy presented to Dr. Terrance Moisan for a Section 12 examination at the request of her employer. She reported she was sprayed by a compound and developed nasal irritation and mild upper eye irritation. She also had facial redness and burning after the spray. She was seen for a sinus infection which caused an eye rash and had allergy testing which was unremarkable. She stated she last worked in October, 2012. She went into a La Z Boy furniture store as a shopper and had

previously worked there as an employee. She had to leave due to perfumes of other customers. Dr. Moisan noted she was 5'4" tall and 200 pounds with a blood pressure of 145/85. Upon examination, her head, eyes, ears, nose and throat revealed chronic eczematoid changes of the upper lids typical of chronic contact blepharitis, mild facial erythema, and slight erythema without specific lesion. Her skin was thickened in bilateral nasal passages with two patches of eczema on her left ear and one patch on her right ear. He diagnosed her with a chronic contact blepharitis and persistence of symptoms even after being gone from the workplace for over a year. Dr. Moisan concluded she may be sensitized to an allergic contactant such as shampoos or cosmetics. He recommended industrial patch testing, if necessary. Dr. Moisan noted she may have been irritated when she was sprayed, but she had rhinitis prior to working at the bank and her chronic rhinitis symptoms were not causally related to this alleged spray.

Dr. Maida reevaluated her on April 29, 2014. She had ear pain and eye pain. Ms. Murphy denied any chest pain, shortness of breath, cough, or fever. Upon examination, Dr. Maida noted her nose is crusted. He diagnosed her with hypothyroidism and recommended she exercise.

On September 24, 2014, Dr. Maida issued another letter indicating that Ms. Murphy had been evaluated by multiple specialists without a specific diagnosis. He concluded she has non-immune hypersensitivity syndrome and she is disabled from work due to this syndrome.

Dr. Moisan reviewed the deposition transcript of Dr. Maida on January 10, 2017. He confirmed his opinion that there were no long term issues from her claimed incident at work on May 26, 2010.

On August 23, 2017, Ms. Murphy presented to Dr. Rhoniel Perdigon in Florida (PX 11). She reported recurrent sinus infections, post-nasal drip, and noted she was sprayed in the face with a chemical and had a lot of sensitivity since then. Dr. Perdigon diagnosed her with recurrent acute sinusitis, allergic rhinitis, hyperlipidemia, and vitamin deficiencies. He prescribed Amoxicillin and Azelastine nasal spray. He noted her cholesterol was high as were her sugars, so he recommended bloodwork.

On October 9, 2017, Dr. Perdigon's records reflect Ms. Murphy reported ongoing sickness from chemical exposure to the face 8 years earlier with issues with her ears and eyes. She requested more Amoxicillin as she had a weird sensation on her tongue and a funny taste in her mouth. Dr. Perdigon noted mild discharge on her tongue, slight inflammation of the right tonsil, and whitish discharge. He diagnosed her with candiasis of the mouth, and acute pharyngitis. She denied improvement at a visit on October 23, 2017. Dr. Perdigon cultured her nasal passages.

On November 8, 2017, Dr. Perdigon noted her mucus will not go away and she tried Mucinex along with three different antibiotics. He prescribed a Nystatin swish and Vitamin C.

Deposition Testimony of Dr. Gerald Maida

The parties proceeded with the evidence deposition of Dr. Gerald Maida on March 16, 2016. Dr. Maida testified he is Board Certified in internal medicine. He could not recall how long Ms. Murphy had been his patient. (PX2 at 7). Dr. Maida testified he saw her on May 19, 2010 and she complained of irritation and inflammation around the left and right nostrils. (PX2 at 10). He referred her to a dermatologist who diagnosed her with eczema and keratosis. (PX2 at 13). Dr. Maida also referred her to an allergist who diagnosed her with non-allergic rhinitis. (PX2 at 15-16). Dr. Maida noted she had symptoms of an allergy with her eyes inflamed and her nose inflamed, but her allergy testing is negative. He testified she had symptoms with no finding of specific things to which she may be allergic, which is not uncommon. (PX2 at 16).

Dr. Maida admitted that, prior to her visit on March 27, 2012, there was no mention in his records that Ms. Murphy had been sprayed in the face at work. (PX2 at 17). When asked if Ms. Murphy magnified her symptoms, Dr. Maida stated he thought the basics of what she told him were true, but some of the details may have been exaggerated but he was unable to test that opinion. (PX2 at 20). Dr. Maida noted she had non-immune hypersensitivity and she told him she was severely affected, but he admitted was unable to prove or disprove her claim. (PX2 at 21-22). He opined that she was unable to return to work in an office setting due to fatigue, confusional thinking, and issues focusing on her job which appeared to be affected at work by her exposure or "whatever that was over there." (PX2 at 23).

On cross-examination, Dr. Maida admitted he may have treated Lynne Murphy before May, 2010. (PX2 at 28). Dr. Maida also confirmed that her alleged exposure at work was not mentioned until a visit on March 27, 2012. He was not aware of the specific date on which the alleged incident happened at work. (PX2 at 40). Dr. Maida agreed that he initially diagnosed her with acute sinusitis, cellulitis and noted she had the Klebsiella bacteria as of May 19, 2010. (PX2 at 44). Dr. Maida also admitted that Ms. Murphy asked him for a letter with specific language indicating that her condition was related to the incident where she was sprayed in the face with chemicals from the cleaning crew. (PX2 at 50).

Dr. Maida confirmed that his opinion on January 21, 2013 was given without reviewing the Material Safety Data Sheet of the alleged chemical exposure and based solely on the history reported by Ms. Murphy. (PX2 at 58-59). He also admitted that all of her symptoms of rhinitis conjunctivitis pre-dated her alleged exposure. (PX2 at 59). Dr. Maida admitted there is some skepticism about the hypersensitivity syndrome

diagnosis. (PX2 at 62). Dr. Maida testified her main problem is rhinitis, which he agreed essentially means she has a runny nose. (PX2 at 67). Dr. Maida admitted that she may be able to work. (PX2 at 67-68). Dr. Maida also stated that, as of October 28, 2013, his primary diagnosis was rhinitis and he agreed that she did not have shortness of breath or asthma-like symptoms documented in his records. (PX2 at 73-74).

Deposition Testimony of Dr. Terrance Moisan:

The parties proceeded with the evidence deposition of Dr. Terrance Moisan on January 18, 2017. Dr. Moisan testified he is Board Certified in internal medicine, pulmonary diseases, and occupational health. (RX4 at 5-6). Dr. Moisan testified he is currently the CEO of Palos Community Hospital, but he does see patients. (RX4 at 7-8). Dr. Moisan testified he reviewed an incident report, dated June 4, 2010 (RX1) which stated Ms. Murphy was infected by Quik Fill 510 used by the cleaning crews and her nasal infections caused trauma and she left the workplace that day. She was then fine and back to work. (RX1, RX4 at 12-13). Dr. Moisan also reviewed a note authored by Lynne Murphy, dated May 26, 2010, which stated the cleaning lady was using a duster around 10:15 as well as a spray cleaner and the odor was strong. (RX2, RX4 at 13). She was taking a phone call and felt it was difficult to breathe as she was on seven medications for bacterial infections of her nose and eyes. Ms. Murphy reported in the note that the cleaning lady cleaned a desk and sprayed trim and she sprayed directly in front of her, causing the spray to go into her face. (RX2, RX4 at 13). Dr. Moisan testified he reviewed the Material Safety Data Sheet for Quik Fill 510 (RX3). Dr. Moisan testified Quik Fill 510 is an irritant and not a sensitizer. (RX4 at 14). He stated irritants do not cause allergies, but exposure to a sensitizer can cause you to develop an allergy if you are around sensitizers for a long enough period of time. One exposure to a sensitizer would not cause sensitization. (RX4 at 14). Dr. Moisan noted her past medical history is significant for arthritis or joint problems, a prior surgery, asthma, bronchitis, skin rashes, heart disease/high blood pressure, diabetes, thyroid and other endocrine problems. (RX4 at 15).

Dr. Moisan testified that Ms. Murphy reported one incident where she was sprayed directly in the face that caused increasing facial redness and burning later in the day. (RX4 at 16). She last worked in the building in October, 2012. (RX4 at 16-17). Ms. Murphy reported intolerance to odors and perfumes in many environments and denied using any new compounds at home. (RX4 at 17). Upon examination, Dr. Moisan stated her blood pressure was modestly elevated and she had chronic eczematoid changes of the upper eyelids, which is typical of chronic contact blepharitis. (RX4 at 17-18). Dr. Moisan noted this is something that lasts for a period of weeks to years and is defined as an inflammation of the upper eyelids, which are typically very sensitive to allergens. (RX4 at 18). This would result from something that contacts the eyelids primarily. He testified that Quik Fill solution is not a sensitizer so this would not cause chronic contact blepharitis. Further, the pattern in the upper eyelids is typical

of a cosmetic or hair agent, or something that touches your eyes every day. (RX4 at 18-19). She also exhibited mild rosacea like features without the pustules to categorize it completely as rosacea with turbinate erythema, or slight swelling and redness of the lining of the nose along the interior. She also had thickened areas of skin around the bottom of the nose with a little fissure, showing chronic eczematoid changes with no dermatitis around the mouth. She also had eczema noted along the pinna, or top of her left ear and right ears. Dr. Moisan opined that this usually results from either a contactant like a shampoo or can be due to seborrheic dermatitis. (RX4 at 19). After evaluating her and reviewing the records, Dr. Moisan noted she has blepharitis and recommended evaluation for a contact allergen to exclude a cosmetic such as shampoo or hair dye or perfumes due to the lesions on her ear. He noted patch testing could be performed. He also noted she had the rhinitis prior to the alleged workplace exposure and her chronic rhinitis and ongoing symptoms were not feasibly related to the alleged spray. (RX4 at 20-21). When asked about chronic hypersensitivity syndrome, Dr. Moisan noted that this is different than hypersensitivity, which is a true allergy. He also stated there is hyperreactivity, which some people get when they have difficulty with nasal stuffiness, sore throats, and other issues. This is due to hyperresponsiveness of the C-receptors in the airway with the etiology unclear. (RX4 at 21-22). Dr. Moisan testified that she does not have hypersensitivity, but he believes Ms. Murphy has exposure to a contact allergen and should have patch testing to rule out the cause. (RX4 at 22-23). Dr. Moisan described patch testing and noted the compounds or bi-products or compounds are left on the skin in a little disk and covered for 24-48 hours to determine if there is a localized reaction. (RX4 at 23-24). With regard to hyperreactivity, other than her reported mild intolerance to odors, there were no other physiological sequelae, so that would be a minimal finding. (RX4 at 23).

Dr. Moisan also commented that Klebsiella pneumoniae positive culture is a gram negative bacteria that is often seen in persons with sinusitis and rhinosinusitis or people with longstanding sinus problems. (RX4 at 26-27). He opined that this bacteria is difficult to eliminate even with antibiotics in people who have chronic rhinosinusitis. (RX4 at 27). Dr. Moisan noted the staph infection she had in March 2012 was not related to her alleged exposure at work as it is not biologically feasible that a staph infection in March, 2012 would have been related to an alleged irritant exposure 2 years prior. (RX4 at 27-28). He also noted staph infections are secondary generally to colonization in someone who has chronic rhinosinusitis. (RX4 at 28).

Dr. Moisan also discussed how cats generally cause an IgE mediated reaction, which is an acute allergic reaction such as a stuffy nose, cough, and wheezing. However, on occasion, cats can cause a chronic contact blepharitis, but doctors are not sure of the exact mechanism to know whether this is IgE mediated or whether it is lymphocyte mediated. (RX4 at 28). Dr. Moisan concluded Ms. Murphy is able to work full duty as a customer support advisor. (RX4 at 30-31).

FINDINGS/ANALYSIS

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

Petitioner, Ms. Murphy, alleges exposure to a chemical at work on May 26, 2010, resulting in chronic hypersensitivity syndrome. She testified she was "hosed" in the face with a cleaning solution used by a janitor. Ms. Murphy alleges that this exposure arose out of and occurred in the course of her employment on May 26, 2010.

The phrase "in the course of" one's employment refers to the time, place, and circumstances surrounding the injury. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 44 (1987). Injuries sustained by a claimant on an employer's premises, or at a place where claimant might reasonably have been while performing his duties, and while claimant is at work, are generally deemed to have occurred in the course of the employment. *Metro. Water Reclamation Dist. of Greater Chi. v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013-1014 (2011). There is no dispute Ms. Murphy was at work on May 26, 2010, when she allegedly was sprayed in her face by cleaning solution. While there is no dispute she was at work on May 26, 2010, Ms. Murphy still must demonstrate that her alleged injury arose out of her employment.

In order for an injury to "arise out of" one's employment, it must have its origin in some risk connected with, or incidental to, the employment. *Caterpillar Tractor Company v. Industrial Comm'n*, 129 Ill.2d 52, 58 (1989). A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in fulfilling his duties. *Fisher Body Division, General Motors Corp. v. Industrial Comm'n*, 40 Ill.2d 514, 516 (1968).

The Arbitrator finds that Ms. Murphy's testimony that she sustained injuries after she was "hosed" in the face by a janitor with cleaning solution was not credible. After reviewing all of the credible evidence, the Arbitrator questions whether she truly was sprayed in the face as she alleges. The Arbitrator finds her testimony lacking for multiple reasons.

- There was no apparent change in Ms. Murphy's condition between May 19, 2010 and June 4, 2010.

Ms. Murphy suffered from a variety of medical problems and sought treatment with Dr. Maida on May 19, 2010, a week prior to the alleged exposure at work for issues related to her face and eye. She had non-work related sinusitis, cellulitis, and a culture positive for bacteria. Dr. Maida prescribed medications for these issues prior to the alleged exposure at work. Her symptoms persisted at a visit with Dr. Maida on June 4,

2010, nine days after her alleged work exposure. During that visit, she did not mention any additional problems other than left leg pain. Dr. Maida referred her to multiple specialists to rule out the cause of her problems.

There is no indication her pre-existing condition changed between May 19, 2010 and her visit on June 4, 2010. Further, the JP Morgan Chase Incident Report mentions that Ms. Murphy reported she was infected with Quikfill 510 used by the ABM cleaning crews on May 26, 2010 around 10:15 p.m. and *her nasal infections caused trauma*, but she is now fine and back to work as of June 4, 2010. (RX 1, PX 9).

- Ms. Murphy did not report a history of her alleged exposure at work on May 26, 2010 to any doctor until she mentioned this to Dr. Gerald Maida, at a visit with him on March 27, 2012.

The medical records do not include a history of Ms. Murphy's alleged work exposure for 22 months. Ms. Murphy saw Dr. Maida nine days after this alleged exposure and failed to mention anything about this alleged exposure to him. She also saw numerous specialists, including Dr. Smart, Dr. Memark, Dr. Kemker, and Dr. Kadlec, yet she never mentioned the alleged exposure at work for almost two years.

At trial, Ms. Murphy tried to explain that she did not know the name of the cleaner to which she was allegedly exposed and this is why she waited to tell Dr. Maida about the incident at work. She claimed that she repeatedly asked her employer the name of the solution, but it took a year to find out what the janitor sprayed her with on May 26, 2010. Ms. Murphy could not explain why it took her another ten months to the report this alleged exposure to Dr. Maida at a visit on March 27, 2012. Even if she truly did not know the name of the cleaning solution, she could have told Dr. Maida that she was sprayed in the face with an unknown cleaning solution. She failed to do so for almost two years.

- Ms. Murphy testified that she was "hosed" in the face with the cleaning solution, yet she never washed off her face or flushed her eyes:

Despite allegedly being "hosed" in the face with cleaning solution, Ms. Murphy admitted that she did not wash her face or eyes. When asked by her attorney on direct-examination, she stated she did not wash her face. On cross-examination, Ms. Murphy agreed that she did not wash her face or eyes. When asked by the Arbitrator if she had access to water, a water fountain, or a bathroom, Ms. Murphy admitted she did have access, but she did not wash her face or eyes. She explained that her employer would not let her leave to wash her face or eyes and she had to stand in the doorway of her supervisor's office for 10-15 minutes until her shift ended. Ms. Murphy admitted that she could go to the bathroom during her shift, but she would sign out when she went to the bathroom.

The Arbitrator further notes Ms. Murphy completed a written statement indicating she may have been more sensitive to chemicals as she was on 7 medications for bacterial infections of her nose, eyes, etc. as of May 26, 2010. She wrote in this statement that her manager told her to get air and move for the duration of her schedule after she reported this alleged incident. (RX 2). This written statement directly contradicts her testimony at trial. At trial, Ms. Murphy claimed that her manager would not let her leave her doorway for 10 to 15 minutes after she reported her alleged exposure and that is why she could not wash her face. In her written statement, Ms. Murphy claimed her manager encouraged her to get air and move for the duration of her shift.

- Ms. Murphy initially testified she has not worked since she left JP Morgan and her only sources of income include Social Security benefits and help from her children. Additional evidence introduced on cross-examination refuted her initial statement.

Despite Ms. Murphy's claim she did not have any sources of income, she was confronted with information on cross-examination that revealed she has an active real estate broker license in the State of Illinois. (RX5). Ms. Murphy also reviewed information showing her involvement in real estate transactions as the "list" agent and also as the "selling" agent in 2010, 2013, and 2015. (RX 6 and 7). She agreed that she recognized the real estate transactions outlined in Respondent's Exhibits 6 and 7, but she was not sure if she received money for the transactions. Ms. Murphy testified she did not report any income on her taxes.

Ms. Murphy also testified she recently sold her townhouse a few weeks prior to her court hearing. She stated Ed from Magnum Realty (she could not recall how to spell his last name) was the listing agent and her property was located at 263 Windsor Court, Unit B, South Elgin, Illinois. On cross-examination, Ms. Murphy testified she did not sell her townhouse. When asked to review the MLS listing for her townhouse located in South Elgin, Ms. Murphy admitted her name was on the MLS listing as the co-lister of the property, shown on page 2 of Respondent's Exhibit 8. She claimed she did not receive any money for this listing and Ed Calusinski put her on the listing as he did not want to handle the showings.

In summary, after reviewing all of the evidence, the Arbitrator concludes that Ms. Murphy's testimony is not credible and not supported by the contemporaneous medical records or her written statement. The Arbitrator notes that Ms. Murphy's conduct at the time of the alleged accident when she got sprayed/hosed in the face with offensive irritating cleaning solution is completely incredulous. She testified that she did not take the logical step to wash out her face. The Arbitrator finds it nearly impossible to believe that a person who gets sprayed in the face/eyes/nose with

noxious chemicals would not try to wipe off and wash off the offensive substances. When questioned, the Petitioner states that she did not do so because she would be in trouble from her supervisor because she is not allowed to use the bathroom without permission. The fact the Petitioner did not even attempt to get such permission seems illogical to the Arbitrator. In addition, the fact that Petitioner does not report this work injury to her doctors for a long time (22 months) also caused the Arbitrator considerable doubt. Petitioner was suffering from other pre-existing medical issues in the ear/nose/throat and eyes area already. It appears to the Arbitrator that Petitioner, at a late date, just connected or boot-strapped her condition of ill-being to the work accident. Without some medical documentation that is accurate and close in time to the accident, the Arbitrator struggles to find any evidence to support Petitioner' claim in regards to causation. In addition, the cross-examination testimony of the Petitioner regarding her work and earnings as a realtor does little to rehabilitate her credibility but rather tarnishes her claim.

Therefore, the Arbitrator finds that Ms. Murphy failed to prove that she sustained accidental injuries which arose out of her employment on May 26, 2010.

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

Ms. Murphy failed to prove that she sustained accidental injuries that arose out of her employment and her current condition of ill-being is not causally related to the alleged exposure on May 26, 2010. Even if she was able to show she sustained an exposure at work, the Arbitrator finds that Dr. Moisan's opinions regarding causation are more persuasive than the opinions of Dr. Maida. Dr. Maida's opinions were not based on all of the evidence. Dr. Maida admitted Ms. Murphy never mentioned an incident at work to him until March 27, 2012, and he also admitted during his deposition that he prepared the causation opinion at her request with the specific language. Dr. Maida also did not review the Material Safety Data Sheet for Quik Fill 510 and he admitted that her complaints may have been exaggerated, although he could not prove anything.

Dr. Moisan concluded she had chronic allergic issues likely resulting from a contact allergen as evidenced by his findings on exam, which would not be related to her alleged exposure to Quik Fill 510, as that is an irritant rather than a sensitizer. He also concluded she is able to work full duty.

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

As Ms. Murphy failed to prove that she sustained accidental injuries which arose out of her employment on May 26, 2010, the Arbitrator finds that Respondent is not responsible for payment of any medical bills incurred by Ms. Murphy.

K. What temporary benefits are in dispute?

As Ms. Murphy failed to prove she sustained accidental injuries which arose out of her employment on May 26, 2010, the Arbitrator finds she is not entitled to any temporary total disability benefits.

L. What is the nature and extent of the injury?

As Ms. Murphy failed to prove that she sustained accidental injuries which arose out of her employment on May 26, 2010, the Arbitrator finds that she is not entitled to any permanent partial disability benefits.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eric Flynn,

Petitioner,

19IWCC0590

vs.

NO: 17 WC 31150

John Boushards Home Remodeling,

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 and prospective medical care, 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 April 17, 2018 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 29 2019

o100819
MEP/ypv
049

Maria Portela

Thomas J. Tyrrell

Kathryn Doerries

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

FLYNN, ERIC Case# **17WC031150**
Employee/Petitioner

19IWCC0590

JOHN BOUSHARDS HOME REMODELING
Employer/Respondent

On 4/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4463 GALANTI LAW OFFICE
LESLIE N COLLINS
PO BOX 99
E ALTON, IL 62024

0522 THOMAS MAMER & HAUGHEY LLP
ERIC CHOVANEC
30 E MAIN ST SUITE 500
CHAMPAIGN, IL 61820

19IWCC0590

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)

Eric Flynn
Employee/Petitioner

Case # 17 WC 31150

v.

Consolidated cases: n/a

John Boushards Home Remodeling
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on March 9, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, October 7, 2017, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $26,910.00; the average weekly wage was $517.50.

On the date of accident, Petitioner was 29 years of age, single with 0 dependent child(ren).

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

April 14, 2018
Date

APR 17 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on October 7, 2017. According to the Application, Petitioner sustained an injury to his right shoulder when he was "lowering" the garage door (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. In regard to the temporary total disability benefits sought by Petitioner, he claimed he was entitled to payment of temporary total disability benefits of 21 5/7 weeks, commencing October 9, 2017, through March 9, 2018 (the date of trial). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent for approximately one year. Petitioner's job duties included carpentry work, installing siding, tearing down old structures, etc. Petitioner testified that on October 7, 2017, he was working in Granite City with two other employees named Gary and Paul (he did not recall their last names). The job involved tearing down a garage which initially required them to remove the garage door. Petitioner said that the garage door was an older style garage door which you would flip up and push in. When the garage door was in that overhead position, Petitioner said that the "arms" needed to be "grinded off."

The garage door was overhead and after the arms were cut, Petitioner and Paul lowered it to waist level and carried it out. Petitioner stated that after they set the garage door down, he was walking around to the front and began to feel a stabbing pain in his front and back of his chest, just below the collarbone.

Petitioner testified he continued to work that day and, sometime later that same day, Petitioner and Paul were in the process of carrying a four foot section of wall to a dumpster. Petitioner then advised Paul he was hurting and asked Gary for help in lifting the section of wall because his shoulder was painful.

Petitioner returned to work the following Monday and advised John Boushard that he had injured his right shoulder at work the preceding Saturday. On cross-examination, Petitioner denied making any statement to Boushard about using a wheelbarrow at the time of the accident. Petitioner also stated he had no prior shoulder or neck symptoms.

John Boushard was the owner of Respondent's business and recently passed away. However, he prepared and signed the First Report of Injury which was received into evidence at trial. The Report was prepared on October 10, 2017. The part of the body affected was indicated as the "Right Shoulder." In regard to how the accident occurred, the Report noted that "Not sure vague on where and what happened. Initially said a wheelbarrow but attorney letter says pulling garage door??" The activity was described as "...lifting garage door" (Respondent's Exhibit 2).

Paul Hatcher testified on behalf of Respondent at trial. Hatcher began working for Respondent in 2001 as a laborer/carpenter. Hatcher was still employed by Respondent when this case was tried. Hatcher worked with Petitioner on October 7, 2017, and confirmed that they did take down a garage door on that date. While Hatcher agreed the job was "labor intensive," he said Petitioner said nothing about having injured his right shoulder at that time. He testified that Petitioner said something about his right shoulder being "sore" after wheelbarrowing concrete and that he had injured it before while playing soccer.

On cross-examination, Hatcher stated he did not have a drivers' license because he had three DUIs. Hatcher was also asked if he had a heroin needle in his arm and he responded he did not, that he did have a "metal flake" in his arms for which it sought medical advice about having it removed.

Gary Thomason testified on behalf of Respondent at trial. Thomason stated he had worked as a carpenter for Respondent for approximately eight years. Thomason confirmed he was present at the job site on October 7, 2017. He said that he assisted Petitioner and Hatcher to move the garage door. Petitioner and Hatcher were at opposite ends of the garage door and Thomason was in the middle. Thomason testified that Petitioner said nothing about having sustained an injury to his right shoulder or that his right shoulder was hurting.

Jeff Boushard testified on behalf of the Respondent at trial. Boushard is John Boushard's son and is co-owner of the company. He was not present at the job site on October 7, 2017; however, he testified that Petitioner worked the following Monday and Tuesday and said nothing about having sustained an injury. He was present on Wednesday when Petitioner informed his father of his having sustained an accident on October 7, 2017.

Boushard also testified that in late October, Respondent made light duty work available for Petitioner, but Petitioner stopped when he advised he could no longer bend over. Boushard also said that prior to October 7, 2017, Petitioner complained of being "sore" after moving wheelbarrows full of concrete.

Petitioner testified in rebuttal and said that Hatcher had, in fact, informed him he had a heroin needle in his arm which had to be removed. He also said that Gary was not in the middle of the garage door when it was moved. In regard to his prior injury, Petitioner stated he had played high school soccer and sustained an injury to a wrist and knee as well as some type of injury to his small intestines, but never sustained any type of injury to either his right shoulder or neck.

Petitioner initially sought medical treatment on October 9, 2017, from Dr. Nicholas Rozell, a chiropractor. According to Dr. Rozell's record of that date, Petitioner was working for Respondent on October 7, 2017, and was taking apart a garage. While taking out the garage door, Petitioner "...suddenly had a sharp pain in his chest (right sided) with no strength in his right arm. He states that he could not move the arm because of the right shoulder and right sided chest pain that made it very difficult for him to breathe." Petitioner also advised that the pain had gotten worse since the injury. Dr. Rozell opined Petitioner had an unspecified rotator cuff tear or rupture of the right shoulder, bicipital tendinitis of the right shoulder and other specified dorsopathies of the cervical region (Petitioner's Exhibit 3).

At the direction of his attorney, Petitioner was subsequently evaluated at Multicare Specialists, by Dr. Mark Eavenson, a chiropractor, on October 16, 2017. According to Dr. Eavenson's record of that date, Petitioner sustained the injury on October 7, 2017, as he was in the process of lifting a garage door. "As he pulled the heavy garage door down and tried to lift up again he felt a burning sensation in his right anterior shoulder/pectoralis." Dr. Eavenson opined Petitioner had sustained a right rotator cuff tear and right cervical disc protrusion. He ordered an MRI scan of both the right shoulder and cervical spine (Petitioner's Exhibit 2).

MRIs of the right shoulder and cervical spine were performed on October 17, 2017. According to the radiologist, the MRI of the right shoulder revealed supraspinatus and infraspinatus tendinopathy without tendon tear and a small partial thickness tear and tendinopathy in the proximal long head biceps tendon. According the radiologist, the MRI of the cervical spine revealed a small central disc protrusion at C3-C4 and C4-C5 (Petitioner's Exhibit 4).

Dr. Eavenson saw Petitioner on October 18, 2017, and reviewed the MRI scans. Because of the findings noted in the scans, Dr. Eavenson referred Petitioner to Dr. George Paletta, an orthopedic surgeon (Petitioner's Exhibit 2).

Dr. Paletta saw Petitioner on October 20, 2017, and he reviewed the MRIs scans. In regard to the accident of October 7, 2017, Dr. Paletta's record of that date noted Petitioner and some coworkers were removing a garage door. Petitioner advised that he and a coworker were supporting the door while another coworker cut the hinges. At that time, "...the garage door came down on them. He had to support it and then walk away from the garage to put it down. He felt some discomfort in the shoulder and then when he had to go back and try to lift the door again he was unable to do so." Dr. Paletta opined Petitioner had a probable partial tear along the long head of the biceps tendon and cervical disc disease (Petitioner's Exhibit 3).

In regard to Petitioner's right shoulder condition, Dr. Paletta recommended continued conservative treatment, but noted that if Petitioner did not improve, surgery might be indicated. In regard to Petitioner's cervical spine condition, Dr. Paletta referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 3).

Petitioner was evaluated by Dr. Gornet on November 15, 2017. According to Dr. Gornet's record of that date, Petitioner and a coworker were holding a large garage door they were dismantling. Shortly afterwards, Petitioner "...lifted a four foot section of a wall and noticed pain." Petitioner stated he had no prior problems with either his neck or shoulder. Dr. Gornet examined Petitioner and reviewed the MRI of the cervical spine. He noted the MRI revealed annular tears at C3-C4 and C4-C5. Dr. Gornet recommended Petitioner continue conservative treatment with Dr. Eavenson and if this was not successful, Petitioner should undergo some steroid injections. He imposed a 10 pound lifting restriction with no overhead work (Petitioner's Exhibit 6).

Respondent tendered into evidence medical records from Dr. Rozell, some of which predated the date of accident. In June/July, 2017, Petitioner was treated for right knee and lumbar spine as well as bilateral cervical pain. The cervical pain was described as aching and stiffness aggravated by lifting and standing (Respondent's Exhibit 3).

Petitioner continued to receive conservative care at Multicare Specialists and was last seen there on March 5, 2018. At trial, Petitioner testified he has not been able to return to work and wants to proceed with the medical treatment recommended by Dr. Paletta and Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on October 7, 2017.

In support of this conclusion the Arbitrator notes the following:

At trial, Petitioner testified he did not have any right shoulder or neck symptoms prior to the accident of October 7, 2017.

There was no evidence that Petitioner had any right shoulder symptoms prior to October 7, 2017; however, Petitioner did have cervical/neck symptoms for which he sought treatment from Dr. Rozell in June/July, 2017, approximately three months prior to the accident of October 7, 2017.

At trial, Petitioner testified that he felt a stabbing pain in the front and back of his chest after he and Paul sat the garage door down.

In the history Petitioner gave to Dr. Rozell, Petitioner stated that he experienced a sudden sharp pain in the right side of his chest and had no strength in his right arm while he was in the process of taking the garage door down.

In the history Petitioner gave to Dr. Eavenson, Petitioner stated he experienced a burning sensation in the right shoulder area after he tried to lift the garage door up.

In the history Petitioner gave to Dr. Paletta, Petitioner stated the garage door came down on him and another employee and he subsequently felt discomfort in the shoulder.

In the history Petitioner gave to Dr. Gornet, Petitioner stated he noticed pain when he lifted a four foot section of a wall.

Accordingly, Petitioner testified as to one version of how the accident of October 7, 2017, occurred but gave different histories as to how the accident occurred to each of the four medical providers.

The two individuals Petitioner worked with at the time of the accident, Paul Hatcher and Gary Thomason, testified at trial and both stated that Petitioner did not sustain an injury to his right shoulder on October 7, 2017.

The Arbitrator acknowledges that the testimony of Paul Hatcher may lack credibility because of his numerous DUIs and the issue of whether he has a heroin needle or a metal flake in his arm. However, as noted herein, there are numerous other reasons that make Petitioner's testimony about the circumstances of the accident questionable.

The First Report of Injury was unclear as to exactly what happened, other than the fact that Petitioner was claiming an injury to the right shoulder. Purportedly, Petitioner injured himself while pushing a wheelbarrow, but then it was pulling a garage door.

Given the preceding, the Arbitrator finds Petitioner did not sustain a work-related accident on October 7, 2017.

In regard to disputed issues (F), (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 issue (C).

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Hewitt,

Petitioner,

19IWCC0591

vs.

NO: 13 WC 24041

Central Door Distributors,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 9, 2019 is hereby affirmed and adopted.

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

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

19IWCC0591

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 29 2019

O102219
MEP/ypv
049

Maria Portela

Thomas J. Tyrrell

Kathryn Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HEWITT, CHRISTOPHER Case# **13WC024041**
Employee/Petitioner

CENTRAL DOOR DISTRIBUTORS **19IWCC0591**
Employer/Respondent

On 4/9/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2152 FRANK A CELANI ESQ
19065 HICKORY CREEK DR
SUITE 150
MOKENA, IL 60448

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
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

CHRISTOPHER HEWITT
Employee/Petitioner

Case # **13** WC **24041**

v.

Consolidated cases: ______

CENTRAL DOOR DISTRIBUTORS
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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **September 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 22, 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 $**33,821.32**; the average weekly wage was $**650.41**.

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 $**82,759.24** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**82,759.24**.

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

ORDER

The Arbitrator finds that the Petitioner's right shoulder condition is causally related to the February 22, 2013 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$433.61 per week** for **191-1/7 weeks**, commencing **March 14, 2013 through October 13, 2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$82,759.24** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical expenses of **$1,073.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of for awarded medical expenses 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 **$390.25 per week** for **325 weeks**, because the injuries sustained caused the **65% 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 **February 22, 2013** through **September 21, 2018**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

[signature]

Signature of Arbitrator

April 5, 2019
Date

APR 9 - 2019

STATEMENT OF FACTS

The Petitioner testified that he is 59 years old and not currently employed. He was hired by Respondent in 2007 and last worked for them in February 2013 as a carpenter/millwright, testifying that the Respondent has since shut down the business. His duties involved taking stock doors and customizing them, as well as making door frames and sometimes delivering the doors and frames. He would receive an order for a custom door, pick up a door in the warehouse from a shelf or a stack and carry it to his workbench in the shop. He would use a plywood template for window cut outs, which he would perform with a router. He testified that this required the use of force and multiple passes with the router to complete a cut. He would then clean the door and floor, install the custom glass window ("door light"), screw in the glass framing, and sometimes would glue and nail moldings to a door or hammer in metal feet. Once completed, he would carry the door out to the dock area for delivery. He testified he is right-handed and would perform these activities mainly with his right upper extremity.

Petitioner testified the routers weigh 30 to 40 pounds and the doors typically weigh between 60 and 100 pounds. Some doors were pre-hung in frames but for others he had to build the frames himself, which would involve some router use. With the frames, Petitioner testified the doors would weigh 140 to 160 pounds. He testified he would move and carry the doors by himself. For deliveries, he would load the doors into a truck, strap them down and deliver them to the customer, noting there could be 10 to 20 doors per delivery and that it could take 3 to 4 hours to load the truck.

Petitioner could not recall ever having any prior right shoulder pain/weakness/numbness or any significant prior problems lifting or maneuvering doors at work due to the right shoulder. Other than his ownership of a women's fitness center, Curves, where he worked for two years, Petitioner testified that he has always worked carpentry/millwright type jobs.

On 2/22/13, Petitioner testified he had completed a door and made it into a pre-hung door. He was putting this door into a crate with a co-worker and when they lifted it up, he testified his right arm popped and he dropped the door. He testified he told the co-worker what happened. He used his other arm to help the co-worker to finish loading it into the crate and testified he then tried to keep working but was not able to do so.

Petitioner testified he initially sought treatment within a week or so with his family physician, Dr. Lubbe, but instead saw his associate, Dr. Danaher, who he testified prescribed pain meds, a sling and x-rays. When Dr. Lubbe returned, they reviewed the x-rays, and he prescribed a right shoulder MRI. The records of Dr. Lubbe (Px1) do not contain the initial report of Dr. Danaher.

A right shoulder MRI was performed on 3/18/13, which reflected: 1) full-thickness supraspinatus and infraspinatus tendon tears with medial tendon macro retraction to the acromion, as well as subscapularis tendinosis; 2) marked teres minor atrophy that may reflect quadrilateral space syndrome; 3) extra-articular tenosynovitis and intra-articular biceps tendinosis/tendinitis; 4) degenerative irregularity of the inferior anterior labrum; and, 5) hypertrophic changes at the AC joint. (Px4).

Petitioner testified he reviewed the MRI with Dr. Lubbe and was advised he had a significant tear and would need surgery. Dr. Lubbe recommended orthopedic surgeon Dr. Coates.

The initial 3/22/13 report of Dr. Coats is written to Dr. Danaher, thanking him for the consultation referral. The history notes Petitioner injured his right shoulder on 2/28/13, feeling a pop while loading a door into a crate, with minimal range of motion since that time. Noting he was able to review the report but not the MRI films at that time, Dr. Coats diagnosed a large to massive right rotator cuff tear, recommended surgery and held Petitioner off work. (Px1; Px3).

The Arbitrator notes that an intake form of Dr. Coats states: "While loading a door into a crate felt a pop continued to work about 1 week later lifting a door & reaching to catch a door from hitting a hammer hurt shoulder arm again." (Px3). However, the parties stipulated to a 2/22/13 accident. (Arbx1).

Petitioner underwent arthroscopic surgery with Dr. Coats on 4/11/13 at Advocate South Suburban Hospital. Surgery involved massive rotator cuff repair, subacromial decompression with acromioplasty, synovial and labral debridement and biceps tenotomy. Post-operative diagnoses included a rotator cuff tear, subacromial impingement, proliferative synovitis, labral degeneration and biceps tendonitis. The report noted severe degenerative wear, proliferative synovitis, labral degeneration, biceps degeneration approximately 80%, and a massive cuff tear from the supraspinatus through the infraspinatus and teres minor. A large footprint was visualized with some granulation tissue, and the subscapularis appeared to be intact with some superior fraying. Following labral debridement, the biceps was found to be deficient so tenotomy was performed versus repair. The report indicates that the rotator cuff was repaired via attachment to the footprint with anchors and sutures. (Px7). On 4/23/13, Dr. Coats held Petitioner off work an additional 6 weeks. On 5/7/13 Petitioner was advised to start passive motion but to keep using a sling. On 5/21/13, Petitioner reported 4/10 pain and stiffness, and he was advised to start weaning from his sling and to start therapy the following week. (Px1; Px3).

Petitioner testified that he performed both home and formal physical therapy starting in June 2013, but indicated his progress was "slow to nothing" and he couldn't really move the right arm.
On 6/25/13, Petitioner reported ongoing difficulty with right arm motion. Dr. Coats noted increased pain with range of motion, that it would take at least 6 to 9 months to get significant functional improvement, and that it would not surprise him if Petitioner needed a muscle transfer to increase strength and motion. Petitioner was continued off work. On 7/30/13, Dr. Coates recommended an updated MRI arthrogram and continued Petitioner off work. (Px1; Px3).

On 8/9/13, Dr. Coates reviewed the MRI, indicating it showed complete rupture of the supraspinatus tendon with mild fatty atrophy. He stated that he believed the rotator cuff tear never appropriately healed and needed revision surgery, so he referred Petitioner to Dr. Mass for evaluation of a latissimus dorsi muscle transfer. (Px1).

On 9/12/13, Dr. Mass noted the MR arthrogram showed a recurrent massive rotator cuff tear with retraction of both the supraspinatus and infraspinatus, along with proximal migration of the humeral head. Petitioner reported having no prior right shoulder problems before his injury. Dr. Mass provided Petitioner with four options: 1) no intervention, 2) shoulder fusion, 3) reverse total shoulder arthroplasty or 4) latissimus dorsi transfer. Dr. Mass recommended the tendon transfer as the best option. The purpose was for both some increase in range of motion as well as preventing arthritis in the shoulder joint due to migration of the humeral head. Dr. Mass noted that the reverse arthroplasty wouldn't be the first choice given Petitioner's young age and work requirements, particularly since the long-term survival of reverse replacements remains unknown. Dr. Mass also noted returning to work as a carpenter would be difficult as anything involving strength or overhead activity would be hard for Petitioner, but that he hoped surgery would allow working in front of him or on the ground to be easier and that he would hopefully be able to do some of the capacities of his job as a carpenter. (Px12).

Respondent had the Petitioner examined by Dr. Marra on 12/10/13 pursuant to Section 12 of the Act. At that time the Petitioner reported pain and dysfunction, but that his primary problem was weakness. After examining Petitioner and reviewing the records of Dr. Mass and the MRI, Dr. Marra opined that Petitioner had a recurrent rotator cuff tear that was causally related to the accident. He recommended a latissimus dorsi transfer for pain, noting it would not significantly improve his right shoulder function. He recommended against a reverse shoulder replacement until the Petitioner was over the age of 60 but indicated if he opted to have such surgery, he should have an FCE to determine any work restrictions. Estimated recovery time with the transfer surgery was a year, and that the Petitioner could likely return to light duty within 3 or 4 months, though he didn't believe it was reasonable to think he would ever return to his regular job as a carpenter regardless of treatment. Dr. Marra opined the Petitioner would still have significant limitations with overhead lifting. (Px10).

Petitioner returned to Dr. Mass on 3/18/14, and he recommended either doing nothing or performing the reverse shoulder arthroplasty along with a partial latissimus tendon transfer. He noted a pure latissimus transfer would have required the 300-pound Petitioner to have his arm casted overhead for 8 weeks. Petitioner testified that they discussed the options and he opted for the shoulder replacement surgery with tendon transfer, which Dr. Mass noted on 4/10/14. The surgery took place with Dr. Mass on 4/25/14, and Petitioner was admitted through 4/28/14. (Px12). Post-operative x-rays reflected near-anatomical alignment without evidence of hardware complications. (Px11). Petitioner testified that Dr. Mass prescribed home therapy and physical therapy. His 5/6/14 note indicates the Petitioner was doing well other than some issues with hearing loss and swelling of his feet, and he recommended some home therapy but continued non-weightbearing exercises, and Norco was prescribed. (Px12).

Post-surgically, Petitioner testified that while his pain did improve, he still couldn't move his arm. He testified his shoulder dislocated while doing a pendulum exercise over his dog's bowl of food, and when he went down to pick up a piece of food to put back into the bowl, his arm was stuck at a 90-degree angle. He tried to wiggle the arm back into place to some degree, but when he stood, he couldn't move his arm.
He returned to Dr. Mass on 5/29/14, and the doctor indicated that, about 4 weeks post-surgery, Petitioner bent down to pick up some dog food with his left hand and when he stood up felt his right shoulder pop out of place. X-rays showed the dislocation as well as a possible fracture around the proximal humerus (the report notes a "new bony fragment"), and Dr. Mass noted he would need to undergo a revision surgery. (Px12). On this same date, Petitioner saw Dr. Luebbe with complaints of bilateral leg edema. A "Note" indicates since his surgery Petitioner reported 4 or 5 episodes of neuralgia in the right lateral hip that lasts for 3 to 4 minutes. (Px1).

Dr. Marra again examined the Petitioner on 7/8/14. He noted a history of Petitioner bending forward to lift up dog food three weeks post-surgery and feeling his right shoulder dislocate. Dr. Marra believed this was a

competent cause of the shoulder dislocating. Asked whether the shoulder dislocation was causally related to the accident and subsequent surgery, Dr. Marra stated: "Yes. While this appears to be a secondary injury, this appears to be a perioperative dislocation of reverse shoulder arthroplasty." He recommended revision surgery with more constrained components or with greater offset and perhaps with a larger diameter glenosphere. He opined that Petitioner had a fair prognosis and would likely be limited to 25 pounds overhead when he fully recovered. (Px10).

Petitioner underwent revision surgery with Dr. Mass on 7/28/14. The report noted that they tried to change the prosthetic from a 6 high mobility to a 9 standard but could not reduce the joint, so a 6 was used and allowed for reduction and good position. Dr. Mass noted he saw that certain positions the elbow drooped where he would externally rotate and the upper arm would become slightly unstable. (Px12).

On 8/13/14, Dr. Mass removed the sutures and Petitioner noted improvement with pain and that the shoulder felt much better than when it was dislocated. He was continued off work and advised to keep using a sling. On 9/16/14, Petitioner reported significant shoulder weakness, problems with range of motion and considerable pain when he tried to reposition his shoulder. Dr. Mass obtained x-rays, which indicated near-anatomic alignment of the arthroplasty and mild arthritis in the AC joint, and prescribed 6 months of aggressive physical therapy, which Petitioner underwent at Athletico for retraining the latissimus muscle for use with pulling motions instead of pulling. Norco was prescribed and he was continued off work. On 10/29/14, Petitioner reported some gains in therapy but that he had discomfort while weaning from narcotic medication while participating in therapy. Motrin was prescribed and Petitioner was advised of the importance of home therapy along with formal therapy. (Px12)

Petitioner testified he has not felt stability in the right shoulder since after the initial surgery. He testified that he felt like he was making some progress in therapy - while he didn't feel his range of motion improved, he felt the movement he had was easier and less painful. At one point, Petitioner testified he was having some problems sleeping while he was in therapy and that this new condition took "a lot of getting used to."

On 1/9/15, Petitioner saw Dr. Mass, testifying he still had a lot of stiffness and lack of motion. The report notes the Petitioner had suffered a heart attack and had stents put in, so his therapy had been discontinued. Mass returned him to therapy but notes he would likely have to discontinue again for a period of time because Petitioner another heart surgery was planned. He was continued off work and advised to follow up in 6 months. Petitioner then returned on 3/19/15, with Dr. Mass noting he underwent bypass surgery three weeks prior and that Petitioner's arm function was not improved since January. Petitioner was unable to actively lift his shoulder, bend his elbow or actively straighten it, though there was "a little bit" of firing of the muscles. He ordered EMG/NCV testing prior to returning Petitioner to therapy, continuing him off work in the meantime. (Px12).

Petitioner testified that at some point he had begun to develop right elbow symptoms, which he reported to Dr. Mass, and then underwent the EMG/NCV in April 2015. Dr. Mass advised him that the testing was negative but told Petitioner to report it to the therapist. The 4/29/15 report of Dr. Mass indicated the testing showed some long-standing carpal tunnel, for which Petitioner had previously undergone surgery. He noted some improvement in the muscles firing so he wanted Petitioner back in therapy for strengthening so long as his heart doctor would allow it. (Px12).

On 6/24/15, Dr. Mass noted Petitioner's shoulder was not subluxing and he was not having any real pain, and while his deltoid was firing, he was not lifting his arm. He stated: "So, we may just need to continue him in therapy. I do not know what it is going to take to strengthen his shoulder because his arm is so weak." On

8/5/15, Petitioner reported some improvement in strength but not in range of motion. Dr. Mass noted the therapist indicated he had full passive motion without any notation of pain but was still having issues with active motion. Exam indicated his ability to fire the deltoid, anteriorly extend the shoulders up to 30 degrees and adduct them to 90 degrees. He had full external and internal rotation. Petitioner was continued with therapy and off work until follow up in 6 to 8 weeks. (Px12).

On 9/29/15, Petitioner reported he felt improved with strength, but was struggling with motion despite some improvement. Dr. Mass' exam indicated "he seems to finally be retraining his deltoid and achieving more forward flexion." Therapy was continued and he released Petitioner to work, indicating "he is only fit for desk duty." (Px12).

Petitioner testified that when Dr. Mass released him to desk duty in September 2015, he had never performed such duty before.

The 2015 records from Athletico Physical Therapy have entries which reference some of the Petitioner's activities. The "History of Injury/Condition" repeated in these records note Petitioner performed most activities of daily living, driving and "yard chores" with his left hand and arm. On 9/11/15, Petitioner indicated he was sore and virtually unable to use his right arm. On 9/21/15, Petitioner reported he was able to use a screw gun at waist level due to feeling better strength in the right shoulder. On 10/7/15, Petitioner reported trying to use his right arm for light sanding. On 10/12/15, Petitioner reported he tried to saw a tree apart but used a chain saw that he was only able to tolerate for 20 minutes. On 10/14/15, Petitioner reported he tried to use the chain saw at waist level and had fatigue after about 20 minutes. On 11/8/15 he reported trying to swing a hammer with his right arm and having to hold his right wrist with his left hand. On 11/11/15, he reported back pain from fixing his lawn mower. (Px9).

Petitioner testified that he still was unable to lift the right shoulder in 2016, testifying: "it was not right, didn't feel right." On 1/12/16, Dr. Mass noted some further improvement in pain and strength with formal and home therapy. Petitioner was able to passively forward flex to 120 degrees and actively just short of 90. He had abduction to about 60 degree and internal rotation to the buttock area. Dr. Mass noted significantly improved pain versus pre-surgery, but that recovery was slower for Petitioner because of the massive tear. He advised continued formal and home therapy for strength and range of motion, and that Petitioner was to remain at nothing more than desk duty and was to follow up in 6 months with x-rays.

Petitioner testified that his pain was improved but he still had motion issues and the latissimus dorsi muscle was sore.

Petitioner was examined by Dr. Marra one additional time on 1/19/16. Petitioner reported no substantial pain but also no substantial improvement in motion, but he felt his strength improved with therapy. Dr. Marra reiterated that the revision surgery remained related to the work accident. While it was noted that Dr. Mass recommended an additional six months or therapy, Dr. Marra didn't think further therapy would help. He opined that Petitioner had reached maximum medical improvement (MMI), still had significant limitation on his ability to use his right arm and should be restricted to 5 pounds of lifting with the right arm and no overhead motion. (Px10). Petitioner testified that Dr. Marra indicated he could require further surgery in the future.

Petitioner testified that Dr. Mass "pretty much agreed" with Marra, but still wanted more therapy, and short of that, he advised restriction to desk duty pending an FCE. He testified that the workers' compensation carrier wouldn't approve further therapy.

Petitioner testified he last saw Dr. Mass on 7/12/16, which was the last time he had any formal treatment. At that time, Dr. Mass noted the therapy had not been approved, and x-rays showed good hardware alignment. He noted Petitioner continued to demonstrate shoulder weakness and an inability to externally rotate the right arm. He provided two options: continued therapy for rotator cuff strengthening and deltoid retraining, or a functional capacity evaluation (FCE) "with a goal of generating an MMI." He noted Petitioner would need long-term follow up and periodic x-rays, recommending that he return in two years, and "in the meantime, he should be limited to desk duty." (Px12).

Orthopedic surgeon Dr. Marra's deposition was obtained on 4/6/18. He testified that he specializes in shoulder and elbow surgery. He initially examined the Petitioner on 12/10/13, following the MRI showing the recurrent cuff tear, and Petitioner complained of pain and weakness but mainly poor shoulder function. Dr. Mass had recommended either reverse shoulder replacement or latissimus dorsi tendon transfer. Following examination which reflected weakness and loss of motion, and review of the MRI scan and Dr. Mass' records, Dr. Marra testified that Petitioner had a recurrent cuff tear that was related to the mechanism of the work accident. He recommended the latissimus dorsi transfer, which he did not feel would have a significant impact on his shoulder function but would reduce pain, and that he should wait until an older age to undergo reverse shoulder replacement. He testified that there is a greater likelihood of failure in younger patients and such failure leaves you with limited subsequent reconstructive options due to the loss of bone. Asked if he felt the Petitioner had any permanent work restrictions, Dr. Marra testified: "I did not feel that he could return to work based on the function of his shoulder." Dr. Marra re-examined Petitioner on 7/8/14. He reported that he had undergone the reverse shoulder replacement in April 2014 and three weeks after the surgery was bending forward to lift up some dog food and felt the shoulder had dislocated. Dr. Mass verified this and recommended revision surgery. Examination reflected an obvious dislocation and atrophy of the deltoid, which Dr. Marra testified remained related to the work accident. He concurred with the recommended revision surgery. Following that surgery, Dr. Marra again examined Petitioner and issued a third report on 1/19/16. He agreed the dislocation occurred with the incident with the dog food. Examination noted anterior deltoid atrophy, significant limitation of shoulder elevation, abduction and external/internal rotation, and it appeared that some of the latissimus transfer had "come undone." Petitioner also had elevation weakness at 4/5. He opined that Petitioner had reached MMI and was capable of performing sedentary work, limiting him to no lifting over 5 pounds with the right arm no overhead use of the arm. (Px18; Rx1).

On cross-examination, Dr. Marra testified that Petitioner's shoulder replacement would likely fail down the road just based on his age: "So, it is conceivable down the road that his function will deteriorate from this point, but not based on what was at the moment of that exam and not for the foreseeable future." He did not dispute that Petitioner would have difficulty shaking hands with the right hand because while he can raise the arm upwards, he cannot move it away from his body and would have to change the position of his body to do it. (Px18; Rx1).

The testimony of orthopedic surgeon Dr. Lieber was obtained on 5/23/18. He examined the Petitioner at the Respondent's request pursuant to Section 12 of the Act on 3/7/18. His subjective complaints included right shoulder weakness, difficulty with overhead activity, stiffness and pain. He had undergone reverse right shoulder replacement. Examination indicated atrophy of the muscles about the right shoulder, decreased range of motion to all extremes, weakness (3+/5) affected by pain, and positive impingement, apprehension, Speeds, O'Brien's, reverse O'Brien's and liftoff testing. Dr. Lieber opined that Petitioner had reached MMI as of 5 months post-surgery (January 2015) and that no further treatment was necessary: "I felt he had a successful reverse shoulder replacement in that positioning; and the overall function, though it wasn't great, I didn't feel that any surgical interventions would be of any benefit." He provided a permanent partial impairment rating of 46% of the right upper extremity or 28% of the body as a whole based on the 6th Edition of the AMA Guide for Evaluation of Permanent Impairment. (Rx2).

On cross-examination, Dr. Lieber testified that he believed another doctor reviewing his report would be able to come up with an AMA rating based on what's in it. He was not aware of any studies involving whether different doctors reviewing the same information give the same impairment ratings. The rating was based mainly on Petitioner having undergone a reverse shoulder arthroplasty, but a QuickDash score is also needed to confirm functional complaints. Basically, he testified that variations that could occur would be within the in-class modifiers, which would involve only a change of a percentage or two. Dr. Lieber testified that he would think the Petitioner could lift more than 5 pounds with his right arm and would encourage him to do so in order to keep his shoulder muscles functional and strong. He agreed that impairment is different than disability and that the rating does not take into account a patient's ability to work. (Rx2).

Occupational medicine physician Dr. Coe testified via evidence deposition on 12/8/17. He examined the Petitioner on 10/3/17 and found he tried to limit his right shoulder use during his visit, he had tenderness to palpation of the areas where his AC and glenohumeral joints normally would be, a lot of atrophy around the right shoulder/pectoral/upper arm musculature, and limited active range of motion with some mild increase in motion passively. Strength was difficult to assess due to complaints of pain, but he had weakness. No neurologic abnormalities were indicated. Dr. Coe's review of the Petitioner's medical records to date, including the surgeries and the final reports of Dr. Mass and Dr. Marra, indicated the Petitioner was no longer treating, that he generally tried to restrict his right arm use to control his symptoms, and that he took daily anti-inflammatory medication. He noted Petitioner is right handed. He testified that both Dr. Mass and Dr. Marra are well known shoulder surgeons in the geographic area. (Px16).

Dr. Coe testified that the only thing stabilizing the Petitioner's right shoulder was the prosthetic ball and socket and some surrounding connective tissue, which had atrophied. He opined that Petitioner's right shoulder condition is causally related to the 2/22/13 accident based on Petitioner's history and a review of the medical records. His conditions of stiffness, weakness and pain are permanent. He acknowledged that Petitioner had mild to moderate arthritis in the shoulder which preexisted the accident, including the AC joint, but that the accident caused the massive rotator cuff tear which necessitated the surgeries. Petitioner's treatment to date has been reasonable, although he still has been left with significant shoulder limitations. Dr. Coe opined that Petitioner is not capable of returning to work in his regular trade as a carpenter. He opined that there are many possible reasons that the initial rotator cuff repair failed. The reverse shoulder replacement involved the deltoid taking over as the musculature that moved the shoulder joint, with the latissimus tendon transfer done to assist with stability and to augment the deltoid. Dislocation is a recognized potential complication of the surgery. Dr. Coe testified that while the Petitioner has good motion and strength of the right hand and a right elbow that "works", there is very limited shoulder motion, and he has weakness and pain with motion on top of that. He opined that the Petitioner cannot do work with tools involving extension of the right arm or which involve vibration, strength or sensitive control. He can't do anything above mid-chest height. He can do some lifting below waist level, but the possibility of dislocation remains a concern and thus this would not be advisable, which is why Dr. Marra recommended permanent restriction of no more than 5 pounds. (Px16).

Dr. Coe acknowledged on cross-exam that he is not a surgeon or shoulder specialist. Petitioner told him he had undergone a cardiovascular surgery and remained under cardiovascular care with medications, but Dr. Coe had not reviewed any medical records regarding this condition. Dr. Coe asked the Petitioner about an incident of lifting a bag of dog food following his second shoulder surgery and feeling a pop in the right shoulder and suffering a dislocation – he told Dr. Coe he had bent forward and reached down to lift a piece of dog food with his left arm when he felt this pop. Asked exactly what his opinion was on Petitioner's ability to work, Dr. Coe testified that Petitioner could not return to his regular job and required significant permanent restrictions, which have nothing to do with any heart condition he may have. (Px16).

On 7/21/17, Petitioner was evaluated by vocational counseling provider Vocamotive, and a report was prepared by counselor Joe Belmonte on 8/18/17. (Px20).

Counselor Belmonte was deposed on 12/11/17. He testified that the Petitioner presented in a very matter-of-fact manner, without anger or negativity about his injury, and was personable and outgoing. His report of function was relatively consistent with the medical record, noting the only medical record Belmonte considered was the 1/19/16 report of Dr. Marra. He noted the Petitioner used his left hand to lift his right forearm to shake hands. Petitioner reported some "negative social things" at his first two high schools before moving to Oak Lawn Public High School, where he graduated after having some remedial classes. He reported no problems with reading but difficulty with comprehension. He had no military experience, college or other formal training. His experience was in trim/finish type carpentry, not construction carpentry, and he had been taught how to work on auto engines by his father. He was a "hunt and peck" keyboarder and indicated he had some difficulty with typing because he had very large hands. Petitioner reported no familiarity with computer software in the workplace. He had some supervisory experience with minor administrative functions but had never worked in a clerical or administrative position. He had some forklift and deliver driver experience. (Px19).

Counselor Belmonte's review of the Dictionary of Occupational Titles (DOT) identified descriptive possible job titles such as truck driver, warehouse worker and sawing/assembly supervisor. Essentially, all of these were in the medium duty category, and per Dr. Marra's report, Petitioner was limited to sedentary work, 5 pounds of lifting with the right arm and no overhead motion. However, given there was no specific restriction on Petitioner being on his feet, Belmonte believed that work at the light work duty level was, in theory, not out of the question for Petitioner so long as his lifting restrictions did not restrict him from such jobs. Despite this, counselor Belmonte opined that Petitioner did not have access to any viable stable labor market offering gainful employment. This is based on his age (58), education (high school graduate, which is considered "limited education"), no real computer literacy or keyboard proficiency, and no licenses or certifications of any kind. His job experience was mainly working with wood without any true supervisory or sales experience and fairly low-level estimation activities, so his work experience is very narrow, and the work restrictions issued by Dr. Marra also must be considered. If you assume Petitioner is limited to desk duty only (i.e. per Dr. Mass), counselor Belmonte testified that only 10-11% of jobs in the U.S. and 20-25% of jobs in the Chicago metro area are sedentary and, based on his experience, only 1% of the jobs in the U.S. involve unskilled sedentary work. Most of such jobs don't exist anymore or have been moved elsewhere out of the country. Many sedentary tasks involve writing, telephone, computer work, etc., and these generally involve some level of reaching with the arms, as would even a machine operator. Taking that into account and avoiding jobs with constant or frequent activities like these, virtually all job possibilities disappear. He testified: ". . . with restrictions along those lines bearing in mind that virtually all other forms of employment are going to require reaching and handling at levels that exceed what it appears this particular Petitioner can do." (Px19).

Counselor Belmonte testified that he cannot account for essentially one-handed duty in a transferrable skills analysis – such analysis is based on how much you can lift, period, and Petitioner is not able to lift over 5 pounds which is even below sedentary level. "Acquired disability" also has to be considered, meaning Petitioner is going to be asked by potential employers why he hasn't worked for 4 years, and he is likely to face a requirement for requesting an accommodation in virtually any line of work Belmonte could think of: "and that means that he is going to have to address that issue, and how he does that and the timing when he does that is going to have to be carefully managed." (Px19).

Counselor Belmonte prepared a vocational plan for Petitioner, but to his knowledge no one has approved the plan. He believed Petitioner would need to be educated on how to talk to prospective employers about his

disability so that he doesn't just go in and say he can't use his right arm due to an injury at work without other things being brought to bear. Secondly, because nowadays many jobs, even at $10 per hour, require online applications, he testified Petitioner would need training in how to do so, how to prepare and provide a resume and cover letter. Otherwise, these tasks would have to be done for him. He testified that Vocamotive has in-house vocational training under the supervision of the State, including keyboarding, computers, software, email, research and data entry. The goal would be increasing Petitioner's marketability and job possibilities. In Belmonte's opinion, any type of professional level estimating job would require the use of a computer and spreadsheet literacy. Estimating jobs with smaller companies often involve the owner or other key person who performs this task and they are not necessarily hiring. Some involve having to climb on roofs or measure windows or carry samples. Given all of the situational factors, the other noted factors and the nature of Petitioner's injury, he testified its reasonable to conclude that Petitioner is at risk for not being able to find a job or being only marginally attachable to the labor force because he can't find steady full-time employment. (Px19).

Counselor Belmonte reviewed the labor market survey prepared by vocational counselor Julie Bose, requested by Respondent, and testified that he did not believe there was a meaningful probability that Petitioner would be able to obtain the jobs listed therein. For example, a security guard overwhelmingly is in the light physical demand level, with sedentary jobs in that category being less than 10% of what's out there. He would also have to go through a credentialing process. He would not be able to have any such job if he had to deal with responding to emergencies. However, he agreed that there are sedentary security jobs out there. (Px19).

On cross-exam, counselor Belmonte testified that he did not focus on any particular geographic area because he had not been retained to do a job search. He testified that the Petitioner would be able to do computer training in Hinsdale or at home via a loaned computer that connects to the internet and has a training program, and the counselor can see what's he's doing, when and how. Again, his opinion is there currently is no stable labor market for Petitioner. If he went through vocational rehabilitation, it would improve his chances but the likelihood of finding employment in a stable labor market would still remain guarded. He acknowledged that keyboards may be available for larger hands. He testified that Petitioner has not been though any vocational testing regarding his reading, writing, spelling, clerical or math skills, nor had he undergone any testing on his fine motor control abilities. Such further assessment would initially be needed if vocational services were authorized by Respondent. Counselor Belmonte acknowledged that his opinions could change after such vocational assessment depending on what the data showed. (Px19).

Vocational rehabilitation counselor Julie Bose also testified via evidence deposition on 1/31/17. She met with Petitioner on 8/2/16 and prepared her report two days later. She noted Petitioner's educational and work histories, similar to that indicated by Belmonte, and that Petitioner indicated he had to have special classes in high school to catch up as opposed to being because he had any learning disabilities, and that his main current "computer" experience is with his smart phone. She noted Petitioner's job duties with O'Gorman Cabinets, Kel Mel and Respondent. Counselor Bose opined that while Petitioner was not able to return to his regular job with Respondent, both physically and because they had shut down, he had acquired skills that could be used in lighter positions. She felt he could sell doors/cabinets for a door/cabinet company or work as a desk clerk at a home improvement center. If he were unable to find work in these fields, given his lack of computer skills and limited right arm use, he could look at "retirement types of jobs" such as unarmed security guard. Because she didn't know if the Respondent was going to retain her for job placement services, she also prepared a vocational rehabilitation plan. (Rx3).

The vocational plan indicated counselor Bose felt Petitioner could earn an entry level wage of $12.98 per hour, per the labor market survey. Bose reviewed the report of counselor Belmonte and noted that while he criticized

her labor market survey for failing to advise prospective employers of his educational background or if computer skills were needed, she indicated that prior to any contact with a prospective employer a job description would have been reviewed to determine this and they wouldn't have been contacted if Petitioner didn't have the necessary educational requirements. She indicated that if Petitioner needed security guard training because it wasn't provided by the employer, it would entail 40 hours and a nominal fee. Counselor Bose indicated that while Vocamotive recommended vocational testing and different training programs, her company did not typically make such recommendations for individuals at the Petitioner's age. She doubted that any computer training would be needed since many companies train their employees on their software, but if it was going to be done it could be done simultaneous to a job search. She stated that when she met with Petitioner in August 2016, he had not formally begun to look for alternative work. She wanted to review any job logs in a self-directed search before opining further on the need for job seeking or placement training. (Rx4).

Counselor Bose testified that her opinions were reliant upon the restrictions instituted by Dr. Marra, no overhead work or lifting over 5 pounds with the right arm. Her labor market survey (LMS) listed 17 prospective employers that had been contacted. Thirty other potential contacts had been non-responsive. 9 of the 17 indicated they were not hiring, and 2 others indicated they could not accommodate Petitioner's restrictions. Several of the employers who were not hiring indicated Petitioner's restrictions could be accommodated given his experience with windows and doors. Counselor Bose's report indicates that every company that was hiring had wage ranges from $12.25 to $14.25 per hour. None of them state the actual work duties that would be involved with the prospective jobs. She testified that the LMS looked for jobs within 30 miles of the Petitioner's residence. However, Bose testified that the wage range was $8.25 to $16.25 per hour, with a median wage of $12.98 per hour. (Rx3; Rx4).

On cross examination, counselor Bose agreed Petitioner was physically unable to return to his regular job with Respondent. While she relied on the restrictions of Dr. Marra, she also did receive a work status report from Dr. Mass' office restricting Petitioner to desk duty and recommending an FCE, which she agreed can be a better measuring tool for physical restrictions than those provided by a doctor without one. She testified that this work note however did not appear to be a final opinion. It was her understanding that Petitioner doesn't have any real keyboarding skills, but that he has not been restricted from typing by Dr. Marra or Dr. Mass. She was aware Petitioner had a heart condition but her understanding is there were no work restrictions issued to him relative to this, so in her opinion it isn't relevant to what jobs he can do over and above his right shoulder restrictions. Her understanding is Petitioner did not do any office work for his employers but did some general cabinet measurements and cost estimates. Counselor Bose agreed that some jobs, such as security guard, could involve contacting a parent company out of state and could not say if two of the security jobs in the LMS would involve work within 30 miles of his home. She agreed that the DOT is "quite dated", but that her experience over 34 years in her field allows her to have a good understanding of what a pro desk clerk or tool clerk does, for example, which are more modern positions. She testified that an unarmed security guard would not be expected to have to confront anyone or remove anyone from their employment premises – they would call for assistance. With regard to interviewing techniques or other aspects of job search training, it was counselor Bose's opinion that the Petitioner would benefit from it, but that he didn't absolutely need it given he had found jobs in the past. Such training would assist him in finding a job "if he takes heed to what we teach him", particularly in terms of how to deal with his disability with prospective employers. Asked if Petitioner was at a disadvantage to start with in a competitive labor market due to his restrictions, counselor Bose testified that what was most important was how he presented himself to prospective employers. (Rx3).

The Petitioner submitted job search logs as Px21, which includes his resume. The job logs cover the period from 7/7/17 to 8/4/17 and 7/2/18 to 7/26/18. He testified he started keeping track of his job applications after his attorney advised him around July 2017. He testified he contacted 27 employers in 2017 and was able to make

more contacts in 2018 once he started using the internet. The Arbitrator notes that many of the jobs he listed in 2017 also indicate they involved internet applications, and many of them on their face would appear to be jobs that would not be within his restrictions, such as lawn care and janitorial services, given he has a 5-pound restriction with his dominant arm. (Px21).

Petitioner testified he graduated high school and generally received C's and D's. After high school he worked at a Millwork Unlimited where he learned how to make custom doors and windows. He next worked at Erickson Builders Supply for approximately 6 years before it was bought out by Kel Mel Supply. He worked there for about 20 years performing the same door/window millwork. He testified there is no way he could perform these jobs now since he cannot lift a door. While he testified that he provided his entire employment history to both Joe Belmonte and Julie Bose, the Arbitrator notes that neither counselor made any mention whatsoever of the Petitioner's time owing and working at Curves.

Petitioner testified that following his meeting with vocational counselor Julie Bose she "eventually" provided a list of prospective employers. He testified that half of them were not hiring, and when he contacted the other half, they were not hiring either. The employers listed for security guard type positions indicated that he had to be licensed. He testified that some of the security guard contacts had multiple locations with openings were far from where he lived. To his knowledge, counselor Bose did not provide him with any interviews or any other types of services. Petitioner testified that at the time he met with counselor Bose he was looking for work but did not keep any record of where or when because he didn't realize he was supposed to. At some point he indicated his attorney advised him to document this, but he couldn't say exactly when this occurred. Petitioner did not believe he had the computer skills or ability to read blueprints that would be needed to be a door/cabinet salesman. He indicated he would also have to carry samples, most of which would weigh over 5 pounds. He testified that he cannot type well with two hands, much less one hand.

Petitioner testified his attorney advised him to meet with counselor Belmonte in July 2017 in Hinsdale. He indicated he is able to drive with his left hand, noting he used to do so when he drove a manual transmission. He discussed his abilities more with Belmonte than Bose. He indicated that counselor Belmonte told him he would need computer skills in order to find work and to be able to communicate better with people. Petitioner never obtained the training, noting it was never offered. Petitioner testified he would be willing to do anything to get work and felt he had done everything that has been asked of him vocationally.

Petitioner testified that his pain is basically gone but he doesn't have any "pull" power. He doesn't feel safe or secure to bend over and put his arm straight without feeling it will dislocate again. He testified that he can't raise his arm out perpendicularly and cannot lift it overhead. He eats left-handed or leans his right arm against the table to use his right hand, noting he can use his right hand better than the left hand. He testified he can't shave because he can't hold his right arm up to his face long enough and can't articulate as needed with the left hand. He puts his belt on his pants before he puts the pants on. With driving, he has to use his left hand. He basically had to learn how to do everything left handed. He has used a computer, but minimally, and is not really able to type. He has wi-fi for his TV, but he doesn't use a computer at home, indicating he goes to the library because their internet is faster for surfing the web. He knows nothing about Microsoft programs.

In reviewing the job logs (Px21), Petitioner testified he generally knows his town and would drive around looking for work. He hadn't applied for a job in years and he said they would look at him like he was crazy because they don't take in-person applications anymore, you have to go online. After 15 to 18 places or so, he started looking for work on the internet. He indicated he figured out how to search a job website and then apply directly to a prospective employer's website. Petitioner testified he had no resume writing training, and no one offered such training. He was never trained in the job search process. He testified he didn't know how to

formally log job applications, so he just tried to write down the information. He indicated it would take him a significant amount of time to complete applications because of the information he needed to provide, so he would get maybe 2 or 3 done per day this way at the library. He received a few responses, but those responses indicated the prospective employers either weren't hiring, or that someone else got the job or that they were going in a different direction.

On cross-examination, Petitioner denied telling his physical therapist at Athletico that he had been using a chain saw, indicating he does not own one, though he agreed he may have told the therapist that he had back pain trying to fix his lawnmower. He agreed he is able to drive with an automatic transmission and has driven some distances, such as to Indianapolis to see his daughter. The Petitioner had a heart attack in January 2015, underwent surgery in March 2015 and then cardiac rehabilitation. He has had no ongoing heart treatment and no doctor has indicated he is restricted from activities due to his heart. He testified he had already been restricted to 5 pounds of lifting when this condition arose.

Petitioner is receiving Social Security Disability (SSDI), approximately $1,340.00 per month. He acknowledged he may have told counselor Belmonte he was afraid of losing his SSDI benefits but testified this wasn't because he was concerned about finding a job, since he would not need such benefits anymore if he had a job.

Petitioner told counselor Belmonte that his daughter helped him prepare a resume (Px21), but he couldn't recall if he actually showed it to Belmonte or not. He did drive a Class C truck (20,000 pounds or less) in some of his jobs to perform deliveries. He did some work as a supervisor while working for Kel Mel, testifying he ended up being the guy who would get job tickets in the morning, copy them and hand them out to the other workers while still doing his regular job. Petitioner agreed he worked from 2001 to 2006 at O'Gorman performing cabinetry. He measured job sites, and as to his indication in his resume that he worked to "design kitchen layouts", he explained what this related to was being on a jobsite and creating a design by hand using pieces of cardboard to illustrate a customer's options. He's had no formal training in kitchen design.

As to the resume indicating he performed Quickbooks/Payroll/Maintenance while at Curves, he testified that someone put Quickbooks on the computer for him and showed him how to enter information in order to printout payroll checks. He believed he told counselor Belmonte about his work at Curves but was not positive. At Curves, there were six employees, including his wife and daughter, and Petitioner testified he was in charge of getting payroll done.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's right shoulder condition is causally related to the 2/22/13 work accident. The parties stipulated that a compensable accident occurred on that date. The Petitioner's unrebutted description of the incident wherein he was putting a heavy door in a crate with a co-worker when he felt a pop in his right shoulder. It appears to the Arbitrator that the Petitioner had preexisting degeneration in the right shoulder, however the work accident via a chain of events analysis was certainly a cause of the right shoulder condition after the accident. There was no evidence presented that Petitioner had any prior problems with his right shoulder despite the evidence indicating he regularly had to lift, maneuver and carry heavy doors and door frames, and he testified he had no previous problems. The Petitioner was subsequently diagnosed with a massive right rotator cuff tear, repair surgery failed, and he ultimately underwent a right reverse total shoulder

replacement and then a revision when the shoulder dislocated after the first replacement. The original surgery replacement surgery also involved a partial latissimus dorsi transfer. The preponderance of the evidence indicates that all this treatment occurred as a result of the 2/22/13 accident.

Some of the presented evidence seems to indicate there may have been a question about how the Petitioner's replaced shoulder became dislocated in terms of whether the Petitioner was lifting a bag of dog food or not. A significantly greater weight of evidence supports that the shoulder dislocation occurred mainly because of how the Petitioner was positioned while he was reaching. Either way, the Petitioner was not performing some unreasonably heavy or unadvised activity when the shoulder dislocated, and certainly not anything that would terminate the ongoing causal relationship of the right shoulder to the 2/22/13 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:

It is clear to the Arbitrator based on the stipulated accident, the above noted findings regarding causation and a thorough review of the medical records in evidence that the treatment rendered to Petitioner for his right shoulder between 2/22/13 and 7/12/16 was reasonable and necessary due to the 2/22/13 accident. He had a complicated situation with a massive rotator cuff tear and repair that ultimately failed. This resulted in the reverse shoulder replacement and revision that left him with symptoms of pain, loss of motion and weakness, for which he underwent a significant amount of physical therapy.

Very few of these expenses were entered into evidence. A bill from St. James Hospital (Px8) indicates it was paid by workers' compensation and has a zero balance. Petitioner also presented a bill from Marian Physical Therapy which indicates payment from workers' compensation that, along with write-offs and discounts, carries a zero balance. (Px6). Billing from Athletico indicates the bills were paid with a zero balance. (Px9).

There is a $1,500.00 bill from South Suburban Open MRI from 3/18/13 (Px4) which does not indicate a zero balance, and for which the Arbitrator was not able to decipher Respondent's evidence of payment (Rx5) to determine if this was paid or not. If not, the Respondent is liable for same.

It appears that the only related medical expense that remains unpaid with certainty is the 7/12/16 bill of Dr. Mass, totaling $1,073.00. (Px14). Respondent argues that this bill was incurred after Dr. Marra had determined the Petitioner had reached MMI. The Arbitrator finds that this visit was more than reasonable given that Dr. Mass asked him in January 2016 to follow up in six months, including updated x-rays. The Arbitrator finds that the Respondent is liable for this bill.

The Respondent is entitled to credit if the awarded medical expenses was paid by Respondent prior to hearing pursuant to Sections 8(a) and 8.2 of the Act.

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

It is unclear to the Arbitrator what the dispute is regarding temporary total disability benefits in this case. The Request for Hearing form (Arbx1) indicates the Petitioner claims entitlement to TTD benefits from 3/14/13 through 10/13/16. The Respondent's Statement of Exceptions acknowledges the Petitioner is entitled to TTD

benefits from 3/14/13 through 10/13/16. It is obvious to the Arbitrator that the TTD incurred is causally related to the work accident and right shoulder condition. The Arbitrator finds the Petitioner is entitled to TTD benefits from 3/14/13 through 10/13/16.

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

The Arbitrator finds that the Petitioner has failed to prove that he is permanently and totally disabled. The Arbitrator also finds that the Petitioner has failed to prove entitlement to wage differential benefits.

In *Ceco Corp. v. Industrial Comm'n*, 95 Ill.2d 278, 447 N.E.2d 842 (1983), our Supreme Court stated that an employee is permanently and totally disabled when he is unable to make some contribution to the work force sufficient to justify the payment of wages. It was further indicated that a person is totally disabled when he is incapable of performing services except for those for which there is no reasonably stable labor market. In determining the employment potential of a claimant, the Court considered the claimant's age, education, training and experience. *Id.*

The Arbitrator acknowledges that the Petitioner sustained a severe and disabling injury to his right shoulder, which is his dominant arm. He also had been provided with significant physical restrictions by Dr. Marra of no lifting over 5 pounds and no overhead use of the arm. However, as indicated by counselor Bose, the "desk duty" restriction indicated by Dr. Mass was not indicated to be permanent.

The Arbitrator believes there are two significant things that fail to support a permanent total disability finding in this case. The first is the failure of Petitioner to inform counselor Belmonte, and counselor Bose, about his ownership of the Curves facilities and whatever the totality of his work activities were while there for two years. This was either a significant oversight on the part of the Petitioner or a purposeful withholding of important information. It is difficult for the Arbitrator to conclude that this was an oversight given the glaring difference between that activity and the Petitioner's career as a trim carpenter. While the vast majority of his work experience has involved finish carpentry, a clearly physical job, his activities in owning and working for his own business may well have been something that significantly expanded his transferrable skills, particularly in more sedentary-type jobs. Petitioner failed to give the counselors in this case the opportunity to consider this information.

Secondly, the evidence presented at hearing also was lacking with regard to the vocational process the Petitioner was involved in following his reaching of MMI. While both parties obtained vocational expert analysis in this case, no vocational services in the form of testing, training and job placement were performed. No evidence was presented as to whether the Petitioner requested formal vocational rehabilitation services from the Respondent, whether this was discussed with Julie Bose, or whether Joe Belmonte's vocational rehabilitation plan had ever been presented to Respondent. The appearance of an initial labor market survey may have resulted in, based on the Arbitrator's experience, an attempt by the parties to amicably settle the claim prior to Petitioner starting a job search. No evidence was presented, such as letters or emails, regarding a demand from Petitioner for such services a denial of such services from Respondent. There are significant gaps in time between the Petitioner being provided with restrictions from Dr. Marra (1/16) and the evaluation by Julie Bose (8/16), and then in the time between counselor Bose interviewing Petitioner and the evaluation by Joe Belmonte (12/17). Petitioner last saw Dr. Mass in 7/16, but both counselors relied upon the restrictions instituted by Dr. Marra. As noted, it was not clear to the Arbitrator at all that Dr. Mass' desk duty restriction was permanent, as he was asking for an FCE.

The Petitioner's self-directed job search was missing key pieces of information that would typically be included in job logs, such as who he may have spoken to and whether he followed up in any way. These searches totaled approximately two months over two years. While Petitioner stated that he looked for many other jobs, he did not testify to or provide documentary proof of when this occurred, who he contacted, whether the jobs were within his restrictions, etc. This is a case where the Petitioner would have a solid likelihood of obtaining vocational rehabilitation services, but the case was tried on a permanency basis and vocational services were not requested at the hearing.

It is difficult to reconcile the Petitioner's indication that he was using a chain saw in the records of Athletico with his denial of this at the hearing. He acknowledged he may have indicated he was working on a lawnmower.

Taking all of this evidence into consideration and weighing it, the Arbitrator finds that the Petitioner has not provided sufficient evidence to show that he is permanently and totally disabled under an odd-lot theory.

While the Petitioner has clearly shown that he has become incapacitated from pursuing his usual and customary line of employment pursuant to Section 8(d)1, for reasons similar to those noted in the Arbitrator's analysis of permanent total disability, the Petitioner has not sufficiently shown what he may be capable of earning. As such, the Arbitrator finds that the Petitioner has also failed to prove entitlement to a wage differential award.

While the Arbitrator finds that the Petitioner failed to prove that he is permanently and totally disabled from any working in any stable labor market or that he is entitled to a wage differential award, he nonetheless has quite clearly sustained a very significant right shoulder injury which has resulted in significant ongoing impairment to its function and strength. He sustained a massive rotator cuff tear, a failure of the repair, a biceps tenotomy, latissimus dorsi transfer and reverse total shoulder replacement and revision of same following a dislocation. This injury therefore involved multiple shoulder area muscles, including the rotator cuff, the latissimus, the deltoid and the biceps.

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

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the Respondent submitted an AMA permanent partial impairment rating into evidence that was provided by orthopedic surgeon Dr. Lieber. He testified that there was an impairment rating of 46% of the right upper extremity, which would translate to 28% of the body as a whole, based on the 6th Edition of the AMA Guide. 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, and that this factor does carry reasonable weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a finish/trim carpenter and was building custom doors at the time of the accident. The evidence is very clear that he is not able to return to work in this prior capacity as a result of the 2/22/13 accident and subsequent surgeries. This factor carries significant weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 54 years old at the time of the accident. The Arbitrator notes that the testimony of counselor Belmonte indicated that Petitioner's current age is in general a negative factor in a competitive search for employment. This factor carries some weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner was earning $650.41 per week with the Respondent at the time of the accident. This equates to a full-time wage of $16.26 per hour. Based on the vocational evidence produced in this case, it is clear the Petitioner suffered a loss of earning capacity in this case. This is a significant factor in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner suffered a massive rotator cuff tear as a result of the accident. Arthroscopic repair using anchors failed and the Petitioner ultimately underwent a reverse total shoulder replacement surgery which had to be re-done after the prosthetic dislocated. The Petitioner testified that he really does not have any significant pain at this point, but that his range of motion and strength have been significantly impacted by the accident. This is supported by Respondent's Section 12 examiner Dr. Marra and the heavy restrictions that have been placed on Petitioner's work activities. The records of Dr. Mass also corroborate the Petitioner's complaints.

The Arbitrator finds that while Petitioner lacked evidence to support an odd-lot permanent total disability award, it is abundantly clear that his injury was serious, he has been left with significant ongoing disability and he may not ever find any competitive labor market employment. This is supported by the opinion of counselor Belmonte, but the Arbitrator finds it significant that the Petitioner left out information about his experience with and at Curves. While the Arbitrator has noted some issue with the Petitioner's credibility in this case to some extent given the failure to mention his involvement with Curves to the vocational experts and the indication twice in the Athletico records that the Petitioner was using a chain saw while he denied owing one, the facts of the Petitioner's physical injury and ongoing physical difficulties is very credible. The injury has clearly resulted in the loss of a trade that he has worked in essentially all of his life. That trade involves physical work that involved forceful use of both upper extremities, particularly the dominant right arm. His restrictions are significant based on the opinions of Dr. Mass, Dr. Marra and Dr. Coe. His AMA impairment rating is significant, and this is a case where there it is clear that the disability based on the Petitioner's main job skills is much greater than the just the physical impairment evaluated by the AMA guide. Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the

Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 65% of the person as a whole pursuant to §8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GLENDA PERRY,

Petitioner,

vs.

NO: 06 WC 15927

19IWCC0592

SPEEDWAY SUPER AMERICA,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. Per the remand order, dated December 2, 2014, the Honorable Robert Lopez Cepero remanded this matter to the Commission to make a "credibility determination with reasonable basis on medical opinions as to work capacity." The remand order further stated that the court "narrowed the review to the medical opinions only," and has instructed the Commission to issue a supplemental decision of its "determination of the credibility of the medical opinions and the reasonable basis as to [Petitioner's] work capacity."

After receiving the remand order, the parties advised the Commission that they were attempting to settle this matter. The matter was regularly continued on the Commission's review call with the parties providing routine status updates. The parties, however, recently advised the Commission that a settlement was no longer possible. This decision, therefore, follows.

Procedurally, this matter was tried before Arbitrator Robert Falcioni on November 2, 2012. Arbitrator Falcioni found that the Petitioner was permanently and totally disabled as of November 12, 2011. The Arbitrator further awarded maintenance benefits from July 10, 2010 through November 11, 2011, and medical expenses totaling $11,225.82.

In support of his Decision, the Arbitrator found the testimony of Dr. Deutsch credible and the testimony of Dr. Dasari compelling. Dr. Deutsch found that the Petitioner suffered from severe, permanent restrictions in her lumbar spine following the two fusions. The restrictions were consistent with Petitioner's resulting physical condition, her continuing physical complaints, the description of her physical capabilities, and the result of the July 2010 FCE and the later 2012 FCE. The Arbitrator found the Petitioner credible and that she fully cooperated with vocational rehabilitation. Petitioner established that she was permanently and totally disabled. Thereafter, the Respondent appealed to the Commission.

The Commission, in its Decision dated April 28, 2014, found that the Petitioner failed to prove that she was permanently and totally disabled and awarded 65% man-as-a-whole. In support of its Decision, the Commission found that Dr. Deutsch testified, in part, that Petitioner was not permanently and totally disabled and could work with restrictions. The Commission noted that the July 6, 2010 FCE revealed that Petitioner could perform at the sedentary level. However, the Commission noted that Petitioner refused to complete all the activities required during the FCE. The Commission also was not persuaded by the June 2012 FCE results as Mr. Hornbuckle, who administered the test, acknowledged Petitioner could do more physically than she was demonstrating. Despite this, Mr. Hornbuckle still found Petitioner could not work full or part-time.

The Commission found that Petitioner intentionally restricted her capabilities during the FCE. The Commission found no evidence to support Petitioner's subjective complaints and that there was no evidence that Petitioner could not work without endangering her health or life, or that she was permanently and totally disabled. The Commission then found that Petitioner failed to prove that she was permanently and totally disabled under the odd-lot theory as she failed to prove a diligent but unsuccessful job search or that she was not able to be regularly employed in the labor market. The Commission noted numerous instances that called Petitioner's credibility into question. The Commission was of the opinion that Petitioner was intentionally restricting her ability to secure employment.

The Circuit Court remanded this matter to the Commission to make a credibility determination with a "reasonable basis" on the medical opinions as to Petitioner's work capacity. The court narrowed the Commission's review to the "medical opinions only" and ordered the Commission to issue a decision as to its determination of the credibility of the medical opinions and the reasonable basis as to Petitioner's work capacity.

The Commission has re-reviewed the medical opinions and affirms its previous opinion that the medical evidence does not support that Petitioner is permanently and totally disabled. Dr. Deutsch's February 17, 2012 examination revealed that Petitioner had a negative straight leg raise and no tenderness to palpation of the lower back. Dr. Deutsch noted that Petitioner had a solid fusion during his examination. When deposed, Dr. Deutsch opined that Petitioner was not permanently and totally disabled. Dr. Dasari agreed that Dr. Deutsch was in the best position to determine Petitioner's permanent restrictions. The Commission finds Dr. Deutsch statement's persuasive as he had a long history of treating the Petitioner.

In further support of its decision, the evidence established that Petitioner was not giving a full effort during her FCE and refused to complete all the activities required by the FCE. The FCE was not a full representation of Petitioner's ability due to her self-limiting behavior. The Commission stands by its previous opinion that there was no objective evidence to support Petitioner's complaints. The Commission finds no credible medical evidence supporting that Petitioner is permanent and total disability.

The Commission re-affirms its prior findings and opinions that the evidence establishes that Petitioner was self-limiting and intentionally restricting her ability to secure employment. Petitioner, therefore, failed to prove that she is permanently and totally disabled.

Having answered the question posed by the Circuit Court, the Commission re-affirms its prior decision dated April 28, 2014.

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

DATED: OCT 3 1 2019

DMM/tdm
d: 10/29/19
052

D. Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

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

Mahmmud Abubaker,
Petitioner,

vs. No. 17 WC 23897

Waldorf Astoria Hotel,
Respondent.

19IWCC0593

DECISION AND OPINION ON REVIEW

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

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 1, 2018, is hereby affirmed and adopted.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 9,300.00. 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 31 2019

Marc Parker

mp-wj
10/17-19
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) ARBITRATOR DECISION

ABUBAKER, MAHMMUD
Employee/Petitioner

Case# **17WC023897**

WALDORF ASTORIA HOTEL
Employer/Respondent

19IWCC0593

On 5/1/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.99% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0307 ELFENBAUM EVERS & AMARILIO
JOSEPH D AMARILIO
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

1139 NOBLE & ASSOCIATES PC
DENNIS J NOBLE
387 SHUMAN BLVD SUITE 210E
NAPERVILLE, IL 60563

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)

Mahmmud Abubaker
Employee/Petitioner

v.

Waldorf Astoria Hotel
Employer/Respondent

Case # **17** WC **23897**

Consolidated cases: **n/a**

19IWCC0593

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **November 30, 2017** and **December 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. 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 provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. X Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ____

FINDINGS

On the date of accident, **5/20/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**67,318.68**; the average weekly wage was $**1,294.59**.

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

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

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

Respondent is entitled to a credit of $**298.60** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**502.73**/week for **14** weeks, which was for a period that commenced on **8/25/2017** and carried through **11/30/2017**, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for the right shoulder surgery that Dr. Wolin has prescribed, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay the outstanding charges for the reasonable and necessary medical services rendered to Petitioner in the amount of $**2,160.00**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

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

Signature of Arbitrator

April 30, 2018
Date

MAY 1 - 2018

State of Illinois)
)
County of Cook)

BEFORE THE
ILLINOIS WORKERS COMPENSATION COMMISSION

19IWCC0593

Mahmmud Abubaker,	)	
	)	
Petitioner,	)	**Setting: Chicago**
	)	
v.	)	**Arb. Brian Cronin**
	)	
Waldorf Astoria Hotel Chicago,	)	**IWCC No. 17WC 23897**
	)	
Respondent.	)	

Hearing under Sections 19(b)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The matter was heard before Arbitrator Brian Cronin on November 30, 2017. The parties stipulated to the occurrence of an accident on May 20, 2017 and further stipulated to an average weekly wage of $1,294.59, inclusive of concurrent employment. In dispute are causation, payment of medical bills, TTD and prospective medical care.

Proofs for re-opened on December 19, 2017 to allow the admission of Joint Exhibit 1, which is the Supplemental Stipulation As To Concurrent Wages. Proofs were then closed.

A. FINDINGS OF FACT

1. Petitioner's Work History and Job Duties

Petitioner testified that he had worked at Respondent's hotel as a houseman since April 2011, when it was known as The Elysian. In November 2011, it became the Waldorf Astoria Chicago. His job title is Houseman. Petitioner testified that he worked a 40-hour week at the Waldorf. His scheduled days were Sunday, Monday, Tuesday, Wednesday and Saturday. He also has a second, part-time job at the Hotel Sax (HEI Hotels) on Thursdays, Fridays and Sundays. Sunday was the only day he was scheduled to work both jobs. Petitioner's duties as a

Houseman for Respondent included moving furniture; collecting the bulk dirty linen and trash, which the Housekeeping staff would leave on the landings; and responding to guest requests.

Petitioner testified that he has lived in Chicago since 2010, and became a US citizen in September 2015. His first language is Arabic. On May 20, 2017 he was in good general health. He had never experienced any right shoulder or back injuries, or sought medical care for back or shoulder pain, and has not sustained any new injuries subsequent to May 20, 2017.

2. Date of Accident: May 20, 2017

Petitioner testified that he was injured at about 11:30 am while lifting mattresses with a co-worker, Erasto Guillen, who is also known as Tito. They had three mattresses to move. While the first two gave them no problem, the third was quite heavy. It was a California mattress, which is larger than a standard king-sized mattress. Petitioner testified that he and Tito had been told to move this large mattress from Room 701 to the 27th floor. Room 701 is a two-room suite with a common foyer and door, and in order to get the mattress out, they had to turn it. The mattress, which was folded, got stuck in the doorway. Petitioner was pulling upward on it with both hands to get it through the door when he felt pain in his back and right shoulder.

Petitioner testified that he called for extra help but no one was available. Using a dolly, he and Tito got the mattress to the elevator and took it up to the 27th floor. Petitioner then went to Security to report his injury, accompanied by Tito. He spoke to Duke, the Security Officer, in Duke's office through the window. Duke asked him to fill out a written report, which he did.

Petitioner handwrote the following statement:

> "I was movie mattress from 701 to 27 floor at 11:30 a.m. on Sat. May 20th.
> The mattress it's to heavy when I lift I feel something like sprain my back
> muscle." (Px 4)

In the typewritten Incident Report that Duke Patterson recorded on May 20, 2017, Duke wrote:

> "On the above date and time Housekeeping employee M. Abubaker reported
> to security an possible lower right-hand side sprained back injury. House-

keeping department employee M. Abubaker stated while himself and another employee Erasto (Tito) Guillen attempted to lift and transport an mattress estimated to be 300 Lbs. as stated by Abubaker and Guillen as they moved mattress from guest room 701 to the 27th FL. Mr. Abubaker immediately felt a sharp pain in his lower right hand side of his back resulting in a small but significant amount of pain. Housekeeping department employee E. Guillen did not sustain any injuries. I RSO Patterson offered Mr. Abubaker medical assistance which he declined instead in favor continuing his work. Abubaker also stated that he just wanted to report the incident for future reference just in case the injury became worst. Mr. Abubaker Swiftly returned back to his regular duties with relative good spirit. At this time no further information to report." (Px 5)

Petitioner testified that he told Duke that Tito was a witness, and that Duke replied that he did not need a witness statement. After he wrote the report, Duke asked if he needed medical attention, and he replied "not now." Petitioner estimated that he was in Duke's office for about 20 minutes. He had gone there right after finishing the job, about 30 to 45 minutes after getting hurt.

Petitioner identified Px 4 as a copy of his report from the date of accident. He testified that Tito Guillen did not sign the report; he wrote the word "Tito" himself. Petitioner recalled asking Duke how to spell sprain, and shoulder. He testified that he thought he had written the word "shoulder" on the report, but agreed it was not there. Shown Px 5, Respondent's Case Incident Report, Petitioner testified that the first time he had seen it was the day before the hearing. He did not type it, and those are not his words. He did not tell anyone he would "swiftly return to work" and was not sure what "swiftly" meant.

Petitioner testified that after finishing his report, he went to his manager and informed her he had hurt himself while lifting a mattress. He asked if he could be spared from lifting for the rest of the day. She agreed, and asked him to just handle guest requests.

Petitioner testified that he finished his shift at 5:30 pm, and got home around 6:15. He took a shower, ate dinner and then sat on the couch for a while. When he tried to get up from the couch, Petitioner testified, he had bad pain in his shoulder and back. He took some Advil, rubbed Ben-Gay on his back and arm, and went to bed about 10:00 pm. The next morning, he

woke up early, about 5:00 am, in pain. He testified that could not lift his arm past his chest; it was too painful. Petitioner testified that he was scheduled to work for Respondent that day, but called and said that he could not come in. He recalled saying that he got hurt yesterday, and that the pain was worse. He did not remember to which Security Officer he spoke, and did not believe he specified the injured body parts. Px 9 consists of a photocopy of text message from Petitioner's manager, Joana, with accompanying timesheet, confirming that he had called off work on Sunday, May 21, 2017.

Petitioner testified that he did go to Hotel Sax, where he was scheduled to start work at 3:00 pm. He met his boss, James Spirek, in the office shortly before 3:00 pm, because his boss had wanted to give him some instructions for a special VIP guest. Petitioner told Mr. Spirek he had hurt his shoulder and could not lift his arm very high, and asked if he could be spared from any heavy lifting. He mentioned his back as well. Mr. Spirek said OK. Petitioner told him he would see a doctor the next day (Monday), when he would get a form to go to Concentra, the Waldorf's occupational health clinic. Petitioner finished his shift but his pain continued.

On cross-examination, Petitioner testified that when he went down to Security to see Duke, Petitioner knew the difference between a shoulder and a back. Petitioner testified that he thought he himself had written down "shoulder" in the report, but he had not. Petitioner testified that he did not seek medical treatment on May 20, 2017 because he thought he could work through it. Petitioner testified that the "pop" in his right shoulder, to which he testified, is not in the Concentra records. However, Petitioner did tell Dr. Westin about this "pop" because Westin asked him to please be specific.

3. Medical treatment at Concentra and light-duty work restrictions

On Monday, May 22, 2017 Petitioner reported to the Waldorf Astoria, Respondent's hotel, at 6:00 am. He testified that he asked his manager for leave to go to Concentra for treatment of his work injury. The manager said they were short-staffed, and he would have to stay until the next houseman reported for work. Petitioner arrived at Concentra around 1:00 p.m., and brought with him the form he had gotten from Duke Patterson in Security. The clinic staff told him they were very busy and could not see him right away. Petitioner had agreed to work at the Hotel Sax that day, starting at 3:00 pm, to help with arrangements for the CEO's visit. He was therefore given an appointment at Concentra for the next day, May 23, 2017.

Pages 3-5 of the Concentra records (Px 2) contain forms filled out by Petitioner and dated Monday, May 22, 2017. They include a screening questionnaire which confirmed he had no symptoms that would demand immediate attention such as a head injury, chest pain or active bleeding. When shown Px 2, p. 3, Petitioner identified it as the form he took to Concentra from the hotel. He had written his name and address, his date of birth and the date of accident himself. The rest of the form had been filled out by Duke Patterson, including marking the boxes for "Work related injury" and "Employee to pay."

On Tuesday, May 23, 2017, Petitioner was seen at Concentra by Abbas Al-Saraf, M.D., who noted a history of a work injury on May 20, 2017 while lifting a heavy mattress. In the Patient Information form, which Petitioner completed, he wrote that on "5/20/17" at "11:30 a.m.," in Room 701, he injured his "back and Arm right." When asked "How did the injury happen?", Petitioner wrote:

> "I was moving heavy mattress with my co worker when I felt something happen in my back after one day my arm hurt to bad."
>
> (Px 2, p. 6)

Petitioner reported constant, moderate pain in the right lateral shoulder and right lower back, which was worse when lifting, bending or elevating his arm. *Id.*, pp. 9-10. He reported that his back pain seemed to be improving since his injury, while his shoulder pain was worsening. *Id.* Dr. Al-Saraf diagnosed a strain to the right shoulder, back and right upper arm. He prescribed Ibuprofen, hot and cold packs, and physical therapy. Dr. Al-Saraf also restricted Petitioner to light-duty work with occasional lifting of 10 pounds or less and no reaching above shoulder level. *Id.*, pp. 12-13.

Petitioner continued to receive physical therapy and medical rechecks at Concentra. On June 1, 2017, Dr. Al-Saraf noted that his back pain was much improved but his shoulder pain was less so. By June 7, 2017, the physical therapist reported that Petitioner's back pain had resolved completely (0/10). *Id.*, p. 36. However, his shoulder pain remained at 7/10 and interfered with sleep. Dr. Al-Saraf ordered an MRI and an orthopedic consult. *Id.*, pp. 39-40.

4. Concentra's specialist recommends surgery; denied by Respondent

On June 13, 2017, Petitioner was examined by orthopedic surgeon Craig Westin, M.D., at

Concentra. (Px 2, p. 43) Dr. Westin noted a history of injury while moving a heavy mattress through a doorway. Petitioner reported a popping sensation in his shoulder at the time of injury, which became more painful that night. *Id.* Dr. Westin's examination showed evidence of a rotator cuff injury and/or labral tear, and he ordered an MRI with contrast. *Id.*, p. 44. The MR images, taken on July 6, 2017, were interpreted as showing a SLAP II-type tear of the glenoid labrum along with possible biceps tenosynovitis. (Px 1, p. 16) Based on the results, Dr. Westin recommended surgery. Dr. Westin agreed this could be scheduled in August upon Petitioner's return from a long-planned trip home to Jordan. (Px 2, p. 45)

Petitioner testified that Respondent denied authorization for surgery in July. He continued to work light duty at Waldorf through August 24, 2017, when he was informed that he had reached his yearly limit for light duty.

5. <u>Surgical recommendation from Dr. Preston Wolin</u>

Petitioner testified that following denial of further care by Respondent's workers' compensation carrier, his primary care doctor referred him to another orthopedic surgeon, Preston M. Wolin, M.D. On August 25, 2017, he consulted Dr. Wolin. (Px 1, p. 6) Upon examining Petitioner and reviewing his history along with the MRI, Dr. Wolin concurred with the need for surgery. He recommended an arthroscopic surgery to repair the labral tear, along with possible open biceps tenodesis. *Id.*, p. 9. He also authored a work status report in which he placed Petitioner on sedentary work restrictions, and indicated his diagnosis of right shoulder labral tear was work-related. *Id.*, p. 10.

On August 29, 2017, Dr. Wolin completed forms that placed Petitioner on FMLA leave for a "right shoulder work injury resulting in SLAP tear in right shoulder which requires surgical fixation." (Px 1, p. 35) On October 20, 2017, he prescribed work restrictions for Petitioner that consisted of no repetitive or over-the-shoulder work with the right arm, with a five-pound weight limit. These would be in effect through the date of surgery, which Dr. Wolin indicated was "awaiting insurance approval." *Id.*, p. 33.

6. <u>Testimony of James Spirek</u>

James Spirek testified that he is Director of Housekeeping at HEI Hotels, of which Hotel Sax is a property, and that he supervises about 50 employees. He knows Petitioner as "Mike" or

"Michael", who works for HEI as a Lobby Attendant. This is a fairly light job that includes cleaning the lobby and other public spaces, and fetching items for guests. Mr. Spirek was in his office on Sunday, May 21, 2017 when Petitioner came in to report he had hurt his arm the previous day at the Waldorf, moving a mattress. He asked for permission to take it easy a little bit at work that day, and avoid heavy lifting. Mr. Spirek said that would be OK, and advised him to be sure to see a doctor. Mr. Spirek testified that he remembered the date because he had a VIP service request that day, which he had discussed with Petitioner. They were expecting a visit from the CEO of HEI.

Petitioner has continued to work at HEI since his injury, and Mr. Spirek has been accommodating his restrictions. He testified that this has not been a problem as Petitioner's job requires no furniture moving and very little heavy lifting. From time to time Lobby Attendants are asked to move mini-fridges in and out of guest rooms. Mr. Spirek testified that he assigns this job to another employee. He has spoken briefly to Petitioner about his injury, and his discussion mainly concerned schedule adjustments. He has had one brief conversation with Petitioner's lawyer, who sent him a subpoena to appear and testify.

7. **Testimony of Erasto Guillen**

Erasto Guillen (known to his co-workers as Tito) has worked for Respondent for just under a year as a Houseman. He recalled working with Petitioner on May 20, 2017, when they moved a heavy, king-sized mattress that weighed about 200 pounds. Mr. Guillen testified that Petitioner told him he had injured himself, and complained of back pain, but did not mention any pain in his arm or shoulder. Mr. Guillen accompanied Petitioner to Security to file an accident report.

Mr. Guillen testified that he later received a call from someone in the Housekeeping Department, who told him to go see Duke in Security and fill out a statement regarding Petitioner's accident. He could not recall the name of the person who had called him. Mr. Guillen identified Rx 1 as that statement, which is dated August 2, 2017. On direct, he testified that both the handwritten statement and the signature were his own.

Mr. Guillen testified that he had spoken with Petitioner only once since completing his written statement. On September 13, 2017, he received a text message from Petitioner asking him to call right away. He texted back that he would call in ten minutes. Mr. Guillen testified

that he did not actually return the call that day, as he was busy. The next day he received another call from Petitioner, and agreed to speak to Petitioner's lawyer who was connected via a three-way conference call. He told the lawyer he did not know anything about Petitioner's shoulder injury, and that Petitioner had not mentioned his shoulder pain on the date of accident. Shortly afterwards he got a text from Petitioner expressing anger and disappointment with his testimony. Mr. Guillen identified Rx 2 as a printed copy of the texts in question from his cell phone.

Mr. Guillen agreed that he did not take any notes on the date of accident. He testified that he went down to the Security Office with Petitioner that day, but did not talk to Duke himself. He could not recall whether he worked the next day. He did not recall when he next saw Petitioner, but thought it had been after Petitioner began working light duty. Petitioner told him about the shoulder injury at that point. He did not know which shoulder Petitioner had injured.

On cross-examination, Mr. Guillen first admitted that he had had "help" from his manager in completing his witness statement of August 2, 2017, because "my English is not too strong." He continued to maintain that he had actually written the statement. Petitioner's Counsel then gave him pen and paper, and asked him to write down a brief phrase from his own alleged statement: "Miky ^ I were removed forniture." Mr. Guillen was unable to do so. His attempt, submitted by Petitioner as Px 10, shows not only that he could not spell the English words involved, but also that his handwriting was quite different from that on the statement. Mr. Guillen then admitted that he did not in fact write the statement, but had merely signed it.

8. <u>Testimony of Duke Patterson</u>

Duke Patterson testified that he worked for Respondent as a Risk and Safety Officer. His duties are to protect the hotel's property and assets. One of his jobs is to take employee incident statements, including reports of injuries. He has a small office on the ground floor of the hotel, with a glass window, where he takes employee reports.

On May 20, 2017, Mr. Patterson met with Petitioner in his office. He testified that Petitioner asked to file a report, which he believed was about a back injury, and that Petitioner "gave me a statement which I compiled into a report." Mr. Patterson identified Px 5 as his report. It is dated May 20, 2017 at 12 pm, about 30 minutes after Petitioner's injury, which occurred at about 11:30 am. He testified that his statement that Petitioner "swiftly returned to

regular duties with relative good spirit" was based on Petitioner's demeanor. Tito Guillen was there initially, then left. Mr. Patterson testified that he did not watch Petitioner fill out an incident report; rather, Petitioner took the form and then brought it back. He testified that he had also taken a statement from Tito Guillen that day. He did not recall if he had incorporated Mr. Guillen's statement into his own. He did not know where that statement was now, as he could not recall where he had put it.

On cross-examination, Mr. Patterson denied speaking to Petitioner since taking his statement. When shown Px 2, p. 3, he testified he had filled out that form on May 22, 2017. He agreed that he authorized a visit to Concentra, and had spoken with Petitioner at that time. He stated that he had taken Mr. Guillen's later written report, Rx 1, and had watched him write it. He could not recall if he had signed it, as a witness or otherwise. On redirect, when asked if Mr. Guillen had made a statement on the date of accident, Mr. Patterson said that it was "highly possible," and that he "believed" he had done so. No such statement, however, was produced or introduced into evidence.

9. <u>Petitioner's testimony on rebuttal</u>

Petitioner testified that he and Tito Guillen had actually spoken by phone for five to ten minutes on September 13, 2017, after their initial exchange of texts. Because he recalled having mentioned to Tito on the date of accident the pop and pain in his shoulder, Petitioner asked him to testify to this at his upcoming hearing. At that time Mr. Guillen had said he remembered Petitioner complaining about his shoulder that day, and told Petitioner he would testify.

Petitioner testified that he heard his lawyer's conversation with Mr. Guillen the next day, as he was included via conference call. The lawyer was in his office and interviewed Mr. Guillen with the help of a Spanish interpreter, using a speaker phone. That was when Mr. Guillen changed his story, and claimed that Petitioner had only mentioned back pain on the date of accident. Petitioner testified that he sent the text in Rx 2 because he was upset with Mr. Guillen for lying. However, he did not threaten him in any way. Petitioner also testified that he had written his report on the date of accident in the Security Office, with Duke watching. He did not take the form away and bring it back.

10. Petitioner's current condition

Petitioner testified that he has continued to work at Hotel Sax three days a week. He has not lost any time from that job. He needs to work two jobs because he supports two families. Besides himself and his wife, he also supports his mother in Jordan. He supported his father, as well, until his death a year ago. Because his duties at Hotel Sax are lighter, he can manage that job with a little help, and his boss has continued to accommodate him. He cannot move the mini-fridges which weigh over fifty pounds, so someone else does that. He is able to drive.

Petitioner testified that he has problems with any overhead activity. It is painful to lift his arm above 90 degrees, or "a little lower than shoulder level." He indicated anterior-superior pain from his shoulder down to his elbow. He also has trouble reaching behind his back, and his wife has to help him into his jacket when getting dressed. Petitioner testified that he wishes to return to Dr. Wolin and to undergo the surgery that he has prescribed.

B. CONCLUSIONS OF LAW

The Arbitrator incorporates by reference the preceding findings of fact, and concludes:

As to issue "F", whether Petitioner's present condition of ill-being is causally related to his injury, the Arbitrator finds as follows:

Petitioner testified to a May 20, 2017 accident in which he injured his right shoulder and low back while moving a heavy mattress with a co-worker. That the accident occurred is not in dispute. Also undisputed is Petitioner's report of the accidental injury approximately one-half hour later. What is in dispute is the body part or parts affected by such accident. Petitioner alleges that he promptly reported an injury to his low back and right shoulder on May 20, 2017, while Respondent claims that Petitioner only reported an injury to his low back that day.

Respondent asserts that Petitioner's accident of May 20, 2017 resulted in only a low back injury, and that Petitioner's current condition of ill-being of his right shoulder is unrelated to that accident. As such, Respondent denies prospective medical care for Petitioner's right shoulder and denies additional TTD benefits.

In support of their position that only Petitioner's low back condition of ill-being is causally related to the May 20, 2017 accident, Respondent relies on the Employee Incident Statement that Petitioner authored on May 20, 2017 (Px 4), the testimony of Duke Patterson, the

Incident Report that Duke recorded on May 20, 2017 (Px 5), the testimony of Erasto "Tito" Guillen, the Employee Incident Statement that Guillen signed on August 2, 2017 (Rx 1), and a photocopy of the September 13-14, 2017 text message conversation that Petitioner had with Tito. (Rx 2)

In support of his argument that Petitioner's low back and right shoulder injuries are causally related to the May 20, 2017 accident, Petitioner relies on his own testimony. Petitioner also relies on the May 22-23, 2017, Concentra records, particularly the following statement of May 23, 2017 regarding a May 20, 2017 accident:

> "I was moving heavy mattress with my co worker when I felt
> something happen in my back after one day my arm hurt to bad."
>
> (Px 2, p. 6)

Petitioner further relies on the testimony of James Spirek, who is Director of Housekeeping at HEI Hotels, which is not a Respondent in this case. Petitioner worked as a Lobby Attendant at Hotel Sax, one of the HEI Hotels, on May 21, 2017. Spirek testified that he was in his office on Sunday, May 21, 2017 when Petitioner reported that he had hurt himself the previous day at the Waldorf while moving a mattress. Spirek further testified that Petitioner asked him if the Hotel Sax could accommodate him, given his shoulder and back injuries.

Petitioner also relies on Px 9, which is a photocopy of a text message he sent to his supervisor at Respondent, Joana, on the morning of May 21, 2017, in which he called off work that day.

Petitioner points out the inconsistencies in the testimony of Respondent witnesses Erasto "Tito" Guillen and Duke Patterson.

Petitioner's initial accident report to Respondent indicates that Tito Guillen was a witness to the accident. (Px 4) However, it was not until August 2, 2017, after learning of Petitioner's need for surgery, and almost three months after the accident, that Respondent first contacted Mr. Guillen for a "witness statement." On direct examination, Mr. Guillen testified not only that Petitioner never mentioned shoulder pain on the date of accident, but also that he himself had authored, written, and signed the statement to that effect on August 2, 2017. (Rx 1)

On cross-examination, however, Mr. Guillen testified that someone else wrote the statement for him.

Duke Patterson testified on direct examination that he watched Mr. Guillen write up his alleged statement on August 2, 2017. Duke further testified that he had taken a statement from Mr. Guillen on the date of accident.

However, on cross-examination, Duke testified that he could not produce the statement he had taken from Guillen and could not recall where he might have put it, or whether he had incorporated it into his own report. (Px 5)

An unfavorable evidentiary presumption may be made when a party, without reasonable excuse, fails to produce evidence which is under its control. *Dollison v. Chicago, R.I. & P. Railroad,* 42 Ill. App. 3d 267, 277 (1st Dist. 1976), citing *Tepper v. Campo*, 398 Ill. 496, 505 (1947) ("It is well-settled that the failure of a party to a suit to produce evidence available to him gives rise to a presumption against him.")

In this case, given Respondent's failure to produce a report from Mr. Guillen on the date of accident, it is reasonable to presume either that no such report exists, or that it would be unfavorable to Respondent if produced. Respondent's efforts to create a favorable report almost three months later (Rx 1) further support this presumption.

Although the Arbitrator finds that on May 20, 2017, Petitioner only reported low back symptoms, he then considers whether Petitioner's failure to report all of the resulting symptoms from the accident on the date of the accident, would, if proven, be a reasonable basis for denying an otherwise well-supported claim.

In *Oliver v. Illinois Workers' Comp. Comm'n*, 46 N.E.3d 914, 399 Ill. Dec. 595 (1st Dist. 2015), claimant was a construction worker who struck his elbow against a steel wall while working. He did not report an injury that day, and was laid off from the job at the end of his shift. He testified that he "did not report every bump and bruise" he received on the job, and had thought, at first, that the injury was not significant. When the elbow became swollen and painful, he consulted a doctor six days after the injury. He then contacted the employer, who refused to file an accident report. In justifying their failure to pay benefits, the employer initially cited the need to obtain medical records; however, at trial they introduced no medical evidence to deny the claim. Instead, they based their denial on claimant's failure to report his accident on the day it occurred and the foreman's testimony that claimant did not appear to be in pain on that day.

The court in *Oliver* specifically found that "*when examined along with the medical*

records and the claimant's testimony, the six-day delay in reporting the accident was reasonable. The claimant's injury worsened over the several days after his accident and did not respond to rest at home. He therefore sought medical treatment and reported his accident to the employer six days later." *Oliver*, ¶43. It was the employer's conduct that had in fact been unreasonable, and the Commission's decision to reverse the penalties imposed by the arbitrator had been both contrary to the manifest weight of the evidence, and an abuse of discretion. *Oliver*, ¶51.

By finding the employer's refusal to pay benefits to be "reasonable," the Commission had "*attempt[ed] to set a precedent that cannot be allowed; that an employee must report an accident on the day it occurs in order to be eligible for benefits. Such an idea is specifically prohibited by the Act, which provides that an accident must be reported within 45 days of its occurrence. 820 ILCS 305/6(c).*" *Oliver*, ¶45 (quoting the circuit court). The purpose of the notice requirement is to enable the employer to investigate the accident, and the claimant's report had clearly fulfilled that purpose. *Id.* at ¶40, 41. The employer's apparent same-day reporting requirement was both contrary to the law and "*unreasonable based upon the fact that many workplace injuries do not manifest themselves until days after the accident.*" *Id.*, ¶46.

In the case at bar, it is undisputed that the May 20, 2017 accident occurred when Petitioner and a co-worker were maneuvering a 300-pound California King mattress through a double door.

Petitioner testified that the mattress, which was folded over at the time, got stuck and that he tried to pull the folded mattress up to chest level when he felt popping in his back and right shoulder.

Petitioner reported the accident one-half hour after it occurred.

James Spirek testified that Petitioner reported a back and shoulder injury to him on May 21, 2017.

On Monday morning, May 22, 2017, Petitioner requested to go to Concentra for treatment, and would have done so if Respondent's own staffing needs had not interfered. On Tuesday, May 23rd, he received treatment for the first time at Concentra, and reported worsening right shoulder pain.

Following the May 20, 2017 accident, the first documented complaints of right arm and shoulder pain were on May 23, 2017.

Causation in a workers' compensation case may be established by a chain of events showing prior good health, an accident and a subsequent injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 96-97, 631 N.E.2d 724 (1994); *see also Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193, 530 N.E.2d 1135 (1988).

The testimony and medical evidence in the case at bar exhibit just such a chain of events.

There is no evidence that Petitioner sustained a right shoulder accident or injury between the time he left Respondent's premises on May 20, 2017 and the time he sought treatment at Concentra on May 23, 2017.

Moreover, Dr. Wolin indicated that his diagnosis of right shoulder labral tear was work-related.

The Arbitrator finds that by a preponderance of the evidence, Petitioner's current condition of ill-being of his low back and right shoulder are causally related to the May 20, 2017 accident.

As to issue "J", the reasonableness and necessity of medical care provided, the Arbitrator finds as follows:

The Arbitrator notes that no medical evidence was submitted that challenged the reasonableness and necessity of the care Petitioner has received to date, including physical therapy, medications and two surgical consultations. Having found Petitioner's condition to be causally related to his work accident, the Arbitrator therefore finds that Respondent shall pay the unpaid medical bills in the amount of $2,160.00 (Px 6), pursuant to Section 8(a) and subject to Section 8.2 of the Act.

As to issue "K", Petitioner's entitlement to prospective medical care, the Arbitrator finds as follows:

Having found a causal connection between Petitioner's workplace accident and his current right shoulder pathology, the Arbitrator therefore relies on the opinions of Doctors Wolin and Westin that such treatment is reasonable and necessary. Please see *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill. App. 3d 705, 691 N.E.2d 13 (2d Dist. 1997). Respondent is ordered to authorize and pay for the surgery that Dr. Wolin has prescribed, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

As to issue "L", regarding Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds as follows:

Having found causal connection, the Arbitrator therefore awards temporary total disability benefits from August 25, 2017 through November 30, 2017, or a total of 14 weeks. Petitioner has testified that he continues to perform light-duty work at his concurrent position with Hotel Sax. Therefore, such benefits shall be paid only with regard to his lost wages from his job with Respondent. According to the Supplemental Stipulation submitted by the parties on December 19, 2017 (Jx 1), Petitioner's average weekly wage with Respondent was $754.09, which results in a TTD rate of $502.73.

Brian T. Cronin
Arbitrator

4-30-2018
Date